New Jersey State Legislature
Office of Legislative Services
Office of the State Auditor

Department of Labor and
Workforce Development
Temporary Disability Benefit Payments

July 1, 2006 to March 2, 2009
The Honorable Jon S. Corzine  
Governor of New Jersey

The Honorable Richard J. Codey  
President of the Senate

The Honorable Joseph J. Roberts, Jr.  
Speaker of the General Assembly

Mr. Albert Porroni  
Executive Director  
Office of Legislative Services

Enclosed is our report on the audit of the Department of Labor and Workforce Development, Temporary Disability Benefit Payments for the period of July 1, 2006 to March 2, 2009. If you would like a personal briefing, please call me at (609) 292-3700.

Stephen M. Eells  
Assistant State Auditor  
August 26, 2009
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Department of Labor and Workforce Development
Temporary Disability Benefit Payments

**Scope**

We have completed an audit of the Department of Labor and Workforce Development, Temporary Disability Benefit Payments for the period July 1, 2006 to March 2, 2009. The audit included benefit payments accounted for in the State Disability Benefit Fund to those individuals entitled to disability benefits who are not covered by the Workers’ Compensation Law. Average annual expenditures totaled $450 million. The State Disability Benefit Fund is primarily funded by contributions from both New Jersey workers and employers.

The department’s primary mission is to ensure the opportunity for employment at fair wages in a safe environment, enhance the quality of the state’s labor force, and administer income support services.

**Objectives**

The objectives of our audit were to determine whether financial transactions were related to the disability program, were reasonable, and were recorded properly in the accounting systems. Another objective was to determine the adequacy of internal controls over the processing and review of disability claims.

This audit was conducted pursuant to the State Auditor’s responsibilities as set forth in Article VII, Section I, Paragraph 6 of the State Constitution and Title 52 of the New Jersey Statutes.

**Methodology**

Our audit was conducted in accordance with Government Auditing Standards, issued by the Comptroller General of the United States.

In preparation for our testing, we studied legislation, administrative code, circular letters promulgated by the Department of the Treasury, and policies of the department. Provisions that we considered significant were documented and compliance with those requirements was verified.
by interview, observation, and through our samples of transactions. We also read the budget message, reviewed financial trends, and interviewed agency personnel to obtain an understanding of the program and the internal controls.

A nonstatistical sampling approach was used. Our samples of financial transactions were designed to provide conclusions about the validity of transactions as well as internal control and compliance attributes. Sample populations were sorted and transactions were judgmentally selected for testing.

**Conclusions**

We found the financial transactions included in our testing were related to the disability program, were reasonable, and were recorded properly in the accounting systems. We also found that controls are adequate to ensure that disability claims are processed in compliance with program regulations. In making these determinations, we noted matters of compliance with regulations and certain internal control weaknesses meriting management’s attention. We also identified an opportunity for cost savings.

**Background**

The Temporary Disability Insurance State Plan is a benefit program which partially offsets wage loss suffered by employees because of their inability to perform regular job duties due to non-occupational illness or injury. This program is administered by the Division of Temporary Disability (division) within the Department of Labor and Workforce Development. The application process involves the submission of an application by the claimant, a medical certificate by the treating physician, and statements of wages from employers. These documents are received in the division’s Claims Intake section where they are scanned, imaged, numbered, and randomly assigned to a claims examiner. The original documents are reviewed by the claims examiner who enters the required information into the Disability Automated Benefits System (DABS) for processing. The DABS system calculates benefits, generates checks, maintains
claim histories, and generates forms and mailings for the program.

The Medical Review Unit Procedures manual outlines the procedures to be followed if a claim appears to be questionable, as in the following instances:

- Medical condition is of a subjective nature;
- Prognosis date extends 10 to 14 days past the current date or is unusually long for the illness or injury;
- Claimant is not under the care of a specialist; or
- Claimant has a high frequency of claims.

The Medical Review Unit (MRU) reviews selected claims upon receipt in the Claims Intake section. When a claims examiner determines that a disability claim is questionable, the case is also presented to the MRU. The MRU may approve or deny the claim, or decide that the claimant should meet with an independent medical examiner for a determination of eligibility.
Reliability of Disability Automated Benefits System Information

Claims examiners post information from disability claim applications into the Disability Automated Benefits System (DABS). When reviewing requests for claim extensions, the examiners have the ability to post to DABS by "cloning" the applicant's previous claim screen. Cloning involves creating a new screen with previous claim data and then updating it with new information which allows the examiners to save time in processing claims. Division personnel explained that this procedure is often utilized, sometimes without properly updating all of the information from the previous screen. They also stated that examiners occasionally post incomplete or incorrect information on DABS from the original claims. Our review of the source information for 21 cases we were testing for proper referral to an independent medical examiner confirmed these statements. DABS did not contain accurate or up-to-date information for eight of these cases. Examples of information that was not accurate were diagnoses and treating doctors. The specific characteristics of these cases did not allow us to project the extent of this problem. However, this should be a concern of management since an average of 9000 claim extensions are filed each month and are therefore subject to cloning.

The information on DABS is used to generate a variety of periodic reports summarizing claims according to a number of characteristics that are used to monitor the program. Our audit included various tests which analyzed DABS information. When DABS screens are not properly posted or updated, these monitoring reports and audit analyses are based on inaccurate information and cannot be relied upon to make proper judgments about the status of disability claims or as guides to select cases for review. Information about program performance needs to be accurate and
timely to enable management to make well-informed decisions.

**Recommendation**

Management should ensure claims examiners are accurately posting and updating DABS screens.

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**Documentation of Independent Medical Examinations**

The Medical Review Unit (MRU) decides whether questionable cases should be forwarded to an independent medical examiner (IME) based on their initial review or referrals from claims examiners. There are 49 doctors throughout the state who have been contracted by the Department of Labor and Workforce Development as IMEs to examine claimants to determine the validity of their disability claims.

Our review disclosed that the program does not maintain adequate documentation for its IME review process. The division does not record the claims that are referred to the MRU by the claims examiners. A record is maintained of the number of claims submitted to and denied by IMEs as a result of the MRU’s initial review. However, this record does not provide any information regarding the reasons for submission to the IME and for the IME’s eligibility determination. Maintaining such documentation could provide insights as to the types of cases that are more or less likely to be denied and would provide guidance for the selection of claims that should be referred to IMEs in the future. As a result of this lack of documentation, management cannot determine whether the IME process is being effectively utilized.

**Recommendation**

The division should record claims referred to the Medical Review Unit by claims examiners. In addition, the record of cases referred to and
decided by IMEs should include a schedule that provides the reasons for submission and eligibility determination.

Utilization of Independent Medical Examinations

The number of claims being sent to independent medical examiners (IME) based on the Medical Review Unit's (MRU) initial reviews has declined significantly in the past two years. During calendar years 2003 to 2007, approximately 1520 cases per year were sent to IMEs. An average of 530 cases were denied each year, representing a denial rate of 35 percent. A total of 1205 cases were sent to IMEs and 561 cases were denied in 2008. As of April 30, 2009, only 245 cases have been sent to IMEs. If this rate continues, only 735 cases will be sent to IMEs for the entire year.

Our review of sample claims revealed a number of claims that should have been sent to IMEs according to the terms of the program manual but were not. For example, the manual states that claims should be referred to an IME when multiple claims have been submitted by a claimant. Our tests of 20 claimants who filed four or more claims from July 1, 2006 to October 10, 2008 revealed that none of these claims had been forwarded to an IME. One claimant with 40 claims since 1989 was never referred to an IME. The manual also recommends referral to an IME for subjective diagnoses and claims approved by non-specialists. These subjective diagnoses include headache, fatigue, and muscle spasms. We analyzed a DABS report from January 31, 2009 to test the referral process. Based on this analysis, we reviewed 13 claims signed by nurse practitioners for diagnoses that were subjective in nature and that exceeded the average number of benefit days. These claims had not been sent to
IMEs. We determined that seven of these claims should have been forwarded to an IME.

Division personnel stated that reductions in staff were the reason for the decline in IME referrals. The high percentage of denials indicates that it is beneficial to continue submitting a significant number of cases to IMEs and that a decrease in referrals could have a negative impact on the reduction of unwarranted disability payments.

**Recommendation**

The division should refer more questionable cases to IMEs. In addition, they should evaluate whether it is cost-beneficial to allocate additional resources to the MRU. Notifying claimants who request multiple extensions that they may be subject to an independent medical examination, which is a proposal the division is considering, could be one method to increase the utilization of IMEs and reduce unwarranted claims.

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**Opportunity for Cost Savings**

**Partial Return to Work Program**

In New Jersey, claimants deemed eligible for temporary disability benefits receive full benefits up until the day they return to work. Our review disclosed another state uses a partial return to work program which transitions employees back into the workplace. This results in employers providing wages for hours worked in a given week, which reduces payments made by the disability program. According to a progress report prepared by the other state, $480,000 was paid to partial return to work program participants from September 1, 2006 to August 31, 2007. This is substantially less than the projected $1.2 million of payments had they collected the full amount of disability benefits during this time period.
Recommendation

The Department of Labor and Workforce Development should consider the implementation of a partial return to work program.
August 19, 2009

Mr. Stephen M. Eells
Assistant State Auditor
Office of Legislative Services
Office of the State Auditor
125 South Warren Street
P.O. Box 067
Trenton, New Jersey 08625-0067

Dear Mr. Eells:

Thank you for the opportunity to respond to your audit report entitled “Department of Labor and Workforce Development Temporary Disability Benefit Payments.” I am pleased with your overall audit conclusion that the departmental financial transactions you tested were reasonable, recorded properly in our accounting systems, and that our controls were adequate to ensure that disability claims are processed in compliance with program regulations.

We do note that you have made some recommendations for improving controls and operations and have included cost saving opportunities for the Department to consider. We have already implemented some changes based on your recommendations and will carefully review others to determine if they can be implemented in a cost effective manner, especially considering the limited resources available.

Details of our response to your recommendations are contained in the attachment to this letter. If you have any questions, please contact James King, Director of Internal Audit.

Sincerely,

[Signature]
COMMISSIONER

Attachment
Audit Report Recommendation:

Management should ensure claims examiners are accurately posting and updating DABS screens.

LWD Response

We concur. We will continue to strive for accurate posting and updating of the DABS screens. Based on your findings, management will issue periodic reminders and reinforce in our training of staff the importance of updating diagnosis and physician information especially when cloning segments on claim extensions. Claims with subjective diagnosis, changes in treating physicians and multiple extensions represent the minority of claims the division processes, which makes periodic reminders even more important.

Audit Report Recommendation:

The division should record claims referred to the Medical Review Unit by claims examiners. In addition, the record of cases referred to and decided by IME’s should include a schedule that provides the reasons for submission and eligibility determination.

LWD Response

We concur. The division has already implemented changes to the IME report that is produced weekly to better monitor the number of claims reviewed and the outcomes of the IME’s. These reports are manual counts of claims reviewed which are then recorded on spreadsheets. The reports will be further refined to ensure compliance with this recommendation.

Audit Report Recommendation

The division should refer more questionable cases to IME’s. In addition, they should evaluate whether it is cost-beneficial to allocate additional resources to the MRU. Notifying claimants who request multiple extensions that they may be subject to an independent medical examination, which is a proposal the division is considering, could be one method to increase the utilization of IME’s and reduce unwarranted claims.

LWD Response

We concur in part. The volume of claims referred for IME’s has decreased since the staff within the Medical Review Unit and the Division of Temporary Disability was reduced as a result of the Early Retirement Incentive in July 2008. Claim staff is no longer available to review and refer the previous volume of claims for examinations.
To the extent that resources remain limited, compliance with referring more cases to IME’s may not be possible. The Division does plan to address other aspects of the IME process including additional training for claims staff with emphasis on how to identify individuals that should be referred for an IME. Also, as stated in your recommendation, we are considering a proposal to notify claimants requesting multiple extensions that they may be subject to an independent medical exam.

Audit Report – Opportunity for Cost Savings

The Department of Labor and Workforce Development should consider the implementation of a partial return to work program.

LWD Response

This issue is not within the control of the Department.

A partial return to work program would require a change to the Temporary Disability Insurance law. While a partial return to work provision may lead to savings in the form of reduced benefit payments, it would be accompanied by a corresponding increase in the administrative cost of the program. In addition, the potential for higher claim incidence exists depending on the approach used to create the partial return to work provision. A more extensive cost-benefit study would need to be performed to assess the value of such a provision, and given the limited resources and the uncertainty of obtaining legislative action, this is not likely to happen in the near future.