

Found Money:



The Benefits Of An Aggressive Approach To Second Injury Fund Recovery

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Employers, insurers, and TPAs often miss the boat when it comes to maximizing second injury fund recovery potential and millions of dollars go unclaimed each year. Are your second injury fund efforts up to par? Here is what you need to know.

The benefits of a comprehensive workers' compensation second injury fund recovery program are many. For the insured employer, recovery puts "money in their pockets" if there are deductibles or retentions or helps to reduce experience modification factors. For self-insured employers and insurers, dollars are recouped, loss costs are lowered and reserves are reduced. Because of the high recovery value of many claims, even a modest increase in the number of recovered claims can have a substantial positive impact.

Second injury funds are therefore the purpose of reimbursing eligible insurers and employers. Employers that do not ask for this money will not get it, but they will continue to finance the fund regardless, paying for others to get paid. Reimbursement is not guaranteed until it is negotiated, awarded and collected in a timely manner. Best Practice seeks not only to capture back the premium paid, but also for recoveries to exceed it. Because qualified claims are often long-term in nature, the per-claim value can average as much as \$300,000 in some jurisdictions. Consequently, failure to identify each and every opportunity, and to collect it in a timely manner, can be extremely costly.

Unfortunately, management of second injury fund recovery is all too often the forgotten stepchild. Many employers and front-line claims staff either do not understand the opportunities or simply are not trained to look for them on a day-to-day basis. In addition, claims staff and risk managers are often overworked and have competing priorities. Even within those organizations that have active recovery programs, opportunities may be untapped. Forensic audits of recovery conducted on tens of thousands of claims nationwide demonstrate that an estimated 15 to 25 percent of the potential is either not collected, under-collected or not collected in a timely fashion.

An Eye-Opening Opportunity

Today, about half of all states have active funds. These funds are known by different names but they share a common principle of reinsuring costs of industrial accidents in which pre-existing impairment contributes substantially to the injured party's long-term disability. Some of the states with the most recovery potential include Alaska, Arizona, Louisiana, Massachusetts, Nevada, New Hampshire, New York and South Carolina. Other jurisdictions, such as Connecticut, Florida, Georgia and Washington, D.C. have funds that have been, or are being, phased out and are in run-off, but, in some situations, recovery opportunities are still available for claims prior to a cut-off date.

States in which material recovery opportunity exists (reimbursement states) currently disburse more than \$750 million a year. A single claim for reimbursement in New York alone could be worth more than \$300,000 of recovery over the life of the claim.

States that take over payments made to injured employees (rather than reimbursing insurers after they have made the payments) account for another estimated \$250 million a year in disbursements. If 15 to 25 percent of the opportunities are missed, this leads to the conclusion that the industry is leaving more than \$100 million on the table each year.

Why second injury fund recovery is overlooked

Typically, potential beneficiaries do not spend the time or money to improve their second injury fund recovery process because they either fail to realize the full monetary potential of recovery dollars that would more than justify such expenses, or they accept that because some money is being recovered, they have it covered.

The process of second injury fund recovery involves three basic functions: identification, investigation and perfection of the case; negotiation and/or litigation; and reimbursement. At a typical insurer or claims administration service, these functions are performed by different sets of people, often with different priorities and workloads. Inevitably, there is slippage as the claim travels from function to function and is subjected to varying skill levels.


The following represent some of the most common reasons why second injury fund recoveries get left behind.

The need to establish goals and metrics. There is a dearth of metrics to measure success and to create recovery goals. This exists both within individual companies and in the industry as a whole. To incorporate a recovery program into a total claims system, management needs to know not only what has been recovered, but also what is in the pipeline - by case, by line of business, by state and by accident year. This information must include a timeline and a risk assessment for recovery. Performance is very hard to improve unless there is something to measure.

Recovery is treated as a commodity. The recovery process is anything but a commodity, particularly on the larger, more complex cases. It involves the application of complex analytical skills that focus on medical, legal and investigative disciplines and will often encompass multiple approaches. All too often, the cost of the recovery process is measured while the potential net benefit of recovery is left unmeasured. A balance must be struck between cost and benefit and the net benefit needs to be measured. A company should not be hesitant to use expert help to achieve maximum results.

Flawed assumptions - "We've already got it covered." One of the most common barriers to recovery is the assumption that the current recovery process is covered and yielding maximum results. This assumption persists despite a lack of metrics or forensic audits to assess effectiveness of existing efforts. A well-run, traditional bundled approach to second injury fund recovery may capture only 80 percent of potential opportunities. That means that at least 20 in 100 files may be missed and another 8 to 12 may not be fully collectable. At as much as \$300,000 per file in some jurisdictions, this means the loss of millions of dollars.

The need for focus. The job of identifying and investigating second injury fund claims has traditionally fallen to claims adjusters, who are often overloaded. They tend to address the



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emergency on their desks first and second injury fund reimbursement if, and when, they can get to it. In the process, valuable time is lost. Statutes-of-limitations and filing deadlines are missed, important protective documents are not filed, and critical medical and employment records are lost with the passage of time.

The need for training and/or specialization. Statutes vary widely by jurisdiction with each having subtleties that require an in-depth knowledge of the system. Critical judicial decisions or changes in the law can alter the roadmap overnight and require a vigilance that cannot be expected of an employee whose main job function has little to do with second injury funds. Knowing how to characterize a reimbursement claim in a manner that succeeds with an individual state fund, as well as dedicating the time that is necessary to make it work, can produce recovery on a claim that would otherwise be turned down. Finally, assembling a reimbursement claim in a professional and organized manner makes it easier and quicker for the fund to agree to honor the claim and for the insurer or employer to be reimbursed.

Defensive rather than proactive orientation. In the negotiation/litigation function, insurers and employers often rely on defense counsel to make decisions and push claims through the system. The recovery task is corollary to the attorney's primary function and often does not get the attention and skill it deserves. Defense counsel may not know the full value of the claim or have enough direct experience to recognize the potential that can be expected from negotiation.

The actual recovery should be given high priority. Despite the fact that recouping cash is the reason for all the efforts in the first place, the process often breaks down on actual collection. The process of tracking the receipt of settlements or judgments requires time and dedication and is best done on a system-wide basis rather than by an individual adjuster. Obtaining the reimbursement of ongoing benefits when a settlement or judgment provides for them is even more important. If the case is not in active litigation, this aspect can often be overlooked and statutes-of-limitations deadlines can be missed.

The need to conduct regular audits. Even though a claim may not show evidence of a prior impairment when it is first opened, or at the moment when a second injury fund checklist is applied, it does not mean that the claim will never qualify for recovery. Such evidence often comes to light only during a later independent medical examination (IME) or a subsequent investigation. But by that time, the focus is no longer on second injury fund claims and the opportunity can be missed. By regularly auditing both new and old claims for recovery potential, an insurer can capture dollars that would otherwise be lost. In-house resources rarely have the time or expertise to conduct dedicated audits for this purpose.

The need to utilize the right expert medical help. Similar to defense counsel, the standard IME doctor does not fully understand the medical opinions needed to establish a claim and adjusters do not always understand how to ask the right questions. As a result, necessary expert opinions are either not given or given without adequate basis to accomplish a resolution of the claim

Best practices yield results

A model for second injury fund recovery requires that the best ideas and unique tools of two very different disciplines be incorporated. A factory-like process is necessary to handle the second injury fund claims that are straightforward and routine. Yet the process must also incorporate a knowledge management system that has many of the attributes of a law firm, but with the propensity for administrative resolution rather than litigation.

Knowledge management refers to the combined use of technology to gather, analyze and organize information, documents and expertise to drive strategy and manage tasks. Use of knowledge management enables standardization of the recovery process and recognition of economies of scale. The process must focus on eliminating error and waste as well as on using the technology to support efficiency. Employees who would thrive using this process must be recruited, trained and retained. Through education, feedback and performance evaluation, knowledge management will also lead to continuous process improvement.

Bundled or unbundled?

An important consideration is whether a second injury fund recovery process should be bundled or unbundled. Organizations need to decide whether to develop or retain a dedicated unit that focuses exclusively on second injury fund recoveries or whether a bundled service will be utilized as part of claims administration. The distinction between bundled services and unbundled services is critical and a decision might hinge on claims volume and the recovery potential. If the claims volume and average cost per claim is low, a bundled service may suffice. Nevertheless, retaining an expert vendor to enhance performance where there are gaps in the process can lead to increased revenue.

It is tempting to view bundled servicing units as more cost effective because the associated expense can be spread out among existing resources. In reality, the

systemic problems associated with a bundled recovery process can lead to a much greater total cost. The prerequisite for success is a focused, proactive, process-engineered system that approaches recovery with dedication, efficiency and expertise. Unfortunately, many insurers and self-insured employers are unwilling or unable to make the financial and/or management commitment to develop such a highly specialized, dedicated unit.

There are many advantages to using the unbundled approach. Highly trained lawyers/claims professionals can mine all opportunities. Focused claims examiners/recovery specialists have statute-of-limitations diaries and ensure that notice is complete and accurate. They are also trained investigative specialists who work with medical experts to produce a complete opinion. Claims for reimbursement are assembled into a petition in which all data are present to achieve immediate resolution. The process should create a better than 85 percent success rate at the first resolution attempt. Negotiators know all the issues, practices and procedures and have access to a national database to apply to special cases. Producers are measured not only by the quality of their work but also by early resolution. Each action step is taken at the earliest possible time. A bonus to resolution of the second injury fund claim is that it often leads to the early resolution of the underlying claim. Using such an unbundled approach results in a significantly higher net rate of recovery and lower total cost.

Success Stories: Real results, real money

Many successful recoveries can be attributed to a dedicated service aggressively pursuing claims that a non-dedicated service would abandon. For example, in one situation an adjuster discouraged an outsourced recovery service from pursuing a file because he had been unable to obtain evidence of employer knowledge of the prior impairment as required by statute. Yet, at \$300,000, the claim had a high exposure potential for a second injury fund

case. The recovery expert was able to obtain evidence of employer knowledge and successful recovery was achieved. In another instance, the claimant had undergone a prior surgery, but the insurer could not provide any evidence of this surgery that predated the second injury. The claim was denied by the fund. When recovery experts took over the claim, they relentlessly pursued a magnetic resonance imaging (MRI) test taken right after the second surgery. Since they were able to obtain films but no report, they had the MRI films read and, in this manner, were able to establish that the employee had in fact had a laminectomy prior to the second injury. On this basis, the fund accepted the case, which had an initial reimbursement value of approximately \$70,000 and a full recovery over its life of \$177,000.

Success stories can be found in the case files of large insurers as well. One large insurer recently presented a case to Special Funds at a Pre-trial Conference, but the case was adjourned because the carrier failed to produce sufficient medical evidence documenting a prior, permanent impairment. Recovery experts were able to dig for the necessary medical evidence to support the claim, which ultimately resulted in a recovery of an estimated \$244,000. In another case, a carrier investigated and ruled out second injury fund reimbursement based on advice of counsel. The reason cited was that the employee was no longer being treated for hypertension, the alleged pre-existing condition upon which the carrier based its claim. Recovery experts were able to find medical records that confirmed that the employee's hypertension only normalized after his work-related stroke and his doctors discontinued his blood pressure medication. Recovery experts applied an alternative legal theory by arguing that based on the nature of the disability that ensued, the employee's pre-existing hypertension played a clear and contributory role in the employee's work-related stroke. With this argument, the insurer recouped \$495,330 that would otherwise have been lost.

Maximizing Recovery

For most organizations, a small amount of planning effort could result in millions of extra dollars hitting the bottom line. The following questions will help in analyzing your current process in relation to Best Practices:

- Have the recovery potential been evaluated and recovery goals established?
- Is the recovery operation bundled or unbundled? If it is bundled, does the necessary expertise exist? Are the necessary staff, systems and disciplines in place to achieve success?
- Is there a proactive audit function that backs up identification by claims personnel? Does the identification process combine both technology and expertise?
- Is there a specialized recovery unit responsible for and rewarded for managing the whole process to success? Are the recovery specialists rewarded for the tasks they can accomplish that will drive success?
- If there is not a specialized recovery unit, does the recovery process utilize specialists to fill gaps in the recovery program?
- Does the process ensure that all opportunities to reduce reserves by offsetting costs onto third parties are consistently pursued in all states?
- Does the system give you the information you need to measure success? Is expected recovery measured? Is actual recovery measured? Is the future value of the recovery of the tail of a long-term claim measured?
- Are the right systems in place? Is there a quality-control audit system? A knowledge-management system? A litigation-management system? A collection and reimbursement system?

Only when these questions are answered in the affirmative can the excellence demanded by Best Practices be realized.

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