



Solicitation Information
7 May 2012

Request for Proposals # 7449694

Title: Analysis & Assessment of Temporary Disability Insurance Program

Submission Deadline: 7 June 2012 @ 2:00 PM (Eastern Time)

Pre-Bid Conference: No

Questions concerning this solicitation must be received by the Division of Purchases at questions@purchasing.ri.gov no later than **18 May 2012 at 12:00 Noon (ET)**. Questions should be submitted in a *Microsoft Word attachment*. Please reference the RFP / LOI # on all correspondence. Questions received, if any, will be posted on the Internet as an addendum to this solicitation. It is the responsibility of all interested parties to download this information.

SURETY REQUIRED: No

BOND REQUIRED: No

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Assistant Director for Special Projects

Vendors must register on-line at the State Purchasing Website at
www.purchasing.ri.gov

Note to Vendors:

Offers received without the entire completed three-page RIVP Generated Bidder Certification Form attached may result in disqualification.

THIS PAGE IS NOT A BIDDER CERTIFICATION FORM

Introduction

The Rhode Island Department of Administration, Division of Purchases, on behalf of the Department of Labor and Training, Division of Income Support is soliciting proposals from qualified Offerors to perform a Business Process Analysis and Assessment (BPAA) of the Temporary Disability Insurance Program and Systems as described elsewhere herein and in accordance with the terms of this Request and the State's General Conditions of Purchase (available at www.purchasing.ri.gov)

The remainder of this document is organized into the following sections:

1. Introduction
2. Instructions and Notifications to Offerors
3. Scope of Work
4. Proposal Submission
4. Evaluation and Scoring Criteria
5. Governing Terms and Conditions
6. Attachment 1 - Temporary Disability Insurance
 - a) History
 - b) TDI Staff Levels and Workload Assessment
 - c) Recent Implemented Initiatives and Projects
 - d) Future Modernization Improvement Projects
 - e) Highlights of the TDI AS-400 System
 - f) TDI Claims Processing Functions
 - g) Customer Service Unit Functions
 - h) Medical Unit Functions
 - i) Record Updates Unit Functions
 - j) Claims Management Unit Functions (CMU)
 - k) Workers Compensation Unit (WC) Functions

The general purpose of this procurement is to develop a set of functional requirements that can be used to provide a baseline to procure services to complete the necessary technical requirements and develop a new TDI system or provide the necessary enhancements to the current system.

The Rhode Island Department of Administration/Division of Purchases is soliciting proposals from qualified firms and organizations to provide professional services to conduct the Business Process Analysis and Assessment in accordance with the terms of this solicitation and the State's General Conditions of Purchase. Any resulting award or engagement from this RFP will be bound by the State General Terms and Conditions (available at www.purchasing.ri.gov).

This is a Request for Proposals, not an Invitation for Bid. Responses will be evaluated on the basis of the relative merits of the proposal, in addition to price; there will be no public opening and reading of responses received by the Office of Purchases pursuant to this Request, other than to name those offerors who have submitted proposals.

Instructions and Notifications to Offerors

Potential offerors are advised to review all sections of this RFP carefully and to follow instructions completely, as failure to make a complete submission as described elsewhere herein may result in rejection of the proposal

Alternative approaches and/or methodologies to accomplish the desired or intended results of this procurement are solicited. However, proposals which depart from or materially alter the terms, requirements, or scope of work defined by this request will be rejected, considered to be non-responsive.

All costs associated with developing or submitting a proposal in response to this request, or to provide oral or written clarification of its content shall be borne by the offeror. The State assumes no responsibility for these costs.

Proposals are considered to be irrevocable for a period of not less than one hundred and twenty (120) days following the opening date, and may not be withdrawn, except with the express written permission of the State Purchasing Agent.

All pricing submitted will be considered to be firm and fixed unless otherwise indicated herein.

Proposals misdirected to other state locations or which are otherwise not present in the Division of Purchases at the time of opening for any cause will be determined to be late and will not be considered. The "official" time clock is kept at the reception area of the Division of Purchases.

In accordance with Title 7, Chapter 1-2 of the General Laws of Rhode Island, no foreign corporation shall have the right to transact business in the State until it shall have procured a Certificate of Authority to do so from the Rhode Island Secretary of State (401-222-3040). This will be a requirement only of the successful bidder(s).

Offerors are advised that all materials submitted to the State of Rhode Island for consideration in response to this Request for Proposals will be considered to be public records, as defined in Title 38 Chapter 2 of the Rhode Island General Laws, without exception, and will be released for inspection immediately upon request, once an award has been made.

It is intended that an award pursuant to this request will be made to a prime contractor, who will assume responsibility for all aspects of the work. Joint venture and cooperative proposals will not be considered, but subcontracts are permitted, provided that their use is clearly indicated in the offeror's proposal, and the subcontractor(s) proposed to be used are identified in the proposal. All subcontracts shall be in writing, requiring the subcontractor to comply with all provisions of the contract and a copy of the subcontract provided to the State. If the State approves the use of a subcontractor, the contractor shall

remain responsible for the work performed. The contractor must notify the State of any changes of status of any subcontractor and must have amendments to these subcontracts approved by the State.

The State of Rhode Island has a goal of ten percent (10%) participation by Minority Business Enterprises (MBE's) in all state procurements. For further information, visit the web site www.mbe.ri.gov. To speak with an MBE officer, call 401-574-8253.

Interested parties are instructed to peruse the Division of Purchases web site on a regular basis, as additional information relating to this solicitation may be released in the form of an addendum to this RFP.

Equal Employment Opportunity (RIGL 28-5.1)

§ 28-5.1-1 Declaration of policy (a) Equal opportunity and affirmative action toward its achievement is the policy of all units of Rhode Island state government, including all public and quasi-public agencies, commissions, boards and authorities, and in the classified, unclassified, and non-classified services of state employment. This policy applies in all areas where the State dollar is spent, in employment, public service, grants and financial assistance, and in state licensing and regulation. For further information, contact the Rhode Island Equal Employment Opportunity Office, at 401-222-3090.

SCOPE OF WORK
Temporary Disability Insurance System
Business Process Analysis and Assessment (BPAA)

Purpose:

The purpose of a Business Process Analysis and Assessment is to obtain a thorough and detailed understanding of the business processes of the Temporary Disability Insurance Program and to break it down into discrete requirements, which are clearly defined, reviewed and agreed upon with the Customer Decision-Makers. During BPAA, the processes are defined providing the foundation for future design and development efforts.

The primary goal of this analysis is to review “As-Is” current processes, determine “To-Be” capabilities and provide a Gap Analysis. The results/findings of the GAP Analysis and recommendations are to be clearly defined in writing. This should provide the necessary information for TDI to determine the best fit solutions for enhancing the business processes and technical solutions.

List of Processes:

- Prepare for BPAA: where steps are taken by the successful vendor to ensure that the project environment and the project team members are adequately prepared to both capture and analyze the business processes utilizing the current business rules as the foundation.
- Determine Business Processes: Where in-scope and out-of-scope business processes are identified, business rules are defined and documented and how it interfaces to and from the current application.
- Define the Process Model: where a pictorial top-down representation including the major business processes that interact with the system is diagrammed and decomposed into manageable functions and sub-functions until no further breakdown is feasible.
- Define Logical Data Model: where data that supports the processes and business rules is logically modeled, identifying entities and their relationships to other entities, and defining attributes with their business definitions
- Validate Business Processes with Models: where the project team ensures that the Process and Logical Data Models accommodate all requirements and business rules.
- Analyze Viable Solutions: where interfaces, processes and data are merged to describe systematically how technology may or may not improve the current processes.

Vendor Experience and Plan :

Describe your methodology for conducting this project through the use of:

- Meetings
- Interviews
- Workshops
- Storyboards
- Visioning
- Use Cases
- Other methods or approaches you have used to provide the required services.

Also describe your approach to learning about the TDI program, its business rules, processes and applications so you can better understand the terms and issues during the analysis.

Provide at least three examples of projects with Temporary Disability Insurance (TDI), Unemployment Insurance (UI) or similar State or Federal Agencies where you've done work of this type.

Provide three references of State or Federal Agencies or companies where you've conducted a Business Process Analysis and Assessment project. Provide information about the project including project size, duration, and deliverables.

Project Plan :

Resources and Timeline: Provide a high level project plan showing a timeline for the project as well as a personnel resource template recommending what Stakeholders and Subject Matter Expert and IT resources from the State as well as the vendor would need to be available for this project. Identify what type of resource you would need and the duration of the support of those resources.

Physical Resources: What physical resources will you require, such as conference rooms, computers, printers, audio visual equipment, and for what duration?

ATTACHMENT 1

Attachment 1 provides a detailed explanation of the Temporary Disability Program and Systems. This information provides the Offeror with the information required to provide an accurate bid on the work involved in the BPAA

PROPOSAL SUBMISSION

Questions may be submitted in accordance with the terms and conditions expressed on page one of this solicitation.

The Proposal Submission Deadline is listed on page one. Responses, an original plus 5 copies and two electronic versions CD/DVDflashdrive, should be mailed or hand-delivered in a sealed enveloped marked “RFP7449694”

Rhode Island Department of Administration

Division of Purchases (2nd Floor)
One Capitol Hill
Providence, RI 02908

NOTE: Proposals received after the above-referenced due date and time will not be considered. Proposals misdirected to other State locations or which are otherwise not presented in the Division of Purchases by the scheduled due date and time will be determined to be late and will not be considered. Proposals faxed or emailed to the Division of Purchases will not be considered. The official time clock is located in the reception area of the Division of Purchases

RESPONSE CONTENTS

Responses must include the following:

1. A completed and signed three-page R I V I P. generated bidder certification cover sheet downloaded from the RI Division of Purchases Internet home page at <http://www.purchasing.ri.gov>.
2. A statement of experience describing the Offeror's background, qualifications, and experience with and for similar projects, and all information described in this solicitation
3. A completed and signed W-9 downloaded from the RI Division of Purchases Internet home page at <http://www.purchasing.ri.gov>.
4. A separately sealed Cost Proposal. This cost proposal will only be opened if the Offeror receives at least 70% of the total points available for their technical proposal
5. In addition to the six hard copies of the proposal required, Respondents are requested to provide their proposal in electronic format (CD/DVD, flashdrive). Microsoft Word / Excel OR PDF format is preferable. Please place the electronic copies in the proposal marked “ Original Response”

The Technical Proposal should contain the following sections:

- **Executive Summary**

The Executive Summary is intended to highlight the contents of the Technical Proposal and to provide State evaluators with a broad understanding of the offeror's technical approach and ability.

- **Offeror's Organization and Staffing**

A description of staffing, including an organizational chart highlighting the persons or units(s) responsible for this project should be demonstrated.

This section shall include identification of all staff and/or subcontractors proposed as members of the project team, and the duties, responsibilities, and concentration of effort which apply to each, as well as resumes, curricula vitae, or statements of prior experience and qualifications.

- **Work plan/Approach Proposed**

This section shall describe the offeror's understanding of the State's requirement, including the result(s) intended and desired, the approach and/or methodology to be employed, and a work plan for accomplishing the results proposed. This section shall include a discussion and justification of the methods proposed for each task identified in the Scope of Work (above), and the technical issues that will or may be confronted at each stage of the project. The work plan description shall include a detailed proposed project schedule by task, a list of tasks, activities and/or milestones that will be employed to administer the project and the task assignments of staff members and level of effort for each.

- **Previous Experience and Background**

This section shall include the following information:

A comprehensive listing of similar projects undertaken and/or similar clients served, including a brief description of the projects and related references

A description of the business background of the offeror (and all subcontractors proposed), including a description of their financial position, and

The offeror's status as a Minority Business Enterprise (MBE) certified by the Rhode Island Department of Economic Development, and/or a subcontracting plan which addresses the State's goal of ten percent (10%) participation by MBE's in all State procurements. For further information, call the MBE Officer at (401) 574-8253.

Any other information the Offeror seems relevant to the evaluation process.

Offeror Qualifications/Requirements

- A brief history of the Offeror's firm, including date of incorporation.
- The selected Offeror shall provide a performance bond in the amount of the contract price.
- The Offeror must include three (3) recent customer references from other states and or entities which these services have been performed. The State's and or entities' name, address, and the contact person's title, organization/agency and phone number must be provided. Give a brief project summary and the start and end dates of the project.
- The Offeror will be responsible for furnishing their own development tools including any/all computer hardware and software. The Offeror is also responsible for items such as office/clerical/administrative support needed to complete this project.
- The Offeror shall be responsible for paying all of their travel, meals and lodging costs incurred during activities undertaken during the scope of work outlined in this RFP
- All costs associated with the preparation, development or submission of bids or other offers will be the responsibility of the Offeror. The State will not reimburse any such costs.
- All documents, correspondence and other submissions to the Division of Purchases are considered public records, pursuant to Title 38, Chapter 2 of the General Laws.
- The Offeror shall provide resumes for all proposed project staff. The resumes should emphasize the skills needed for this project.
- All employees of the Offeror and any subcontractor assigned to this procurement prior to commencing work under the contract shall have a criminal history background check done, including a fingerprint search, the costs of which shall be paid by Offeror and any subcontractor and the results of which shall be furnished to the State.
- Explain any past or outstanding lawsuits related to the Offeror's past performance under contract on the development or implementation of any business process analysis/redesign, and computer hardware, software, and systems development/implementation projects.

- The Offeror must prepare and submit an initial work breakdown structure (WBS), preferably in Microsoft Project format, with target dates and a schedule of deliverables as tied to the payment schedule.
- The Offeror must submit a high level description of the project approach and proposed time lines.
- The Offeror and any subcontractors shall agree it and its entire staff assigned to this project will adhere to state non disclosure policies governing confidentiality of individual records and sign a confidentiality agreement.
- Drug Free Workplace: In accordance with Executive Order No 91 - 14, the Offeror who does business with the State and their employees shall abide by the State's drug-free workplace policy and the Offeror shall so attest by signing a certificate of compliance.

Proposal Evaluation Criteria:

The State will commission a Technical Review Committee which will evaluate and score all proposals using the following criteria. The Vendor must receive a total of 70% of all available technical points in order for the cost proposal to be opened and considered.

Technical Proposal

| | |
|--|-----------|
| Offeror Qualification – Technical, Business Expertise & References | 40 points |
| Project Approach/Plan | 35 point |

Cost Proposal

| | |
|------|-----------|
| Cost | 25 points |
|------|-----------|

The Low bidder will receive one hundred percent (100%) of the available points for cost. All other bidders will be awarded cost points based upon the following formula:

$$(\text{Low bid} / \text{Offerors bid}) * \text{available points}$$

For example: If the low bidder (Offeror A) bids \$70,000 and Offeror B bids \$100,000 and the total points available are twenty-five (25), Offeror B's cost points are calculated as follows:

$$\$70,000 / \$100,000 * 25 = 17.5 \text{ pts}$$

The top two (2) scoring Offerors eligible for award may be required to give an oral presentation of the proposed solution. Offerors will be contacted to make arrangements for times and dates. The selected Offerors should expect to conduct one 2 hour session to review their solution and answer any questions regarding their proposal. The Technical Review Committee may revise original scores of the top two Offerors based on the Offeror's oral presentation.

Notwithstanding the above, the State reserves the right not to award this contract, award in whole or in part or on the basis of cost alone, to accept or reject any or all proposals, and to award in its best interest.

Proposals found to be technically and/or substantially non-responsive at any point in the evaluation process will be rejected and not considered further.

The State reserves the right to determine priority among services offered and may contract for partial or whole services indicated in all proposals, and award each section to a combination of the Offeror's solutions as a partial or whole contract in the best Interest of the State of RI. The State also reserves the right not to contract for any/all services indicated here in an initial contract.

The State may, at its sole discretion, request certifications or affirmations, as appropriate.

The Technical Review Committee will present written findings, including the results of all evaluations, and recommendation to award to the Division of Purchases, State Purchasing Agent (or her designee) who will make the final award. Upon receipt of final approval, a web posting will indicate that a final selection has been made.

END

ATTACHMENT 1

RI Temporary Disability Insurance History

Temporary Disability Insurance (TDI) provides benefit payments to insured RI workers for weeks of unemployment caused by a temporary illness/disability. The TDI program, enacted in 1942, was the first of its kind in the United States. It protects workers against wage loss resulting from a non-work related illness or injury and is funded exclusively by RI workers. Only four other states: California, Hawaii, New Jersey, New York and Puerto Rico have a TDI program. Claimants have three options to file a claim for TDI benefits:

- The first option is to complete a paper application by calling 401-462-8420 and take option #1 to voice-record the information on to the Telepath System. The system will ask for their name, social security number and address. A representative hears the information and types it into the recorded data on the system to allow the system to automatically mail the claimant a paper application.
- The second option is to pull down a paper application from the TDI web site at www.dlt.ri.gov/tdi under the tab entitled "How to File a TDI Claim". Print the form, complete it and mail it to our department.
- The third option is to file the claim on-line via the internet at www.dlt.ri.gov/tdi.

Benefits are calculated based on the wages earned during the established base period. The regular base period is the first 4 completed quarters of the last 5 completed quarters from the quarter in which the claim is filed. When a claimant does not meet the eligibility requirements under the regular base period, we utilize the alternate base period. The alternate base period is the last 4 completed calendar quarters from the quarter in which the claim is filed. The benefit rate is calculated at approximately 4.62% of the total high quarter wages in the base period added to the dependency allowance, which is \$10.00 per child or 7% of the weekly benefit rate, up to 5 children under the age of 18 or disabled children over 18 years old.

In Rhode Island, there are approximately 45,000 TDI claims filed annually. TDI processes approximately 40,000 new claims annually and 5,000 refiled claims. This reflects 70% of claims filed on-line via the internet (approx. 31,500 claims) and 30% of the claims (approx. 13,500 claims) are filed by paper applications.

To be eligible for TDI benefits: a person must meet the earning requirements in the base period quarters, be unemployed due to the illness or injury and be medically certified by a Qualified Healthcare Provider (QHP) as required in section 24-41-11 of the General Laws in Chapter 41.

Frequently asked questions regarding the TDI program may be found in TDI's website at www.dlt.ri.gov/tdi.

In the previous years the claim loads vary but within a very small margin. Please refer to the chart on the next page for a glance at the difference between the year 2007 and 2008. Also in this chart, please find the current staffing levels and a general list of responsibilities.

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TDI Staff Levels and Workload Assessment

| Claim Loads | Year Ending 2007 | Year Ending 2008 |
|--|-----------------------------|---|
| Total Claims | 46,474 | 45,485 |
| Number of Payments | 449,608 | 442,240 |
| Amount of Payments (net) | \$169,211,712. | 173,649,461 |
| Average Weekly Benefit Amount | \$376.35 | \$363.00 |
| Average Duration per Claim (weeks) | 12.64 | 10.60 |
| Staff Levels | Current | Responsibilities/Tasks |
| Benefit Claims Specialists (BCS) | 18 | Process: Medical forms, appeals, redeterminations and update changes to claims- ie: effective date, waiting period & return to work dates. |
| Senior E.&T. Interviewers (Sr. E. & T. Interv) (1-Sr. E. & T is on long term leave & 1- position is vacant) | 18 | Process: New and refiled claim applications received by mail or via the internet, claim changes ie: add a new QHP, change address or add a return to work date. Also take customer service calls via the phone. |
| Imaging Representative | 1 | Enters every form/document into an imaging system by social security number to allow all staff ability to view and print any document After imaging, forms are shredded. |
| E. & T. Assistant/ Spanish Interpreter (position is currently vacant- covered by other staff) | 1 | Dept. of Labor & Training Receptionist- greets and directs guests to the appropriate units/representatives within the complex. Operates IDI's Telepath software system by retrieving claimant's names, addresses and social security numbers left in a voice recording by listening and typing the information This will automatically mail the claimant a paper application preprinted with their name and address. |
| Registered Nurses | 2 | Two registered nurses review and case manage complex claims in efforts to maintain the program's credibility and to ensure benefit payments are within the established Medical Duration Advisory guidelines (MDA) The MDA is a software program that allows TDI to determine the average length of time needed to recover from each specific illness/injury. The nurses also determine which claimants require an impartial examination, which is a medical examination conducted by an impartial QHP selected from TDI's impartial examiners' roster. TDI pays for this service. |
| E.&T Managers | 3 | -One manager oversees the staff and workflow in the Customer Service (taking in-coming calls from customers) & Applications Units (processing paper and internet applications) -One manager oversees staff and workflow in the Medical Unit (processing medical certifications from QHP's) - One manager oversees staff and workflow in the Workers Com & Record Updates Units Also serves as liaison for staff in the Information System Department (ISD). Communicates and troubleshoots all system issues with ISD affecting claims. |

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| Senior Manager | 1 | Oversees overall workflow and performance in all Units. Develops and implements policies & procedures. Identifies, develops & tracks training programs for staff. Keeper of Records for TDI including: correspondence with attorneys, insurance companies, social security & subpoenas. Covers for each Unit Manager as needed. |
| Administrator | 1 | Responsible for overall operations in customer service and timely benefit payments by: identifying programs strengths and weaknesses, developing streamlined processes and procedures, re-define workflows. Identify and implement legislative changes. Maintain overall staff moral to ensure quality performance. Develop reports. Communicates all issues and accomplishments with staff and managers. Brainstorm complex claims with nurses, managers and medical consultant. The Medical Consultant is a Doctor that is available for TDI, via a special contract, to discuss complex claims and or provide TDI with professional medical opinions/recommendations. |
| Assistant Director | 1 | Oversight of all operations in TDI. Reviews and approves all policies, procedures & legislative changes. Communicates with the Director for TDI requests re: staff, overtime, supplies & customer issues. Provides input and decisions on complex claims. Provides on-going support for continuous improvements and initiatives. |

Recent Implemented Initiatives and Projects

In our quest to pursue continuous improvements in the TDI program, to provide quality customer service, the following initiatives were developed and implemented:

| Date | Project | Project Description |
|-------------------|---|--|
| August 2005 | Claims Management Unit (CMU) | TDI developed a Claims Management Unit to investigate and resolve claims where there may be abuse of TDI program by the customers or Qualified Healthcare Providers (QHP's). This unit is staffed by two registered nurses who also provide education and communicate with the medical and employer communities. |
| October 2005 | Medical Disability Advisory Guidelines (MDA) | TDI implemented the use of the Medical Disability Advisory Guidelines (MDA) software in order to provide more consistency in the certification process of the length of time required for each illness/injury. |
| January 2006 | Partial Return to Work Program | Affective 1-1-06, a partial return to work program was developed and implemented through proposed legislation that modified current TDI law, section 28-41-5 (d). This allows claimants to work part time while transitioning into full time employment during their recuperation process. |
| September 2007 | Implementation of the Electronic Payment Card (EPC) | TDI developed and implemented the Electronic Payment Card (EPC) method of benefit payments allowing claimants two options to receive payments: by the EPC or direct deposit into a personal savings or checking account. |
| January 2008 | Garnish out-of-state child support requests | Developed and implemented a process to garnish out-of-state child support requests. |

ATTACHMENT 1

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|---------------|-------------------------------------|---|
| July 2008 | CMU Tracking Fields added to AS-400 | Additional fields were added to the AS-400 system to accommodate the Case Management Unit's actions and objectives, which monitors the impact of this unit's efforts on claims. |
| December 2008 | Recruitment of Impartial Examiners | Additional Impartial Examiners were recruited and added to TDI's Impartial Examiners Roster. This includes a newly developed agreement with each Impartial Examiner. |
| June 2009 | TDI Procedure Manual | The TDI Procedure Manual was updated and is accessible by all staff via their common TDI folder in their computer system. |
| January 2009 | Elimination of Split Waiting Period | TDI implemented section 28-41-12 of the TDI law. |

Future Modernization Improvement Projects

In efforts to improve program effectiveness and efficiency, the following project plans are in process for the near future (Timelines have not yet been determined):

- Have the ability to fax directly to imaging- all medical forms. This feature will allow the fax machine to automatically image the document into our imaging system. Preventing various staff members from handling hundreds of papers manually.
- Electronically process Internet "clean claims". When an internet claim is received and it does not require any information to be verified or obtained, it is considered a "clean claim". With specific programming changes to the AS-400 system, these claims would automatically process into the AS-400 system without staff interaction.
- Incorporate the TDI overpayment process into the Unemployment Insurance (UI) Overpayment Unit. Currently UI has a comprehensive Overpayment Unit and TDI also has a condensed version of an Overpayment Unit, both conducting duplicate functions. Programming would be required to allow the TDI system to communicate with the UI system and have just one Overpayment Unit process all overpayments by using one process and procedure.
- Transfer TDI's current Interactive Voice Response (IVR) system to an updated IVR system called Accessnet
- Improve the current programming with the Internet application process to allow for a more friendly process providing more flexibility in completing the application on-line.
- Streamline the Workers Compensation Unit to eliminate duplication and provide the required forms to be sent automatically by the AS-400 system instead of manually
- Implement a "Notice of First Payment" letter for claimants to be sent to all new and refiled claims when the first benefit payment is processed

Highlights of the TDI AS-400 System

Senior E. & T. Interviewers enter the claims into the AS-400 system from paper or on-line applications and the following system actions occur. The system automatically develops and sends to the mail room various forms such as:

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- During the claim entry process the claimant's wages are found in the Host Wage Inquiry (option #4 from the AS-400 Main Menu). The wages are reviewed and committed, which brings them onto the claim and the system automatically calculates the benefit rate. The benefit rate is determined as specified in the TDI law- section 28-41-5
 - The benefit rate is calculated utilizing the wages earned in the base period
 - The regular base period is the first 4 quarters of the last 5 completed quarters from the quarter in which the claim is filed. When a claimant does not meet the eligibility requirements in the regular base period, we utilize the alternate base period
 - The alternate base period is the last 4 completed calendar quarters from the quarter in which the claim is filed
 - The benefit rate is calculated at 4.62% of the total high quarter wages in the base period added to the dependency allowance, which is \$10.00 per child or 7% of the weekly benefit rate, up to 5 children under the age of 18 or disabled children over 18 years old
 - The total number of credits or weeks the claimant has to receive on each claim is equal to 36% of the total base period wages divided by the weekly benefit rate (not including dependency allowance). The most a claimant may receive in benefit credits is an amount equal to 30 full weeks
- When the wages are committed and the claim's benefit rate is calculated, the system automatically develops and sends a TDI-51 (Monetary Determination), which is the claim's determination letter, to the claimant informing him/her of the benefit calculations. This allows the claimant time to review the wages and how TDI determined the benefit rate. In addition, it provides the claimant with appeal rights if he/she does not agree with the wages reported to TDI and used to calculate the benefit rate.
- Along with the TDI-51 (Monetary Determination) form the claimant receives a letter indicating the PIN number on the claim which is required when calling customer service to obtain information about the claim or utilize the Interactive Voice Response system (IVR) to update or check the claim status. Together with this packet is also a form for the claimant to complete and mail to TDI when he/she returns to work.
- TDI-4B (Employment Verification Report), to the employer to verify the claimant's last day of employment. The employer is instructed to not return the form if they agree with the claimant's last day of work. The system places a "Y" for yes in the field "Outstanding 4B" for 10 days to allow time for the employer to respond. After 10 days, the system automatically changes the "Y" to a "N" for no. The 10 days allows for the employer to communicate with us any changes and allows TDI staff to make any required adjustments to the claim's last day of employment. The system will not allow the claim to be paid while this field has a "Y". It pays the claim only when it changes to "N", meaning the TDI-4B is no longer considered outstanding.
- Also the system develops and sends to the mail room a form, TDI- 3 (Medical Certification Form) to the Qualified Healthcare Provider (QHP). The system records the date this form was sent and will send a second request automatically after 10 days. QHP's are provided with 5 days to complete this form and either mail or fax it back to TDI. The 10 day window allows for the form to arrive and be fully processed by staff. This form is the medical certification document required to determine eligibility for benefit payments.
- When the application is entered and the forms are sent, the system automatically enters a claim Record Status code of "A" for Active and Pay Status code of "P" for medical pending. The system will not pay the claim until the Record Status code is "A" for active and the Pay Status code for "A" for Approved.

ATTACHMENT 1

- When the medical documentation is received from the QHP, it is imaged immediately into an imaging system that all staff has access from their desktop. All forms are imaged by the claimant's social security number and TDI form number. When imaged, the medical documents are provided to each Benefit Claims Specialist (BCS) in the Medical Unit according to the social security numbers assigned to complete the following tasks:
- Review, approve/deny and enter the information into the medical screen. The medical screen is completed with the date the form was received from the QHP, the disability code and the weeks of duration to recuperate from the illness/injury including determining the effective date of the claim.
- When the medical screen is completed, the claim's status codes change automatically to; Record Status code is "A" for active and the Pay Status code for "A" for Approved. This will allow the claim to be paid for the weeks the QHP certified the claimant.
- The system will continue to send benefit payments weekly until there are 2 weeks or less left on the claim of medical certification.
- When no medical documentation is received from the QHP after a second request, the BCS will place a denial code of "1"- no medical information. A denial letter is automatically sent via mail by the system with the preprinted verbiage explaining the denial reasons. Each denial notice provides the claimant with the right to appeal the decision with instructions clearly identified at the bottom of each decision.

When there are 2 or less weeks of medical certification left on the medical screen the system will automatically complete and mail a TDI-105 form (Notice to Update Claim) to the claimant. This form provides instructions for the claimant to call TDI's Interactive Voice Response (IVR) system at 401-462-8700. The system will ask questions to establish if the claimant has returned to work or is still under a QHP's care.

- If the claimant has not returned to work or recuperated, the system will automatically send a TDI-3C form (Medical Certification) to the QHP on the medical screen to obtain additional medical documentation. At this time an extension medical record appears with the date the TDI-3C was sent to the QHP.
- When the TDI-3C is returned, the BCS will complete the entries into the extension medical record screen; the date the TDI-3C was received, the medical code and the duration of time the QHP is providing
- If the TDI-3C is not returned the claim is denied by entering the denial code "A" which is for "no further extensions" approved by the QHP. The system will automatically mail the claimant a denial letter with the pre-determined verbiage for denials with code "A". Each denial letter provides instructions on how to appeal the decision.

When the BCS determines that a claim is complex or the QHP is providing more weeks of recuperation than what the Medical Disability Advisory (MDA) guidelines is suggesting, the claim is routed to the nurses in the Case Management Unit (CMU) for review and follow-up. Often a brainstorming session occurs with the BCS and the nurses to take the most appropriate course of action. As a result, the following actions may occur, depending on the scenario:

- The BCS may send a "Chart Review" request form to the QHP for more details of the illness and any complications. The Chart Review form is found in the TDI Common folder for staff to complete manually and mail.
- The nurses may decide to send the claimant to have an impartial examination by a doctor on the TDI-Impartial Examiners roster. TDI would pay for this visit.

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- The nurses may decide to call the doctor directly and have a conversation to best understand the most appropriate next step.
- All the actions and findings conducted by the nurses are tracked in the remarks screen in the AS-400 system under #19 from the Main Menu. This also allows the nurses to notate all notes and justification for actions taken. This part of the system was developed to allow management to run reports of the outcomes for all cases managed by the nurses.

During the process of entering claims or entering medical information to a claim, it is often found that changes or additions are required.

- Some changes can be completed by a Sr. E. & I. Interviewer by entering the changes in the AS-400 system such as: address change, adding or changing a QHP, adding or changing direct deposit information or adding a return to work date.
- Other, high level changes that affect the status of the claim must be added by a BCS in the Record Update Unit. BCS in the Record Update Unit have a higher classification with access to the "Special Programs" options in the AS-400 system. This allows other changes to be processed such as:
 - Change or amend claim's affective dates & benefit year begin dates
 - waiting period week change
 - enter overpayments or overpayment corrections
 - changes to the balance of credits
 - adding a redetermination record to correct the claims benefit rate
 - producing supplement payments
 - delete medical extensions
 - obtaining the information and completing the workers compensation screen of the AS-400 system
 - changing return to work dates
 - troubleshoot the Unemployment Insurance claims that file a claim for TDI to ensure there are no overlapping benefit weeks being paid
 - process claims that appear on the "Transitional" claim list. The system automatically develops this list of claims having a Benefit Year Ending date, which means a new claim must be filed and with future medical certification weeks left on the medical screen
 - process information regarding death notices. When a current claimant passes away, usually the QHP or a family member notifies TDI. If there are still benefits due or benefits overpaid, the family member is notified. A copy of the death certificate is required along with proof of claimant's estate executrix in order for TDI to provide the last payments due up to the date of death
 - develop reports utilizing various work queries such as the overpayment monthly report

Processing Partial Payments

When a QHP indicates to the claimant he/she may return to work part time while recuperating to return to work full time, TDI law- Section 28-41-5 (5) allows for partial TDI benefit payments while working part time. Partial payments are for those weeks the claimant works and earns (gross earnings) less than the claim's benefit rate. Partial payments are calculated in the AS-400 system when a part time return to work date has been entered on a claim. Any staff member may enter the partial return to work date. When this date is entered, full benefit payments stop as

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of the partial return to work date and the following forms are generated automatically by the AS-400 system:

- TDI-4E, which is a “Partial Earnings Statement” form, is generated and sent to the claimant to request the gross earnings for the specified weeks he/she is claiming partial payments
- TDI- 4P, which is a “Claim Status Update” form, is generated to each employer to request the employees last day worked, if reduced hours are available and if the claimant has returned to full time work or reduced hours
- TDI-122, which is a “Notice of Partial Status” form, is generated for to the customer to inform the customer their Qualified Healthcare Provider (QHP) has authorized he/she to return to partial employment
- When the TDI-4P is received, the staff reviews the form for any discrepancies from the employer such as; hours available for claimant to work and if he/she is back to work part time or full time
- When the TDI-4E is received, the staff reviews the form for any discrepancies such as: claimant indicates she took vacation time and did not work at all or indicates working less than the available part time hours due to complications in the recovery or the wages are different each day. When clarifications are obtained the wages are entered into the AS-400 in the “Maintain Earnings” screen for payment. When the claim has a date in the return to work part time field and wages have been entered into the “Maintain Earnings screen, the system will automatically process partial payments. The system will automatically reduce the gross earnings entered into the system by 20% of the claim’s benefit rate and add the dependency allowance to determine the partial benefit payments.
- When the customer is up to date with partial payments, meaning they were paid weekly up to last week, a letter is sent with instructions to call the Interactive Voice Response system (IVR) and report the partial earnings. The system will process the payment automatically and no longer requiring the claimant to mail the TDI- 4E form indicating the gross earnings.
- Per Rule # 30 of the TDI Rules and Regulations, TDI may provide partial return to work benefits up to 8 weeks. When a claimant is collecting partial payments in excess of 8 weeks, the claim is referred to the nurses in the Case Management Unit for review of illness to determine if eligible for continued partial payments beyond the 8 weeks. Each case is reviewed individually and is depending on the severity of the illness. Most claimants receiving over the 8 weeks of partial payments are on receiving cancer treatments.
- Many different issues can arise when a customer is on partial TDI benefits. Some situations can require some vast research by calling the employer, the claimant and or the Qualified Healthcare Provider. For example when the claimant:
 - Is collecting a salary, sick or vacation pay, which affects the gross earnings each week
Claimants do not always report this information properly
 - Claimant decides to take a vacation or extra days off
 - Earnings appear irregular, claimant is not working the same amount of hours as originally indicated
 - Claimant has weeks with earnings in excess of the benefit rate- does this mean they are back to work full time or was it just for one weekEach partial payment may take 5-25 minutes to process.

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TDI Claims Processing Functions

Processing TDI Paper Applications

Staff is assigned to the Applications tasks depending on the workload demands. Each morning applications, TDI-1 form, received with the day's mail are distributed to Senior E&T Interviewers for review, and the data is entered into the AS-400 system.

- A careful review is made of each item on the application for accuracy and completeness and when necessary, appropriate corrections are made
- When pulling wages from the "Host Wage Inquiry" in the AS-400 system, a review must be made of each employer to determine if they are subject to the TDI tax laws. Some claimants may not pay TDI taxes. Usually this occurs with municipal employees and TDI staff is required to verify with the employer and or our Tax Unit to ensure the claimant paid into TDI taxes, which would make them subject to collect TDI benefits
- Wages must be retrieved using the Host Wage Inquiry screen and be reviewed for accuracy.

Each paper application may take 10-30 minutes to process.

Processing TDI Internet Claims

An Internet filed claim is easier to review and enter into the AS-400 system since it is easier to read and the system provides tips on how to answer some of the questions. The Sr. E. & T. Interviewers review the information on the internet claims for accuracy and completeness. The following is the process to accept and process the claims from the internet system:

- Each morning internet claims filed by claimants the prior day are pulled from the system and each page consisting of 17 claims are distributed to staff
- Staff will review and enter the internet data information into the AS-400 claim system
- The claim may be committed when all changes have been made

Each internet application may take 10-20 minutes to process.

Processing a Refile Application

A refile claim is an additional claim for benefits within the benefit year of the new claim. The benefit year is established when a new claim is filed providing the claimant TDI benefit payments. Claimants are permitted to file one new claim per year. When a new claim is filed, the claim's benefit year ending date is also determined. TDI staff shall determine if the claim is a refile on an already established claim or a new claim. The claim could be a duplicate application, a returned application or an existing claim that was previously determined monetarily ineligible; meaning a claim without sufficient wages to be eligible for benefit payments. From the AS-400 Main Menu, option #1 will indicate all the claims filed under the social security number entered. This indicates if the claimant needs to file a new claim or refile on the already established claim.

Miscellaneous Functions in the Applications Unit

- Process payments – a daily list is generated including all the payments due to be paid the next business day by the AS-400 system. The list is divided among the Sr. E. & T. Interviewers to review and process the payments. At this point the BCS in the Medical

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Unit has entered the data received from the Qualified Healthcare Provider onto the Medical Screen. The E. & T. Interviewers examine each claim on the payment list to calculate and enter the payment effective date on the master screen-2nd page. When the effective date is entered and the medical duration has been added on the medical screen the system will automatically change the claim's "Record" code to "A" for active and the "Payment" code to "A" for approved for payment. This will allow the system to send the payment.

- Image all records/documents such as: paper applications, monetary determinations; copies of benefit decisions, appeal requests, claim change requests, return to work forms, employer forms & all paper documents received in TDI.
- When the forms are imaged, the medical related forms received from the Qualified Healthcare Providers are distributed to the Benefit Claims Specialist in the Medical Unit for review and data entry onto the AS-400 medical screens. When all forms are processed and imaged, they are placed in the shredding bins found throughout the office.
- Re-indexing for the imaging system– an error report is generated on a daily basis, listing documents the system was unable to find a record to be indexed to. These documents have to be investigated and indexed to the correct records. The majority of these error reports are faxed medicals that the scanner misreads the barcodes. Other examples that seldom occur are: applications and forms that are imaged the same day the claim is entered, manual keying errors when executing the verifying process during imaging and forms that staff have notated incorrect social security numbers.

Customer Service Unit Functions

An average of 6 Sr. E. & T. Interviewers are assigned to the Customer Service Unit to answer customer calls. The number of assigned staff is dependent upon the daily workload demands and call volumes. The following are this unit's functions:

Answer Calls from Customers

- Respond to questions regarding the status of the claim or provide general information regarding the TDI Program. To provide the status of the claim the Sr. E. & T. Interviewer obtains the information by reviewing the following screens in the AS-400 system:
 - The "master" & "medical" screens to look for what is pending or what has been processed in order for the claim to be paid. Medical certification, missing wages or verification of last day of work may be pending.
 - View the imaging system to see if the medical documentation has arrived, if the medical is in imaging, print it and place it in the Medical Unit's "Fast Track" tray. This will ensure the medical is entered as a priority after the claimant's call.
 - If the claimant added a new QHP, enter the information on the medical screen and fax or mail the proper medical TDI form.
 - Update the claim with the newly provided information such as: return to work date or change of address or phone number.
 - Notate all actions taken as a result of the call in the remarks screen of the claim.

Medical Documentation Processing

- Enter initial medical certifications sent by QHP or Hospital

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- When medical extensions are generated from Customer Service calls or the current Qualified Healthcare Provider they are forward to Medical Unit to review, enter and or process payments

Provide Records to Governmental and Private Agencies and Attorneys

- Secure permission from DLT Legal Department for release of information to non governmental agencies or attorneys, and any governmental agencies requesting medical or other personal documentation
- When TDI receives a subpoena for claim information, the request is sent to the department's legal office for approval. Upon approval from legal, copies are made and mailed to the requester.
- Requests from attorneys require the following process which is handled by a manager:
 - Send a template letter to the attorney indicating the information will be sent as requested when a \$35.00 payment is received by TDI to cover costs to view, copy and mail copies of the required claim screens and documents.
 - When the \$35.00 payment is received, print outs of the claim screens and copies of documents are mail to the attorney and notated on the claim's remark screen.

TDI Help Line Emails (from customers)

- Respond to approximately 50-60 emails received daily from customers who either choose not to call or cannot get through on the phone lines.
- If the question is regarding a specific claim it cannot be addressed via email; if a general response will not resolve the issue, an outgoing call from customer service is made to the claimant
- If requesting a copy of payment history, it is mailed to the claimant's address on record and a note is entered in the remarks screen of the claim.

DLT Receptionist- Front Desk

- Receptionist/Interpreter takes/ transfers calls for all DLT departments
- Greets walk-in customers; calls individual departments when necessary
- Provides basic customer information for TDI claimants who have questions or need assistance; forms are provided for both TDI and UI claimants who need issues resolved
- When not greeting customers, handles other office functions such as transcribing the voice messages from TDI's Telepath phone system. The Telepath phone system allows claimants to call in and leave a voice recording requesting a paper application to be mailed to their home address. The receptionist listens to the information and types the voice recorded information so that the system will mail a paper application the following day, which is all done automatically. (requests average 100 per day)

Miscellaneous Tasks

- Contact customers [who may have called TDI via other departments e.g., Director's office, Governor's office, Senator's office etc.] as requested by manager to resolve and or provide claim status updates

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Medical Unit Functions

The medical Unit team consists of Benefit Claim Specialists (BCS) who conduct all of the following functions:

Receipt of Medical Forms

Open mail and have it imaged; depending on volume of mail and BCS's present to open mail it may take 3 BCS 10-20 minutes per day per BCS. Medical certification forms, TDI 3 & TDI 3C, received by fax or by mail from the Qualified Healthcare Providers are sorted, imaged and returned to Medical Unit for processing. They are assigned to BCS based on claimant's SS number.

Processing TDI 3 and TDI 3C Forms

The Medical Unit's main function is to process the TDI-3 (Statement of Attending Physician) and TDI-3C (Continued Statement of Attending Physician), which are the medical forms completed by the Qualified Healthcare Providers. The BCS review the medical documentation as follows:

- Ensures the diagnosis clearly identifies the illness, we look for diagnosis and not symptoms
- Ensures the weeks provided is within TDI's Medical Disability Advisory (MDA) guidelines, which is a software utilized by all Medical Unit staff found on their desktop.
- When information is very limited or vague, obtain additional information from QHP's and or claimant
- The claim could be routed to the nurses in the Claims Management Unit (CMU) for an impartial examination by an Impartial Examiner on the TDI roster
- The TDI 3C form is reviewed for weeks previously paid, dates, diagnoses, and additional weeks certified are within the MDA guidelines

Each review takes 2-15 minutes depending on the extent of additional research required.

Impartial Examinations

The nurses in the CMU Unit review claims and identify the appropriateness for a claimant to be referred for an impartial medical examination. When a customer has received the average number of weeks paid for the particular illness or injury and has not recovered or returned to work, the claim should be reviewed by the CMU Unit. Each case is viewed individually taking the medical condition into consideration. When the CMU unit staff (nurses) determines when a claimant requires an impartial examination by a specialist in the field, the following process occurs:

- The CMU staff select the specialist closest to the claimant's home from the established TDI Impartial Examiners roster
- A "Y" is entered in the space next to "Imp. Exam" on the AS-400 master screen and the impartial examiner's physician code is entered in the "MD Code" field of the AS-400 system. This will create a physician screen for the impartial examiner and the following 2 forms are generated automatically by the AS-400 system:
- The TDI-25 form (Notice of Impartial Examination-claimant), is mailed to the claimant to notify he/she of the request to have an impartial examination. This form provides instructions and time limits for the claimant to establish the appointment and notify TDI of the established appointment date

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- When the claimant notifies TDI of the Impartial Examination appointment date, the nurses update the Medical Screen in the AS-400 with the appointment date and time
- The TDI-25A form (Notification to Impartial Examiner) is mailed to the Impartial Examiner doctor to complete and provide TDI with the results of the examination
- The Impartial Examiner returns the TDI-25F form completed within 3 days to one week following the appointment directly to the CMU staff to determine the course of action on the claim.

Processing Appeals

All TDI decisions provide an appeal rights clause at the bottom. It instructs the claimant to submit, in writing a letter or note indicating the reasons they wish to appeal the decision. When the appeal letters/notes are received, the BCS in the Medical Unit take the following steps:

- Enter a note in the Remarks screen that the appeal was received and the date received
- Review the reason for the appeal as notated on the appeal letter and review the claim's documents to determine the course of action required.
- If the claimant is disputing for example; the return to work date the QHP provided or any other information the QHP provided, staff contacts the QHP to obtain clarification. The clarifications are obtained by sending a TDI-114M form (Request for Additional Information). If the QHP responds with correct information, the claim is updated with the correct information and the appeal does not need to be sent to the Board of Review.

The Board of Review is an independent entity established to hear appeals from TDI and Unemployment Insurance claims. They weigh all the facts, laws and rules and make a decision to either agree or disagree with the department's decision.

- If the QHP provides the same information and it does not match what the claimant is providing TDI, the case is sent to the Board of Review for a hearing.
- Copies of the claim's screens are sent to the board of review together with a summary from TDI indicating the rationale for the need of the appeal hearing together with the original appeal request from the claimant. This packet is sent directly to the Board of Review and the appeal is tracked in a separate excel spreadsheet in TDI.

Assigning New QHP Codes

Applications and customer service requests reflecting QHP's not currently listed in our AS400 medical data base are sent to Medical Unit for review and set up.

- Internet Doc Finder is queried to find QHP listing in particular state. Type of provider and license number is recorded, address reviewed and TDI's Excel spreadsheet is updated with appropriate code. Code is determined alphabetically by QHP name and assigned the next sequential number on the spreadsheet. QHP record added to AS400 medical database. Application returned to claims or existing claim record updated with the new QHP.
- When only partial information is available, BCS query the tool "Internet Reverse Look-up" to confirm telephone number and address of QHP.
- If it's an out of state QHP, contact the Dept. of Health for that particular state and obtain the needed information such as license number and status of the QHP.

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- Occasionally the QHP's office must be contacted to retrieve all required information. Review and set up of new QHP in AS400 requires 5-20 minutes per QHP depending on research required.

Miscellaneous Functions/Tasks

Daily, documents are received by each BCS for review, which includes but not limited to:

- Appeals letters from claimants are reviewed and considered for either set up for Board of Review or sent for additional information to QHP
- Medical Records from hospitals are routed to the nurses in the Case Management Unit for review and approval to be used instead of the TDI 3 or TDI 3C forms.
- Retrieve approximately 20 voice messages daily from the QHP line voice mail box (ext. 28447) and take appropriate action such as: correct the prior information provided by the QHP on the medical form, send a duplicate form, send the form to a different QHP and or answer questions regarding the TDI form itself
- Retrieving approximately 5 voice messages daily from the impartial examination phone line (ext. 28430) and update the claim record as needed. The impartial medical QHP may have questions on how to complete the forms to report his findings properly, report to TDI that the claimant reported to the appointment and or is ready to return to work

Approximately 45 minutes per day for this process for each BC Specialist.

Record Updates Unit Functions

Processing Direct Deposits

The Record Updates Unit team consists of 4 BCS, who have special access to the systems record updates screens found in "Special Projects" in the main menu of the AS-400 system. Their functions are often complex and requires someone that is highly detail oriented. Their tasks and responsibilities involve the following:

- Review the "Returned Items Report" from TDI's Clearing House. The Clearing House receives all the direct deposit requests and they in turn transfer each request to individual customers' bank accounts utilizing the routing and bank account numbers.
- This report provides benefit payments requests that the bank was unable to deposit in the claimant's account due to incorrect account or routing number information. As a result, the funds are returned to TDI via the Dept. of Labor Treasurer's office, who will re-deposit the funds back into the TDI fund
- Review the claims direct deposit screen on the AS-400 to ensure the information in our system is the same as the bank is reporting on the report.
- Contact the claimant to notify him of the funds being returned. Usually the claimant verifies the information and provides the correct account information
- The payments returned are voided and the correct payments are re-processed under the proper account information.

Depending on situation, this task may take 5-30 minutes for each claim

Record Updates & Claims Adjustments

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Customer Service staff, Sr. E. & I. Interviewers and or managers may route claim update requests to the Record Update Unit staff. These requests are a result of claimants providing incorrect information on the application and the claimant, employer or QHP provides TDI with the correct dates. The requests are sent to the Record Update Unit by completing a routing slip (TDI-31 form) explaining the correction requirement along with any documentation to justify the request. The requests consist of the following:

- Correct dates on claim such as the first unable to work date due to the illness, the last day of work, return to work or recovery dates, effective payment dates, benefit year beginning and benefit year ending dates
- Claims may be re-determined by changing or adding wages originally missing from specific quarters. This occurs when TDI has missing wage information from the employer in the wage record screen. When the claimant receives their monetary determination, they notice the missing wages which affect their benefit rate calculations. Wage information is changed or added on a second screen for the disputed employer by adding a redetermination record on the AS-400 system. The claim is then re-computed to determine the total wages and high quarter wages to establish a correct benefit rate. An updated monetary determination, TDI-51 form is mailed to the claimant.
- TDI provides an additional benefit to claimants who have dependents under the age of 18 or over 18 and disabled. Sometimes the claimant forgets to complete the dependency section of the form and contacts us after the claim is processed. The Record Updates Unit staff may add or subtract dependency allowance. To subtract dependency allowance, usually occurs when a claimant stops receiving benefits and the spouse files for TDI benefits. The dependency allowance is transferred to the spouse's claim
- Pay supplemental benefits
- Correct claims entered under wrong social security number. Either the claimant or the employer will report to TDI that the claim is reflecting the incorrect social security number.
- Processing ex-service Military Claims requiring backdating of the base period to pick up the year of wages prior to entering the service for active duty. This was made possible through an amendment to Section 28-39-2 (2) of the law for the definition of the base period.
- Detecting and process possible overlaps of benefit payments when a claimant is in receipt of Unemployment Insurance (UI) benefits and files a TDI claim. UI is notified via a memo and informed of the date the TDI claim is made effective. When TDI makes the claim effective during a week the claimant received UI benefits, TDI will send the payment(s) directly to UI to offset any overpaid weeks in UI.
- Process Child Support Garnishments received from Family Court by adding information to Child Support screen in the AS400 system. TDI has an agreement with The Child Support Enforcement Agency to garnish TDI benefits for any Family Court request received by TDI
- Review the invalid Social Security Numbers list received from the Social Security Office. If the claimant has an active claim, send a letter to the claimant
- Transitional Claims Processing: When a claim is currently active and the Benefit Year Ends, the claim appears in the Transitional Claim Report to alert us to file a new claim for the claimant. The BCS prints the claim screens, commits the wages from the "Host Wage Screen" and enters the same information from the prior claim in all screens. Amount of claims varies each day from about 3-15 claims. (15 minutes per claim)

Depending on the update it may take from 5-60 minutes per claim

Processing Overpayments

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- TDI detects on average, a minimum of fifty overpayments a week. The majority of these overpayments are manually detected by TDI staff through investigation on claims and information received from numerous sources. However, the AS-400 system also detects potential overpayments automatically for staff on claims that are paying duplicate weeks. This report is received daily from the Information System Department (ISD). BCS verifies the potential overpayments, calculates and enters the overpayments in the "Overpayment" screen of the AS-400 system.
- TDI Repayment Report – run totals tape of deposits; bring to Business Affairs (15 minutes)
- Answer telephone calls regarding status of overpayment
- Process overpayment checks received from claimant
- Once per month, the TDI Overpayment report is run by the BCS in the Record Update Unit and it's provided to Beverly Smith in Business Affairs. (this process takes 3-7 hours each month)

Claims Management Unit Functions (CMU)

The Medical Claims Unit consists of two registered nurses and they work together with the Medical Unit to review claims with questionable illnesses or claims that exceed the standard Medical Duration (MDA) guidelines. This often required a dialogue with the Qualified Healthcare Providers (QHP's) when the claimant fails to recover from the illness within the MDA guidelines without any complications or the illness does not appear to inhibit the claimant from working. The nurses' initiative has resulted in the following positive outcomes utilizing their medical expertise and becoming involved with the claim and the QHP, providing early intervention:

- The QHP agrees to less weeks of medical certification to recuperate providing more appropriate medical durations
- Obtaining additional medical documentation from the QHP to justify or deny extended duration. The QHP may provide additional weeks of medical certification, meaning a longer period of time to recuperate, when there are no complications or no medical treatment plans in place. Usually, when there is no additional documentation, such as a treatment plan, the QHP agrees the person is well enough to return to work.
- The overall outcomes of the claims having the nurses involved in managing such cases, have resulted in closed cases due to claimants returning to work and or reduced durations or cases denied for lack of further extensions by the QHP
- Educate the medical community by presenting workshops to staff from medical offices or visiting a large office or hospital and make a presentation to the staff about TDI and its forms. These presentations allows for health relationships with the medical community on how to complete TDI medical forms (TDI-3, TDI-3C, Chart Review- attending physician statements), and prevent fraud as well as maintain the programs credibility

Workers Compensation Unit (WC) Functions

The Workers Compensation Unit's team consists of Benefit Claims Specialists (BCS) staff members. TDI claimants may be allowed to receive TDI benefits while waiting for the Workers Compensation claim to be approved or denied. No individual shall be entitled to receive TDI benefits for any week(s) in which Workers Compensation payments are provided.

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Tasks/Functions Required to Process TDI/Workers Compensation Claims

When a customer indicates on the application they filed for WC or the illness or injury is work connected the following tasks are required:

- Create and complete a WC record screen in the AS-400 system.
- When the customer or QHP indicates the illness or injury is work connected, the staff ensures the claim has a "Record" code of "W" which stands for Workers Compensation
- The Workers Compensation screen in the AS-400 is completed with the required data such as: employer's name, insurance company information, WC petition number and attorney's information- many calls may be required to obtain all required information
- Manually complete and mail a TDI-165 form (Acknowledgement Agreement) to notify the customer they are not permitted to receive benefits from both TDI and WC
- Enter a date in the claims WC screen for the system to automatically generate the employer form TDI-152 (W.C. Employer Inquiry).
- Enter a date in the claims WC screen for the system to automatically generate TDI-151 form (WC Insurer Inquiry) to the WC Insurance Carrier of the company the claimant works for
- As each form is returned to TDI the data is entered in the WC screen
- Mail appropriate denial notice to the claimant when information is received from the insurance company that the customer is currently collecting WC
- When the insurance company indicates the WC claim is pending approval, TDI will provide benefit payments while the WC case is pending approval and TDI places a lien against the WC claim, which is the TDI-150 form (Notice of Lien). The lien is to let Insurance Company know that upon settlement of the WC case, the insurance company shall pay TDI back for the weeks the claimant received in benefit payments while waiting for WC to decide the case
- Process TDI-154 (WC Insurer Follow-up) from the insurance company to determine status of WC claim
- When the WC claim is settled and approved for benefits, depending on the period of time the WC payments will cover, TDI notifies the claimant of the period of time TDI can no longer provide benefits. This notice is sent to the claimant on a TDI-164 form (Notice of Subrogation).
- Remove lien from the WC screen if WC benefits are not approved
- Complete the overpayment screen if the claimant received both TDI and WC during the same period of time