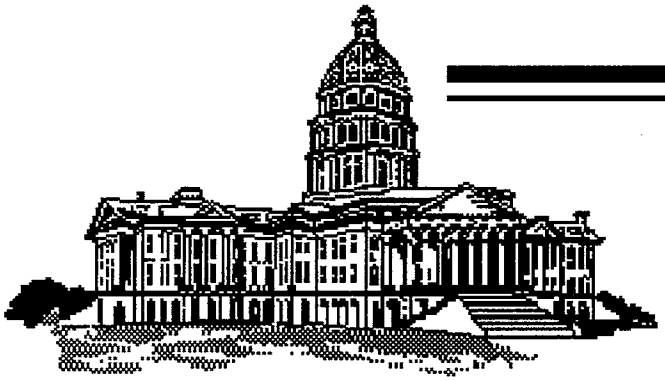

PERFORMANCE AUDIT REPORT

Reviewing the Workers' Compensation Claim By Former Insurance Commissioner Fletcher Bell

A Report to the Legislative Post Audit Committee
By the Legislative Division of Post Audit
State of Kansas
August 1994

94-38

Legislative Post Audit Committee

Legislative Division of Post Audit

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PERFORMANCE AUDIT REPORT

REVIEWING THE WORKERS' COMPENSATION CLAIM BY FORMER INSURANCE COMMISSIONER FLETCHER BELL

OBTAINING AUDIT INFORMATION

This audit was conducted by Cindy Lash, Tom Gress, and Kelan Kelly. If you need any additional information about the audit's findings, please contact Ms. Lash at the Division's office.

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Summary of Legislative Post Audit's Findings

Was the former Insurance Commissioner's workers' compensation claim handled appropriately? Mr. Bell's claim was not handled appropriately. The State Self-Insurance Fund failed to investigate the claim to ensure that Mr. Bell's injuries were compensable. It also did not seek a second medical opinion on Mr. Bell's condition before proposing a settlement. When a second opinion was sought, the Self-Insurance Fund used a doctor with whom it had little familiarity and who it has not used before or since. In addition, Fund staff did not ask the doctor to give an opinion about the relationship between Mr. Bell's injury and his degenerative back condition. The Self-Insurance Fund also failed to ask the Workers' Compensation Fund to help pay for the award even though the Self-Insurance Fund's staff knew Mr. Bell had a pre-existing degenerative back condition.

Finally, the Division of Workers' Compensation's administrative law judge who handed down the award did not use his statutory authority to have Mr. Bell's condition independently evaluated even though the judge expressed strong reservations about the disability ratings used to determine Mr. Bell's award.

How would the changes to the workers' compensation statutes made by the 1993 Legislature have affected the handling of Mr. Bell's claim? One set of changes--altering the formula used to determine disability awards for functional impairments--would have reduced Mr. Bell's award by more than half, from $94,000 to $45,000. Other changes might have helped cut the award further. Moreover, a maximum placed on functional impairment disability payments would have limited Mr. Bell's award to $50,000 regardless of the extent of his injuries.

This audit includes a recommendation for the Department of Administration to provide oversight of the Self-Insurance Fund's handling of workers' compensation claims, particularly investigation. We would be happy to discuss this recommendation or any other items in the report with any legislative committees, individual legislators, or other State officials.

Barbara J. Hinton

Barbara J. Hinton
Legislative Post Auditor

REVIEWING THE WORKERS' COMPENSATION CLAIM BY FORMER INSURANCE COMMISSIONER FLETCHER BELL

In 1989, then-Commissioner of Insurance Fletcher Bell filed a workers' compensation claim which stated he had sustained a back injury while lifting a briefcase from his car. In 1991, Bell received a total award of almost $95,000 to be paid out over several years, in addition to benefits for future medical care. After the State Self-Insurance Fund requested a review of the award in 1993, Mr. Bell agreed to a settlement in which he would forego any claim to disability compensation beyond what had already been paid (nearly $55,000), although medical benefits for the injury would be paid for life.

A number of legislative concerns were raised about the case, such as whether Commissioner Bell received preferential treatment in regard to his workers' compensation claim, and whether he had a pre-existing back injury that contributed to his disability. Other concerns included how the physicians who examined Mr. Bell were selected and whether the State handled the claim as aggressively as it would have handled a claim by a less prominent State employee. Finally, legislators wanted to know whether the new workers' compensation provisions enacted by the Legislature in 1993 would have made a difference in the handling of Mr. Bell's case, particularly the size of his award.

The Legislative Post Audit Committee authorized a performance audit to answer the following questions:

1. **Was the former Insurance Commissioner's workers' compensation claim handled appropriately?**

2. **How would the changes to the workers' compensation statutes made by the 1993 Legislature have affected the handling of Mr. Bell's claim?**

To answer these questions, we interviewed current and former staff of the State Self-Insurance Fund and the Division of Workers' Compensation to learn how the system for handling claims was supposed to work. We reviewed Mr. Bell's files at the Self-Insurance Fund and the Division of Workers' Compensation, and talked again with current and former employees of both offices to try to find out why Mr. Bell's case was handled as it was. We reviewed a sample of 27 other claims that were filed with the Self-Insurance Fund for back injuries caused by lifting. We also obtained limited information on previously reported claims by a group of 11 workers' compensation attorneys, all but one of which were handled by private insurance companies. Finally, we reviewed the changes made to the workers' compensation statutes in 1993, and determined how those changes would have affected Mr. Bell's claim.

This audit didn't–and never was intended to–look at whether Feltcher Bell injured his back lifting a briefcase from his car in the winter of 1989. Rather, it focused on whether the State Self-Insurance Fund and the Division of Workers' Compensation adequately carried out their responsibilities for this claim. The Attorney General's Office has investigated other aspects of this claim.

In conducting this audit, we followed all applicable government auditing standards set forth by the U.S. General Accounting Office.

We found four major problems in the handling of Mr. Bell's claim at the Self-Insurance Fund:

- the claim was never investigated to determine whether it was compensable
- staff appeared ready to settle the claim without a second medical opinion (and when they did get one, an unfamiliar doctor was used)
- the Workers' Compensation Fund was not impleaded to help pay Mr. Bell's award, even though he had a pre-existing condition
- physicians were not deposed at Mr. Bell's hearing before the Division of Workers' Compensation.

We also found it was not unusual for State employees' claims to be inadequately investigated by the Self-Insurance Fund. We found that the Division of Workers' Compensation did not exercise options it had available to resolve the conflicting disability ratings presented in this claim. Finally, we found that recent changes to the workers' compensation statutes would have reduced Mr. Bell's initial award by more than half. However, State law would still allow such claims to be filed and paid, so long as they were determined to be the result of a work-related injury.

These and other related findings are discussed in more detail following a brief overview of the State's system for handling workers' compensation claims.

Overview of the Workers' Compensation System For State Employees

Under current Kansas law, nearly all employers with an annual payroll of $20,000 or more (except agricultural pursuits and some other occupations) must provide workers' compensation coverage for their employees. This coverage is intended to allow employees to receive prompt medical treatment and compensation for work-related injuries without having to go through litigation.

Employers may provide the required coverage by purchasing a standard workers' compensation insurance policy from a commercial insurance carrier, by becoming self-insured, or by becoming part of a group-funded pool. The State of Kansas is self-insured. Its program is administered by staff of the State Self-Insurance Fund, located in the Division of Personnel Services in the Department of Administration.

A Workers' Compensation Claim Can Range from Payment for Limited Medical Treatment To Compensation for Permanent Total Disability

Many injured employees need only limited treatment involving a few visits to a doctor, and they return to work in a few days, if they were off work at all. In these cases, workers' compensation simply pays the medical bills for the injured employee. However, some employees suffer more severe injuries that cause them to be partially or totally disabled. These employees are eligible for compensation for their disabilities in addition to payments for their medical treatment. The following types of disability payments are possible under the workers' compensation laws:

- *Temporary partial disability* is paid when an employee suffers an injury that results in a temporary loss of use to some part of the body.

- *Permanent partial disability* is paid when an employee suffers an injury that results in a permanent loss of use to some part of the body. Mr. Bell was compensated for a permanent partial disability to his back. Compensation for this type of disability is described in the box on the following page.

- *Temporary total disability* is paid when an employee is completely and temporarily unable to engage in any type of substantial and gainful employment.

- *Permanent total disability* is paid when an employee is completely and permanently unable to engage in any type of substantial and gainful employment.

Determining What Permanent Partial Disability Is Worth

Permanent partial disability is paid when an employee suffers an injury that results in a permanent loss of use of some part of the body. For specific permanent disabilities, such as loss of use of an arm or an eye, the employee is paid 2/3 of his or her average weekly wage up to the current statewide maximum of $319 for a limited period of time, ranging from 10 weeks to 225 weeks, depending on the nature of the loss, up to a maximum of $100,000. For general permanent partial disability (which refers to injuries in such areas as the back, head, hip and abdomen), the employee is paid an amount equal to 2/3 of his or her average weekly wage multiplied by the percent of disability he or she has suffered. The payments can continue for a maximum of 415 weeks. Mr. Bell suffered a general permanent partial disability.

The percent of permanent partial general disability may be measured in terms of either a work disability or a functional disability.

Work disability refers to some reduction in the employee's ability to do the same type of work as before the injury.

Functional disability is the loss of part of the total functioning of the body. (Mr. Bell's award was based on a functional disability rating—the functioning of his back was impaired as a result of his injury.)

An employee with both a work disability and a functional disability is entitled to benefits based on the greater of the two disabilities. Since 1993, payment based upon a functional disability has been limited to $50,000, while payment based on a work disability is limited to $100,000. At the time of Mr. Bell's award, payment for a functional disability was capped at $100,000.

State Employees' Work-Related Accidents Are Handled by the State Self-Insurance Fund

When a State employee is injured on the job, he or she reports the injury to the employing agency. The agency then reports the accident to the State Self-Insurance Fund by telephone, and follows up by completing and mailing in an accident report.

When a claim is received by the Self-Insurance Fund, it is supposed to be investigated by claims adjustors (advisors and investigators). In investigating a claim, staff are responsible for doing the following:

- interviewing the injured employee
- interviewing the employee's supervisor, if necessary
- interviewing co-workers and others who witnessed the accident, if necessary
- searching the Fund's database to determine if the employee had previous claims
- obtaining wage information from the State's personnel and payroll system (this would be used in determining a claimant's average weekly wage)
- obtaining medical reports from the physician who treated the employee
- obtaining medical records from other providers as needed
- requesting a Form 88 search (Notice of Handicapped Employee) from the Division of Workers' Compensation.

Together, this information is used to determine whether the claim is compensable under the law as a work-related injury, and if so whether the injured employee is entitled to receive medical benefits only, or if he or she also is entitled to receive temporary or permanent disability benefits.

An employee does not need an attorney to file a Workers' Compensation claim, but he or she may hire an attorney at any point after the injury. Claims normally are handled from investigation through settlement by staff adjustors, but if the em-

ployee hires an attorney before his or her case is settled, the Director of the Self-Insurance Fund personally handles the claim.

If the claim is compensable—that is, the injury arose out of and in the course of the employee's job—the Self-Insurance Fund pays the medical bills. In late 1989, the Fund began entering into contracts with medical providers to provide services to State employees who were injured on the job. Currently, there are contracts with medical providers in six cities—Kansas City, Lawrence, Manhattan, Topeka, Wichita, and Winfield. State employees in these cities must use these providers, or must obtain permission from the Self-Insurance Fund to see a different medical provider, for the bills to be fully paid by workers' compensation. If an employee uses a non-contract or non-approved medical provider, State law limits workers' compensation liability to $500 (raised from $350 in 1993) in medical bills. If an employee is off work for more than one week, he or she becomes eligible for temporary disability payments.

If an employee's condition has stabilized and is not likely to improve, but he or she still has a disability, the State Self-Insurance Fund explores settlement options. The employee's situation is referred to as reaching "maximum medical improvement." Generally, the treating physician provides a disability rating which is forwarded to the Self-Insurance Fund. Fund staff may have the employee evaluated by a second physician, or may simply begin negotiations on a settlement.

If the employee agrees to the terms of the settlement, the Self-Insurance Fund pays the remaining medical and wage benefits agreed upon. If the employee disagrees with the settlement, he or she normally hires an attorney, at which point the attorney representing the Self-Insurance Fund also becomes involved. This attorney handles all legal issues until a settlement agreement is reached, or the claim is litigated in the Division of Workers' Compensation.

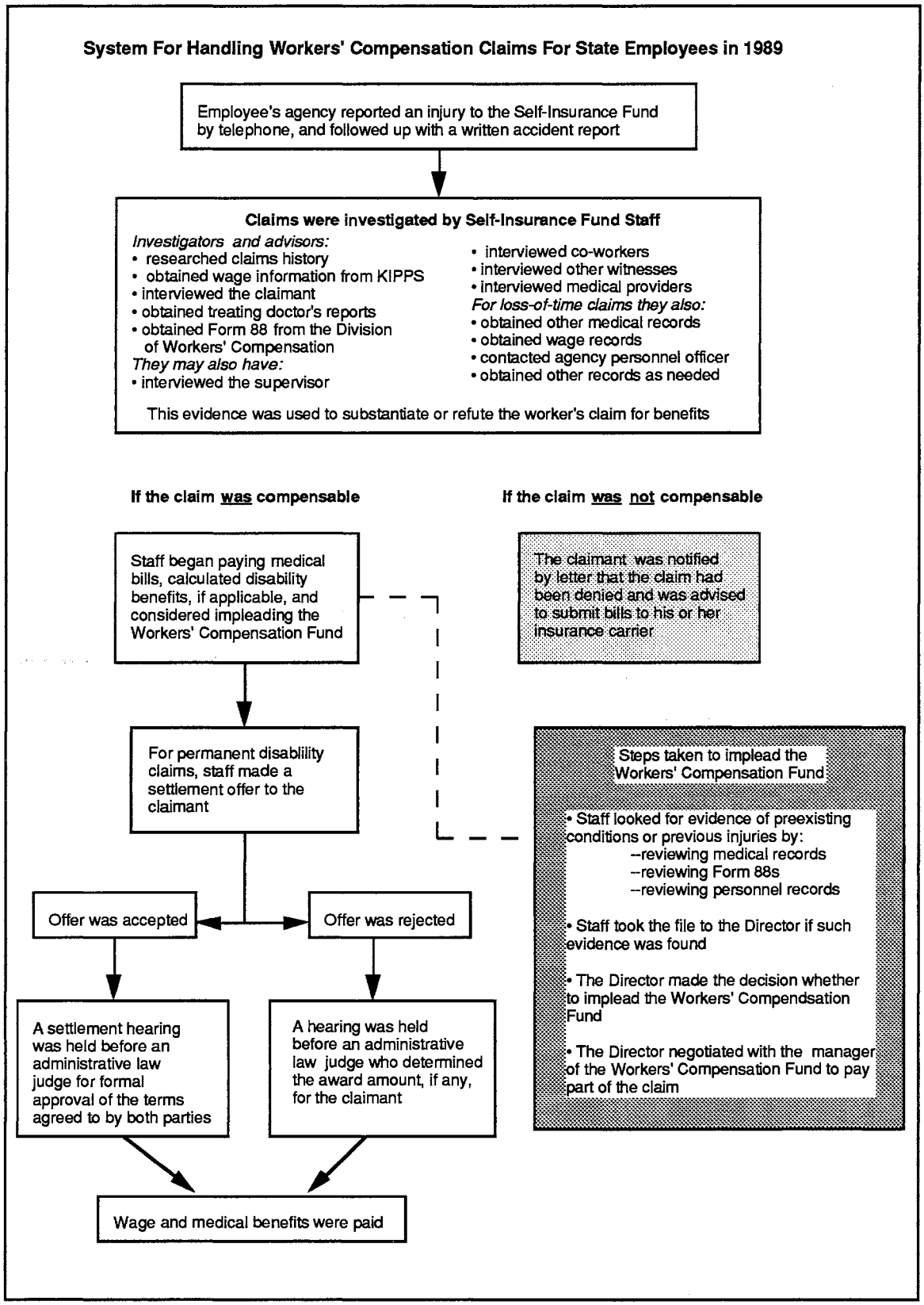
The graphic on page six, which describes the workers' compensation system for State employees, shows in more detail how the Self-Insurance Fund handles claims.

The Division of Workers' Compensation Becomes Involved If an Employee Requests a Hearing on His or Her Claim Or Has a Permanent Disability

The Division of Workers' Compensation, located in the Department of Human Resources, is the portion of the workers' compensation process responsible for hearing disputed claims. The Division serves not only the State and its employees, but all employers and employees in Kansas who are covered by the Workers' Compensation Act.

For claims that are disputed, or in which the employee has a permanent disability, the Division's staff of administrative law judges conduct three types of hearings:

System For Handling Workers' Compensation Claims For State Employees in 1989



- *preliminary hearings* are held to try to resolve disputes in claims where the injured employee has not reached maximum medical improvement. In these hearings the administrative law judge hears motions, such as requests for medical bills to be paid, that are not heard during other hearings. In addition, vocational rehabilitation matters may be considered in preliminary hearings.

- *regular hearings* are held after the injured employee has reached maximum medical improvement, but does not agree with the settlement offered by the employer. During these hearings, evidence is submitted from both the employee's attorney and the attorney for the Self-Insurance Fund. In addition, the employee testifies before the judge. The administrative law judge reviews the evidence and determines the settlement amount the employee should be awarded.

- *settlement hearings* can occur at any point in the claims process. A settlement occurs when both parties agree to the details of the award. However, the settlement must be presented to and approved by the Division in a formal, on-the-record hearing.

In Some Cases, the Workers' Compensation Fund, Administered by the Insurance Department, May Be Tapped to Pay Some or All of An Employee's Award

The Workers' Compensation Fund, previously called the Second Injury Fund, was established in 1945 to encourage employers to hire disabled veterans and victims of industrial accidents. This was accomplished by relieving employers of workers' compensation liability if these individuals became totally disabled as a result of a subsequent work-related accident. The Workers' Compensation Fund is administered by the Insurance Department. Over the years, the Fund's charge has broadened, so that it now covers virtually all employees with pre-existing conditions or previous injuries.

Until 1990 State employees were required to complete a Form 88 (Notice of Handicapped Employee) if they had any one of 17 handicapping conditions set out in K.S.A. 44-566 to document the State's awareness of these conditions. These forms were filed with the Division of Workers' Compensation. Since 1990, the Self-Insurance Fund has asked employers of injured workers to file an affidavit stating whether they were aware of the employee's pre-existing condition.

The graphic on the facing page shows the steps taken by staff of the State Self-Insurance Fund to involve the Workers' Compensation Fund in a State employee's claim. Basically, staff of the Self-Insurance Fund look for evidence that the employee's current injury is related to either a previous injury or a pre-existing medical condition. This evidence often is found by reviewing an employee's Form 88, medical history, or personnel records.

If staff find that the current injury may be related to a former injury or existing medical condition, the Director of the Self-Insurance Fund must decide whether to try to tap the Workers' Compensation Fund to help pay the claim. Generally, the State Self-Insurance Fund must prove that the employer had knowledge of the employee's previous injury or medical condition, and that this injury or condition contributed to the current injury. If the Director thinks the evidence satisfies both criteria—knowledge and contribution—the Director will negotiate with the attorney in charge of the Workers' Compensation Fund to pay all or part of the claim.

The Workers' Compensation Fund is being phased out. It is perceived as unnecessary in light of the passage of the federal Americans with Disabilities Act. The Act does not allow employers to discriminate in hiring or retention based on an applicant's or employee's pre-existing medical condition. Effective July 1, 1994, no claims for new injuries can be filed against the Workers' Compensation Fund, although claims still might be filed for injuries that occurred before that date.

Without the Workers' Compensation Fund, the State Self-Insurance Fund will be fully responsible for paying the legitimate claims of injured State employees, whether or not they had a pre-existing injury or medical condition.

Was the Former Insurance Commissioner's Workers' Compensation Claim Handled Appropriately?

We found many irregularities in the handling of Mr. Bell's claim at the Self-Insurance Fund. The claim was never investigated to determine whether it was compensable under the workers' compensation statutes. A second medical opinion was not sought in a timely manner and, when it was, an unfamiliar doctor was used. In addition, the Workers' Compensation Fund was not impleaded to help pay Mr. Bell's award, even though staff at the Self-Insurance Fund were aware he had a pre-existing degenerative back condition. Neither Mr. Bell's treating physician nor the doctor who provided the second opinion were asked to comment on the relationship between the back condition and his briefcase-lifting injury. Finally, neither physician was deposed during Mr. Bell's hearing before the Division of Workers' Compensation, even though we were told it was unusual not to have such depositions.

We also found it was not uncommon for workers' compensation claims to be poorly investigated by staff of the Self-Insurance Fund. In most of the 27 additional workers' compensation claims we reviewed, the investigations were inadequate to determine whether the claims should have been paid by the State.

When Mr. Bell's case went for hearing before the Division of Workers' Compensation, the administrative law judge—in spite of expressing strong reservations about the disability ratings presented to him—did not use his authority to order an independent medical evaluation of Mr. Bell. He also did not follow a written opinion of the Director of Workers' Compensation which stated that, when administrative law judges are faced with conflicting disability ratings, they should accept the rating of the doctor most familiar with the claimant. These and other findings are described in more detail in the sections that follow.

The State Self-Insurance Fund Did Not Follow Its Reported Procedures In Handling the Former Insurance Commissioner's Claim

At the time of Fletcher Bell's claim, the State Self-Insurance Fund did not have any written procedures for processing claims. However, current and former staff consistently told us that when an injury was reported, they would:

- call the agency to confirm details of the accident
- interview the claimant, and possibly the supervisor and co-workers or witnesses to determine whether the claim was compensable
- begin paying medical bills, whether or not the claim had been fully investigated
- obtain medical records
- consult with the Director if they questioned the compensability of the claim

- consult with the Director if, after reviewing medical or other records, it appeared there were grounds to implead the Workers' Compensation Fund
- turn the claim over to the Director if the claimant obtained an attorney

We reviewed Mr. Bell's file at the Self-Insurance Fund, and discussed the case with a number of current and former employees of the Department of Administration who had first-hand knowledge of the case to determine whether it was handled according to reported customary procedures. Our review showed that the case was not handled in accordance with the practices that were described to us.

Mr. Bell's claim never was investigated to determine if it was compensable, and no one claims responsibility for overseeing the claim. Staff of the Self-Insurance Fund are supposed to investigate claims to determine whether the accident or injury arose "out of and in the course of employment," the conditions needed for a compensable claim as defined by the Workers' Compensation Act. Information in an investigation is best obtained from multiple sources, including the "reporting officer" designated by the State agency, the claimant, the claimant's supervisor, witnesses, and others who might have relevant information about the accident.

The Self-Insurance Fund made no such investigation of Mr. Bell's claim. Although medical records were obtained showing that Mr. Bell suffered an injury, there is nothing in the claim file kept by the Self-Insurance Fund to show that Mr. Bell was interviewed about his accident. Moreover, there is nothing indicating that either Department of Insurance personnel or anyone who may have witnessed Mr. Bell's accident were interviewed about the circumstances surrounding the claim. Finally, it does not appear that any other evidence was collected to help determine if Mr. Bell's injury was compensable.

As noted in the timeline on the facing page, Mr. Bell's claim was reported to the Self-Insurance Fund on January 31, 1989. No action was taken on the claim until February 6, 1989, when Mr. Bell's attorney hand-delivered a copy of a preliminary hearing request to George Welch, the Director of the Self-Insurance Fund. (Mr. Welch is referred to throughout this report as the Director of the Self-Insurance Fund. At the time of Mr. Bell's claim, Mr. Welch's title was Administrative Officer III; however, he was the senior person in the Fund's office and was responsible for day-to-day management of the Fund.)

Mr. Welch stated that, because of the political sensitivity of a claim being filed by the Commissioner of Insurance, he immediately took the claim to his supervisor in the Division of Personnel—the Health Benefits Administrator—and that together they took the claim to the Director of Personnel. Mr. Welch stated that management of the claim was taken out of his hands that day. He said he assumed any investigation of the claim would be handled by the Director of Personnel, and that if she had wanted him to investigate the claim, she would have specifically told him to do so. He said from that point on, he assumed the claim was compensable and arranged for payment of medical bills as they were submitted.

Major Dates in the Fletcher Bell Workers' Compensation Case

October 6, 1987	Mr. Bell was involved in a motor vehicle accident; he suffered neck injuries and upper back pain.
January 20, 1988	Mr. Bell consulted Dr. John Wertzberger, a Lawrence physician, for help with low-back and neck discomfort.
June 14, 1988	Dr. Wertzberger wrote Mr. Bell's lawyer a progress letter that described Mr. Bell's "significant aggravations of his mechanical low back problem".
November 16, 1988	Mr. Bell underwent a magnetic resonance imaging (MRI) examination of his back. Dr. Wertzberger noted that Mr. Bell's back condition had deteriorated.
December 9, 1988	Mr. Bell submitted a Notice of Handicapped Employee to the Department of Insurance that identified bulging lumbar disks and spinal stenosis as his handicaps.
January 18, 1989	Mr. Bell was injured in Kansas City, Missouri, while lifting his briefcase from his car.
January 31, 1989	Mr. Bell's accident was reported to the State Self-Insurance Fund.
February 6, 1989	Mr. Bell's attorney filed for a preliminary hearing.
November 29, 1989	Mr. Bell received a 25% disability rating from Dr. Wertzberger.
February 1990	A settlement proposal was made. The Secretary of Administration asked the Self-Insurance Fund to get a second opinion on Mr. Bell's disability from another physician.
July 6, 1990	Dr. Glenn Barr, a Kansas City, Missouri, physician hired by the Self-Insurance Fund, rated Mr. Bell's disability at 37%.
December 26, 1990	Mr. Bell's lawyer made a settlement offer but the Self-Insurance Fund rejected it.
January 11, 1991	A regular hearing was conducted in Topeka before Administrative Law Judge James Ward. Medical reports were submitted and Mr. Bell testified.
February 22, 1991	Judge Ward issued an award of $94,569 for Mr. Bell based on a 30% disability rating. He also made a provision for Mr. Bell to receive future conservative medical care, with the Self-Insurance Fund to pay the costs.
February 1993	Newspapers reported Mr. Bell's award.
March 10, 1993	The State Self-Insurance Fund asked the Division of Workers Compensation for a review-and-modification hearing on Mr. Bell's award.
September 29, 1993	An agreed award between the Fund and Mr. Bell was filed, reducing the amount of the award Mr. Bell originally received from $94,569 to slightly less than $55,000.

Both the Health Benefits Administrator and the then-Director of Personnel dispute this version of events. They state they were unaware of Mr. Bell's claim until Mr. Welch brought them a proposed settlement offer in February 1990, one year after the claim was filed.

Based on these conflicting statements, it is impossible for us to determine who was in charge of Mr. Bell's claim during the first year after it was filed. However, the Health Benefits Administrator was not employed by the State until March 1989, which would mean Mr. Welch had the file for at least one month after the claim was filed. (He subsequently stated that he may have held the claim for the first month after it was filed, or he may have taken it to the Director of Personnel by himself when he initially received it.) The issue of who was initially in charge of the claim is significant, because that person was responsible for ensuring that an investigation was done.

In effect, no one took responsibility for overseeing Mr. Bell's claim and investigating it in a timely manner (while memories are fresh and other evidence is more easily obtained) to determine whether it was compensable.

Staff appeared ready to settle Mr. Bell's claim without a second medical opinion about the severity of his disability. The State Self-Insurance Fund does not always obtain a second medical opinion before settling a claim. For example, if the claimant was treated by and received a disability rating from a physician under contract with the State Self-Insurance Fund, officials likely would not request a second opinion.

At the time of Mr. Bell's injury, the State Self-Insurance Fund did not have contracts with any physicians in the Topeka-Lawrence area. Claimants generally went to the physician of their choice, although the Self-Insurance Fund could disapprove payment for a physician if the treatment seemed questionable. However, according to officials, Mr. Bell's physician was highly respected and had, in fact, been hired by the Self-Insurance Fund many times to provide a second opinion on a claimant.

In early February 1990 (one year after the claim was filed), the Director of Personnel submitted a proposed settlement for Mr. Bell's claim to the Secretary of Administration. The proposed offer, which would have given Mr. Bell a $66,000 lump-sum settlement and pay for any future medical expenses he incurred as a result of the injury, was based on a 25% disability rating by Mr. Bell's physician, Dr. Wertzberger. (The profile on the facing page describes the proposal.) The Secretary suggested getting a second doctor's opinion, and asked the Department of Administration's legal division to review the proposed settlement.

The Self-Insurance Fund obtained its second opinion from a physician it never before or since used. Seth Valerius, the attorney within the Department who handled most settlements for the Self-Insurance Fund stated he could not work on Mr.

Bell's claim because his wife was employed in the Insurance Department by Mr. Bell. The case was assigned to Billy Newman, who at the time had limited experience with workers' compensation cases. Mr. Newman told us he wanted to get a second opinion from a doctor who was not from Kansas (who presumably would have no ties to the Kansas Department of Insurance) and who used the American Medical Association Guidelines to evaluate disability levels. Mr. Newman mentioned these criteria to Mr. Valerius (although he said he may not have mentioned that this was in relation to Mr. Bell's claim), and Mr. Valerius suggested Dr. Barr, a Kansas City, Missouri, physician he had recently deposed. Mr. Newman selected Dr. Barr—who was not otherwise known to anyone in the Self-Insurance Fund or the Division of Workers' Compensation—to provide the second medical evaluation of Mr. Bell.

The second opinion the Department received rated Mr. Bell's disability at 37%, significantly higher than the 25% rating by Mr. Bell's own physician.

In selecting physicians for disability evaluations, the claimant and the State Self-Insurance Fund have different objectives. Claimants benefit from physicians who give a higher disability rating—which translates to a higher award—while the Self-Insurance Fund tries to select physicians known for conservative ratings, which lowers the award. By selecting a physician whose rating habits essentially were unknown, the Self-Insurance Fund placed itself in a very vulnerable position, which was not consistent with its past history of selecting conservative physicians.

No One Claims Responsibility For Developing the Initial Settlement Proposal for Mr. Bell's Claim

In February 1990, the Director of Personnel notified the Secretary of Administration that a $66,000 settlement was about to be made to Fletcher Bell for a work-related back injury sustained in January 1989.

Curiously, no one claims responsibility for developing the offer. The Health Benefits Administrator stated that the Director of the Self-Insurance Fund, George Welch, brought the settlement offer to her for approval, and she took it to the Director of Personnel because of its sensitive nature. Mr. Welch initially stated that Billy Newman, a Department of Administration attorney, put the settlement offer together.

However, both Mr. Newman and the Director of the Department of Administration's legal division state that Mr. Newman did not work on the case until the Secretary of Administration received the proposed settlement and asked the legal division to review it.

When we presented Mr. Welch with a page from Mr. Bell's claim file that showed the calculations used to arrive at the settlement offer, he acknowledged that the calculations could possibly be in his handwriting. He stated that the Director of Personnel probably would have asked him what the settlement with Mr. Bell would cost.

We were interested in finding out who developed the settlement offer because this information would help shed light on who was responsible for failing to investigate the compensability of Mr. Bell's claim.

The calculations below show how the initial settlement offer was derived. The two variables that determine the size of an award are average weekly wage and the disability rating. The other factors in the formula are standard for all general permanent partial disability claims.

$	1,051.60	**average weekly wage**
	x .66	two-thirds
$	700.44	
	x .25	**disability rating (25%)**
$	175.11	weekly benefit
	x 415	number of weeks benefit is paid
$	72,670.65	total benefit allowable
	[5,813.65]	8% discount for lump-sum payment
$	66,857.00	initial proposed settlement

State Self-Insurance Fund staff did not involve the Workers' Compensation Fund even though they knew about Mr. Bell's pre-existing back disease. As noted earlier, when an injured employee has a pre-existing condition or injury, it is often possible for the employer to implead the Workers' Compensation Fund to pay some or all of the award. There have been many questions about why this Fund, which is administered by the Insurance Department, was not impleaded for Mr. Bell's claim.

Mr. Bell was involved in a car accident in 1987, in which he suffered injury primarily to his neck and upper back. He did not file a workers' compensation claim following this accident. He did seek medical treatment for ongoing effects of the accident through November 1988, at which time he requested a Magnetic Resonance Imaging (MRI) examination of his back. The MRI showed significant problems with his lower back, which Mr. Bell's physician described as profuse protruding discs and spinal stenosis—a degenerative back condition.

Mr. Bell completed a Form 88A, Notice of Handicapped Employee, and submitted it to the personnel office of the Insurance Department on December 9, 1988. The form identified bulging lumbar disks and spinal stenosis. When Mr. Bell's physician reviewed the MRI, he noted that Mr. Bell would be highly susceptible to recurrent problems over the months and years, and scheduled Mr. Bell for an evaluation. In January 1989, before the evaluation took place, Mr. Bell reported he was injured lifting a briefcase from the trunk of his car.

Mr. Newman, the attorney for the Self-Insurance Fund, and Mr. Welch, the Director of the Self-Insurance Fund, initially told us they had never seen a copy of Mr. Bell's Form 88A. Both claimed they were unaware of Mr. Bell's pre-existing back disease. Later, Mr. Newman recalled that he obtained a copy of the Form 88A from the Insurance Department, and that he had discussed the form with Mr. Welch. He said it was Mr. Welch's opinion that there was no basis for impleading the Workers' Compensation Fund.

Mr. Bell's attorney asked Mr. Bell's physician—Dr. Wertzberger—to comment on the possible relationship between the previous car accident and the briefcase-lifting injury. Dr. Wertzberger stated there was no relationship, and Mr. Bell's attorney sent a copy of that opinion to the Director of the Self-Insurance Fund, stating there was no basis to implead the Workers' Compensation Fund. There is no documentation to suggest that either Mr. Bell's attorney or anyone at the Self-Insurance Fund asked Dr. Wertzberger to comment on the relationship between the spinal stenosis and the briefcase-lifting injury.

Similarly, when Dr. Barr—the physician hired to give the second opinion on Mr. Bell—reported his findings, he stated that the injuries from the car accident essentially had subsided by the time of the briefcase-lifting injury. There is no evidence to suggest Dr. Barr was asked to address the possible relationship between the spinal stenosis and the briefcase-lifting injury.

Had the Workers' Compensation Fund been impleaded, it would have created an inherent conflict of interest for Mr. Bell. As Insurance Commissioner, he had ultimate authority to make payments from that Fund. To address this conflict, an independent entity such as the Attorney General's Office would have had to oversee the involvement of the Workers' Compensation Fund on Mr. Bell's claim.

The attorney for the Self-Insurance Fund did not take depositions from the physicians who examined Mr. Bell. When Mr. Bell's claim came for a regular hearing in the Division of Workers' Compensation, only Mr. Bell testified. Neither attorney elected to depose the physicians who examined him, choosing instead to simply enter the two medical evaluation reports as evidence.

Mr. Newman told us it was a good strategy not to depose the physicians for the following reasons:

- Mr. Bell's physician, Dr. Wertzberger, was well respected by the administrative law judges, and his lower rating was likely to be viewed as credible
- Dr. Barr might look more credible under cross-examination because he examined Mr. Bell seven months after Dr. Wertzberger examined him, during which time Mr. Bell's condition could have deteriorated

We received mixed information about the significance of not deposing the physicians. Most people we talked with who had experience with the workers' compensation system said not deposing physicians was highly unusual. They told us that attorneys normally depose physicians to try to challenge their credibility and question their basis for giving the disability rating they gave.

However, one person with long-time experience in the Division of Workers' Compensation told us that not deposing the physicians in this case made sense. Because the State-selected physician gave Mr. Bell a higher disability rating than his own physician, the Self-Insurance Fund would have had to attack its own witness, an awkward situation at best. In a letter submitted to the administrative law judge shortly after Mr. Bell's 1991 hearing at the Division of Workers' Compensation, Mr. Newman ultimately did just that. Among other things, he argued that the physician he selected, Dr. Barr, had improperly applied the American Medical Association Guidelines.

Deposing the doctors also would have given the State Self-Insurance Fund's attorney the opportunity to ask the doctors about the relationship between Mr. Bell's spinal stenosis and his injury from lifting the briefcase.

The Administrative Law Judge Did Not Do All He Could Have Done To Address Perceived Irregularities in the Case

We think the public might have been better served in Mr. Bell's case had James Ward, the administrative law judge who presided over Mr. Bell's regular hear-

Mr. Bell Was Allowed to Use the Physical Therapist of His Choice, Rather Than One With Whom the State Had a Contract

Concerns have been raised about Mr. Bell being able to choose his own medical provider for physical therapy treatment. Our review showed that when Mr. Bell's claim was filed in 1989, the State had no contracts with medical providers to treat injured State employees.

Although the State subsequently developed contracts with medical providers, Mr. Bell's 1991 award allowed him to continue treatment with his doctor. The concerns about Mr. Bell's use of medical care providers arose over his desire to use a non-contracting provider for physical therapy

In June 1992, the State Self-Insurance Fund was advised by Mr. Bell's attorney that Mr. Bell likely would be undergoing additional physical therapy. In response, Self-Insurance Fund staff informed Mr. Bell's attorney that it expected Mr. Bell's doctor to follow the normal procedure of referring Mr. Bell to the State's contract care provider—Lawrence Memorial Hospital.

Mr. Bell's attorney informed Self-Insurance Fund staff that Mr. Bell's doctor had referred him to Plaza Physical Therapy before the State's contract with Lawrence Memorial Hospital. The attorney also stated he assumed a referral to the historical care provider would present no problem for them.

Self-Insurance Fund staff responded by stating they would pay only the usual charge for physical therapy treatment at Lawrence Memorial Hospital under the terms of the contract. Staff did not refuse to allow Mr. Bell to use Plaza Physical Therapy.

After Mr. Bell's attorney learned the Self-Insurance Fund would pay only the amount charged by Lawrence Memorial Hospital for Mr. Bell's physical therapy treatment, the attorney demanded that Mr. Bell be allowed to receive treatment from Plaza Physical Therapy regardless of the State's contract. In July 1992, after assuring themselves that Plaza Physical Therapy was cost-competitive, Self-Insurance Fund staff wrote to Mr. Bell's attorney advising him that it would pay for treatment provided by Plaza Physical Therapy as long as the appropriate medical records were submitted.

ing, appointed a neutral physician to resolve discrepancies between the two disability ratings Mr. Bell received.

The regular hearing was held after the Self-Insurance Fund and Mr. Bell failed to agree on the extent of Mr. Bell's disability. As previously discussed, there was a large difference between the disability ratings assigned by the physician hired by the Self-Insurance Fund and by Mr. Bell's treating physician.

Judge Ward split the difference between the ratings, assigning Mr. Bell a 30% disability rating. Although there apparently was a district court ruling stating that it was acceptable to split the difference between conflicting disability ratings, a 1989 administrative opinion written by Robert Anderson, then the Director of the Division of Workers' Compensation, stated that splitting the difference between ratings was inappropriate. The Director's opinion said awards should be based either on the rating of the physician most familiar with the injured worker, or on the rating of a neutral physician appointed by an administrative law judge.

Judge Ward could have requested an independent medical evaluation of Mr. Bell, but he did not. K.S.A. 44-516 gives administrative law judges the power to, at their own discretion, appoint up to three neutral physicians in a case where there is a disputed injury.

Although Judge Ward first noted in his findings that the higher disability rating Mr. Bell received could be explained in part because Mr. Bell had additional

complaints about problems with both his legs, he then stated concerns about the impairment ratings varying "in an inexplicable way." He discussed two specific examples where the doctors–both using the same American Medical Association Guidelines for rating work-related injuries–reached different conclusions and different disability ratings for the same type of conditions. "Other instances of like discrepancies are present in the record concerning the ratings of claimant's impairment by the two doctors," wrote the judge. "It is impossible to tell which are the correct assignments of value since the AMA Guidelines are not in evidence."

The judge told us that although he knew of the statutory authority to appoint a neutral physician, he adhered to his long-standing policy of never becoming involved in "gathering evidence." Judge Ward said it would be difficult for him to decide whether a physician was truly neutral. Rather, he said he appoints neutral physicians only when one of the parties in a case makes a legitimate request for them. He said he would have granted such a request in the Bell case had either party asked for a neutral physician. But, he said, lawyers for both sides said they wanted his decision to be based on the physicians' reports.

The Self-Insurance Fund Failed To Investigate Most of the Other Claims We Reviewed

To determine whether the handling of Mr. Bell's case was typical, we looked at a sample of workers' compensation claims filed by other State employees for back injuries occurring between October 1988 and March 1989 (three months on either side of Mr. Bell's accident). During that timeframe, 180 claims were filed by State employees for back injuries caused by lifting. We selected a random sample of 20 of these 180 claims, although we later dropped one claim because the date of the accident had been coded incorrectly and was outside our timeframe. We noted several characteristics of these claims:

- the injuries were sustained primarily by lifting patients at one of the State hospitals, or by lifting trash cans or construction materials
- the injuries were typically diagnosed as lumbosacral strain or sprain
- all but one claim were medical-only claims; that is, the claimant either was never off work as a result of the injury, or was off less than one week and had no permanent disability. The Self-Insurance Fund paid only medical bills.

Because Mr. Bell's circumstances did not closely resemble these claims—his injury was caused by lifting a briefcase, his condition was diagnosed as acute herniated disc superimposed on significant spinal stenosis and, while he never missed work as a result of his injury, he had a permanent partial disability—we decided to supplement our work with an additional sample of claims.

We went back through the 180 back injury claims, and selected all claims that resulted in a finding of extended temporary or permanent disability. We reviewed

eight of the 10 claims that met this criteria–one claim was impossible to analyze because the case file covered multiple accidents, and the other claim was for Mr. Bell.

Through newspaper reports, we also were aware of other people who filed claims for injuries similar to Mr. Bell's. However, with one exception these people were not State employees, and therefore their claims did not go through the State's system. As a result, we could not compare how these claims were handled with Mr. Bell's claim. Factual information about these claims is contained in Appendix A.

We found that the eight claimants in our sample with more serious injuries had essentially the same causes as the 19 claimants with less-serious injuries: lifting patients, trash cans, and shop materials. Five of the eight were diagnosed as having lumbar strains or sprains, two had disc problems, and one was diagnosed with fibromyositis (chronic muscle inflammation). These claimants all received disability payments for time off work, and in all but one case, for permanent partial or total disability. Their awards ranged from nearly $9,000 for a claimant with only temporary total disability, to $109,000 for a claimant who was permanently totally disabled. These figures do not include medical payments made for the claimants. A profile of one of these claims is located on page 20.

The Self-Insurance Fund fully investigated only a few of the claims we reviewed. In each of the 27 claims (19 from our original sample plus 8 from the expanded sample), Self-Insurance Fund staff completed all the required paperwork. They also obtained wage information on each of the claimants from the State's personnel and payroll system, and required that medical reports be submitted before medical bills were paid.

However, staff in the Self-Insurance Fund did virtually nothing to determine whether these claims were compensable; that is, that they had actually arisen out of and in the course of the claimant's work. Only seven of the 27 claimants were interviewed about their accidents. Witnesses were never interviewed. The table on the facing page provides additional information about what the Self-Insurance Fund staff did to investigate these claims.

When we asked about the lack of investigation of these claims, the Director of the Self-Insurance Fund stated that, during the time period we reviewed, his staffing levels had been reduced and staff were struggling to keep up with the workload. In addition, he stated that for the 19 claims that were medical-only (cost of treatment ranged from $20 to nearly $1,700), it would not have been cost-effective to have staff spend time interviewing claimants and other involved parties.

We question whether Self-Insurance Fund staff initially have sufficient information to determine that a reported injury will result in a low-cost, medical-only claim. Two of the eight claims in our sample of more serious injuries initially were classified as medical-only. Ultimately these two claims resulted in settlements of $24,132 and $30,350, excluding medical payments.

State Self-Insurance Fund's
Investigation Activities for Selected Claims

Claim	Called Agency For More Details	Obtained Medical Records	Interviewed Claimant	Interviewed Supervisor	Interviewed Witnesses
Fletcher Bell		√		na	
Disability claims in our sample					
1	√	√			na
2	√	√	√	√	na
3	√	√			na
4	√	√	√		
5	√	√			na
6	√	√	√		
7	√	√	√	√	
8	√	√			
Medical-only claims in our sample					
9	√	√			na
10	√	√			na
11	√	√	√	√	na
12	√	√			na
13	√	√			na
14	√	√			na
15	√	√			na
16	√	√	√		
17	√	√			na
18	√	√			na
19	√	√	√		na
20	√	√			
21	√	√			na
22	√	√			na
23	√	√			na
24	√	√			
25	√	√			na
26	√	√			
27	√	√		√	

We were asked to look at whether Mr. Bell's claim was handled as aggressively by the State as were the claims of less prominent employees. We found little in the claim files that would let us evaluate this. But, as the table above shows, the fact that Mr. Bell's medical bills were paid and his claim settled with no investigation as to its compensability was not unusual.

The Claims We Reviewed Involving the Division of Workers' Compensation Appeared To Be Handled Appropriately

We also wanted to see how the Division of Workers' Compensation typically handled claims that came within its scope to determine if Mr. Bell's claim was han-

dled similarly. Of the 27 claims we reviewed, 19 were medical-only claims that never came in contact with the hearing process that the Division oversees.

Of the eight disability claims, five had some type of hearing within the Division of Workers' Compensation. Our review found no problems with the way the five hearings were handled. The other three claims were resolved as "agreed awards." An agreed award occurs when both parties are representated by lawyers and they agree to the disability rating. The settlement is payed out over the full 415 weeks and either party may or may not give up any of their future rights under the Workers' Compensation Act.

Properly Investigating Claims Will Not Always Prevent Large Awards

On February 24, 1989, a Winfield State Hospital employee injured her back while lifting a patient. As a result of the accident, the employee suffered a lower-back sprain. In May 1989, the injured employee hired an attorney, who requested temporary total disability payments for her until she could return to work.

The State Self-Insurance Fund, following established procedures for investigating claims, interviewed the claimant, her supervisor, and the agency personnel officer. The claims adjustor obtained a list of her previous workers' compensation claims, medical records from the treating doctor, and wage records. From the information gathered, the Self-Insurance Fund determined that the claim was compensable.

While the Self-Insurance Fund was investigating the claim, the employee requested and received a leave of absence without pay from early April 1989 to the end of May 1989. Because she was a new employee limited to 60 days leave without pay, Winfield State Hospital ended her employment in May 1989 when she did not return to work within 60 days.

The employee then moved from Kansas to New Mexico where she went to work part-time as a cocktail waitress. She worked only part-time because she said she had difficulty finding adequate child care. However, nothing in the file suggested she could not work full-time.

Based on his examination of the employee, the treating doctor determined that she had a 3% permanent physical impairment to the whole body as a result of the accident. She was examined by a second doctor, selected by her attorney, who gave her a 5% permanent physical impairment. The Self-Insurance Fund sent her to a third doctor in New Mexico, who also gave a permanent partial disability rating of 5% to the whole body.

The employee also was evaluated by a firm specializing in personnel assessments. This evaluation indicated that the employee had a 59% reduction in her ability to perform work in the open market. In other words, her disability prevented her from doing nearly 60% of the jobs she could have done before the injury. However, the firm's owner testified that, in his opinion, the reduction was between 60% and 70%.

The employee's attorney wanted to settle the claim based on the fact that she had a 55% wage differential between her full-time salary at Winfield State Hospital and her earnings as a part-time waitress. Based on this wage difference, the award would have been about $50,000. The Self-Insurance Fund wanted to settle the claim based on the 5% functional disability rating for about $5,000.

The employee refused the settlement proposed by the Self-Insurance Fund. The claim went to a hearing before an administrative law judge in March 1991. Based on the evidence submitted concerning the functional disability and the wage differential, the judge issued an award for the employee of 59% permanent partial disability due to the reduction in earning capacity. The amount awarded was $67,392.

After the award was issued, the Self-Insurance Fund asked for a review by the Director of the Division of Workers' Compensation. The assistant director ruled that the employee was entitled to a $20,184 award based on a 3% permanent partial disability.

The employee and her attorney appealed the Director's decision to the district court. In September 1991, the district court judge overturned the Director's award, and gave the employee an award of $76,242. The judge arrived at this award based on a 65% loss of ability to perform work in the open labor market, and a 74% reduction in the ability to earn a comparable wage. Taken together, these ratings resulted in a 69.5% work disability.

Despite its efforts to investigate this claim, propose a reasonable settlement based on the degree of disability, and appeal the initial award, the State Self-Insurance fund had to pay nearly $80,000 in permanent disability wage benefits to this woman in addition to medical benefits.

**Two Years After Mr. Bell's Award,
The Self-Insurance Fund Reopened the Case,
Eventually Succeeding in Reducing the Award**

On March 10, 1993 the Self-Insurance Fund applied for a review-and-modification hearing. The application asked that an independent health care provider examine Mr. Bell and report on his change of condition.

On March 20, the first news reports of Mr. Bell's golf games appeared. Three months later, on June 30, the Self-Insurance Fund amended its application to use both the golf games and medical records indicating that Mr. Bell did not seek care for his injuries for almost two years, from September 4, 1990, to June 11, 1992, as reasons for reviewing and modifying the award.

Staff in the Self-Insurance Fund began an investigation of Mr. Bell's claim at that point, hiring someone to interview Mr. Bell's golf partners and others, and to observe Mr. Bell playing golf. Several physicians and exercise physiologists also were contacted for opinions on Mr. Bell's condition. The physicians indicated that Mr. Bell's golf games and his failure to obtain medical care clearly showed that his injury had healed. None of the physicians, though, would agree to appear as expert witnesses because of the case's high visibility.

The administrative law judge ordered that two neutral physicians examine Mr. Bell. Administrative law judge George Robertson replaced James Ward on the case after Judge Ward removed himself from the matter because of public comments he made. On July 23, 1993, Judge Robertson ordered that two neutral physicians, one in Kansas City and one in Wichita, examine Mr. Bell. However, before those examinations occurred, Mr. Bell and the Self-Insurance Fund reached an agreement.

The agreement ended Mr. Bell's disability payments in return for the Self-Insurance Fund paying for ongoing medical treatment. The agreement between Mr. Bell and the State closed the case. It called for Mr. Bell to give up the remaining $39,707 of the $94,000 due in disability payments, and to waive his rights to vocational rehabilitation benefits. The Self-Insurance Fund agreed to pay for Mr. Bell's future medical care for the back condition caused by the briefcase-lifting injury. (To date, the Fund has paid almost $16,000 in medical bills for Mr. Bell's injury.) It also agreed not to challenge Dr. Wertzberger's diagnosis and treatment and not to seek future review and modification hearings.

Had the case gone before the administrative law judge, the State could have done no better on the disability issue than it did in the agreement. The administrative law judge might also have ruled that Mr. Bell was not entitled to future medical benefits at that time, but Mr. Bell could have petitioned for benefits at a later date. But to the State's detriment, the judge also could have upheld the original award or extended it to the maximum $100,000 then available under the law.

How Would Changes To the Workers' Compensation Statutes Made by the 1993 Legislature Have Affected the Handling of Mr. Bell's Claim?

One set of changes to Kansas' Workers' Compensation statutes would have reduced Mr. Bell's award by more than half, from $94,000 to almost $45,000. Other changes might have helped cut the award further. Despite these changes, injuries similar to Mr. Bell's still will be eligible for compensation if they are work-related.

In addition to statutory changes, the written procedures now in place for handling cases at the Self-Insurance Fund likely would have meant that Mr. Bell's claim would have been investigated more thoroughly.

Changes to Workers' Compensation Laws Would Have Reduced Mr. Bell's Award by Nearly Half

Amendments to the State's Workers' Compensation statutes in 1993 changed the formula for determining functional disability payments and imposed a $50,000 maximum on payments for functional disabilities.

Mr. Bell's award under the new law, based on the 30% disability rating he received, would have been $44,663, less than half the $94,000 award he originally received in 1991. Moreover, even if Mr. Bell's disability rating were higher, he couldn't have received more than $50,000 under the cap.

Other statutory changes that might have had an effect on Mr. Bell's case:

- *K.S.A. 44-510e(a)* was amended to require administrative law judges to refer claimants to independent medical examiners when there are disputes over functional impairment. An administrative law judge then uses the independent medical examiner's report to help make a decision. Mr. Bell would have been referred to an independent medical examiner if this amendment had been in effect. This might have helped resolve the difference between the two conflicting ratings physicians gave Mr. Bell, but there is no way to know if the new rating would have been higher or lower.

- *K.S.A. 44-501(c)* forbids compensation for merely aggravating a pre-existing injury or condition. Instead, the employee is compensated only for any increased disability. Had this amendment been in effect and had the Self-Insurance Fund shown that the briefcase accident only aggravated Mr. Bell's spinal stenosis, the claim might have been denied. Even if Mr. Bell had shown that the accident increased his disability, the Self-Insurance Fund still would have had a smaller payout because it would have been liable only for the increased disability, not the entire condition.

•*K.S.A. 44-501(h)* allows workers' compensation awards to be reduced by money received from retirement plans or social security payments. Mr. Bell is a retired member of the Kansas Public Employees Retirement System. Potentially, some of his retirement benefits could have been used to offset his award.

New Written Procedures at the State Self-Insurance Fund Might Have Led Staff to Challenge the Compensability Of Mr. Bell's Claim or to Implead the Workers' Compensation Fund

In 1991, after Mr. Welch was promoted to Director of the Self-Insurance Fund, staff began to develop written procedures. The new procedures require several steps that were not taken during Mr. Bell's case:

- interviewing the claimant in every claim and maintaining a written report of the interview
- interviewing witnesses to an accident to confirm as many details as possible
- interviewing the employer in every case where the investigator finds it necessary to confirm information, including the existence of prior disabilities.

If those procedures had been used in Mr. Bell's case, the Self-Insurance Fund would have had more and better information to help determine whether the claim was compensable. Staff would have interviewed both Mr. Bell and any witnesses to the accident, such as those attending the Kansas City meeting and co-workers who observed Mr. Bell in the Insurance Department's offices after the accident.

Those interviews might have provided the Fund's staff with information about Mr. Bell's pre-existing back condition from the spinal stenosis, which could have been used to implead the Workers' Compensation Fund and mitigate the liability of the State Self-Insurance Fund.

Changes to the Workers Compensation Act And the Self-Insurance Fund Will Not Radically Alter the System

Since its enactment in 1911, the Kansas Workers' Compensation Act essentially has been a no-fault system; injured employees give up their rights to sue employers for negligence (foregoing a possible large damage award), while employers surrender their rights to many defenses available in a negligence lawsuit.

That no-fault aspect, however, leads to a system where claims generally are paid. Haggling and litigation usually are limited to disputes over how much each claim is worth, not whether claims are compensable. K.S.A. 44-501(g) calls for a liberal construction of the workers' compensation statutes, and Kansas courts have strictly followed that lead. In 1978, the Kansas Supreme Court wrote "Throughout our many decisions ... this court has been firmly committed to the rule of liberal con-

struction of the act in order to award compensation to the workman where it is reasonably possible to do so, and to make the legislative intent effective and not to nullify it."

Although several changes the Legislature made in 1993 dealt with substantive problems within the workers' compensation system–for example, trying to ferret out fraudulent claims–most changes were procedural and were intended to mitigate the payouts insurers and employers make. The basic intent of the workers' compensation law–that compensable claims should be paid and compensability will be liberally construed–has not changed.

Conclusion

Fletcher Bell's claim was not handled appropriately, but neither were many of the other back injury claims we reviewed during this audit. The biggest failing we saw was the lack of an investigation to determine whether the claim was compensable. It appeared that Mr. Bell's claim sat without any type of investigation for almost a year. Timely investigations are critical so that the facts can be recorded before memories of the events fade or become distorted.

Another major failing in handling Mr. Bell's case was the Self-Insurance Fund's failure to ask questions about the connection between Mr. Bell's degenerative back condition and the alleged briefcase-lifting injury. At this point, no one can say how much the award might have been, or how much of the tab the insurance industry-funded Workers' Compensation Fund might have picked up, if that connection had been established.

Reforms enacted by the 1993 Legislature would have significantly reduced the amount of disability compensation that Mr. Bell could have received. However, even with those reforms, the type of claim filed by Mr. Bell would continue to be compensable.

Several weaknesses identified in this report have been addressed by recent changes to the Workers' Compensation Act. For example, statutes now require administrative law judges to request an independent medical evaluation when presented with differing disability ratings, and because the Workers' Compensation Fund is being phased out, there will no longer be any question of failure to implead it. Because of these changes, we make only one recommendation.

Recommendation

To help ensure that the State Self-Insurance Fund pays only claims that are compensable under the State Workers' Compensation Act, the Secretary of Administration should require the Self-Insurance Fund to follow its new procedures for handling claims, which include interviewing the claimant and any witnesses in every claim, and interviewing the employer if necessary. The Secretary should arrange for spot checks of claim files to see that the procedures are being followed.

APPENDIX A

The Workers' Compensation Claim of 11 Kansas Lawyers

The Workers' Compensation Claims of 11 Kansas Lawyers

As Kansas legislators grappled with reforming the state's workers' compensation laws during the 1993 session, one problem came to the debate's forefront: that persons familiar with how the system worked – particularly lawyers who specialize in workers' compensation cases – might have used their detailed knowledge of the complex system to obtain large workers' compensation awards for themselves.

Fletcher Bell's award raised the issue in March 1993 when newspapers reported the case. In later months there were news reports that 11 workers' compensation lawyers had received awards for functional impairments ranging from $10,000 to more than $100,000 for disabilities caused by on-the-job injuries.

Finally, another news report told of two workers' compensation claims filed by a Lawrence physician. The physician said the injuries he had suffered in 1991 and 1992 were caused by "prolonged captive sitting" while giving testimony in workers' compensation cases. The claims have not been resolved because the physician's injuries have yet to reach maximum medical improvement.

Other states have reported similar claims from workers' compensation insiders. In Missouri, newspaper reports detailed awards given to such insiders as:

•a St. Louis lawyer specializing in workers' compensation cases received $65,000 for injuries suffered in a fall in his office and for hurting his shoulder while closing a file cabinet drawer. The lawyer also had filed a third claim for "overexertion while carrying a briefcase."

•the wife of an administrative law judge, who received $30,000 for "panic attacks".

•a doctor who rated workers' compensation injuries, who filed his own claim after he said he fell on his buttocks while hanging curtains in his office.

We looked at the claims of the 11 Kansas lawyers mentioned in the newspaper reports. Because all but one of the claims were made against private law firms and their insurance companies, we did not have access to files showing how the insurers handled or investigated the cases. Instead, we were limited to reviewing files at the Division of Workers' Compensation.

Among the findings: The insurers settled all the cases, meaning they were completed by informal and perfunctory settlement hearings. Settlement hearings occur when the parties have reached an agreement and, as part of the settlement, agree to forego some or all of their rights under the Kansas Workers' Compensation Act. Those include the right to a full-fledged administrative hearing before a full-time administrative law judge and the right to reopen a case for review-and-modification.

Although some claims involved injuries that appeared to have ongoing ramifications, such as degenerative discs or herniated discs, all of the lawyer-claimants gave up their rights to future medical payments. All cases used medical reports to support disability ratings, but physicians were deposed in only three cases. The depositions appeared to be taken to try to apportion liability between the insurance carrier and the Workers' Compensation Fund. This Fund pays part or all of claims of injured workers who suffered from preexisting injuries that contributed to or caused the on-the-job accident.

In none of the cases involving the lawyers did it appear that the insurance companies challenged the compensability of the claims. The lawyers, in response to the news articles about their claims, strongly maintained that their claims were work-related and compensable.

Below is a table outlining details about the 11 lawyers' claims:

Injury and Cause	Insurer	Settlement	Disability Rating	Average Weekly Wage
Back injury; lifted a briefcase	St. Paul Fire & Marine	$28,000	N/A	$1,500
Back injury; lifted a briefcase	ITT Hartford	$40,000	3%	$4,818
Back injury; lifted a briefcase	State Farm	$67,500	6%	$3,644
Back injury; slipped and fell on ice	ITT Hartford	$25,000	10%	$957
Back injury; reached for book	State Self-Insurance	$30,000	9%	$1,298
Back injury; file didn't say how it occurred	St. Paul Fire & Marine	$55,419	7%	$2,861
Back injury; tripped and fell	St. Paul Fire & Marine	$36,453	5%	$2,635
Knee injury; tripped and fell	Cigna	$10,741	6%	$1,000
Shoulder injury; chair fell on shoulder	CNA Insurance Co.	$107,913	10%	$5,615
Shoulder injury; auto accident	St. Paul Fire & Marine	$60,000	6%	$3,000
Numerous injuries; auto accident	State Farm	$70,000	10%	$2,500

APPENDIX B

Agency Response

On August 5, 1993, we provided a copy of the draft audit report to the Department of Administration and the Division of Workers' Compensation. Their written responses are included as this Appendix.

In response to the Department of Administration's comments, we made several wording changes to the audit. The most significant change occurred in the middle of page 12, where we changed the sentence in bold type. Initially, we had stated that the Self-Insurance Fund did not seek a timely medical opinion of Mr. Bell. In its response, the Department of Administration objected to the use of the word "timely", pointing out that a second opinion can be obtained any time before a case is submitted to the administrative law judge. The point we wanted to make was that the agency appeared ready to settle Mr. Bell's claim without seeking a second medical opinion, we changed text in the final draft to reflect that fact.

STATE OF KANSAS

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GLORIA TIMMER, *Secretary*

JOAN FINNEY, *Governor*

August 10, 1994

Barbara Hinton
Legislative Post Auditor
800 SW Jackson, Suite 1200
Topeka, Kansas 66612-2212

Dear Ms. Hinton:

Thank you for providing us the opportunity to review your legislative post audit report before the final copy is prepared. Overall, I believe the conclusions set out on page 24 of the Post Audit review are accurate and agree with the recommendations which follow thereafter. I did want to address the four points listed on page 2 in order to provide a clearer picture of how this case was handled.

"The claim was never investigated to determine whether it was compensable."

I concur with this finding. The State Self-Insurance Fund staff neither interviewed Mr. Bell or others regarding whether his briefcase lifting injury arose in the course of his employment. I also concur with the similar findings that in the majority (75%) of the selected 1988 and 1989 cases involved in the audit staff's review, including Mr. Bell's, there was no interview with the claimant and there was an inadequate investigation to determine the work-related nature of claimant's injuries. This shortcoming has been addressed through the adoption of written policies and procedures developed in 1991 and further by allocation of additional staff in the 1993 budget process.

"A second medical opinion was not sought in a timely manner (and when it was, an unfamiliar doctor was used)."

In Mr. Bell's case a second medical opinion was sought some six months prior to the regular hearing. A medical opinion can be requested at any time before a case is submitted to the administrative law judge. This label of "untimely" is in error.

It appears the auditors found it to be significant that the medical opinion was sought after an in-house discussion on possible settlement. Those discussions were based upon a rating by the treating

physician. Mr. Newman advises me that the value of a case, developed through in-house discussions about possible settlement, is often a factor in deciding whether a second opinion will be sought. It does not appear that the second opinion in this case was outside the scope of time usual to workers' compensation cases generally.

The audit report also noted the doctor providing the second opinion was "unfamiliar" to the State Self-Insurance Fund staff. This is contradicted by the report itself on page 13 which indicates that he was recommended by the State Self-Insurance Fund's staff attorney who devoted 100 percent of his time to workers' compensation matters. That attorney advised Mr. Newman the doctor followed the protocol outlined in the AMA Guides and, based upon past experience of the advising attorney, it was felt that he was an excellent witness in workers' compensation evaluation matters.

Mr. Newman has indicated that based on that information, he knew:

1. That the doctor's criteria for impairment evaluation would be clinically sound (according to the AMA Guides),

2. The kinds of information the doctor would use to document the nature of the impairment,

3. The specific procedures for acquiring that information including the tests to be performed and the equipment to be used, and

4. The structured format for analyzing, recording and reporting the information.

This information provided sufficient data upon which to base a decision to hire a particular rating physician.

"The Workers' Compensation Fund was not impled to help pay Mr. Bell's award, even though he had a preexisting condition."

I too have some concerns on this topic. However, George Welch, Director of the State Self-Insurance Fund, indicated that in his best professional judgment there was an inadequate basis to impled the Worker's Compensation Fund.

Mr. Welch's judgment was based solely upon Dr. Wertzberger's letter, dated January 4, 1990, which stated in part "I, therefore, conclude that Mr. Bell's low back situation at the present time is totally related to the incident in January 1989 and that there is no contribution from his previous vehicular accident. Prior to the briefcase incident in 1989, I conclude that Mr. Bell was intermittently

inconvenienced and went about his day-to-day and job activities in a protective mode; however, he was not handicapped from obtaining or retaining his employment related to any incident prior to January 18, 1989."

"Physicians were not deposed at Mr. Bell's hearing before the Division of Workers' Compensation."

I discussed this with Mr. Newman and he enumerated the following points which support his decision. Any decision whether to depose a physician must be based upon the particular facts of each case. Generally, the claimant's attorney would first schedule a doctor for deposition who provided the highest disability rating. The respondent, in order to present a balanced picture of the case, would then be required to offer alternative evidence through a deposition of the doctor providing the lowest disability rating.

In this case, the claimant's attorney did not depose the physician providing the highest disability rating. By taking this step, he passed up the opportunity to establish Dr. Barr's credentials and buttress the doctor's opinion for the higher disability rating.

On the other hand, had Mr. Newman chosen to depose Dr. Wertzberger, the claimant would have been given that opportunity to discredit the doctor with the lower rating.

Based upon Mr. Newman's explanation, it appears this aspect of the case was handled appropriately.

"Recommendations"

I concur with the recommendations outlined on page 25 of the audit report and have so directed the State Self-Insurance Fund. Periodic spot checks will be taken in order to assure that established policies and procedures are being followed.

I appreciate the difficulty of the job and the professionalism of the audit team and thank you again for the opportunity to respond.

Sincerely,

Gloria M. Timmer

Gloria M. Timmer, Secretary
Department of Administration

GMT:sls

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Joan Finney, Governor
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August 15, 1994

Barbara Hinton, Auditor
Division of Legislative Post Audit
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Topeka, Kansas 66612

Re: Draft Report - Fletcher Bell Case

Dear Ms. Hinton:

Thank you for the opportunity to review your draft report of Reviewing the Workers Compensation Claim by Former Insurance Commissioner Fletcher Bell.

There are two issues which are directly related to the Division of Workers Compensation: 1) the judge did not seek an independent medical opinion, and 2) then director of Workers Compensation, Robert Anderson, had issued an administrative opinion which stated that splitting the difference between ratings was inappropriate.

Kansas law has allowed administrative law judges to request independent medical examinations for a number of years. During the time period of the Bell case, the Division's administrative law judges rarely used independent medical examinations for the majority of workers compensation cases unless the examination was specifically requested by the parties involved. As noted in the report, the changes in 1993 have mandated using independent medical examinations anytime the parties cannot agree on the percentage of functional disability rating so that this situation should not occur again.

Director Anderson had issued an administrative opinion for an individual case which did state that splitting the difference was inappropriate. A District Court judge in another workers compensation case during the same time period ruled that splitting the difference between conflicting impairment ratings was appropriate. Until the issue of conflicting impairment ratings was decided by the Court of Appeals or the Supreme Court, either opinion, or a hybrid of those opinions, could be used. Again, the 1993 changes have eliminated the Director's administrative opinions and District Court

opinions and placed these decisions in the hands of a Board of Appeals made up of five members.

There are a few minor issues which should also be clarified:

On page three of the report, you state that "all employers with an annual payroll of $10,000 or more must provide workers compensation coverage..." Current law sets the payroll limit at $20,000.

On page four of the report, the boxed text refers to an employee's average weekly wage being multiplied by the percentage of disability. An employee's average weekly wage is always capped at a state-wide maximum which is adjusted annually.

On pages 19 and 20 of the report, you state that 19 of the 27 claims never came in contact with the Division. These cases had been reported to the Division via accident reports filed with the Division; however, the cases had not been in contact with the workers compensation hearing process.

On page 20 of the report, you refer to an agreed award as a settlement. An agreed award is not a settlement. An agreed award is an open-ended agreement between the parties which preserves the rights of the claimant for a specified period. A settlement is the final statement or lump sum payment for a specific case and future rights are typically terminated. As well, the agreed award is signed by an administrative law judge and is filed with the Division.

Again, thank you for the opportunity to review this report. It was a pleasure working with you and your staff again. If we can be of any other assistance to you, please feel free to call.

Sincerely,

George Gomez
Workers Compensation Director

APPENDIX C

Current Claim Investigation Procedures of the Self-Insurance Fund

At the conclusion of the August 24, 1994 Legislative Post Audit Committee meeting, Chairman Salisbury requested that the Division include a copy of the Self-Insurance Fund's new procedures for investigating workers' compensation claims as an appendix to the audit. In addition, a complete copy of the procedures related to handling claims is on file and available for review at the Division's offices.

Procedure One - Investigation of Claims

K.S.A. 44-577(b) - The secretary of administration shall investigate, or cause to be investigated, each claim for compensation against the state workers' compensation self-insurance fund. For the purposes of such investigations, the secretary of administration is authorized to obtain expert medical advice regarding the injuries, occupational diseases and disabilities involved in such claims.

1. The principle responsibility of the insurance claim investigator is to investigate each claim against the Fund until such time as there are no material facts left to be reconciled. This is to include the interview of all persons who have information about the circumstances of the accident and injury. The questions of how, what, when, why and where must be answered and it is the responsibility of the investigator to make the decision as to when all these have been answered to the point where benefits can be paid without doubt as to compensability.

   1.1 Claimant interviews shall be conducted in each case except where the investigator deems a claimant interview extraneous to the investigation. Claimant interviews shall be personal face to face contact whenever possible. Use of the telephone will be condoned only in limited situations. Claimant interviews shall be noted in each file with written reports. In any case where a policy or procedure is not performed as set forth in this manual, the written report must reflect the reason standard operating procedure was not followed.

      1.1.1 Details of Accident - Obtain a complete statement regarding the accident. What happened? How did this accident occur" What was the primary cause of the accident? Where did the accident occur? Who witnessed the accident?

      1.1.2 Work history is important in all cases where permanent partial disability will likely be a factor. Work disability must be reported in the interview section of your written report, listing the jobs and employers the claimant as had in the fifteen years preceding the date of accident.

      1.1.3 Medical histories are important in all loss of time cases, especially those where permanent partial disability may be a factor. The investigative report must

reflect all past medical conditions, injuries, medical care, workers' compensation claims, or pre-existing disabilities reported by the injured worker.

1.1.4 The Act provides that in order to provide injured workers full and fair information about their rights and responsibilities under the Act, Kansas employers must distribute educational and informational materials as prescribed by the Director. In order to meet this obligation, it shall be the duty of the investigator to provide each injured worker with the "Attention" form formally known as K-WC 270.

1.2 Witness interviews shall be conducted in every case where there was a witness to the activity that lead up to or caused the accident or injury unless, in the best judgment of the investigator, such interview of a witness would be extraneous to the investigation. In any case where a known witness is not interviewed, the written report shall reflect the reason for not interviewing such witness.

1.3 Supervisor interviews shall be conducted when deemed necessary by the investigator. Such interviews shall confirm length of service, record of previous employers, copies of position descriptions, records of prior disabilities if known, and any other information deemed pertinent to proper adjudication of the claim.

1.4 Physician interviews, or other reports from physician's office staff, shall be obtained in every claim for benefits. Such reports may be in the form of actual copies of office or clinic notes, written summaries of treatment provided, for 1104-G, or any other suitable report form so long as it contains the nature of the complaint and subsequent treatment.

1.4.1 Medical records following the initial report should be submitted by the physician for each billing cycle or more often as requested by the investigator. Medical records in each file should be kept current.

1.4.2 When a medical history is developed in the

course of the investigation, complete medical records shall be obtained from the provider of care. Medical histories have a significant impact on all loss of time claims and must be a part of the file at the earliest possible time.

1.5 Workers' compensation director's records shall be checked on every loss of time claim file. This is done by computer check and investigative notes shall note this check was performed.

1.6 Subrogation or third party negligence can have a dramatic impact on a claim file. During the course of investigation, careful attention must be given to the possibility of recovering losses from a negligent third party. When the possibility exists for such recovery, the investigator shall refer the file to a staff attorney in order to place the negligent party on notice of the Fund's subrogation claim. Keep the staff attorney advised of progress on the file so that no time limits are overlooked and a demand can be made at the appropriate time.

1.7 The Workers' Compensation Fund can be implead on all claims where the date of accident was prior to July 1, 1994. During the course of the claim investigation and file management, careful attention should be given to the possibility of impleading the Fund. The Fund is to be implead in every case where it appears a pre-existing condition may have contributed to further disability. Every claim file in which it appears there could be Fund liability shall be discussed with the director. The director will determine whether or not to implead the Fund based upon information contained in the investigative file.

1.7.1 Review records in the Workers' Compensation Director's office, and if there is a history of prior claims for similar conditions, impleading the Fund is a possibility. Obtain those records for the file.

1.7.2 Review records in the Self Insurance Fund files, and if there is a history of prior claims for similar conditions, impleading the Fund is a possibility.

1.7.3 Review personnel records to determine whether or not the injured worker revealed a pre-existing condition or disability at the time of hire or

subsequent to that time. Obtain copies of pertinent records for the investigative file.

1.8 Each assigned claim file is to be thoroughly investigated and shall contain the following:

1.8.1 The file must reflect claimant met with personal injury arising out of and in the course of his employment;

1.8.2 The notice of injury given by the employee was within ten days of the alleged date of accident. If notice was not given within ten days, the investigative report must reflect a just cause for delay;

1.8.3 The employee must have been a State employee;

1.8.4 There must be a written claim for compensation in each claim for lost time benefits;

1.8.5 There must be a wage statement from the division of accounts and reports as soon as the injured worker is placed in a leave without pay status and is receiving workers' compensation benefits;

1.8.6 Complete medical records must be ordered from each provider of services who has treated the employee for the injury or for any other injury to the same part of the body;

1.8.7 A position description shall be obtained from personnel files and submitted to the attending physician in all extended loss of time files where the employee is off work longer than three weeks;

1.8.8 Evidence for possible impleading of the Fund shall be collected during the course of the investigation and such evidence shall be noted in the file when the investigation is completed;

1.8.9 Evidence for possible subrogation shall be collected during the course of the investigation and possible action against a negligent third party shall be recorded in the file when the investigation is completed;

1.8.10 Fraud and abuse of the system will not be tolerated. Any suspicion of or report of fraud or abuse shall be thoroughly investigated and reported to the director for further action. The following activities may be considered as possible fraud or abuse:

1.8.10.1 Making a false or misleading statement in an effort to obtain or deny workers' compensation benefits;

1.8.10.2 Misrepresenting or concealing any fact that could cause the State to inappropriately assess a case;

1.8.10.3 Fabricating, altering, concealing or destroying any document;

1.8.10.4 Bringing a claim for workers' compensation benefits which has no basis in fact.

Procedure Six - Litigated Claims For Benefits

6. Notice of attorney intervention may come to the attention of the claims investigator in several ways, including application for hearing, telephone calls, announcement by claimant or a demand for records. Each employee and their attorney shall be treated with courtesy and dignity regardless of differences in the case.

6.1 Upon receipt of notice of claimant attorney intervention, the investigator to whom the case is assigned shall retain full responsibility for case management.

6.1.1 The investigator shall respond to all demands for copies of medical records, wage statements, job descriptions and other materials as we are required to share with claimant.

6.1.2 The investigator shall retain management responsibility of the file without referral to the legal section until such time as there is a filing for hearing and a benefit review conference has been conducted. The investigator shall respond to all correspondence from the attorney until receipt of notice of filing for hearing is received.

6.2 It shall be the responsibility of the investigator to prepare and respond at all benefit review conferences before the case is assigned to legal staff.

6.2.1 Upon receipt of notice of a preliminary hearing, K.S.A. 534a, the investigator shall review the case file. A theory of defense shall be stated clearly in the file with sufficient evidence to support that theory. (See App. 6.2.1)

6.2.2 At the benefit review conference, K.S.A. 44-5,111, the investigator shall present the theory of defense and the evidence to support that theory.

6.2.3 If there is no theory of defense or evidence to support non payment of benefits as demanded by claimant, the investigator should have reached agreement on benefits before such conference.

6.3 When no agreement is reached at benefit review conference, the investigator shall immediately prepare the file for referral to a staff attorney.

6.3.1 The investigator, on the day of the benefit review conference, shall prepare a statement of the theory of defense and indicate all evidence in file that supports that theory.

6.3.2 The investigator shall examine the file, mark all documents needed by legal, have copies made, and submit the copied file to legal.

6.3.2.1 Documents needed by legal section in cases submitted for "settlement hearing only" include:

- a printout of all expenses paid to date on the file (computer)

- a copy of the last disability voucher

- a wage statement from accounts and reports

- a copy of disability payment breakdown (computer)

- a copy of medical rating report or other materials to support settlement agreement

- a copy of settlement calculations work-sheet

- a copy of all correspondence between all parties relative to settlement negotiations

- a copy of Fund impleading letters

- a copy of all 1101-A forms which settlement covers

- a copy of claimant's attorney's correspondence

- a copy of Fund attorney's correspondence

- a copy of vouchers paying unauthorized medical

- all correspondence from the Director of Workers' Compensation office

- the settlement check or copy of voucher

- any subrogation documents

- documents from any other attorney involved in any way

- a copy of any child support documents

- a memo requesting legal section to conduct a settlement hearing and the basis for such settlement

6.3.2.1 Documents needed by legal section in litigated cases:

- a copy of all accident reports, including 1101-A, agency accident reports, written notes concerning the accident and any other reports relative to how the accident occurred

- a copy of previous accidents documentation (data from the division of workers' compensation, prior accident files, employer reports such as applications or form 88)

- a copy of all statements, recorded or written, including video tapes

- a complete copy of all medical records collected for this file

- a copy of all correspondence in the file written by any party

- a copy of all employment tasks for the preceding 15 years

- a copy of all vocational records, including loss of labor market access, loss of comparable wage,

functional capacity reports

- a printout of all expenditures to date (computer)

- a copy of the latest benefits voucher

- a wage statement from accounts and reports

- a copy of benefit review conference reports

- a copy of any and all correspondence from the claimant attorney, Fund attorney, the division of workers' compensation or any other legal entity

- a copy of all working documents or research performed by the investigator

- a printout of all disability payments made (computer)

- a copy of all personnel records gathered in the course of the investigation

6.3.3 The legal staff shall establish a separate legal file for the defense of the claim.

6.4 Management of all claims remains with the investigator at all times, including defense measures, settlements and all other activities.

6.4.1 The attorney assigned the file shall provide the investigator with legal advise and request authority for all actions to be taken in defense of the file.

6.4.2 The investigator shall give full consideration to legal advise before taking action on litigated claim files.

6.5 Staff attorney may provide defense of litigated claim files or may refer such defense work to contract attorneys.

6.5.1 The legal section shall maintain records of all defense work, including location

of all current litigated claim files and the attorney of record in each case.

6.5.2 The legal section shall provide the director with a monthly report on litigated claim files, covering number of litigated claims, litigation costs, files assigned to contract attorneys and other pertinent information.

6.5.3 Staff attorney shall appear as co-counsel on all litigated claim files that are referred to contract attorneys.

6.6 Contact in the form of telephone calls, letters, or other correspondence after a claim file is referred to legal shall be between the attorney for claimant and attorney of record.

6.6.1 All incoming correspondence on a litigated claim file shall be sorted out by the mail section and routed to the legal section. Legal shall make a copy for their file and route the original correspondence to the investigator. The legal section shall respond to all correspondence and provide the investigator copies of all responses.

6.6.2 Telephone calls received on litigated cases from claimants shall be referred to the claimant's attorney.

6.6.3 Telephone calls received on litigated cases that have been referred to legal from claimant's attorney shall be referred to the attorney of record.