

*State of New Jersey
Office of the State Comptroller
Audit Division*



***A PERFORMANCE AUDIT OF WORKERS'
COMPENSATION CLAIM MANAGEMENT***

For the period January 1, 2012 through June 30, 2015

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Acting State Comptroller

July 9, 2020

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BACKGROUND

The New Jersey Workers' Compensation Law was enacted in 1911. *N.J.S.A. 34:15-1 et seq.* The workers' compensation program provides medical treatment, wage replacement, and permanent disability compensation to employees who suffer job-related injuries or illnesses and death benefits to dependents of employees who have died as a result of job-related injuries or illnesses.¹ The law requires all New Jersey employers not covered by federal programs to have workers' compensation insurance coverage or self-insurance approval. *N.J.S.A. 34:15-70 et seq.*

An employee who is determined to have a work-related injury,² referred to as the claimant, is eligible for compensation payments after a seven-day waiting period. *N.J.S.A. 34:15-14.* Compensation payments are subject to rates established by the Commissioner of the Department of Labor and Workforce Development (Labor) and are limited to 70 percent of the employee's weekly wages received at the time of the injury. *N.J.S.A. 34:15-12.*

New Jersey's workers' compensation insurance program covers state government employees, employees of certain higher education institutions, and employees of the New Jersey Sports and Exposition Authority. The State of New Jersey is self-insured for workers' compensation. The Department of the Treasury (Department), Division of Risk Management (Division), established by *N.J.S.A. 52:18A-219*, is responsible for the management and administration of workers' compensation benefits for covered employees.

The Division delegates the management of medical services to a managed-care organization (vendor). During the audit engagement, in January 2018, the then-current contract with the vendor expired. The contract was rebid and awarded to the same vendor with a contract term of January 28, 2018 through January 27, 2023.

1 This report will use "injury" to refer to both injury and illness.

2 A determination is made by either an insurance company or a self-insured entity. If the matter is disputed, the claim is submitted to the Division of Workers' Compensation for a determination by a Judge of Compensation. *N.J.S.A. 34:15-20.*

In Fiscal Years (FY) 2014 and 2015, the Division reported 5,365 and 4,984 newly filed claims, respectively, and estimated that it managed 8,000-10,000 open claims each year. The Division estimated that each claims investigator was assigned, on average, 600 to 700 open claims during the audit period. In FYs 2014 and 2015, the Division issued workers' compensation claim payments in the amount of \$93.5 million and \$91.3 million, respectively.

AUDIT OBJECTIVE, SCOPE, AND METHODOLOGY

We conducted a performance audit of the workers' compensation claim management for claims processed between January 1, 2012 and June 30, 2015, except where noted. The objectives of our audit were to assess the Division's management and administration of the claims processing for the workers' compensation program and its oversight of the vendor's compliance with certain reporting requirements pursuant to the provisions of the contract.

To accomplish our objectives, we reviewed relevant laws, Division policies and procedures, claim data, claim payments, and the contract for vendor services. We also interviewed certain Division personnel to obtain an understanding of their job responsibilities, overall operations, and the Division's internal controls.

As part of our review, we used statistical and non-statistical sampling methods. We designed our samples to provide conclusions about the validity of the sampled transactions, the adequacy of internal controls, and compliance with applicable laws, regulations, policies, and procedures with regard to the same. The results of our audit were not projected to the entire population of claims because our samples were not designed to be projected.

We performed this audit pursuant to the State Comptroller's authority as set forth in *N.J.S.A. 52:15C-1 et seq.* 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 objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

SUMMARY OF AUDIT RESULTS

We identified weaknesses in the Division's operating practices and internal controls for the management and administration of the workers' compensation program. Specifically, our audit found that the Division:

- Improperly processed workers' compensation benefits totaling \$54,605 contrary to the program limitations of the workers' compensation statutes, and its own policies and procedures.
- Did not properly ensure that the vendor responsible for managing medical services satisfied all contract requirements.

The Division must improve its current practices, revise and develop policies and procedures, and increase management oversight to achieve greater operational effectiveness and improve compliance with state regulations and internal policies and procedures.

We make seven recommendations to address the weaknesses we identified.

AUDIT FINDINGS AND RECOMMENDATIONS

Claim Management

The Division's inadequate policies and procedures and weak internal controls, including its lack of monitoring and oversight of the workers' compensation claims processing, resulted in improper payments.

We selected a statistical sample of 30 claimants from the audit population of 8,333 claimants. A summary of the workers' compensation population and our sample of claims is summarized in the following chart.

Summary of Audit Population and Sample				
	Number of Claimants	Total Unique Claims	Number of Transactions	Total Claim Payments
Population	8,333	10,336	204,696	\$ 84,552,253
Sample	30	41	3,712	\$ 2,146,255

For those claimants who submitted a new claim between January 1, 2012 and June 30, 2015, we judgmentally selected the six claimants with the highest number of claims submitted throughout their total state employment. These six claimants collectively filed 266 workers' compensation claims between 1978 and 2016.

Claim Processing

The claim process is described in the Division's policies and procedures contained in the Investigator's Procedure Manual (Manual). A claim is initiated when an injured employee's human resources (HR) representative files an injury report with the Division. The Division reviews the claim and makes a determination regarding the claimant's eligibility for benefits. Upon finding a claimant is eligible, the Division requests the claimant's HR representative to provide

information about the employee and the employee’s wage data. This information is requested and obtained through emails exchanged between the claims investigator and the employee’s HR office. The 30 claimants in our audit sample received a combined total of 554 claim payments for compensation valued at \$622,456. Our audit testing included verifying that the payments were calculated in accordance with the workers’ compensation statutes and internal policies and procedures, as required by the Manual.

The Division’s Manual instructs the claims investigators to include overtime earnings paid to the claimant during the preceding six months in calculating weekly earnings. Our audit found that the Division did not have a formal process for requesting, receiving, or reviewing claimant wage data, nor a standard template for computing the compensation benefits. Each claims investigator manually calculates the compensation payment using the information received from the claimant’s HR office. Sufficiently detailed policies and procedures would ensure that claims investigators consistently and accurately calculate workers’ compensation benefits in accordance with the statutory and regulatory limitations.

Our audit found 370 of the 554 compensation payments tested were not calculated in accordance with statutory requirements and Division policies, which resulted in improper payments in the amount of \$54,605.

Total Improper Payments	Number of Improper Payments	Reason for Improper Payment	Note
\$ 21,156	233	Overtime earnings excluded from claimant weekly earnings	1
\$ 3,845	119	Calculation Errors	2
\$ 17,320	10	Claimant approved for Accidental Disability Pension	3
\$ 12,284	8	Claimant returned to work	4
\$ 54,605	370		

Specifically, our audit found that the Division:

1. Processed compensation payments totaling \$21,156 for seven claimants without verifying that the payments were accurately calculated using all relevant wage data pursuant to statutory requirements set forth in *N.J.S.A.* 34:15-37 and the Manual. Our audit found that benefits for those seven claimants were not calculated using each claimant's overtime pay as required by the Manual. If the Division used a formal template or claim calculation process to ensure that it requested, received, and confirmed the total compensation for claimants, these claim processing errors that resulted in improper payments may have been avoided.
2. Miscalculated compensation payments to five claimants totaling \$3,845. The miscalculations included: (1) a \$426 overpayment to one claimant because the benefits were paid at 100 percent and not limited to 70 percent of the claimant's total earnings, contrary to *N.J.S.A.* 34:15-12 and the Manual; (2) calculation errors including overpayments totaling \$598 to two claimants and an underpayment of \$29 to one claimant; and (3) overpayments of \$2,792 to one claimant because the claims investigator failed to accurately compute compensation benefits using actual hours worked. We also noted during our testing that this error continued outside of our audit scope, through FY 2016, resulting in additional overpayments totaling \$2,198 to the same claimant. Upon notification of this, the Division informed us that it would, and subsequently did, withhold future compensation benefits in FY 2017 as a method to recapture approximately \$5,000 overpaid to this claimant. Overpayment errors occurred because the Division failed to utilize a formal claim calculation process that includes a completed template that is reviewed and approved by a supervisor.
3. Failed to recoup \$17,320 from one claimant who received both compensation payments and an accidental disability pension for a six-month period. The Manual specifies that the claimant must reimburse the state for workers' compensation benefits received after the accidental disability pension begins. Neither the Department's Division of Pensions and Benefits (Pensions and Benefits), nor the

Division, were aware of the overlapping benefits issued to this claimant. After we informed the Division, the Division alerted Pensions and Benefits, which initiated recoupment of the overpayment. To prevent the payment of overlapping benefits, the Division and Pensions and Benefits should communicate promptly regarding changes in a claimant's work status.

4. Did not have an adequate process to monitor when a claimant returned to work or to terminate a claimant's benefits after returning to work. This weakness resulted in compensation payments of \$12,284 over a four-month period in FY 2015 to a claimant who had returned to work, contrary to *N.J.S.A. 34:15-12* and the Manual. After we alerted Division officials of the overpayment, the Division notified the appropriate Treasury officials. The Division has since advised us that Treasury initiated collection efforts.

Case File Reviews

Claims investigators are required to maintain updated case files for each claimant and to monitor each claimant's case. Of the 41 claims submitted by the 30 claimants in our statistical sample, we judgmentally sampled ten of the claims. Our audit found that the Division inadequately documented the case file reviews. We noted that the case files for these ten claims lacked documentation, evidence of case monitoring, and evidence of case file reviews. We also noted significant lapses in time – on average 44 days – between the entries of case file notes that reflected any review, update, or change in claim status for claimants who received compensation payments. The lack of timely review and documentation of such review by claims investigators, including, at a minimum, the update of claim status and verification of a claimant's return-to-work status, resulted in improper benefit payments.

Claimants with Multiple Claims

Workers' compensation programs, in part, are intended to promote safety and prevent accidents. Effective workers' compensation programs identify opportunities to prevent a claim and to eliminate, or minimize the severity of, future injuries. Minimizing the severity of an injury may reduce recovery time for an injured employee and lower the cost of a claim to an employer.

Our review included case file reviews of six claimants, with at least one open claim during the audit testing period, who had submitted the largest number of claims during their state employment. The objective of this review was to identify what actions were taken by the Division to identify and monitor claimants who filed multiple claims. These six claimants collectively filed 266 claims throughout their state careers between 1978 and 2016. We judgmentally selected 101 of the 266 claim incident reports and accompanying case files.

Our audit found that 23 of the 101 claim incident reports, or 23 percent, lacked evidence of the claimant's supervisor's agreement with the details of the claim. There was no evidence that the claims investigators made further inquiries to the claimant's supervisor. In addition, there was no evidence that the Division conducted any follow-up actions such as surveillance, safety officer interviews, or site visits to verify the accuracy of the claim. Nor was there any evidence that the Division evaluated whether the conditions that caused the accident could be mitigated.

The Manual did not include policies and procedures to address claimants that file multiple claims. The Manual states that a claims investigator's responsibility may include conducting field investigations and witness interviews and initiating and overseeing surveillance activity when compensation benefits are approved. The Manual did not provide detailed scenarios, criteria, or examples of when each of these follow-up actions should occur and did not define the supervisory role in reviewing and approving these actions. Without specific guidance, claims investigators have too much discretion in deciding if and when to initiate such investigations. Without such procedures to conduct follow-up investigations of multiple claims, the Division potentially delays remedying underlying safety issues and fails to prevent additional injuries. The lack of follow-up investigations weakens effective claim management and hinders detection of abuse of the workers' compensation program.

Multiple Claims Filed at a Single Facility

During our audit we noted that the Division did not have specific procedures in place to identify, monitor, and address repeat injuries that may be prevented through corrective action or health and safety training. Pursuant to *N.J.S.A. 52:18A-221*, the Division is required to "assist the various departments and agencies of State Government in developing sound plans of risk management,

including developing programs to protect physical assets, and developing and implementing safety programs to mitigate both the frequency and severity of accidental loss and by reviewing these plans and programs from time to time.” The Division does not have the authority to mandate a department or agency make necessary repairs or changes.

During the audit, the Division informed us about a specific facility with multiple claims resulting from faulty gate and door lever mechanisms. We requested all claim data associated with the faulty gate and door levers. The Division identified 23 claims submitted between 2007 and 2019 by 19 employees related to injuries caused by the defective gate and door levers at the facility. The Division informed us that since 2007 it has paid over \$1.5 million in workers’ compensation benefits directly related to this facility’s gate and door levers. The Division has not yet quantified future workers’ compensation liability for the current open claims or for any future claims. The Division advised us that the estimated cost to replace the gate and door levers at the facility is \$4 million. The Division further informed us that the Division and the facility’s management team had discussed the replacement of the gate and door levers to prevent future injuries, but to date, the gate and door levers have not been replaced and the hazard remains.

The Division should improve oversight and monitoring of claims that focus on safety and accident prevention. Doing so would likely reduce the number of repeat injuries and thereby lower the cost of the workers’ compensation program.

Recommendations

1. Implement a process to ensure wages specified in the policies and procedures are used in the calculation of workers’ compensation benefits. In addition, ensure consistent calculation of workers’ compensation wage benefits through the use of a formal process and template to request and obtain wage data from a claimant’s Human Resources office.
2. Develop policies and procedures to reduce payment errors through the use of a formal process, such as the supervisory review and approval of a standard template, or an automated function in the claim management system, to calculate compensation benefits in lieu of the manual process currently in place.

3. Implement policies and procedures that effectively manage multiple claims to prevent potential abuse of the workers' compensation program and to improve safety and accident prevention. In addition, assess the current automated system and determine if information technology detective controls can be designed to identify multiple claims by a single claimant or for a single location.
4. Develop policies and procedures to identify claimants with overlapping benefits as a result of employment or work status changes. These procedures should include appropriate coordination with other state agencies to identify and prevent overlapping benefits and to recover and recoup improper payments.
5. Implement policies and procedures that require more frequent case file reviews and timely monitoring of claimants' work status changes.
6. Revise policies and procedures to improve claim management operations to prevent abuse and improve safety. These procedures should establish the criteria and protocols for authorizing the use of investigatory techniques, including, for example, the timing and frequency of site visits, witness interviews, and surveillance.

Oversight of Vendor Services

The Division failed to implement controls to provide adequate oversight and monitoring of the contracted vendor to ensure all performance requirements of the contract were met.

The Division contracts with a vendor to manage the medical services for eligible claimants. The scope of work in the contract states that the vendor shall “provide workers’ compensation (WC) managed care services to State employees receiving benefits compensable under the State’s WC program and applicable laws and regulations.” The scope of work further states that the vendor shall provide a program that includes: provider network access certified by the Department of Banking and Insurance for all compensable medical claims; medical management of claims, including a provider program to support claimant return-to-work; medical bill repricing, processing and payment; and an electronic interface with the Division for reporting and payments. The Division is responsible for ensuring that the vendor satisfies all reporting requirements in the contract.

Medical Reports

The vendor’s certified provider network includes “primary care physicians (PCPs), specialists, hospitals, physical therapy centers, ambulatory surgical centers, diagnostic centers, sub-acute and skilled nursing facilities, as well as, home care, durable medical equipment, pharmacies, laboratory services, and other services and healthcare professionals.” The contract terms require providers in the network to adhere to the Physician and Healthcare Professional Office Manual (Provider Manual). The Provider Manual requires service providers to fax patient treatment plan forms within one business day of the office visit. The Provider Manual reminds providers to submit the projected return-to-work date while noting any restrictions.

We judgmentally selected 10 of the 41 sampled claims to verify that service providers submitted medical reports to the vendor pursuant to the Provider Manual terms. The Division received 411 medical reports for these ten claims. Our testing found that the Division received 186 of the 411 medical reports later than one business day after the medical treatment was provided, contrary to

the vendor's Provider Manual requirements. On average, the Division received these reports 32 days after the medical treatment date. In addition, we found that in 359 of the 411 medical reports reviewed, or 87 percent, the service providers did not include the estimated return-to-work date. The vendor's failure to ensure that the providers satisfied the reporting requirements may result in longer claim periods, a delayed return to work, and an increased workers' compensation expense that would be reduced with appropriate monitoring.

Recommendation

7. Develop policies and procedures to include appropriate monitoring of the vendor's reporting requirements to ensure that all provider reports are submitted to the vendor as required and that these reports include all relevant and required claimant data including the return-to-work date.

REPORTING REQUIREMENTS

We have provided a draft copy of this report to Division officials for their review and comment. The Division agreed with the audit findings and conclusions, and its response indicated they have already taken some actions and will continue to implement corrective actions to address our recommendations. Their comments were considered in preparing our final report and are attached as Appendix A.

We are required by statute to monitor the implementation of our recommendations. In accordance with *N.J.A.C. 17:44-2.8(a)*, within 90 days following the distribution of the final audit report, the Division is required to provide a report to us detailing the corrective action taken or underway to implement the recommendations contained in the report and, if not implemented, the reason therefore. We will review the corrective action plan to evaluate whether the steps taken by the Division effectively implement our recommendations.

We thank the Division for the courtesies and cooperation extended to our auditors during this engagement.

APPENDIX A - AUDITEE RESPONSE



State of New Jersey

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DRM RESPONSE TO OSC RECOMMENDATIONS

General Comment regarding Recommendations

Management is committed to sharing the results of the Office of the State Comptroller (OSC) audit report, and our responses, with all Workers' Compensation (WC) unit staff. Further, we will instruct our Training Coordinator and custodian of our Procedures Manual to review and update our manual, where necessary, to reflect all of the points covered in your report, and our response to OSC Recommendations. Our Training Coordinator and unit Supervisors will be required to review the manual with staff to ensure that all are familiar with any changes made to our policies or procedures. All manual updates and staff review will be done during the 90-day window that commences after distribution of this report, per OSC Reporting Requirements.

Recommendations

1. The Division will make enhancements to its existing template to capture all relevant data for calculating weekly Worker's Compensation (WC) benefits including, but not limited to, overtime data.
 - 1.1 Our staff IT personnel are discussing with the Division of Revenue & Enterprise Systems (DORES) the possibility of integrating the Template into RMIS, our claim information system. This may or may not be possible due to the age of the system and its limitations. We will be able to report on this within the 90 days that follow the final distribution of the audit report.
2. The Division has a system in place for requesting wage data, including overtime, from State agencies. Investigators are required to study the Division Manual to make sure they have all pertinent data before placing an injured employee on WC. To ensure uniformity in the data we require from our clients, a memorandum was also issued in 2016 to all agencies participating in the State's Workers' Compensation program outlining what information is required. In addition, the Division has a template for the investigators to use when computing weekly benefits. The Division will send another letter to all client agencies, in addition to a form letter for use when

requesting initial WC benefits for the injured employees. In view of the auditor's comments, further enhancements will be made to the template to minimize the possibility of error.

- 2.1 It is our belief that the proposed enhancements to the WC template, as cited above, will greatly reduce the possibility of error.
3. Multiple claims do not necessarily point to potential abuse. Rather, they could be the result of the individual's physical condition, lack of training, and occupation, etc. The Division is in regular discussion with State agencies in identifying programs that would reduce recurrence of injuries. Our Training Coordinator has held several meetings with individual agencies' Safety Officers to stress the importance of safe practices at work. It must be noted that the majority of our claims are generated from high-risk facilities like State Prisons, Developmental Centers and Psychiatric Hospitals. The Division can make recommendations, but implementing those recommendations rests with the individual agency. In order to fully implement this recommendation, the Division would need a full time Occupational Health and Safety Officer which we do not have, nor are we budgeted to have. It should be further noted that DRM does not have the authority to mandate a department or agency make necessary repairs or changes. Each agency has its own Occupational Health and Safety Officer on their own staff and payroll for these purposes. It is our policy to communicate to agencies our concerns and recommendations regarding defects or practices that lead to employee injury. However, it is the agency's responsibility to adopt or supplement our recommendations.
4. The Division already has this program in place. The Division of Pensions and Benefits (DPB) has identified an employee to serve as our contact to coordinate benefits. This individual is known to all Division staff. When an employee is approved for accidental disability pension and is known to have received WC benefits for the same period, DPB is entitled to offset. A form letter is used by DPB to request information from DRM *before* issuing the first check to the employee. These requests are accorded high priority by the Division and are assigned to the unit supervisor for review and response. The Division will remind all State agencies to notify the Division when a WC claimant applies for disability pension. The investigators and their immediate supervisor will be responsible to periodically follow up with DPB for status updates and ensure the information is passed on to the assigned Deputy Attorney General (DAG), if applicable.
5. The Division has in the past implemented internal "round table" reviews of the high dollar amount claims. The Division investigators communicate regularly with their Human Resource (HR) representatives and the Case Managers (CM) at Horizon Casualty Services (HCS) before extending an employee's WC benefits. All investigators will be instructed to follow this procedure, with regular monitoring for compliance by Supervisors. The Division's case entries have improved significantly during recent years. With the hiring of additional staff and lowering of caseloads, the Division is confident it will continue to improve further.

6. With regard to surveillance, the Division orders it when, after consultation with our assigned DAG's, it is determined that there is strong evidence of fraud and that the activity will likely support that finding. Surveillance is costly and rarely produces desired results. Experience shows that the doctors and judges rarely alter their opinions based on surveillance footage.
- 6.1 Claims Investigators (CI) now question Human Resource (HR) regarding the number of claims by one claimant, and in some instances alert the HR to the possibility of a Fitness for Duty exam option. We have implemented a new procedure which requires HR's to complete a questionnaire and return to their respective CI prior to a determination of compensability.

Oversight of Vendor Services

7. Prior to the new contract with Horizon, effective January 28, 2018, the Performance standards in the expiring contract were deficient, leaving some of the issues OSC cites in their report unaddressed in terms of penalties. Current DRM management addressed these, and other deficiencies, in the RFP of 2017 that set the stage for the current contract.
- 7.1 Since the award of our new contract, quarterly performance reviews have been conducted by the Bureau Chief. As the current contract now provides for 10 percent retainage from monthly vendor invoices until such time that the quarterly review is complete, and performance is deemed satisfactory, we hold the vendor accountable for deficiencies.
- 7.2 Please note that, except for the last quarter, all quarterly performance reviews since contract inception have been deemed unsatisfactory by the Division. This has resulted in forfeiture of over \$626,000.00 in vendor fees. The Division's management and supervisory staff hold monthly and quarterly meetings with Horizon's management and supervisory staff in order to share our concerns and suggest needed improvements. Some of the improvements made by the vendor are listed below:

Case Management

- Improved timeliness of scheduling appointments, at least 90% are scheduled within 3 business days.
- Implemented Official Disability Guidelines (ODG) for Return to Work (RTW) and Physical Therapy (PT) utilization. HCS documents the claim file with the guidelines and communicates the guidelines to the treating provider.
- Implemented enhancements to Provider Search Tool by adding participation in Outcomes Focused Network (OFN) and payer experience (use of in network providers on day of surgery).
- Implemented a workflow that, upon receipt of the dictated report, the case manager must document that it has been reviewed and that there were either no changes noted or any additional findings are documented.
- Expanded OFN to include additional specialties in an effort to direct care to the best provider that will lead to better outcomes, administrative efficiencies, and better workers' compensation payer experience.

- HCS Provider Relations team visited highly utilized network providers to explain the urgent need to receive medical reports after office visits. This communication has led to the receipt of dictated reports in a timely manner.
- Added 2 additional nurse case manager positions to staff, reducing caseloads.

Pharmacy Management

- Implemented the ability to preclude unauthorized providers from participating in the pharmacy system so that prescriptions are not filled through these providers.
- Implemented Opioid management program where, upon the first fill of an opioid, the claim file is documented and an opioid education letter is sent to the injured worker. After 30 days of opioids, case manager discusses weaning and alternative medications with treating provider.
- Implemented Generic prescription workflow to encourage treating providers to utilize generic medications when available.

Quality

- HCS completed two Clinical Quality programs:
 - Reviewed spine surgery over an 18-month period to see if there were repeat surgeries or re-admissions.
 - Conducted an HCS Outcomes Focused physician assessment by reviewing all rotator cuff surgeries in an 18 month period and found that physicians are following HCS' Outcome Focused Network (OFN) guidelines. RTW results were excellent, far exceeding ODG guidelines.
- Implemented formalized training program for new hires and expanded training of entire team regarding case management best practices.
- Enhanced focus on monitoring key quality metrics that led to improved case management.

Based upon the vendor's willingness to work with the Division to meet performance demands, we are confident improvements will continue through the term of the current agreement.