AR-1

Accountability Review Findings

Dates of Review: September 9, 2013 – September 13, 2013

Office Reviewed: Cleveland District Office

Reviewing Office: Branch of Policy, Regulations and Procedures

Review Period: July 1, 2012 – June 30, 2013

Standard:	Category #: 1 Category Name: Part B Initial Claims

Sample Size (total # of indicators in the element that were reviewed):	573
Number of cases reviewed:	45
Number of errors in element:	22
Acceptable rating:	85%
Rating for review:	96

Describe Findings:

The majority of Part B initial claims were processed correctly and timely. Recommended Decisions were written at a high quality standard, with several examples of cases where the assigned CE excelled. There were at least 5 cases where the assigned CE carefully structured the Recommended Decision in a logical and claimant-friendly manner. For example, many CE's in the pool used introductory and conclusory statements regarding the key issues in the Explanation of Findings, which could probably be identified as a best practice.

In terms of readability, there were a few Recommended Decisions which highlighted areas for improvement that did not necessarily rise to the level of an error. Consistency in placement of information in the decision could be helpful to readers; for example, in this sample pool, the pertinent facts of the case were found in different sections of the RD, either in the Statement of the Case or Explanation of Findings, and sometimes in the Conclusions of Law. Although all Recommended Decisions reviewed included the pertinent facts somewhere in the body of the decision, the best decisions included all facts with dates and quantitative data in the Statement, generalized facts with analysis in the Explanation of Findings, followed by a brief Conclusions of Law.

Development letters in the sample pool met the requirements soliciting for necessary information on the claim.

TRENDS IN ERRORS:

- There were 2 errors which would affect the adjudication outcome. For example, EE4's alone cannot establish employment. In another example, contemporaneous evidence verifying isolated dates was inappropriately used to verify a continuous multi-year period.
- There were some errors that did not affect outcomes. Missing the earliest accepted diagnosis date for the condition being accepted. Missing latency period for kidney cancer. States incorrectly that employee must be a contractor employee, even for Part B. Incorrectly indicates that NIOSH could not reconstruct a dose.
- There were other non-substantive errors, which involved formatting and logic. Structure - an introductory/conclusory statement regarding the key issue can help. Conciseness – favoring long quotations over paraphrasing would be clearer. Repetition – Dose requirement, SEC requirements repeated in multiple sections of the RD. Standard – not spelling out the survivorship requirements and why one party is entitled to benefits.

Improvements Since Last Accountability Review:

Other Significant Findings:

REVIEWER(s):	DATE:
Monica Yoon	9/13/2013

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Reviewing Office: Branch of Policy, Regulations and Procedures

Review Period: July 1, 2012 – June 30, 2013

Standard:	Category #: 2 Category Name: Part E - Causation Claims

Sample Size (total # of indicators in the element that were reviewed):	551
Number of cases reviewed:	45
Number of errors in element:	59
Acceptable rating:	85%
Rating for review:	88%

Describe Findings:

Overall, the findings of the Accountability Review found that Claims Examiners conducted good development and analysis of causation. Development letters provided good information regarding what evidence was needed to resolve causation issues and recommended decisions were well written.

In general, the Claims Examiners utilized the relevant resources (including SEM) in order to develop for occupational exposure. However, SEM was not always filtered correctly because in certain cases the Claims Examiner would start the search by filtering the employee's job category instead of first filtering by the health effect based in accordance with policy.

In some cases (for example [redacted] and [redacted] the Contact Medical Consultants made the exposure determination and offered opinions based on their own assessments of the level of exposure or lack thereof. In most those cases, there was no attempt to make an assessment as to the level of exposure so an accurate medical opinion could be obtained.

We also reviewed quite a few hearing loss cases. In hearing loss cases, a diagnosis of bilateral sensorineural hearing loss is a part of the causation determination in accordance with program policy. A trend we noticed in a number of the cases (for example [redacted] was that the Claims Examiner accepted a diagnosis of bilateral sensorineural hearing loss that was made by an audiologist. Audiologists are not physicians according to program policy and should not be used as a source of a diagnosis.

In several cases (for example [redacted], the cover letter did not summarize what conditions were being accepted, denied or deferred. For example, the cover letter would state "This is a recommended partial acceptance" but would not indicate the conditions that were denied or deferred.

Some of the Explanation of Findings sections in the Recommended Decisions were conclusory and did not include sufficient analysis as to the specific factors used to establish causation in the cases. In some cases, the analysis was provided instead in the Statement of the Case section. However, in some cases (for example [redacted]), there was a lack of analysis to be found in the entire decision. For example, Claims Examiners did not always explain how they identified the toxins that were referred. In those cases, the Claims Examiner usually referenced the SEM and other sources in the Recommended Decision but did not provide an analysis of **how** SEM or the other sources resulted in a finding that the employee had exposure to the identified toxins.

Finally, some recommended decisions (for example [redacted]) are still using an exhaustive list of conclusions of law instead of making a clear and concise statement regarding what is accepted and/or denied.

Improvements Since Last Accountability Review:

Other Significant Findings:

In the majority of cases that were not referred to the IH, there is no analysis being performed regarding the extent of exposure. Any toxin listed in SEM is being taken as confirmed exposure and being sent the CMC for opinion. The CMC will at times make a determination as to extent and duration. While it was determined that this was not an error for the AR, it is clearly an issue for further discussion.

REVIEWER(s):	DATE:
David Flores	9/13/13
Yolanda Banks	9/13/13

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Reviewing Office: Branch of Policy, Regulations and Procedures

Review Period: July 1, 2012 – June 30, 2013

Standard:	Category #: 3 Category Name: Part E - Impairment Claims

Sample Size (total # of indicators in the element that were reviewed):	497
Number of cases reviewed:	46
Number of errors in element:	21
Acceptable rating:	85%
Rating for review:	95%

Describe Findings:

The 2013 AR for the Cleveland District Office regarding Category 3 *Impairment Claims* shows high performance standards. Specifically, development letters in this area were outstanding, providing the correct medical requirements necessary for Contract Medical Consultant reviews. The district office is also noted for excellent customer service and diligent attention to details for providing all needed medical evidence to Contract Medical Consultants for impairment rating. There were few errors found mainly in the recommended decisions although overall, the review did not find any specific trends. The few errors found are as follows:

Reviewers found that in one of the recommended decisions ([redacted], the impairment doctor provided an impairment report and in the report he referenced medical evidence that was not found as part of the case file.

In a couple case files ([redacted]) the recommended decisions provided repetitive information in the statement of the case/explanation of findings.

Case [redacted], the recommended decision provided incorrect values in the calculation of the employee's impairment rating and the incorrect values were also found in ECS.

Lastly, case [redacted] the recommended decision was based on the condition of colon cancer although in the explanation of findings the conditions of pulmonary fibrosis, pneumoconiosis and COPD were mentioned.

Improvements Since Last Accountability Review:

Other Significant Findings:

REVIEWER(s):	**DATE:**
Melissa M Cortes	09/13/13

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Office Reviewed: Cleveland District Office

Reviewing Office: Branch of Policy, Regulations and Procedures

Review Period: July 1, 2012 – June 30, 2013

Standard:	Category #: 4 Category Name: Part E - Wage Loss Claims

Sample Size (total # of indicators in the element that were reviewed):	406
Number of cases reviewed:	36
Number of errors in element:	31
Acceptable rating:	85%
Rating for review:	91%

Describe Findings:

The overall review of the findings for wage loss indicates that the claims examiners are developing the cases timely and they are thoroughly reviewing the medical and employment evidence in determining if loss wages is warranted.

The overall review on the recommended decisions for wage loss shows the claims examiners are writing in a clear and concise manner so that the reader can easily interpret the information. The decisions are well written in a logical order and the claim examiners are thoroughly notating the calculations used in arriving at the award amount.

Some specific AR findings include:

[redacted] The survivor was awarded $25,000.00 based on presumptive 10 to 19 year wage loss. The employee may have 20 years of wage loss period. Development should been done to determine if the employee's earning for 1965 was less than 50% of his AAW, if so, the survivor has a potential award of $50,000.

[redacted] The introductory paragraph stated the survivor was entitled to $275,000 but the actual amount was $300,000. The CoL stated that the survivor was entitled to $125,000.00 under Part E but she was actually entitled to $150,000 (this incorrect statement appeared in paragraph 3 from the bottom).

[redacted] This was a wage loss denial. The Statement of the Case fails to mention the development letters that were sent out, requesting the employee provide medical evidence from a physician. The Statement of the Case first mentions FAB accepted COPD on April 17, 2012, then mentions the FAB awarded the employee impairment benefits for COPD on July 06, 2012. Second paragraph mentions the employee claimed WL and the date. Third paragraph mentions all the verified employment dates at Portsmouth and Savannah.

[redacted] The Statement of the Case and Explanation of Findings for wage loss were exactly the same. The Explanation of Findings failed to mention that the employee's NSSRA is 66 year old, per SSA, and that he would have reached is NSSRA in 2015.

[redacted] The CE failed to include wages of $13,126.41, for the year 2010 in the wage loss calculations.

[redacted] The CE accepted the claim for wage loss based on [redacted] medical reports. The physician never stated the employee was unable to work due to covered illness for the periods of 2011 and 2012.

[redacted] The conclusions of law contained 6 paragraphs and stated the employee "is a covered employee" twice; "a covered contractor employee" twice and listed citations from 42 U.S.C. for Part B and Part E.

[redacted]- The Statement of the Case contained irrelevant information; fails to mention the name of the physician that indicated the employee was unable to work during the particular time frame in question and the CE stated " the medical paperwork was simply too difficult to comply". In the Explanation of Findings the CE stated that "the evidence does establish that your covered illness contributed to your wage loss".

[redacted] The medical evidence for wage loss for the years 2011 and 2012 was based on a letter dated January 18, 2011, from a doctor, in which he opined "he certainly is unable to return to any occupation at this time".

Five wage loss cases did not have the wage loss calculation worksheets in the case file.

Improvements Since Last Accountability Review:

Other Significant Findings:

REVIEWER(s):	**DATE:**
Jean LaFontant	9/13/13

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Reviewing Office: Branch of Policy, Regulations and Procedures

Review Period: July 1, 2012 – June 30, 2013

Standard:	Category #: 5 Category Name: Payment Processing

Sample Size (total # of indicators in the element that were reviewed):	421
Number of cases reviewed:	71
Number of errors in element:	6
Acceptable rating:	90%
Rating for review:	99%

Describe Findings:

The Cleveland District Office did an exceptional job on payment processing. They are diligent at correcting deficiencies by requesting new EN-20s when necessary, making phone calls for clarifications, checking the USPS website for a best address, etc., to avoid any potential problems in the processing of payments. They are also very conscientious about placing memos in the file to explain any potential issues with a claimant's completion of the EN-20. The office exercises good judgment on when a memo can be added to file, instead of burdening the claimants for completion of new EN-20s, which delays payments. This shows good quality customer service.

There were only six errors found on the 70 cases reviewed.

Three cases had issues with the AOP received date. Case [redacted] was not date stamped. Case [redacted] had two date stamps, one day apart, with no explanation why they used one date over another. And case [redacted] had a different AOP received date in ECS than what was date-stamped on the actual form.

Another case, [redacted] the claimant abbreviated a portion of their street name (Chester) with only "CH", which is not a standard abbreviation. The PTF & ECS reflected the full name of the street. There was no memo of explanation, phone call to verify which to use, no checking the address in USPS, and no request for a new EN-20. The discrepancy on the EN-20 vs. the PTF/ECS led to an error on the indicator that verifies the claimant submitted a valid EN-20. It also led to an error on the indicator that verifies whether the PTF was completed correctly.

Finally, there was one case, [redacted], which did not reflect a phone call was made to verify the account and routing information (in the file or ECS).

Overall, they did an excellent job.

Improvements Since Last Accountability Review:

Other Significant Findings:

REVIEWER(s):	**DATE:**
Sarah Friedman	September 13, 2013
Melissa Cortes	September 13, 2013

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Office Reviewed: Cleveland District Office

Reviewing Office: Branch of Policy, Regulations, and Procedures

Review Period: July 1, 2012- June 30, 2013

Standard:	Category #: 6 Category Name: Reopening Requests

Sample Size (total # of indicators in the element that were reviewed):	180
Number of cases reviewed:	30
Number of errors in element:	2
Acceptable rating:	85%
Rating for review:	99%

Describe Findings:

For this category, the Accountability Review team reviewed cases with reopening requests received by and resolved by the district office within the AR period. In this review, the Cleveland District Office excelled in the reopening category with a 99% rating. While a trend wasn't noted, the two documented errors are as follows:

- [redacted]: Within the case history section of this Director's Order of November 9, 2012, the writer unnecessarily references Part B criterion for a Part E COPD reopening.

- [redacted]: In this case, the claimant was issued two separate final denials regarding his cancer claim, one under Part B and the other under Part E. The claimant requested that his Part E denial be reopened and SEM searched for new toxic exposure. The background section of the reopening order of November 1, 2012, included irrelevant Part B acceptance criterion.

Improvements Since Last Accountability Review:

Other Significant Findings:

None

REVIEWER(s):	DATE:
Rodney Alston	September 13, 2013

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Reviewing Office: Branch of Policy, Regulations and Procedures

Review Period: July 1, 2012 – June 30, 2013

Standard:	Category #: 7 Category Name: In-Home Health Care Requests

Sample Size (total # of indicators in the element that were reviewed):	142
Number of cases reviewed:	45
Number of errors in element:	9
Acceptable rating:	85%
Rating for review:	93%

Describe Findings:

Overall, the review indicated compliance with all procedures with few exceptions. In general Home Health Care (HHC) authorization requests were addressed in a timely and accurate manner, with all applicable development letters and HHC approval/denial letters documented in the case file. Of the cases that were found to be in error, the reviewers noted the following:

1) In three of these cases, the approvals were incorrect based on the information provided either in duration of approval or the extent.
2) In one case, the letter of medical necessity from treating physician and plan of care ordered 12 hours/wk of RN/LPN and 12 hours/month of TCM. The thread approved only the RN/LPN for the 12 hours/wk for the DOS of 6/26/11 to 12/22/11. Also saw no face to face examination notes submitted with the HHC request. Also the approval letter authorizing the HHC was not located in the file.
3) One case reviewed there was no evidence of face to face examination and no plan of care that was submitted with the HHC request.

Improvements Since Last Accountability Review:

Other Significant Findings:

REVIEWER(s):	**DATE:**
Sandra Dillard	09/13/2013