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CONSTRUCTION RISK MANAGEMENT

CLAIM AUDITING

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The claims audit is the anathema of day-to-day claim operations. Nothing is more disruptive. Yet, if properly defined, nothing is more informative and helpful in improving a claim management program. This article will examine the need for a regular auditing program and provide a recipe for a three-dimensional approach to the process in order to maximize the accuracy of the audit results.

The Need for Claim Auditing

The need to conduct regular claims audits has already been widely discussed. With the magnitude of self-insured claims programs (including self-funded programs) and the millions of dollars spent on claim administration fees, what better way to verify whether the money spent has been justified or wasted? In essence, an audit of closed and open claims should accomplish several things.

First and foremost, a claim audit should provide verification of performance standards. Performance standards may be set by a contract between a principal and its claim administrator, or they may be based on what an experienced claims person would do under similar circumstances. The claim audit should review a number of items, as delineated below, to verify that claims are being handled consistently with whatever performance standards apply on the basis of practice and by contract.

Claim audits should also verify that reserves have been adequately set and are being monitored adequately and adjusted in a timely fashion. In view of new Accounting Standards Board requirements (FASB and GASB) that require the posting of reserves and incurred but not reported (IBNRs) losses on balance sheets, it is important that a claim audit verify the adequacy of reserves.

Finally, a claim audit should also verify the efficient use of the dollars being spent for claims handling and claim payments. A thorough audit will verify that claim expenses are being used to the best advantage.

These goals and objectives encompass both quantitative functions (e.g., verification of reserve levels) and qualitative functions (e.g., review of performance standards). These two types of claim audits are best analyzed separately, although both typically play a part in the audit process.

Quantitative Auditing

A quantitative claim audit is normally done by accountants and certified public accountants (CPAs), not by persons experienced with claims or claims personnel. The quantitative claim audit verifies that reserves as represented on computerized loss runs match the claim file. Also included is verification of the claim counts per file handler and claim examiner, as well as verification of loss payments. There is also usually a reconciliation of the checking account against the claim file to ascertain whether the loss runs and checking accounts match the claim file.

Unfortunately, such quantitative claim auditing techniques do not verify whether reserves are accurate in relation to the damages claimed. The quantitative audit also does not effectively verify whether or not a client's money is being efficiently spent or whether the client is getting the best possible services available. These types of issues are generally part of the qualitative claim audit.

While a qualitative claim audit will certainly take into consideration many of the verifications commensurate with a quantitative audit, the issues involved for a qualitative claim audit are far more extensive.

Qualitative Auditing

A qualitative claim audit goes far beyond dollar and claim count verifications, involving the quality of file handling and control. Is the file being adequately investigated on a timely basis? Was the investigation thorough and complete in relation to exposure? Is the file being actively managed and on active diary?

A related issue is the quality of the claims personnel. Are the experience levels—from telephone adjusters through senior litigation managers—commensurate with generally accepted practices? (For example, it is not uncommon to require that telephone adjusters have 2 or more years of similar experience, field investigators—3, examiners—5 years' total experience with supervisors having at least 7, unit supervisors—10, special casualty examiners who handle only the most severe losses, i.e., those with loss reserves over $50,000—15, and management personnel—at least 20.) Is there an effective continuing education program in place? Adequately trained and experienced personnel make the claim process more effective and efficient.

Another issue is the quality and adequacy of internal systems and procedures. Is the internal and external paper-flow efficient, accurate, and effectively monitored? Are the computer systems that track reserves, payments, and related reports consistent with a modern risk management information system?

Finally, the qualitative claim audit will attempt to verify any performance standards that may exist by contract or generally accepted practice. Are claim files open too long? Is litigation being adequately controlled? Is the ratio between new claims and closed claims per month realistic? These qualitative issues can help ascertain whether a client's money is being efficiently spent on the best possible claim services.

There are many file management issues to be reviewed in a qualitative claim audit. These are generally graded from an acceptable or unacceptable handling standpoint at both the claim examiner and claim supervisor levels. While different standards may apply from state to state with regard to what is considered quick and efficient handling, the basic issues are the same.

Initial File Handling and Contact

The first issue to be reviewed is whether the file was handled on a timely basis, beginning

with the initial report. Was the file physically opened within 24 hours, and was there initial contact with either the claimant or other important witnesses within 72 hours thereafter? A good qualitative claim audit should track the date of loss, the date the file was opened, and the date the file was first handled. Specific attention should be given to clerical accuracy on file opening, including initial data entry and data processing.

Timely initial handling, including the date of first claimant contact or the attempt to do so, should also be tracked. As auditors, we recognize that claim administrators and claim adjusters are not guarantors of completing the job. However, they are obligated to make a good-faith effort toward completing the task. Thus, in those instances where they have attempted to make initial claimant contact or have attempted to perform any of the other investigatory functions without result, those good-faith attempts should be regarded as acceptable handling.

Investigation

After initial claimant contact and file opening practices have been evaluated, standard substantive file handling and investigation issues must be examined. These include obtaining prior medicals when necessary. The Claimant Index Bureau should be used, and follow-up performed on any positive Bureau reports and recommendations of independent medical examinations when prior medicals are in issue or the medical damages claimed are in question.

Other investigation procedures include obtaining documentation of damages to support the injuries claimed, obtaining photographs or diagrams of the location of loss when warranted, obtaining all witness statements (written or recorded), and determining whether there is a thorough investigation of questionable/fraudulent claims and whether clerical handling of investigation materials and general file housekeeping are being acceptably accomplished.

An investigation of all qualitative issues should be completed within 90 days, except in those instances where the claimant's medical treatment extends far beyond that period or where the intervention of defense counsel to subpoena an uncooperative claimant's records becomes necessary. Faster claim investigation means that the claim is developed faster and reserves are set early. When this is accomplished, not only can the claim be properly investigated, evidence be documented and preserved, and witnesses be identified for future use, but more importantly, the IBNR factor can be greatly reduced by having the claim accurately developed in a shorter period of time.

Reserve Review and Reserve Adequacy

Beyond investigation issues are, of course, reserves. Is the loss reserve accurate at the time the file is reviewed. If not, does the reserve need to be increased or decreased? It is not uncommon as well to have expenses for attorneys and/or outside vendors separately reserved. A corollary question therefore becomes: Are expense reserves accurate, and do they need to be increased or decreased?

In reviewing these issues, one must be careful to audit the files consistently with the performance standards under the contract and with generally accepted practices. Reserves can ordinarily be set one of two ways: on the basis of the exposure of loss or on the basis of ultimate net payout. The latter considers not only the exposure, but also such issues as comparative negligence, contributory negligence, and contribution from other potential codefendants. Thus, the auditor must bear in mind contractual requirements, reserve philosophy, and investigation philosophy when determining whether handling by the claim administrator is acceptable or unacceptable.

Another important question in analyzing reserves is whether any payments were made in excess of the loss reserve or in excess of the expense

reserve. This would necessitate either an increase to cover the reserve before or after payment is made. These are issues to be identified separately and tracked. The amount of increase or decrease for each type of reserve, as well as any amount paid over the existing reserve, is also important to track as a dollar figure.

The final issue is whether reserves are adjusted on a timely basis. Reserves should be adjusted as claim information is developed through ongoing investigation. Adjustments should be done on a routine basis; standard practice dictates that reserves be reviewed every time the file is reviewed by an examiner for any reason. If the reserves have not been adjusted on a timely basis, this should be graded accordingly, especially when payments are to be made in excess of the current reserve, which would require an adjustment. Such payments are not considered timely adjustments in most instances unless they are due to "surprise." An example of a surprise increase would be a claim reserved for $7,500 which, at the last minute, is settled for $8,000. The last-minute reserve adjustment of $500 would not be considered improper. Generally speaking, a payment that is within 10 percent of the current reserve is considered an acceptable handling matter.

One issue associated with untimely reserve adjustments is the question of whether clerical support failed to increase reserves as requested. Often an examiner or supervisor may request an increase of reserves that does not get input into the computer system. Such clerical failures should be identified in the audit and a method of preventing them put in place.

Payment Control and Supervision

The claim audit should determine whether there is adequate control, security, and review of the payment process and check issuance. One issue to be reviewed is whether payments—both loss payments and expense payments to outside vendors such as attorneys and independent field adjusters—are being made promptly and accurately.

Another payment control factor is whether there has been proper analysis of all documentation supporting the payment. Was management control properly exercised through all levels of authority so that no payments were made in excess of an examiner's or supervisor's authority? Were checks issued with clerical accuracy? Finally, were payments made on questionable or fraudulent claims without management review to determine whether the payment should in fact have been made?

These are important qualitative issues especially when dealing with money. Another important factor is the security of the check writing system, check issuance, and check stock. The check writing data entry should be limited to only the most trusted data entry personnel and only after an authorized supervisor has reviewed and approved a check request. The check stock itself should be kept in a secure, locked environment, and the print run should be closely supervised. The checks themselves should require two signatures for any amount. Finally, if the check-writing system is automated and integrated with the risk management information system (RMIS), the system should reject any check data entry where the payment exceeds the applicable reserve. Indeed, when reviewing a check request, the approving supervisor should check the reserve impact as well.

Supervision and Control of Examiner/Adjuster Staff

It is not uncommon for there to be a number of examiners who must report to a specific supervisor. Usually, a supervisor will direct the actions of four or five examiners. It is typically the supervisor's responsibility not only to verify and approve payments and settlements in excess of examiner authority—if the examiner has any—but also to review the supporting documentation. It is not uncommon for supervisors to approve increases in reserves should reserves go beyond

the examiner's authority—if they have any. Finally, the supervisor should routinely review all claim files within his or her "unit" on a periodic basis and document that review in the file.

Thus, when it comes to reviewing the supervisor's handling of the claim file, there are several issues to consider. Most importantly, is the file documented showing supervisory direction to the file handlers? Is the direction given consistent with generally accepted standards? Is the quality of supervision acceptable? Finally, supervisors should not be directly involved with the handling of a claim, instead providing supervisory direction only.

The audit should also reflect whether there has been personal handling of the file by the supervisor. If the claim audit reveals that investigation issues were not timely handled, or other issues were not acceptable, if reserves were not accurately set, adjusted timely, and/or payments were not found to be acceptable, then supervision of the file may not have been adequate. Even though a supervisor may be properly documenting direction, if the direction has not been implemented by the examiner, and the supervisor fails to catch it, if reserves are inadequate, etc., then the *quality* of supervision being provided should be questioned. It is entirely conceivable that supervisors may miss issues in their review of the file and fail to give needed direction to examiners that will have a direct negative impact on the quality of the file handling. Not only will the examiner be found to have mishandled the file from an acceptable/unacceptable standpoint, the same would be true of the supervisor of the unit.

Litigation

One of the larger allocated loss adjustment expense items on any self-insured/claim-managed program is litigation control and management. It is necessary for the claim administrator and/or the client to have an established litigation procedure that not only guarantees the best possible defense on behalf of the client, but is also balanced by cost control and counsel supervision. Nothing can increase allocated loss adjustment expense faster than unnecessary or unapproved discovery. Proper attorney management guidelines must be set by the administration and client at the onset, and a defense counsel panel must be agreed upon too.

Among the most important litigation management issues to be audited are the following: Is the defense counsel assigned a member of the approved panel? Are their billings in line and consistent with generally accepted billing practices? Are they on a quarterly billing routine so that bills can be reviewed periodically in order to maintain cost control? Have any defaults taken place due to counsel mistakes? Counsel should be routinely required to provide status reports citing both new developing information and how this information impacts liability and damages. Counsel can often report what facts they have obtained through discovery but not how such facts influence damages or liability. Thus, an auditor should assess the quality of recommendations being made by counsel.

Counsel should be expected to provide a "game plan" for resolution of issues that may require litigation. Faster settlements mean lower settlements, as well as less money spent on attorneys' fees. Defense counsel should be involved with moving toward resolution. The file should also reflect that counsel is reporting periodically and not performing unnecessary work.

There should also be clear division of responsibility. Is counsel conducting field investigations that should be performed by the claim administrator? This is an important issue. If the claim administrator underbids in order to be awarded a contract, relying on defense counsel or an outside investigator appointed by counsel to conduct field investigation, such costs become allocated loss adjustment expense in the file because they were conducted by an outside third party. This division of responsibility is completely improper. Such maneuvering is done to the detriment of the client and should be brought to light in the audit.

Risk Transfer Issues

Many claims involve the possibility of codefendants, other parties completely at fault, and therefore the possibility of subrogation and salvage recoveries. These are very important issues that reduce the ultimate net cost on any particular claim. Some qualitative issues to review when this is a possibility involve the authorization and filing of cross-complaints. At the initial handling of the claim, did the claim administrator attempt to refer the claim to some other responsible third party so that the claimant would not be looking toward the current client? Have subrogation issues been identified and has subrogation been pursued? If pursued, how much money was recovered? If ignored, how much money was potentially lost? Salvage could be dealt with in the same manner. Was salvage in issue? If so, were any salvage dollars recovered and deducted from the net settlement, or was the salvage issue missed so that no monies were recovered? This is not only measured on an acceptable or unacceptable handling basis, but by how much money was gained or lost as a result.

Sometimes clients may themselves do the salvage and/or subrogation handling within their own organization. If this is the case, was a "subrogation notice memo" provided to the client so that their own internal subrogation department could follow-through? If not, again, how much money was potentially lost as a result? This should be tracked separately as part of the grading process.

General Performance Issues

There are always going to be general performance issues. These include whether the file is routinely on diary and being followed. Generally speaking, not only should the supervisors periodically review the files for supervisory direction (every 90 days), but the examiner should also have the file on diary for handling. The diary process should include reviewing reserves, looking for recently received correspondence requiring response, and making any other claim decisions as warranted. There should be adequate activity logs or memoranda within the file to make it possible to determine whether the diary is being followed.

Another general performance issue is whether payments have been made to unauthorized outside vendors. Have outside investigators or outside adjusters been retained, through counsel or otherwise, when the work should have been performed by the claim administrator? Have vendors been retained by the administrator that should not have been engaged?

The claim administrator should also determine whether a claim has such an exposure as to require a report to an excess or umbrella insurer. Often, late reports to an excess or umbrella insurer may give rise to a coverage defense by the insurer.

Have any statute of limitations been ignored? This is very important, especially with regard to governmental entities who may have immunity based on governmental tort liability statutes. Are there specific statute of limitations requirements that must be followed?

Another general performance issue is communication with defense counsel. Is it periodic? Is it accurate? Is appropriate response being received? Defense counsel will often write the examiner for assistance without receiving an answer. Does the file reflect that the examiner is responding to the needs of counsel? Is appropriate control over defense counsel being exercised? Is counsel being supervised by the claim examiner in accordance with the attorney management guidelines noted above?

Has the file been reopened after being closed without payment? Have unnecessary closings taken place? Finally, does the file match the loss run (consistent with a quantitative file review), and what is the current reserve if the file is still open? Another amount to be noted is how much was paid on a closed file if the file was closed. Finally, how much reserve was

"recaptured" if settled within the reserve (e.g., if the file was reserved for $7,000 and the claim settled for $5,000, this would constitute a $2,000 reserve recapture)?

This ends the qualitative file review process. As outlined, there are numerous issues to be reviewed from a qualitative file handling standpoint. However, this is not the end of a thorough qualitative claim audit. The following issues should also be reviewed.

Personnel

As noted earlier, it is important that claims personnel at all levels have the requisite length of experience and expertise needed to deal with the claims they handle. It is also important to establish contractually the caseloads per file examiner. It is not uncommon to require that caseloads not exceed 275 claimant files per examiner to ensure that the examiner has the proper time to review and control a claim file. Assuming that files routinely come up on diary every 90 days, this would mean that anywhere from 5 to 10 claim files per day would come up on diary. This leaves the examiner with enough time to deal with "pop-ups" such as unanticipated incoming telephone calls and correspondence.

Finally, as to personnel, there must be adequate management staff in an appropriate ratio to examiners and field investigators. A proper number of clerical staff to support the needs of the entire claim organization is necessary as well.

Internal Systems and Procedures—Paper-flow

The claims auditing process does not end with the file review and review of personnel issues. There must also be adequacy of administrative procedures, the RMIS computer system, and other internal procedures. This requires a walk through the office to see not only how paper flows throughout the office, but also how mail is handled. The easiest way to do this is to conduct a paper-flow tour. What happens when a letter or other important correspondence arrives, and where does it go? An auditor should follow that piece of paper all the way to the claim file, and an auditor should determine how the claim file ends up on an examiner's desk for review. Internal paper-flow, such as payment request authorizations, reserve change authorizations, and requests for authority, should also followed and noted.

How are new claims identified and how are they processed? This too is a paper-flow issue. New claims should be followed throughout the organization from the time they arrive until the time of review and assignment.

Equally important is the handling of new lawsuits. New lawsuits should be routed directly to the person in the organization who is solely responsible for tracking lawsuits and maintaining a suit log so that no defaults are taken due to mishandling within a claim administrator's office.

Internal and external authority levels and loss reporting should be reviewed. How much settlement authority has been delegated to the claim administrator and at what levels? At some point, authority on high-exposure claims cannot rest with the claim administrator, but instead rests with the client. In those instances, is the client being properly notified on a timely basis, and are appropriate decisions being made?

Finally, and as part of the contract between the administrator and client, there should be requirements for statistical and monthly performance reports to be provided to the client. These reports would typically include the number of claims open in a given period, the aggregate reserves, the number of claims closed in that same period with the aggregate amount, and which claims are currently open. In addition, statistical reporting should include the number of files open, the number of files closed during that period, and the remaining number count. Is the ratio of new claims to closed claims below 100 percent or equal to or above 100 percent, indicating that the claim administrator is closing more files than are received?

There are numerous other statistical reports generated from a risk management information system that are part of generally accepted practices. A thorough qualitative audit reviews what is being provided the client on a monthly basis and whether this meets generally accepted standards.

Three-Dimensional Claim Auditing Methodology

While all of the above issues provide an excellent recipe to providing a thorough and qualitative claim audit, there is still the question of a methodology to implement it. A claim management program may involve thousands of claim files. A claim audit reviews only a random sample of these. Many claim auditors like to use the "terminal number" method to target files for random audit. This entails pulling any claim file that is open ending in a zero or a five, and any closed claim file ending in a two or a seven. While this may be "statistically pure" and purely random, it also is easily identifiable by the audit target, allowing them to pre-review files ending in those numbers for cleanup prior to audit. In addition, this type of random sampling may not always give the auditors the type of cross-section necessary to take an accurate "snapshot" of the file handling over time.

A methodology we have adopted and found to be extremely accurate is more three-dimensional. Under this system, a special loss run of open and closed claims is requested, sorted by year of claim origin and by reserve/authority level. These are often sorted by file handler as well. From those special loss runs, and on a pro rata basis, a mixture of open and closed files by reserve level, by year of origin, and by file handlers is pulled. Because this is not done on a random terminating file digit number basis, no audit patterns can be determined by the audit target. This results in an accurate cross-section of claims by exposure levels/reserve levels, by year of origin, by status (open and closed), and by file handler. This provides an extremely accurate, three-dimensional cross-section of files to be reviewed. From this, it is easy to determine when files were well handled, when they were not well handled, why they were not well handled, by whom, etc.

We have also determined a unique methodology to reviewing a claim file. More often than not, files are reviewed "from the ground up," starting with the earliest correspondence and moving to the most recent. However, another methodology involves developing a "claim abstract" for every claim. Basically, this is an audit trail of the claim file generated from the risk management information system. The claim abstract should show when the claim was opened, the date of loss, the usual and customary claimant information, and a reserve/payment history by date and reason. By comparing the dates of the claim abstract to the diary dates and activity logs, as well as the supervisory reviews, it can be determined whether the file is being reviewed on a diary basis, whether reserves are being "stair-stepped" as opposed to being set when information has developed, and whether any number of other activities are consistent with diary review, control, and supervision. Even a brief comparison of the claim abstract to diary activity and activity notes can reveal a number of qualitative issues. This procedure takes only 5 to 10 minutes and should tell the auditor a great deal about the file handling without ever having read the "blood and guts" of the file.

Walk-through

As noted earlier, it is important to conduct a walk-through to determine paper-flow throughout the office. A walk-through of the data processing system should also be conducted. Finally, although the audit review process may not result in specific grades, trends can be identified, and a "closing interview" conducted with the management of the claim administrator to go over the initial findings and conclusions, giving management an opportunity to respond.

Summary

A thorough qualitative claim audit program can provide much useful information to a self-insured client, especially by determining whether the firm's money is being properly spent. Since many self-insured retention programs involve millions of dollars, it is important for the money that is spent to be properly monitored, controlled, and managed.

Frederick J. Fisher, J.D., is the founder and currently the senior vice president of E.L.M. Insurance Brokers, a wholesale & MGA facility specializing in professional liability and specialty line risks. In 1975, Mr. Fisher began his career as an independent E&O claims adjuster. In 1982, he ultimately bought the company, continuing with claims while expanding the firm's services to include qualitative claim auditing, risk management, and loss control services and acting as a TPA. His claim auditing techniques and recommendations resulted in substantial client savings (including the SCRTD). Many insurers and self-insureds adopted not only the performance standards raised in the audits but also his recommended attorney management guidelines as a base, which are still in use today by many major insurers.

In 1995, he formed what is now known as ELM Insurance Brokers, a firm that has acted as an MGA and wholesale broker of professional liability insurance and specialty lines. He has lectured extensively on professional liability issues since 1978 and authored over 64 articles in trade journals and periodicals. He is the author of *BROKER BEWARE, Selling Real Estate within the Law.* He designed a program to conduct on-site pre-underwriting risk management assessments of a client's professional liability exposures. In 1993, he was elected to the Professional Liability Underwriting Society (PLUS) Board of Trustees. After serving in all officer capacities, he was elected president in 1997. He remains a special materials expert for several RPLU courses and senior technical advisor for *The Professional Liability Manual,* first published by the International Risk Management Institute in 1990. He testifies regularly as an expert witness in cases dealing with the duties and obligations of professionals as well as on coverage and claims-made issues.

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