CLAIMS STAFFING REQUEST

Trindel's Workers' Comp Claims Dept. is requesting authorization to hire two additional employees to our staff. These two employees will be Claims Clerical Assistants. They will assist the claims examiner's with scanning and indexing mail, processing letters to claimants, medical providers and legal counsel, phone calls, requests for subpoenaed records, scheduling medical-legal exams, processing utilization review requests and letters and processing provider checks.

Our Workers' Compensation Injury Management Program has grown in the last two and a half years to a staff of five. The claims examiners are performing their own clerical functions such as indexing incoming mail, sending out required letters, ordering medical records, etc. These tasks are taking up valuable time in which the examiner would otherwise use to work their claims in a more thorough manner and move them to resolution quicker.

With the goal of implementing new claims software, we will also be moving to a different bill review vendor and utilization review vendor. This will increase our work load substantially, however, it will give us better control of our work product and allow us to streamline our processes. The duties we need to cover are sending letters for all claims with requests for medical treatment. This is a mandatory requirement. Additionally, we will be generating the checks for all payments from our office. With this we are required to include an Explanation of Benefits for all medical treatment payments. Both processes required quite a bit of manual labor.

Trindel averages about 225 new claims per year. In the last two fiscal years we have averaged 450 medical treatment requests which are reviewed, and either approved, denied or modified by utilization review. This is a mandatory process within our workers' comp system. With this there are several letters, (and multiple times, sometimes) that must be generated for each request. There is also a whole new process if a denial or modification of a request is disputed which entails copying the claimants medical file for the previous six months and sending it to an independent medical reviewer to either uphold the initial determination or override it.

With regards to bill review, we average 3800 bills per year with our current caseload, which will generate almost the same number of checks to be processed. With the bill review process the bills will be reviewed by the examiner for approval to pay, then sent to the bill review vendor for processing. In turn the bill review vendor will send us a "batch" of bills to generate the checks and include the Explanation of Benefits (EOB) with the check explaining how the bill was paid. Including the EOB with the check is a mandatory requirement within our system.