Management Audit of the Disability Compensation Division and A Study of the Correlation Between Medical Access and Reimbursement Rates Under the Medical Fee Schedule

A Report to the Governor and the Legislature of the State of Hawaii

Report No. 02-07
March 2002

THE AUDITOR
STATE OF HAWAII

Office of the Auditor

The missions of the Office of the Auditor are assigned by the Hawaii State Constitution (Article VII, Section 10). The primary mission is to conduct post audits of the transactions, accounts, programs, and performance of public agencies. A supplemental mission is to conduct such other investigations and prepare such additional reports as may be directed by the Legislature.

Under its assigned missions, the office conducts the following types of examinations:

1. *Financial audits* attest to the fairness of the financial statements of agencies. They examine the adequacy of the financial records and accounting and internal controls, and they determine the legality and propriety of expenditures.

2. *Management audits*, which are also referred to as *performance audits*, examine the effectiveness of programs or the efficiency of agencies or both. These audits are also called *program audits*, when they focus on whether programs are attaining the objectives and results expected of them, and *operations audits*, when they examine how well agencies are organized and managed and how efficiently they acquire and utilize resources.

3. *Sunset evaluations* evaluate new professional and occupational licensing programs to determine whether the programs should be terminated, continued, or modified. These evaluations are conducted in accordance with criteria established by statute.

4. *Sunrise analyses* are similar to sunset evaluations, but they apply to proposed rather than existing regulatory programs. Before a new professional and occupational licensing program can be enacted, the statutes require that the measure be analyzed by the Office of the Auditor as to its probable effects.

5. *Health insurance analyses* examine bills that propose to mandate certain health insurance benefits. Such bills cannot be enacted unless they are referred to the Office of the Auditor for an assessment of the social and financial impact of the proposed measure.

6. *Analyses of proposed special funds* and existing *trust and revolving funds* determine if proposals to establish these funds are existing funds meet legislative criteria.

7. *Procurement compliance audits* and other *procurement-related monitoring* assist the Legislature in overseeing government procurement practices.

8. *Fiscal accountability reports* analyze expenditures by the state Department of Education in various areas.

9. *Special studies* respond to requests from both houses of the Legislature. The studies usually address specific problems for which the Legislature is seeking solutions.

Hawaii's laws provide the Auditor with broad powers to examine all books, records, files, papers, and documents and all financial affairs of every agency. The Auditor also has the authority to summon persons to produce records and to question persons under oath. However, the Office of the Auditor exercises no control function, and its authority is limited to reviewing, evaluating, and reporting on its findings and recommendations to the Legislature and the Governor.

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OVERVIEW

Management Audit of the Disability Compensation Division and A Study of the Correlation Between Medical Access and Reimbursement Rates Under the Medical Fee Schedule

Report No. 02-07, March 2002

Summary

This audit and study was conducted pursuant to Senate Concurrent Resolution No. 147, S.D. 1 of the 2001 Regular Session. The resolution requested the Auditor to conduct a management audit of the Department of Labor and Industrial Relations' Disability Compensation Division and a study of whether an injured employee's access to medical care is being curtailed due to the practice of tying reimbursement rates to the medical fee schedule.

The division employs about 124 employees and administers benefit programs that provide health care and economic relief to workers for on- or off-the-job injuries and illnesses. These benefit programs are the workers' compensation, temporary disability insurance, and prepaid health care described in the Hawaii Revised Statutes, Chapters 386, 392, and 393, respectively.

We found that the division's internal control system contains some serious deficiencies affecting fiscal accountability and if not corrected, could permit fraud to go undetected. For example, the director lacks policies over the waiver of penalties for violations of the workers' compensation law. During FY1999-2000 and FY2000-01, the division administrator waived $950,000 of over $1.2 million in penalties without approval of the director. In addition, we found the division's position descriptions did not reflect the actual duties of staff managing the Special Compensation Fund. We found some staff performing work functions unrelated to their position description and some functions performed by staff outside the division. Furthermore, we found financial reporting of penalties and reimbursements from employers was piecemeal and of questionable usefulness. For example, the division had no single computer system to maintain statewide information on penalties nor one financial report that presented total receivables for statewide penalties assessed by the division. Effective internal controls help to ensure that an organization achieves its goals, produce accurate and reliable financial reports, and safeguard its assets.

We also found that the division invested over $750,000 for a new computer system without an updated departmental information systems plan and an appropriate steering committee, and failed to integrate the system with its strategic plan and goals. Consequently, much of the division's financial reporting system continues to be maintained manually and the accuracy, reliability, and usefulness of any computer data is highly questionable. For instance, we found that a $10,000 penalty assessment did not appear on the department's Administrative Services Office records.

Finally, we found that weak oversight by the director has resulted in serious management issues for the division and its administrator. For the audit, we conducted a survey of the division's employees to assess morale and office culture. With a response rate of about 70 percent, we found that over 60 percent did not trust the administrator, almost 41 percent reported morale within the division was poor, and 35 percent felt their personal morale was low. In addition, over 52 percent felt that the administrator had favorites and almost 25 percent of respondents felt improprieties occurred in the division. Low morale often prevents an organization from operating effectively and efficiently.

The Legislature also requested that we study concerns regarding injured workers being denied access to medical services under the current workers' compensation law. In our study, we found no significant evidence to demonstrate that injured workers' access to medical care was curtailed by tying reimbursement of medical services to the Medicare fee schedule. We found that current reimbursement rates do not significantly impact the provision of medical services, do not significantly contribute to the departure of providers from the state, and are not unreasonable. We also found that use of the Medicare reimbursement rate is widely accepted by other states, easy to implement, and cost-beneficial. Comprehensive increases in the fee schedule are unnecessary as the law allows the director of labor to adjust the fee schedule to address inequities. However, legal and practical barriers result in inefficiencies and cause the adjustment process to be ineffective.

Recommendations and Response

We recommended that the director of labor implement written policies over the penalty waiver process, complete the department's information systems strategic plan, and exercise adequate oversight over the division administrator. Oversight would include establishing a plan for the administrator to improve on the division's internal controls, the information systems, and the morale of staff within the division. We also recommended that the director evaluate the administrator's compliance with the plan.

To address practical barriers in the medical fee adjustment process, we recommended that the director of labor allocate sufficient resources to obtain statistically valid surveys, implement mechanisms to obtain information from health care providers, and educate providers about the fee adjustment process. To address the legal barriers, we recommended that the director seek an exemption from the state Small Business Regulatory Flexibility Act of 1998 for the fee adjustment process. The current law requires an additional, extensive impact statement and review process that adds more than a year to the fee adjustment process.

The Department of Labor and Industrial Relations generally agreed with our audit recommendations and noted that it has implemented or will be implementing procedures to comply with the recommendations.

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A Report to the Governor and the Legislature of the State of Hawaii

Submitted by

THE AUDITOR
STATE OF HAWAII

Report No. 02-07
March 2002

Foreword

This is a report of our audit of the Department of Labor and Industrial Relations' Disability Compensation Division and a study of whether an injured employee's access to medical care is being curtailed due to the practice of tying reimbursement rates to the medical fee schedule. This audit and study was conducted pursuant to Senate Concurrent Resolution No. 147, Senate Draft 1 of the 2001 Regular Session.

We wish to express our appreciation for the cooperation and assistance extended by officials and staff of the Department of Labor and Industrial Relations and others whom we contacted during the course of the audit.

Marion M. Higa
State Auditor

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Chapter 1
Introduction

This audit and study was conducted pursuant to Senate Concurrent Resolution (SCR) No. 147, S.D. 1 of the 2001 Regular Session. The resolution requested the Auditor to conduct a management audit of the Department of Labor and Industrial Relations' Disability Compensation Division and a study of whether an injured employee's access to medical care is being curtailed due to the practice of tying reimbursement rates to the medical fee schedule. Legislative concerns over the division's administration of workers' compensation claims prompted the request for the management audit.

Background on the Disability Compensation Division

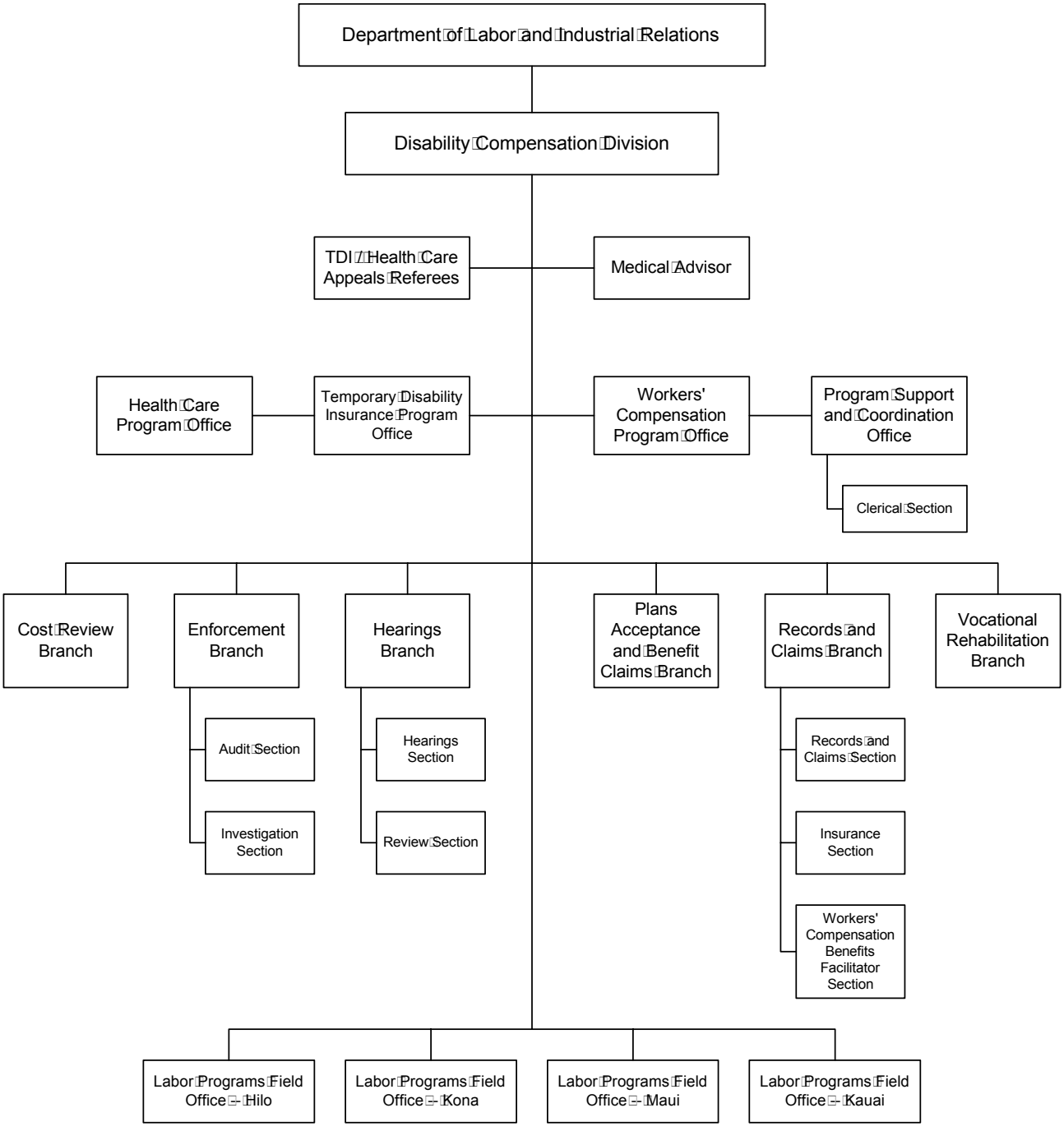
The Disability Compensation Division is one of five divisions within the Department of Labor and Industrial Relations. The division administers benefit programs that provide health care and economic relief to workers for on- or off-the-job injuries and illnesses.

Organizational structure of the division

The disability division is comprised of four program offices and six functional branches. Three of the program offices, Temporary Disability Insurance, Workers' Compensation, and Health Care, are responsible for programs by the same names. The fourth program office, Program Support and Coordination, coordinates technical and support services for the entire division, which includes personnel, budgeting, and coordinating implementation of new programs and projects. The division's six functional branches—Records and Claims, Hearings, Enforcement, Plans Acceptance and Benefit Claims, Cost Review, and Vocational Rehabilitation—participate in each of the above three program areas in varying degrees. The medical advisor and temporary disability insurance/health care appeals referees are per diem employees or on contract.

The disability division's employees total 124 statewide—78 work exclusively in Honolulu while the remaining 46 employees are at four neighbor island field offices. The division's field office staff also receives assistance from non-division staff who are assigned to other labor department programs. Exhibit 1.1 displays the organization of the Disability Compensation Division.

Exhibit 1.1
Disability Compensation Division of the Department of Labor and Industrial Relations



Source: Department of Labor and Industrial Relations.

Roles and responsibilities of the division

Specific chapters in the Hawaii Revised Statutes (HRS) describe the roles and responsibilities for the division's three major program areas. Chapter 386, HRS, the Workers' Compensation (WC) Law, covers on-the-job injuries. Chapter 392, the Temporary Disability Insurance (TDI) program, covers employees who are unable to work due to an off-the-job sickness or injury and may receive income replacement benefits. The division also administers Chapter 393, the Hawaii Prepaid Health Care (PHC) law, which requires employers to provide health care coverage for eligible employees.

Three major program areas of responsibility

The WC law establishes an employer-paid insurance program that provides economic relief for employees who are injured on the job. Benefits cover medical and indemnity (lost wage) expenses for employees. Authorized expenses include medical and hospital costs. Indemnity expenses include permanent disability and/or disfigurement awards and vocational rehabilitation expenses. The WC program is administered through the division's five branches: Cost Review, Enforcement, Hearings, Records and Claims, and Vocational Rehabilitation.

The TDI law is also an employer-paid program that provides partial wage loss benefits to employees who suffer off-the-job injuries or illnesses. The TDI program is administered through the division's sixth branch, Plans Acceptance and Benefit Claims, as well as its Enforcement Branch.

The state's Prepaid Health Care (PHC) Act requires employers to provide health care benefits to eligible employees with coverage that includes hospitalization, surgery, medicine, diagnostic tests, and maternity benefits. The division administers the PHC program like its TDI program, through the Plans Acceptance and Benefit Claims and Enforcement branches. Hawaii was the first state to adopt a prepaid health care law.

Program areas are supported by six functional branches

Six branches support the disability division's three major programs in varying ways. Nearly a third of the division's Oahu employees work in the Records and Claims Branch which consists of three sections: Records and Claims, Insurance, and Workers' Compensation Benefits Facilitator. The Records and Claims Section receives and resolves complaints and provides informational and clerical assistance to the division and public. The Insurance Section manages insurance policies endorsements, expirations, and cancellations, and employers' compliance with insurance coverage requirements. It also processes and directs payments to disabled workers from the Special Compensation Fund. The

Benefits Facilitator Section responds to inquiries from claimants, attorneys, insurance carriers, and employers; educates claimants on their rights and benefits under the law; and recommends improvements in the claims process to benefit all parties in the workers' compensation system.

The Hearings Branch, comprised of a fifth of the division's Oahu employees, prepares, hears, and adjudicates workers' compensation award cases through its two sections. Its Review Section prepares cases for hearings, schedules hearings, and issues administrative decisions for cases not requiring hearings. Its Hearings Section conducts administrative hearings of workers' compensation claims to determine employers' liability, extent of payment to disabled workers, death benefits, and compromises on awards and attorney fees.

The Enforcement Branch enforces compliance with all three laws, WC, TDI, and PHC, through its Audit and Investigation Sections. The branch assesses and collects penalties related to the Special Compensation Fund, but the fund is administered by the department's Administrative Services Office.

The Plans Acceptance and Benefit Claims Branch reviews and approves insured and self-insured plans as meeting all requirements of the temporary disability insurance and prepaid health care laws. The branch processes special disability fund payments to claimants and premium supplementation payments to employers. It schedules hearings to adjudicate temporary disability insurance appeals.

The Cost Review Branch reviews, qualifies, and monitors health care providers and their treatment plans to ensure that medical care and services provided are necessary and appropriate. The branch conducts investigations, holds administrative hearings, and adjudicates cost issues with health care providers.

The Vocational Rehabilitation Branch is primarily responsible for reviewing and approving rehabilitation providers' plans for injured workers; for certifying rehabilitation agencies; and for referring injured workers to rehabilitation and monitoring their progress.

Special funds help support important division functions

Annual general fund appropriations of over $4 million support the division's operations. The majority, or 84 percent, of total expenditures are for personnel salaries. Exhibit 1.2 shows the division's general fund allotments and expenditures over the past four fiscal years.

Exhibit 1.2
Disability Compensation Division
General Fund Allotments and Expenditures, FY1996-97 to FY1999-2000

	FY1996-97	FY1997-98	FY1998-99	FY1999-2000
Allotments	$4,199,833	$4,909,357	$4,619,394	$4,275,882
Expenditures	$4,103,619	$4,141,298	$4,083,079	$4,098,894

Source: Department of Labor and Industrial Relations.

However, the division also receives and administers three special funds: the Special Compensation Fund, Special Fund for Disability Benefits, and Special Premium Supplementation Fund. Revenue for these funds is generated primarily through assessments, penalties, and interest income. Together, the funds have averaged over $18 million in revenue and interest income and approximately $17.6 million in expenditures over the past six fiscal years (FY1994-95 through FY1999-2000).

The Special Compensation Fund

Section 386-151, HRS, establishes the Special Compensation Fund to provide medical, rehabilitative, income, and indemnity benefits to workers who suffer work-connected injures or to the employee's dependents in the event of death. The fund is used to pay benefits to a worker whose employer has defaulted in providing workers' compensation coverage as well as to pay for three positions in the Workers' Compensation Benefits Facilitator Unit. Benefits paid from the fund are recovered from the defaulting employers.

The fund's revenues are derived from assessments, fines and penalties, and benefits from deceased employees who have no dependents. The director may assess insurance carriers and self-insured employers to replenish the fund whenever its predetermined balance is insufficient to meet its obligations. Fines and penalties imposed by the director on any person who violates the workers' compensation law are also deposited into the fund.

The Special Fund for Disability Benefits

Section 392-61 establishes the Special Fund for Disability Benefits for individuals who become temporarily disabled off-the-job and are ineligible for unemployment insurance benefits. The fund also pays temporary disability benefits to employees who are entitled to benefits but cannot receive them because of an employer's bankruptcy or employer noncompliance with the TDI law.

The fund is supported by contributions, fines and penalties, and interest income. A one-time assessment of employers in 1969 was used to establish the fund, but no assessments have been levied since then. During the past six fiscal years (FY1994-95 through FY1999-2000), the fund's balance increased from $5.8 to nearly $7.2 million. Average interest income of over $300,000 per year accounted for 99 percent of the fund's revenues. Total expenditures averaged about $56,000 over the same period.

The Special Premium Supplementation Fund

The Special Premium Supplementation Fund under Section 393-41 was initiated with a general fund appropriation of $375,000. The fund defrays the cost of providing health care benefits for certain employers who employ fewer than eight employees and meet eligibility requirements under Section 393-45, HRS. Interest income, which averaged about $141,000 a year, comprises 95 percent of the fund's revenues while expenditures average under $30,000 a year. The fund's balance over the past six fiscal years (FY1994-95 through FY1999-2000) has increased from $2.6 to $3.2 million.

Prior audits of the workers' compensation process have included issues involving the division

Our prior reports have reviewed the workers' compensation payment process, claims process, and the Special Compensation Fund, but we have not specifically conducted any management audits of the Disability Compensation Division. In our *Audit of the Workers' Compensation Payment Process in State Agencies* (Report No. 01-03), issued in February 2001, we found that the state workers' compensation payment process was mired in delays and that division's issuance of decisions contributed to those delays. The division was also inconsistent in assessing penalties. We recommended that the department address delays in processing workers' compensation payments by:

- Reducing the amount of time it takes to schedule hearings, including time limits for medical evaluations, and ensuring that hearings decisions are issued in a timely manner and in accordance with Section 386-86;

- Seeking a legislative amendment to Section 386-95 to require that employers file WC-3 annual reports by January 31 of the next year after a calendar year has ended (rather than by December 31 of the same year); and

- Establishing a system to identify violations of Chapter 386, monitoring such violations, and assessing related penalties to ensure compliance with the law.

The department disagreed with our finding that decisions were not timely but agreed that the reporting date for WC-3 annual reports should be changed to January 31. Regarding the assessment of penalties, the department stated that it lacked sufficient resources to conduct 100 percent compliance monitoring.

Our 1997 *Audit of the Special Compensation Fund of the Workers' Compensation System,* Report No. 97-3, found that the Workers' Compensation Benefits Facilitator unit should be funded by general funds instead of a special fund. We also found that the Special Compensation Fund had grown larger than needed to meet its obligations and recommended that the department improve its management of the fund by more appropriately matching its revenues to its expenditures. The department generally agreed with our findings. However, no legislation has been enacted to change the funding mechanism of the facilitator unit. The department also stated that its formula for charging levies is designed to match revenues with expenditures, but that the formula may not consider cases in progress or bankruptcies because of the variable and uncertain nature of the information.

Our 1996 Report No. 96-5, *Study of the Workers' Compensation Claims Process for State Employees,* did not include any recommendations directed towards the division or the Department of Labor and Industrial Relations.

Background on Hawaii's Medical Fee Schedule

The term 'medical fee schedule' refers to both the Medicare Resource-Based Relative Value Scale (MRBRVS, or Medicare-based schedule) and Hawaii's supplemental fee schedule. The Medicare-based schedule is the scale used by health practitioners nationwide when computing reimbursement rates for services provided under Medicare. Hawaii uses the same scale, adjusted to 110 percent (which means the Medicare Fee Schedule plus 10 percent) when reimbursing practitioners for workers' compensation-related services.

Hawaii's supplemental fee schedule lists reimbursement rates for selected workers' compensation-related services that are not covered in the Medicare-based schedule. The Department of Labor and Industrial Relations develops, distributes, and periodically updates the supplemental fee schedule as allowed through administrative rules.

Legislative history of the medical fee schedule in Hawaii

Act 116, Session Laws Hawaii (SLH) 1963, established the medical fee schedule in the workers' compensation law. The medical fee schedule limits employers' liability for injured workers' medical services to medical, surgical, and hospital services and supplies at the community's prevailing rates.

Act 78, SLH 1973, amended the workers' compensation law, tying the medical fee schedule to annual changes in the U.S. Department of Labor's Consumer Price Index for the Honolulu Region. Under Act 78, the director is responsible for establishing, reviewing, and, if necessary, revising the department's regulation relating to the medical fee schedule. While the Hawaii Legislature amended the workers' compensation law relating to the medical fee schedule in the 1979, 1985, and 1987 legislative sessions, the amendments made no substantive changes to the fee schedule.

However, Act 234, SLH 1995, significantly changed the workers' compensation law by tying Hawaii's medical fee schedule to the Medicare-based schedule instead of the Consumer Price Index. The law specified that beginning January 1, 1997, charges for medical services were not to exceed 110 percent of fees in the Medicare-based schedule. Act 234 also required the director of labor and industrial relations to annually update the schedule based on changes to the Medicare-based schedule, statistically valid surveys, or data on prevalent medical services charges provided by the appropriate state agency. Act 260, SLH 1996, subsequently expanded the requirement to update the medical fee schedule from once a year to once every three years or annually, as required.

Studies relating to the medical fee schedule

The Hawaii State Legislative Reference Bureau (LRB) and the University of California at Los Angeles (UCLA) conducted studies on the medical fee schedule in 1998 and 1999, respectively. The UCLA Center for Health Policy Research's study, *The Use of Resource-Based Relative Value Scales for Provider Reimbursement in State Workers' Compensation Programs,* analyzed the use of resource-based relative value scale systems. The LRB study, *The Medical Fee Schedule Under the Workers' Compensation Law*, assessed the impact of using the Medicare-based schedule on access to medical care for injured workers in Hawaii.

The UCLA study found that adopting a resource-based relative value scale (RVS), i.e., the Medicare-RBRVS, potentially improves the fairness of payments for workers' compensation services. The UCLA report surveyed 20 states and found that a resource-based RVS had several major advantages over other types of relative value scales. Namely, the Medicare-RBRVS undergoes more extensive public development, review, and scrutiny than any other RVS and is updated annually with input from all of the American Medical Association's specialty groups as well as from non-physician providers represented by the Health Care Professionals Advisory Committee.

The LRB report concluded that the Medicare-RBRVS had a negative impact on access to specialty care by injured workers and that the fee schedule should be adjusted. The LRB based its conclusions on its analysis of responses from a health care provider survey. The report stated that health care providers were concerned about the lowered fees under the Medicare-RBRVS system, which combined with a decrease in health care providers' treatment of workers' compensation cases created a negative impact. The report explained that access to specialty care was diminished because the number of providers who treat workers' compensation cases had decreased. The LRB report concluded that the fee schedule should be increased to at least 125 percent of the Medicare-RBRVS, but not over 130 percent.

Objectives of the Audit

1. Assess whether the Disabilities Compensation Division is managed efficiently and effectively.

2. Assess whether or not an injured employee's access to medical care is being curtailed due to the practice of tying reimbursement rates to the medical fee schedule.

3. Make recommendations as appropriate.

Scope and Methodology

In evaluating the management of the division, we assessed the efficiency, effectiveness, and legal compliance of selected divisional operations; adequacy of the division's management tools; morale and office work environment within the division; and use and administration of the division's special funds. We evaluated processes and procedures relating to the division's operations for case processing, hearings, penalties, reporting, and special funds.

For the audit, we reviewed and evaluated strategic plans, written procedures, memorandums, complaints, financial statements, management reports, workers' compensation files, and other documents. We also performed interviews, observations, document reviews, surveys, and analysis of statistical data. Our work focused on program and fiscal operations from FY1998-99 to FY2000-01.

We concentrated our testing on the division's operations in Honolulu where the majority of claimant information and agency financial information are centralized. However, we also visited the neighbor island branch offices to review their case files and operations.

We reviewed applicable state statutes including Chapter 386 (Workers' Compensation), Chapter 392 (Temporary Disability Insurance), and Chapter 393 (Prepaid Health Care Act). We also reviewed administrative rules under Title 12, Subchapter 3, Section 10 (Workers' Compensation), Section 11 (Temporary Disability Insurance), Section 12 (Prepaid Health Care), Section 14 (Rehabilitation), and Section 15 (Workers' Compensation Medical Fee Schedule). We also used procedures provided by the division and the General Accounting Office (GAO) standards for internal controls, strategic planning, and information systems as applicable. In addition, the State's *Distributed Information Processing and Information Resource Management* and the System Development Methodology requirements were used to assess the division's compliance with planning of data processing resources.

To accomplish the study's objectives, we examined whether access to care, in terms of number of practitioners versus number of workers' compensation patients in Hawaii, is increasing or decreasing; whether workers' compensation patient access to medical care in Hawaii is declining; the rate at which other jurisdictions reimburse for workers' compensation claims; and the impact of the 1995 change in the reimbursement rate schedule. Our focus for the study was on the period after Act 234, SLH 1995, was amended when the reimbursement rate schedule was capped at 110 percent of the Medicare schedule.

We evaluated division procedures and operations, conducted interviews, and gathered and analyzed relevant data. We obtained workers' compensation data from other states, national organizations related to workers' compensation, and Hawaii's Department of Commerce and Consumer Affairs. We also surveyed medical practitioners to determine their reasons for accepting or declining workers' compensation patients and surveyed patients regarding their ability to find appropriate care for their workers' compensation injuries. We also examined the division's process to adjust reimbursement fees.

Our audit and study included surveying and sampling to obtain information. They included the following activities:

- To help us evaluate the division's office culture and morale, we mailed out surveys to employees to obtain their perspectives on the organization and its leadership. We mailed out a total of 120 surveys primarily to division employees, with the exception of the administrator. The list of employees surveyed also included other departmental employees who performed some division tasks. We received 86 responses for a response rate of 71.6 percent. Some of the departmental employees did not complete the survey and returned it with the explanation that they were not division employees.

- To help us determine whether injured workers encountered difficulties in obtaining medical care due to the 1995 change in the medical fee schedule, we surveyed persons who had filed workers' compensation claims before and after that year. We selected a statistical sample of names and addresses from the division's records for two sets: those injured in 1994 and those injured in 2000. The division provided us with the 1994 claimants (total of 42,651) and the 2000 claimants (total of 31,834) from which we determined that 520 surveys would be mailed to each group. We received 86 responses from the sampled 1994 claimants and 151 responses from the sampled 2000 claimants. The response levels of 16 percent and 29 percent, respectively, based on a scientific sampling provided an 85 percent confidence level and a precision rate of ±10 percent.

- To help us determine the medical community's perspective on the medical fee schedule and their attitudes toward treating workers' compensation patients, we surveyed medical care providers from different specialties. For our survey, we duplicated, with its permission, the 1998 survey administered by the Legislative Reference Bureau for its 1998 study, *The Medical Fee Schedule Under the Workers' Compensation Law*. However, we used a different methodology for selecting our population. The bureau's study surveyed 2,400 physicians and 300 chiropractors. The bureau also published the survey in newsletters for physical therapists and acupuncturists. The study's mailing did not differentiate among medical specialties who may or may not treat workers' compensation patients. In contrast, we surveyed specific medical specialties licensed by the Department of Commerce and Consumer Affairs who do treat such patients. Exhibit 1.3 displays the medical specialties that we surveyed.

From the 21,189 in-state licensed practitioners listed at the Department of Commerce and Consumer Affairs, we selected on a statistically random basis, 1,823 to receive our mail surveys. We received 520 responses for a 28.5 percent response rate. The sampled population and response rate provided an overall 85 percent confidence level and a precision level of ±10 percent for all practitioners surveyed.

Our work was conducted from May 2001 through December 2001 in accordance with generally accepted government auditing standards (GAGAS).

Exhibit 1.3
Medical Practitioner Survey Recipients

Specialty	Total Licensees	Out-of-State Licensees	In-State Licensees	Surveys Mailed	Responses Received	Response Rate %
Chiropractors	539	242	297	148	58	39%
Dentists	1,352	337	1,015	170	72	42%
Dispensing Opticians	131	18	113	113	20	18%
Doctors of Medicine	6,158	2,882	3,276	173	62	36%
Massage Therapists	3,925	551	3,374	170	23	14%
Naturopaths	75	19	56	56	17	30%
Licensed Practicing Nurses	2,368	182	2,186	175		
Registered Nurses	11,458	1,939	9,519	172		
Total Nurses			11,705	347	41	12%
Optometrists	347	121	226	170	68	40%
Osteopaths	370	253	117	117	16	14%
Physical Therapists	774	220	554	158	46	29%
Podiatrists	74	40	34	34	20	59%
Psychologists	531	109	422	167	73	44%
Administrator			0	0	1	0
Other			0	0	3	0
Total	28,102	6,913	21,189	1,823	520	28.5%

Source for licensees: Department of Commerce and Consumer Affairs.

Chapter 2

Weaknesses in the Overall Management of the Division Create Significant Risks for the State

The Disability Compensation Division of the Department of Labor and Industrial Relations administers the state's workers' compensation, temporary disability insurance, and prepaid health care laws. The purpose of these laws is to protect the interests of employees injured on- or off-the-job by helping workers recover and return to work in a timely manner. To achieve this purpose, the division must be managed effectively and efficiently.

Summary of Findings

1. The Disability Compensation Division's internal control system contains some serious deficiencies that currently affect fiscal accountability and if not corrected, could allow fraud to go undetected.

2. The director of labor's weak oversight of the administrator of the Disability Compensation Division has resulted in significant internal conflict and human resource management issues.

Serious Flaws in the Division's Internal Controls Undermine Fiscal Accountability and Increase Risks for Fraud and Lost Revenues

Internal controls ensure that organizations achieve their goals and objectives, produce reliable financial reports, and protect assets from fraud or loss. The Disability Compensation Division's internal control system is deficient in several control areas. Inadequate supervisory review, poor financial reporting, and inaccurate position descriptions hinder the division's ability to protect its assets and resources. In addition, the development of its new computer system failed to capture necessary data that would improve the division's system of internal controls.

Internal controls are essential for safeguarding assets and for reliable financial reporting

Internal controls are processes, procedures, or activities that occur throughout an organization's operations and are designed to provide reasonable assurance that the organization achieves its objectives. Effective organizations need internal controls to reasonably ensure that:

- Obligations and costs comply with applicable laws;

- Assets are safeguarded against waste, loss, unauthorized use, and misappropriations; and

- Revenues and expenditures are recorded and accounted for properly so that reliable financial and statistical reports may be prepared to ensure accountability of its assets and effective organizational management.

Deficiencies in the overall control system will result in inadequate financial reports. Deficient financial reports prevent management from having necessary information to make informed judgments and decisions to manage and improve an organization.

A good internal control system requires that the agency's organizational structure clearly define key authority, responsibility, and lines of reporting. Policies and procedures and an organizational structure should address lines of reporting and authority.

Good internal controls that safeguard assets include activities that prevent or detect unauthorized transactions and unauthorized access to assets that could result in losses. For example, management approvals on transactions and properly documented transactions are internal control activities that demonstrate safeguarding of assets. Adequate controls entail a vendor payment requiring a proper invoice with the cost and description of the item or services, proper authorization or signature approving the purchase, and documents showing the receipt of the item or services rendered. Without these controls, an organization cannot ensure that its assets are properly used or possibly misappropriated.

Internal controls also include quality system-generated financial reports that affect management's ability to make informed decisions. Financial reports summarize transactions and account for the assets, liabilities, and equity of an organization. The strength of an organization's financial reporting system can detect unrecorded transactions or potential risks relevant to waste, fraud, and abuse.

The division's internal control system contains significant flaws

The Disability Compensation Division's internal control system contains several significant flaws. The administrator's ability to waive penalties without supervisory review is one example. Other internal control deficiencies are poor financial reporting, out-of-date position descriptions, and inadequate tracking of financial information, which all result in increased risks for fraud.

Supervisory review of penalty waivers has been inadequate

The director of labor and industrial relations exercises very little supervisory control of the Disability Compensation Division administrator's waiver of penalties. Section 386-123, HRS, authorizes the director of labor to assess penalties on employers for violations of the workers' compensation law. The section also permits the director to

reduce all or any part of the penalty except for $250 for good cause. However, the division's administrator has assumed authority over reducing penalties without receiving the proper delegation of authority from the director to do so.

To ensure that businesses retain insurance coverage on their workers, the law allows the director to assess penalties on employers for failing to obtain coverage, file a report of injury, submit a physician's report, or file a copy of the insurance policy. The most common penalty is failing to obtain coverage. Under Section 386-123, employers are subject to penalties of not less than $250 a day or $10 for each employee per day. There is no cap on the amount an employer can be penalized. Most penalties are initiated during the hearings process and assessed at the final decision. However, branch offices can initiate penalties when the branch office discovers violations of the workers' compensation law. The division administrator signs each penalty before it is sent to the employer.

During FY1999-2000 and FY2000-01, branch-initiated penalties totaled over $1.2 million. However, approximately $950,000, or about 80 percent, was waived by the division administrator. The $950,000 administrative reduction addressed two penalties assessed in February 2001. In May 2001, the administrator reduced the $887,000 penalty to $25,000. In August 2001, he reduced the $78,060 penalty to $1,000.

The administrator has no policy, written or otherwise, regarding penalty waivers. The administrator reviews and grants penalty waivers on a case-by-case basis without any established criteria for determining the appropriateness or response time of the waiver. In the above examples, both penalties were assessed in the same month but the first was waived in three months and the second was waived in six months. Several division managers and supervisors stated that recommendations for penalties are sent to the administrator who makes the final decision. We found no indication that the department director approves the administrator's waivers. The administrator's justification for the waivers is that he does not want to put companies out of business. This practice is a serious breach of internal controls since it provides the administrator with unquestioned and unwritten authority to waive a violator's penalty. This authority violates Section 386-123, HRS, and allows the administrator to function beyond the scope of his position and authority.

This penalty waiver process represents a serious weakness in internal controls, especially considering the degree of authority, without accountability, placed in one person's hands. The administrator's authority encompasses both the ability to assess and to waive a penalty. There is no formula or limit on the dollar amount that the administrator can waive. There are no guidelines on how one can initiate the waiver. There are no guidelines or criteria on types of supporting evidence that

must be submitted to justify a waiver. For the waiver of $77,000 described above, the only supporting evidence provided by the administrator was a letter from the company stating that it had no employees during a certain time period. If the concern is not to bankrupt a business by forcing compliance with disability laws, one logical criterion could be to secure proof of the employer's financial instability, such as financial statements, before granting a waiver. We found no evidence of such support to aid the administrator in his waiver decisions.

In addition, the director has no policy regarding these penalty waivers. The department director claimed that the authority to waive penalties had been delegated to the division administrator by the previous director and that the division administrator is in the best position to authorize the waivers. However, we found that the previous director's letter delegated to the administrator the authority to "sign all awards granting benefits" and did not specifically include the authority to waive penalties. The authority to waive penalties without proper oversight and guidelines raises significant concerns of fairness and equity. Penalty waivers should be controlled by written policy and be approved by the director.

Financial reporting deficiencies hamper management reviews

The division manages the Special Compensation Fund as established under Section 386-151, HRS. The fund accumulates assessments from insurers and employers for current and projected workers' compensation payments. Penalties and reimbursements from employers are also deposited into the fund. Employers reimburse the fund for payments made by the fund on behalf of the employer. The fund pays wage benefits to employees or fees to physicians when the employer fails to pay. Although the Disability Compensation Division manages the fund, the department's Administrative Services Office (ASO) performs most of the financial reporting for the fund.

However, financial reporting for the Special Compensation Fund is piecemeal and of questionable usefulness. No single accounting system holds all relevant information on receivables for the Special Compensation Fund. Most penalties are assessed through the hearings process. These penalties are entered into the division's old mainframe computer system and into a personal computer spreadsheet at the ASO. The division's mainframe computer system's "Outstanding Penalties and Reimbursements" report contains penalties issued by a decision but does not show payments made by the party involved, reductions from an appeals board decision, or branch-initiated penalties. The division is unable to print a penalty report for a specific time frame; therefore, a year-by-year comparison of assessed penalties cannot be done.

Information on penalties reduced by subsequent appeals or partial payments by employers are recorded on the ASO's personal computer,

but not in the old mainframe system. The ASO's spreadsheet that lists receivables for penalties shows penalties issued by decisions, payments received, and adjustments made but does not show branch-initiated penalties. The division maintains a separate listing for branch-initiated penalties that are not included either on the mainframe system or in the ASO's personal computer spreadsheet. Consequently, there is no single system that holds statewide relevant information for penalties nor one financial report that presents total receivables for statewide penalties assessed by the division.

The division also cannot report total payments made from the Special Compensation Fund and relies on the ASO's accounting of payments without verifying the information. The division notifies the ASO that payment should be made from the fund for medical or wage benefits on behalf of a delinquent employer. These notifications contain a copy of the decision from the hearing. The division approves an invoice for payment and sends the invoice to the ASO but does not verify that payment was appropriately made. The division does not keep a subsidiary ledger to verify the ASO's balances for the Special Compensation Fund. The division is unable to verify if any payments were excluded from this report or if erroneous amounts were recorded. During our fieldwork, we were unable to obtain a total listing of payments made and could not verify the completeness of the ASO's listing. Reports lacking necessary information are not useful.

Position descriptions are inaccurate and outdated

The control environment is a control standard against which an organization's internal controls are assessed. The control environment creates a culture of accountability by establishing a positive and supportive attitude towards improvement and the achievement of program outcomes. A key factor in the control environment is the assignment of authority and responsibility to staff. To accomplish this, management ensures that staff position descriptions clearly indicate the degree of authority and accountability delegated to each position and that the responsibility assigned is accurate and current. Management identifies appropriate knowledge and skills needed for various jobs. Current and accurate position descriptions help ensure that employees possess such knowledge and skills for their jobs.

The division's written position descriptions do not adequately reflect the actual duties and responsibilities of staff responsible for managing the Special Compensation Fund. We found some staff performing work functions unrelated to their position description. In fact, some duties were being performed by staff outside the division. Without accurate position descriptions, the division does not know whether the staff

currently responsible for managing the Special Compensation Fund has the requisite skills and knowledge to properly perform the job at an acceptable level.

The division's weak organizational environment increases opportunities for fraud

Fraud can occur at all levels within an organization. According to a study by a national consulting company, poor internal controls are the number one cause of fraud, while management's override of internal controls is second, and collusion between employees and third parties is third. The division's weak internal controls, including management's override of controls, invite the possibility of fraud.

Internal control standards require clearly documented criteria or guidelines and transactions authorized and executed by persons acting within the scope of their authority. However, we have seen how the division administrator has no written criteria or guidelines for waiving penalties. The administrator grants penalty waivers on a case-by-case basis without the proper delegation of authority to waive such penalties.

The lack of a division policies and procedures manual is another weakness in the division's internal control system. The lack of a manual creates a weak link in the chain of accountability. The division's current procedures manual is simply an instructional manual for the new computer system. The division claims that the Department of Attorney General advised against documenting office policies. We found no written evidence to support any advice of this nature. The examples we have presented and the weak financial reporting represent a weak system of internal controls.

The new computer system does not capture necessary data for assessment of performance

The division investment of over $750,000 for a new computer system proceeded without a proper evaluation of its information technology and organizational needs. Information technology investments and proper evaluation require a capital investment strategy that integrates organizational goals with capital decision-making. Integrating the organization's goals with the capital investment ensures that the investment helps the organization achieve its strategies and goals. However, the division developed its new computer system without integrating its overall strategic plan and goals.

The division contracted with a consultant on June 5, 1998, expecting the consultant to complete its new computer system by December 1999. For the duration of this development, the division was also working on its first strategic plan. During our audit fieldwork, the division was working on its third iteration of its strategic plan and had not yet completed its performance measures. As a result, the division was unable to integrate

its computer system's capacity to efficiently track the necessary information for measuring performance and meeting goals as established in its strategic plan.

The division does not know whether its new computer system, which primarily tracks hearings and related information, can help the division meet its goals. Much of the division's financial reporting systems are maintained manually. It has yet to finalize and integrate performance measures with its computer system. Performance measures are tied to mission goals and objectives and can be quantified to measure problems and track progress. Good measures can provide the information needed to meet goals and objectives.

It is not too late for the division to integrate its new computer system with its program information. However, the division has yet to conduct a post-installation evaluation of the overall computer system, which is a critical step in measuring whether the computer information system is operating effectively. After the system has been installed and operational for several months, a re-examination can determine how well the system meets its original and cost/benefit justifications. The re-examination would also determine whether changes or enhancements are required to improve or prolong the useful life of the system. Since the division failed to conduct a post-installation evaluation, it is unaware of the effectiveness of its computer systems and what further enhancements could be beneficial.

The new computer system was developed without adequate planning

The Department of Labor and Industrial Relations did not adequately oversee the division's development of its new information system. The division developed its information system without an updated departmental information systems strategic plan and an adequate executive steering committee.

The State's Information and Communications Services Division (ICSD) of the Department of Accounting and General Services requires state agencies to submit a *Distributed Information Processing and Information Resources Management* or DIPIRM plan for distributing and managing processed information. The plan defines departmental functions, processes, data, or operations that will benefit from the use of technology. In developing the plan, the department identifies the requirements for integration and interfacing of data, functions, and processes among all organizational entities. The labor department's latest state information system strategic plan or DIPIRM is dated 1994.

Without an up-to-date strategic information systems plan, the department has not adequately assessed data integration and interfacing requirements of all its divisions.

According to the State's System Development Methodology (SDM) guidelines, a steering committee should include all organizational entities having a direct or indirect interest in information systems-related matters, projects, and issues. In developing its new computer system, the division's steering committee, which guided the development effort, lacked adequate representation from concerned parties. The department's Administrative Services Office was not on the steering committee even though it generates various financial reports for the disability division. As a result of insufficient attention to financial reporting, the division's new computer system fails to generate efficient financial reports. Instead, financial reporting for the division remains a cumbersome manual process whereby paperwork is passed from the division to the Administrative Services Office where staff must manually enter the information into a personal computer. To obtain some very basic financial information, the division staff must prepare separate reports from different computer systems.

On the positive side, the department has since ensured that its information systems are developed properly with participation from all interested parties. The department recently produced a draft copy of its strategic plan for the development of its information systems that requires a review by an executive steering committee comprised of representatives from the department's various divisions and offices. We believe this draft plan review process is a step in the right direction, and the director should encourage its further development.

Accuracy and usefulness of computer data is highly unreliable

The division's reporting of total receivables due for the Special Compensation Fund must be gathered from different sources, and discrepancies in the source cast doubts on the accuracy of the data. The division's mainframe report called "Outstanding Penalties and Reimbursements" does not provide updated or complete information on penalties because the mainframe tracks only the initial penalty assessments from decisions rendered. Branch-initiated penalties and reductions or waivers are not recorded. The ASO's personal computer-based spreadsheet maintains a running balance for each penalty, but its accuracy is questionable. For example, a $10,000 penalty assessed in a September 15, 1999 hearing (and recorded in the mainframe) does not appear on the ASO's printout of the spreadsheet. A penalty of $5,308.63, from an October 4, 2000 decision, also does not appear on the ASO's spreadsheet printout. In addition, a recent printout of the ASO's spreadsheet, dated June 30, 2001, incorrectly shows a penalty of $10,950

when the penalty had been reduced to $1,251.80 in a June 19, 2001 appeal. The division can develop neither a consolidated nor a reliable receivables report.

The mainframe computer's tracking of claimants for each insurance carrier is also unreliable because it contains errors that affect the division's ability to conduct standard audits. The mainframe report, "Cases By Selected Carriers/Adjustors" lists cases of individual claimants for each insurance carrier and shows the benefit payments paid by the company during the current and prior years. Under the workers' compensation law, insurance companies pay injured workers wage and medical benefits. At the end of the year, the insurance company reports benefits paid and applies for reimbursements of overpaid benefits from the division. In testing whether the division made timely reimbursements to the insurance company, we noted that the mainframe report does not list all claimants found in the year-end reports. The division informed us that the missing claimant is in the computer system, but a system limitation causes the claimant from appearing in the report. However, the Enforcement Branch uses this mainframe report to audit insurer's services to individual claimants. Claimants that do not appear on the mainframe report will never be audited, and the division cannot be assured that all claimants receive appropriate services.

Weak Oversight by the Director Has Resulted in Serious Management Issues for the Division Concerning its Administrator

A former director implemented a strategic planning initiative in 1996 that revealed significant morale issues within the division. Five years since that initiative, we found that morale problems identified in 1996 continue and are focused largely on the management style of its administrator. Since the problems affect the division's human resources, a most important type of resource for any organization, the director of labor should ultimately be held responsible for the efficient management and morale of the division.

The director's strategic planning initiative revealed problem areas with the administrator

The former director's 1996 strategic plan initiative, titled ZING, revealed problems with the division's management. The director's ZING approach was intended to promote quality management, customer driven goals, and employee empowerment. The first step in the ZING approach was a "self-assessment" through employee surveys of strengths and weaknesses. Almost 80 percent of the division staff responded, and the results showed serious problems with the division's management.

Low morale, fear of retaliation, and lack of direction were common themes

The self-assessment found managers and staff having different perspectives on the morale and working environment within the division. Managers were satisfied with performance, but staff expressed criticism over the lack of leadership, lack of direction, and inadequate information within the division.

The survey contained questions in various categories, but common themes pointed to a negative atmosphere. The categories covered in the survey were: 1) leadership, 2) information and analysis, 3) strategic quality planning, 4) human resource excellence, 5) management of process quality, 6) quality and operational results, and 7) customer focus and satisfaction.

The self-assessment reported very few positive findings except that supervisors were satisfied with their units' performance and with the current processes. Under the leadership category, staff reported lacking sufficient direction from the administrator "to properly focus their efforts to produce the desired synergism to support the division." Staff also reported that "the culture of the division fosters fear and distrust for some employees." Within the strategic planning category, staff felt that the division focused on short-term goals and failed to recognize long-term goals and planning strategies. Under the human resources category, staff felt uninformed on how they fit in the division's goals, and some felt certain branch offices were "suffering from severe morale problems."

Information is lacking for proper assessment of performance

The self-assessment also reported that staff lacked adequate information to properly assess their performance. The report stated that the lack of guidance and leadership have caused managers to rely on past data collection efforts and have done little to improve key measures of performance. The staff found that the inflexible mainframe computer system prevented creative thinking and that using the obsolete and deteriorating equipment to maintain services was a major hurdle. Staff also reported that the lack of set goals made it difficult to establish appropriate measures and compare products and services with competitors.

Staff provided recommendations to address the criticism rendered in their self-assessment. Most of the recommendations were directed at forming strategic plans with appropriate long term goals, providing training, and addressing morale problems. Staff generally found the ZING process to have promising possibilities and encouraged its continued implementation.

Efforts to reduce conflict were unsuccessful and problems still exist

The division's attempt to implement the ZING guidelines and recommendations was perfunctory at best. Even with the third iteration of its strategic plan and implementation of a new computer system, we found that the division's problems still exist, and in some cases, appeared to be more serious.

Our survey of all division employees, except for the administrator, found that division employees repeated many of the 1996 complaints. Staff complained about the lack of leadership, poor division morale, and distrust of the administrator. While our survey results indicate that steps taken to address the problems may not have been properly implemented, the survey also indicated a more serious level of antagonism within the division.

Actions to resolve conflict have not produced appreciable results

To address the perceived lack of guidance, the staff in 1996 recommended establishing a strategic plan, long-term goals, and written policies and directives. To combat the culture of fear and distrust, staff recommended the establishment of ZING teams to seriously consider employee suggestions. Staff believed that the continuation of the ZING approach could improve morale and foster greater trust. Staff also believed that a new computer system and associated processes would make operations more efficient.

The then-director required the division to establish process action teams to address and resolve identified issues and problems. The division administrator formed several teams, and the staff also formed teams with the approval of the administrator. Since its attempt to initially develop a strategic plan in 1999, the division has annually worked on completing a strategic plan. In addition, the division also implemented a new computer system, which can schedule hearings, provide email communications, and generate some reports quicker than the old mainframe computer system.

However, we found that other division actions were either only partially or poorly implemented. For example, the division's strategic plan lacks finalized performance measures and was developed with limited staff participation. The new computer system does not meet original expectations of staff who are currently burdened with using two computer systems. The process action team approach received little guidance and direction from the administrator and produced very little to address morale issues. One staff referred to the process action teams as committees of people with a common interest that later evolved into a "process action team."

Staff appear fearful of administrator and have expressed morale problems

Over 70 percent of the 120 division employees responded to our survey on division morale and office culture. We modeled the survey instrument after a "Leadership Competency Survey Instrument" developed by a local market research firm. See Appendix A for other responses to our survey. The staff responses indicated that low morale, distrust and fear of the administrator, and poor leadership continue to affect the division staff.

A significant number of staff, over 60 percent, disagreed with the survey question that the administrator is widely trusted. Individual survey responses were indicative of the staff's fear of the administrator. The respondents described the administrator as being retaliatory, vindictive, threatening, and intimidating. Other comments from the surveys included:

- *We could have a good working division if working together were encouraged and that trust could be built instead of an environment of distrust and feeling that management working towards their own ends instead of the good of the division and the public.*

- *Administrator should be more conscious of his playing favoritism with certain individuals and branches/units, stop his "intimidation tactics" in getting his point across, and try to earn the trust and respect of division staff.*

- *[The administrator] manages by intimidation and threats. It is difficult to trust him and he is not approachable at all. He is vindictive and also retaliatory. He lets his emotions get I (sic) the way of making sound decisions. He has threatened many individuals with either firing them or eliminating their positions.*

- *He has held meetings using expletives and has threaten (sic) our office, with reorgs (sic), job eliminations and terminations.*

- *I feel that once your audit team leaves DCD, there will be some type of reprisal or backlash.*

- *This survey must be kept highly confidential, as the administrator is highly retaliatory.*

The fear and distrust of the administrator is so prevalent that most staff did not describe morale problems during personal interviews and only provided evidence of low morale through the anonymous survey

instrument. Almost all staff made positive remarks about morale in speaking with our staff, making such positive comments as the following:

- *Morale is good. Employees are happy because they come to work.*
- *Everyone is happy. Once they come to this division, they don't want to leave.*
- *Morale is positive. It's pretty good-nobody leaves.*
- *If morale were not OK, there would be more absentees and sickness.*
- *Morale is positive. There are no excessive requests for leave and no in fighting.*

However, our survey results showed a different picture of the division's morale. Almost 41 percent reported that the division's morale was poor and 35 percent felt their personal morale was low. Individual comments concerning the morale within the division included:

- *We have very low morale because of poor management of this office. ...I feel very frustrated because since (sic) morale is low with other people, quality of work is decreased and it creates more work for other workers.*
- *My level of morale has been consistently poor since the change to do (sic) this current administrator and continues to get worse.*
- *Morale seems to be at an all-time low. Guidance from management is poor.*

Respondents also felt that the division's poor leadership caused low morale. Individual comments included the following:

- *It is frustrating to have poor leaders.*
- *Poor leadership, communication, staff shortages, overworked, no vision.*
- *Unpredictable leadership; employees always 'the blame'; priorities unclear; responsibilities not clearly defined.*
- *Poor leadership on all levels which approaches situations on a reactive rather than proactive rectification.*

Survey of staff shows significant internal conflict within the division

Besides the low morale and fear of the administrator, survey respondents also noted some significant internal conflicts within the division. While some respondents agreed that the administrator was skilled in spoken and written communications, over 60 percent responded that he could not be trusted. Over 52 percent felt that the administrator appears to play favorites and does not have the patience to hear people out.

In addition, staff also expressed concerns over inappropriate use of state resources. Almost 25 percent of the respondents felt that there were improprieties within the division such as sale of cosmetics, misuse of break times and lunch hours, constant use of equipment for personal matters, and community activism during work hours.

The respondents made the following comments regarding favoritism and improprieties in the division:

- *Employees leaving early from work before 4:00.*
- *People use the Xerox machine freely without compensating for materials used. But selling of food items and crafts have stopped.*
- *If you see "high" morale marked, these are probably from those employees that are favored because they get what they want. …Unless you are favored, he will not see your point of view.*
- *Selling personal products,… to employees, insurance representatives and attorneys, who appear [at] hearings.*
- *[The administrator] micromanages the staff too much and too often. He has favorites and shows favoritism.*
- *People coming in late, going home early, taking longer breaks and lunches than allowed.*
- *Many employees (both supervisory and non-supervisory) do not do their jobs professionally… or do not do their jobs. Administrator is aware of this problem and knows who these personnel are, but does nothing.*
- *Management positions evidently do not have "job descriptions". They seem to just dole out the work and are not too keen on assisting in the day to day operations… We also have a situation*

where one worker spends much time involved in community activism during work hours: phone calls, no adherence to state work hours.

- *There are those who are the administrator's favorites who are probably the only people that really knows what's going on or what's "coming down" in this division, those who are indifferent, and those who detest him for his management style and arrogance.*

- *Longer than 10 minute breaks on a regular basis. Certain individuals are allowed to do only what they choose to do; those that don't complain have additional duties added.*

- *Individuals utilizing company time for personal purposes.*

Comments received in some of the surveys suggest significant adverse feelings toward the administrator. Comments included "*Remove the administrator," "He is bringing down DCD," "Let someone else take over… anybody but [him]," "He consistently threatened us with our jobs … he berates you and belittles you in front of others," "Our meetings with him are scolding sessions,"* and *"I live with fear."*

On the other hand, some respondents expressed support for the administrator. Written comments included *"I find the questions being asked very questionable and sounding more like a character assassination rather than an objective audit of the performance of the division. Are these the kinds of questions that are normally asked in these types of legislative audits or is this some sort of witch hunt? This is not to say that the administrator is performing 100 percent satisfactorily and without any fault. There are areas where there is room for improvement however, the line of questioning is very suspect," "He does listen – not sure he's trying to understand,"* and *"What kind of survey is this? This is more like a 'witch hunt'."*

Other favorable comments included:

- *[The administrator] has consistently demonstrated a strong commitment to maintaining good employee morale and high standards of efficiency.*

- *[The administrator] is fiscally generous to staff. Provides 'prizes' for contests and contributes significantly to the employee 'Holiday Party,' reducing attendee cost. …He has an open door policy.*

- *My experience with [the administrator] has been very positive.*

- *[The administrator] needs to be more firm in his leadership. He frequently tries to be patient and listen—not easy with a staff of about 80.*

However, overall comments submitted by survey respondents were generally negative. Fifty-nine respondents submitted written comments with their surveys. Of the 59, 47 surveys were generally negative, 7 were neutral, and 5 included positive comments about the administrator.

The labor director is ultimately responsible for the effective and efficient administration of the division. The significant negative undertones in the responses indicate what appear to be some severe morale problems at the division. Low morale often prevents an organization from operating effectively and efficiently. The director must exercise his authority and responsibility over the administrator to seek improvements in the morale and the equitable treatment of staff and working conditions at the division. These responsibilities should include some degree of planning, evaluating, and controlling. Specifically, the director must establish a plan to improve morale and the working conditions within the division, periodically assess the plan with the administrator and staff, and exercise corrective measures as necessary to ensure that the plan is achieved.

Conclusion

The Legislature requested that the Auditor conduct a management audit of the Disability Compensation Division to ensure the efficient and effective administration of the workers' compensation law. Serious internal control deficiencies hinder the division from operating efficiently and effectively. The director has failed to adequately oversee the administration of the division and address morale problems identified and still pervasive since 1996. The director is responsible for the proper administration of the workers' compensation law and the management of the division, and should take the necessary corrective actions to address the multitude of problems identified.

Recommendations

1. The director of labor should implement written policies and procedures over the penalty waivers process. The policies should, at a minimum, include the following:

   a. Clarify the administrator's authority with respect to granting penalty waivers;

   b. Require that all penalty waivers be reviewed by the director; and

   c. Ensure that policies over penalty waivers are followed.

2. The director of labor should complete the department's draft information systems strategic plan and ensure that future computer systems be reviewed by the executive steering committee.

3. The director of labor should require the administrator to improve internal controls, information systems, and morale within the division. The director should exercise adequate oversight over the administrator by evaluating the administrator's compliance with the plan.

    a. To improve internal controls, the plan should require the administrator to:

        1) Implement written policies on how penalties are waived, including: who can initiate a waiver, time limits for when a waiver can be initiated and approved, what supporting materials are required, what amounts can be waived, and how waivers are evaluated and documented;

        2) Improve financial reporting of the Special Compensation Fund to ensure that all revenues, receivables, payments, and expenditures are comprehensively accounted for; and

        3) Update position descriptions to ensure that authorities and responsibilities related to the Special Compensation Fund reflect current operations.

    b. To improve information systems, the plan should require that the division:

        1) Integrate the use of its information system in the division's strategic plan to measure performance measures;

        2) Conduct a post-installation review of its information systems; and

        3) Comply with the department's information systems strategic plan in future developments or enhancements of computer systems.

    c. To improve morale, the plan should require that the administrator:

        1) Establish a process action team staffed with appropriate personnel with explicit instructions and adequate guidance to make recommendations on improving morale;

2) Implement the process action team recommendations; and

3) Conduct a re-assessment of staff views after an appropriate time has lapsed.

Chapter 3

Injured Workers' Access to Medical Care Is Not Significantly Curtailed

The Legislature requested the Auditor to study concerns regarding injured workers being denied access to medical services under the current workers' compensation law. Senate Concurrent Resolution 147, Senate Draft 1, 2001 Regular Session, states that health care providers were not accepting workers' compensation cases due to the tying of the reimbursement rates to a rate of 110 percent of the Medicare Resource Based Relative Value Scale. Specifically, the concurrent resolution requested that the Auditor determine whether an injured employee's access to medical care is being curtailed due to the practice of tying reimbursement rates to the medical fee schedule.

Summary of Finding

The use of the Medicare Resource Based Relative Value Scale System for reimbursement of medical services is appropriate. We found no significant evidence to demonstrate that injured workers' access to medical care was curtailed by tying the reimbursement of medical services to the Medicare fee schedule. We also found that the director of labor can adjust the fee schedule to address inequities, but legal and practical barriers result in inefficiencies and cause the adjustment process to be ineffective.

Use of the Medicare Standard for Workers' Compensation Reimbursements is Appropriate

Hawaii's workers' compensation law uses a medical fee schedule, based on the Medicare Resource Based Relative Value Scale System, to limit reimbursements of medical services. Although injured workers are the primary concern under the workers' compensation law, the fee schedule also considers various competing needs. Our study of local and national data, survey results, and interviews with government officials indicate that Hawaii's Medicare-based workers' compensation fee schedule has not significantly compromised injured workers' access to medical care and is an appropriate system to balance the needs of injured workers, employers, and insurers.

Medicare Resource Based Relative Value Scale System is used for workers' compensation reimbursements in Hawaii

Hawaii's workers' compensation law has undergone several major changes. Hawaii first enacted its workers' compensation law in 1915. In 1961, the Legislature created the fee schedule and based it on three factors: 1) the community of the treatment, 2) the injured person's standard of living, and 3) the prevailing cost of the treatment if the injury had not been covered under the workers' compensation law. In 1973, the Legislature required that the fee schedule be adjusted annually by the percentage increase of the Consumer Price Index because the old method of determining the fee schedule based on prevailing costs was "unadministerable." In 1995, the Legislature enacted the latest major reform in workers' compensation as a direct response to rising costs. Act 234, Session Laws of Hawaii (SLH) 1995, amended the medical fee schedule to limit reimbursement of physician's fees to 110 percent of the fees prescribed in the Medicare Resource Based Relative Value Scale system.

The Medicare-Resource Based Relative Value Scale system or RBRVS is a reimbursement system designed to replace the long-standing charge-based system for reimbursing physicians for their services. Under the charge-based system, payments were based on each physician's charges. Under the relative value system, the fee schedule relates payments to resources physicians use (such as office and other expenses) to provide a service rather than what physicians charged for the services.

The use of a fee schedule to regulate workers' compensation medical reimbursements is popular among many states, but maintenance and update of the schedule differs. Currently, Hawaii is one of 40 states that regulate workers' compensation medical reimbursements to providers using a fee schedule. However, there is no one common method of updating the fee schedules. Some states use methods such as having a committee to negotiate updates, using a percent increase in the average weekly wage, or limiting changes to the Consumer Price Index. In Hawaii, the fee schedule changes as the Medicare RBRVS fee schedule changes. However, through the administrative rules process, the director of the Department of Labor and Industrial Relations can establish a supplemental fee schedule for selected workers' compensation-related services not covered in the Medicare-based schedule. Although states differ in updating their fee schedules, controlling costs was the common rationale for adopting a fee schedule based on relative values.

Rationale for development of the Medicare RBRVS

Medicare implemented the RBRVS in 1992 to address criticisms of the former method of physician payment, known as usual, customary, and reasonable (UCR) payment. UCR was viewed as inflationary and inequitable. Critics of the UCR system noted that it distorted the relationship between the resources used to treat patients and the payment for those services, and overvalued surgical services relative to primary

care and preventive services. A research team at the Harvard School of Public Health developed the RBRVS to measure the relative work effort of physicians for a wide range of services. The Centers for Medicare & Medicaid Services (formerly the Health Care Financing Administration), which administers the Medicare program, claims that the resourced-based fee schedule is a fairer physician payment system because payments are linked to the actual resources used to provide the medical service rather than to a physician's historical costs.

The RBRVS system combines various values and factors in a complex formula

Under the RBRVS system, a value is assigned for each physician's procedure. The values are established by evaluating the procedures in relation to each other within an area of medical practice. The various medical services are assigned a value taking into account such factors as time and intensity, physical effort and skill, and mental effort and stress expended by doctors. The relative value for physicians' services consists of three components: (1) the "work" component, (2) the "practice expense" component, and (3) the "malpractice" component. The values assigned to each of these components are published in the Federal Register in the year when adjustments are made.

The work component reflects the physician's time and intensity in furnishing the service and includes activities before and after direct patient contact. The practice component reflects resources used in furnishing the service such as office rent, and wages of personnel, but does not include malpractice expense. The malpractice component reflects the medical risk factor and includes the doctor's experience and the type of practice. The process of assigning relative value units to these various components is ongoing and is periodically adjusted by the Centers for Medicare & Medicaid Services. The following formula describes the calculation of payments acceptable under Medicare.

$$\text{Payment} = [(\text{RVUw} \times \text{GPCIw}) + (\text{RVUo} \times \text{GPCIo}) + (\text{RVUm} \times \text{GPCIm})] \times \text{CF}$$

Where	RVU	=	relative value unit
	GPCI	=	geographic practice cost index
	w	=	physician work component (i.e., RBRVS)
	o	=	office expense component
	m	=	malpractice expense component
	CF	=	conversion factor

Each relative value unit is also adjusted by a separate Geographic Practice Cost Index (GPCI) that reflects the region's cost of living. This adjustment factor is reviewed every three years and printed in the Federal Register when changed. The final part of the formula is a

conversion factor that changes the relative value units into a dollar figure. An example of this calculation is as follows:

Service: CPT 99205, Office/outpatient visit, new patient, extended (i.e., 60 minutes face-to-face)

Location: Los Angeles (Carrier 02050, locality 18)

RVUw	=	2.67	RVUo	=	1.26	RVUm	=	0.07
GPCIw	=	1.055	GPCIo	=	1.199	GPCIm	=	0.846

Medical Fee Schedule allowed amount = {[2.67 x 1.055] + [1.26 x 1.199] + [0.07 x 0.846]} x $34.7315 = **$152.36**

Today, Hawaii is one of six states that specifically uses the Medicare RBRVS system, making Medicare RBRVS the most commonly used basis for those states utilizing a medical fee schedule for determining workers' compensation charges.

The medical fee schedule helps to balance competing needs

The overriding goal of the fee schedule in the workers' compensation law is to protect the interests of injured workers and other parties significantly affected by the law. The State, as an employer, is interested in keeping its costs down. Private sector employers are also concerned that premiums are affordable. Finally, physicians, who treat injured workers, want to be fairly compensated for the services they render. Using the medical fee schedule is intended to balance these competing needs.

Section 386-21(c) of the Hawaii Revised Statutes, attempts to ensure some balance among competing interests. First, the statute requires that injured workers be given a certain level of medical care.
Section 386-21(c) states that rates and fees are "adequate to ensure at all times the standard of services and care intended by this chapter to injured employees." Second, the section allows the director of labor and industrial relations to establish reasonable reimbursement rates for certain medical procedures. The section further states that "if the director determines that an allowance under the medicare program is not reasonable...the director may, at any time, establish an additional fee schedule or schedules not exceeding the prevalent charge for fees for services actually received by providers of health care services to cover charges for that treatment, accommodation, product, or service." And finally, the statute considers employers' interests when the director is required to "adopt a reasonable rate that shall be the same for all providers of health care services to be paid for that service or procedure." By establishing a "reasonable rate," the statute requires the director to establish appropriate reimbursement standards for insurance companies and affordable insurance rates for employers.

There is no significant evidence to indicate that the medical fee schedule curtails injured workers' access to medical care

To determine whether injured workers were being denied medical care, we conducted surveys of injured workers. We mailed out surveys to claimants who filed workers' compensation claims with the Department of Labor and Industrial Relations in 1994 and claimants injured in 2000 to determine whether access to medical care was affected by the change to the medical fee schedule law in 1995. The results of surveys reveal no significant evidence that injured workers were denied access to medical care due to the change in law.

Our survey results, noted in Exhibit 3.1, indicate that there was little difference in obtaining medical treatment prior to and after the change in the medical fee schedule. To determine if access to care was impacted, our survey asked, "Before your injury was classified as a workers' compensation injury, did you experience any difficulty in getting medical treatment?" We found that 83.7 percent of the 1994 claimants and 80.1 percent of the 2000 claimants responded that they had no difficulty in obtaining care for their injury.

Our survey also indicated little difference in the way health care providers treated patients after discovering they were workers' compensation cases. Our survey asked, "After your injury was classified as a workers' compensation injury, did you experience any difficulty in getting medical treatment?" The purpose of this question was to determine whether health care providers treated workers' compensation cases differently from non-workers' compensation cases. Of the responses received from the 1994 claimants, 84.9 percent responded that they did not experience difficulty in obtaining care. Only one respondent indicated having difficulty in obtaining care because the doctor refused to take workers' compensation cases. Of the responses received from the 2000 claimants, 89.4 percent indicated that they did not experience any difficulty in obtaining care. In comparison, only 2 percent, an increase of 1 percent over 1994 claimants, experienced difficulty in getting medical care because their doctor refused to accept workers' compensation patients.

Current reimbursement rates do not significantly impact the provision of medical services

We also did not find any significant evidence to indicate that medical service providers were denying care to workers injured on the job. We surveyed medical practitioners to determine whether or not the reimbursement rates were causing medical practitioners to deny care to injured workers. Our survey can be found in Appendix B. Based on our survey, we found no conclusive evidence warranting concern that medical providers were denying care to injured workers.

Exhibit 3.1
Claimant Survey Results

	1994 Claimants (86 responses)		2000 Claimants (151 responses)	
	Frequency	Percent of total (86)	Frequency	Percent of total (151)
What area of your body was affected by your work related injury?				
Head (includes eyes, ears, nose, mouth)	10	11.6%	12	7.9%
Neck	13	15.1%	21	13.9%
Back	24	27.9%	57	37.7%
Shoulder	17	19.8%	25	16.6%
Trunk (includes chest, abdomen, hips, pelvis)	5	5.8%	10	6.6%
Upper Extremity (includes finger, hand, wrist, elbow, arm)	31	36.0%	53	35.1%
Lower Extremity (includes toe, foot, ankle, knee, leg)	15	17.4%	47	31.1%
Respiratory, circulatory, digestive, reproductive, endocrine, or other bodily system	2	2.3%	5	3.3%
Other	9	10.5%	11	7.3%
What type of specialist(s) did your injury require				
Physical Therapist	31	36.0%	72	47.7%
Massage Therapist	16	18.6%	27	17.9%
Dispensing Optician	1	1.2%	0	0.0%
Dentist	2	2.3%	1	0.7%
Chiropractor	15	17.4%	10	6.6%
Osteopath	1	1.2%	6	4.0%
Optometrist	3	3.5%	0	0.0%
Podiatrist	1	1.2%	4	2.6%
Psychologist	1	1.2%	3	2.0%
Naturopath	3	3.5%	1	0.7%
Other	37	43.0%	58	38.4%
Before your injury was classified as a workers' compensation injury, did you experience any difficulty in getting medical treatment?				
Yes, because it was difficult for me to physically get to the doctor or specialist	1	1.2%	2	1.3%
Yes, because the doctor or specialist was busy or booked up for at least a week when I needed an appointment	2	2.3%	3	2.0%
No, I had no difficulty in obtaining care for my injury	72	83.7%	121	80.1%
Not applicable	8	9.3%	18	11.9%
After your injury was classified as a workers' compensation injury, did you experience difficulty in getting medical treatment?				
Yes, because it was difficult for me to physically get to my doctor or specialist	2	2.3%	2	1.3%
Yes, because the doctor or specialist was busy or booked up for at least a week when I needed an appointment	3	3.5%	3	2.0%
Yes, because the doctor(s) or specialist(s) I chose refused to take workers' compensation cases	1	1.2%	3	2.0%
No, I had no difficulty in obtaining care for my injury	73	84.9%	135	89.4%

We found that workers' compensation patients constitute a higher percentage of the physician's workload now than in 1995. The survey results showed that, prior to 1995, 42.1 percent had no workers' compensation caseload while today there are only 33.1 percent who have no workers' compensation caseload. The results also showed a slight increase in the number of practitioners whose caseload consisted of workers' compensation cases. The data showed that 55.7 percent of practitioners treat workers' compensation cases as compared to 51.7 percent who had workers' compensation cases prior to 1995.

The survey's responses also showed that practitioners did not overwhelmingly declare the fee schedule as the main reason for not treating workers' compensation cases. When the respondents were asked to rank the three most important reasons for the change in the number of worker compensation patients they treat, paperwork processing and controverted claims received as many responses as changes in the fee schedule. Similarly, when practitioners were asked to rank the three main reasons for changing their policy on treating workers' compensation patients, practitioners were just as likely to choose paperwork processing and controverted claims, as the changes in fee schedule. Based on these results, we find it difficult to conclude that the reimbursement levels, exclusively, are adversely impacting medical providers' decisions to treat workers' compensation patients.

However, the results do show a disconcerting trend that proportionately fewer practitioners today (35.9 percent) are accepting all workers' compensation cases as compared to 1995 (48.1 percent). The survey results of practitioners describing workers' compensation cases as more costly and requiring more paperwork may help to explain this trend.

Current reimbursement rates do not significantly contribute to the departure of medical service providers from the State

We also found little evidence to indicate that tying reimbursement rates to the Medicare RBRVS fee schedule forces medical practitioners to leave Hawaii. Since the workers' compensation law changed in 1995, some medical service providers have claimed that practitioners were being forced out of business or leaving the state because of the low level of medical reimbursements. Contrary to those claims, we found a general increase in the number of medical providers since 1994 (Exhibit 3.2).

Exhibit 3.2
Number of Registered Medical Practitioners in Various Specialty Fields from 1994-2001

Specialty	94-95	95-96	96-97	97-98	98-99	99-00	00-01	Percent Change 94-95 to 00-01
Chiropractors	516	454	506	443	505	481	538	4.3%
Dentists	1,354	1,311	1,345	1,326	1,362	1,326	1,352	-0.1%
Dispensing Opticians	139	152	140	146	133	145	131	-5.8%
Doctors of Medicine	5,633	5,373	5,809	5,576	6,289	5,481	6,458	14.6%
Massage Therapists	2,381	2,742	2,903	3,220	3,296	3,707	3,922	64.7%
Naturopaths	51	52	57	59	63	63	72	41.2%
Nurses (LPN)	3037	2,727	2,898	2,808	2,357	2,699	2,337	-23.0%
Nurses (RN)	12,287	11,422	11,874	11,558	10,514	11,899	11,222	-8.7%
Optometrists	320	319	342	337	363	311	346	8.1%
Osteopaths	321	346	327	360	365	385	376	17.1%
Physical Therapists	654	759	674	769	658	741	756	15.6%
Podiatrists	69	63	65	63	67	58	73	5.8%
Psychologists	407	440	440	464	466	490	529	30.0%
Total	27,169	26,160	27,380	27,129	26,438	27,786	28,112	3.5%

Source: Department of Commerce and Consumer Affairs.

According to these figures, with the exception of dentists, nurses and dispensing opticians, all other medical specialties have seen an increase in the number of licensed practitioners in the state. The decline in nurses is a nationwide trend. In addition, Hawaii ranks sixth out of 30 western region metropolitan areas with 204.1 physicians per 100,000 population. Hawaii ranked higher than some major cities such as San Jose, California; Las Vegas, Nevada; Phoenix-Mesa, Arizona; and San Diego, California.

The increase in the number of physicians is even more significant when tied to the number of workers' compensation claims occurring in the years of relevance. Workers' compensation claims have decreased by 25.4 percent from 1994 to 2000, while the number of licensed medical practitioners increased by 3.5 percent during the same period. The ratio of licensed practitioners to claims increased from .64 in 1994 to .88 in 2000, resulting in an increase of about 39 percent. This increase indicates that there are more practitioners per claim today than in 1995.

Current reimbursement rates are not unreasonable

We found Hawaii's workers' compensation reimbursement fees are not unreasonable when compared with reimbursement fees paid by one of Hawaii's private health insurance organizations. Our review of the most

common Current Procedural Terminology (CPT) codes under Hawaii's medical fee schedule revealed that in most instances, workers' compensation reimbursements are higher than reimbursements by a private health organization. Current Procedural Terminology (CPT) codes identify the procedure or service rendered by a physician.

We compared the ten most used CPT codes in Hawaii's workers' compensation medical fee schedule with the eligible reimbursement rates of the Hawaii Medical Services Association (HMSA), and as noted in Exhibit 3.3, seven of the ten most used CPT codes are reimbursed higher under workers' compensation than by HMSA.

Additionally, from 1995 to 2001, the Medicare Fee Schedule has kept pace with the average annual increases in the Medical Professional Consumer Price Index, which reflect changes in medical cost. Over the seven-year period from 1995 to 2001, the medical professional price index has increased by an average of 3.5 percent. Over the same time period, the federal government increased the Medicare reimbursement rate by an average of 3.5 percent as well.

Exhibit 3.3
Comparison of the Ten Most Common CPT Code Fee Reimbursement Rates—HMSA vs. Workers' Compensation

CPT Code	Description	Specialty	WC Eligible 2000	HMSA Eligible 2001	HMSA Eligible 2002
97110	Therapeutic Exercises	All Specs	$28.75	$22.80	$22.80
97124	Massage Therapy	All Specs	$26.72	$19.90	$19.90
97140	Manual Therapy	All Specs	$33.85	$26.50	$26.50
99213 F	Office/Outpatient Visit, first visit	Internal Med	$59.36	$67.90	$68.60
99214 F	Office/Outpatient Visit, first visit	Internal Med	$92.33	$67.90	$68.60
72148	Magnetic Image, Lumbar Spine	All Specs	$719.41	$704.10	$704.10
97014	Electric Stimulation Therapy	All Specs	$19.58	$15.30	$15.30
97545	Work Hardening	All Specs	$50.31	$108.80	$108.80
98941	Chiropractic Manipulation	Chiropractor	$43.08	$37.44	$37.44
72141	Magnetic Image, Neck and Spine	All Specs	$664.66	$704.10	$704.10

Source: WorkComp Hawaii, A Subsidiary of HMSA.

Use of the Medicare reimbursement rate is widely accepted and cost-beneficial

In 1999, the University of California at Los Angeles (UCLA) Center for Health Policy Research analyzed the benefits of using a RBRVS system for workers' compensation. In its report, titled *The Use of Resource-Based Relative Value Scales for Provider Reimbursement in State Workers' Compensation Programs,* the university found that the RBRVS presented several advantages such as fairness of payments for services, ease of implementation, and participation by the American Medical Association (AMA).

In conducting the study, UCLA surveyed 20 states and the U.S. Department of Labor that use the Medicare RBRVS or the major commercial alternative known as Relative Values for Physicians (RVP). The study found that states adopted RBRVS to control costs and improve fairness by eliminating reimbursement based on billed charges. States also believed that the RBRVS would simplify the administration of workers' compensation by establishing a more rational, uniform system of billing and payment consistent with other major payers such as Medicare, Medicaid, and private insurers who used RBRVS.

All states surveyed were satisfied that their fee schedule had achieved the goals of fairness and ease of implementation. States believed that fairness is achieved because the RBRVS is based on national surveys of physicians, and physicians provide ongoing input through the maintenance and updating process. Maintenance and updates are based on annual recommendations provided by the AMA's Specialty Society Relative Value Scale Update Committee (RUC). The RUC makes recommendations to the Health Care Financing Administration, with Congress as the final arbiter. Other health care professional groups also make recommendations to the RUC through the Health Care Professionals Advisory Committee. Congress requires a mandatory five-year review of the entire set of relative value units to ensure that they reflect current medical practice and technology.

States found the RBRVS easy to implement, and no state reported significant problems resulting from the lack of a phase-in period. However, the method each state uses to maintain or update its fee schedule differs among the states. Most states change the fee schedule's conversion factors in relation to percent changes in statewide average weekly wage or in the national consumer price index. Some states use a negotiation process. The federal Department of Labor uses different conversion factors for different medical fields of practice and updates them annually.

Provisions Are Available to Adjust the Fee Schedule For Competing Needs But Barriers Impede the Process

Current statutes and administrative rules provide opportunities for the director of labor and industrial relations to adjust the workers' compensation medical fee schedule if reimbursements are inadequate. However, legal requirements and resistance by medical service providers in providing cost data render the process inefficient. Furthermore, the director failed to allocate appropriate resources to workers' compensation research efforts and has not maximized participation by medical practitioners.

Current law allows for adjustments by the director

Section 386-21, HRS, allows the director of labor and industrial relations to establish additional fee schedules if an allowance under the Medicare program is not reasonable or does not exist. Additionally, the law also requires the director to update the fee schedules every three years or annually, based upon—future charges, additions prescribed by the Medicare RBRVS system applicable to Hawaii, or by a statistically valid survey of prevalent charges for services actually received by providers of health care. Any party can petition the Disability Compensation Division of the department for increases to the medical fee schedule.

Since Act 234 became effective in 1995, the division has updated the workers compensation medical fee schedule in three separate years: 1995, 1996, and 1997. Each update addressed different medical professions. The 1995 updates addressed anesthesia and radiology service issues. In 1996, anesthesia, acupuncture and physical therapy codes were adjusted. In 1997, the division adjusted dental codes and physical therapy codes. The division is currently obtaining data to evaluate amendments for proposed changes to certain medical fee codes for 2002.

Only a few medical profession associations have made use of the availability to petition the division for changes to the medical fee schedule. For example, over the past two years, only the Hawaii Emergency Physicians Associated, Inc. and the Hawaii Medical Association (HMA) petitioned the division for an increase to some of the medical codes.

Comprehensive increases in the fee schedule are unnecessary

The 1998 Legislative Reference Bureau (LRB) study of the medical fee schedule under the workers' compensation law recommended that the ceiling be raised to not less than 125 percent but not more than 130 percent of Medicare-RBRVS. LRB based its findings on its survey of health care providers. LRB stated that "the medical fee schedule set at 110 percent of the Medicare RBRVS appears to have had a negative

impact on access to specialty care by injured workers and has diminished the number and quality of providers who treat patients in workers' compensation cases."

With LRB's permission to use its survey format, we adjusted the methodology and tasks to meet our objectives. Instead of mailing surveys to all health care providers as in the LRB's study, we surveyed providers from specific medical specialties that handle or are involved with workers' compensation cases. Using this method, our results would not be skewed with information from health care providers who normally would not service workers' compensation patients. In addition, we developed a separate survey for workers who were injured in 1994 and workers who were injured in 2000. The purpose of these surveys was to obtain the injured workers' perspective in getting access to medical care before and after the medical fee schedule was tied to the Medicare RBRVS system.

A comprehensive increase of the medical fee schedule would unjustifiably raise cost and be counterproductive to legislative intent. One of the Legislature's purposes for passing Act 234 in 1995 was to reduce the spiraling costs of workers' compensation coverage. Since enactment of this reform, insurance rates and premiums have been significantly reduced. Data from the Disability Compensation Division indicate that from 1995 to 2000, a total of almost $112 million have been saved. The Department of Commerce and Consumer Affairs indicated that insurance premiums have decreased by over 40 percent since 1995.

Increasing the reimbursement rate of the medical fee schedule would have a significant impact on the workers' compensation costs and insurance premiums. The Department of Commerce and Consumer Affairs' Insurance Division analyzed the impact on insurance premiums for specific increases in the schedule and found that employers' insurance premiums would increase by several million dollars. The dollar impacts are based upon the Medicare cost structure as of March 2001 and assumes there will be no change in utilization relative to affected procedures. In addition, the State Actuary cautioned that changes in the workers' compensation medical fees will impact costs associated with automobile insurance claims because Section 431:10C-308.5(b), HRS, ties charges and treatments for auto insurance claims to the workers' compensation supplemental medical fee schedule. Exhibit 3.4 displays the impact of the workers' compensation insurance premiums based on an increase to the medical fee schedule.

Exhibit 3.4
Impact on Workers' Compensation Insurance Premiums from an Increase in the Medical Fee Schedule

Proposed Amendment	Insurance Premium increase (percent)	Insurance Premium increase (dollars)
From 110 percent of Medicare to 120 percent of Medicare	2.2 percent	$3,143,000
From 110 percent of Medicare to 125 percent of Medicare	3.2 percent	$4,572,800
From 110 percent of Medicare to 130 percent of Medicare	4.0 percent	$5,716,000
From 110 percent of Medicare to the federal workers medical fee schedule	11-14 percent	$16,000,000-$20,000,000

Source: Department of Commerce and Consumer Affairs.

Section 386-21(c), HRS, allows the director to establish a supplemental fee schedule or set reasonable rates for certain medical procedures. Using this law to selectively address increasing fees under compensated services is far more effective than implementing a comprehensive blanket increase to the entire medical fee schedule. This position is also supported by an organization that represents health care providers. The Hawaii Medical Association, which in the past opposed tying the fee schedule to Medicare, recently testified that an effort must be made to target only those codes that are primarily utilized by the workforce. Furthermore, said HMA, any adjustment should not be made on a blanket percentage increase but on the importance of quality care for the purpose of rehabilitating the injured worker.

Barriers impede the fee adjustment process

Legal and pragmatic barriers hinder the director's ability to efficiently adjust reimbursement rates for under-compensated procedures. First, adjustments to the fee schedule must undergo public hearing requirements. Second, the Small Business Regulatory Flexibility Act of 1998 adds several months to the adjustment process. These legal requirements impede the efficiency of the rate adjustment process. Furthermore, resistance from medical providers to disclose information needed by the director to support and justify any fee adjustments, inhibits change.

Legal barriers are time-consuming

The Small Business Regulatory Flexibility Act (SBRFA), Act 168, SLH 1998, requires that administrative rules that may impact small businesses be reviewed by the small business regulatory review board as a means to determine the impact on the business community. Specifically, the Act requires agencies to complete an extensive business impact statement evaluating the cost ramifications to small businesses. This added review process has lengthened adjustments to the medical fee by more than a

year. The division began the process of adjusting the medical fee schedule in 1998. It began by surveying medical providers, but did not reach the public hearing stage until September 2001. According to the division administrator, the delay was caused by the extra layer of review required by the small business regulatory act.

The administrative rules process under Chapter 91, HRS, also adds time delays to changes to the medical fee schedule. In 1995, 1996, and 1997, the division amended its medical fee schedule only after taking 6 months, 5 months, and 3 months, respectively for each amendment process from the setting of the date for the public hearings to the enactment of the changes. The time lag was due to Chapter 91's requirements for holding a public hearing, reviewing public testimony, and receiving executive approval before a rule can be adopted.

Other barriers limit the effectiveness of the fee adjustment process

The director also failed to allocate adequate resources to conduct research on the medical fee schedule. Furthermore, the lack of cooperation from medical practitioners and health plan providers to provide cost information adversely impacted the division's ability to collect necessary data to make adjustments to the fee schedule. The medical practitioners' lack of awareness of the fee schedule amendment process further renders the process inefficient.

Section 386-21 states that updates to the fee schedule could be based on a statistically valid survey of prevalent charges for fees for services actually received by health care providers. Currently, the division relies on one staff person from the Department of Labor and Industrial Relations' Operations Management Information (OMI) section to obtain the necessary data for the survey. This staff person's responsibility also includes gathering information for the department's other federally mandated programs. OMI has a staff of 16 who provide research and statistical services for the department's divisions. However, only one research manager and one assistant are assigned to workers' compensation issues. Before staff reductions in 1996, workers' compensation issues were researched by six employees. As a result, the level of research related to workers' compensation has significantly diminished.

In addition to lacking sufficient help to conduct research and collect data, the research manager also encounters obstacles in obtaining critical information from medical service providers. Health care plan contractors and health care providers are reluctant to release data on costs and fees of services they provide. They claim that the data is proprietary and express concerns over the potential for price fixing.

Health care providers' lack of knowledge of the fee schedule adjustment process presents another obstacle. The department's administrative rules allow health care providers to petition the director for an adjustment of fees. However, the health care providers' response to our survey show that almost 80 percent of the providers were unaware that they could petition the director for changes to the fee schedule. This lack of awareness and participation in the fee schedule amendment process renders the law ineffective.

Conclusion

The primary purpose of the workers' compensation law is to protect the interest of injured workers. However, the Legislature realized that countervailing interests exist and therefore, built into the law the ability for the director of labor and industrial relations to balance competing needs. We found no significant evidence to show that injured workers' access to medical care is being curtailed by the use of the Medicare RBRVS for workers' compensation reimbursements. However, we found that certain legal and pragmatic barriers prevent the system from operating fairly and efficiently.

Recommendations

The director of labor and industrial relations should take the necessary steps to improve the amendment process for the workers' compensation medical fee schedule. Specifically, the director should take the following measures:

1. Allocate sufficient resources to conduct research on workers' compensation issues and ensure that statistically valid surveys, as required by Section 386-21(c), HRS, are completed;

2. Seek an exemption from the Small Business Regulatory Flexibility Act of 1998 for the fee adjustment process;

3. Implement mechanisms to mandate the provision of necessary information by health care providers to complete the statistically valid surveys required by Section 386-21(c); and

4. Educate health care providers about their recourse to petition for adjustments to the medical fee schedule.

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Appendix A
Survey Results of Division Employees

Do you have a position description?

	Frequency	Percent
Yes	72	83.7
No	2	2.3
Not sure	7	8.1
No response	5	5.8
Total	86	100.0

Is your position description accurate?

	Frequency	Percent
Yes	50	58.1
No	20	23.3
Not sure	1	1.2
No response	15	17.4
Total	86	100.0

Are you aware of improprieties within the division?

	Frequency	Percent
Yes	21	24.4
No	59	68.6
Other response	1	1.2
No response	5	5.8
Total	86	100.0

Have you ever felt coerced to perform or act contrary to your professional judgment?

	Frequency	Percent
Yes	13	15.1
No	68	79.1
No response	5	5.8
Total	86	100.0

Identify the level of morale within the division:

	Frequency	Percent
High (very good)	2	2.3
Medium (acceptable)	43	50.0
Low (poor)	35	40.7
No response	6	7.0
Total	86	100.0

Identify your level of morale in the division:

	Frequency	Percent
High (very good)	8	9.3
Medium (acceptable)	44	51.2
Low (poor)	30	34.9
No response	4	4.7
Total	86	100.0

Check one rating for each item which best represents your perception of the Disability Compensation Division's administrator. If you do not have sufficient experience with the administrator to rate a particular item, leave it blank.

	Percentage of Responses					
	Strongly Agree	**Agree**	**Disagree**	**Strongly Disagree**	**No Response**	**Total**
a. Creates strong morale and spirit within the division; shares wins and successes.	5.8	16.3	29.1	26.7	22.1	100.0
b. Deals with problem situations in a timely manner without allowing them to fester.	5.8	18.6	29.1	20.9	25.6	100.0
c. Distributes workload appropriately.	3.5	24.4	18.6	20.9	32.6	100.0
d. Handles pressures of the job in a positive and constructive manner.	5.8	22.1	15.1	19.8	37.2	100.0
e. Holds frequent development discussions, providing challenging and stretching tasks and assignments to others.	3.5	19.8	22.1	18.6	36.0	100.0
f. Is able to motivate division employees to do their best.	2.3	19.8	24.4	25.6	27.9	100.0
g. Is adequately skilled in spoken communication to serve as an effective leader.	4.7	39.5	18.6	16.3	20.9	100.0
h. Is adequately skilled in written communication to serve as an effective leader.	4.7	40.7	11.6	14.0	29.0	100.0
i. Is dedicated to providing the highest quality products and services which meet the needs and requirements of internal and external customers.	3.5	23.3	31.4	12.8	29.0	100.0
j. Is easy to approach and talk to.	8.1	37.2	19.8	17.4	17.5	100.0
k. Is effective at setting goals and planning for both individuals and the division.	1.2	22.1	30.2	15.1	31.4	100.0
l. Is good at establishing clear directions.	0.0	19.8	30.2	18.6	31.4	100.0
m. Is sufficiently competent in the technical knowledge relevant to the division to be an effective administrator.	4.7	30.2	23.3	11.6	30.2	100.0
n. Is widely trusted.	2.3	8.1	36.0	24.4	29.2	100.0
o. Listens carefully to understand various points of view, regardless of whether or not he agrees.	3.5	26.7	27.9	17.4	24.5	100.0
p. Practices attentive and active listening, and has the patience to hear people out.	4.7	14.0	36.0	16.3	29.0	100.0
q. Provides people with the information needed to do their jobs and feel good about being a member of the division.	0.0	24.4	22.1	17.4	36.1	100.0
r. Provides positive and corrective feedback that is current, direct, complete, and "actionable."	2.3	20.9	26.7	18.6	31.5	100.0
s. Seeks input about the ways in which he can be a more effective leader.	3.5	11.6	31.4	22.1	31.4	100.0
t. Sees conflict as opportunities for improvement.	4.7	25.6	18.6	18.6	32.5	100.0
u. Supports division employees by standing up for them, even when it is hard to do.	4.7	17.4	26.7	20.9	30.3	100.0
v. Takes ownership of decisions by standing by them and accepting their consequences.	3.5	19.8	18.6	24.4	33.7	100.0
w. Treats subordinates equitably and does not play favorites.	1.2	17.4	25.6	26.7	29.1	100.0

Appendix B
Results of Survey of Medical Practitioners

	MD	PT	MAT	DIO	DT	DC	DOS	OD	PO	PSY	ND	RN/LPN	Total	
No. of Mailings	173	158	170	113	170	148	117	170	34	167	56	347	1,823	
No. of Responses	62	46	23	20	72	58	16	68	20	73	17	41	516	
Response rate	35.8%	29.1%	13.5%	17.7%	42.4%	39.2%	13.7%	40.0%	58.8%	43.7%	30.4%	11.8%	28.3%	

3 - Practice setting

	MD	PT	MAT	DIO	DT	DC	DOS	OD	PO	PSY	ND	RN/LPN	Total	
Individual	30	14	20	9	56	50	9	39	12	54	11	4	308	59.7%
Group	20	5	2	5	13	4	4	18	4	5	4	5	89	17.2%
Employee of HC facility	9	27	1	6	3	1	3	9	1	13	0	26	99	19.2%
Other	0	0	0	0	0	2	0	0	1	1	0	0	4	0.8%
No response	3	0	0	0	0	1	0	2	2	0	2	6	16	3.1%
														100.0%

4 - Length of time provided HC services in Hawaii

	MD	PT	MAT	DIO	DT	DC	DOS	OD	PO	PSY	ND	RN/LPN	Total	
Less than 3 years	4	9	5	1	3	14	1	8	1	3	2	4	55	10.7%
3 - 6 years	6	7	6	1	3	8	4	6	3	6	2	8	60	11.6%
More than 6 years	49	30	12	18	66	34	11	53	13	63	11	25	385	74.6%
No response	3	0	0	0	0	2	0	1	3	1	2	4	16	3.1%
														100.0%

5 - Currently, % of patients that are WC cases

	MD	PT	MAT	DIO	DT	DC	DOS	OD	PO	PSY	ND	RN/LPN	Total	
None	15	9	13	11	26	11	3	32	3	31	4	13	171	33.1%
1 - 25%	34	9	4	6	39	17	9	29	11	32	5	14	209	40.5%
26 - 50%	4	13	2	0	1	12	1	0	1	7	2	1	44	8.5%
51 - 75%	1	8	2	0	0	10	1	0	0	0	2	0	24	4.7%
76 - 99%	2	1	0	0	0	1	0	0	0	1	1	1	7	1.4%
100%	0	1	0	1	0	0	0	0	0	0	1	0	3	0.6%
Other	0	1	0	0	3	0	0	3	0	0	0	2	9	1.7%
No response	6	4	2	2	3	7	2	4	5	2	2	10	49	9.5%
												41		100.0%

5b - Prior to 1995, % of patients that are WC cases

	MD	PT	MAT	DIO	DT	DC	DOS	OD	PO	PSY	ND	RN/LPN	Total	
None	19	7	15	13	44	17	5	29	3	42	10	13	217	42.1%
1 - 25%	34	21	7	6	27	32	10	33	14	27	3	14	228	44.2%
26 - 50%	2	12	0	0	0	4	1	0	0	0	2	1	22	4.3%
51 - 75%	1	3	0	0	0	2	0	0	0	0	0	0	6	1.2%
76 - 99%	1	1	0	0	0	0	0	0	0	2	1	2	7	1.4%
100%	0	0	0	1	0	0	0	0	0	0	0	2	3	0.6%
Other	1	1	0	0	1	1	0	3	0	0	0	0	7	1.4%
No response	4	1	1	0	0	2	0	3	3	2	1	9	26	5.0%
														100.0%

6 - Choose three most important reasons for the change in WC cases you treat (For this question, the numbers represent the number of respondents who ranked the category as the top three most important reasons)

	MD	PT	MAT	DIO	DT	DC	DOS	OD	PO	PSY	ND	RN/LPN	Total	
6a - No change	6	4	1	3	14	4	2	9	2	5	2	5	57	11.0%
6b - Personal preference or professional interest	3	6	3	1	4	6	1	4	2	4	3	2	39	7.6%
6c - Changes in fee schedule of reimbursement	16	16	4	2	19	24	10	3	7	19	7	3	130	25.2%
6d - Controverted claims, including down coding by 3rd party billing reviewers	14	14	5	1	14	29	9	4	7	16	8	5	126	24.4%
6e - Paper work processing	16	14	7	2	22	26	11	7	9	17	7	5	143	27.7%
6f - Clerical staff training	1	0	0	1	0	3	0	4	0	0	0	1	10	1.9%
6g - Other	7	7	1	1	3	8	1	3	1	4	2	2	40	7.8%

7 - Due to 1995 WC law changes, how has access to appropriate HC changed?

	MD	PT	MAT	DIO	DT	DC	DOS	OD	PO	PSY	ND	RN/LPN	Total	
Increased	1	0	1	2	0	0	0	2	1	1	0	4	12	2.3%
Decreased	23	26	8	0	18	41	11	5	10	31	8	6	187	36.2%
Stayed the same	5	5	0	4	3	3	0	7	0	0	3	2	32	6.2%
Don't know	28	14	14	13	48	13	5	52	6	34	5	20	252	48.8%
Other	0	0	0	0	2	0	0	0	0	1	0	1	4	0.8%
No response	5	1	0	1	1	1	0	2	3	6	1	8	29	5.6%
														100.0%

8 - Since 1995, how has administrative hours you spend in WC changed?

	MD	PT	MAT	DIO	DT	DC	DOS	OD	PO	PSY	ND	RN/LPN	Total	
Increased	20	26	5	0	12	24	7	7	10	16	4	3	134	26.0%
Decreased	5	0	1	0	3	9	2	1	1	2	5	0	29	5.6%
Stayed the same	9	3	3	6	8	7	3	20	3	9	0	2	73	14.1%
Not applicable	22	17	14	13	45	17	4	37	3	38	6	26	242	46.9%
Other	1	0	0	0	1	0	0	0	0	2	1	1	6	1.2%
No response	5	0	0	1	3	1	0	3	3	6	1	9	32	6.2%
														100.0%

9 - Since 1995, how has the number of staff processing WC claims changed?

	MD	PT	MAT	DIO	DT	DC	DOS	OD	PO	PSY	ND	RN/LPN	Total	
Increased	12	23	3	1	4	13	5	5	5	8	2	3	84	16.3%
Decreased	6	1	2	0	2	9	4	0	1	2	4	1	32	6.2%
Stayed the same	18	5	2	5	14	15	3	22	5	10	2	3	104	20.2%
Not applicable	20	17	16	13	48	19	4	38	6	45	8	24	258	50.0%
Other	1	0	0	0	1	0	0	0	0	1	0	1	4	0.8%
No response	5	0	0	1	3	2	0	3	3	7	1	9	34	6.6%
														100.0%

10a - What is your current policy on WC cases

	MD	PT	MAT	DIO	DT	DC	DOS	OD	PO	PSY	ND	RN/LPN	Total	
Accept all	21	30	7	7	21	27	7	38	7	5	5	10	185	35.9%
Do not accept new patients, continue to treat current WC cases	10	0	0	0	7	2	2	1	0	9	1	1	33	6.4%
Low priority, appointments not scheduled w/in week of 1st call	3	2	0	0	5	6	1	0	2	6	0	0	25	4.8%
Do not Treat WC patients	16	5	12	7	21	6	3	12	4	28	7	7	128	24.8%
Other	6	9	3	3	14	15	3	13	4	16	1	11	98	19.0%
No response	6	0	1	3	4	2	0	4	3	9	3	12	47	9.1%
														100.0%

10b - Prior to 1995, what was your policy on WC cases

	MD	PT	MAT	DIO	DT	DC	DOS	OD	PO	PSY	ND	RN/LPN	Total	
Accept all	35	34	9	7	33	36	9	31	12	23	10	9	248	48.1%
Do not accept new patients, continue to treat current WC cases	3	0	0	0	6	0	0	1	0	4	0	0	14	2.7%
Low priority, appointments not scheduled w/in week of 1st call	1	0	0	0	2	2	0	0	0	4	0	0	9	1.7%
Do not Treat WC patients	9	4	8	6	8	1	1	12	2	15	3	5	74	14.3%
Other	5	5	2	2	14	6	1	13	0	13	2	11	74	14.3%
No response	9	3	4	5	9	13	5	11	6	14	2	16	97	18.8%
														100.0%

11 - Rank the three most important reasons for any change in policy (For this question, the numbers represent the number of respondents who ranked the category as the top three most important reasons)

	MD	PT	MAT	DIO	DT	DC	DOS	OD	PO	PSY	ND	RN/LPN	Total	
11a - No change	5	4	2	4	8	2	3	14	2	5	2	4	55	10.7%
11b - Personal preference or professional interest	3	4	0	1	4	3	1	3	2	6	1	2	30	5.8%
11c - Changes in fee schedule of reimbursement	16	11	3	1	17	23	7	4	5	21	5	5	118	22.9%
11d - Delays in prior approval for treatment	8	7	2	0	7	13	2	3	4	9	2	4	61	11.8%
11e - Controverted claims, including down coding by 3rd party billing reviewers	15	7	2	0	15	28	7	4	6	12	5	2	103	20.0%
11f - Paper work processing	17	9	3	2	19	18	7	6	10	19	5	3	118	22.9%
11g - Clerical staff training	2	1	0	2	0	4	0	4	1	1	0	0	15	2.9%
11h - Other	2	2	2	1	1	5	2	3	0	1	0	1	20	3.9%

12 - Compare time spent by provider and staff in WC cases to time spent in similar injuries under the Medicare system

	MD	PT	MAT	DIO	DT	DC	DOS	OD	PO	PSY	ND	RN/LPN	Total	
WC takes less time	1	3	1	1	0	2	0		0	0	0	0	9	1.7%
About the same	12	13	3	8	17	8	3	21	1	3	3	11	103	20.0%
10% more	8	6	0	2	7	5	2	7	2	5	0	6	50	9.7%
25 % more	14	10	3	1	11	19	3	12	3	15	3	1	95	18.4%
50% more or greater	11	7	4		4	17	6	3	11	15	1		81	15.7%
Other	6	4	5	4	13	3	0	7	0	14	6	4	66	12.8%
No response	10	3	7	3	20	4	2	17	3	21	4	18	112	21.7%
														100.0%

13 - Compare the cost of WC cases to similar injuries under the Medicare system

	MD	PT	MAT	DIO	DT	DC	DOS	OD	PO	PSY	ND	RN/LPN	Total	
WC costs less	2	2	0	1	1	1	1	1	1	0	0	3	13	2.5%
About the same	13	17	5	9	23	13	4	32	6	10	4	6	142	27.5%
10% more	4	6	1	2	5	6	3	5	3	3	0	5	43	8.3%
25 % more	20	6	2	0	6	13	3	3	3	12	2	2	72	14.0%
50% more or greater	4	7	2	1	2	10	2	2	3	5	1	0	39	7.6%
Other	7	5	5	4	13	2	0	7	1	13	6	5	68	13.2%
No response	12	3	8	3	22	13	3	18	3	30	4	20	139	26.9%
														100.0%

14 - Compare the quality of care for patients under WC to care received under private insurance

	MD	PT	MAT	DIO	DT	DC	DOS	OD	PO	PSY	ND	RN/LPN	Total	
WC is better than private	3	5	3	0	0	14	1	2	1	1	2	2	34	6.6%
Worse than private	19	9	2	1	22	8	8	4	3	19	3	7	105	20.3%
About the same	26	27	4	12	23	31	6	37	11	21	6	9	213	41.3%
Other	4	3	4	4	7	2	0	8	0	10	2	4	48	9.3%
No response	10	2	10	3	20	3	1	17	5	22	4	19	116	22.5%
														100.0%

15 - Aware that law allows the director to change specific reimbursement fees?

	MD	PT	MAT	DIO	DT	DC	DOS	OD	PO	PSY	ND	RN/LPN	Total	
Yes	7	5	0	1	3	7	1	1	2	3	1	0	31	6.0%
No	45	39	18	17	58	49	15	57	15	57	14	26	410	79.5%
Other/Don't know	1	0	0	0	2	0	0	1	0	0	0	2	6	1.2%
No response	9	2	5	2	9	2	0	9	3	13	2	13	69	13.4%
														100.0%

16 - Have you ever tried to increase a fee for a specific procedure?

	MD	PT	MAT	DIO	DT	DC	DOS	OD	PO	PSY	ND	RN/LPN	Total	
No, never tried	48	38	19	17	52	51	14	57	13	52	13	20	394	76.4%
Yes, tried but was unsuccessful	4	7	0	0	5	6	2	0	4	4	2	1	35	6.8%
Yes, tried and was successful	1	0	0	0	0	0	0	0	0	0	0	0	1	0.2%
Other	3	0	1	1	3	0	0	2	0	3	0	2	15	2.9%
No response	6	1	3	2	12	1	0	9	3	14	2	18	71	13.8%
														100.0%

MD = Medical Doctor; PT = Physical Therapists; MAT = Massage Therapist; DIO = Dispensing Optician; DT = Dentist; DC = Chiropractors; DOS = Osteopaths; PO = Podiatrists; PSY = Psychologist; ND = Naturopath; RN/LPN = Nurses

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Response of the Affected Agency

Comments on Agency Response

We transmitted a draft of this report to the Department of Labor and Industrial Relations on February 21, 2002. A copy of the transmittal letter to the department is included as Attachment 1. The department's response is included as Attachment 2.

The department responded that it appreciated our efforts and generally agreed with our recommendations. The director indicated that he would increase oversight of the division by:

1) Developing better revenue and expenditure records and procedures to address lines of reporting and authority;

2) Approving all waivers of penalties and developing better waiver criteria;

3) Updating division positions involved in Special Compensation Fund activities; and

4) Developing better Special Compensation Fund processes to eliminate manual redundancies and to generate timely and useful management financial reports.

The department also agreed that the new computer system is not complete and integrated with the division's strategic plan, but that the division is developing the methodology to capture measurable information to support its strategic plan goals. In addition, the department agrees with the need to incorporate computer issues with the division's strategic plan and to ensure alignment with the department's information systems strategic plan. However, the department did not address whether it will conduct a post-installation review of its information systems.

The department also appreciated our recommendation regarding efforts to improve management of human resources and staff morale, but claims that personnel actions within the division do not indicate major problems. The department noted that the division has not experienced serious absenteeism, low retention, or numerous employee complaints either with the director or with the union. The department claims that a failure to communicate effectively probably contributed to a "low trust" rating, but that the division administrator is currently attending a management development course to enhance his leadership skills. The department also responded that the administrator has implemented

various procedures and fully agrees with the need to form a process action team to deal with morale issues. However, the department did not address whether the division would reassess staff views after an appropriate interval of time.

With regards to our recommendations on the medical fee schedule, the department stated that it is committed to providing reasonable fees for medical services and agrees with our recommendations to improve the process for adjusting the medical fee schedule. The department responded that it will assess the availability of resources to adequately support the adjustment process, seek legislative support for an exemption from the Small Business Regulatory Flexibility Act of 1998, seek additional enforcement measures to enforce compliance with the law, and continue to educate and work with health care provider organizations on the process to obtain medical fee schedule adjustments.

STATE OF HAWAII
OFFICE OF THE AUDITOR
465 S. King Street, Room 500
Honolulu, Hawaii 96813-2917

MARION M. HIGA
State Auditor

(808) 587-0800
FAX: (808) 587-0830

February 21, 2002

COPY

The Honorable Leonard Agor, Director
Department of Labor and Industrial Relations
Keelikolani Building
830 Punchbowl Street
Honolulu, Hawaii 96813

Dear Mr. Agor:

Enclosed for your information are three copies, numbered 6 to 8 of our confidential draft report, *Management Audit of the Disability Compensation Division and A Study of the Correlation Between Medical Access and Reimbursement Rates Under the Medical Fee Schedule*. We ask that you telephone us by Monday, February 25, 2002, on whether or not you intend to comment on our recommendations. If you wish your comments to be included in the report, please submit them no later than Thursday, February 28, 2002.

The Governor and presiding officers of the two houses of the Legislature have also been provided copies of this confidential draft report.

Since this report is not in final form and changes may be made to it, access to the report should be restricted to those assisting you in preparing your response. Public release of the report will be made solely by our office and only after the report is published in its final form.

Sincerely,

Marion M. Higa
State Auditor

Enclosures

ATTACHMENT 2

STATE OF HAWAII
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
OFFICE OF THE DIRECTOR
830 PUNCHBOWL STREET, ROOM 321
HONOLULU, HAWAII 96813

February 28, 2002

The Honorable Marion M. Higa
State Auditor
Office of the Auditor
465 S. King Street, Room 500
Honolulu, Hawaii 96813-2917

Dear Ms. Higa:

Thank you for the opportunity to respond to your Management Audit of the Disability Compensation Division and A Study of the Correlation Between Medical Access and Reimbursement Rates Under the Medical Fee Schedule. We appreciate and agree with the recommendations in the report in our continuing efforts to improve State Government service to the people of Hawaii.

We agree that greater oversight by the Director's office would ensure stronger internal control and human resource management. The Department of Labor and Industrial Relations (DLIR) will be developing oversight procedures to enhance the Director's oversight of Disability Compensation Division (DCD) activities. We believe this will also facilitate stronger understanding and support of DCD activities.

I would like to point out that the DCD under Gary Hamada has accomplished much since his appointment as Administrator in 1992. He was the 1994 and 1996 DLIR Manager of the year under two different Directors. His dedicated work with the Legislature, Insurance Commissioner, labor unions and insurance industry during 1994 and 1995 contributed much to passage of Act 234 which has resulted in:

1) reductions in annual workers' compensation costs of $343 million during 1994 to $231 million during 2000,

2) reductions in annual claims which peaked at 57,000 during 1991 to 32,000 during 2000,

3) reductions in annual injury frequency from 8.3 per 100 employees during 1994 to 6.0 per 100 during 1996, and

4) reductions in annual employer insurance premiums from $362 million during 1994 to $160 million during 2000.

Mr. Hamada's efforts to improve customer service have resulted in reducing the hearings backlog statewide from 12-18 months to current levels of 3-6 months. Ninety-eight percent of decisions are issued within 60 days of hearings. Settlements, which previously required 60 days for approval, are currently being approved within 10-14 days. With the support of the Legislature, the Facilitator Unit was authorized in 1996 to assist injured workers, insurance carriers, health care providers and the general public. This unit is focused on educating and assisting customers navigate through DCD programs. Mr. Hamada's initiative resulted in Act 256 in 1998 that dramatically changed the role of DCD in administrating the vocational rehabilitation (VR) program. The DCD previously directly reviewed, monitored and approved all VR activities. The DCD currently intervenes only when the parties, the injured worker, VR counselor and insurance carrier cannot agree and issues required adjudication. Mr. Hamada also greatly reduced the volume of medical reports submitted to the DCD by requiring reports filed only when required to adjudicate an issue. Previously, all medical reports (one report every month) were filed for over 60,000 open claims. These accomplishments were achieved in response to and in spite of reduction in DCD staffing from 143 to current staffing authorization of 119.

While I believe these achievements are noteworthy, DLIR and DCD are always seeking ways to improve. The following is provided in direct response to the concerns and recommendations identified in the report.

Internal controls

We agree that better internal control procedures relating to Special Compensation Fund (SCF) activities are required. We would like to note that the SCF is audited annually by an independent auditor and no findings of fraud have been indicated. Specifically, the following actions will be taken in response to this audit.

1. DCD will be developing better revenue and expenditure records and procedures to address lines of reporting and authority.

2. The Director will approve all waivers of penalties and better waiver criteria will be developed.

3. DCD positions involved in SCF activities will be updated to reflect these responsibilities.

4. Contract with a consultant to develop a better SCF accounting processes to eliminate manual redundancies and enable timely and useful management financial reports.

Computer system

We agree that the DCD's new computer system is not complete and does not integrate all of the goals identified in its strategic plan. In addition, DLIR is working on providing better support to all of its divisions. DCD was only recently authorized a dedicated Data Processing System Analyst position. The DCD computer system design team consisted of non computer staff from within DCD, who were willing to learn and work on this project with the consultants. While there are many improvements that are needed, the most important include total separation from the DCIS mainframe to eliminate maintenance of duplicate systems, implementation of electronic claims reporting, enhanced employer records, and development of electronic records storage system. While these deficiencies have been identified by the DCD, the DLIR has chosen not to fund these requirements at this time due to the current difficult fiscal situation.

One of the major customer service goals is to timely adjudicate controversies. The new system does provide valuable information enabling DCD to track cases requiring DCD intervention from initial requests for intervention to timely issuance of the final decision. The system will eventually be able to support the planned electronic records storage system. While not fully developed, DCD continues to develop the methodology to capture measurable information to support goals identified in its strategic plan. DCD also agrees with the need to incorporate computer issues into its own strategic plan and ensure alignment with the DLIR information systems strategic plan.

Management Issues, Staff Morale

We can always improve in this area. While reporting negative anonymous survey indicators, the report also indicated very positive interview results that the auditor attributed to fear. While the report indicates prevalence of low morale and intimidation, the personnel actions within the division do not indicate major problems. The DCD has not experienced serious absenteeism problems, low retention, and numerous employee complaints with the director or with the union, nor have any negative personnel actions been taken by the DCD. The DCD has lost 25 individual over the last 7 years. Nineteen retired or passed away, one was terminated after threatening staff members, one relocated to the mainland, one moved to accept a promotion, one left to work in the private sector and two moved to another public sector position. The 1998 refocusing of

the vocational rehabilitation mission resulted in the rifting of 13 positions. All but one of those rifted individuals continues to be with or have returned to the DCD.

However, the DCD does appreciate the information that we need to work harder at improving employee morale. The administrator fully understands his responsibility to enable his employees to perform at their highest level with clear guidance and timely support. He has initiated programs, focused on improving morale. These programs include improving communication with the entire staff by e-mailing staff meeting minutes to all employees, creating a DCDispatch bi-monthly newsletter, visiting neighbor island offices providing information and opportunity to discuss concerns and issues, requiring all employees to attend ZING training, formation of numerous Process Action Teams to allow employees to participate in developing improvements and allowing branch supervisors and District Office Managers to independently develop the DCD's Strategic Plan.

The DCD strategic plan focuses first on people issues by building trust through better communication and cooperation, secondly providing training and education to internal and external customers and finally focusing on specific program goals. While the DCD has not fully implemented strategies and goals identified in its current strategic plan, process action teams have been formed to develop measures for success. Our annual review and update of the strategic plan is necessary to identify new goals and strategies required to provide optimal service to internal and external customers. Our failure to communicate effectively and fully implement major improvements in the claims processing system probably contributed to "low trust".

Finally Mr. Hamada is currently attending the Exempt Management Certification Program sponsored by DHRD to further enhance his leadership skills. He has found this program to be extremely valuable. He has indicated that he has greater influence over his direct reports but needs their support to create a positive environment throughout the DCD. He will be sending his direct reports to similar leadership training programs, such as the Frontline Leadership Management Development Program.

We totally agree with the recommendation to form a Process Action Team to focus on ways to improve employee morale.

Medical Access and Reimbursement Rates under the Medical Fee Schedule

The DLIR is committed to providing reasonable fees for medical services. This is important to ensure availability of providers willing to treat workers' compensation and no fault claimants. The DLIR also agrees with the

recommendations of the Legislative Auditor relative to steps to improve our process to make the workers' compensation medical fee schedule (WCMFS) adjustments. The Research office will access availability of resources and will take steps necessary to adequately support WCMFS activities. We will ask the Legislature for support to exempt workers' compensation from the Small Business Regulatory Flexibility Act of 1998. While section 386-21.5 requires health care plans to provide the director with maximum allowable medical fee information, we agree that additional measures must be developed to force compliance with this requirement. The DLIR will continue to educate and work with the Hawaii Medical Association and other health care provider organizations on the process and requirements necessary to obtain medical fee schedule adjustments.

DLIR and the DCD would like to thank the Legislative Auditor for their report. The Legislative Audit staff should be acknowledged for their professionalism and courtesy throughout the conduct of the audit.

Very truly yours,

Leonard Agor
Director