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STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

February 21, 2020

Ms. Clarissa M. Rodriguez
Chair
Workers' Compensation Board
328 State Street
Schenectady, NY 12305

Re: Report 2018-WCB-01

Dear Chair Rodriguez:

Our Office examined[1] the Workers' Compensation Board (Board) payments (claims) to claimants, attorneys, insurance companies and medical providers from the Board's special funds during the period January 1, 2018 through December 31, 2018. Our objectives were to determine whether claims were appropriate and complied with: (i) the New York State Workers' Compensation Law and (ii) mandated fee schedules (where applicable).

In addition to our daily review of claims, we assisted the Board to: (i) convert the claims payment process from its Financial Management Information System (FMIS) to the Statewide Financial System (SFS), and (ii) correct and reprocess erroneous federal 1099-MISC reporting forms. We also followed up on previous findings related to duplicate payments to determine what action the Board took to recover overpayments and are working with the Board to obtain additional data to enhance and streamline our audit process.

A. Summary of Results

Our Office identified 775 errors totaling more than $4.4 million as a part of our daily audit. Most of these errors could have resulted in an inappropriate payment had they gone undetected. In addition to our daily audit, we identified 6,725 processing errors totaling nearly $1.9 million. Board Officials attribute these errors to transition issues they experienced when converting from their FMIS to SFS.

Our Office issued federal 1099-MISC (1099-MISC) reporting forms on behalf of the Board for the first time. Incorrect payment information provided by the Board for both FMIS and SFS payments

[1] We performed our examination in accordance with the State Comptroller's authority set forth in Article V, Section 1 of the State Constitution, as well as Article II, Section 8(1) and (7), and Article VII, Section 111 of the State Finance Law.

resulted in the issuance of 2,235 erroneous 1099-MISCs, totaling over $1.3 billion, which our Office corrected and reissued. The Board has implemented new business processes to prevent a reoccurrence in the future.

In addition, Board officials reviewed duplicate payments identified in our 2017 annual report and indicated they would recover the money where possible.

Lastly, our auditors worked collaboratively with the Board to identify areas of improvement to streamline the claims payment process after SFS conversion. Among these, our Office was provided access to Third Party Administrator (TPA) systems which contain the documentation necessary for auditors to substantiate claim accuracy. In addition, the Board was authorized to mass-approve large files of vouchers in SFS based on claim payment information provided by the TPAs.

We continue to identify areas of potential improvement in the claims payment process, including obtaining data from the Board and its TPAs to perform analytics that would enhance and streamline the audit process and improve our ability to identify fraud, waste, and improper payments.

We shared a draft report with Board officials and considered their comments (Attachment C) in preparing this final report. The comments of this Office on the Board's response are set forth in Attachment D. Board officials generally disagreed with our findings or attributed them to the Board's one-time transition to the SFS. Board officials also stated that our audit procedures failed to support the Board's change in business process resulting from this transition. Finally, Board officials stated the Board discovered and notified our Office of the 1099-MISC errors.

B. Background and Methodology

The Board processed nearly 431,000 claims totaling nearly $829 million from its four special funds in 2018 - the Uninsured Employers Fund, the Special Fund for Disability Benefits, the Second Injury Fund, and the Fund for Reopened Cases.

From January through March 2018, the Board processed claims for all special funds using the Board's FMIS. Claims were reviewed and approved by staff at the: (i) Board, (ii) Special Funds Conservation Committee (SFCC), or (iii) TPAs. In April 2018, the Board fully transitioned its claims payment process to the SFS.

As part of claims payment process, Board staff is required to indicate on the voucher if the payment amount is reportable to the Internal Revenue Service (IRS). Each entity that received

$600 or more in reportable payments was issued a federal form 1099-MISC. The 1099-MISC form specified the total amount reportable to the IRS for calendar year 2018.

During 2018, the Board entered into new contracts with four TPAs - FCS Administrators Inc., NCACOMP Inc., SAFE LLC, and Triad Group LLC - to perform the Board's claims administration responsibilities. In September 2018, the SFCC ceased operations and the Board transitioned the SFCC's responsibilities to the TPAs.

The TPAs are responsible for case management, processing indemnity and medical payments, and providing monthly reports to the Board.

To accomplish our objectives, we used data analytics to identify high-risk claims for review and reviewed mandated fee schedules, bills from medical providers, receipts and any other pertinent documentation which supported the claims. We also met with Board and SFS officials, as needed, to assist in the transition to SFS and correction of erroneous 1099-MISC forms.

C. Details of Findings

1. Daily Audit Findings

Our Office identified and disallowed 775 errors totaling more than $4.4 million that were approved by the Board and submitted to our Office for audit, approval and payment (see Attachment A). Of these, 640 errors totaling more than $2.7 million could have led to an inappropriate payment had they gone undetected. These errors included: duplicate payments; claims containing claimant or payment errors; claims payable to the wrong payee; claims with incorrectly calculated compensation; claims containing unsupported charges; or claims not processed in compliance with mandated medical fee schedules. The remaining 135 errors were claims that contained accounting or data entry errors and include one major "outlier" where the Board erroneously classified two claims totaling more than $1.1 million to SFCC as a payment to a separate SFCC account established for other purposes.

In addition to the potential monetary impact of the Board's approval of inappropriate claims for payment, there are long term consequences for inappropriate claims that go undetected and/or uncorrected by the Board, SFCC or one of the TPAs. For example:

- Duplicate Payments – Duplicate payments are wasteful and can erode confidence in the program. In addition, unless the funds are returned voluntarily, significant effort by the Board and/or the TPAs may be required to recover the overpayment.

- Claimant or Payment Errors – If the Board, SFCC, or a TPA references the incorrect case information, payments to claimants could be applied incorrectly to the wrong case number. This could result in future underpayments to deserving parties and overpayments to undeserving parties. If the Board or the TPAs use incorrect payment terms, this delays timely payment to claimants and could result in significant penalties imposed on the Board for not making payment in accordance with Workers' Compensation Law.

- Wrong Payee – Payments to the wrong payee must be cancelled and reissued to the correct payee, which, like recovering duplicate payments, is a wasteful use of resources. In addition, the correct payee may receive a delayed payment or go unpaid, and failure to pay the correct payee timely can also lead to penalties of up to 20 percent of the payment assessed against the Board.

- Incorrectly Calculated Compensation – The majority of compensation payments calculated incorrectly are the result of a Board, SFCC, or TPA employee using the wrong rate or incorrect period of time when calculating the payment or failing to pay attorney fees correctly. If a claimant or attorney is underpaid, the Board could incur significant penalties.

- Unsupported Charges – Unsupported charges occur if the Board does not properly authorize a claimant's services or the Board or TPA cannot provide sufficient, appropriate evidence to support the claim. As a result, claimants could receive services they are not entitled to, driving up the cost of compensation and medical payments.

- Noncompliance with Mandated Fee Schedule – If a TPA uses the fee schedule incorrectly, medical providers could be overpaid or underpaid. Either situation requires reprocessing of the medical bill. In addition, underpayments may result in costly arbitration and administrative awards while overpayments may be difficult and time consuming to recover.

- Accounting or Data Entry Errors – Accounting and Data entry errors occur when an employee of the Board, SFCC or one of the TPAs enters either the wrong accounting codes and/or the incorrect vendor identification number on a voucher in the SFS. While these errors may not result in an inappropriate payment, failure to identify and correct data entry errors could limit the Board's ability to effectively monitor TPA performance, contaminate data submitted to the SFS, delay and/or prevent legitimate payments and could result in significant penalties being imposed on the Board.

2. Processing Errors

In addition to the findings identified in our daily audit, our auditors identified 6,725 inappropriate claims totaling nearly $1.9 million resulting from processing errors by the Board when uploading claims into the SFS. This includes 3,037 inappropriate claims totaling more than $1.1 million that would have resulted in an erroneous payment to an entity that was not entitled to the funds had the errors gone undetected. Of these, 1,708 inappropriate claims totaling nearly $810,000 were payable to the wrong payee and 1,329 inappropriate claims totaling nearly $318,000 were duplicate payments.

The remaining 3,688 inappropriate claims totaling more than $758,000 contained incorrect case or accounting information. This incorrect information could result in improper payments (see "Claimant or Payment Errors" above) and would have hindered the Board's ability to monitor TPA accuracy and perform necessary data analytics (see "Accounting or Data Entry Errors" above).

To resolve these errors, our auditors worked with Board officials to deny inappropriate claims and stop payments. The Board processed adjustment vouchers to correct case and accounting information. In addition, the Board is actively working with the affected vendors to recover any money paid inappropriately and periodically updates our Office on the status of these recovery efforts.

3. Federal IRS Form 1099-MISC Errors

To ensure complete and accurate federal reporting, the Board provided our Office with a file of reportable payment information from its FMIS for the first quarter of the year. Payments processed through the SFS during the remainder of the year required the Board to indicate if the payment was reportable on the voucher. The information from FMIS and SFS was used by this Office to generate 1099-MISC forms for calendar year 2018.

After the IRS forms were generated, it was determined that the file the Board provided from its FMIS listing the amount of payments reportable by vendor was incorrect. Additionally, we determined the Board failed to properly indicate if the payment was reportable on nearly 241,000 vouchers in SFS. As a result, the amount reported on the 1099-MISC forms issued to 2,235 vendors and the IRS was incorrect by nearly $1.36 billion.

Our auditors worked with the Board to reprocess corrected forms. According to Board officials, the transition from FMIS to SFS contributed to the errors on 1099-MISC reportable payments

processed in the SFS. The Board has implemented new business processes to prevent a reoccurrence in the future.

4. Duplicate Payments

In our 2017 annual report to the Board, we reported that our auditors identified, and Board officials confirmed, 97 claims totaling more than $166,000 in Calendar Year 2016 were duplicate payments. In response to the draft report, the Board indicated that the duplicate payments identified in our 2017 annual report were re-reviewed and the Board made every effort to recover duplicate payments. In total, the Board determined and our auditors agreed that 91 payments totaling nearly $151,000 were duplicate and recoverable; of this amount, the Board recovered nearly $82,000. The Board continues to work with the TPAs to recover the remaining duplicate payment amounts.

5. Data Requests

Our auditors have requested access to diagnosis related systems, data files, and copies of TPA subcontracts to perform data analytics that would enhance and streamline our audit process and improve our ability to identify fraud, waste, and improper payments (see Article 2, §8-c of the State Finance Law, commonly known as the Enterprise Fraud Act). The Board is in the process of providing access to the diagnosis related systems and has agreed to work with the TPAs to provide requested data files. As of the date of this report, however, we have not yet received copies of the TPA subcontracts.

Recommendations

1. *Take necessary steps to ensure the Board and the TPAs accurately process claims.*
2. *Recover any monies paid inappropriately as a result of incorrect uploading of claims to the SFS.*
3. *Ensure vouchers correctly indicate whether or not the payment is reportable to the IRS.*
4. *Continue to recover duplicate claims identified in the 2017 annual report to the Board.*
5. *Continue to work with this Office to identify areas of improvement to streamline claims processing.*

We thank the management and staff of the Workers' Compensation Board for the courtesies and cooperation extended to our auditors. Please provide a response to this report by March 23, 2020, indicating any actions planned to address the recommendations in this report.

Sincerely,

Bernard J. McHugh
Director of State Expenditures

Encl: Attachment A
Attachment B
Attachment C
Attachment D

cc: Mary Beth Woods, Executive Director
Suzanne Aluise, Director of Financial Administration

Attachment A

Workers' Compensation Board
Error Types by Claims Processing Entity
Resulting from Daily Audit Activities
Calendar Year 2018

Error Type	WCB		SFCC		Triad		NCA		SAFE		FCS		Total	
	#	Amount	#	Amount	#	Amount	#	Amount	#	Amount	#	Amount	#	Amount
Duplicate Payments	7	$8,363	2	$232,235	109	$794,283	7	$26,789	3	$693	2	$4,124	130	$1,066,487
Claimant or Payment Errors	33	495,284	32	46,430	4	6,434	4	32,105	0	0	2	1,463	75	581,716
Wrong Payee	8	153,810	16	137,723	1	325	0	0	0	0	0	0	25	291,858
Incorrectly Calculated Compensation	47	149,988	4	607	32	16,909	100	86,910	25	24,543	2	5,990	210	284,947
Unsupported Charges	8	40,140	10	21,155	14	97,344	13	94,001	3	25,758	0	0	48	278,398
Noncompliance with Mandated Fee Schedule	2	3,418	29	66,871	102	123,985	4	12,245	13	9,742	2	1,045	152	217,306
Accounting or Data Entry Errors	12	134,174	3	1,149,918	10	24,323	33	166,126	76	230,215	1	3,180	135	1,707,936
Total	**117**	**$985,177**	**96**	**$1,654,939**	**272**	**$1,063,603**	**161**	**$418,176**	**120**	**$290,951**	**9**	**$15,802**	**775**	**$4,428,648**

Attachment B

Workers' Compensation Board
Summary of Processing Errors
Calendar Year 2018

Error Type	Total	
	#	Amount
Wrong Payee	1,708	$809,784
Duplicate Payments	1,329	317,888
Incorrect Case and/or Accounting Information	3,688	758,430
Total	**6,725**	**$1,886,102**

Attachment C

NEW YORK STATE OF OPPORTUNITY. Workers' Compensation Board

ANDREW M. CUOMO
Governor

CLARISSA M. RODRIGUEZ
Chair

September 30, 2019

Bernard J. McHugh
Director of State Expenditures
Office of the State Comptroller
110 State Street
Albany, NY 12236

Dear Mr. McHugh:

Attached please find the Workers' Compensation Board's comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report (2018-WCB-01).

As noted in the report, the Board processes more than $800 million annually from its various special funds. OSC has identified $6.4 million in errors for the audit period. However, the Board objects to most of the findings identified as errors in OSC's report.

Calendar year 2018 (the audit period) was a time of great transition in the Board's approach to managing the payments from the various special funds. Not only did we move to the Statewide Financial System, but we also procured the services of qualified third-party administrators (TPAs) to manage over 180,000 claims within the Fund for Reopened Cases.

Prior to the transition, every payment to a claimant, medical provider, attorney, etc., was manually entered into the financial system as its own voucher. The Board generated approximately 260,000 uniquely auditable payments per year. Because the payments on these claims are now administered by TPAs, the Board currently only makes 1,600 payments per year. Instead of paying claimants, medical providers, attorneys, etc., directly, we now fund the TPAs for payments they are making.

OSC's audit procedures fail to recognize or support this change in business practice. Therefore, solely to accommodate OSC's audit needs, we have continued to create 260,000 vouchers and we have 3-4 FTEs newly dedicated to this function. Board resources dedicated to this effort would be more effectively utilized in the front-end management of the Board contracted TPAs. As such, beginning in 2020, we will only enter the 1,600 vouchers into SFS. We are committed to working with OSC in developing a new approach to satisfy their audit goals.

As to the details contained in the OSC draft report, the Board agrees with approximately $1 million worth of findings. We consider the balance of reported findings to be either improperly identified errors or unique isolated incidences related to the massive transition completed during the audit period.

Examples of issues the Board has with OSC's findings include:

- Improperly Identified Errors
  - Errors flagged for payments where the payee, amount and account were all correct.

*See State Comptroller's Office Comments

- Audit findings that are included in more than one category and are therefore counted twice.
- Errors flagged as having "incorrect payment terms", an SFS distinction that has no relevance within workers' compensation.
- Vouchers that were rejected because OSC did not receive a quick enough response regardless of whether the vouchers were correct.
- Legitimate findings of error extrapolated to reflect a value vastly disproportionate to the actual error.

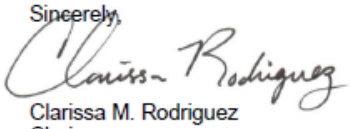
- Transition Issues
  - Errors that occurred in the manual manipulation of data solely as the result of the Board's attempt to accommodate OSC.
  - Upload files that were duplicated during the transition period that would have been identified during reconciliation and adjusted from subsequent reimbursements to the TPA.

Of course, the Board takes the $1 million in valid findings very seriously. We will make every effort to continue to address the issues that led to these findings, and take whatever steps are necessary to ensure that they do not reoccur.

The substantial efforts OSC has long undertaken to learn about the claims administration processes performed by the Board and its third-party administrators are apparent and appreciated. However, the Workers' Compensation Law is complex, and the administration process is nuanced. As the Board continues to refine its procedures to maximize the efficiencies expected by moving to the SFS/TPA model for managing claims, it will continue to work with OSC to ensure payments made are appropriate. The Board will make every effort to keep OSC apprised of any procedural changes so that their audit procedures can be adjusted accordingly.

Thank you for the opportunity to comment.

Sincerely,



Clarissa M. Rodriguez
Chair

*See State Comptroller's Office Comments

Attachment C

New York State Workers' Compensation Board
Comments on the Office of the State Comptroller's Draft Report 2018-WCB-01

Background

The Board processes more than $800 million annually from its various special funds, including the Special Disability Fund (WCL §15.8), the Fund for Reopened Cases (WCL §25a), the Uninsured Employers' Fund (WCL §26a) and the Special Fund for Disability Benefits (WCL §214). Prior to April 2018, the Board processed these payments from its internal Financial Management Information System (FMIS). After a multi-year transition from FMIS to the Statewide Financial System (SFS), the Board began to process these payments from SFS in April 2018.

At the same time as the massive conversion to SFS occurred, management of the more than 20,000 active claims of the Fund for Reopened Cases (as well as an additional 160,000 inactive claims that can reopen) was transitioned away from the Special Funds Conservation Committee (SFCC) to four competitively procured Third-Party Administrators (TPAs). The TPAs are licensed by the Board and collectively possess decades of experience with specific expertise managing claims in the complex workers' compensation system. The TPAs are responsible for all aspects of case management including the direct payment of all appropriate indemnity, medical, legal, defense of fund, etc. Prior to the transition, the Board made roughly 260,000 payments annually to claimants, medical providers, attorneys, etc. from the Fund for Reopened Cases. In the current environment, the TPAs make these payments directly; the Board now processes less than 1,600 payments a year to the TPAs.

Before the TPAs release payments (to claimants, medical providers, attorneys, etc.), they request funding from the Board. To protect fund assets, this is provided "just-in-time", with only a 10 to 14-day (and in some instances less) turnaround from TPA request to Board funding. OSC insists on pre-auditing all medical and compensation payments that are now being made by the TPAs before the just-in-time funding is released. In other words, OSC is auditing the 1,600 payments as if the Board continues to make 260,000 payments. This means that the TPAs and the Board must create files and manipulate data for the sole purpose of preserving OSC's audit procedures. The Board has transformed our approach to managing these claims, only to be held to OSC requirements based on the previous environment. Ironically, this has given rise to many of the findings identified by OSC.

* Comment 1

Additionally, to satisfy OSC pre-audit requirements, the Board has significantly limited its review period. In fact, the Special Funds Group (SFG), the unit within the Board responsible for the oversight of the TPAs and for approving the just-in-time funding, is only given 24-48 hours to review payment requests. Then the Accounting Unit only has 24-48 hours to ensure the data is accurately input to SFS. OSC has at least five business days to perform their pre-audit. This scheme has proven untenable, as it is simply illogical to reduce the Board's review period in favor of providing OSC extra review time.

* Comment 2

Moreover, many of the audit findings have highlighted that the coding established for the TPAs to use when submitting funding requests, and for input to SFS, has proven to be unnecessarily complicated. For example, separate expense codes were established for different types of medical treatment: durable medical goods expense code is 316416 and diagnostic/office visit coding is 316414. The appropriate coding for an office visit where durable medical goods were provided can be open to interpretation. While the distinction may have been relevant under the old manner of

* Comment 3

*See State Comptroller's Office Comments

managing claims, this information does not need to be tracked in SFS; specific data, when (and if) needed, is available from the TPAs upon request.

* Comment 3

It is the Board's position that valid payments are achieved when the correct payee is paid the correct amount, from the correct account. The Board considers any payments that meet this standard as valid, and should not have been flagged as an error by OSC. The Board will consolidate our coding into a more manageable structure starting in 2020; coding that has no impact on payee, amount or account will be discontinued.

* Comment 4

1099-MISC

The audit report states that "incorrect payment information provided by the Board for both FMIS and SFS payments resulted in the issuance of 2,235 erroneous 1099-MISCs, totaling more than $1.3 billion, which our office corrected and reissued". The Board takes exception to the way this issue is being portrayed. To effectuate the April 2018 transition from FMIS to SFS, a FMIS data file was created by ITS and sent to SFS for merging. Unfortunately, the query run to produce the file extracted information from the wrong field. This error was then amplified by a system setting that multiplied the payment amounts by the number of vouchers in each payment, ultimately overstating 1,020 suppliers by $1.2 billion. This file was sent to OSC on November 28, 2018 with the Board's request that it be reviewed for any issues or concerns. No response was ever received.

* Comment 5

On January 25, 2019, the Board (not OSC) discovered the error and promptly notified OSC. Unfortunately, by that time the 1099s had already been produced. The Board was still able to send a corrected file on January 29, 2019, prior to the February 1, 2019 deadline. Separately, 436 other 1099s were sent erroneously due to the way certain suppliers were set up during the conversion process. The system settings have since been corrected, and these events will not reoccur.

Summary of Findings

Given this context, and with the 1099 issues aside, the $6.4 million in audit findings can be categorized as follows:

	Valid Findings	Transition Issues	Invalid Findings	Total Findings	Reference
Duplicate Payments	$462,689	$603,799		$1,066,488	See Note #1
Claimant or Payment Errors	$4,311		$577,404	$581,716	See Note #2
Wrong Payee	$211,156		$304,794	$515,950	See Note #3
Incorrectly Calculated Compensation	$109,789		$175,158	$284,946	See Note #4
Unsupported Charges	$122,641		$155,757	$278,398	See Note #5
Noncompliance with Mandated Fee Schedule	$113,908		$103,397	$217,305	See Note #6
Accounting or Data Entry Errors	$0	$3,500	$1,618,123	$1,621,623	See Note #7
Total Attachment A	**$1,024,494**	**$607,299**	**$2,934,633**	**$4,566,425**	
Wrong Payee	$0	$809,784		$809,784	See Note #8
Duplicate Payments	$0	$317,888		$317,888	See Note #8
Incorrect Case and/or Accounting Information	$0	$758,430		$758,430	See Note #8
Total Attachment B	**$0**	**$1,886,102**	**$0**	**$1,886,102**	
Grand Total	**$1,024,494**	**$2,493,401**	**$2,934,633**	**$6,452,527**	

*See State Comptroller's Office Comments

Attachment C

As shown, the Board considers $2.9 million of the $6.45 million in findings to be invalid. An additional $2.49 million is related to the massive transition completed during the audit period, and, as such, is not expected to be repeated.

Details for findings the Board considers invalid or strictly the result of the transition are as follows:

Note #1	$603,798 identified as "duplicate payments" was the result of duplicated upload files received from the TPAs during the transition period. These would not have resulted in duplicate payments being issued to claimants, providers, attorney's etc. These would have been identified during reconciliation and subsequent reimbursements to the TPAs would have been adjusted accordingly.
Note #2	Errors identified as "claimant or payment errors" that the Board considers invalid findings include: • $553,331.86 of these findings indicated "wrong case number"; while the case number may not have been indicated on the voucher, each voucher indicated the correct payee, in the correct amount, and from the correct account. Of this amount, $25,098.34 was counted twice. • $24,072.46 of these findings indicated "incorrect payment terms"; this is an arbitrary coding in SFS that does not apply for these types of payments; not a valid finding.
Note #3	Errors identified as "wrong payee" that the Board considers invalid findings include: • $170,517.95 also included on Attachment B; see Note #8. • $86,313.18 in one voucher with correct payee, in the correct amount, and from the correct account; supplier id was incorrect but had no impact on payment. • $42,818.05 flagged by OSC as incorrect supplier; supplier indicated was a d/b/a. • $3,600.00 identified by Board who requested denial. • $1,190.00 indicating wrong case number; voucher indicated the correct payee, in the correct amount, and from the correct account. • $325.00 denied because OSC did not receive timely response; voucher was correct. • $30.00 counted twice.
Note #4	Most of the errors identified as "incorrectly calculated compensation" were legitimate errors identified by OSC but then overstated based on extrapolation. OSC correctly found errors but then multiplied that by 26 weeks assuming they were paid in error bi-weekly for an entire year. There is no basis for this artificial inflation, as there is no support for the assumption that a full year's worth of payments was owed, or would have been paid incorrectly. It is noteworthy that ten of the findings included as "incorrectly calculated compensation" were for $.20 or less, five of which were for $.02.

* Comment 6

* Comment 7

* Comment 4

* Comment 8

* Comment 9

*See State Comptroller's Office Comments

Attachment C

Note #5	OSC identified $278,398 in "unsupported charges", or charges they consider not properly authorized by the Board, or not adequately documented. Under WCL, claims administrators are permitted, encouraged, and required to make decisions to voluntarily pay benefits without a formal decision directing such payments. Proper TPA claims administration involves cost benefit analyses at every turn. Claims administrators may opt to pay certain claimed benefits, even where there may not be a clear entitlement, to avoid the imminent litigation costs associated with disputing such claims. Claims administrators may wait to collect monies owed until it can be recovered in a lump sum, rather than collect in installments, to avoid the risks of overpayment or underpayment. Claims administrators may negotiate medical bill payment rates or contract with third-party entities to secure better pricing for services and equipment. After careful evaluation, the Board has entrusted these claims administration decisions and practices to the expert TPAs. In some cases, delays caused by OSC's review resulted in penalties. For example, OSC would not permit an advanced payment of a pending decision, even though the parties had agreed to the findings contained therein. This ultimately resulted in a delayed payment and penalties totaling $3,225. OSC also overstated their findings by multiplying many of them by 26 weeks assuming they were paid in error bi-weekly for an entire year. There is no basis for this artificial inflation, as there is no support for the assumption that a full year's worth of payments was owed, or would have been paid incorrectly.	* Comment 10 * Comment 11 * Comment 9
Note #6	The Board disagrees with $103,396.60 in errors identified as "non-compliance with mandated fee schedule". Due to its complexity, many insurance companies and TPAs use third-party software companies and bill review companies to perform medical bill reviews. OSC auditors have clearly worked diligently to try to fully grasp the bill review process. However, in some of the cases containing bills associated with higher value OSC audit findings, the medical providers have filed objections to the amounts they were ultimately paid. In one instance, the provider has hired an attorney to pursue litigation. Accordingly, some of the OSC reported findings remain unresolved – and could result in subsequent payments *plus interest*. Moreover, pursuant to WCL, nothing in the fee schedule "shall prevent voluntary payment of amounts higher or lower than the fees and charges fixed therein." Contrary to OSC's independent interpretation, payments at less than the fee schedule are legally permissible and often the result of negotiation. As such, the Board maintains that payments that are or appear to be less than the fee schedule are valid and should not be subject to unnecessary scrutiny.	* Comment 12 * Comment 10

*See State Comptroller's Office Comments

Note #7	Each of the vouchers included in this category would have resulted in the correct amount being paid to the correct payee from the correct account and therefore the Board does not consider them to be valid findings. Many of these were the result of the overly complicated account code structure, which is being addressed: • $1,061,666.00 relates to one payment with SFS vendor coding issues; • $545,412.13 in product coding issues; • $11,044.40 no error was identified; • $3,500.00 for a payment made in April when the FMIS-SFS transition was done; voucher had FMIS coding.
Note #8	The findings shown on Attachment B are the result of the transition from the FMIS/SFCC to the SFS/TPA model coupled with the Board's attempt to accommodate OSC despite the new approach to managing these claims. Most notably, under the new model the Board has moved from making more than 260,000 payments a year to less than 1,600. However, to accommodate OSC, the TPAs are required to associate each payment they make with a separate voucher. This means that instead of requesting one lump sum payment with a supporting document for review, TPAs must produce a payment spreadsheet with numerous columns and often over a thousand rows, singling out each individual payment voucher. As SFS can only accept a limited number of rows for import, Board staff is then required to manipulate these spreadsheets and the information contained therein. The Board has dedicated 3-4 FTEs to this effort. However, the manual intervention left the data prone to human error. We have implemented procedures to ensure the errors that occurred in the manual manipulation of these files will not be repeated. The Board moved from the FMIS/SFCC model of managing claims to the SFS/TPA model with the expectation of achieving efficiencies. We no longer make 260,000 payments a year; we only make 1,600. While the Board appreciates that reasonable supporting documentation for the 1,600 payments must be available, it is unreasonable to expect the same information that supported the 260,000 payments. Beginning in January 2020, the Board will implement new procedures aimed at maximizing the efficiencies of the new model, while at the same time ensuring payments made are in compliance with all applicable statutory requirements.

* Comment 3

* Comment 13

* Comment 1

Response to Findings

Regarding the specific recommendations made, we offer the following:

1. **Recommendation:**

   Take necessary steps to ensure the Board and its TPAs accurately process claims.

   Response:

   The TPAs are licensed by the Board and collectively possess decades of experience with specific expertise managing claims in the complex workers' compensation system. Our contracts with them have robust reporting standards and oversight provisions. In addition,

*See State Comptroller's Office Comments

the Board, in its capacity as the administrator of the Workers' Compensation Law, enforces all statutory, regulatory and administrative requirements.

2. **Recommendation:**

   Recover any monies paid inappropriately as a result of incorrect uploading of claims to the SFS.

   Response:

   The Board made every effort to recover funds that were inappropriately paid because of incorrect uploading of claims to SFS. Subsequent payments were offset or funds were returned.

3. **Recommendation:**

   Ensure vouchers correctly indicate whether or not the payment is reportable to the IRS.

   Response:

   The system settings have been corrected; payments will be appropriately reported to the IRS.

4. **Recommendation:**

   Continue to review and recover where appropriate duplicate claims identified in the 2017 annual report to the Board.

   Response:

   All duplicate payments were reviewed; the Board made every effort to recover duplicate claims where appropriate.

5. **Recommendation:**

   Continue to work with this Office to identify areas of improvement to streamline claims processing.

   Response:

   The Board will continue to work with OSC to identify areas of improvement to streamline claims processing. At the same time, the Board continues to refine its procedures to ensure it maximizes the efficiencies expected when moving to SFS and the TPAs. It would be helpful if the Board had the ability to run the various queries employed by OSC to detect duplications, payment rate changes, and other similar findings to improve efficiencies on the front end.

*See State Comptroller's Office Comments

Attachment D

State Comptroller Comments on Auditee Response

1. Article V, §1 of the New York State Constitution requires this Office to audit all State payments before they are made and to prescribe the methods of accounting necessary to support the audit. This pre-audit responsibility includes all payments made by the Board and payments made by the Third Party Administrators (TPA) on behalf of the Board. Accordingly, any changes to the current payment process must ensure this Office's audit responsibility remains intact and must include a clear, substantive, and efficient reconciliation process. We will continue to work with the Board to find solutions that are mutually agreeable and meet both the processing needs of the Board and auditing responsibility of this Office.

2. This Office does not prevent the Board from reviewing claims when they are uploaded into the SFS and submitted for our approval, and the overall timeframe allows for the Board and/or the TPAs to provide any necessary supporting information. The Board can and should continue its review of claims after submitting the files into SFS. Up until the date of our approval, our Office will return any claims upon the Board's request and will not include such claims in our findings. We appreciate the Board taking steps to perform additional audit procedures on these payments; this is an important part of the review and approval process.

3. The Board is responsible to ensure claim and associated information (e.g. coding and payment) is correct, as this information is integral in determining the ultimate payee and type of payment to avoid improper payments. The coding on the SFS voucher also provides a direct link to the supporting documentation in the TPA source system to validate TPA claims. The current coding used for SFS mirrors the coding previously used by the Board in its FMIS, with the exception of certain code changes requested by the Board.

4. The Board asserts "valid payments are achieved" when the payee, amount, and account are correct. However, for the majority of claims processed in SFS from September 2018 to the date of this report, the TPA is identified as the "payee" and the claimant or provider that is ultimately paid is identified by the case number. Additionally, the product code which identifies what the payment is for is necessary for the audit of the payment. While the Board has streamlined claims processing responsibilities through the use of TPAs, our audits found that when the information is incorrect on the SFS voucher, it is also incorrect in the TPA source systems and could lead to inappropriate payments to claimants and

providers. As discussed in the final report, our auditors asked Board and TPA staff to confirm the proper payment amount for each claim we questioned prior to rejecting or adjusting the payment.

5. Agencies processing payments are responsible to ensure the accuracy of tax reporting information submitted in the SFS or otherwise. This Office is required to issue 1099-MISC forms to recipients based on agency information and report 1099-MISC data to the IRS by January 31 each year. Due to the large volume of data to be reported each year, this Office routinely completes its work before the January 31 IRS filing deadline to avoid penalties for the State and its agencies.

   While the Board provided this Office with the FMIS file for review in November, our auditors had no means to independently verify that the tax reporting data was correct. Our review of this file was to ensure all required fields were completed. In addition for calendar year 2018, the Board improperly designated the tax reportability of the vast majority of the vouchers processed in SFS. Going forward we appreciate the Board's intention to take corrective steps to properly designate the tax reporting status on each voucher to avoid future issues.

6. Regardless of the cause for the improper payment, our auditors prevented more than $6.3 million improper payments from being made. Our auditors confirmed with the Board and TPA staff that each rejection or voucher adjustment was necessary to correct inappropriate and/or erroneous claims prior to denying or adjusting the payment. We removed 18 transactions totaling less than $225,000 from Attachment A because those errors were also reported in Attachment B. We also changed the categorization of one error in Attachment A (see Comment 9).

7. The Board does not dispute the identified payments were duplicates and audit standards require our Office to take appropriate action when improper payments are identified.

8. This Office adjusted the findings and attachments in this final report for 17 claims totaling nearly $138,000 initially categorized as "Wrong Payee" that were included in the findings on both Attachment A and Attachment B in the draft report. We also re-categorized an additional $86,000 in findings from "Wrong Payee" to "Accounting or Data Entry Errors". Our auditors verified with Board staff that a claim totaling nearly $43,000 was payable to the wrong supplier prior to rejecting the claim.

9. A portion of the findings in the category “incorrectly calculated compensation” represent findings extrapolated over a maximum of 26 weeks, or approximately 8 percent of the total findings ($23,000). This Office regularly offers a conservative assessment of potential overpayments that could result from findings. Our auditors will review any analysis the Board would like to provide to support different assumptions and adjust our findings going forward. With respect to the audit findings of $.20 or less, Board staff requested each voucher be rejected or adjusted.

10. For the payments our auditors identified that were for amounts lower than the fees charged, the Board staff advised us, in general, of their authority to make the lower payments. However, no evidence was provided to indicate that the reduced payment was the result of negotiation, for example, and not a processing error. This Office previously requested the TPA subcontractor agreements so that our auditors could familiarize themselves with relevant terms and avoid unnecessary work for all parties.

11. This Office is sensitive to the potential for, and impact of, penalties. Further, our auditors expedited specific claims at the Board’s request. The Board, however, has not identified any instance where our audit work caused delay in payment resulting in penalties. We ask that the Board bring situations to our attention that could result in penalties prior to submitting the claims for approval.

12. The Board is responsible to ensure payment amounts are correct and to provide appropriate supporting information. This Office did not take action on a claim before requesting the Board or its TPAs to provide evidence to support that the claims were correct as submitted.

13. The Board contends that it is only required to make 1,600 payments a year to TPAs. However, in addition to the Board payments to the TPAs, this Office must audit the resulting payments processed by the TPAs on behalf of the Board, which total more than 260,000 each year. This Office remains dedicated to working with the Board to implement improvements that meets the responsibilities of our respective staffs and ensures accuracy of payments to claimants.

NEW YORK STATE OF OPPORTUNITY. Workers' Compensation Board

ANDREW M. CUOMO
Governor

CLARISSA M. RODRIGUEZ
Chair

March 23, 2020

Bernard J. McHugh
Director of State Expenditures
Office of the State Comptroller
110 State Street
Albany, NY 12236

Dear Mr. McHugh,

The following serves as the Workers' Compensation Board's response to the Office of the State Comptroller's (OSC) Audit Report (Report 2018-WCB-01).

I. The Board Disputes a Large Volume of the OSC's Audit Findings.

OSC has identified approximately $6 million in errors for the audit period out of the more than $800 million the Board processes annually from its various special funds. Of that amount, the Board agrees with roughly $1 million in findings but objects to the remaining $5 million. As described below, roughly half of that $5 million was the result of the Board's attempt to accommodate OSC's audit process. The remaining half resulted from coding errors related to system transition. None of these findings would have ultimately resulted in incorrect payments. Additional details on the specific findings and the Board's responses are included as Attachment A.

II. OSC's Audit Failed to Recognize the Business Practices of the Board.

Before responding to the specific errors identified in OSC's report, the Board wants to explain again the context of OSC's audit. During calendar year 2018 (the audit period), the Board made an extremely large transition in its approach to managing payments from the various special funds. Not only did we move to the Statewide Financial System, but we also procured the services of qualified third-party administrators (TPAs) to manage over 180,000 claims within the Fund for Reopened Cases.

Prior to the transition, every payment to a claimant, medical provider, attorney, etc., was manually entered into the financial system as its own voucher. As a result, the Board generated approximately 260,000 uniquely auditable payments every year. Because the payments on these claims are now administered by the TPAs, the Board currently only makes 1,600 payments per year. Instead of paying claimants, medical providers, attorneys, etc., directly, we now fund the TPAs for payments they are making.

OSC's procedures during the audit period failed to recognize or support this change in business practice. Therefore, solely to accommodate OSC's audit demands, we continued to create 260,000 manually entered vouchers, which required 3-4 dedicated Full Time Equivalents (FTE). Almost $2 million of the findings identified occurred solely as the result of the manual entry of these vouchers demanded by OSC. Board resources dedicated to this effort would be more effectively utilized in the front-end management of the Board contracted TPAs. We note that as part of its regular business practices, the Board would not have manually entered these vouchers. As such, and as OSC is aware, beginning in April 2020, the Board will only enter the 1,600 vouchers into Statewide Financial System (SFS), which is our regular business practice and will greatly reduce the possibility of any errors. We will provide OSC with the supporting data needed to perform the audit function.

III. OSC's Audit Incorrectly Identified Many Purported Errors.

As to the details contained in the OSC audit report, the Board agrees with approximately $1 million in audit findings. We consider the balance of the findings to be either improperly identified errors or unique isolated incidences related to the massive transition completed during the audit period.

Examples of issues the Board has with the OSC's findings include $1.6 million that OSC categorizes as "accounting or data entry errors" where the correct payee would have been paid the correct amount but were flagged simply because of an overly complicated account code structure. Other findings reflect OSC's attempts to apply basic audit protocols to complex workers' compensation payments. The findings the Board considers invalid include:

1. Improperly Identified Errors
    a. Errors flagged for payments where the payee, amount and account were all correct.
    b. Errors flagged as having "incorrect payment terms," an SFS term that has no relevance in workers' compensation law.
    c. Vouchers that were rejected because OSC did not receive a quick enough response regardless of whether the vouchers were correct.
    d. Legitimate findings of error extrapolated to reflect a value vastly disproportionate to the actual error.
    e. Payments deemed "unsupported" or as "non-compliance with mandated fee schedule," which ignore the complex workers' compensation environment.

2. Transition Issues
    a. Errors that occurred in the manual manipulation of data solely as the result of the Board's attempt to accommodate OSC.
    b. Upload files that were duplicated during the transition period that would have been identified during reconciliation and adjusted from subsequent reimbursements to the TPA.

IV. The Board Has Taken Action in Response to the OSC's Audit.

In spite of our disputes with OSC's findings, the Board takes the $1 million in findings very seriously. We have developed front-end review protocols that will identify many of the issues that led to the legitimate findings, as well as the other items identified by OSC. The Board continues to develop internal systems that will assist us to more accurately review the TPA's funding requests before vouchers are entered to the SFS. This will include the identification of duplicates and accounting or data entry errors (which were the largest categories of findings in the OSC report). The output from these internal systems will result in single vouchers for each funding request and will contain an attachment with all the details that were previously manually loaded under the multiple voucher approach. We understand that this will result in the need for OSC to alter its audit approach. However, this represents the most efficient manner for the Board to manage these payments.

The substantial efforts OSC has long undertaken to learn about the claim's administration processes performed by the Board and its TPAs are apparent and appreciated. However, the Workers' Compensation Law is complex, and the administration process is nuanced. As the Board continues to refine its procedures to maximize the efficiencies expected by moving to the SFS/TPA model for managing claims, it will continue to work with OSC to ensure payments made are appropriate. The Board will continue to keep OSC apprised of procedural changes so that audit procedures can be adjusted accordingly.

In response to the five recommendations made by OSC, we offer the following responses:

1. Recommendation: Take the necessary steps to ensure the Board and the TPAs accurately process claims.

   Response: The Board continues to disagree with several of the categories of "errors" identified in the report. However, for those categories of errors that we agree are correctly identified in the report, the Board has taken significant steps to eliminate or significantly mitigate them. For example, the Board has redesigned its preaudit process to ensure better detection of errors, including potential duplicate payments. Additionally, as you know, the TPAs are licensed by the Board and collectively possess decades of experience with specific expertise managing claims in the complex workers' compensation system. Despite this level of expertise, occasional mistakes can occur. OSC's agreement to allow the Board more time to conduct its preaudit will also allow for closer review of the reimbursement requests. Finally, our TPA contracts have robust reporting standards and oversight provisions, including post-audits which we will continue to monitor and manage.

2. Recommendation: Recover any monies paid inappropriately as a result of incorrect uploading of claims to the SFS.

   Response: The Board made every effort to recover funds that were inappropriately paid because of incorrect uploading of claims to SFS. Subsequent payments were offset, or funds were returned. Further, as discussed above, the incorrect uploading was related to OSC's requirement

that every single payment be loaded into SFS, despite the new business model adopted in 2018. Moving to the consolidated voucher approach will ensure these types of issues are eliminated as of April 2020.

3. Recommendation: Ensure vouchers correctly indicate whether or not the payment is reportable to the IRS.

   Response: The system settings have been corrected; payments are now appropriately reported to the IRS. We would like to reiterate that this issue was identified by the Board, not OSC, and corrective action was immediately taken. Revised files were sent to the IRS prior to the February 1, 2019 deadline.

4. Recommendation: Continue to recover duplicate claims identified in the 2017 annual report to the Board.

   Response: All duplicate payments were reviewed; the Board made every effort to recover duplicate payments where appropriate and over 60% of any overpayments have been recovered or resolved. The remaining 40% relates primarily to large carriers and current 15.8 requests continue to be offset by the outstanding balance owed.

5. Recommendation: Continue to work with this Office to identify areas of improvement to streamline claims processing.

   Response: The Board will continue to work with OSC to identify areas of improvement to streamline claims processing. We appreciate OSC's willingness to redesign its audit process in order to fully leverage the Board's new business model.

Thank you for the opportunity to comment.

Sincerely,

Clarissa M. Rodriguez
Chair

Attachment

Attachment A

New York State Workers' Compensation Board
Comments on the Office of the State Comptroller's Report 2018-WCB-01

Background

The Board processes more than $800 million annually from its various special funds, including the Special Disability Fund (WCL §15.8), the Fund for Reopened Cases (WCL §25a), the Uninsured Employers' Fund (WCL §26a) and the Special Fund for Disability Benefits (WCL §214). Prior to April 2018, the Board processed these payments from its internal Financial Management Information System (FMIS). After a multi-year transition from FMIS to the Statewide Financial System (SFS), the Board began to process these payments from SFS in April 2018.

At the same time as the massive conversion to SFS occurred, management of the more than 20,000 active claims of the Fund for Reopened Cases (as well as an additional 160,000 inactive claims that can reopen) was transitioned away from the Special Funds Conservation Committee (SFCC) to four competitively procured Third-Party Administrators (TPAs). The TPAs are licensed by the Board and collectively possess decades of experience with specific expertise managing claims in the complex workers' compensation system. The TPAs are responsible for all aspects of case management including the direct payment of all appropriate indemnity, medical, legal, defense of fund, etc. Prior to the transition, the Board made roughly 260,000 payments annually to claimants, medical providers, attorneys, etc. from the Fund for Reopened Cases. In the current environment, the TPAs make these payments directly; the Board now processes less than 1,600 payments a year to the TPAs.

Before the TPAs release payments (to claimants, medical providers, attorneys, etc.), they request funding from the Board. To protect fund assets, this is provided "just-in-time", with only a 10 to 14-day (and in some instances less) turnaround from TPA request to Board funding. OSC insists on pre-auditing all medical and compensation payments that are now being made by the TPAs before the just-in-time funding is released. In other words, OSC is auditing the 1,600 payments as if the Board continues to make 260,000 payments. This means that the TPAs and the Board must create files and manipulate data for the sole purpose of preserving OSC's audit procedures. The Board has transformed our approach to managing these claims, only to be held to OSC requirements based on the previous environment. Ironically, this has given rise to many of the findings identified by OSC.

Additionally, to satisfy OSC pre-audit requirements, the Board has significantly limited its review period. In fact, the Special Funds Group (SFG), the unit within the Board responsible for the oversight of the TPAs and for approving the just-in-time funding, is only given 24-48 hours to review payment requests. Then the Accounting Unit only has 24-48 hours to ensure the data is accurately input to SFS. OSC has at least five business days to perform their pre-audit. This scheme has proven untenable, as it is simply illogical to reduce the Board's review period in favor of providing OSC extra review time. OSC has suggested that we are not precluded from continuing to review these pay requests even after they are submitted to them

for audit. Instead, and in order to ensure that the appropriate reviews are performed by the Board prior to submission to OSC for approval, we are adjusting the process flow.

Moreover, many of the audit findings have highlighted that the coding established for the TPAs to use when submitting funding requests, and for input to SFS, has proven to be unnecessarily complicated. For example, separate expense codes were established for different types of medical treatment: durable medical goods expense code is 316416 and diagnostic/office visit coding is 316414. The appropriate coding for an office visit where durable medical goods were provided can be open to interpretation. While the distinction may have been relevant under the old manner of managing claims, this information does not need to be tracked in SFS; specific data, when (and if) needed, is available from the TPAs upon request.

It is the Board's position that valid payments are achieved when the correct payee is paid the correct amount, from the correct account. The Board considers any payments that meet this standard as valid and should not have been flagged as an error by OSC. The Board will consolidate our coding into a more manageable structure starting in 2020; coding that has no impact on payee, amount or account will be discontinued.

1099-MISC

The audit report states that "incorrect payment information provided by the Board for both FMIS and SFS payments resulted in the issuance of 2,235 erroneous 1099-MISCs, totaling more than $1.3 billion, which our office corrected and reissued". The Board takes exception to the way this issue is being portrayed. To effectuate the April 2018 transition from FMIS to SFS, a FMIS data file was created by ITS and sent to SFS for merging. Unfortunately, the query run to produce the file extracted information from the wrong field. This error was then amplified by a system setting that multiplied the payment amounts by the number of vouchers in each payment, ultimately overstating 1,020 suppliers by $1.2 billion. This file was sent to OSC on November 28, 2018 with the Board's request that it be reviewed for any issues or concerns. No response was ever received.

On January 25, 2019, the Board (not OSC) discovered the error and promptly notified OSC. Unfortunately, by that time the 1099s had already been produced. The Board was still able to send a corrected file on January 29, 2019, prior to the February 1, 2019 deadline. Separately, 436 other 1099s were sent erroneously due to the way certain suppliers were set up during the conversion process. The system settings have since been corrected, and these events will not reoccur.

Summary of Findings

Given this context, and with the 1099 issues aside, the $6.3 million in audit findings can be categorized as follows:

	Valid Findings	Transition Issues	Invalid Findings	Total Findings	Reference
Duplicate Payments	$462,689	$603,799	$0	$1,066,487	See Note #1
Claimant or Payment Errors	$4,311		$577,405	$581,716	See Note #2
Wrong Payee	$211,156		$80,702	$291,858	See Note #3
Incorrectly Calculated Compensation	$109,789		$175,158	$284,947	See Note #4
Unsupported Charges	$122,641		$155,757	$278,398	See Note #5
Noncompliance with Mandated Fee Schedule	$113,908		$103,398	$217,306	See Note #6
Accouting or Data Entry Errors	$0	$3,500	$1,704,436	$1,707,936	See Note #7
Total Attachment A	**$1,024,494**	**$607,299**	**$2,796,856**	**$4,428,648**	
Wrong Payee	$0	$809,784	$0	$809,784	See Note #8
Duplicate Payments	$0	$317,888	$0	$317,888	See Note #8
Incorrect Case and/or Accounting Information	$0	$758,430	$0	$758,430	See Note #8
Total Attachment B	**$0**	**$1,886,102**	**$0**	**$1,886,102**	
Grand Total	**$1,024,494**	**$2,493,401**	**$2,796,856**	**$6,314,750**	

As shown, the Board considers $2.7 million of the $6.3 million in findings to be invalid. An additional $2.49 million is related to the massive transition completed during the audit period, and, as such, is not expected to be repeated.

Details for findings the Board considers invalid or strictly the result of the transition are as follows:

Note #1	$603,799 identified as “duplicate payments” was the result of duplicated upload files received from the TPAs during the transition period. These would not have resulted in duplicate payments being issued to claimants, providers, attorney’s etc. These would have been identified during reconciliation and subsequent reimbursements to the TPAs would have been adjusted accordingly.
Note #2	Errors identified as “claimant or payment errors” that the Board considers invalid findings include: • $553,332 of these findings indicated “wrong case number”; while the case number may not have been indicated on the voucher, each voucher indicated the correct payee, in the correct amount, and from the correct account. Of this amount, $25,098 was counted twice. • $24,072 of these findings indicated “incorrect payment terms”; this is an arbitrary coding in SFS that does not apply for these types of payments; not a valid finding.
Note #3	Errors identified as “wrong payee” that the Board considers invalid findings include: • $42,800 flagged by OSC as incorrect supplier; supplier indicated was a d/b/a. • $32,800 also included on Attachment B of the audit report; see Note #8 • $3,600 identified by Board who requested denial. • $1,190 indicating wrong case number; voucher indicated the correct payee, in the correct amount, and from the correct account. • $325 denied because OSC did not receive timely response; voucher was correct. • $30 counted twice.

Note #4	Most of the errors identified as "incorrectly calculated compensation" were legitimate errors identified by OSC but then overstated based on extrapolation. OSC correctly found errors but then multiplied that by 26 weeks assuming they were paid in error bi-weekly for an entire year. There is no basis for this artificial inflation, as there is no support for the assumption that a full year's worth of payments was owed or would have been paid incorrectly. It is noteworthy that ten of the findings included as "incorrectly calculated compensation" were for $.20 or less, five of which were for $.02.
Note #5	OSC identified $278,398 in "unsupported charges", or charges they consider not properly authorized by the Board, or not adequately documented. Under WCL, claims administrators are permitted, encouraged, and required to make decisions to voluntarily pay benefits without a formal decision directing such payments. Proper TPA claims administration involves cost benefit analyses at every turn. Claims administrators may opt to pay certain claimed benefits, even where there may not be a clear entitlement, to avoid the imminent litigation costs associated with disputing such claims. Claims administrators may wait to collect monies owed until it can be recovered in a lump sum, rather than collect in installments, to avoid the risks of overpayment or underpayment. Claims administrators may negotiate medical bill payment rates or contract with third-party entities to secure better pricing for services and equipment. After careful evaluation, the Board has entrusted these claims administration decisions and practices to the expert TPAs. In some cases, delays caused by OSC's review resulted in penalties. For example, OSC would not permit an advanced payment of a pending decision, even though the parties had agreed to the findings contained therein. This ultimately resulted in a delayed payment and penalties totaling $3,225. OSC also overstated their findings by multiplying many of them by 26 weeks assuming they were paid in error bi-weekly for an entire year. There is no basis for this artificial inflation, as there is no support for the assumption that a full year's worth of payments was owed or would have been paid incorrectly.

Note #6	The Board disagrees with $103,396.60 in errors identified as "non-compliance with mandated fee schedule". Due to its complexity, many insurance companies and TPAs use third-party software companies and bill review companies to perform medical bill reviews. OSC auditors have clearly worked diligently to try to fully grasp the bill review process. However, in some of the cases containing bills associated with higher value OSC audit findings, the medical providers have filed objections to the amounts they were ultimately paid. In one instance, the provider has hired an attorney to pursue litigation. Accordingly, some of the OSC reported findings remain unresolved – and could result in subsequent payments *plus interest*. Moreover, pursuant to WCL, nothing in the fee schedule "shall prevent voluntary payment of amounts higher or lower than the fees and charges fixed therein." Contrary to OSC's independent interpretation, payments at less than the fee schedule are legally permissible and often the result of negotiation. As such, the Board maintains that payments that are or appear to be less than the fee schedule are valid and should not be subject to unnecessary scrutiny.
Note #7	Each of the vouchers included in this category would have resulted in the correct amount being paid to the correct payee from the correct account and therefore the Board does not consider them to be valid findings. Many of these were the result of the overly complicated account code structure, which is being addressed: • $1,061,666 relates to one payment with SFS vendor coding issues; • $545,412 in product coding issues; • $86,313 in one voucher with correct payee, in the correct amount, and from the correct account; supplier id was incorrect but had no impact on payment; • $11,044 no error was identified; • $3,500 for a payment made in April when the FMIS-SFS transition was done; voucher had FMIS coding.

Note #8	The findings shown on Attachment B of the audit report are the result of the transition from the FMIS/SFCC to the SFS/TPA model coupled with the Board's attempt to accommodate OSC despite the new approach to managing these claims. Most notably, under the new model the Board has moved from making more than 260,000 payments a year to less than 1,600. However, to accommodate OSC, the TPAs are required to associate each payment they make with a separate voucher. This means that instead of requesting one lump sum payment with a supporting document for review, TPAs must produce a payment spreadsheet with numerous columns and often over a thousand rows, singling out each individual payment voucher. As SFS can only accept a limited number of rows for import, Board staff is then required to manipulate these spreadsheets and the information contained therein. The Board has dedicated 3-4 FTEs to this effort. However, the manual intervention left the data prone to human error. We have implemented procedures to ensure the errors that occurred in the manual manipulation of these files will not be repeated. The Board moved from the FMIS/SFCC model of managing claims to the SFS/TPA model with the expectation of achieving efficiencies. We no longer make 260,000 payments a year; we only make 1,600. While the Board appreciates that reasonable supporting documentation for the 1,600 payments must be available, it is unreasonable to expect the same information that supported the 260,000 payments. Beginning in January 2020, the Board will implement new procedures aimed at maximizing the efficiencies of the new model, while at the same time ensuring payments made are in compliance with all applicable statutory requirements.