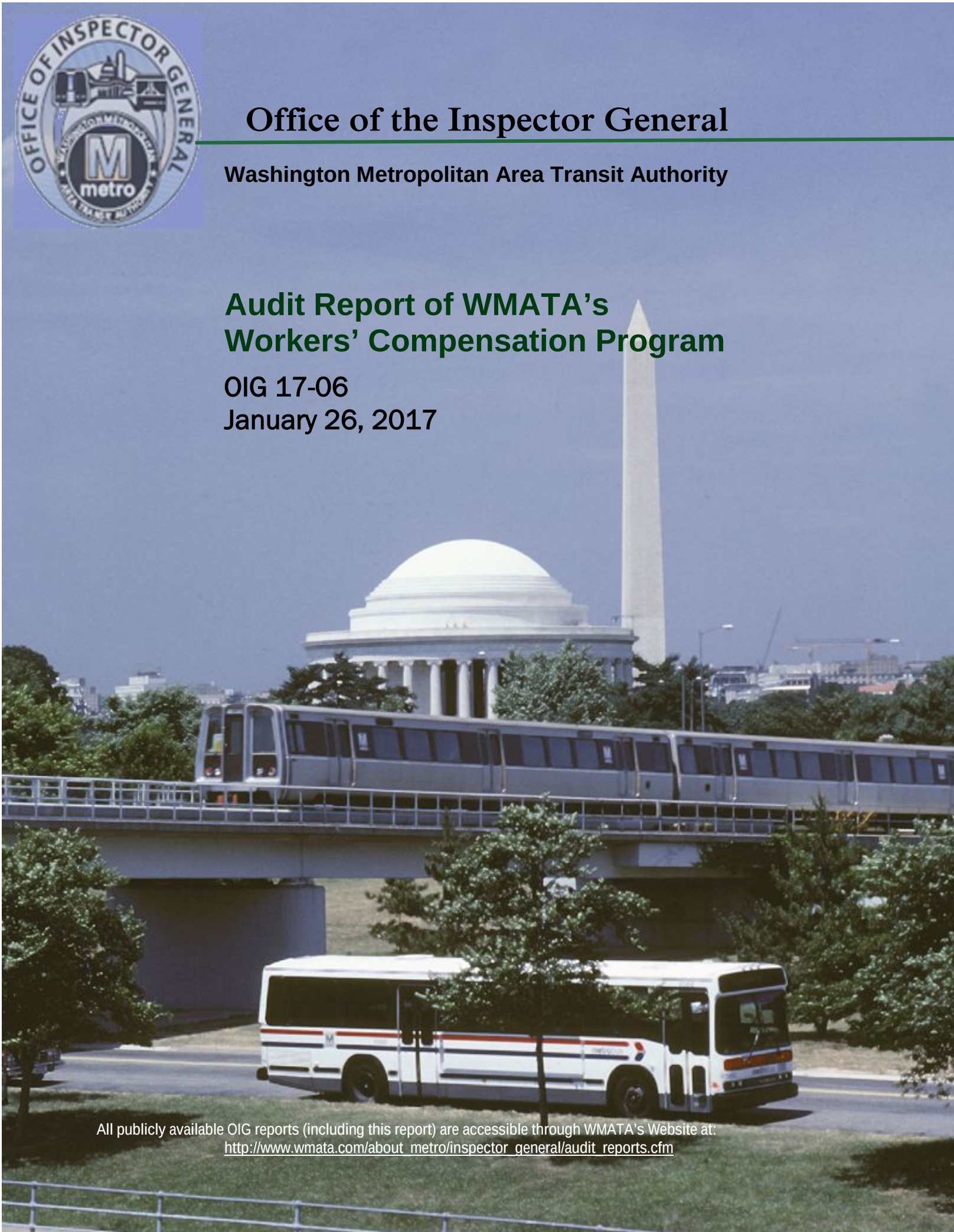
Office of the Inspector General

Washington Metropolitan Area Transit Authority

Audit Report of WMATA's Workers' Compensation Program

OIG 17-06
January 26, 2017



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Washington Metropolitan Area Transit Authority
WASHINGTON, D.C. 20001

**OFFICE OF
INSPECTOR GENERAL**

MEMORANDUM:

FROM: OIG – Helen Lew ***/S/*** DATE: January 26, 2017

TO: GMGR – Paul Wiedefeld

SUBJECT: Audit of WMATA's Workers' Compensation Program (OIG 17-06)

This Final Report, entitled *Audit of WMATA's Workers' Compensation Program,* presents the results of our audit. The audit objective was to determine the effectiveness and efficiency of the Workers' Compensation Program. Following an exit meeting conference on August 30, 2016 and the issuance of a Draft Report, WMATA staff provided written comments. WMATA staff concurred with the overall OIG draft report.

Please provide information on actions taken or planned on each of the recommendations within 30 days of the date of this report. Actions taken or planned are subject to OIG follow-up.

We appreciate the cooperation extended to us by your staff during the audit. If you have any questions or comments about our report, please contact me on (202) 962-[redacted] or Stephen Dingbaum, Assistant Inspector General for Audit, on (202) 962-[redacted].

Attachment

cc: CFO - D. Anosike
SAFE - P. Lavin
COUN - P. Lee

Office of the Inspector General

Washington Metropolitan Area Transit Authority

Results in Brief

OIG 17-06
January 26, 2017

Audit of WMATA's **Workers' Compensation Program**

Why We Did This Review

In fiscal year (FY) 2015, WMATA spent $26,283,781 on workers' compensation. Of that amount, $4,536,457 was expended on new claims. WMATA contracts with a Third Party Administrator (TPA) to process workers' compensation claims. After the TPA completes its investigation to determine whether the case is compensable or non-compensable, WMATA reviews the case and approves their decision.

The audit objective was to determine the effectiveness and efficiency of the Workers' Compensation Program.

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What We Found

WMATA has a workers' compensation program in place to provide a form of protection to employees who are injured while on the job. OIG identified two opportunities for improving the efficiency and effectiveness of WMATA's Workers' Compensation Program. Specifically, OIG found:

- no viable, continuous fraud detection program; and
- a lack of monitoring and oversight of the Third Party Administrator (TPA).

The lack of a viable fraud detection program increases the risk of potential fraud, fraud not being detected and the associated savings estimated not being realized. Additional savings can be realized with better monitoring and oversight of the contract.

The report makes recommendations to develop an effective fraud detection program and to improve the controls over the TPA.

Management's Response

The CFO accepted the recommendations in this report and provided actions being taken to correct the issues noted in the report. Corrective actions should be completed in calendar year 2017.

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ABBREVIATIONS AND ACRONYMS

ABBREVIATION	DESCRIPTION
COTR	Contracting Officer Technical Representative
COUN	General Counsel
CSP	Client Service Plan
IT	Information Technology
OIG	Office of Inspector General
OSH	Occupational Safety and Health
OSHA	Occupational Safety and Health Administration
RISK	Office of Risk Management
TDP	Transitional Duty Placement
TPA	Third Party Administrator
WC	Workers' Compensation
WMATA	Washington Metropolitan Area Transit Authority

BACKGROUND

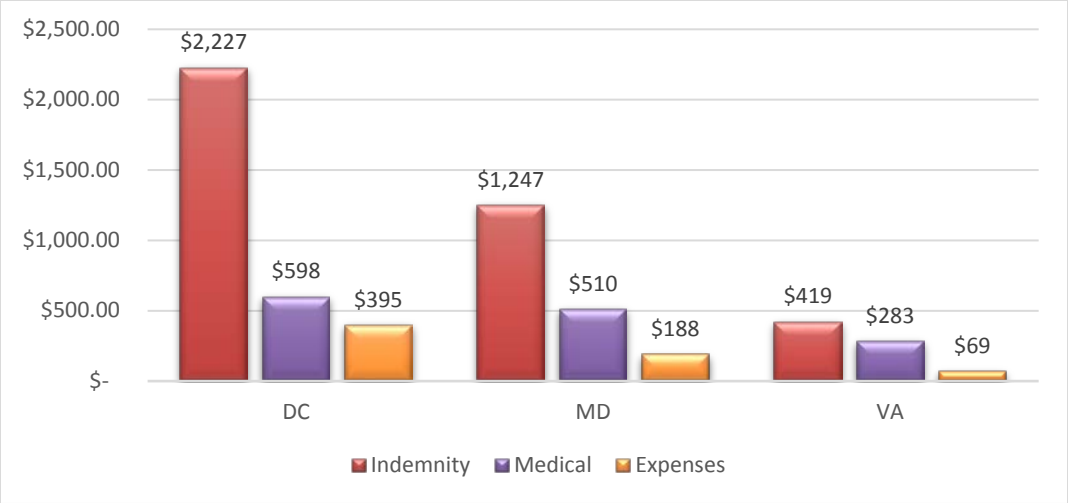
The Washington Metropolitan Area Transit Authority (WMATA) established its Workers' Compensation (WC) Program in accordance with the laws of the District of Columbia, the State of Maryland, and the Commonwealth of Virginia. The laws and regulations of the three jurisdictions are in place to provide a form of protection to employees who are injured while on the job. These laws and regulations provide legal guidance for employees and employers on their responsibilities to address and process WC claims, for which WMATA self-insures. In FY 2015 WMATA spent a total of $26,283,781 in workers' compensation. Of that amount, $4,536,457 was expended on new claims.

The WC Program is administered by a manager within the Office of Risk Management (RISK). The WC Manager serves as the Contracting Officer Technical Representative (COTR) on the contract with WMATA's Third Party Administrator (TPA). The WC Manager is assisted by two WC specialists who review open claims and provide technical guidance and assistance on claim-related matters. The TPA is responsible for workers' compensation claims handling services. After the TPA completes its investigation to determine whether the case is compensable or non-compensable, WMATA reviews the case and approves their decision.

During the period July 1, 2014 – December 31, 2015, 1,350 new claims were submitted to the TPA, averaging 75 claims per month (1,350 claims/18 months). One hundred of those claims were fully denied and one claim was partially denied[1] showing a 7.41 percent denial ratio (100 denied claims/1,350 submitted claims). For this period, the total expenses (indemnity,[2] medical,[3] and expenses[4]) paid was $5,941,146, and 268 new claimants[5] were on the WC roll as of December 31, 2015. Chart 1 on page 3 shows the total workers' compensation expenses paid by the three WMATA jurisdictions.

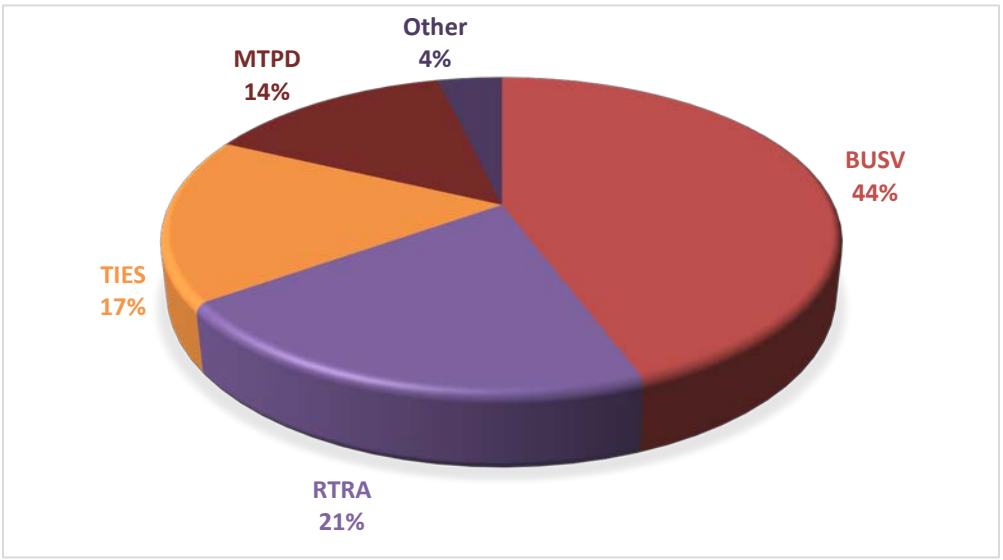
[1]Claim ID # [redacted] was partially denied and can be found on both the accepted and denied reports. The claim was submitted to treat two body parts; however, treatment for only one body part was accepted.
[2]Indemnity describes payments made to an injured or sick employee whose injury or illness occurred as a result of employment.
[3]Medical describes payments made to healthcare providers necessary to diagnose and treat injured employees.
[4]Expenses describe payments made on behalf of WMATA for allocated services (legal fees, surveillance fees, etc.)
[5]The universe of claims included claimants who filed multiple claims totaling 146 claims and 618 claims were closed during our audit period (1,250 approved claims – 150 multiple claims – 832 closed claims = 268 claimants on WC roll). According to the TPA's Claims Manager, a closed claim is a claim where the claimant has obtained a medical release from the physician, the claimant's file has resolved via settlement, or a claim was denied.

Chart 1
Total WC Expenses for new claims 7/1/2014 – 12/31/2015 (In Thousands)



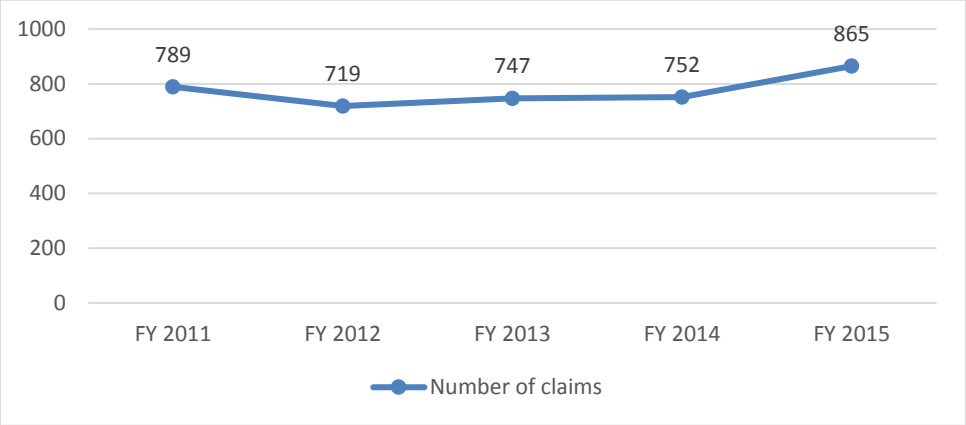
Of the 1,250 claims accepted, employees in Bus Services (BUSV), the Office of Rail Transportation (RTRA), Transit Infrastructure & Engineering Services (TIES), and the Metro Transit Police Department (MTPD) filed the majority of the claims as can be seen in Figure 1 below.

Figure 1
Percentage of Claims by Department/Office

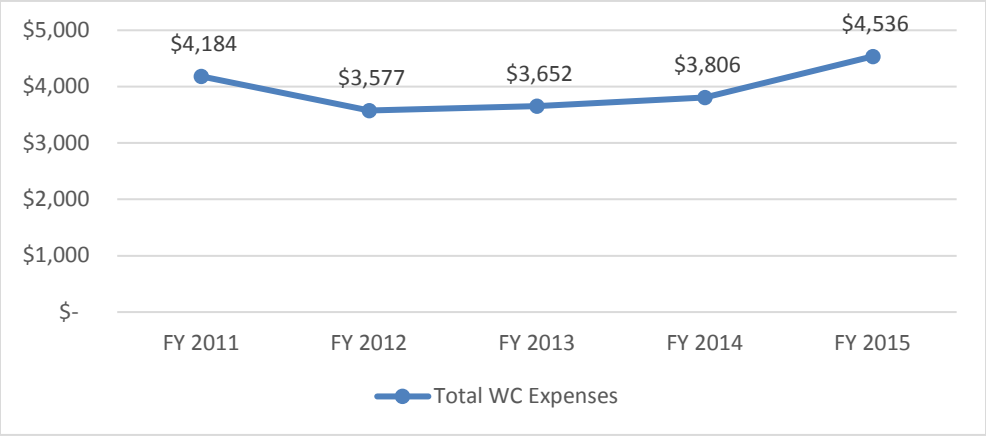


WMATA has experienced some spikes and decreases in the number of participants and cost in the WC Program. Over the past five fiscal years, WMATA's WC Program received 3,872 new claims for a total of $19,642,938 in expenses.[6] The claims processed by WMATA's previous TPA in FY 2012 had the fewest number of new claims and expenses at 719 and $3,576,660, respectively. Over the next three years, the total number of new claims and expenses began to increase with WMATA's current TPA, whose performance period started in July of 2013. The number of claims and expenses have been steadily increasing each year. The five-fiscal-year trend analysis can be found in Graphs 1 and 2 below.

Graph 1
Five-Fiscal-Year Trend Analysis: Number of New Claims Filed



Graph 2
Five- Fiscal-Year Trend Analysis: Total New WC Expenses (In Thousands)



[6]Includes indemnity, medical, and allocated expenses.

AUDIT OBJECTIVE AND RESULTS

Audit Objective

The audit objective was to determine the effectiveness and efficiency of the Workers' Compensation Program.

Audit Results

WMATA has a workers' compensation program in place to provide a form of protection to employees who are injured while on the job. OIG identified two opportunities to improve the effectiveness and efficiency of WMATA's Workers' Compensation Program. Specifically, OIG found:

- no viable, continuous fraud detection program; and
- WMATA did not adequately monitor and oversee the TPA's performance.

The lack of a viable fraud detection program increases the risk of potential fraud, fraud not being detected and the associated savings estimated not being realized. Additional savings can be realized with better monitoring and oversight of the TPA.

FINDINGS AND RECOMMENDATIONS

Finding 1 - *The Workers' Compensation Program Lacked a Viable Fraud Detection Program (Risk – High)*[7]

WMATA did not ensure the TPA had a viable fraud detection program as required by the contract. The WC Program did little to identify and detect potential fraud among claimants on the payroll. Specifically, the WC Program conducted few surveillances on questionable claimants and did not have a sufficient number of surveillance triggers. This occurred because the WC Manager did not adequately monitor the TPA's work for compliance with the contract. The lack of a viable fraud detection program increases the risk of potential fraud, fraud not being detected, and the associated savings not being realized.

What Is Required

Workers' Compensation Contract CQ13052 Appendix A

- Section 2.00 of the contract states, "WMATA's Workers' Compensation Office shall be responsible for monitoring TPA activity and enforcing provisions of this contract."
- Section 6.04(e) of the contract states, "Investigate and pursue any indication or suspicion of a fraudulent claim."
- Section 6.04(g) of the contract states, "Subject to prior approval of, and at the expense of WMATA, the TPA will employ outside professionals such as surveillance…to assist in the investigation and adjustment of claims."
- Section 6.04(i) of the contract states, "Each claim must be evaluated for the presence of 'fraud triggers'."[8]
- Section 6.07(d) of the contract states, "The Claims Administrator must ensure that all surveillance assignments are documented in writing."

[7]Details of these findings, which are rated as High, Medium, and Low Risk require management corrective actions to strengthen internal processes and provide for more effective efficient operations.
[8]The term "triggers" is not defined in the contract or the CSP.

Client Service Plan (CSP)

- Section 4.7.1 of the CSP states, "Each claim must be evaluated for the presence of 'fraud triggers'."

- Section 7.2 of the CSP states, "The Claims Administrator must determine when surveillance or outside investigation is necessary and seek written approval from WMATA prior to assignment.

What We Found

The TPA does not have a formal fraud detection program

WMATA did not ensure the TPA had a viable fraud detection program as required by contract. The WC Program did little to identify and detect potential fraud among claimants on the payroll. Sections 6.04 (e) and (i) of the WC contract the TPA stated, "Although there is no method to eliminate fraud in insurance claims, our company has successfully implemented an anti-fraud program, which has resulted in substantial savings to our clients and the successful prosecution of offenders." The TPA assured WMATA they have, "developed the following anti-fraud program to help minimize claim payments and improve the overall cost of property and casualty coverage throughout the industry: (a) screening of claims, (b) effective use of surveillance, (c) effective use of physicians, (d) report of earnings, and (e) medical interviews." However, during the course of the audit, the TPA could not provide any documentation or support they had implemented such an anti-fraud program.

A critical part of screening claims is using fraud triggers. At the beginning of this audit, the TPA had five fraud triggers: (a) multiple claims filed by a claimant, (b) no witnesses, (c) accident occurred on a Monday, (d) doctors that argue the diagnosis, and (e) injured worker not willing to abide by return to work/light duty work policy. However, OIG could not determine whether each claim is continuously evaluated for potential fraud, i.e., the claimant continues to be eligible for workers' compensation.

On May 17, 2016, OIG met with the Executive Vice President of the TPA to discuss the fraud detection program. As a result of that conversation, the TPA revised their fraud policy, effective May 23, 2016 to include new system enhancements and added fraud triggers to ClaimPilot.[9] According to the revised policy, the new system enhancements are "yes" or "no" tabs for responses to the fraud triggers and an automated fraud report that would be generated if three or more fraud trigger questions were answered "yes."

[9]ClaimPilot is the TPA's web-based claims management system that tracks day-to-day risk-related and claims handling activities.

On June 16, 2016, the TPA provided an automated fraud report along with five additional fraud triggers: (a) claim was reported late,[10] (b) claimant refused treatment, (c) claim filed after termination, (d) flag on a provider, and (e) employee performance issues.

On August 11, 2016, OIG's Information Technology Specialist (IT) obtained the TPA's WC database to determine whether the established fraud triggers were in the system to produce the automated fraud report. OIG's IT Specialist could not trace the fraud triggers to the table and field in the database. The TPA was unable to provide the tables and field links for each trigger. While there may be fraud triggers, the triggers are not linked in the TPA's database to produce the automated fraud report. As a result, OIG could not find the fraud triggers in the database.

Another critical part of screening claims is to periodically ensure claimants continue to be eligible to receive benefits. The TPA's Claims Manager mentioned that continued eligibility is determined through the claimant's medical documentation and conducting "alive and well" checks, if applicable. If there is no corroborating medical documentation to substantiate disability, scheduling an independent medical examination can be an option. Documentation in the workers' compensation files showed that the TPA requested independent medical examinations, as needed.

The TPA did not implement sufficient amount of surveillance triggers

The WC Program conducted few surveillances on questionable claimants and did not have a sufficient number of surveillance triggers. During the audit period, the WC Manager set the duration of surveillance for two days. According to an August 2010 article from Pursuit Magazine, when a claimant's injury is subjective,[11] the best course of action is to conduct surveillance over several days. Neither the WC Manager nor the TPA track the number of surveillance requests. Rather, they seem to use their intuitive knowledge to remember cases where surveillance was requested.

According to the TPA's Claims Manager, surveillance is conducted as a result of (1) receiving an anonymous tip about a claimant, (2) suspected malingering, and (3) medical treatment exceeded the normal. In addition, the Claims Examiners have to believe surveillance is needed. Since surveillance requests were not tracked, OIG obtained and reviewed the TPA's Accounts Payable ledger[12] to determine the number of surveillances conducted during the audit period.

Based on our review of the Accounts Payable Ledger, we determined at least four requests were made for surveillance, but only one surveillance was conducted during our audit period. The claimant's First Report of Injury or Illness[13] for this surveillance noted the claimant suffered pain to multiple body parts while [redacted]. The claimant was surveilled four times as a result of an anonymous tip which stated the claimant was not injured.

[10]The claim wasn't reported within 24 hours of the incident or notification of an injury for employee.
[11]Subjective injuries include soft-tissue injuries, emotional injuries, and phantom pain.
[12]The TPA's Accounts Payable ledger was reviewed to determine how much money was paid to the surveillance vendor during our audit period.
[13]The claimant's injury was found in ClaimPilot; it was not noted in the surveillance investigation report.

According to the surveillance investigation reports, no fraud was found. Further, 36 hours and four days were spent on this claimant's surveillance. The surveillance costed WMATA $2,922. See Appendix B in this report for a case study of this surveillance.

According to the Director of RISK, surveillance investigation reports are reviewed and appropriate steps are taken, depending on the surveillance results in conjunction with General Counsel (COUN) and the TPA.

Why This Occurred

The WC Manager did not adequately monitor TPA's work for compliance with the WC contract

The TPA is monitored through annual internal audits conducted by the WC Manager and Specialists. The internal audits conducted in 2014 and 2015 showed the WC Manager measured the TPA's fraud program performance against the following parameters established in the CSP: (1) Investigation, (2) Medical Management, (3) Coding, (4) Litigation Management, (5) Reserves, (6) Claims Management, and (7) Supervision.

However, the investigation section in both audits measured whether the TPA (a) made a three-point contact,[14] (b) completed initial investigation,[15] (c) took recorded statements,[16] (d) filed state documentation timely,[17] and (e) addressed subrogation.[18] The Investigation performance parameter established in the CSP is inadequate because it did not include a performance measurement for evaluating fraud. The CSP does not require the TPA to "Investigate and pursue any indication or suspicion of a fraudulent claim" as stated in the WC contract, Section 6.04(e).

The WC Manager stated that evaluating claims for fraud is not easy. In addition, the WC Manager believed the WC Commissioners never rule in WMATA's favor, but instead rule in favor of the claimant. Because of this, the WC Manager did not put emphasis on the TPA's requirement to evaluate each claim for fraud triggers, which is contained in both the WC contract and CSP. As a result, the TPA was not rated on their contract performance relative to evaluating each claim for fraud triggers.

[14]Contract CQ13052, Section 6.04(c) states, the claims administrator shall perform the following: "Ensure that three-point 24-hour contact is completed on each new lost time claim, or that reasonable attempts to complete the three-point 24-hour requirement is evidenced and documented in each file. Unsuccessful attempts to contact parties by phone shall be followed by a letter to that party. Three-point contact includes, but not limited to, the requirements listed herein; (1) Employee – to verify description of accident, medical/disability status with names of medical provider, and medical and claim history. (2) Employer/Supervisor – to verify description of accident, job title, description of duties, history of employment, injury disability status, return to work possibilities and any other pertinent information; and (3) Healthcare Provider – to establish history or injury, diagnosis, prognosis, and to confirm that work status is addressed so that employee can return to work as quickly as medically possible."

[15]Contract CQ13052, Section 6.04(b) states, "The investigations shall include consideration of severity of injury, potential extent of disability, questions of eligibility for compensation, verification that the accident or injury occurred on the job and opportunities for subrogation."

[16]Contract CQ13052, Section 6.04(f) states, "Take recorded statements from all parties involved in a loss when there are any questions regarding compensability of the claim."

[17]Neither WC Contract nor the CSP mention which state documentation the TPA is responsible for filing.

[18]According to the TPA's Claim Manager, subrogation is the recovery or reimbursement of funds paid on behalf of an injured WMATA employee, who suffered injuries as a result of a non-WMATA employee.

Why This Is Important

Increased Potential for Financial Loss

The lack of a viable, continuous fraud detection program increases the risk of potential fraud, fraud not being detected, and the associated savings not being realized. According to a 2015 article, "Studies show that only 1 to 2 percent of workers' compensation claims are fraudulent."[19] Applying these percentages to WMATA's $26M workers' compensation program, WMATA may have paid more than $260,000 (1 percent of $26 million) in fraudulent claims during FY 2015.

Continual Eligibility for Workers' Compensation

It appears the TPA has some fraud triggers that address the claims handling investigation process when a claim is received. However, the TPA only has two fraud triggers[20] that would address the claimant's continual eligibility in the WC program that would initiate surveillance. Establishing additional fraud and surveillance triggers, as well as, applying the triggers on an ongoing basis throughout the duration of the claim may enhance the TPA's fraud detection program. OIG shared some additional fraud and surveillance triggers with the TPA which can be found in section Appendix C of this report.

Recommendation:

We recommend that the GM/CEO:

1. Develop and implement a robust fraud detection program that includes provisions for:

a. Continuously evaluating claims for fraud triggers using an automated reporting system.
b. Measuring the TPA's performance against the fraud requirement stated in the WC contract when conducting annual audits.
c. Establish/Reassess fraud and surveillance triggers to be applied on an ongoing basis throughout the duration of the claim. (Action: Director of RISK) *(Risk – High)*

[19]Cullen, Lisa. "A Job to Die For: Why So Many Americans Are Killed, Injured or Made Ill at Work and What to Do About it." Common Courage Press, 2002. Public Broadcasting Service. N.p.: n.d. Web. 17 Nov. 2015
[20]The 'Claimant refused treatment' and 'Injured worker not willing to abide by return to work/light duty work policy' fraud triggers.

Finding 2 - WMATA Did Not Adequately Monitor and Oversee the TPA's Performance (Risk – High)

The WC Manager did not adequately monitor and oversee the TPA's performance to ensure the TPA provided deliverables established in the WC contract. Specifically, the (1) TPA was not properly recording some Occupational Safety and Health Administration (OSHA)-related claims and (2) TPA's Nurse Case Manager did not have copies of light-duty job descriptions. This occurred because the TPA's OSHA Coordinator prematurely ended the OSHA diaries, the TPA's Supervisors and Claims Examiners are not trained to report OSHA recordable injuries, and there is no coordination between the Nurse Case Manager and the Transitional Duty Placement[21] (TDP) program.

What Is Required

29 Code of Federal Regulations 1904 OSHA

Section 1904.7(a)(1) states, "You must consider an injury or illness to meet the general recording criteria, and therefore to be recordable, if it results in any of the following: death, days away from work, restricted work or transfer to another job, medical treatment beyond first aid, or loss of consciousness. You must also consider a case to meet the general recording criteria if it involves a significant injury or illness diagnosed by a physician or other licensed health care professional, even if it does not result in death, days away from work, restricted work or job transfer, medical treatment beyond first aid, or loss of consciousness."

Workers' Compensation Contract CQ13052 Appendix A

- Section 2.00 of the contract states, "The TPA must also segregate OSHA recordable[22] injuries from WC compensable claims and provide that information to WMATA's Safety Department."

- Section 6.013(b) of the contract states, "The Claims Administrator must ensure that the Nurse Case Manager is provided with WMATA's job descriptions and that this information is communicated to the treating physicians."

- Section 6.020 of the contract states, "…(a) input OSHA data when initially establishing new claims in database, (b) track time away from work and days of restricted work activity, (c) produce OSHA 300 logs, 300A and 301 forms for an individual location, or for all locations at the same time, and …(f) add industry classification and exposure data for OSHA 300A."

[21]The Transitional Duty Placement program is a component of the Office of Workforce Availability that places and monitors employees in temporary positons while recovering from their injury.
[22]Work-related injuries or illnesses that meet OSHA's requirements as recordable.

What We Found

The TPA did not always accurately record OSHA-related claims

The Manager in Occupational Safety and Health (OSH) from the Department of Safety & Environmental Management (SAFE) stated that the TPA often makes errors recording OSHA-related claims which he must spend a lot of time manually correcting. The Manager of OSH provided a listing of 50 erroneously recorded claims from calendar year 2015. Out of 10 claims from a judgmental sample, none were properly recorded.

- Six claims were assigned an OSHA designation that were not OSHA recordable.
- Specifically, four claims were not work-related and two claims had no days away from work, which do not qualify as OSHA recordable.
- Four claims were not assigned an OSHA designation that were OSHA recordable.
- Specifically, two claims had medical treatment beyond first aid,[23] and two claims had days away from work, which qualify as OSHA recordable.

The TPA's Nurse Case Manager did not have all of WMATA's job descriptions

Job descriptions are needed by treating physicians to determine when an injured employee can return to work; however, the TPA does not have all of WMATA's job descriptions. WMATA's job descriptions include light-duty job descriptions from the TDP Program, as well as the pre-injury job descriptions. Providing light-duty job descriptions to the treating physician helps them determine whether an injured employee can perform those duties sooner than waiting until they can return to their pre-injury position.

Why This Occurred

Diaries Closed Prematurely[24]

The TPA's OSHA Coordinator is responsible for collecting the OSHA injury information, completing Forms 300 and 300A,[25] and providing the forms to the Manager of OSH. The OSHA Coordinator would close the OSHA diary after the OSHA designation was determined through the medical records. However, claims can be denied after the medical records are received. An example of a denied claim would be a case where the claimant did not suffer a work-related injury. In this case, the injury would not be OSHA recordable. As a result, the OSHA Coordinator would be unaware of the change in the claim status because the diary would have been prematurely closed.

[23]Two medical prescriptions were prescribed.
[24]A diary is a reminder or tickler providing notification that something is required or necessary to be completed on a claim.
[25]Form 300 is used to classify work-related injuries and illnesses and to note the extent and severity of each case. Form 300A is used to record the total injuries and illnesses for each category.

Lack of Training

According to the TPA's Claims Manager and OSHA Coordinator, the TPA's Supervisors and Claims Examiners were never trained on initially reporting OSHA recordable injuries. Due to the lack of training, the TPA's Claims Examiners automatically code claims with a "days away from work" OSHA designation. Meanwhile, the TPA's Claims Supervisors do not review the OSHA designation for accuracy. As a result, some OSHA-related claims were improperly recorded.

There is No Coordination between the TPA's Nurse Case Manager and the TDP Program

According to both the TPA's Nurse Case Manager and the TDP Coordinator, there is no coordination between the TPA's Nurse Case Manager and the TDP Program. The lack of coordination occurs because the TPA's Nurse Case Manager is not required to interact with the TDP Coordinator. In an interview with the TPA's Nurse Case Manager, OIG learned the TPA's Nurse Case Manager interacts with her third-party vendor, WMATA's injured employees, treating physicians, and the TPA's staff. As a result, the TPA's Nurse Case Manager does not have the TDP Program's light-duty job descriptions.

Why This Is Important

WMATA's Integrity and Reputation are Adversely Affected

Failure by SAFE to correctly report the OSHA designation on a workers' compensation claim could adversely affect WMATA's integrity and reputation. According to the Department of Labor, employers must post a summary of injuries and illnesses recorded the previous year. Posting inaccurate injuries and illnesses can result in misleading information on WMATA's safety environment.

In addition, the Manager of OSH told OIG he and a safety officer generally spend about 20 hours a month correcting erroneous OSHA designations and fixing the Forms 300 and 300A. This is not efficient use of limited staff resources in OSH.

Timeliness is Adversely Affected

Failure by WMATA to provide the TPA's Nurse Case Manager with the light-duty job descriptions can adversely affect how quickly claimants return to work in light-duty or full-duty capacities. In turn, the TPA's Nurse Case Manager cannot provide treating physicians with the light-duty job descriptions.

Recommendations:

We recommend that the GM/CEO:

2. Provide OSHA training to the TPA's Claims Supervisors and Claims Examiners on how to accurately record OSHA-related claims. (Action – Director of RISK) *(Risk – Low)*

3. Provide the TPA's Nurse Case Manager with the TDP program's light-duty job descriptions so treating physicians can determine whether an injured employee can perform this type of duty sooner than waiting until the employee can return to their pre-injury position. (Action – Director of RISK) *(Risk – Low)*

CONSOLIDATED LIST OF RECOMMENDATIONS

Recommendations:

We recommend that the GM/CEO:

1. Develop and implement a robust fraud detection program that includes provisions for:

a. Continuously evaluating claims for fraud triggers using an automated reporting system.
b. Measuring the TPA's performance against the fraud requirement stated in the WC contract when conducting annual audits.
c. Establish/Reassess fraud and surveillance triggers to be applied on an ongoing basis throughout the duration of a claim. (Action: Director of RISK) *(Risk – High)*[26]

2. Provide OSHA training to the TPA's Claims Supervisors and Claims Examiners on how to accurately record OSHA-related claims. (Action: Director of RISK) *(Risk – Low)*

3. Provide the TPA's Nurse Case Manager with the TDP program's light-duty job descriptions so treating physicians can determine whether an injured employee can perform this type of duty sooner than waiting until the employee can return to their pre-injury position. (Action: Director of RISK) *(Risk – Low)*

[26]Recommendations are rated as High, Medium, or Low Risk and require management corrective actions to strengthen internal processes and provide for more effective and efficient operations.
High – Exception is material to accomplishing organizational objectives. Corrective action by appropriate Senior Management is required. Resolution would help avoid loss of material assets, reputation, critical financial information or ability to comply with critical laws, policies, or procedures.
Medium – Exception may be material to accomplishing organization objectives. Corrective action is required and the results are reported to management quarterly. Resolution would help avoid negative impact on the unit's assets, financial information, or ability to comply with important laws, policies, or procedures.
Low – Exception has a minor impact on the accomplishment of organization objectives but may result in inefficient operations. Resolution would help improve controls and avoid inefficient operations within the unit.

SUMMARY OF MANAGEMENT'S RESPONSE

The CFO accepted the recommendations in this report and provided actions being taken to correct the issues noted in the report. Corrective actions should be completed in calendar year 2017.

Appendix A

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of the audit was to determine the effectiveness and efficiency of the Workers' Compensation Program.

Scope

Our scope included a review of WMATA's Workers' Compensation Program from July 1, 2014 through December 31, 2015.

Methodology

We reviewed applicable workers' compensation statutes. We reviewed applicable policies and procedures for workers' compensation developed by WMATA. We interviewed management and staff in RISK and SAFE. We conducted off-site interviews with the TPA's management and staff. A survey instrument was developed and used to ensure consistency in gathering information. We reviewed the workers' compensation process, analyzed data collected, and assessed internal controls.

The universe of processed workers' compensation claims during our audit period was extracted from the TPA's ClaimPilot system by our IT Specialist. Our IT Specialist assessed the data for sufficiency and appropriateness. The universe of processed claims with the use of surveillance during our audit period was obtained from the TPA's ClaimPilot system. We reviewed all claims involving the use of surveillance, specifically, the investigation reports and invoices. These were reviewed to determine the sufficiency of the surveillance efforts.

The universe of erroneously processed OSHA designated claims for the period of our audit was obtained from the Manager of OSH. A judgmental sample was selected from the universe of 50 for the audit period. We examined the claim files from the TPA's ClaimPilot system and reviewed the diary notes and documentation to determine OSHA applicability.

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

Appendix B

SURVEILLANCE CASE STUDY

According to the investigation report, on December 5, 2015, the investigator travelled to the claimant's reported mailing address. A United Parcel Service worker attempted to deliver a package to the residence, but there was not an answer at the door. As a result, surveillance was discontinued on that day. On December 12, 2015, the investigator returned to the claimant's residence. The investigator called at the claimant's door and spoke to claimant's father. When it appeared the claimant's parents reside at the given mailing address and the claimant could not be found, the surveillance was discontinued.

The WC Manager approved two additional days for this claimant to be surveilled again three months later. According to the second investigation report, on March 1, 2016, the claimant was found leaving his residence. The investigator followed the claimant to a Metro Station. Then, the claimant was followed to the next location which appeared to be a doctor's office. Afterwards, the claimant was followed to several different locations, but the investigator eventually lost the claimant and surveillance was discontinued. On March 10, 2016, the investigator returned to the claimant's residence. The claimant was not observed and surveillance was discontinued.

Before the first surveillance attempt was conducted, the claimant had been on the workers' compensation roll for approximately six months. After the first surveillance attempt was conducted, the claimant returned to the workers' compensation roll for two months before being surveilled for a second time. The investigator did not observe anything that would show fraud. The claimant is still on the workers' compensation roll.

Appendix C

FRAUD AND SURVEILLANCE TRIGGERS

List of Fraud Triggers[27]

1. The employee has a poor attendance record at work
2. The injured worker is a new employee
3. The accident occurs immediately before or after vacation
4. The accident occurs immediately prior to an employee's retirement
5. The employee is injured after giving notice to separate from place of employment
6. The employee's alleged injury relates to a pre-existing health problem
7. The employee has a part-time job that is labor intensive*
8. The employee provides a telephone number but doesn't live at the address associated with it*

List of Surveillance Triggers*[28]

1. The claimant changes treating physicians frequently
2. The claimant suddenly changes addresses
3. The claimant refuses to attend scheduled examinations
4. The claimant is unreachable
5. The claimant's lifestyle is incompatible with their known income

*These triggers can be applied to a claim throughout the duration of the claim.

[27]Fulmer, Scott. "Top 40 Red Flags which May Indicate Workers' Compensation Fraud." Pursuit Magazine n.d.: n. pag. Web. 27 Jul. 2013.
[28]Ibid

Appendix D

MANAGEMENT'S RESPONSE FROM THE CHIEF FINANCIAL OFFICER

Appendix D

M E M O R A N D U M

SUBJECT: Response to OIG Audit of Workers' Compensation Program No. 17-06

DATE: January 13, 2017

FROM: CFO – Dennis Anosike [redacted]

THRU: GM/CEO – Paul J. Wiedefeld [redacted]

TO: OIG – Helen Lew

The following represents the Chief Financial Officer's Corrective Action Plan (CAP) in response to OIG's Audit of WMATA's Workers' Compensation Program.

OIG Recommendation 1
Develop and implement a robust fraud detection program that includes provisions for:

a) Continuously evaluating claims for fraud triggers using an automated reporting system.
b) Measuring the TPA's performance against the fraud requirement stated in the WC contract when conducting annual audits.
c) Establish/Reassess fraud and surveillance triggers to be applied on an ongoing basis throughout the duration of a claim.

Management's Response:
Management accepts these recommendations.

a) Subsequent to the OIG audit, the Third Party Claims Administrator (TPA) implemented fraud triggers and recently indicated that they would develop an automated reporting system to monitor results. Management will provide the status of the automation to OIG by the end of FY2017.
b) The contract requires the TPA to "investigate and pursue any indication of or suspicion of fraudulent claim…" and that "each claim must be evaluated for the presence of 'fraud triggers'." RISK will modify the scope of TPA audits to include TPA compliance with its contractual obligations as they pertain to fraud. The audit samples will be reviewed to ensure the TPA's application of the fraud triggers and that subsequent actions are being taken by the TPA. These modifications will be incorporated into the next audit of the TPA which will be completed prior to the end of FY2017.

Washington Metropolitan Area Transit Authority

c) RISK has initiated this recommendation by working with the TPA to address WC claim fraud and abuse through the duration of the claim, including relevant fraud and surveillance triggers. This effort will be completed by the end of the third quarter of FY2017.

OIG Recommendation 2
Provide OSHA training to the TPA's Claims Supervisors and Claims Examiners on how to accurately record OSHA-related claims.

Management's Response:
Management accepts this recommendation. As discussed with OIG on January 10, 2017, RISK will require the TPA to provide training to their staff on OSHA recordable claims and the reporting of such to WMATA's Department of Safety and Environmental Management. A routine training plan will be implemented by the TPA by the end of the third quarter of FY2017.

OIG Recommendation 3
Provide the TPA's Nurse Case Manager with the TOP program's light-duty job descriptions so treating physicians can determine whether an injured employee can perform this type of duty sooner than waiting until the employee can return to their pre-injury position.

Management's Response:
Management accepts this recommendation. WMATA's Return-To-Work program does not utilize job descriptions for all light duty job assignments. However, to the extent that light duty job descriptions are available, they will be provided. This recommendation has been implemented.

TO REPORT FRAUD, WASTE, OR ABUSE

Please Contact:

Email: wmata-oig-hotline@verizon.net

Telephone: 1-888-234-2374

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