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BY THE COMPTROLLER GENERAL

Report To The Congress

OF THE UNITED STATES

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Injury Compensation Process Delays Prompt Payment Of Benefits To Federal Workers.

Payments of benefits under the Federal Employees' Compensation Act are not being made on time as measured by the Department of Labor's criteria for timeliness. Delays occur at each level of claims processing. GAO found that injured workers, their employing agencies, physicians, and Labor contribute substantially to delays. The average processing times from the date workers made the claims to the date of payment were 129 days for traumatic injuries and 270 days for occupational diseases. In most cases, the criteria allow 5 to 10 days, respectively, for workers and Federal agencies to submit claims and Labor 5 days to make payment.

Labor has taken or has planned actions to help workers, Federal agencies, and physicians become more aware of their rights, responsibilities, and roles in the injury compensation program. Labor has also taken or has planned actions to improve its claims processing. The effect of these actions on timeliness cannot yet be determined because some planned actions have not been implemented. GAO is recommending that Labor take additional actions to improve claims processing times and that the Office of Management and Budget consider assigning more claims processing responsibilities to Federal agencies to help improve timeliness.

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GAO/HRD-81-123
SEPTEMBER 25, 1981

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON D.C. 20548

B-203935

To the President of the Senate and the
Speaker of the House of Representatives

This report discusses claims processing problems that are delaying the prompt payment of benefits under the Federal Employees' Compensation Act. Federal workers who sustain employment-related injuries have remedy against the Government only by the act and prompt payment of benefits is necessary for them to avoid financial hardship.

We made our review at the request of Congressmen John P. Hammerschmidt and Pat Williams; Senator John C. Danforth; former Senator Warren G. Magnuson; the former Chairmen of the Subcommittee on Civil Service and General Services of the Senate Committee on Governmental Affairs and the House Committee on Post Office and Civil Service; the former Chair of the Subcommittee on Compensation and Employee Benefits of the House Committee on Post Office and Civil Service; and the former Chairman of the Subcommittee on Human Resources of the Committee on Post Office and Civil Service. Each of the requestors stated their concern that administrative deficiencies cause delays in claims processing.

Copies of this report are being sent to the Director, Office of Management and Budget, and the Secretary of Labor.

Milton J. Socolar

Acting Comptroller General
of the United States

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

INJURY COMPENSATION PROCESS DELAYS PROMPT PAYMENT OF BENEFITS TO FEDERAL WORKERS

D I G E S T

Payment of benefits under the Federal Employees' Compensation Act are not being made within the Department of Labor's criteria for timeliness at the four district offices GAO reviewed.

The former Chairmen of the Subcommittee on Civil Service and General Services of the Senate Committee on Governmental Affairs and the House Committee on Post Office and Civil Service, the former Chair of the Subcommittee on Compensation and Employee Benefits of the House Committee on Post Office and Civil Service, the former Chairman of the Subcommittee on Human Resources of the House Committee on Post Office and Civil Service, and several other members of the Congress asked GAO to review the claims processing system for administrative deficiencies that were causing delays in the settling of claims. This report responds to their requests for an evaluation of claims processing problems.

The act provides for compensation benefits to Federal workers who sustain employment-related injuries. Injured workers make claims for benefits. Their employing agencies and physicians provide evidence supporting claims and Labor determines eligibility and, if approved, pays the claims. (See p. 1.)

To evaluate timeliness of claims processing, GAO reviewed a sample of 564 compensation payments made during the first 6 months of fiscal year 1980 in Cleveland, Denver, Jacksonville, and Washington, D.C. GAO found that, under Labor's criteria, about 98 percent of the payments for wage loss were not timely--average processing times from the date workers made the claim to the date of payment were 129 days for traumatic injuries and 270 days for occupational diseases. In most cases, the criteria allow 5 and 10 days, respectively, for workers

and Federal agencies to submit claims and Labor 5 days to make payment. (See pp. 4 to 6.)

Workers, Federal agencies, physicians, and Labor must coordinate the processing of claims, and the failure of any party to act promptly at a given point can delay the entire process. GAO found that all parties contribute substantially to delays in claims processing.

--Injured workers are not filing timely and well-documented injury notices and compensation claims.

--Federal agencies are not complete or timely in processing injury notices and claims.

--Physicians' reports are often untimely and incomplete.

--Labor's actions to (1) resolve questions about notices of injury and (2) develop and pay claims are not timely. (See pp. 7 and 28.)

Reasons why workers, Federal agencies, and physicians are not prompt with their claims processing responsibilities were not determinable from the case files. Labor and other Federal officials told us, however, that there were a number of reasons. Workers do not fully understand their responsibilities, are lax in completing claims forms, and are careless about providing details on the cause of injury. Supervisors and compensation clerks do not fully understand the procedural requirements of the injury compensation program and compensation clerks often have additional duties.

Also, they said that physicians often do not follow instructions for furnishing medical reports, do not provide necessary medical rationale to justify opinions on the relationship between injuries and employment, and provide only information that workers want documented. (See pp. 14, 15, 20, 21, and 24.)

Labor has taken or has planned actions to help workers, Federal agencies, and physicians better understand their claims processing responsibilities. For example, Labor has issued instructions

requiring agencies to (1) provide their workers pamphlets and (2) place posters in the workplace describing what to do when injured. GAO noted, however, that at the agencies GAO visited their efforts to help workers become aware of their rights and responsibilities were sporadic. (See pp. 14 and 15.)

Labor also conducts seminars and workshops for personnel of the Federal agencies on injury reporting and claims processing. For example, 3-day workshops train compensation clerks on claim form accuracy and completeness and coordinating claims processing. Labor's records indicate that the agencies are making extensive use of this assistance, and a Labor study showed that compensation clerks attending the workshops prepared more error-free claims than those by their untrained counterparts. (See p. 21.)

To improve timeliness, Labor's Jacksonville district office and the Tennessee Valley Authority are experimenting with electronic transfer of claims. (See p. 22.)

Labor is also developing a national medical program to improve cooperative efforts with the medical community. Labor officials believe that the program will improve communication with medical personnel, enhance their understanding of claims processing, and encourage compliance with procedures. (See p. 24.)

GAO found or was advised by Labor officials that a large claims workload and staff problems--such as the need for full-time permanent staff instead of temporary employees--contributed to Labor's processing problems. (See p. 32.)

In recent years, Labor has begun or has planned actions to improve its claims processing. For example, Labor has begun automating its manual claims processing system. GAO has found that Labor's actions show promise for improved processing procedures, but it is too early to evaluate their impact on timeliness. (See p. 40.)

Labor has also made legislative proposals on pay increases for its medical staff and changing the appeals process to correct problems slowing claims processing that are beyond its administrative control. (See p. 44.)

GAO concludes that:

--Labor's actions to help agencies inform workers about their rights and responsibilities before injuries occur are generally sufficient. However, agencies' efforts to promote awareness of the injury compensation program were sporadic.

--Delays resulting from supervisors and compensation clerks not having adequate knowledge about claims processing and the clerks having additional duties are problems that must be dealt with by Federal agencies.

--Labor's actions should be expedited to inform physicians of their roles and responsibilities. Its actions recognize that well-informed physicians are essential to timely claims processing. (See p. 25.)

--The problems of workload and staffing may be lessened significantly through Labor's recent actions to improve claims processing. Until these actions are fully implemented, however, it is difficult to determine their impact on improving timeliness. (See p. 44.)

GAO believes that Labor's use of a through-the-mails operation for claims processing, rather than one of onsite investigations and personal contact, greatly diminishes its ability, in many cases, to gather information vital to making prompt determinations of workers' eligibility to receive compensation benefits. An alternative would be to adopt claims processing techniques used in the workers' compensation insurance industry. Such techniques emphasize onsite investigations to gather injury details and immediate, close, and continued personal contact with injured workers, their employing agencies, and physicians. Additional claims processing responsibilities incorporating similar techniques could be delegated to Federal agencies. (See p. 46.)

RECOMMENDATIONS TO THE SECRETARY OF LABOR

GAO is making recommendations to enhance workers' awareness of their rights and responsibilities under the injury compensation program and to improve claims processing by Federal agencies and physicians. (See p. 26.)

RECOMMENDATION TO THE DIRECTOR, OFFICE OF MANAGEMENT AND BUDGET (OMB)

In view of the potential advantages that could stem from adopting compensation techniques used in the workers' compensation insurance industry, the Director of OMB should determine the feasibility of placing in the Federal agencies specific processing and monitoring responsibilities for workers' compensation claims, such as

--onsite investigations of injuries to gather injury data and to assure, if necessary, the propriety of continuing compensation payments;

--marshalling injury data, including medical evidence, to assist injured workers establish claims;

--obtaining medical progress reports at appropriate intervals to provide current information about the worker's medical condition; and

--handling inquiries from injured workers and their families, physicians, and Labor.

If the Director determines that placing additional claims processing responsibilities in the Federal agencies is feasible, he should submit legislation to the Congress to so amend the act. (See p. 50.)

AGENCY COMMENTS

Labor concurred with GAO's findings for causes delaying compensation payments to injured Federal workers and agreed to take action on GAO's recommendations. Labor believed that, while GAO's statistics on processing times were probably accurate for the time of its review, Labor's statistics on the processing of traumatic notices of injury indicate that current processing times are better. According to Labor, the improvement in processing traumatic injury notices reflects considerable improvement in making compensation payments. Labor expects further improvements through automating compensation payments and from legislation proposed by the administration which would free the processing system from many minor injuries, thus allowing the Office of Workers' Compensation

Program's claims examiners more time to concentrate on cases with compensation claims. (See pp. 27 and 45.)

Regarding GAO's proposal that OMB determine the feasibility of delegating to Federal agencies additional claims processing responsibilities, Labor stated that it was preparing regulations to require Federal agencies to provide improved claims information and conduct investigations (for the Office of Workers' Compensation Programs). OMB stated that determining whether Federal agencies should take on added responsibilities would not be meaningful at this time. OMB cited Labor's actions to improve the processing of claims and the administration's proposed legislation to correct a number of deficiencies in the act as its basis for not undertaking the study. (See p. 49.)

GAO believes that Labor's actions to improve claims processing will result in more timely processing of claims. However, timely processing of traumatic injury notices does not necessarily indicate that compensation payments are made more promptly and estimates on the extent of that improvement are speculative until Labor's automated compensation system can accurately show processing times for wage loss claims. GAO did not evaluate the administration's legislative proposal, which was included in the Omnibus Budget Reconciliation Act of 1981, H.R. 3982, but subsequently deleted. (See p. 45.)

GAO also believes that Labor's actions to promulgate regulations requiring Federal agencies to provide better claims information and make investigations are in line with GAO's recommendation to increase Federal agencies' involvement in the injury compensation program. Labor's authority to further increase their involvement to the extent GAO is recommending may be limited. GAO disagrees with OMB's position not to determine at this time the feasibility of placing in the Federal agencies added responsibility under the program. GAO continues to believe that adopting compensation techniques used in private industry would further improve the handling of claims and other compensation matters under the program. For this reason GAO is recommending that OMB make that determination. (See pp. 48 and 49.)

Contents

ABBREVIATIONS

COP	Continuation-of-pay
GAO	General Accounting Office
OMB	Office of Management and Budget
OWCP	Office of Workers' Compensation Programs
TVA	Tennessee Valley Authority

CHAPTER 1

GETTING BENEFITS TO WORKERS: WHO IS RESPONSIBLE AND FOR WHAT

We reviewed claims processing under the Federal Employees' Compensation Act, as amended (5 U.S.C. 8101), at the request of several members of the Congress. Our review was to identify where and why delays in the processing of claims were occurring.

The act authorizes compensation benefits and seeks to provide prompt and reasonable income to disabled workers whose regular paychecks are interrupted by job-related injuries. In general, the act covers all civil officers and employees of any branch of the Federal Government. About 3 million Federal employees (and certain non-Federal employees, such as law enforcement officers injured in connection with Federal crimes) are covered under the act. The act is the only remedy an injured Federal worker has against the U.S. Government.

BENEFITS

Benefits under the act include compensation for loss of wages, dollar awards for bodily impairment or disfigurement, medical care for injury or disease, rehabilitation services, and compensation for survivors. The act defines "injury" as including "* * * in addition to injury by accident, a disease proximately caused by the employment * * *," and the term "compensation" as including both the money allowances payable to a worker or his or her dependents and other benefits, such as medical care and vocational rehabilitation services.

Money allowances take the form of:

--Monthly payments for wage loss which continue as long as the disability.

--Payments for specified time periods (called scheduled awards) for loss, or loss of use, of a member or a function of the body (e.g., loss of an arm or loss of hearing).

In 1974, the Congress amended the act to authorize employing agencies to continue a worker's pay up to 45 days for a traumatic

injury. 1/ This change, referred to as the "continuation-of-pay" (COP) provision, established immediate full-salary benefits (subject to income tax, retirement, and other deductions) to workers awaiting claims settlement by the Department of Labor. Its intent was to eliminate the gap in some workers' cash flow resulting from delays in claims processing.

Individuals who receive benefits and who administer the system for delivering them have certain responsibilities, and their promptness in discharging their responsibilities directly affects the timeliness of claims processing.

WORKERS MUST MAKE A CLAIM FOR BENEFITS

Workers who sustain job-related injuries 2/ are primarily responsible for initiating the required forms that give notice of injury and establish claims for benefits. In every case of injury, workers or someone acting on their behalf should file the form "Notice of Injury" with their employing agency. That form, in addition to giving notice of the injury, serves as the basis for (1) electing COP in traumatic injury cases, (2) paying the medical bills, and (3) establishing that the injury was employment related. The latter is especially important to workers because they are not eligible for benefits unless a causal relation exists between their injury and employment.

Workers, whose disability goes beyond 45 days in traumatic injury cases or who were not eligible for COP, to claim lost wages must file the form "Claim for Compensation" with their employing agencies. If their claims are approved, workers generally receive checks equal to two-thirds of their gross pay (three-quarters if they have one or more dependents) until they return to work. Workers who elect COP may claim money allowances under the act after 45 days has elapsed, if their disability continues. Workers also may elect to go on annual or sick leave instead of claiming compensation. If the worker later claims compensation for the period during which leave was used, he or she must refund any amount received greater than the amount of compensation paid. The worker

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1/A traumatic injury is defined as a wound or other condition of the body caused by external force, including stress or strain. The injury must be identifiable as to time and place of occurrence and member or function of the body affected; and be caused by a specific event or incident or series of events or incidents within a single day or work shift.

2/In this report, the term "injury" includes occupational diseases, such as heart or lung conditions caused by employment.

then is credited with the leave taken. Statistics show that for fiscal year 1979, workers reported 109,301 disabling traumatic injuries of which COP was elected in 90,789 cases, and leave was elected in 7,151 cases. For the other traumatic injuries, either the workers were denied COP or Labor's statistics did not show how the claim was resolved.

FEDERAL AGENCIES' INVOLVEMENT IN CLAIMS PROCESSING

Though workers must take the first step in establishing a claim for benefits, their employing agencies become involved in processing claims thereafter, and the agencies' efforts are critical to timely processing.

Federal agencies, when injury and claims forms are received, are required to complete their portion of the forms, and submit them to Labor. In turn, Labor requires the agencies to assist injured workers by

--promptly authorizing medical care in traumatic injury cases,

--providing them with proper forms to give notice of injury and to claim benefits,

--advising them of their right to elect COP or to use leave for the period of disability,

--advising them in occupational disease cases to furnish supporting medical and factual information with the claims, and

--making any additional reports that may be required to settle the claims.

MEDICAL REPORTS ARE REQUIRED FOR EACH CLAIM

No claim can be settled without medical evidence supporting causal relation and disability. Physicians who attend injured workers must maintain adequate records so that they can report on (1) the history of the job accident; (2) the exact description, nature, location, and extent of injury; (3) X-ray findings or other studies (if done); (4) the nature of treatment rendered; and (5) the degree of impairment resulting from the injury. A physician's opinion on causal relation is important to claims processing because it is a key factor in Labor's determination of whether a worker is entitled to benefits.

Generally, Labor relies on physicians and other medical providers to forward all medical reports and charges for medical, hospital, surgical, or other services rendered. In the absence

of supporting medical reports, Labor's regulations and procedures provide that reimbursement for medical care cannot be made and claims cannot be paid.

LABOR HAS ULTIMATE RESPONSIBILITY FOR CLAIMS PROCESSING

Once workers, Federal agencies, and physicians have submitted the proper forms and supporting evidence, Labor must make a decision to award or deny benefits. Within Labor, the Office of Workers' Compensation Programs (OWCP) in the Employment Standards Administration is responsible for that decision.

OWCP administers the act through a Division of Federal Employees' Compensation at the national office--which develops policies and procedures--and 15 district offices. In the OWCP district offices, claims examiners have the primary responsibility for examining and developing claims and for deciding whether workers are entitled to benefits. For a proper disposition of claims from workers, the claims examiners are authorized to obtain any additional information they consider necessary from witnesses to an accident, Federal agencies, physicians, or a consulting physician(s).

Each OWCP district office has a district medical director, who is a physician. The claims examiner may seek the medical director's advice concerning medical aspects of a worker's injury and the job relatedness of such injury. The decision, however, concerning workers' entitlement to benefits is the claims examiner's responsibility. A worker who is dissatisfied with a decision may request a hearing before the Branch of Hearings and Review in the Division of Federal Employees' Compensation. The Branch may issue compensation orders that either sustain, modify, reverse, or remand the decisions of district offices.

A worker may also appeal adverse decisions to the Employees' Compensation Appeals Board. The Board is a quasi-judicial board of three members appointed by the Secretary of Labor with authority to hear and make final decisions on appeals from Labor's determinations and awards. The Board's decisions are final and conclusive on all questions of law and fact and are binding on all parties.

OBJECTIVES, SCOPE, AND METHODOLOGY

We reviewed the processing of claims to identify where and why delays were occurring at the request of the former Chairmen of the Subcommittee on Civil Service and General Services of the Senate Committee on Governmental Affairs and the House Committee on Post Office and Civil Service, the former Chair of the Subcommittee on Compensation and Employee Benefits of the House Committee on Post Office and Civil Service, the former Chairman of the Subcommittee on Human Resources of the House Committee on Post Office and Civil Service, and several other members of the Congress. To evaluate

Labor's processing of claims we randomly selected compensation payments from Labor's daily payment rolls for the first 6 months of fiscal year 1980 at four district offices. 1/ Our review focused on the timeliness of claims processing as measured by Labor's criteria. No evaluations were made of Labor's criteria or its determinations of workers' entitlement to benefits.

We randomly selected for detailed review 431 claims out of 1,762 on which Labor's Jacksonville, Cleveland, and Denver district offices made first compensation payments to injured workers between October 1, 1979, and March 31, 1980.

Because some records at the Washington, D.C., district office were missing, we were unable to identify all claims in which the office made first compensation payments between October 1, 1979, and March 31, 1980. However, we did identify 815 claims in which the office either (1) made first compensation payments to injured workers between October 1, 1979, and March 31, 1980, or (2) received a claim and established a case file during the period of October 1, 1978, through March 31, 1980. These 815 claims were assumed to be the equivalent of the first compensation payments identified at the other three district offices. We randomly selected a sample of 133 of the 815 claims for detailed review. (See p. 7 for additional details on the attributes of our sample.)

Statistics related to percentages of claims that exceeded Labor's criteria for timeliness and average numbers of days to process claims were calculated by combining the unweighted sample results for all four district offices. The statistics may be different from results that would have been obtained if all cases were reviewed or if each district's sample results were weighted by the relative size of its claims workload. However, calculations in that manner would have been unduly complicated because of (1) differences in identifying the claims workload between the Washington, D.C., district office and the other three offices, (2) deficiencies in Labor's recordkeeping system that would not allow identification of all disease claims from the total number of claims, and (3) missing dates of receipt on claim forms particularly at the Washington, D.C., district office.

We selected the Jacksonville, Denver, and Washington, D.C., districts because of specific congressional concerns about claims processing in these offices. We selected Cleveland because Labor officials said it was one of the better offices. We began our review in March 1980 at the Labor headquarters in Washington, D.C., and at the four district offices. We reviewed the act and its legislative history; Labor's regulations, implementing policies, and procedures; Labor's internal audit reports; and other Labor

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1/The district offices were Cleveland, Ohio; Denver, Colorado; Jacksonville, Florida; and Washington, D.C.

reports on administration of the act. At the district offices, we interviewed various officials, including assistant deputy commissioners, chief claims examiners, and claims examiners We also reviewed the administrative workload and evaluated the claims processing procedures and other data at these offices.

In addition, at selected Federal agencies we interviewed personnel to obtain information about claims processing procedures, practices, and experiences. These interviews were conducted at post offices, Veterans Administration hospitals, a naval shipyard, the Government Printing Office, and at installations of the U.S. Forest Service, the Tennessee Valley Authority (TVA), and the Department of Defense. Our work at these agencies was limited to discussions concerning claims processing procedures and problems.

CHAPTER 2

WORKERS, FEDERAL AGENCIES, AND PHYSICIANS CONTRIBUTE TO DELAYS IN CLAIMS PROCESSING

Our review of 564 compensation payments showed that about 98 percent of those for wage loss were not timely; averages from the date workers made claim to the date of payment were 129 days for traumatic injuries and 270 days for occupational diseases. Although the act's goal is to provide benefits to workers promptly after their pay ceases, these averages indicate that the goal is not met.

Payments were not prompt because

--workers were not filing timely and well-documented injury notices and claims,

--Federal agencies were not timely or complete in processing injury notices and claims, and

--physicians reports often were untimely and incomplete.

Labor's processing problems, which are discussed in chapter 3, also contributed to delays in making timely payments.

Because timely claims processing requires a highly coordinated effort among all parties, the failure of any party to act promptly at a given point can delay the entire process. Thus, given that compensation benefits are not payable until workers have established their eligibility, the failure to make timely claims and provide complete documentation does delay receipt of benefits. Although not all injuries involve interruption of income, in some cases financial hardship can result from delays in claims processing. Notwithstanding whether a financial hardship exists, no injured worker should have to wait long periods for benefits that he or she has a legal right to.

ATTRIBUTES OF SAMPLE

The 564 payments in our sample were made to workers of 24 Federal agencies (see app. I) for the following reasons:

--380 for wage loss,

--94 for leave buy-back,

--65 for scheduled awards, and

--25 in lieu of retirement benefits. 1/

Workers for the U.S. Postal Service received the largest number of the payments, 180 or about 32 percent; followed by 169 or about 30 percent to Department of Defense workers. The next largest blocks of payments went to workers at the Veterans Administration (50) and TVA (45).

The largest number of payments were for traumatic injuries, 443 or about 79 percent. Payment for occupational diseases totaled 121 or about 21 percent. Back strain was the most common injury for which compensation was claimed. The following tables show some of the major classifications for traumatic injuries and occupational diseases.

Type of injury	Number	Percent of total
Traumatic:		
Back strain	129	22.9
Multiple strain	109	19.3
Fracture	68	12.1
Contusion	44	7.8
Other (note a)	93	16.5
Total	443	78.6
Disease:		
Hearing loss	20	3.5
Mental, nervous condition	12	2.1
Heart condition	9	1.6
Hepatitis	7	1.2
Other (note a)	73	13.0
	121	21.4
Total	564	100.0

a/The remaining injuries included conditions, such as arthritis, ulcers, emphysema, amputations, food poisoning, and tuberculosis.

The following tables show, where data on claims processing were available, the time to process notices of injury and claims in our sample of 564 compensation payments. Processing times have two segments: (1) the time workers and their employing agencies take to file notices of injury and submit claims and (2) the time Labor takes to settle and pay them.

1/Workers who are eligible for both retirement benefits under the Office of Personnel Management and workers' compensation benefits must choose one or the other.

Segment	Notices of injury (note a) Type of injury	Number filed	Average days to process	Processing time 0 to 30 (days)	31 to 90 (days)	91 or more (days)
Date of injury to date Labor received notice	Traumatic	356	50	188	126	42
	Disease	111	260	20	32	59
Total		467		208	158	101
Date Labor received notice to date approved	Traumatic	356	100	114	134	108
	Disease	111	438	3	10	98
Total		467		117	144	206

a/ The Washington, D.C., district office failed to stamp the date of receipt on 85 of the 122 notices for traumatic injury and 10 of the 11 notices for occupational diseases. Also, two notices of traumatic injury were not date stamped upon receipt by the Cleveland and Denver district offices. Accordingly, the 97 notices were excluded from the table.

Segment	Claims (note a) Type of injury	Number filed	Average days to process	Processing time 0 to 30 (days)	31 to 90 (days)	91 or more (days)
Date of claim to date received by Labor	Traumatic	395	25	318	57	20
	Disease	114	35	82	20	12
Total		509		400	77	32
Date Labor received claim to date paid	Traumatic	395	130	135	113	147
	Disease	114	428	14	10	90
Total		509		149	123	237

a/ The Washington, D.C., district office failed to stamp the date of receipt on 44 of the 122 claims for traumatic injury and 6 of the 11 claims for occupational diseases. Also, five claims--four traumatic and one occupational disease--were not date stamped upon receipt by the Cleveland and Denver district offices. Accordingly, the 55 claims were excluded from the table.

The preceding table included claims for wage loss, leave buy-back, scheduled awards, and where workers' compensation benefits were elected over retirement benefits. Because wage loss claims are most likely to involve financial hardships for workers and because they were the largest number (380) of claims in our sample, the following table shows the processing time for the 334 wage loss claims in our sample, where data were available.

	Claims for wage loss (note a)					
			Average	Processing time		
Segment	Type of injury	Number filed	days to process	0 to 30	31 to 90	91 or more
				(days)		
Date of claim to date Labor received claim	Traumatic	290	24	238	41	11
	Disease	44	33	34	6	4
Total		334		272	47	15
Date Labor received claim to date paid	Traumatic	290	105	114	89	87
	Disease	44	237	13	5	26
Total		334		127	94	113

a/The Washington, D.C., district office failed to stamp the date of receipt on 40 of the 105 claims for traumatic injury and 3 of the 5 claims for diseases. Also, three claims for traumatic injury were not date stamped upon receipt by the Cleveland and Denver district offices. Accordingly, the 46 claims were excluded from the table.

WORKERS NOT FILING TIMELY AND WELL-DOCUMENTED INJURY NOTICES AND CLAIMS

The act requires workers who are injured while performing their duties to (1) give written notice of injury within 30 days to their supervisor, (2) state the cause and nature of injury, and (3) provide other data, such as the date and place the injury occurred. Also, the act provides that compensation is payable only if workers file claims. We found that workers, in many cases, did not file timely or well-documented injury notices and claims.

Timeliness of injury notices

To provide benefits to workers promptly, Labor's regulations require workers to submit a written notice within 2 days for traumatic injuries and within 30 days for occupational diseases. In about

44 percent of the 564 compensation payments we reviewed, workers did not file timely notices of injury. Average times (measured from date of injury to date notice of injury was filed) were 15 days for traumatic injuries and 192 for diseases. Workers' performance in filing notices of injury was as follows.

	At the four district offices			
		Days to file		
Type of injury	Number filed	0 to 2	3 to 20	20 or more
Traumatic	443	262	118	63
		0 to 30	31 to 90	91 or more
Disease	121	53	28	40
Total	564			

Workers who fail to timely report their injuries risk either forfeiting or delaying receipt of benefits. They also add to the administrative burden of settling claims, especially in traumatic injuries, where timely election of COP eliminates a claim for lost wages or buy-back of leave. More significant, however, is that until a notice of injury is filed, neither employing agencies nor Labor can take action to ensure injured workers receive all benefits due under the act.

The following case examples illustrate some of the effects associated with late filing of injury notices.

--A mail carrier for the U.S. Postal Service strained his left ankle after slipping on a rock. The injury occurred on May 13, 1978, but the notice was not filed until November 25, 1978--about 6 months later. The worker used leave for the period of disability and later submitted a claim to buy it back. A notice of injury filed within 30 days would have eliminated that claim because the worker could have elected COP. The worker stated on the notice of injury that after returning to work he forgot to fill out the form.

--A 33-year-old TVA conveyor-car dumper operator had a heart attack after loosening frozen coal in a hopper. After the attack he used leave for 3 months, returned to work for 6 months, and was dismissed because of medical restrictions. He then filed a notice of injury on February 23, 1979, almost 1 year after the attack on March 6, 1978, and later submitted a claim for benefits. Benefits were awarded 11 months after the claim was submitted, after Labor determined that the

attack was job related. A more timely notice of injury may have resulted in Labor making that decision sooner than it did and awarding benefits more promptly. By waiting 1 year to file the notice, the worker delayed action by Labor to determine if he was due benefits. The worker stated on the notice that it was late because the agency could no longer use him because of his medical limitations.

Timeliness of claims

Workers disabled by traumatic injuries may elect continuation of regular pay. If they return to work within 45 days, no claim is necessary. (The injury notice is the basis for electing COP.) If disabled beyond 45 days, Labor's regulations require that workers together with their employing agencies submit claims within 5 days following the end of the 45-day period. Workers who cannot work because of their disabilities and are not eligible for continuation of regular pay are required to submit their claims within 10 days after pay stops. For example, workers not eligible for COP include workers who do not report their traumatic injuries within 30 days or render personal service to the United States without pay or for nominal pay.

For occupational diseases, the worker's period of disability is the major determining factor in claiming compensation. For instance, workers together with their employing agencies are required to submit a claim to Labor

--within 10 days after pay stops if the disability is limited or

--upon returning to work if the disability is less than 10 days, but more than 3 days.

In about 53 percent of the 380 claims for wage loss in our sample, workers did not submit claims within these criteria. Average times (measured from the date wage losses began to the dates workers filed claims) were 25 days for traumatic injuries and 164 days for diseases. Workers' performance in submitting claims was as follows.

	At the four district offices			
		Days to file		
Type of injury	Number filed	0 to 5	6 to 20	21 or more
Traumatic	333	161	79	93
		0 to 10	11 to 30	31 or more
Disease	47	18	5	24
Total	380			

Adequacy of injury details provided

Labor's regulations require workers to provide complete details on the circumstances surrounding their injuries. The preprinted injury and claim forms require identifying and descriptive details, such as

--name, place of employment, and date and time of injury;

--period for which compensation is claimed and salary information; and

--a narrative statement of the cause and nature of the injury.

For occupational diseases Labor's instructions on the preprinted form for notice of injury ask for a separate narrative statement containing (1) a detailed history of the disease from the date it began; (2) complete details of types of substances or conditions of employment that the worker believes are responsible for the disease; (3) a description of specific exposures to substances or stressful conditions causing the disease, including location where exposure or stress occurred, as well as the number of hours each day and days each week of such exposure or stress; (4) an identification of the part of the body affected; and (5) a statement as to whether the worker ever suffered a similar disease and if so, the full details as to its onset, history, and medical care received.

Our sample of 564 compensation payments showed that incomplete injury details were often a factor delaying Labor's decision to award benefits.

Details required	Claims requiring additional details			
	Notice of injury		Claims	
	Traumatic	Disease	Traumatic	Disease
Employment	39	7	29	12
Medical	84	9	70	12
Both	123	86	90	62
Total	246	102	189	86

Incomplete injury details slowed the processing of claims and increased the administrative burden to settle them. As a result the award of benefits to workers was delayed. For instance, if additional details are required Labor must describe (most commonly by correspondence) what is needed to settle the notice of injury and pay the claim. Further processing of the claim is suspended until a response is received. The following case illustrates some of the effects caused by incomplete injury details.

--A city mail carrier for the U.S. Postal Service suffered pain in his left chest and shoulder at home one evening. The condition was later diagnosed as myalgia (tenderness or pain in the muscles) of the left pectoralis major muscle. Labor received the notice of injury on June 18, 1978, from the worker alleging that the exertion of servicing 975 delivery stops caused the condition. On July 5, 1978, in attempting to determine whether the condition was job related, Labor asked the worker to provide injury details required on the preprinted form: (1) a detailed statement on the factors of employment believed to be the cause; (2) a detailed history of the disability, i.e., when it started, the part of the body affected, and activities before the onset of the current condition; and (3) a statement on whether similar conditions had existed. Three requests were made to the worker, his employing agency, and physician before sufficient details were received on June 25, 1979. On September 27, 1979, Labor approved the condition as job related and notified the worker that, if he wished to buy back the leave used (he was off work more than 4 months), he must submit a claim, which he did. Therefore, failure to provide complete details slowed the determination of whether the condition was job related, increased Labor's administrative burden by having to suspend processing and request additional details, and resulted in the worker waiting about 16 months for Labor to determine that he was entitled to benefits.

Too many variables exist to reasonably attribute lack of complete injury details entirely to workers. For instance, even though workers are primarily responsible for providing such details, completeness depends on the quality of evidence available to workers and their ability to communicate that evidence. More importantly, the uniqueness of each injury calls for a judgment on the part of Labor as to when details are sufficient. Workers, therefore, may not know when details are sufficient.

Reasons cited for delays and Labor's actions

The reasons why workers often filed notices of injury late and failed to submit claims promptly were not always determinable from the case files. Workers sometimes provided statements on why actions were not timely, but as with the types of injuries they varied considerably--from "forgot to fill out form" to "supervisor said injury would go away." Officials at Labor and other Federal agencies, however, gave us several reasons why they think the delays occurred. Some of the reasons were that workers (1) do not fully understand their responsibilities; (2) are lax in obtaining, completing, and submitting required forms; and (3) are careless about providing injury details.

Although Labor has not made studies to determine probable causes of delays, it has taken actions to help workers become more aware of their rights and responsibilities when injured at work. For example, in addition to its regulations and instructions on the preprinted forms, Labor has provided instructions on what workers should do when injured in Pamphlet CA-11 ("When Injured at Work") and in Pamphlet CA-13 ("Wallet Card"). Labor requires Federal agencies to distribute these pamphlets to workers. Similar instructions are contained on Poster CA-10 "What a Federal Employee Should Do When Injured at Work," and Labor requires Federal agencies to post this poster throughout the workplace. Agencies may obtain these documents from Labor or the U.S. Government Printing Office.

Although we did not evaluate worker awareness of the program, officials at the agencies we visited told us that generally their workers were adequately informed, stating that workers were given the pamphlets and that posters were placed throughout the workplace. Furthermore, they said that, in addition to assistance from the agency's compensation clerks, workers may obtain information through newsletters periodically published and distributed by the agency.

Even though our work at the agencies was limited, we noted that efforts of the agencies to help workers become aware of their compensation rights and responsibilities were sporadic. For example, at a Veterans Administration hospital in Colorado with a staff of about 1,200, officials had not placed Poster CA-10 in the workplace because they were unaware of its existence. We also found only one issue of a newsletter in the past 2 years that contained information about the program. Similar conditions existed at several other agencies. For instance, no posters were in the workplace and no information was published in the base newspaper within the past year at the U.S. Marine Corps Logistics Base in Georgia with a work force of about 2,000. At a nuclear plant construction site in Alabama, where about 4,100 workers were employed, we observed a large sign in the medical office waiting room informing workers to report all injuries to their supervisor, but in the work areas we toured, no posters on what-to-do-when-injured were evident.

FEDERAL AGENCIES ARE NOT TIMELY OR COMPLETE IN PROCESSING WORKERS' INJURY NOTICES AND CLAIMS

The act provides that immediately after an injury which results in a worker's probable disability, the agency shall report that injury to Labor. Also, as provided by the act, Federal agencies are to receive and process workers' claims. The act does not define "immediately" or specify the amount of time the agencies are allowed to take to process a worker's notice of injury or claim. The act gives Labor authority to prescribe the type of injury

information to be reported. We found that Federal agencies, in many cases, did not process timely or well-documented injury notices and claims.

Timeliness in processing injury notices

Labor's regulations require Federal agencies to complete their portion of the notice of injury and submit it to Labor if the worker is disabled or is likely to incur medical or other related expenses. Agencies have 2 days for traumatic injuries and 10 days for occupational diseases to complete and submit the notices.

From our sample of 564 compensation payments, in about 94 percent of the 467 payments where data were available, Federal agencies did not process workers' notices of injury within the 2- or 10-day periods. Average times (measured from the date workers filed written notices to the date Labor received them) were 36 days for traumatic injuries and 68 days for diseases. The agencies' performance in processing workers' notices of injury was as follows.

	At four district offices			
		Days to process		
Type of injury	Number filed	0 to 2	3 to 20	21 or more
Traumatic	356	9	121	226
		0 to 10	11 to 30	31 or more
Disease	111	19	1	91
Total	a/467			

a/The Washington, D.C., district office did not stamp the date of receipt on 85 traumatic injury notices and 10 occupational disease notices. Two traumatic injury notices were not date stamped by the Cleveland and Denver district offices.

Agencies taking too long to process workers' notices of injury can contribute to delays in Labor's determination of workers' entitlement to benefits. For example:

--A molder for the Norfolk Naval Shipyard amputated the distal tip of his third right finger by dropping a bar on it. He filed the notice of injury on March 2, 1978, 1 day after the accident. The shipyard provided medical care and paid 2 weeks of COP, but did not submit the notice of injury until June 7, 1978. On June 26, 1978, Labor notified the worker that it had approved the injury as job related and that he

was entitled to additional benefits, i.e., a scheduled award. The shipyard, by delaying 3 months in processing this notice of injury, delayed Labor's determination of the worker's entitlement to benefits. The case file contained no evidence as to why the delay occurred.

Timeliness of claims processing

Labor's regulations require Federal agencies, together with their workers, to process claims within 5 days for traumatic injuries and 10 days for diseases. In about 86 percent of the 334 compensation payments for wage loss, agencies did not process workers' claims within these time frames. Average times (measured from the date workers made claims to the date Labor received them) were 24 days for traumatic injuries and 33 days for diseases. Agencies' performance in submitting claims was as folows.

	At four district offices			
		Days to process		
Type of injury	Number filed	0 to 5	6 to 20	21 or more
Traumatic	290	36	159	95
		0 to 10	11 to 30	31 or more
Disease	44	11	23	10
Total	a/334			

a/The Washington, D.C., district office did not stamp the date of receipt on 40 claims for traumatic injuries and 3 claims for diseases. Three traumatic injury claims were not date stamped by the Cleveland and Denver district offices.

Failure to process workers' claims promptly can delay the receipt of benefits. For example:

--A letter carrier for the U.S. Postal Service dislocated his right elbow in a fall at work. He received COP, but remained disabled after 45 days. At that time, on August 25, 1979, he submitted a claim for lost wages, remaining disabled almost 2 months until he returned to work on October 16, 1979. The Postal Service did not process the worker's claim until October 16, 1979, the day he returned to work. Although Labor paid the claim on November 1, 1979, the Postal Service was responsible for delaying benefits to the worker at the time he was disabled. No reason was evident from the case file for the delay.

Adequacy of injury details provided

Labor's regulations require agencies to furnish all details pertinent to a worker's injury when processing injury notices and claims. For example, in completing notices of traumatic injury, agencies must provide such descriptive data as (1) the worker's hours of work, (2) when the injury occurred, and (3) pay status of the worker. With regard to the nature and cause of the worker's injury, agencies have six questions that require a "yes" or "no" response:

(1) Was the worker in performance of duty at the time of injury?

(2) Was injury caused by willful misconduct, intoxication, or intent to injure self or another?

(3) Was injury caused by a third party?

(4) Do medical reports show worker is disabled for work?

(5) Does your knowledge of the facts about this injury agree with the statements of the worker and/or witnesses?

(6) Does the employing agency controvert COP?

If their information differs from that of workers, in questions 1, 2, 5, and 6, the agencies must provide a detailed report explaining the reasons.

For occupational disease, in addition to completing the notice of injury, agencies are required to provide a separate narrative statement. That statement should (1) describe in detail the work performed by the worker; (2) identify fumes, chemicals, or other irritants or situations that the worker was exposed to which allegedly caused the condition; and (3) state the nature, extent, and duration of exposure, including hours per day and days per week. Attached to that statement should be (1) copies of all physical examination reports (including X-ray reports and laboratory data) on file for the worker, (2) a record of the worker's absence from work caused by similar disease or illness, and (3) statements from each coworker who has first-hand knowledge about the worker's condition and its cause.

Our review of 564 compensation payments showed that incomplete injury details were often a factor delaying Labor's decision to award benefits. Agencies failing to provide complete injury details can delay Labor's decision on whether workers are entitled to benefits. By having to request additional details, Labor's administrative burden of processing claims is increased. For example:

--A mail carrier for the U.S. Postal Service was assaulted by a patron. Labor received the worker's notice of injury on November 30, 1979, and his claim for wage loss on January 7, 1980. Labor approved the injury as job related and paid the worker's claim on February 19, 1980, after two requests to the Postal Service for details on why the incident occurred. Lack of complete details on the nature and cause of the injury at the time the forms were submitted delayed Labor's decision on whether the worker was eligible for benefits, delayed receipt of benefits to the worker, and increased Labor's administrative burden by requiring two requests for additional details.

As with workers, too many variables existed to reasonably impute inadequate details solely to the agencies. For instance, in completing notices of injury, agencies must make a judgment on whether workers have provided complete and accurate details. That decision may depend on the evidence available to the agencies and their capacity to evaluate the evidence and provide additional details, if necessary. In addition, the uniqueness of each injury calls for a judgment on the part of Labor about the need for additional details. The agencies, therefore, may not know when details are sufficient.

Claims processing practices of Federal agencies

Following is a general description of claims processing and problems of TVA and the U.S. Postal Service and comments from officials of other agencies we visited.

TVA

Analysis of the 125 compensation payments for traumatic injuries made by the Jacksonville district office showed that 42 were to TVA workers. TVA employs about 50,000 workers, about 50 percent of them work at six power generating plants that are under construction. If a worker is injured, a compensation clerk at the site normally prepares the injury notice and sends it to the worker's supervisor for completion. When the injury notice or claim is returned, the clerk forwards it to TVA's compensation unit in Chattanooga. This unit checks the forms for completeness and accuracy and forwards them by mail to the Jacksonville district office.

According to TVA officials, the processing time for notices of injury ranges from 42 to 77 days. The average processing time for the 42 notices of injury in our sample was 77 days--20 days for workers and 57 days for TVA. Similar conditions existed with the processing of notices of injury for disease and for claims. A special study made by the Jacksonville district office in June 1980 also confirmed TVA's lengthy processing times.

The supervisor for TVA's Compensation Unit said that processing times were extended because

--there were not enough compensation clerks at job sites to handle the volume of work,

--compensation clerks at the job sites were not always knowledgeable of their duties, and such factors as low pay caused frequent turnover for this position, and

--compensation clerks at job sites did not have the time to pursue the gathering of necessary injury details.

The supervisor also said that Labor's 2-day requirement for submitting notices of traumatic injury was unrealistic for TVA and that TVA was working toward a deadline of 2 weeks.

U.S. Postal Service

In our sample of 564 payments, 180 (32 percent) of the compensation payments were made to U.S. Postal Service workers. The Postal Service has established a workers' compensation unit consisting of five regional offices that administer the injury compensation program and a headquarters office that primarily establishes program policy and procedures. Actual processing of injury notices and claims, however, is the responsibility of compensation specialists at postal sites. For example, injury compensation specialists administer the program at the main post office in Cleveland, Ohio. They receive injury reports and claims from supervisors, gather additional injury details, if necessary, and submit the forms by mail to Labor.

A spokesperson for the U.S. Postal Service's workers' compensation unit told us that processing times vary significantly among sites. Some specialists were more diligent than others in gathering injury details and encouraging supervisors to complete forms promptly. She could not provide an estimate of processing times. However, for the 129 notices of traumatic injury in our sample of 180 payments, the average was 41 days 1/ from the date of injury to the date Labor received the notices. Workers averaged 18 days to file notices of injury and the installations averaged 23 days to submit the notices to Labor. Similar conditions existed with processing notice of occupational diseases and claims for compensation.

1/The average number of days is based on 129 notices filed with the four district offices. The Washington, D.C., district office date stamped only 10 notices of the 30 submitted.

According to the spokesperson, processing of the necessary forms is often delayed because first-line supervisors take a passive view toward their compensation work and, in prior years, received little, if any, training on these matters. Also, injury compensation specialists at the main post office in Cleveland told us that first-line supervisors often fail to complete the forms. These specialists said that returning forms to supervisors for completion extended the time for submitting them to Labor.

Other Federal agencies

Officials, including compensation clerks, at the other agencies we visited cited similar problems affecting timely processing of injury notices and claims. They said that

--supervisors often take too long to complete necessary forms and some supervisors lacked adequate knowledge about their compensation duties and

--there was not adequate staff to efficiently process required forms and in addition to compensation work other personnel matters, such as helping to administer annual performance ratings, were assigned.

Labor's actions to help agencies improve claims processing

Although Labor has not made studies to determine probable causes of delays, it has taken actions to help agencies improve their processing of claims. For example, on request from agencies, Labor conducts seminars for supervisors and compensation clerks on injury reporting and claims processing. Workshops are also conducted to assist compensation clerks. The 3-day sessions cover such topics as (1) checking forms for completeness and accuracy; (2) handling inquiries; and (3) serving as a link between workers, agencies, and Labor.

We did not evaluate this program's effectiveness, but Labor's records indicated that the agencies are using technical assistance. As of March 1980, 183 seminars had been attended by 8,668 people, and 315 workshops by 3,110 people. Labor's evaluation showed that individuals who attended the workshops prepared more error-free claims than those who had not attended.

At the agencies we visited most compensation clerks had attended either a Labor-sponsored seminar or workshop or both. Their comments, e.g., "very helpful," "excellent," and "beneficial," suggested that such training was helpful. Several officials commented that seminars should be held more often and that advanced training, especially for occupational diseases, was needed.

Labor also holds quarterly meetings with agencies' top management to gain their cooperation and help them better understand the requirements of claims processing. Labor officials believe that these meetings have increased cooperation. For example, Labor and the U.S. Postal Service are involved in a project of returning injured workers to assignments compatible with their injury-related disabilities. Other projects include cooperative arrangements for improving claims work at the U.S. Air Force Logistics Command and TVA. Labor officials regard these projects as prototypes for those it seeks to undertake with other agencies.

Experiment with electronic communication

At the time of our review, the Jacksonville district office was establishing with TVA an experimental communication system. Both had purchased similar systems to electronically transfer time-critical documents, such as notices of injury, claims for compensation, and medical evidence.

Both said it will reduce processing times. For example, TVA may immediately notify Labor of an injury or death and transfer the data--employment and medical--required to establish a claim. Labor can review the transmission and use the same channels to request additional data.

The electronic system between TVA and Labor had begun operation in October 1980 and, as of May 1981, its effectiveness had not been evaluated.

PHYSICIANS' REPORTS OFTEN ARE UNTIMELY AND INCOMPLETE

The act provides that a worker's claim shall, except in the case of death, be accompanied by a medical report stating the nature of the injury and probable extent of the disability. Labor's regulations require an "immediate medical report" from physicians who treat injured workers. Also, Labor's instructions on the preprinted report form for attending physicians emphasizes that medical reports are required before benefits are payable. We found that physicians, in many cases, did not provide timely or adequate reports for Labor to determine the extent of or whether a worker's injury resulted from his or her employment.

Timeliness of medical reports

Our sample of 564 compensation payments indicated that physicians were not always prompt in submitting their reports. Average times (from the date physicians first provided medical care to the date they completed their initial reports) were 40 days for traumatic injuries and 115 days for diseases. Physicians' performance in completing their initial reports was as follows.

Types of injury	At four district offices: Number completed	Days to complete: 0 to 10	11 to 30	31 or more
Traumatic	401	153	97	151
Disease	108	29	23	56
Total	a/509			

a/Fifty-five reports were either not available for review or not dated by physicians.

Until Labor has determined that a worker's injury is job related, no benefits are payable. A key factor for that decision is medical opinion, and reports that are not furnished timely can delay Labor's decision on whether workers are entitled to benefits.

Completeness of medical reports

Labor's regulations require physicians to maintain adequate records so that they may provide (1) a history of the worker's injury; (2) the exact description, nature, location, and extent of injury; (3) the X-ray findings or other studies, if done; (4) the nature of the treatment rendered; and (5) the degree of impairment arising from the injury. The "Attending Physician's Report" forms, which are identical for both traumatic injuries and diseases, call for this information. Physicians who give opinions on causal relation must provide rationale. In determining the extent of rationale, the nature of the condition for which compensation is claimed is an important factor. For example, no rationale would be required to support causal relation in a claim based on a broken arm sustained when a worker fell off a loading dock at work, but extensive rationale would be required to support a claim based on a heart attack suffered at home on a day off.

In about 51 percent of the 380 claims for wage loss in our sample, the need for additional medical evidence was a factor delaying Labor's decision to award benefits.

Type of injury	Number of claims requiring additional medical evidence
Traumatic	165
Disease	28
Total	193

Medical reports that are not adequate for Labor to evaluate causal relation cause delays in settling claims and increase the the administrative burden of claims processing.

Reasons cited for delays and incomplete medical reports and Labor's actions

As with workers and their employing agencies not providing complete injury details, too many variables existed to reasonably attribute inadequate medical reporting solely to physicians. For example, the subtle, complicated questions of cause and effect, especially for occupational diseases, are often difficult, if not impossible, for medical science to answer conclusively. Because of the uncertainty surrounding cause-effect relationships, physicians may not have definite answers. Furthermore, the adequacy of medical evidence is a judgment decision made by Labor's claims examiners. Physicians may not know what medical rationale in each case is needed for the claims examiners to reach a decision on whether a condition resulted from a worker's employment.

The reasons why physicians' reports are often late and incomplete were not determinable from the case files. Labor and other Federal agencies' officials we interviewed, however, told us several reasons why they think reports are late and incomplete. Among them were:

--Instructions are not followed for furnishing reports.

--Not enough time taken to justify opinions on causal relation.

--Reports contain only the information that workers want documented.

Although Labor has not made studies to determine probable causes, it is developing a national medical program to improve cooperative efforts with the medical community. According to Labor officials, the program will serve to (1) improve communication with Federal agencies' medical personnel to enhance their understanding of compensation issues and the role they play in the compensation process and (2) reach out to the general medical community which serves injured workers to assure acceptance of compliance with program procedures. An official at Labor's national headquarters told us that the program had not yet been completely developed.

Also, as part of its medical program, Labor is developing standards for evaluating causal relation in difficult and time-consuming claims involving conditions, such as stress (i.e., heart attacks, strokes, and hypertension), lower back injuries, asbestosis, various conditions which can be aggravated by work-related factors, and radiation cases. Development of these guidelines has not yet been completed, but Labor officials believe that once developed, they should result in better evaluations of causal relation.

CONCLUSIONS

Our review of the four district offices showed that, in many cases, workers, Federal agencies, and physicians did not meet Labor's criteria for promptness in claims processing. Therefore, failure to timely file claims for benefits, process claims, submit medical reports, and provide adequate injury details were delaying compensation payments to injured workers.

Labor has implemented or has planned actions to help workers, Federal agencies, and physicians better understand their roles in the injury compensation program. Before workers sustain injuries, Labor's pamphlets and poster, in our opinion, are generally sufficient for making workers aware of their basic responsibilities and rights. They also can be constant reminders of the proper action to take once an injury occurs. For maximum effectiveness, however, they should be available to all workers; and in turn, workers should be periodically reminded that the data contained on them are important. Labor, therefore, should reemphasize to officials of Federal agencies the need to post and maintain in the workplace Poster CA-10 and provide their workers with Pamphlets CA-11 and CA-13. Labor should also encourage Federal agencies to use their local newsletters for periodic reminders to workers of their compensation rights and responsibilities.

Also, to assist workers in filing claims after they have suffered a work-related injury, we believe that Labor should develop a flow chart type checklist that (1) outlines responsibilities and rights, (2) shows the specific forms to be completed in claiming benefits, and (3) shows both the sequences and the timing for submitting the required forms. Such a checklist would be a more graphic description of the basic information workers need to claim benefits and could be made a part of the notice-of-injury form which is generally the first form workers fill out and submit after an injury occurs. The "check-off" feature and easy-to-read language would help workers better understand the sequence for claiming benefits and for determining if they have followed required procedures. Because Federal agencies have their own procedures for processing workers' claims, Labor's development of such a checklist may have to be individually tailored to meet specific requirements of the major Federal agencies.

Labor's seminars, workshops, and meetings with agency top management may be the most effective means Labor has for promoting timely claims processing by Federal agencies. However, the problems cited for delays, such as supervisors and compensation clerks not having adequate knowledge about claims processing and clerks having other duties assigned, are problems that we believe must be dealt with by the agencies. Labor is attempting to alleviate these

problems by offering technical assistance and encouraging agencies to process claims more timely. We believe that it would also help the agencies' top management correct processing problems if Labor provided them with periodic reports on the time it takes them to process claims. We also believe that Labor should determine how effective the experiment of the Jacksonville district office and TVA with electronic transfer of data is in promoting timely processing of claims and whether use of electronic communication has a broader application.

Labor's actions also recognize that well-informed physicians are essential to timely claims processing. Its plans for a national medical program aimed at increasing their awareness about reporting requirements may help improve physicians' performance. Also, adequate standards for evaluating causal relations may help Labor better explain what it requires from physicians and that, in turn, may help physicians provide more complete reports and opinions.

RECOMMENDATIONS TO THE SECRETARY OF LABOR

To enhance workers' awareness of their compensation rights and responsibilities, we recommend that the Secretary

--reemphasize to Federal agencies the need to provide workers with pamphlets and to post and maintain injury posters in the workplace;

--encourage Federal agencies to use their local newspapers for periodic reminders to workers on benefits for work-related injuries; and

--develop a flow chart type checklist outlining workers' rights, responsibilities, and procedures for claiming benefits for work-related injuries.

We also recommend that the Secretary

--provide Federal agencies with periodic reports on the time it takes them to process claims before the claims are submitted to Labor for adjudication;

--ascertain whether the electronic transfer of compensation data between Labor district offices and other Federal agencies would improve claims processing and, if so, implement the use of such electronic data transfer techniques where appropriate; and

--expedite the development of a national program to improve cooperative efforts with the medical community.

AGENCY COMMENTS

On July 31, 1981, in response to our draft report, Labor concurred with our findings on the causes delaying compensation payments to injured Federal workers. Labor agreed with our recommendations and stated that the Department will take the following actions within 60 days:

--Reemphasize to Federal agencies the need to provide workers with pamphlets and to post and maintain injury posters in the workplace.

--Encourage Federal agencies to make more use of their local newspapers as periodic reminders to workers on benefits for work-related injuries.

--Develop a flow chart type checklist outlining workers' rights, responsibilities, and procedures for claiming benefits for work-related injuries.

Labor also stated that by January 1, 1982, the Department would (1) implement our recommendation to provide Federal agencies periodic reports on their timeliness, a service the Department is now doing on an ad hoc basis and (2) after ascertaining whether electronic transfer of compensation data would improve claims processing, decide whether to implement our recommendation on the use of such techniques. With regards to our recommendation that Labor expedite its program for improving cooperative efforts with the medical community, Labor stated that the Department will improve liaison with the medical community by implementing both national and local programs.

CHAPTER 3

LABOR CONTRIBUTES TO DELAYS IN CLAIMS PROCESSING

In the preceding chapter we discussed some of the problems external to Labor that contribute to delays in claims processing. This chapter discusses Labor's problems in promptly processing claims. Our review of 564 compensation payments showed that, of the 334 compensation payments for wage loss, for which data were available, Labor averaged 105 and 237 days to develop and pay claims for traumatic injuries and occupational diseases, respectively. No one cause can be cited for the delays. Our review showed that several factors, such as a large claims workload and problems with staffing--such as the need for full-time permanent staff instead of temporary employees--contributed to the delays.

Labor in recent years has begun or has planned actions to improve claims processing. These actions, which include automating certain aspects of claims processing, have shown promise for improved processing procedures. The effect on timeliness, however, is difficult to determine because Labor has not yet fully implemented the improvements.

LABOR NOT PROMPTLY PROCESSING NOTICES OF INJURY AND CLAIMS

The act provides that "The Secretary of Labor shall determine and make a finding of facts and make an award for or against payment of compensation * * *" after (1) considering the worker's claim and employing agency's report and (2) completing investigations, if necessary.

Timeliness in processing injury notices

Labor's Federal Procedure Manual contains standards for settling workers' notices of injury. Notices of traumatic injury are to be settled within 45 days after receipt and notices of occupational diseases within 180 days. Settlement of notices of injury must be complete before Labor can award benefits.

From our sample of 564 compensation claims, we found that, for about 59 percent of the 467 payments where data were available, Labor did not process the notices of injury within its standards. Average times (measured from the date notices were received to the date Labor approved them) were 100 days for traumatic injuries and

438 days for occupational diseases. Labor's performance in processing notices of injury was as follows.

Type of injury	At four district offices: Number received	Days to process: 0 to 45	46 to 90	91 or more
Traumatic	356	153	95	108
		0 to 180	181 to 365	366 or more
Disease	111	39	26	46
Total	a/467			

a/The Washington, D.C., district office did not stamp the date of receipt on 85 notices of traumatic injury and 10 notices for disease. Two notices for traumatic injury were not date stamped by the Cleveland and Denver district offices.

Timeliness in processing claims

Labor's Federal Procedure Manual also contains standards for settling workers' claims. Claims based on traumatic injuries and occupational diseases are to be processed and authorized for payment within 5 days after receipt. The 5-day standard is predicated on the basis that the claim was payable when received as a result of Labor's previous review of the notice of injury and determination that the worker's injury was job related and he or she was entitled to benefits.

Of the 334 claims for wage loss in our sample, 227 (98 percent) were not processed and paid within 5 days. Average times, (measured from the date claims were received to the date Labor paid them) were 105 days in traumatic injuries and 237 days in occupational diseases. Labor's performance in processing and paying the claims was as follows.

Type of injury	At four district offices: Number received	Claims paid within (days): 0 to 5	6 to 20	21 to 30	31 or more
Traumatic	290	6	68	40	176
Disease	44	1	8	4	31
Total	a/334				

a/The Washington, D.C., district office did not stamp the date of receipt on 40 claims for traumatic injury and 3 claims for occupational diseases. Three claims for traumatic injury were not date stamped by the Cleveland and Denver district offices.

Based on records contained in the case files, only 88 of the 380 claims for wage loss were payable at the time Labor received them. The other 292 claims were not payable at the time of receipt because of the following reasons.

Number	Reason
51	Determination on notice of injury not made
109	Additional medical and employment data required
132	Notice of injury not settled and additional medical and employment data required
292	

Failure to promptly develop and pay claims can delay benefits to injured workers. For example:

--A warehouse worker for the U.S. Army sustained a low-back strain on May 4, 1978, while lifting boxes. He filed the notice of injury on May 24, 1978, received 45 days COP, and submitted a claim for wage loss on June 19, 1978. Labor received the notice of injury on May 31, 1978, but took no action to settle it until June 20, 1978--1 day after receiving the worker's claim. At that time Labor requested that the worker provide details, such as how the injury happened and the immediate effects. A supporting medical report was also requested. Labor allowed 2 months to lapse and then on August 18, 1978, made a second request for the details. The worker and his employing agency submitted the details to Labor on August 22, 1978, and on September 13, 1978, respectively. Labor approved the injury as job related on October 30, 1978, over 1 month after receiving the details. Moreover, despite repeated inquiries by the worker and his employing agency about the status of the claim and notification that the worker was being harassed for payment on medical bills, Labor's payments were not made until March 11 and 18, 1980--almost 17 months after approving the injury as job related. Neither the case file nor district officials could provide reasons for the delay.

Other work standards for processing claims not met

Labor's Federal Procedure Manual contains additional standards for completing work necessary to process and pay claims. Although Labor requires its district offices to report monthly work backlogged, those monthly reports show only totals and do not provide information on how long work remained at any one work station.

(Labor uses the term "backlog" to quantify--at any point in time--the number of claims for which some action was due, i.e., clerical, claims examiner, fiscal, or medical.) By inventorying work at several processing stations and using Labor's records when available, we found that standards for completing work often were not met. The case files did not indicate why long periods often lapsed in developing claims or, once developed, paying them.

Problems with meeting work standards at the several work stations were evident at the four district offices, though in varying degrees. For instance, Labor requires mail to be attached to appropriate case files within 2 days. Labor's inventory of unattached mail on the days tested showed that Cleveland had 422 pieces, Denver 1,156 pieces, Jacksonville 6,244 pieces, and Washington, D.C., 1,153. Based on the volume of daily mail, that number of pieces represented backlogs of about 1-1/2, 5, 8-1/2, and 1-1/2 days, respectively.

Correspondence with workers, other Federal agencies, and physicians is to be typed within 1 week. At all offices turnaround time for typed correspondence often exceeded this standard. At Denver, on the day we tested, 13 of 42 cases had been in the typing pool more than 7 days. Typing turnaround at Cleveland during May and June 1980 averaged 8 days, with some cases taking 20 to 40 days. Similar delays existed at the Jacksonville and Washington, D.C., district offices.

District medical directors' opinions are due within 2 weeks from the time the examiners submit claims to them for review. Two district offices had problems obtaining timely medical reviews. For example, at the Washington, D.C., district office on the day of our test, 410 claims were awaiting medical review and the average waiting time was 31.5 days. Many claims had been awaiting review several months. At the Denver district office the backlog of claims awaiting medical review was estimated at about 3 months. The Cleveland and Jacksonville district offices were receiving timely medical reviews.

Responses to priority written inquiries, i.e., to members of the Congress, are to be made within 14 days. Available records showed that standard is not always met, but response times are improving. For example, in fiscal year 1978, the Jacksonville district office averaged 45 days in responding to priority correspondence. By the fourth quarter of fiscal year 1979, that average had decreased to 15 days, and during the first quarter of fiscal year 1980, the office answered all 692 priority inquiries within Labor's 14-day standard. Available records at the other three district offices showed similar improvement in response times.

Responses to priority telephone inquiries are to be made within 2 days. Available records indicate that response times are not always within the 2-day standard, but they are improving. For example, for a 2-week period in January 1980, the Cleveland district office responded to 61 inquiries, 33 of which (or about 54 percent) were made within 2 days. For a 2-week period in June 1980, however, it responded to 45 inquiries, 38 of which (or about 84 percent) were made within 2 days. Available records at the other three district offices showed similar improvements.

Medical bills are to be paid within 10 days after receipt. For all 15 district offices, Labor reported that for the 4-week period ended May 29, 1980, 10,251 medical bills were paid. Of that number 3,269 (or about 32 percent) were paid within 14 days of receipt. Although Labor's records do not measure against the 10-day standard, the small number paid within 14 days shows that the 10-day standard is often exceeded. However, according to Labor's records, since it automated the bill paying procedures in July 1978, steady improvement in timeliness has been achieved.

Period ending 4 weeks	Number of bills paid	Paid within 14 days		Paid within 28 days	
		Number	Percent	Number	Percent
6-01-78	2,015	249	12.4	815	40.4
5-31-79	8,807	1,613	18.3	3,659	41.5
5-29-80	10,251	3,269	31.9	7,654	74.7

The table shows that the number of bills paid has increased fivefold and the percent of bills paid within 14 days of receipt has increased from 12.4 to 31.9 percent. Bills paid within 28 days (which includes those paid within 14 days) have increased from 40.4 to 74.7 percent.

REASONS FOR DELAYS IN CLAIMS PROCESSING

The reasons most often given by Labor officials for not meeting work standards were too great a workload for the staff to handle effectively and staff problems, such as the need for more full-time permanent staff instead of temporary employees. Accordingly, we analyzed workload trends and staff data along with work being done at the processing stations. We did not make a detailed review of staff utilization and productivity at Labor. We found that Labor's workload is high volume and generally has increased steadily over the last several years with more recent increases moderating. Staffing has also increased significantly, but only in recent years. While the imbalance between workload and staff is not as great as it was, we did find that staff shortages in some areas, turnover at one district office, and the reliance on temporary employees to handle processing functions have contributed

to delays in claims processing. In addition, we found that Labor's management information system has not yet developed to the point that work areas where processing problems exist can be identified.

Workload is high and relatively uncontrollable

The Congress in enacting the COP amendment in 1974, sought to reduce:

--The time lag between injury and receipt of benefits.

--The number of claims filed.

--Labor's claims processing time.

--Backlog of claims.

Following the 1974 amendments, however, the number of wage loss claims escalated dramatically. During fiscal year 1974, workers filed about 12,000 wage loss claims. During fiscal year 1976, the first full year after the amendments, the number rose to about 80,000 and, during fiscal year 1979, surpassed the 90,000 mark. These increases occurred even though the Federal work force remained fairly stable. Thus, instead of a decrease in claims filed, the number of claims for lost-time injuries increased. (COP is claimed for traumatic injuries by submitting only a notice of injury. Before this amendment workers had to file a claim form in addition to the notice of injury.) Furthermore, Labor's administrative work was increased substantially because the ultimate decision on workers' entitlement to COP was still Labor's. That required the following decisions:

--Was the injury traumatic?

--Should the claim for COP be controverted?

--Did the employing agency pay the correct amount of COP in accordance with rules and regulations?

--Was COP claimed timely?

These decisions are required in addition to all those on entitlement to benefits existing before the COP amendment. Also, Labor must notify Federal agencies of its decisions that COP was or was not paid properly.

All areas of Labor's workload during the past 10 years have grown substantially. The rate of workload growth, however, has moderated in recent years. For example, during fiscal years 1970-79, notices of injury or death increased by 72.7 percent,

claims for compensation by 73.3 percent, and persons receiving compensation for extended periods by 104.4 percent. The changes in some areas of incoming workload are shown in the following table.

Fiscal year	Notices of injury or death	Claims for compensation	Persons receiving extended compensation
1970	120,625	17,795	23,462
1971	111,851	20,987	25,331
1972	109,578	26,774	27,502
1973	112,417	28,231	29,114
1974	123,001	31,025	32,244
1975	144,897	35,615	36,479
1976	191,172	40,324	42,401
1977	207,615	30,301	44,576
1978	200,780	31,637	45,595
1979	208,375	30,845	47,947

In addition to the 1974 COP amendment, Labor officials cite several other factors for the increased workload, such as (1) greater worker awareness of the program--brought about largely through the activities of unions and through Labor's sponsored seminars and (2) the complexity of many of the claims filed by workers. According to Labor's studies, about one-third of all claims filed involve disease-related conditions and timely processing of these types of claims is affected by difficult and time-consuming questions on whether the disease is related to employment. In addition, according to Labor, Federal agencies are also aware that conditions outside the workplace can contribute to or aggravate diseases and often controvert workers' claims.

Backlog indicates a timeliness problem

Although the pace of workload increases has begun to moderate, Labor officials believe that many of the problems caused by earlier large increases are still having repercussions, such as the large backlog of unprocessed claims. Labor officials have stated that reducing the backlog would help achieve more prompt claims processing. (Labor could concentrate on the incoming workload rather than on the claims backlog.) In recent years, as a result of Labor's efforts to reduce it, the backlog has fluctuated, but generally has increased significantly. For the 10-year period, fiscal years 1970-79, the backlog increased 303 percent, as shown in the following table.

Fiscal year	Reported backlog
1970	31,557
1971	18,776
1972	22,800
1973	35,424
1974	38,660
1975	23,795
1976	37,748
1977	103,016
1978	94,454
1979	127,103

At the end of fiscal year 1980, Labor reported that the backlog of unprocessed claims had been reduced to 72,686.

Reported backlog for the district offices we visited also showed fluctuations. The changes for the past 3 fiscal years were:

District office	Backlog at end of fiscal year		
	1977	1978	1979
Cleveland	4,951	5,865	10,150
Denver	2,831	2,333	3,377
Jacksonville	29,075	10,736	3,827
Washington, D.C.	8,058	8,471	4,784

These reports show backlogs worsened in two offices and improved in two. Information on how long claims work remained at any one work station was not available.

In January 1980, Labor's Branch of Hearings and Review had more than 3,000 appeals backlogged, many for long periods. The Assistant Secretary of Labor, in testifying before the House Subcommittee on Labor Standards of the Committee on Education and Labor in May 1980, attributed this backlog to Labor's increased productivity over the previous 2 years. He said that a larger volume of claims settled resulted in more dissatisfied claimants and therefore, a larger volume of appeals.

To reduce the backlog, Labor formed a task force, which in 3 months disposed of about 2,500 appeals and was dissolved. At the time of our review, the Branch was receiving about 300 requests monthly and had about 1,500 backlogged cases. The Branch chief said that appellants would not experience long delays as before.

The Branch's standard was to schedule a hearing within 120 days after receiving a request and to issue a decision within 30 days after the hearing had closed. Records indicated that the Branch is meeting the 120-day scheduling standard, but aggregate records to measure performance on decisions were not available.

Staffing problems

Over the past several years OWCP has requested additional staff to handle the increased workload, and it has made a study supporting the need for more full-time permanent staff instead of temporary employees. Some of the requests, however, were rejected or reduced by Labor or by the Office of Management and Budget (OMB). The Congress, at times, provided additional staff for OWCP that Labor had not requested.

Adequate overall staffing has been a longstanding problem

The following table shows, for fiscal years 1970-81, OWCP staff requests for administering the act along with the levels approved by the Congress.

Fiscal year	Requested by OWCP	Approved by Labor	Approved by OMB	Approved by the Congress	Positions allocated to the division by Labor
1970	(a)	(a)	(a)	(a)	(a)
1971	(a)	(a)	(a)	(a)	(a)
1972	(a)	(a)	(a)	472	472
1973	(a)	424	424	424	424
1974	445	445	445	469	469
1975	584	469	469	469	469
1976	487	487	487	487	487
1977	623	610	610	645	645
1978	713	655	645	621	621
1979	1,100	1,100	853	853	853
1980	1,100	1,100	853	853	853
1981	1,089	1,089	853	853	853

a/Labor was unable to supply these data.

The following are some of the actions that impacted on staffing:

1973 - Staff reduced by 48 because of the President's economy action to reduce employment in the executive branch.

1974 - The Congress added 24 permanent positions that Labor had not requested. Also, 21 more positions and twenty-five 2-year temporary employees were added by the 1974 supplemental appropriations.

1975 - After an office-by-office analysis of the backlog and the need to reduce it before implementing automated processing techniques, OWCP requested 115 additional positions. Labor denied the request, but the Congress

added 74 temporary positions for the last 6 months of fiscal year 1975.

1976 - Labor transferred 18 positions to the Federal Employees' Compensation Program from the Longshoremen's and Harbor Workers' Compensation Program. The Congress authorized continuing the 74 temporary positions through 1976. OMB and Labor authorized OWCP to hire 108 additional temporary employees to help handle the backlog.

1977 - OWCP requested 13 permanent and 52 temporary positions. Labor denied the 13, but approved the 52 temporaries. The Congress added 35 full-time positions to help OWCP reduce the backlog. In a supplemental appropriation, the Congress approved Labor's request for 123 permanent positions and 55 staff years of temporary assistance.

1978 - OWCP requested an additional 68 positions. Labor recommended an increase of 10, which OMB denied. Funding for 200 temporary positions was authorized and 24 positions were transferred to other programs. Labor also reprogramed funds to allow OWCP an additional 250 positions for fiscal year 1978 only.

1979-80 - OWCP requested 71 additional positions for fiscal year 1979. Labor, in a supplemental budget request, proposed an additional 408 positions (100 for fiscal year 1979 and 308 for fiscal year 1980). OMB proposed an increase of 232 (25 for fiscal year 1979 and 207 of the 408 requested in the fiscal year 1979 supplemental), and the Congress approved it.

1981 - OWCP and Labor requested 236 additional positions to replace temporaries and reduce overtime. OMB denied the request, proposed a ceiling increase for 200 temporary employees without additional funding, and the Congress approved.

In further support of its need for additional staff, OWCP made a staffing study of its district offices in August 1978. That study concluded that for the district offices to handle the claims load, reduce the backlog, and process claims more timely, they needed an additional 213 positions beyond the 813 allocated to them in July 1978. That study also found that the district offices had an "inordinately high percentage of temporary and/or part-time personnel," concluding that program operations were "seriously hampered and rendered less effective" by the use of such personnel. An official at OWCP's national office told us that he believed 300 additional full-time permanent positions were needed above the 853 now authorized.

Need for full-time permanent employees

We discussed the failure to meet work standards with Labor representatives in the four district offices we visited. Reasons most often given for not meeting work standards related to staff problems, such as shortages in full-time permanent employees, frequent turnover and long time lapses before positions were filled, and a need for better allocation of staff to critical work areas not meeting work standards. They said that while temporary employees can help in certain areas of claims processing and that occassional overtime may contribute to workers' productivity, overuse of either was not the solution to long-term improvements in claims processing. Staff as of July 1980 and overtime use for the four district offices are shown in the following table.

District office	Permanent full-time staff	Temporary staff	Overtime hours	
			Fiscal year 1979	Percent change over fiscal year 1978
Cleveland	61	17	10,521	+78.8
Denver	26	11	6,411	+17.5
Jacksonville	93	22	2,925	-45.6
Washington, D.C.	75	14	a/18,631	+ 4.5

a/Records available for only three quarters (9 months).

Management officials at all four district offices told us they have staff problems though in varying degrees. For example, at the Cleveland district office the work station for maintaining case files and processing incoming mail had three permanent full-time and five temporary employees. A management official said that two or three additional permanent full-time employees were needed to effectively process the work at this station. He believed that additional help could be obtained by moving employees from other work stations. The Jacksonville district office had three permanent full-time and seven temporary employees assigned to process incoming mail and maintain case files. A supervisory official said that one or two additional full-time permanent employees were needed. He also said that temporary employees helped handle the workload, but that considerable supervisory time was required to train new employees who replaced the temporary ones. Furthermore, he stated that without overtime work the mailroom could not keep the backlog from increasing. Similar conditions existed at the Denver and Washington, D.C., district offices.

Except for Cleveland, officials at the district offices believed that the number of claims examiners was not adequate to efficiently process claims. For instance, an official in the Jacksonville district office said that the 30 claims examiners

each had about 500 cases assigned. He believes that between 200 and 300 cases is the optimum workload for each claims examiner. At the Cleveland district office where the claims examining staff increased from 5 in fiscal year 1975 to 25 by March 1980, an official said that, if the backlog can be reduced--once all examiners are experienced--the current claims examining staff would be adequate to handle the workload.

Shortage of medical directors

The adequacy of the number of medical directors has also been a problem. For example, in November 1979, the Cleveland district office hired nine physicians on a contract basis to help its two part-time medical directors clear a backlog of about 1,000 claims. A management official in the Cleveland district office said that the backlog resulted from inadequate staff, but with the help of the contract physicians the backlog is no longer a problem.

The Denver district office had one part-time medical director and three physicians on contract. Backlog of claims awaiting a review was still a problem at the time of our review. Although the medical director is to work only 20 hours each week, he said that he works 25 hours each week because of the volume of claims to be reviewed.

The Jacksonville district office had one full-time medical director. He said that he reviewed about 1,000 claims each month and that was too much for one person. A management official in the Jacksonville district office said that one medical director was not sufficient. He also said that some work had been contracted to local physicians, but their reviews took too long. Case files had to be taken to the physicians and picked up once reviewed. He believed that an additional part-time physician to work at the district office would be the best alternative.

The Washington, D.C., district office had one physician part time to review claims. A management official in the Washington, D.C., district office attributed the large backlog of claims awaiting review to the problem of not having enough physicians. She said that about 150 claims each week were being sent to the Seattle district office for review. She also said that additional physicians could not be hired because of a hiring freeze.

Staff turnover

Staff turnover was not a problem at three district offices we visited, but for the Denver district office it had been significant. Six of its 10 claims examiner positions turned over at least once during a recent 20-month period. During the period, vacancies existed for up to 3-1/2 months, and at one time, 3 of the 10 positions were vacant at the same time. Management officials told us

such vacancies meant that remaining examiners attempted to absorb the overflow but backlogs developed. They said that supervisory examiners assisted with the extra workload generated by vacancies.

The turnover problem with the Denver staff was more severe in other sections of the district office including the mailroom, fiscal, typing, and medical sections. During the 20-month period, the turnover rate for 18 support positions was about 180 percent with 32 changes. In the mailroom, for example, where 5 positions are normally filled, there were 12 turnovers with vacancies as long as 6 months. As of May 1980, one position had been vacant since mid-February 1980. Turnover in the typing section was also substantial with seven changes to the three authorized positions. The following table reflects turnover which occurred in each section.

Denver
Staff Turnover

(Oct. 1, 1978, through May 31, 1980)

Section	Normal staffing	Number of changes	Turnover percent of normal staffing
Examiners	10	6	60
Mailroom	5	12	240
Typing	3	7	233
Fiscal	6	7	117
Other	4	6	150
Total	28	38	136

Management officials said that heavy caseloads were a major factor in staff turnover. Other reasons given for high turnover were (1) lack of opportunity for advancement, (2) need for permanent employment, (3) low employee morale, and (4) employee stress. They also said that for efficient operations, at least nine additional permanent full-time employees were needed.

LABOR'S ACTIONS TO IMPROVE CLAIMS PROCESSING

In May 1980 testimony before the Subcommittee on Labor Standards of the House Committee on Education and Labor, the Assistant Secretary of Labor said that when he took over the office in 1977, Labor's claims processing system was so administratively weak that it was in a virtual state of collapse. He noted that a number of investigations had identified serious "systemic" deficiencies, such as a lack of effective claims management and processing procedures, that needed to be corrected before claims processing could be timely

and efficient. Labor has taken a number of actions to improve its claims processing.

Automating claims processing

Labor is in the process of automating its manual claims processing system. This action, according to Labor officials, is its single most comprehensive action to improve claims processing. Labor officials said that through automation they can reduce the claims backlog and improve productivity--two measures they consider essential to more efficient and prompt service to injured workers.

Labor began designing the automated system in 1974. If current schedules hold, the system is to be fully operational by the mid-1980s. At the four district offices we visited, some of the system had been implemented and was being used to help better manage and process claims. For example, the callup card system was being automated, giving the claims examiners a daily list of claims to be reviewed. Claims continued to show on the report until some action was taken, thereby providing a record of claims that had overdue callup dates. Another daily report provided the location of claims in the processing system and how long they had been at the particular work station. Claims examiners and clerical staff used that report to establish priority work. Management officials and supervisors used it to monitor and evaluate staff performance at particular work stations and for determining reasons for slow moving claims.

Also with the automated system Labor has the capability to rapidly determine the location of claim files as they moved through or are filed in its processing system. With this capability, Labor was able to reduce its manual searches for files, thus enabling the district offices to (1) respond more timely to inquiries, (2) distribute mail more efficiently and promptly, and (3) maintain better control over files with fewer lost or misplaced files.

Over the next few years Labor is planning to more fully implement its automated system. For example, during fiscal year 1981, Labor plans to automate

--typing of most correspondence through the use of a word processing system and

--payment of claims once the claims examiners have awarded benefits.

Labor also plans to pilot test more comprehensive and sophisticated techniques during fiscal year 1981. The planned system includes:

--More complete data bases.

--Automatic edit checks (error identification and correction).

--Reduced dependence on physical case file folders.

--A standardized decision process that reduces potential for haphazard claims development.

--Extensive automated reporting and measurement capabilities.

Anticipated implementation date for this system is fiscal year 1984.

Management information system is part of automation effort

For many years Labor's management information system was limited essentially to periodic statistical and narrative reports which dealt mainly with levels of program activity. No information was routinely available concerning the timeliness of claims processing. Management officials at the operating levels also had no information that they could rely on to help them ensure that processing actions were being taken in a timely manner.

In his May 1980 testimony the Assistant Secretary said that Labor had reached the stage in its automation efforts to concentrate on the development of a management information system. He said that Labor planned to phase in the system during the next few months. He also said that the system would provide timely, accurate production data and would give management the information it needs to establish better control over claims processing.

A Labor official told us that the system--which provides management with reports on inventory, incoming workload, production, response to inquiries, and processing times--became operational in November 1980. We did not evaluate the system's effectiveness.

Improved procedures for inquiries

Improved procedures for handling inquiries is a step Labor has taken to provide better service to injured workers or someone inquiring on their behalf. Responding to inquiries, whether by telephone, mail, or in person, was formerly the responsibility of whomever was available at the time--claims examiners, clerks, or secretaries. This procedure did not provide effective or timely responses and often occupied most of the claims examiner's workday. In recent years, Labor established contact units for the primary purpose of responding to inquiries. At the four district offices, Labor had staff assigned to handle inquiries both from workers and other parties and, as discussed earlier, records indicate improved performance.

Guidance and training for examiners

Labor has also taken measures to increase staff productivity. It has revised and has updated its procedures manual for claims examiners. The revised version includes accountability procedures to improve compliance with program policy and work standards on claims processing.

In 1977, Labor also began an agencywide basic and advanced level program to educate its claims examiners about the requirements of claims processing and their responsibilities as claims examiners. To supplement this formal training, Labor requires each district office to provide a minimum of 2 hours inhouse training that covers such topics as new procedures, policy statements, and interpretation of medical evidence.

Most claims examiners at the four district offices had taken the two-part training program. Comments of claims examiners and management officials about the training varied.

--Training did not prepare them for handling complex claims.

--Training was valuable, but should have come earlier in their career.

--Most claims examiner training came from on-the-job experiences.

--Training was effective in promoting consistency in decision-making.

--Refresher courses were needed to keep examiners up to date.

Labor officials said that training and the revised procedures manual have improved both the quality and uniformity of claims processing.

Also, Labor is strengthening its medical program capability to help claims examiners evaluate injuries that present difficult and time-consuming questions on causal relation to the workers' employment. For instance, since 1977, Labor has been preparing guidelines for four conditions which, according to Labor's statistics, account for a large number of claims filed each year, i.e., heart disease, pulmonary, low-back problems, and psychiatric. Once developed and tested, the new guidelines will be incorporated into the procedures manual.

Legislative proposals on paying medical staff and changing appeals process

Labor has determined that a shift from mostly traumatic injury to more disease-related claims has increased the need for highly skilled physicians to assist claims examiners in settling questions of cause, extent and degree of impairment, and duration of disability. Because of pay limitations--regular pay and cash bonuses may not exceed the $50,112.50 pay limitation for general schedule employees--Labor officials believe the Department has difficulty hiring physicians skilled in the evaluation of difficult injuries, usually disease-related cases.

Labor has proposed legislation to authorize payment to physicians in excess of the ceiling. Such a measure, according to the proposal, would strengthen its medical decisionmaking capability by giving it the same advantage enjoyed by the Veterans Administration and the Public Health Service in competing for the limited supply of physicians.

Labor also has proposed legislative changes to the appeals process. According to Labor's findings, current appeal procedures have systemic problems and confuse appellants. They also result in multiple handlings of a claim because the Employee Compensation Appeals Board remands many appeals to Labor for further development. This practice and the right of an appellant to request reconsideration of a claim at any time have increased the workload of both Labor and the Board. To eliminate these problems, Labor has proposed, for decisions that are appealed by workers, a mandatory three-step appeals process, i.e., (1) review at the district office level, (2) followed by a hearing before the Branch of Hearings and Review, and (3) finally an appeal to the Board.

Labor has also proposed limiting the Board's authority to substantial questions of law and fact and allowing appellants only one opportunity to reopen a claim. Labor officials believe that this proposal will preserve the rights of appellants while at the same time significantly reduce the workload of Labor and the Board.

CONCLUSIONS

We found that, in many cases, Labor's processing of claims at the four district offices did not meet its own criteria for timeliness and was contributing to delays in injured workers receiving their compensation benefits. The problems of workload, staffing, and claims processing may be lessened significantly through Labor's actions, especially through the automation of claims processing procedures. However, it is too early to determine their full effect on timeliness.

Labor has also identified problems affecting timely processing of claims that lie beyond its administrative control. Labor believes that for long-term improvements additional full-time permanent staff is a better alternative than either temporary employees or overtime. Its legislative proposal identified areas where Labor believes changes are necessary for more prompt and efficient claims processing. We evaluated neither the relative merits of full-time permanent versus temporary help or the use of overtime, nor the specific issues which would be dealt with by Labor's legislative proposals.

AGENCY COMMENTS AND OUR EVALUATION

Labor stated that our report is probably accurate on claims processing times at the time of our review. The Department, however, believes that current processing times are better. Its response cited that, in fiscal year 1981, the Department has seen an improvement in the timeliness in processing traumatic injuries (date of receipt by OWCP to date of adjudication by OWCP) from 62 percent within 45 days, as of October 1980, to 81.2 percent within 45 days, as of June 30, 1981. According to Labor, this advance in the time of adjudication invariably reflects considerable improvement in payments.

Labor also said that more information on timeliness of payments will be available later this calendar year when all district offices are brought on line with its automated compensation payment system. Labor believes that the automated system should reduce the time to make compensation payments by 5 to 10 days. Labor also said that the Department expects that the legislation proposed by the administration will free the processing system of many minor injuries, thus allowing OWCP claims examiners more time to concentrate on cases with compensation claims.

For the four district offices visited, we believe that the statistics accurately represent Labor's processing time for wage loss claims. We also believe that, given the actions Labor has taken to improve claims processing, timeliness of processing will improve. However, of the 380 claims for wage loss in our review, 292 (or about 63 percent) were not payable at the time Labor received them because additional medical and employment data were required. This indicates that, even though the notices of injury were settled timely, Labor's processing times for the corresponding claims would still be extended. In our opinion, estimates on the extent of improvement in timeliness are speculative until Labor's automated compensation system can accurately show processing times for wage loss claims.

The administration's proposal to make legislative changes to the act was not evaluated in this review, and we cannot comment on the expected results. The administration's proposal, however, was included in the Omnibus Budget Reconciliation Act of 1981, H.R. 3982, but was subsequently deleted.

CHAPTER 4

DELEGATING ADDITIONAL PROCESSING RESPONSIBILITIES TO FEDERAL AGENCIES COULD ALLEVIATE DELAYS IN CLAIMS PROCESSING

Labor's contacts with injured workers, Federal agencies, and attending physicians are essentially through the mail. Labor has taken or has planned significant actions to improve claims processing. In our opinion, however, even with these actions, Labor's use of a through-the-mail operation rather than one of onsite investigations--when warranted--and personal contact, greatly diminishes its ability to gather information vital to prompt determinations of workers' eligibility to receive compensation benefits.

An alternative to the current administration of the Federal Employees' Compensation Act, which should result in more timely determinations of eligibility, would be to adopt claims processing techniques used in the workers' compensation insurance industry. Given the relatively small number of workers covered by the act, however, and the wide geographic dispersion of those workers, it may not be feasible to provide Labor enough staff to carry out such techniques. However, because the Federal agencies (1) are already geographically dispersed, (2) generally have first-hand knowledge of the worker and his or her working conditions, (3) are the disabled worker's most likely source of reemployment, and (4) should have a legitimate interest in the welfare of an injured worker, it may be both feasible and desirable to give Federal agencies added responsibilities for claims processing while leaving Labor with responsibility for decisions on entitlement.

CURRENT PROCEDURES DO NOT PROVIDE FOR ONSITE INVESTIGATION OR PERSONAL CONTACT TO OBTAIN INJURY DETAILS

To obtain the information it needs to determine an injured worker's eligibility for compensation benefits, Labor's contacts with injured workers, Federal agencies, and physicians are essentially through-the-mail transmissions of forms and form letters. As a result, Labor's claims examiners rarely have first-hand knowledge about the details of a worker's injury, whether the disability is really work related, or whether the physician has an accurate understanding of the conditions alleged to have caused the worker's injury. In addition, this through-the-mail operation is time consuming and can lead to confusion as to what information Labor needs to determine eligibility.

In contrast, representatives of several insurance companies have told us 1/ that onsite investigations--interviewing injured workers, witnesses, employers, and physicians--were essential for effective claims development. One major insurance association, which underwrites about 25 percent of the workers' compensation business provided by U.S. insurance companies, expects an investigator to visit the worker within 48 hours of learning of the injury and within 5 to 6 days of the injury. The investigator informs and assures the injured worker, gathers substantiating employment data, and discusses the specifics of the injury and the insurer's reporting requirements with the physicians. According to representatives from the private insurance industry, personal contact with workers immediately after an injury occurs and frequently thereafter is important for maintaining an injured worker's motivation to return to work and to encourage his or her medical recovery and rehabilitation.

FEDERAL AGENCIES COULD MANAGE CLAIMS PROCESSING

A more person-oriented injury compensation program could be achieved if Labor relied on appropriately trained staff at the Federal agencies to make onsite investigations of work-related injuries, marshall all injury details--including medical evidence, handle inquiries originating from workers, their families, physicians, and Labor, and monitor the status of injured workers to help determine their needs and/or provide assistance in returning them to gainful employment.

Labor also could rely on them to meet with or contact physicians to inform them of the importance that timely reporting has for Labor's determination of eligibility and provide details on

--the conditions of a worker's job that may have caused or contributed to an injury,

--the kind of medical findings Labor is seeking to settle the worker's claims,

--supplemental reporting (if required), and

--other details about the worker's injury or job that could add to the physician's opinion on causal relation or about the worker's ability to return to work.

1/"Improvements Still Needed In Administering The Department of Labor's Compensation Benefits For Injured Federal Employees" (HRD-78-119, Sept. 28, 1978), pp. 43 and 44.

"Multiple Problems With The 1974 Amendments To The Federal Employees' Compensation Act" (HRD-78-80, June 11, 1979), pp. 65 and 66.

Staff at the Federal agencies, in essence, would be responsible for managing that portion of the claims processing external to Labor and act as Labor's primary contact for injured workers, workers' supervisors, witnesses, and physicians.

Officials from both Labor and other Federal agencies said that claims processing times could be improved if the agencies' personnel were used to implement a person-oriented injury compensation program. Generally, Labor officials believed that increased responsibilities for Federal agencies would improve processing times, provided they commit staff whose primary duties are compensation matters. Agencies also believed that this was an ideal alternative. It could work well if they had full-time workers' compensation staff and if Labor would establish meaningful and realistic standards for claims processing and enforce compliance. Also, some officials said that a faster means of communication between Labor and the agencies would improve timeliness of claims processing. Labor has an experiment underway with TVA for electronic transfer of claims and injury details (see ch. 2).

Because our review was limited to assessing Labor's processing of claims and visiting selected agencies, we assessed neither the adequacy of the agencies' resources to take on the type of additional responsibilities for claims processing discussed above, nor the impact the delegation of these responsibilities would have on the agencies' operations. Because of the potential benefits of such a delegation in improving claims processing and in aiding injured workers to timely receive all compensation benefits they have a legal right to, we believe that this matter should be assessed on a Government-wide basis.

OMB has general oversight responsibility for organization and management practices of all Federal agencies. Therefore, we believe that OMB should determine whether it would be feasible to delegate to Federal agencies added responsibility for claims processing including onsite investigations--when warranted--to gather injury details, marshall injury data, and monitor the welfare of injured workers who receive benefits under the Federal Employees' Compensation Act.

AGENCY COMMENTS AND OUR EVALUATION

Department of Labor

Labor stated that it is preparing regulations that will require Federal agencies to provide improved claims information and conduct investigations for OWCP.

Labor's actions in promulgating regulations for procedural changes are in the direction intended by our recommendation; i.e., more Federal agencies' involvement in the injury compensation

program. Its authority, however, to require Federal agencies to take on added responsibilities along the lines we are recommending may be limited. Federal agencies, in our opinion, must take on additional program responsibilities in order for the processing of claims and other compensation matters to be handled efficiently and effectively.

Office of Management and Budget

In our draft report, we proposed that the Director of OMB study the feasibility of placing in Federal agencies specific processing and monitoring responsibilities under the injury compensation program. On August 6, 1981, in response to our draft report, OMB stated that such a study would not be meaningful at this time because of (1) Labor's actions to improve claims processing and (2) the administration's proposed legislation to correct "a number of deficiencies in the structure of the law." OMB also stated that, under the actions taken by Labor and the proposed legislation, many of the problems identified in our report as the basis for our recommendation may not be as significant. Furthermore, OMB stated that it will monitor the situation and "if experience shows that organizational problems result that cannot be resolved by the Secretary of Labor under the law, we would certainly carry out appropriate studies."

We disagree with OMB's reasoning for not determining the feasibility of delegating to Federal agencies added responsibilities under the injury compensation program. First, our report clearly shows that Labor's approach to compensation matters arising under the act does not provide for techniques considered by representatives from private industry as essential to an effective compensation program. Our report also shows that, if Labor should adopt such techniques, it could not implement them without help from the Federal agencies. Second, Labor's actions to improve claims processing are not of the type that would require the kind of Federal agencies' involvement in the program encompassed by our recommendation. For the most part, Federal agencies would have no additional responsibilities that are not now required by the act and Labor's regulations. Also, the legislative changes were not enacted.

Although we did not evaluate the administration's legislative proposal, we believe that legislative changes to the act and Labor's actions could lessen the problems identified in our report affecting timeliness of claims processing. In our opinion, however, delegating additional responsibilities to the Federal agencies would complement both the proposed legislative and procedural changes; further strengthening and improving the handling of compensation matters under the injury compensation program.

Given the significant benefits to both the Federal Government and injured workers that could result from adopting compensation techniques similar to those used in the private sectory, we continue to believe that OMB should determine the feasibility of delegating to the Federal agencies added responsibility for claims processing and other compensation matters under the injury compensation program.

RECOMMENDATION TO THE DIRECTOR OF OMB

We recommend that the Director of OMB determine the feasibility of placing in Federal agencies specific processing and monitoring responsibilities, such as

--onsite investigations of injuries to gather injury data and to assure, if necessary, the propriety of continuing compensation benefits;

--marshalling injury data, including medical evidence, to assist injured workers establish a claim;

--obtaining medical progress reports at appropriate intervals to provide current information about the worker's medical condition; and

--handling inquiries originating from injured workers, their families, physicians, and Labor.

If the Director of OMB determines that placing additional claims processing responsibilities in Federal agencies would be feasible, we recommend that he submit legislation to the Congress to amend the Federal Employees' Compensation Act.

The proposed legislation should give the Secretary of Labor responsibility for

--issuing regulations to guide the Federal agencies in carrying out their responsibilities,

--reviewing and supervising the activities of the agencies, and

--making all decisions relating to the eligibility, reduction, or termination of benefits, using information developed by the agencies or Labor personnel.

FEDERAL AGENCIES AND NUMBER OF CASES IN OUR SAMPLE

Agency	Number of cases
Action	1
Architect of the Capitol	1
Department of Agriculture	23
Department of Air Force	50
Department of Army	58
Department of Commerce	3
Department of Defense	5
Department of Health, Education, and Welfare	13
Department of Housing and Urban Development	4
Department of the Interior	15
Department of Justice	7
Department of the Navy	56
Department of Transportation	20
Department of the Treasury	10
General Services Administration	7
National Aeronautics and Space Administration	2
Office of Personnel Management	1
Smithsonian Institution	1
Tennessee Valley Authority	45
U.S. Government Printing Office	9
U.S. Information Agency	1
U.S. Postal Service	180
U.S. Soldiers and Airmen's Home	2
Veterans Administration	50
Total	564

APPENDIX II

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
WASHINGTON, D.C. 20210

JUL 31 1981

Mr. Gregory J. Ahart
Director
Human Resources Division
U. S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

This is in reply to your letter to the Secretary requesting comments on the draft GAO report entitled, "Injury Compensation Process Delays Prompt Payment of Benefits to Federal Workers".

The Department's response is enclosed.

The Department appreciates the opportunity to comment on this report.

Sincerely,

Robert B. Collyer
Deputy Under Secretary

Enclosure

U.S. Department of Labor's Response to the
Draft General Accounting Office Report
Entitled --

Injury Compensation Process Delays Prompt
Payment of Benefits to Federal Workers

Recommendations:

Re-emphasize to Federal agencies the need to provide workers with pamphlets and to post and maintain injury posters in the workplace.

Encourage Federal agencies to make more use of their local newspapers as periodic reminders to workers on benefits for work-related injuries.

Develop a flow chart type checklist outlining workers' rights, responsibilities, and procedures for claiming benefits for work-related injuries.

Response:

The Department will implement these recommendations within 60 days.

Recommendation:

Provide Federal agencies with periodic reports on the time it takes them to process claims before the claims are submitted to Labor for adjudication.

Response:

The Department will implement this recommendation on a quarterly basis by January 1, 1982. This service is currently provided on an "ad hoc" basis.

Recommendation:

Ascertain whether the electronic transfer of compensation data between Labor district offices and other Federal agencies would improve claims processing and, if so, implement the use of such electronic data transfer techniques where appropriate.

Response:

The Department is in the process of ascertaining whether the electronic transfer of compensation data between Labor district offices and other Federal agencies will improve claims processing. A decision on the implementation of this recommendation is expected by January 1, 1982.

Recommendation:

Expedite the development of a national program to improve cooperative efforts with the medical community.

Response:

The Department will improve its current liaison with the medical community by implementing both national and local programs.

Comment:

The Department concurs with the reasons GAO finds for delays in payments. Workers, employing agencies, physicians and OWCP all share some blame. While the report probably accurately reflects the processing times of FEC cases at the time of the review, the Department believes that the report does not reflect current processing. In fiscal year 1981, the Department has seen an improvement in the timeliness in processing traumatic injuries (date of receipt by OWCP to date of adjudication by OWCP) from 62 percent within 45 days, as of October 1980, to 81.2 percent within 45 days, as of June 30, 1981. This advance in the time of adjudication invariably reflects considerable improvement in payments. More information on timeliness of payments will be available later this calendar year as every FEC office is brought on line with the automated compensation payment system. This system itself should reduce by five to ten days the effort of calculating and setting up the payment for Treasury.

The Department expects that the legislation proposed by the Administration will remove from the FEC processing system many of the minor injuries thus leaving OWCP claims examiners free to concentrate on cases with compensation claims. The Department is also preparing regulations that will require employing agencies to furnish improved claim information and conduct investigations for OWCP.

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

AUG 6 1981

Honorable William J. Anderson
Director, General Government Division
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Anderson:

Thank you for the opportunity to comment on your draft report, "Inquiry Compensation Process Delays Prompt Payment of Benefits to Federal Workers."

Your draft report recommends on page 65 that the Director of the Office of Management and Budget study the feasibility of placing in the employing agencies specific claims processing and monitoring responsibilities under the Federal Employees' Compensation Act (FECA). We note the report's findings that the Office of Worker's Compensation Programs (OWCP) has improved claims processing. Moreover, additional improvements have occurred since the completion of the GAO review. New quality-of-performance and workload standards have been established to assure that claims are processed in both an accurate and timely manner. Also, OWCP has established a monitoring and quality control program. Under this program, all cases on the long-term disability roll are reviewed annually. In addition, the Department has an active investigation program that verifies the continuing disability of claimants. This effort is being carried out by a joint OWCP/Wage-Hour Division investigation program aimed at verifying the status of disabled workers receiving FECA benefits.

Along with these administrative actions, this Administration has submitted legislation designed to assure that federal workers disabled as a result of their employment are returned to gainful work as soon as possible and to discourage the filing of questionable claims. It does this by correcting a number of deficiencies in the structure of the law that have resulted in the abuse and misuse of the FECA program.

APPENDIX III

A study along the lines recommended in the draft report would not be meaningful until there had been sufficient operating experience under the new legislation and the new operating improvements. Many of the problems identified in the report as a basis of the recommendation might not be as significant under the new legislation and procedures. OMB will, of course, continue to monitor performance, and if experience shows that organizational problems result that cannot be resolved by the Secretary of Labor under the law, we would certainly carry out appropriate studies.

Again, we appreciate the opportunity to comment on your draft report. If I can be of further assistance, please let me know.

Sincerely,

Edwin L. Harper
Deputy Director

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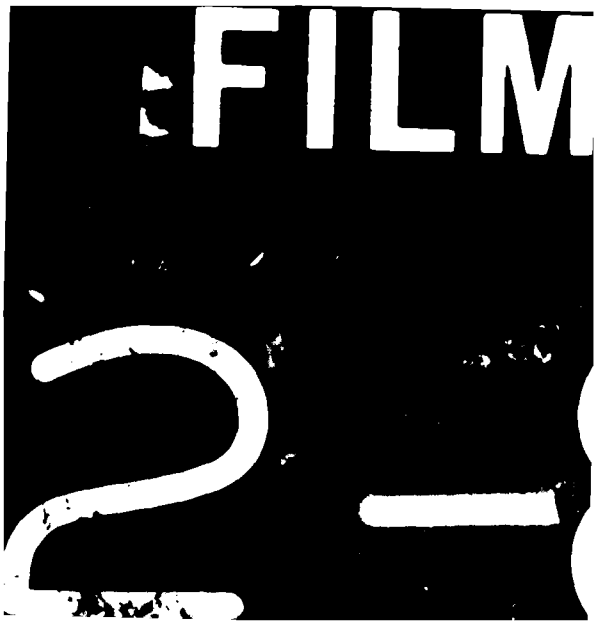
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