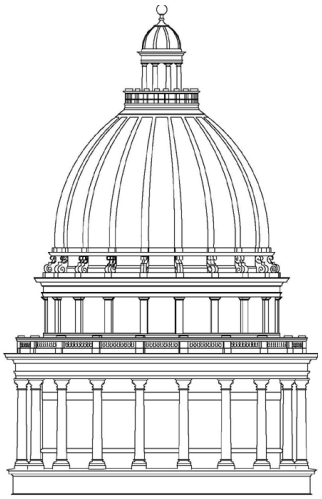
REPORT TO THE

UTAH LEGISLATURE

Number 2013-03



A Performance Audit of The Labor Commission's Adjudication Division

February 2013

Office of the
LEGISLATIVE AUDITOR GENERAL
State of Utah

STATE OF UTAH
Office of the Legislative Auditor General

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AUDITOR GENERAL

February 15, 2013

TO: THE UTAH STATE LEGISLATURE

Transmitted herewith is our report, **A Performance Audit of The Labor Commission's Adjudication Division** (Report #2013-03). A digest is found on the blue pages located at the front of the report. The objectives and scope of the audit are explained in the Introduction.

We will be happy to meet with appropriate legislative committees, individual legislators, and other state officials to discuss any item contained in the report in order to facilitate the implementation of the recommendations.

Sincerely,

John M. Schaff

John M. Schaff, CIA
Auditor General

JMS/lm

Digest of A Performance Audit Of The Labor Commission's Adjudication Division

Chapter I: Introduction

The Adjudication Division helps resolve disputes between injured workers and their employer's workers compensation insurers. Because injured workers face a loss of income, difficulty obtaining new employment, and high medical bills, it is essential that the process for resolving disputes be handled in a fair and timely manner.

Chapter II: Injured Worker Claims Can Be Resolved in a More Timely Fashion

Division's Timeliness Standards Not Always Met. The Division has created time standards for each phase of its adjudication process. Approximately 73 percent of claims are settled early and are therefore not subject to those time requirements. However, of those claims that do go through the entire adjudication process, about one in four do not meet the division's time standards. This means that some claims that should take no more than 10-19 months to resolve may take more than two years.

Appeals to the Labor Commission Can Add Months to Adjudication Process. Delays in the Labor Commission's internal appeals process have contributed to the agency's reputation for having a slow adjudication process. Claims resolved by the Adjudication Division can be appealed to the Labor Commission or to an Appeals Board. In the past, the Labor Commission accumulated a large backlog of claims on appeal. In January 2009, the commission had 133 cases that had been on appeal for more than one year. Of those, 44 cases were pending for more than two years. During the past several years, the commission has managed to reduce its backlog of cases on appeal.

Division Should Take Steps to Reduce Delays. The division is limited in its ability to reduce delays in the adjudication process because most delays are caused by the litigants themselves. However, we found there are scheduling problems and other mistakes made by the Adjudication Division and the Labor Commission that have unnecessarily delayed the process. Through better scheduling of hearings and by raising greater awareness of the need to avoid delays, the division can promote a more timely adjudication process.

Chapter III: Labor Commission Must Avoid the Appearance of Bias

A Review of Claims, Attorney Interviews Revealed No Evidence of Bias. There is little evidence that the Labor Commission's proceedings are biased against injured workers. Six cases of alleged bias were examined as well as a random sample of 30 workers compensation cases. In each case examined, we found no evidence that the proceedings were biased against the injured worker. In addition, the low number of cases overturned on appeal also suggests that judges are providing a fair application of the law to the evidence presented. Finally, we interviewed nine attorneys who frequently represent injured workers. They were unable to provide evidence of biased decisions.

Perception of Bias Puts Division's Credibility At Risk. Certain actions by judges and the division's medical panels can give the impression that decision makers are not entirely objective. The legitimacy of the adjudication process depends not only on avoiding actual bias but also on avoiding the perception of bias. For this reason, the agency must take steps to avoid the appearance that decision makers are biased.

Chapter IV: Greater Oversight Needed of Medical Panels

Panel Members Need Training, Oversight, and Standards. Concerns have been raised about the quality of some medical panel reports, particularly those prepared by physicians with relatively little experience serving on medical panels. Because of the vital role they play, physicians who participate on medical panels must receive the oversight and training they need to properly perform their responsibilities. We recommend the Adjudication Division develop a strong set of policies and guidelines for conducting medical panels, and hire a physician to oversee the training and recruitment of medical panel chairs and to review the quality of medical panel reports.

REPORT TO THE

UTAH LEGISLATURE

Report No. 2013-03

A Performance Audit of The Labor Commission's Adjudication Division

February 2013

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Chapter I
Introduction

Employees with work-related injuries may face loss in income, inability to obtain new employment, and high medical bills. For these reasons, it is essential that the Labor Commission strive to resolve injury disputes in a fair and timely manner. When an injured worker and the employer's insurance company disagree about the amount of compensation owed, the injured worker can have his or her claim adjudicated by Utah's Labor Commission. The Legislative Auditor General has been asked to examine two concerns regarding the commission's adjudication process: (1) whether claims are resolved in a timely fashion, and (2) whether the administrative courts are biased in favor of the employer's insurance companies.

Employees with work-related injuries may face loss in income, inability to obtain new employment, and high medical bills.

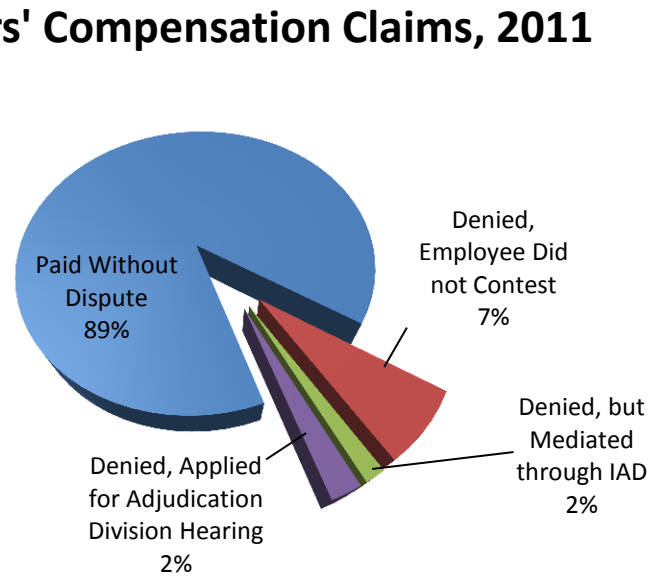
Two Labor Commission Divisions Administer Workers' Compensation Claims

The Industrial Accidents Division is the primary administrator of workers' compensation in Utah. Its staff monitors employers and insurance carriers to ensure that rules are enforced and fees for noncompliance are applied. The division's staff also mediates disputed workers' compensation claims. When claims are not successfully resolved by the Industrial Accidents Division, they may be submitted for formal review by an administrative law judge within the Adjudication Division.

Industrial Accidents Division Receives And Processes Compensation Claims

The Industrial Accident Division administers Utah's law requiring all employers to carry workers' compensation insurance, with few exceptions. If an employee is injured on the job, employers are required to report that injury to the division. During the year 2011, the Industrial Accidents Division estimates there were about 50,000 work-related injuries. Figure 1.1 describes how those claims were resolved.

Figure 1.1 Workers' Compensation Claims Reported During 2011. Nearly 90% of all claims reported were paid within 45 days.



Industrial Accidents estimates that 89 percent of worker compensation claims are not disputed and are directly paid out. These are usually claims for low-cost injuries such as cuts and broken bones. The remaining 11 percent of claims are more complex and initially denied by the insurance carrier. Within this subset, about 7 percent are uncontested by the employee and dropped. Nearly 2 percent of initially denied claims are settled through mediation with the division. The remaining 2 percent of claims fail to achieve resolution through mediation. These cases are filed with the Adjudication Division and are reviewed by an administrative law judge. The focus of this report is the Adjudication Division and its handling of these 2 percent of workers' compensation claims.

Nearly 90% of claims are paid within 45 days. Applications for hearings with the Labor Commission account for only 2% of all injury claims.

Adjudication Division Conducts Claim Reviews

When claims are not resolved through the mediation process, they may be submitted for formal review to the Adjudication Division. During 2011, 978 disputed claims were resolved by the division. Each claim is assigned to an administrative law judge who oversees a legal process that may include a discovery period to identify the facts surrounding the claim, a formal hearing before an administrative law judge, a review by a medical panel, and the issuance of a final order. The purpose of the administrative review process is to provide a fair, correct, and efficient decision on disputed claims.

Adjudication Is Similar to Court, But Commission Has Final Word

The Labor Commission's adjudication process is governed by administrative law and, though it bears many similarities to a court, is not governed by usual common law or statutory rules. Both the injured worker and the responding insurance company must actively participate in the administrative process or they risk losing their case. A judge makes a decision on the case, but the Labor Commission's appeals process gives the Commissioner (or the Appeals Board) the final word.

Administrative Law Offers an Expedited Review of Claims

Prior to the Workers' Compensation Act enacted in 1917, disputes regarding an injured employee's compensation were mainly resolved through civil litigation. These suits took years to settle, and employees often depended on government welfare while waiting for their claims to be resolved in court. Under the current workers' compensation system, workers and their employers operate under a no-fault insurance system. Compensation is paid by workers' compensation insurance carriers to employees with work-related injuries, regardless of fault. Disputes may arise if it is unclear whether the injury actually occurred at the worksite or whether the employee suffered permanent or temporary disability. The Labor Commission has the authority to resolve such disputes through a hearing process overseen by the Adjudication Division and its administrative law judges.

Workers' compensation operates under a no-fault system. Compensation is paid by insurance carriers for employees with work-related injuries regardless of fault.

Administrative Law Grants Judges Some Flexibility. As mentioned, not all the same rules apply to an administrative hearing as in the state and federal court systems. Many court rules of evidence are in place to protect the jury from confusing evidence. In contrast, administrative hearing rules for evidence, such as admissibility, are not as complex because cases are presented solely to an administrative law judge. For example, a medical panel may be appointed by the judge and its report included as part of the evidentiary record. The judge decides the facts of the case, the law to be applied, and the final judgment.

Judicial courts hear a variety of cases presented by a variety of parties. Labor Commission judges are specialized adjudicators with expertise in workers' compensation law that enables them to distinguish between misleading and relevant evidence.

Injured Workers and Insurance Carriers Must Submit Evidence, Prove Their Cases

Employees and insurance companies must present evidence supporting their claims. If they fail to present evidence, they risk losing their cases.

Participants in an administrative process must present evidence supporting their claims. If they fail to present evidence, they risk receiving an unfavorable ruling.

Injured Workers Must File Claims, Submit Medical Records. Injured workers are required to report injuries to their employers within 180 days. If the employer rejects the employee's claim for compensation, the employee can then file an application with the Labor Commission. The injured worker must include supporting medical documentation with the application. In a dispute over medical issues, the worker must also authorize the release of health information. Without filing the correct documentation, the claim may be delayed, and if not corrected, dismissed.

Insurance Carrier Must Accept or Deny a Worker's Claim. After an employee reports an injury, insurance carriers have 45 days to accept or deny a claim. If the insurance company denies the claim (by denying a work-related injury occurred), or if the employer fails to respond within 45 days, the employee may file an application for a hearing with the Labor Commission.

If an employee files an application for a hearing with the Adjudication Division, the employer's insurance carrier must either accept liability or submit an "answer" or defense stating the basis for denying liability. If the claim is denied for medical reasons, copies of medical reports sufficient to support the denial of liability should be included.

Hearing Process, Medical Panels, and Final Orders

Parties have four to five months to prepare for a hearing. At the hearing, both sides present their cases to a judge. If there is a medical dispute, many times the judge refers the claim to a medical panel. A medical dispute could be a disagreement about whether the injury was

work-related or a pre-existing condition, what amount of disability the injury caused, or whether the employee's condition has become stable.

A medical panel is formed when an administrative law judge appoints a physician to act as panel chair. The medical panel chair may invite other physicians to participate if the chair feels special expertise is needed. Physicians who participate on medical panels are compensated on an hourly basis from the state's Uninsured Employers' Fund. Normally, the panel reviews all the worker's medical records, conducts a medical examination of the injured worker, requests any necessary tests, and then provides a report responding to the specific questions asked by the judge. The judge uses the medical panel report, along with all other evidence presented in the medical and hearing records, to come to a final decision. The judge's order is final unless appealed to the Commissioner or Appeals Board.

The judge uses the medical panel report, along with all other evidence presented in the medical and hearing records, to decide the case.

Audit Scope and Objectives

Recent allegations of excessive delays and system bias prompted members of the Utah Legislature to ask for an audit of the Labor Commission's workers' compensation adjudication process. The audit team was asked to look at possible bias toward complainants and excessive delays in the Labor Commission's adjudicative process.

Upon completing our initial review of the process, we discovered that having effective medical panels is essential to both the timely resolution of claims and the division's ability to avoid a biased outcome. For this reason, the audit team devoted additional time to reviewing the operation of the division's medical panels.

The audit findings are described in three chapters:

- Chapter II – Claim adjudication timeliness
- Chapter III – System bias toward complainants
- Chapter IV – Medical panel efficiency and effectiveness

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Chapter II
Injured Worker Claims Can Be Resolved in a More Timely Fashion

Although the majority of employee claims filed with the Adjudication Division are resolved quickly, a substantial number are not. The Adjudication Division has established time standards for each phase of its adjudication process. Failure to meet those time frames can add to the hardship endured by injured workers who are often discouraged due to unemployment, high medical bills, and poor health. The division can take steps to promote a more timely resolution of injured worker claims.

The division must take steps to promote a more timely resolution of injured worker claims.

Many Claims Are Not Completed Within the Division's Time Requirements

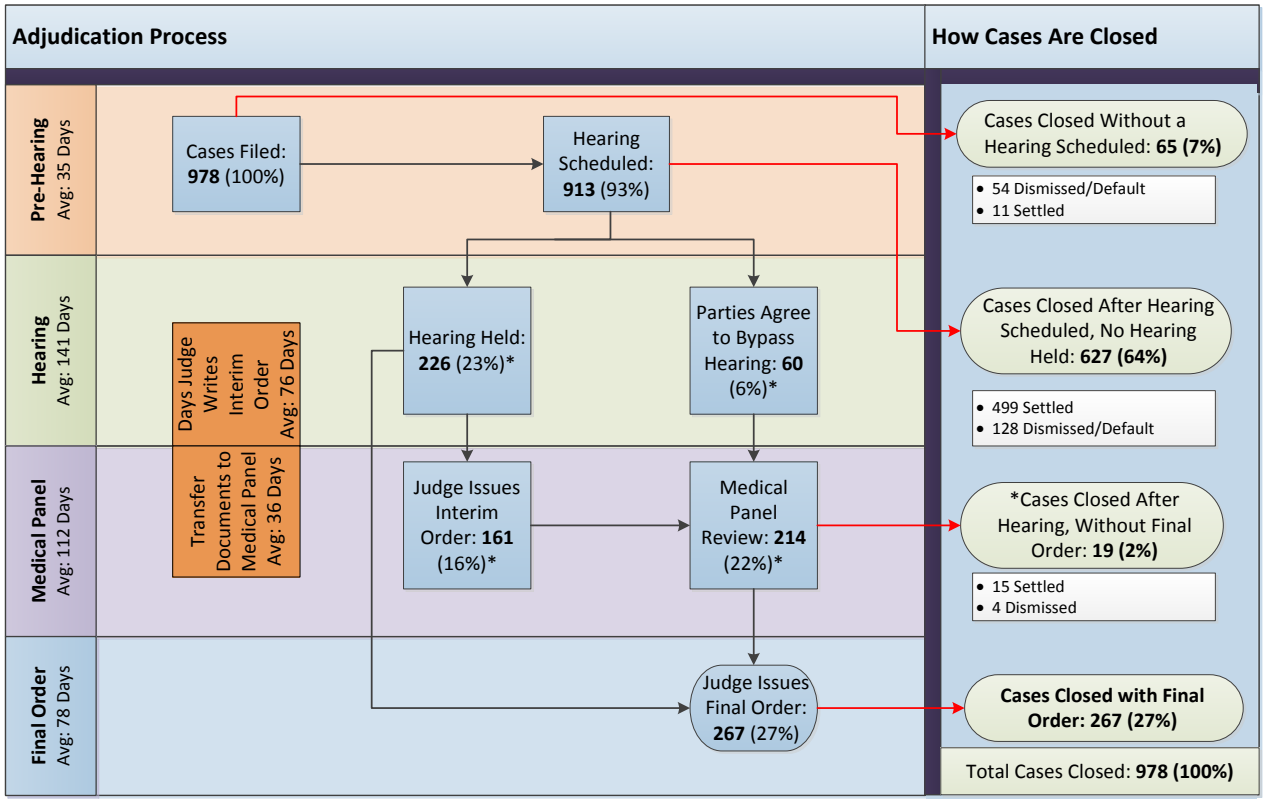
Most injured worker claims are either settled or dismissed without going through a long adjudication process. The division has created policies that establish time frames for each facet of the hearing process in an attempt to minimize the time taken. These timeliness policies are often treated as unenforced guidelines by division staff. Claims which are highly disputed tend to exceed the division's set time limits.

Most Claims are Settled or Dismissed Before a Hearing Is Held

It is important to recognize that most claims are resolved quickly, without holding a hearing or completing the entire adjudication process. To show the time required to resolve claims, we have broken down the process into four phases: prehearing, hearing, medical panel, and final order. As shown in Figure 2.1, relatively few claims complete all four phases. Seven out of ten claims are either settled or dismissed prior to a final hearing order.

Most claims are resolved early without completing the entire adjudication process or even holding a hearing.

Figure 2.1 Adjudication Process. Of the 978 claims closed during 2011, a judge issued a final order on only 267.



*Not all claims proceeded to the next phase. Claims were settled or dismissed at these points.

Figure 2.1 describes the adjudication process for claims closed in 2011. The right column shows whether each claim was settled, dismissed, or had a final order from a judge. Interestingly, 692 (70 percent) of claims are resolved without a hearing. This suggests that the majority of injured worker claims are fairly straightforward and can be resolved quickly once parties exchange information.

Our concern regarding the timely completion of claims focused on the 267 claims, or 27%, for which a judge issued a final order.

Because most claims are resolved fairly early in the process, our concern about the timely completion of claims focused on the 267 claims for which a judge issued a final order. These claims, which represent only 27 percent of claims, tend to be complex and highly disputed, typically completing all four phases of the adjudication process. It appears that these claims, not those resolved early in the process, have led legislators to question the timeliness of the agency's adjudication process. The following sections describe the time policy for each of the four phases described in Figure 2.1. The low success rate in achieving these time policies is outlined in Figure 2.3.

Time Requirements Have Been Set for Each Phase

In an effort to encourage participants to resolve their disputes in a timely manner, the Adjudication Division has established time requirements for each phase of the adjudication process. Most are dictated by the Labor Commission's own administrative policy rather than statute. Some standards, such as the time granted for a medical panel review, are unenforced guidelines, not requirements. We used these policies and guidelines to evaluate the division's ability to process claims in a timely fashion. The four phases of the process and their timeliness policies are described below.

We used the division's policies and guidelines to evaluate its ability to process claims in a timely fashion.

Prehearing: 30 Days. The prehearing phase begins after the application for a hearing is filed. The insurance company is given 30 days to review the case and write an answer to the employee's claim.

Hearing: Four to Five Months. The commission schedules a hearing four to five months after the insurance company files an answer. During this phase, both parties exchange information and prepare for the hearing. As mentioned, 70 percent of claims are settled before a hearing is held.

Medical Panel: 10 Months. If, at the hearing, a medical issue is disputed, the judge may refer a claim to a medical panel. Medical panel members are contracted and paid by the commission.

When a case goes to a medical panel, there are usually two additional steps that add to the timeline. First, judges are given three months to write an interim order summarizing the facts established at the hearing for the medical panel's use. Second, judges send the interim order, with all medical documents, to the medical panel. Gathering and sending documents to the medical panel takes 36 days on average. The medical panel reviews the medical record, performs a physical examination of the employee, and submits a report. Though there is no formal policy, the Adjudication Division expects medical panels to submit a report within six months. The entire medical panel phase is expected to take as long as 10 months.

Final Order: Three Months. The judge issues a final decision on the case three months after examining the evidence presented at the hearing and (if applicable) in the medical panel's report.

Due to the way the division's policy is written, judges are actually allowed more than three months to prepare their interim and final orders. The policy states orders are due "by the end of the third month following the date the case is ready for order." The division has interpreted this policy to mean that judges have three months after the end of the month the case is ready. As a result, judges actually have between 89 and 122 days to write an order depending on the day and month the case is ready for a decision.

Figure 2.2 lists the time required to complete each phase of the process according to the Labor Commission policy.

Figure 2.2 Four Phases in the Adjudication Process. Completing all phases could require as much as 19 months.

Phase	Days
Prehearing	30
Hearing	150
Medical Panel	
Interim Order	89+
Documents to Medical Panel	30
Medical Panel Report	180
Final Order	89+
Total	**568+**

If claims stay in each phase the maximum time allowed by policy, the claim will take about 19 months to resolve if sent to a medical panel.

Each phase requires at least one month and as many as 10 months to complete. If claims stay in each phase the maximum time allowed by policy, the claim will take about 19 months to resolve if sent to a medical panel.

Many Claims Not Resolved within Division's Time Standards

Even though the time standards allow as many as 19 months, some cases are not resolved within this time. We used two approaches to measure the division's timeliness in processing claims. First, we reviewed individual phases to evaluate whether claims completed each phase within the expected time frames. Second, we considered the time required to complete the entire process. Both approaches

revealed that claims are often not completed within expected time frames.

Time Requirements for Individual Phases Have Not Always Been Met. The division has not tracked compliance with their timeliness standards. Figure 2.3 presents the commission's time requirements for each phase and the percentage of cases that do not comply with the time standard for that phase.

Figure 2.3 Many Claims Not Resolved within Division's Time Standards. Cases that are out of compliance with the division's timeliness standards can add months to the adjudication process.

Policy	Average Days	Percent Out of Compliance	Average Days Out of Compliance
Employers have **30** days to file an answer to application	35	55%	5
Hearing is set **150** days after receiving employee's answer	141	30	84
Medical panel considered late after **180** days	112	11	87
Judges are given three months to write interim orders	76	1	44
Judges are given three months to write final orders	78	21	30

Figure 2.3 shows that more than half of the insurance companies' answers to applications are returned after the commission deadline. Likewise, 30 percent of claims wait more than five months before a hearing is held, and judges take more than three months (as defined in policy) to write final orders in 21 percent of cases. The following section shows the overall time required to complete the entire adjudication process.

Thirty percent of claims take more than five months to reach a hearing.

Overall Time Requirements Have Often Not Been Met. To evaluate overall timeliness of cases, we reviewed claims that completed the entire process. Because settlements and dismissals were closed before the full adjudication process was complete, we did not include them in our evaluation of overall timeliness. As mentioned, 978 claims closed during 2011. Of those, 267 claims received a final order from a judge. Of the 267 claims with a final order, 54 claims were resolved without a medical panel. These claims should have been completed

within nine months. Figure 2.4 shows that 48 percent (30%+18%) of the claims not requiring a medical panel did not meet that standard.

Figure 2.4 Claims without a Medical Panel Should be Resolved within Nine Months. Nearly half of claims without a medical panel did not meet the division's timeliness standard (nine months).

Approximately half of claims without a medical panel did not meet the division's timeliness standard of nine months.

Days to Resolve	Number of Claims	Percent of Claims
0-9 Months	28	52%
9-12 Months	16	30
12-19 Months	10	18

According to the division's policy, cases requiring a medical panel should take no more than 19 months. In 2011, medical panels reviewed 213 claims. Figure 2.5 shows that 78 percent were completed within the preferred time frame, 22 percent (16%+6%) did not.

Figure 2.5 Claims Reviewed by a Medical Panel Should Be Done within 19 Months. One in five claims sent to a medical panel were not completed within the 19 months. [1]

One in five claims sent to a medical panel were not completed within the 19-month policy requirement.

Time to Resolve	Number of Claims	Percent of Claims
0-19 Months	167	78%
19-24 Months	33	16
>24 Months	13	6

Cases that go to a medical panel have an extra 10 months added to the process. We found that 16 percent took from 19 to 24 months to complete, and 6 took longer than 24 months. As a result, even with 10 additional months, a total of 22 percent (16% + 6%) of claims took longer than the division's policies allow.

In total, about three-quarters of all claims with a final order are resolved within the division's time standards. However, approximately one of every four claims is not meeting the time requirements set by the division. These injured workers are experiencing a longer process than the division's policies require.

[1] The nineteen-month standard, used in Figure 2.5, includes 90-days for interim and final orders which is somewhat less than the division's actual policy which gives judges until the "end of the third month."

Steps Should Be Taken to Promote Timely Resolution of Claims

Even with generous time allotments, division time policies are not met for one in four cases. We found that all parties share responsibility for some delays. In some cases, there is little the division, the employee, and the insurance carrier can do to avoid delays. Even so, there are steps the division can take to promote a more timely resolution of some injured worker claims.

Most Delays Are Unavoidable

We have concluded there is little the division can do to avoid the majority of delays in the hearing process- especially those caused by the litigant. A limited test showed that the majority of hearing delays were caused by the litigants themselves (See Figure 2.6 on page 9). Many injury claims are quite complex and some employees have little understanding of the adjudication process. As a result, they make mistakes that cause delays. The following are examples of litigant-caused delays that we observed:

A limited test showed that the majority of hearing delays were caused by the litigants themselves

- The injured worker amended the application, thus changing the employer's time allotment for filing an answer
- The injured worker named the wrong employer in the claim
- Incomplete or incorrect addresses resulted in returned mail
- The injured worker fired his or her attorney
- Employee showed up on wrong hearing date, so a new hearing was scheduled
- Employee did not show up for a scheduled physical exam
- Hearing was postponed in anticipation of a settlement that never happened; hearing was rescheduled
- Employee died shortly after claim was filed
- Medical evidence was not complete or not made available during discovery
- A key witness was unable to make the hearing date

Because the division does not have complete control of these events, it is difficult for administrators to enforce time requirements while being flexible enough to allow late, yet relevant, actions.

A Review of Continuances Reveals All Participants Share Blame for Delays

Some have suggested that the insurance companies' attorneys are to blame for most delays in the adjudication process. However, we found that all parties contributed to the delays caused by continuances. In addition, there is usually a legitimate reason for requesting most continuances.

We found there is usually a legitimate reason for requesting most continuances.

A Continuance Is a Formal Request (Motion) to Reschedule a Hearing. A case with several continuances is likely to be one that does not meet the division's time requirements. Common reasons for requesting a continuance include: (1) the failure of the parties to fully disclose information during the discovery process, (2) the unavailability of a special witness, and (3) scheduling conflicts that prevent one of the parties from attending the hearing.

To gain approval for a continuance, a participant must submit a written request to the judge. The judge must then authorize the continuance, reschedule the hearing, and notify the parties of the new hearing date. Of the 978 cases closed during the year 2011, 300 continuances were identified. Some hearings were rescheduled multiple times due to continuances. Generally speaking, the cases that are most likely to miss the division's time standards are those with multiple continuances.

All parties involved shared some responsibility for delays.

All Participant Groups Asked for Continuances. By identifying which party initiated each continuance, we obtained some insight into which groups are most responsible for adjudication process delays. Although the attorneys representing employer insurance companies tend to request more continuances than employee attorneys, we concluded that all involved parties share some responsibility for delays.

Of the 978 cases closed in 2011, there were 175 instances in which a continuance was requested by the insurance company, the employee, or both. For those requests, we reviewed the division's case histories to identify who requested the continuance. An additional 125 continuances were initiated without a formal request. Case histories do not show who initiated continuances without formal requests, but a review of 30 randomly selected cases allowed us to estimate which parties were typically responsible for those continuances. The majority of continuances requested informally were initiated by the judge or

staff. Figure 2.6 shows the percentage of continuances attributed to each party.

Figure 2.6 Continuances. The employers' insurance companies requested the most continuances, but a large number of continuances were also requested by the employees and the division.

Party	Continuances Formally Requested	Continuances with No Formal Request	Total	Percent of Total
Employer/ Insurance Carrier	97	17	114	38%
Employee	67	17	84	28%
Division	0	91	91	30%
Joint	11	0	11	4%
Total	175	125	300	100%

Insurance companies requested the most continuances, but a large number of continuances were requested by the employees and the division.

Figure 2.6 shows that, of 300 continuances, 38 percent were initiated by insurance companies, another 28 percent by employees, and 30 percent by the division itself. Sometimes, though the attorney for the insurance company requested a continuance, it was actually the employee's action that caused the delay. For example, in one case, the employee missed a physical examination scheduled with the insurance company's physician. Although the insurance company requested the continuance, it was the employee who caused the delay.

Because some continuances requested by the insurance company were due to the employee's lack of cooperation during the discovery phase, we believe that Figure 2.6 overstates the number of delays caused by insurance companies. As a result, we found no continuances that were unjustified or used to intentionally delay the process.

Division Should Take Steps To Reduce Delays

There is little the division can do to avoid delays caused by the litigants themselves. However, scheduling problems and other mistakes made by the Adjudication Division and the Labor Commission have unnecessarily delayed the process. We believe the division can promote a more timely adjudication process with better scheduling of hearings and by raising awareness of the need to avoid

The division can promote a more timely process with better scheduling of hearings and by raising awareness of the need to avoid delays.

delays. The Labor Commission should also continue to minimize the time that claims are on appeal.

Better Planning by Adjudication Division Can Reduce Delays. While the litigants are responsible for most of the delays we observed, the division also contributed to adjudication process delays. The following describe some occasions when the division needed to reschedule a hearing or otherwise delayed a case.

- The physician assigned to chair a medical panel forgot about the assignment. It took six months for the division to contact him and ask why he had not yet submitted a report.
- Hearing rooms have been double booked.
- Hearings have been cancelled but staff took weeks to reschedule.
- A judge's hearings have been rescheduled to accommodate vacations, doctor visits, or other agency meetings.

We realize that some scheduling conflicts are unavoidable. For example, if a judge unexpectedly becomes ill, a hearing will need to be postponed. However, we believe many continuances initiated by the division can be avoided through better planning and management of the hearing calendar planning and scheduling.

Raise Awareness by Setting Goals and Reporting Performance. By setting goals and reporting the performance against those goals, the division can raise awareness of the need to process claims in a timely fashion. In the past, even though the division had timeliness standards, little was done to actually monitor performance against those standards.

When we began the audit, the division's monthly statistical reports offered little information regarding how quickly claims were being processed. The reports offered information regarding how many cases were processed, but did not identify how many cases had exceeded the agency's time standards.

The division's balanced scorecard now includes several performance measures that had not been tracked previously.

The new division director, appointed in July 2012, has made an effort to improve awareness of the need to process claims in a timely fashion. The division's balanced scorecard now includes several timeliness measures that had not been tracked previously. However, the reports do not track performance by individual judge and are not regularly reviewed by each judge. The new director has also begun to

focus on the division's oldest cases. She regularly reviews the progress being made on those cases with each judge.

We recommend that the division issue a monthly report that describes the extent to which each judge's caseload is complying with the division's timeliness standards. Once the division has tracked its performance over several months, the division should consider whether the standards for some phases may be reduced. For example, six months may be too much time to allow medical panels to review a case. By reevaluating its standards, the division may be able to further reduce the time required to complete certain phases.

Labor Commission Needs to Minimize The Number of Cases on Appeal

In recent years, the Labor Commission's appeals process has been a major contributor to the agency's slow adjudication process. The commission has since reduced the backlog of cases on appeal. However, the Labor Commission should take steps to assure that it never again allows a backlog of cases on appeal.

Labor Commission Accumulated a Significant Backlog of Cases on Appeal. Once a judge has issued a final order, the parties have thirty days to appeal the decision to the Labor Commission. Of the 978 cases closed in 2011, 267 had a final order issued. Of those, 56 (or 21 percent) were appealed to the Labor Commission. The appeals can be made to the Labor Commissioner or the commission's appeals board, which consists of three individuals who represent employees, employers, and the public. In either case, the actual legal review of the case is handled by the Deputy Commissioner and a commission staff attorney.

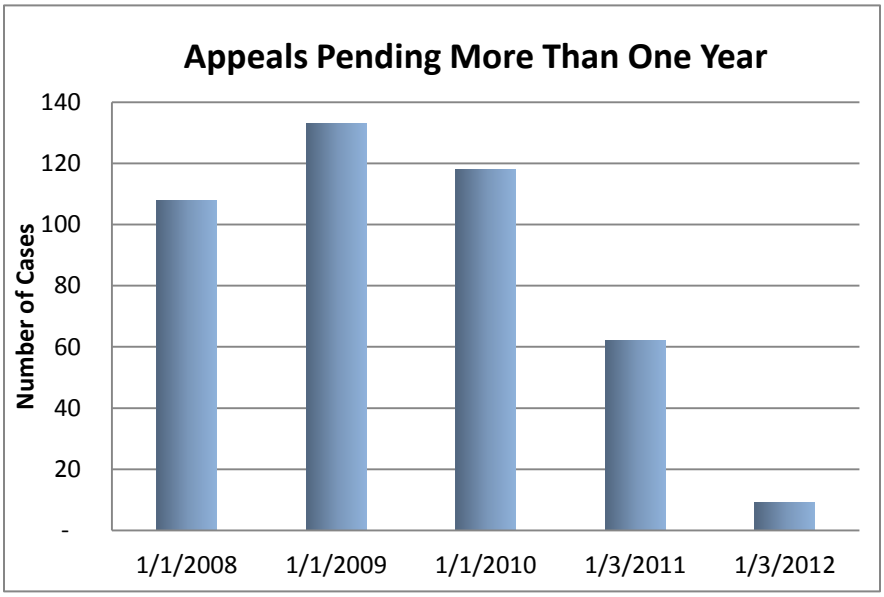
The average length of time to complete the commission's appeals process has been 254 days.

According to commission records, the average length of time to complete the commission's appeals process has been 254 days. This is the average time the 56 cases closed in 2011 were on appeal. Of those, 23 (39 percent) were on appeal for more than 300 days, and 5 cases (10 percent) were on appeal for more than 400 days.

Another way to measure the commission's backlog of cases on appeal is to consider the year-to-year change in the caseload. Figure 2.7 compares the number of cases on appeal for longer than one year

during each of the past five years. It shows the Labor Commission has reduced its caseload significantly since 2009.

Figure 2.7 Drastic Reductions in Appeals Time. The commission has reduced the number of cases on appeal for longer than one year.



The commission has cut appeals time by more than 90% in the past four years.

Figure 2.7 shows that in January 2009, the commission had 133 cases that were on appeal for more than one year. Of those, 44 cases were pending for more than two years. By January 2010, the situation had not significantly improved. There were 118 cases on appeal for more than one year (with 57 on appeal for more than two years). As recently as January 2012, there were only nine cases on appeal longer than one year. So it appears the commission has done well in reducing its appeals caseload. However, the past backlog, with some cases on appeal for two years, may explain why there has been a concern regarding delays in the agency's adjudication process.

The large backlog in the past, with some cases on appeal for two years, may explain why there has been a concern regarding delays in the agency's adjudication process.

The Labor Commission Should Maintain a Low Caseload of Claims on Appeal. To avoid accumulating another large backlog of cases, the Labor Commission should take steps to ensure its standards regarding appeals are followed. Current policy requires that 90 percent of appeals be decided within 3 months and that 100 percent be decided within 5 months. The commission should monitor and report on its performance against those standards. That performance should be included in the agency's balanced scorecard and regularly reviewed with staff.

Recommendations

1. We recommend that the Adjudication Division examine its approach to scheduling hearings and identify ways to reduce the number of continuances initiated by the division.

2. We recommend that the Adjudication Division evaluate its standards for the timely completion of claims and consider whether the standards for some phases might be reduced.

3. We recommend that the Labor Commission monitor compliance with its policies governing the timely resolution of claims on appeal and that they regularly report their performance against those standards.

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Chapter III
No Direct Evidence Of Bias Found

We found no evidence that the Labor Commission's proceedings are biased against injured workers. Our findings are based on a review of six cases of alleged bias as well as a random sample of workers' compensation cases. In addition, the low number of cases overturned on appeal suggests that judges' decisions, in the opinion of the Commission and Court of Appeals, are supported by the evidence presented. Finally, we interviewed nine attorneys who frequently represent injured workers. They were unable to provide specific instances of biased outcomes.

We found no evidence that the Labor Commission's proceedings are biased against injured workers.

On the other hand, certain actions by judges and the division's medical panels could give the impression that decision makers are not entirely objective. The legitimacy of the adjudication process depends not only on avoiding actual bias but also on avoiding the perception of bias. For this reason, the agency must take steps to avoid even the appearance that decision makers are biased.

Claims Review, Attorney Interviews Revealed No Evidence of Bias

This audit of the Labor Commission was requested by legislators who had received complaints that commission staff, administrative law judges and medical panels are biased against injured workers. Concerns of bias were also raised after it was discovered that two judges had secretly ordered medical panels to revise their reports. Furthermore, allegations were brought that judges were unduly influenced by relationships with insurance companies or that they based decisions on factors other than the material found in the evidentiary record.

Lacking the necessary legal expertise, we did not attempt to consider whether judges were making sound legal decisions. Instead, we sought to determine whether decisions could be supported by the facts contained in the evidentiary record. We also searched for any evidence that judges are influenced by factors other than the evidence

presented. We developed a fourfold approach to identify evidence of bias in the adjudication process. These tests are explained in the following four sections.

Examination of Six Cases Revealed No Evidence of Bias

The judge appears to have based her decision on the evidentiary record.

We found no evidence of bias in six cases which had allegedly been handled in an unfair manner. The six cases, involving four employees, were brought to our attention by a legislator, news reports, and an employee's attorney. In each case, we were told, the outcome reflected a tendency to favor the insurance companies over the injured worker. Our review found no evidence to support such claims. In each case we examined, the judge appears to have based her decision on the evidentiary record, including reports from multiple physicians who personally examined the injured worker and the worker's medical history.

Case #1: A Worker with a Shoulder Injury Claimed the Judge Was Biased and Intentionally Delayed the Adjudication Process. This worker suffered repeated injuries to his shoulders at several places of employment. He filed three separate claims described here as cases #1, #2, and #3. He asserted that, in each case, the judge and medical panel were biased, the judge and the employer's insurer intentionally delayed processing his claims, and he was unfairly denied the benefits he deserved.

Documents submitted with his first claim, filed in 2005, suggest the claim was delayed by the injured worker himself by his lack of response to discovery requests. When the adjudication process was finally completed, the injured worker won his claim. He received compensation for temporary disability and related medical expenses. Because he received compensation and contributed to delays, we found no evidence in the record supporting allegations of adjudicatory bias and delays.

Case #2: Worker Reinjured His Shoulder. In 2006, the same worker filed a claim against a new employer after he reinjured the same shoulder while placing a 13-pound object on a shelf above his head. The judge determined the worker had a pre-existing shoulder condition caused by a past motorcycle accident and the workplace injury described in case #1. Thus, the judge concluded that, to hold the new employer responsible, the worker must meet a higher

standard of legal causation, as required by the Allen Rule established by the Utah Supreme Court. To meet this higher standard, a worker must show the physical exertion undertaken when the injury occurred was greater than exertion undertaken in normal, everyday life. The judge concluded the worker's injury did not meet the higher standard of legal causation applicable to the case. For this reason, the judge issued an order dismissing the claim without sending it to a medical panel.

Under appeal, the Appeals Board ordered that the case be examined by a medical panel. The panel found that a pre-existing condition had contributed to the injury. This finding agreed with the judge's original conclusion regarding the injury. The judge again concluded that lifting a 13-pound object above one's head did not constitute extraordinary exertion and the claim was dismissed. That decision is supported by the medical evidence in the case file and specifically by the comments of four physicians who examined the injured worker.

The panel found the worker had a pre-existing condition that contributed to the injury.

Case #3: The Same Worker Injured His Other Shoulder and a Wrist. In 2010, the same worker (described above two cases) filed another claim after he said he was injured working for a third employer. The injuries to his other shoulder (not the same shoulder previously described) and to his wrist were sustained while lifting a 45-pound object off an eye-level shelf. He also claimed to suffer symptoms consistent with a hernia "a few weeks after the accident." The worker had injured both his shoulder and wrist in previous accidents. After this workplace accident, seven different physicians examined the shoulder. Some of these physicians also provided treatment for his shoulder pain, generally with cortisone injections or narcotics. His wrist was examined by at six physicians and his hernia was examined by one physician.

Initially, the employer's insurance company agreed to cover $26,300 in medical expenses for the shoulder injury and roughly $7,300 in lost wages. The worker then asked that they pay for his wrist and hernia condition, further care for his shoulder, and permanent partial disability. The employer rejected the claim, stating the shoulder condition had stabilized and the worker failed to meet the higher standard of legal causation required by the Allen Rule.

The judge referred the claim to a medical panel, concluded both injuries were "slight, temporary aggravations of pre-existing conditions" and the hernia was not caused by the industrial accident. The judge accordingly issued a decision that did not award further benefits and denied benefits for the hernia.

The worker appealed the judge's decision to the Labor Commission, which called for a new medical panel with greater expertise related to the injury claims. The new panel also concluded the worker had strained his shoulder and wrist. The judge concluded the worker was ineligible for additional benefits and denied benefits for the hernia. We found no evidence that the case was handled in an unfair or biased manner. It appears the judge's decision was based on information contained in the evidentiary record.

We found no evidence that the case was handled in an unfair or biased manner.

Case #4: A Worker Injured His Back While Performing Employment Duties. A worker filed a compensation claim for a lower back injury sustained while he and another worker installed three 200-pound objects. After placing one object in position, the worker felt pain in his lower back and down his left leg. He rested, but later finished installing the other two objects.

During the following year, the worker had back surgery, which was covered by the workers' compensation fund. The worker's condition seemed to have improved and he returned to work. Roughly a year and a half after the surgery, he experienced recurring back pain and underwent another surgery covered by the workers' compensation fund; however, the pain continued. Approximately two years later, the worker sought coverage for additional surgery, appropriate follow-up care, and medications. The insurer argued that the worker's condition had stabilized and disputed the need for ongoing treatment. The case was then submitted to a medical panel.

The medical panel, which included an occupational medicine specialist, concluded that the worker's condition had stabilized and he could use alternatives to the requested opioid-based pain medication. They also suggested physical therapy but did not recommend surgery due to the risk of a poor outcome.

A new panel was assigned, which essentially arrived at the same conclusions as the first panel had.

Both the worker's attorney and insurer's attorney raised concerns about the validity of the panel's decision when it was discovered that the judge had requested changes to the panel report and subsequently had the old version destroyed. A new panel was assigned, which

essentially arrived at the same conclusions as the first panel. Ultimately, the worker and employer reached a settlement on a lump sum payment.

Case #5: An Injured Worker Traveled Back to Utah, Only to Learn His Hearing Had Been Cancelled. In this case, the worker had been injured on a Utah construction site, but later moved to another state. He was required to return to Utah for his adjudication hearing. After arriving in Salt Lake City, he discovered the hearing had been cancelled within a half hour of the scheduled time. It was reported that the attorney for the employer's insurance company acted maliciously in cancelling his hearing in an effort to force him to settle his claim.

Commission records show that, four days prior to the scheduled hearing, the attorneys had agreed to a continuance because the insurer's attorney discovered his witnesses had scheduling conflicts. Although the request for continuance had been submitted to the division, the judge was not available to grant approval until four days later, on the day of the hearing. Consequently, the continuance was not granted in time for the injured worker to avoid traveling to Utah.

The worker's attorney said that his client actually benefitted from the continuance because it allowed them more time to prepare his case. In addition, the insurance company agreed to pay the worker's travel cost to any future hearings. The parties agreed to send the case to a medical panel and no additional hearings were held.

Based on the comments of the employee's attorney and our review of the case documents, we cannot attribute any malicious intent to the rescheduling of the hearing. However, better communication might have allowed the continuance to be approved with enough prior notice for the employee to cancel his trip. Though inconvenienced, the employee was not harmed by the cancellation and, according to his attorney, benefitted from the delay.

Though inconvenienced, the employee was not harmed by the cancellation.

Case #6: A Medical Panel Allegedly Exceeded Its Authority in a Hip Injury Case. An apartment complex maintenance worker slipped on some ice and injured his hip, aggravating a previous injury received when he was a soldier in the Bosnian war. The worker sought medical treatment and eventually underwent a hip replacement. He

then sought compensation from his employer's worker liability insurer, claiming the treatment was necessitated by his fall at work.

After a medical panel examined the worker, they conducted a literature search on exploding bullets to verify the worker's claim of being hit by a bullet that "exploded and…had pieces go several different directions." The panel verified that exploding bullets were used in the Bosnian war and concluded that the war injury had caused the hip condition. The employee's attorney claimed the medical panel's reliance on information obtained from an "internet search" was inappropriate. The attorney said the physicians went outside their area of expertise by seeking out and interpreting information not identified in the judge's findings of fact.

It appears, however, that the medical panel's inquiry was actually consistent with guidance received from the judge, who had asked the panel to report any related additional facts that were not already described in the judge's findings of fact. Moreover, the physicians sought clarification from a literature search after being told by the injured worker that he was wounded by an exploding bullet. After reviewing his x-rays and medical records, the medical panel concluded the evidence showed the injury was due to preexisting injuries, not due to a slip on the ice at work.

The panel's findings are well supported by the evidence in the medical records and by the injured worker's own statements.

Based on the information in the case file, we found no evidence to suggest that the physicians' research on exploding bullets was inappropriate. It was merely an effort to verify information provided by the injured worker himself. In addition, the panel's findings are well supported by the evidence in the medical records and by the injured worker's own statements to the medical panel.

No Evidence of Bias Found in Cases Selected at Random

A review of 30 randomly selected cases revealed no evidence of actual bias against injured workers. Our objective was to obtain a broad view of how claims are handled in general. One case did contain information suggesting bias in favor of an injured worker and against the employer's insurance company. However, based on evidence later obtained from the medical panel, the judge ruled against the injured worker. Because judges' decisions always reflect the findings of the medical panel, we find insufficient evidence to support allegations that judges are biased against injured workers. In fact, the outcomes of

We find insufficient evidence to support allegations that judges are biased against injured workers.

these claims seem to be supported by the evidence found in the evidentiary record.

We randomly selected 30 cases which had been sent to medical panels and had completed all four phases of the adjudication process. For each case reviewed, we answered the following questions:

- Did the judge's final order reflect the medical panel's findings and recommendations?
- Did the judge's final order support the claims of the employee or the insurance company?
- Did the panel include physicians with expertise in areas related to the subject at hand?
- Did the panel weigh in on non-medical issues outside their areas of expertise and did the panel limit itself to the facts established by the judge?
- Was there any evidence of bias or preferential treatment towards one party or the other?
- Did the judge disregard important facts contained in the evidentiary record?
- Was the final order supported by the evidentiary record?

Our review produced the following results:

Judges' Decisions Reflect the Findings of the Medical Panel. In each of the 30 cases reviewed by medical panels, the judges' final orders reflected the medical panels' findings and conclusions. This observation suggests that judges rely on the conclusions of the medical panels, when medical issues are the primary focus of dispute. It also suggests that it is extremely important that medical panels provide an objective review of a claim. The role of medical panels is discussed further in Chapter IV.

Judges' final orders reflected the medical panels' findings and conclusions.

Judges' Final Orders Favor Injured Workers About as Often as They Favor Insurance Companies. Of the 30 claims sampled, employees won in 14 of the claims and the insurance carriers won 13. The three remaining claims were either decisions which favored both parties to some extent or were settled before a decision was made. To verify those results, we reviewed an additional 32 cases. With a total of 62 cases reviewed, we found 28 decisions favored the insurance carrier

and 27 favored the injured workers. The remaining seven claims favored neither party.

Medical Panels Always Include Experts in a Field Broadly Related to the Injury. In each of the 30 cases examined, the medical panel had expertise in a field relevant to the worker's injuries. Occasionally, a panel chair was selected who did not have expertise in the field related to the injury. However, in those cases, other physicians on the panel had backgrounds suited to the injury being evaluated.

On the other hand, we question whether some panels with general expertise in a field could not benefit from having more specialized experts. For example, a panel may include an occupational medicine specialist with broad training related to workplace injuries, who might not be ideally suited to evaluate a complex orthopedic problem. Concerns regarding the expertise of medical panel members are addressed further in Chapter IV.

In a few instances, panel members provided information or made comments that were unrelated to the medical issue at hand.

Sometimes Panels Have Commented on Matters Unrelated to Medicine. In most cases, the medical panels limited themselves to answering the questions posed by the judge, with conclusions being generally related to their examination of the medical history and the injured worker's condition. However, in a few instances, panel members provided information or made comments that were unrelated to the medical issue at hand.

One panel reported information that did not seem to have much bearing on the medical questions they had been asked. For example, the report states how long the injured worker worked for his current employer (not the same employer when he was injured), that he enjoyed the work and received good wages and benefits. The panel also discussed his education history and family situation. Finally, the panel stated the employee should "further his education to ensure he will have earning capacity in spite of having a bad back".

Based on our review of the case file, it appears the panel's conclusions and the judge's decision were supported by the medical evidence presented. However, medical panels should confine their report content to the relevant medical issues to avoid giving the impression that they might have been influenced by unrelated factors.

One Judge's Notes Suggest Bias in Favor of an Injured Worker. In the case notes, the judge expressed a personal animosity toward the individual acting as a witness for the insurance company. The notes also expressed clear support for the employee. However, the medical panel that reviewed the case concluded the person did not suffer a valid workplace injury. After receiving the panel's report, the judge then ruled against the employee and in favor of the insurance company. As a result, even though the judge's notes indicated favor for the employee, the final decision was based on the factual evidence.

Decisions Appear to Be Supported by the Evidence Presented. After carefully reviewing 30 cases, we found that the written orders issued by each judge appear to be supported by the evidence presented during the discovery phase of the process. Therefore, we find little support for allegations that the judges' are biased toward one party. Although the medical panels sometimes include information that is not relevant to the case, the judges' decisions do not appear to be based on that information. In each case, there was sufficient factual medical evidence provided in the record to support the decisions handed down by the judge.

In each case, there was sufficient factual medical evidence provided in the record to support the decisions handed down by the judge.

Relatively Few Decisions Are Appealed and Overturned

The low number of cases overturned on appeal suggests that judges are, according to the Labor Commission and Utah Court of Appeals, providing a fair application of the law to the evidence presented. The number of decisions appealed and overturned is a basic performance measure of any judicial process. In fact, it is a measure that is currently reflected on the Adjudication Division's balanced scorecard as a percent of decisions upheld.

Claims may be appealed when one of the disputing parties believes the judge made an incorrect decision. Appeals are first submitted either to the Labor Commissioner or to the Appeals Board. The Labor Commission's attorneys prepare a legal brief for the case. The recommendations in the brief are then acted on by the Commissioner or the Appeals Board. Decisions at the commission level can be further appealed to the Utah Court of Appeals and eventually to the Utah Supreme Court.

We found that few claims, whether appealed by the employee or employer, have ever been reversed upon appeal. From January 2010, to November 2012, we found that 1,991 appealable cases had been closed by the division's judges; of those 408 (or 20 percent) were appealed to the commission and only 25 decisions were reversed. Over this period, 6 percent of appeals were reversed, accounting for about 1 percent of all closed cases. This suggests a fairly low error rate on the part of the judges.

We found it is extremely rare for a decision by the Labor Commission to be overturned by the Utah Court of Appeals. Of 408 claims appealed to the commission since 2010, 75 (or 18 percenet) were appealed to the Court of Appeals with no direct reversal of the order. Four claims were sent back to the court to alter the judge's decision in some way, but the Court of Appeals made no substantial change to the judges' orders. The low number of cases reversed on appeal suggests the Labor Commission has a fairly reliable adjudication process.

It is extremely rare for a decision by the Labor Commission to be overturned by the Utah Court of Appeals.

Interviews of Employee's Attorneys Produced No Clear Evidence of Bias

Interviews conducted with employee attorneys uncovered no clear evidence of biased decisions. A few offered stories they had heard from others but none offered a first-hand account of a biased outcome. On the other hand, several of the attorneys raised concerns regarding the behavior of judges and medical panels that, to them, demonstrate a lack of objectivity. Such actions alone do not prove there was an unfair or biased outcome. However, they do raise concerns about the professional conduct of some judges and medical panels.

Attorneys Had Concerns with Conduct of Judges and Medical Panels. We asked nine attorneys a series of questions aimed at identifying injured worker claims that were unfairly handled or which resulted in a biased outcome. As a group, they represent 46 percent of all injured worker claims filed with the division. While no specific instances of bias were reported, the attorneys' claim the actions by judges and medical panels give the perception of bias. In summary, they expressed concern that:

- Judges exhibit inappropriate courtroom behavior
- Judges decisions are improperly influenced by the Labor Commission

- Judges lack experience and training
- Medical panels go beyond their scope during evaluations

While their experiences do not prove that claims have been handled in an unfair or biased manner, at the very least, the actions they describe suggest the appearance of bias. The perception of bias may hurt the credibility of the adjudication process as much as any actual instance of bias. This matter is described more fully in the following section.

The perception of bias may hurt the credibility of the adjudication process as much as any actual instance of bias.

In conclusion, our review of case files and our interviews with attorneys did not reveal concrete evidence of bias against injured workers. Our limited review does not prove that claims are always handled in a fair and unbiased manner, only that decisions are largely supported by the evidence in the medical record. On the other hand, certain actions by judges and medical panels may still give the impression of bias. In the following section we describe the damage that can result from such behavior.

Perception of Bias Puts Division's Credibility at Risk

Some judges' and medical panelists' actions have given participants the impression that the adjudication process is unfair. The division is taking steps to avoid behavior that might be interpreted as biased and we recommend the division continue these efforts. Success could be measured through the division's participants' surveys and a reduction in the number of claims appealed.

Some Conduct Leads Participants to Believe Judges and Panel Members Are Biased

Instances of questionable judicial and medical panel behavior have been noted by attorneys, judges, panel members, and litigants. These reported behaviors include the following:

- **Unpleasant Courtroom Behavior.** Instances of a judge rolling eyes, scolding attorneys off-record, interrupting closing arguments, and giving more attention to one party's arguments over another have been reported to us. Parties experiencing events like these could question the impartiality of the process.

One judge sent at least five reports back to medical panel chairs for revisions without notifying the other parties.

- **Revisions to Medical Panel Reports Not Being Shared with All Parties.** In an effort to train medical panel chairs in writing reports, one judge sent at least five reports back to medical panel chairs for revisions without notifying the other parties. Although no substantial changes were made and the conclusions remained the same, the lack of transparency and hiding the action can convey distrust in the adjudication process.

- **Casual Courtroom Proceedings.** In one case, closing arguments were not recorded. The judge recognized the mistake and brought the problem to the attention of a colleague. The judge was told closing arguments were not evidence and there was no need to inform the attorneys involved. The apparent lack of concern for maintaining a proper record could lead some to question the credibility of the adjudication process.

- **Medical Panel Chairs' Potential Conflicts of Interest.** Two medical panel chairs work for an occupational medicine clinic that receives large donations from a major insurance company. An executive from that same insurance company sits on the clinic's board of directors. The clinic's close ties with the insurance company may lead some to question whether the clinic's physicians can remain objective while serving as panel chairs. Such conflicts of interest should be avoided to prevent the possibility of undue influence.

- **Some Medical Panels Attempt Additional Fact-Finding.** Attorneys have claimed medical panels do not rely solely on the findings of fact provided by the judge. For example, one panel was accused of searching for additional non-medical facts to support the conclusions of its evaluation. The practice can give the impression that medical panels may not be completely reliant on the facts established at the hearing and given to them by the judge. Such additional fact-finding goes outside the legal process and could cause concerns among the participants.

- **An Injured Worker Had Same Judge and Medical Panel on Two Separate Cases.** An injured worker submitted separate workers' compensation claims for separate injuries, but was assigned the same judge for each claim; the judge used the

same medical panel members in each case. Using the same judge and medical panel for multiple claims could lead to a perception of bias because of prior experience with the worker.

Labor Commission Acknowledges the Need To Avoid the Appearance of Bias

The Labor Commission recognizes that public confidence in its administrative proceedings will be lost if judges and panel members demonstrate partiality. Because of this risk, the Labor Commission has taken several steps to address concerns regarding the impartiality of judges and panel members. We encourage the agency to continue these efforts.

The Labor Commission has taken several steps to address concerns regarding the impartiality of judges and panel members.

The Labor Commission Has Adopted a Judicial Code of Conduct. Shortly after we began our audit, the Labor Commission adopted a Code of Judicial Conduct. The code acknowledges that "public confidence in the judiciary is eroded by improper conduct and conduct that creates the appearance of impropriety." It includes standards aimed at promoting the "independence, integrity, and impartiality of the judiciary." Among others, the Code of Judicial Conduct includes standards regarding:

- Impartiality and fairness
- Discourtesy, bias, prejudice, and harassment
- External influences on judicial conduct
- Competence, diligence, and cooperation
- Ex parte communication

The full text of the code of conduct is available on the Adjudication Division's website.

Employees, employers, insurance carriers, and attorneys are given the opportunity to complete a survey.

The Adjudication Division Conducts Surveys of Hearing Participants. In October 2012, the Adjudication Division began to administer an online survey to all participants in the division's adjudicative process. Employees, employers, insurance carriers, and involved attorneys are given an opportunity to complete the survey.

Survey questions focus on the judge's performance in the following areas:

- Legal knowledge and ability (competence) of the judge
- Fairness, impartiality, and courtroom demeanor of the judge
- Communication skills of the judge
- Self-control and temperament of the judge

Thus far, an insufficient number of surveys have been submitted to draw conclusions. As additional surveys are received, the division may have more meaningful results.

The surveys are an important tool to ensure that judges receive feedback about their conduct during proceedings. They provide a means of holding judges accountable for their behavior. In fact, one attorney we interviewed said he has noticed that judges' behavior has improved since the division began conducting regular surveys.

Advisory Committee Meetings Are Being Used to Identify Ways to Improve Process. The division has begun to hold periodic meetings with interested parties to discuss ways to improve the hearing process. These meetings have included employees' and insurance companies' attorneys, judges, and division staff. During the October 2012 meeting, the parties discussed ways the process could improve including late submissions and handling motions consistently. The division director said she plans to use discussions from these meetings to improve the judicial process and instruct judges on consistency.

The division has begun to hold meetings with interested parties to discuss ways to improve the hearing process.

Labor Commission Must Take Steps To Avoid the Appearance of Bias

The Labor Commission can encourage its judges and panel members to avoid the appearance of bias by taking the following steps:

Measure Progress in Terms of Cases Appealed. The number of cases appealed is perhaps the best indicator of the public confidence in the adjudication process. As the division works to improve public confidence in the process, it should begin to see a decline in the number of cases that are appealed.

Avoid Repeatedly Assigning the Same Judge and Medical Panel to the Same Injured Worker. The division needs to avoid the appearance of bias by assigning different judges and panels to employees with repeated claims.

Provide Judges and Panel Members with Training. Judges and panel members should receive training on avoiding conduct that may be perceived as disrespectful, prejudiced, or biased.

Require Compliance with Standards Regarding Conflicts of Interest and Bias. The Labor Commission has established a Judicial Code of Conduct that requires judges to remain impartial and to avoid conflicts of interest.

Recommendations

1. We recommend that the Adjudication Division provide professional conduct training to its judges and medical panels to mitigate behaviors that could be perceived as biased.

2. We recommend that the Adjudication Division avoid assigning the same judge and medical panel to claims filed by the same injured worker for different injuries. Such practice will help avoid the appearance of bias.

3. We recommend that the Adjudication Division require judges and medical panels to comply with its standards regarding conflicts of interest and bias.

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Chapter IV
Greater Oversight Needed Of Medical Panels

Because of the vital role they play, medical panel chairs need to receive greater oversight and training. Concerns have been raised about the quality of some medical panel reports. We were unable to measure the extent to which problems may exist. In fact, the problems may be limited to a group of relatively new panel chairs. Even so, we recommend the Adjudication Division develop a strong set of policies for the conduct of medical panels and a set of standards for panel reports. A key step is the hiring of a physician medical director to oversee the training and recruitment of medical panel chairs and review the quality of medical panel reports.

Some medical panel reports are prepared by physicians with relatively little experience serving on medical panels.

Concerns Raised about the Quality Of Some Medical Panel Reports

We received a number of complaints regarding the quality of some medical panel reports. For example, employees, insurance companies, administrative law judges, and physicians have all expressed concern that some panels (1) express opinion on matters outside their areas of expertise, (2) prepare poorly written reports, and (3) are inconsistent in how they approach the same type of claims.

We were unable to systematically evaluate the performance of the division's medical panels. We considered hiring a medical consultant to help us evaluate the quality of medical panel reports. However, we quickly determined that the underlying problem facing the medical panels is a lack of oversight and guidance. We concluded, therefore, that regardless whether the problems are widespread or limited to a few new panel chairs, our recommendation would be the same. The division needs to provide its medical panels with greater oversight and guidance than they currently receive.

Panels Expressed Opinion on Matters Outside Their Expertise

The most common complaints we heard regarding medical panels is expressing an opinion on specialized medical conditions for which they do not have expertise, expressing an opinion on legal matters, and expressing an opinion related to the employee's personal life. The following material provides some examples.

Some Panels Have Commented on Medical Issues Outside of Their Areas of Expertise. A physician with many years of experience as a panel chair was asked to prepare a training session for his fellow panel members. To prepare, he reviewed two medical panel reports written by a physician with relatively little experience as a panel chair. The experienced physician said he was surprised that the panel tried to evaluate an employee's injuries without consulting a physician with expertise in the specific injury.

The panel had tried to evaluate an employee's injuries without consulting a physician with the proper expertise.

A second physician, employed part-time by the Labor Commission, expressed similar concerns regarding a medical panel report that he reviewed. After reading one panel report, he said he was surprised at the conclusions they had made and indicated that he would have responded differently to the judge's questions.

The concerns expressed by these two physicians reflect problems they identified in a few medical panel reports. They had been asked to review the reports because others had also expressed concerns about the quality of the work performed. Their comments were not aimed at medical panel reports in general. So we have little evidence showing how extensive the problems may be. However, several judges and attorneys also expressed concern about panels that lack the specialized expertise needed to evaluate certain injuries.

Some Panels Have Expressed an Opinion on Legal Issues. Several judges, physicians, and attorneys said some medical panels have a tendency to express their opinions on the legal implications of their medical findings. For example, one physician said his fellow panel members tended to "step on legal toes by offering opinions that encroach on legal rather than medical issues." He suggested his fellow panel members must "avoid sounding like a lawyer wannabe… in reports by avoiding legal language… ."

In one medical panel report we reviewed, the panel made its assessment of the employee's medical condition as directed, then finished with this legal conclusion: "…there is no period of temporary total disability evident." The statement suggests an attempt by the panel to resolve the debate regarding the employee's disability status, which is the responsibility of the judge. By including such language in a medical panel report, the medical panel seems to be placing itself in the role of the judge.

Panels Have Commented on Injured Workers' Personal Lives. Some medical panels remarked on the employee's personal challenges, such as their economic situation and prospects for future employment. There may be some instances in which commenting on such matters sheds light on the employee's medical condition; however, generally speaking, such matters are out of place in a report documenting an individual's medical condition and the cause of their injuries.

Physicians are not empanelled to evaluate legal facts associated with the case, the injured worker's job prospects, or other matters related to the worker's personal life.

We reviewed one report in which the panel commented on the employee's living situation (lost his home, living with parents) and wife's employment status (working as maid to supplement income). The report concluded that the difficult economic situation was a consequence of the employee's industrial accident. However, those matters are outside the scope of a medical panel review.

There are two reasons why it is inappropriate for panels to include information that is unrelated to an employee's medical condition: (1) the physicians are neither qualified nor is it their role to comment on the injured worker's job prospects or other personal matters, (2) including such matters in a medical panel report gives the appearance that the medical evaluation is based in part on factors other than the medical evidence they have observed or the legal facts provided to them by the judge.

Some Medical Panel Reports Are Poorly Written

Parties say panel reports are confusing, contain too much information (or too little), and do not provide support for conclusions.

Judges, physicians, and attorneys have expressed concern that some panel reports are confusing, contain too much information (or too little), and do not provide support for conclusions.

Some Reports Contain Unnecessary Information. Some panels summarize an injured worker's complete medical history but do not

use that information to reach a conclusion regarding the employee's medical condition. Several attorneys and judges have told us that this excess information makes the reports difficult to read and confuses the reader.

Some panels express opinions regarding matters that, at best, have an indirect bearing on the medical injury in dispute. For example, one medical panel made the following observation about the employee's medical condition, then took the opportunity to express frustration about patients in general who do not take responsibility for their own health care.

> The [employee's] psychosocial factors are significant… . With the right attitude and effort the medical panel feels that [the employee] could improve… . He cannot lie back and have a physical therapist or massage therapist do all the work and expect to get benefit out of it. …too often patients like [this employee] try to transfer responsibility for their health to the therapist.

The judge responsible for the above-referenced case stated that such remarks "…can create controversy and they do not assist the ALJs in determining the issues of a case." Our concern is that such comments may also lead some readers to question whether the panel is truly impartial and basing its decisions on medical facts or whether conclusions are based on the panel's subjective views of the employee's attitude.

Some panels do not focus on simply assessing the employee's medical condition.

Some Panels Do Not Provide Clear Answers to the Judges' Questions. Judges and attorneys involved in workers' compensation cases have expressed frustration with the lack of clarity in some medical panel reports. For example, one judge found that some panel statements, like those below, did not help resolve the disputed medical condition but only added confusion.

> "It is possible but highly unlikely…"
> "It is more likely than not…"
> "It is more likely than not unrelated to the industrial accident…"

Another concern is that even when panels provide specific conclusions, they do not always explain how they arrived at their conclusions. If judges are to succeed in resolving disputed claims, they need medical panels to describe the information they considered and how that medical evidence helped them arrived at a conclusion.

Questions Raised Regarding Consistency of Medical Panels

Several attorneys and physicians have expressed concern about panels' lack of consistency in handling the same types of claims. The concern is that the conclusions reached by a medical panel may differ depending on which physician serves as the panel chair. If a medical review process is to be considered valid, it should produce consistent results regardless of which physician is chairing the review panel.

Reliability of medical panels is questioned.

One attorney who has represented dozens of injured workers has observed that the outcome of a medical panel review largely depends on which physicians are selected to serve on the panel. She said that sometimes she will tell her client "that we have some new medical panel doctors that I don't trust to know what they are doing." Therefore, she said, the outcome is not predictable. We spoke with several other attorneys who expressed similar views.

We also interviewed two physicians who have a great deal of experience with medical panels. They told us there is a problem with a lack of consistency in how medical panels reach their conclusions. Both said they have read panel reports with which they have strongly disagreed. Both suggested that at least a few of the division's panel chairs are not well informed regarding (1) the role of medical panels, (2) the need to have experts on the panel, and (3) the need to "build a case for a conclusion rather than just expressing an opinion." Their remarks suggest that some panel chairs, especially those who are relatively new to the process, are drawing conclusions that are not supported by the facts, are not defensible, and do not follow the same rational used by other, more experienced panel members.

Panels Need Training, Oversight, and Standards

Although we do not know the extent to which problems may exist, it is fairly obvious that the medical panels play such a vital role that they should receive some degree of oversight. The Adjudication Division seems to agree and has assembled a medical committee to identify concerns and provide training for panel members. We support

the division's efforts but believe two additional steps must be taken to provide greater oversight of the medical panels: (1) develop written instructions, policies, and procedures, to guide the work of medical panel physicians and (2) employ a staff physician who can oversee the panel, recruit new panel members, and review panel reports.

Medical Committee Investigating Issues Surrounding Medical Panel Solutions

Recently, the division created a "medical committee" to examine the issues and challenges facing medical panels. The committee includes representatives from all interested parties, including physicians, attorneys for employees, attorneys for insurers, judges, and commission staff. The group has identified a list of issues they plan to consider. Their efforts should help clarify the role of medical panels and help panel members understand how they should approach their work. They developed the following lists of training items to be avoided and items that should be done.

The Labor Commission formed a medical committee to identify issues and prepare training for the medical panels.

Training should direct medical panels to avoid the following:

- Chasing obscure or highly unlikely diagnosis
- Recommending tests or procedures that lack validity
- Overestimating the probability of future problems or needs
- Disproportionately focusing on pain issues
- Offering opinions on legal matters
- Recapping the employee's entire medical history without clearly identifying a connection to the panel's conclusion
- Drawing conclusions in a specialized area of medicine for which they have no training
- Raising new issues not already in dispute

Medical panels should accomplish the following:

- Explain the underlying basis for a decision
- Gain a greater understanding of medical causation
- Apply standards of reasonable medical probability
- Be specific when asked to outline future medical care

The committee has been meeting on a quarterly basis to begin addressing the above issues. They anticipate their work will result in a training curriculum for panel members.

Adjudication Division Should Provide Medical Panels with Formal Training and Written Instructions

Because the role of medical panels is so important to the adjudication process, we believe the division needs to provide better training and formal written instructions to its panel members. In fact, one of the most common recommendations we heard from judges, attorneys, and medical panel chairs is that panel members need better training and instruction.

The division needs to provide formal written guidelines and instructions to its panel members.

For example, one medical panel chair stated he, "would like to know more about what the ALJs would like to see in the medical panel reports." The physician said he has had no formal training and feels like there should be training for medical panel members. He stated he would like to know from ALJs if his reports are user-friendly. An attorney echoed similar concerns, "Procedural manuals would be helpful, and the panel chair should conform to written standards."

The division hasn't added new panel members recently, however, in the past, new panel members were given little formal guidance before they begin reviewing claims. They would be invited to meet with the division director to receive some informal instruction. The director would give them copies of past panel reports to review. A copy of the Labor Commissions' Impairment Rating Guide was also provided even though medical panels do not regularly perform impairment ratings. However, the division's policies and procedures provide little guidance on how panels should operate. We find this level of training and instruction to be inadequate.

Some medical panel chairs agree. In fact, an audit commissioned by the Governor's office found that "five out of 13 medical panel chairs surveyed said they believe training for medical panel chairs is insufficient." In response, the division has charged its medical committee, which meets quarterly, to identify issues that should be taught at future training sessions for its medical panel chairs.

The role that panels play is so important to the division's adjudication process that it warrants a more structured and formal approach than it currently receives. Judges and panel members should be given a set of formal written instructions to guide them in dealing with routine issues such as causation and establishing medical

The absence of structure and formality causes the problems we have found with the medical panel reports.

probability. Panel members should be given a template to guide them as they prepare a report. By providing medical panels and judges with a more formal structure, the division should be able to achieve more consistent results.

Staff Physician Needed to Oversee Medical Panels

A popular idea for improving the quality of medical panel reports is to provide the division with a staff physician who can act as a guide to and director of medical panels. Such a position could actually reduce the cost of the panel process. If created, the position could be funded from the same source as are regular panel members – through the Uninsured Employers' Fund.

Improved Oversight Is Possible. The current panel process has evolved from a loose set of directives that are applied differently by each panel. Greater standardization and oversight is possible through the creation of a medical panel director position with the following responsibilities:

- Create and enforce standards
- Train physician/panel members
- Increase the physician pool for panels
- Ensure panels include appropriate specialists
- Monitor the quality of medical panel reports

Cost savings may be achieved if medical panel process improvements result in a more consistent and predictable process.

Currently, the cost of medical panels is paid from the Uninsured Employers' Funds. In fiscal year 2012, the total cost of medical panels was nearly $800,000. The division estimates that the cost of salary and benefits of a part-time medical panel director would be $109,353. The cost of a fulltime position was estimated to be $205,622. We believe the cost of medical panels and a medical panel director should operate from a single budget and be funded from the same fund.

An effective medical panel director could enable the division to reduce the number of medical panels convened, thus reducing overall medical panel costs. Further cost savings might be achieved if improvements to the panel process produce a more consistent and predictable adjudication process. Increased consistency could lead to fewer requests for review and fewer cases being appealed.

Statutory Changes Are Needed. The Utah Code allows the division to cover the cost of medical panels and a medical director

from the Uninsured Employers' Fund. However, the current statute only allows for covering the cost of a medical director on a case-by-case basis. Hiring a fulltime medical panel director funded from the Uninsured Employers' Fund requires a minor modification of statutory language.

Currently ***Utah Code*** 34A-2-601 states:

> For a claim referred … to a medical panel, medical director, or medical consultant … the commission shall pay out of the Uninsured Employers' Fund the expenses of: a study or report of the medical panel, medical director, or medical consultant; and the medical panel's, medical director's, or medical consultant's appearance before an administrative law judge.

Changes in Code needed to hire a Medical Panel Director.

The above statutory language applies only to individual claims. Funding an ongoing position may require some clarification in the statute. We recommend the Legislature amend the relevant statutory language to enable the division to hire a medical panel director.

Recommendations

1. We recommend that the Adjudication Division formalize its medical panel process by adopting formal policies to govern the process and written guidelines to instruct panel members of their responsibilities.

2. We recommend that the Adjudication Division hire a physician to act as director of medical panels. The physician must have expertise in handling worker injuries and dealing with workers' compensation issues.

3. We recommend that the Legislature add language to ***Utah Code*** 34A-2-601 allowing the Adjudication Division to pay for a medical panel director from the Uninsured Employers' Fund.

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Agency Response

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February 12, 2013

John M. Schaff, CIA
Auditor General
Office of the Legislative Auditor General
W315 Utah State Capitol Complex
Salt Lake City, UT 84114

Re: Report No. 2013-03; A Performance Audit of the Labor Commission's Adjudication Division

Dear Mr. Schaff:

The Utah Labor Commission and the Adjudication Division (jointly "Commission") are pleased to provide the following response to the Auditor General's January 2013 Performance Audit ("Audit"). The Commission strongly supports the use of performance audits as an important tool to improve state government.

The Commission appreciates the Audit's measured and well-reasoned findings; while many of the recommendations were already being addressed by the new Division Director and Commission staff prior to the Audit, the Audit provides helpful and objective insight into continued areas for improvement. As discussed below, the Commission has implemented or will implement each recommendation made in the Audit.

The Commission takes seriously its responsibility to impartially and professionally adjudicate workers compensation claims and is heartened by the Auditors' conclusions that the Commission operates ethically, without bias and generally, in a timely manner. The Commission worked closely with the Auditor's Office staff throughout the audit process and looks forward to working with all stakeholders to affect real change in how the Commission adjudicates and resolves the hundreds of claims it receives each year.

The Commission addresses the Audit's specific findings and recommendations as follows.

Chapter I—"Introduction." This portion of the Audit provides general background; no response from the Commission is therefore necessary.

Chapter II—"Injured Worker Claims Can Be Resolved In A More Timely Fashion." The Commission agrees with each of the Audit's recommendations in Chapter II regarding timeliness. As discussed below, new policies and performance standards to improve timeliness have already been implemented at each step of its process.

Timely resolution of appeals:

- The Commission has reduced the backlog of pending appeals from 238 in March 2008 to 24 as of February 1, 2013.
- The Commission has established deadlines for resolving cases on appeal.

Timely resolution of claims before ALJs.

- The Commission's goal is to reduce the time for issuing orders by 50% within the next 18 months.
    - New policy requires that orders in cases referred to a medical panel be issued within 90 days (down from the 120 day standard in July 2012); otherwise final orders must be issued within 60 days. By June 2014, ALJs will be required to issue all orders within 60 days.
- The Commission is working with stakeholders to improve medical panels, which will in turn reduce the age of cases. A more detailed discussion of medical panels is included in response to Chapter III of the Audit.
- The Commission is using its database to ensure timely follow-up with medical panels.
- The Commission has improved its computerized scheduling system so as to avoid double-booking attorneys and hearing rooms.
- Clerks have been trained and are reminded of the need for accuracy and completeness in documenting case histories, and avoiding hearing continuances.
- The Division is drafting a practice manual, which will increase accuracy, consistency and efficiency of ALJs, staff, practitioners and parties.
- ALJs are required to schedule annual and planned sick leave as far in advance as possible. For unforeseen absences, another ALJ will step in to hear scheduled cases in order to avoid continuances.
- The ALJ's working hours are now set at the beginning of each year so as to avoid the continuances required by changes to the State's workweek schedule made in 2011.
- The Commission plans to undertake an "Operational Excellence" process-improvement project during the summer of 2013.

Chapter III—"No Direct Evidence of Bias Found." Impartiality and fairness to all litigants is an absolute and non-negotiable objective of the Commission's adjudicative system. The

Commission is therefore gratified that the Audit found "no evidence that the Labor Commission's proceedings are biased against injured workers."

Having said that, the Commission agrees with the Audit's comment that perceptions of bias, even when those perceptions are not correct in fact, can undermine the legitimacy of the adjudicative process. The Commission is concerned that some actions by ALJs and medical panel members allowed a perception of bias. The Commission has implemented or is in the process of developing policies to address this problem.

- In September 2012, the Commission adopted a Code of Judicial Conduct modeled after the Utah Code of Judicial Conduct. This Code imposes high standards of professionalism and ethical conduct. An ALJ's failure to abide by the Code can result in disciplinary action up to and including termination.
- The Utah Rules of Professional Conduct for attorneys have been incorporated into ALJ performance standards. Again, failure to abide by those Rules can result in disciplinary action.
- The Commission conducts annual surveys of attorneys regarding ALJ performance. The Commission has now implemented surveys for all participants after every hearing to provide feedback to ALJs and allow management timely oversight of their performance.
- In October 2013, the ALJs will be required to take a six week on-line course from the National Judicial College on "Ethics and the Administrative Law Judge."
- The Commission will no longer automatically assign the same ALJ and medical panel to all cases involving a particular injured worker.
- The Commission is providing information to medical panels regarding conflicts of interest and bias.

Chapter IV—"Greater Oversight Needed of Medical Panels." Medical panels are a critical component of the workers compensation adjudication system. Proper training and oversight of panel members is essential. Improvements to medical panels were already being made by the new Division Director and Commission prior to the Audit. As noted in the Audit, the Commission has convened a "think tank" of experienced doctors, lawyers and ALJs to examine and develop solutions for medical panel problems.

The Commission enthusiastically supports the Audit's recommendation of hiring a medical director to recruit competent panel members, provide training, and maintain the quality of panel reports. But irrespective of whether the Legislature chooses to authorize and fund a medical director, the Commission is determined to improve the medical panel process. To that end, the Commission agrees with each of the Audit's recommendations:

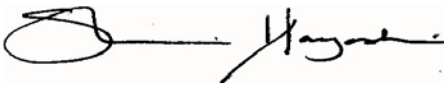
- The Commission is drafting model instructions and questions to help medical panels understand issues presented to them, and apply the correct standards to those issues.

- The Commission is working with ALJs to improve the quality and scope of the interim orders they send to medical panels.
- The Commission will require that every panel include at least two members.
- To reduce backlog, the Commission is working with recruiting new panel members throughout Utah who have a variety of medical expertise.
- The Commission will continue to hold its annual training conference for medical panelists but with a more comprehensive curriculum.
- The Commission will improve its procedure for handling objections to medical panel reports.

CONCLUSION

The Commission appreciates the effort put forth by the Auditor General's staff in conducting this Audit. The staff exhibited the highest level of professionalism, thoughtfulness and concern about "getting it right." The Commission is committed to implementing all of the Audit's recommendations over the next several months and will carry on with the continuous process of identifying additional methods to promote the timely and fair adjudication of disputes coming before it.

Sincerely,



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