**Claims Processing**

Every compensation program strives to process claims quickly, accurately, and consistently. The actual speed and quality of the work will depend on factors both within and outside program management’s control. Staff size – crucial in handling volumes of claims – may be limited by state budget officials and legislatures. The level of automation may depend on resources that the program may not have. Yet a program can refine its work flow, analyze necessary and unnecessary steps in the claims process, build consistency through clear policies, and maintain a motivated and trained staff. In other words, whatever the fiscal reality facing a program, there is much that a manager can do that will affect the success of the program’s claims processing.

Every program is unique in its staffing and resources, so it is impossible to point to any one successful path to take in improving program performance. The following material simply tries to describe what some of the issues are, and how some states approach these challenges.

**Increasing Speed and Efficiency**

A primary goal for every compensation program is to process applications as quickly, fairly, and accurately as possible. The evaluation of a program rests largely on how well it does this central task.

While speed is crucial – many advocates, providers, legislators, and interested parties want to know first how quickly claims are processed – accuracy is equally vital. If claims aren’t handled according to the law, and if mistakes in eligibility or payment are made, programs have failed just as much as if a claim is unduly delayed.

Clearly, programs must learn to balance speed and quality. Some of the primary factors in enabling states to work efficiently and well are the following:

* Sufficient staff to document and analyze claims
* Staff training to ensure understanding of the program’s governing law, rules, and procedures
* Automated systems that maximize staff resources
* Work flow that moves claims through necessary steps efficiently, eliminating duplication and waste
* Clear policies and procedures for staff to follow in analyzing claims, so that work follows accepted rules, and consistency is maintained
* Sufficiently trained advocates in law enforcement and nonprofit service provider organizations to help victims file complete applications and to provide promptly necessary documentation, like police reports
* Ample funding to allow claims to be paid without delay, once adjudicated
* Performance goals and measures to motivate staff and evaluate work
* Quality control components to ensure accurate and consistent work.

***Staff Size***

Staff sizes vary tremendously from state to state. While no optimal staff size has ever been calculated – and probably can’t be, given variations in program responsibility, statutory requirements, and decision-making structures – we do know that many programs appear understaffed, based on the pressures they face in keeping up with current caseloads. Some comparisons with other states handling similar volumes of claims may be helpful, but program size varies for many reasons, and accurate comparisons between states are difficult. Some states, for example, may place a premium on helping victims with other resources, so less time is spent on processing claims.

***Staff Training***

Orienting and training staff is a primary function of any manager. Staff needs to understand the following:

* Program mission, mandates, and goals
* Eligibility Requirements
* Benefits
* Process for documenting applications
* Rules or standards to follow in making recommendations or decisions on applications
* Basic concepts and terms used by medical and mental health providers
* Basic issues relating to victimization and trauma
* The criminal justice process

A thorough training of new staff may take any number of days, depending on the program’s own processes, and its time constraints in bringing employees up to speed.

Managers also should consider providing specialized training on time-management techniques.

***Automation***

While every program has some degree of automation, many managers feel that their claims management systems lack some features that could make processing better. It is often difficult to obtain sufficient resources to update or overhaul software and hardware to take advantage of the latest in technology.

Most advanced automated systems today can generate automatically the letters to victims, police and providers that request necessary information. Claims screens that provide all information on applicants and the status of work on the application are common. Software that allows automated statistics to be generated for purposes of state and federal reporting also is standard.

Among the latest ideas in automation is the use of scanning systems that allow virtually “paperless” file management. Programs that have adopted this process use staff to scan every document that comes into the office, then place them in the appropriate electronic file for a specific claim. Rather than being dependent on pieces of paper that can be viewed by only one individual at a time, anyone logged onto the system can view any particular case file and document. Programs also remove the risk that a paper file will be lost or unable to locate.

States have procured their automated systems in a variety of ways. Some have used outside vendors, and others have used state government information technology specialists. A few have imported software developed in other states, but most who have done so have found that extensive changes had to be made to customize the software for their program, and these can be costly and time-consuming. Managers also must make sure that the vendor who transfers the software from another state commits sufficient training time for staff, and is available to tinker with the software as issues that require changes arise.

Contact NACVCB for more information about which states are using advanced automated processes.

***Work Flow***

Efficient work flow means that claims move speedily through only those steps and those individuals necessary to accomplish the various tasks on a claim. The most efficient work flow for any given compensation program depends on many individual factors, such as staff size, level of automation, and legal requirements.

There are significant differences in how programs approach work flow. Just as one example, some programs use one claims specialist to perform all work on a claim, from requesting documents to evaluating eligibility, and on through analyzing expenses and making payments on them. Other programs divide these functions among two or three different staff, using administrative assistants to gather the documents, analysts to look at the police reports and make eligibility decisions or recommendations, and payment specialists to determine which specific expenses should be paid. No study exists showing which is the more efficient way to do the work of processing a claim, and the result may depend on who is doing the work – in other words, some people may work efficiently if they do everything, while others may fare better if focused on only one task. And some programs have found that rotating staff regularly through different functional responsibilities helps keep them motivated and promotes personal development as well.

The steps taken on a claim also are worthy of analysis. Does every claim need to be documented with a full medical report? Some programs don’t seek medical records unless absolutely necessary in questionable cases; other programs ask for them in every case. Which approach is likely to take more time overall? And which provides a greater degree of certainty that any issues regarding the legitimacy of the expense can be examined? The preferences and proclivities of decision makers in analyzing claims may determine the best procedure for a particular program to follow, and the result may make a difference either in speed or accuracy.

***Policy and Procedure Manuals***

Many states have found that having clear policies and procedures for staff to follow in analyzing claims contributes to efficiency and helps maintain consistency. While many programs rely only on formal written rules that go through a legislatively determined process (publication, comment, and finalization), some programs have developed internal written policies and procedures that help staff and decision makers navigate through various fact situations to reach uniform decisions.

For example, a policy and procedure manual might cover common contributory-conduct scenarios, such as passengers riding in cars driven by drunk drivers, or escalation of force in mutual combat situations. It also might provide direction in evaluating exceptions to reporting and filing requirements, or simply set out procedures to accomplish more mechanical tasks, like how to detail restitution information on a paid claim.

***Processing Checklists***

It is standard for programs to have checklists showing what must be found in a file to document an application fully. The list might have boxes to check off for the police report, for medical bills, for the various potential types of collateral resources, and for other documentation depending on the type of claim. These essential materials or elements are listed so that the processor, and the manager, can determine at any time what is in hand and what is missing.

***Training Others to Improve Claim Quality***

Some programs have increased their processing speed and efficiency by improving the quality and completeness of the claims submitted to them. If claims come into the program with all the documentation necessary to reach decisions on eligibility and payment, compensation staff has less work to do on the claims. A number of programs have developed training to encourage and empower advocates and assistants in victim-witness programs to gather police reports, medical bills, employer verifications, and other necessary documents prior to submitting the claim on the victim’s behalf. Sometimes, particularly if the claim is coming from a prosecutor’s office or police victim-witness program, staff in those outside agencies are in a position to get police reports quickly and efficiently, thus saving compensation staff from having to request it and wait for it. If people who help victims know what they’re doing, they can make a tremendous difference in shortening the amount of time claims processing staff must spend on claims.

Oregon uses an Expedited Determination Coversheet that trained and approved advocates can use to accompany the application from the victims with whom they’re working. It provides a checklist for advocates to follow, and seeks additional information that will help speed the processing of the claim by the program. Applications that are filed through this procedure are processed more quickly than other applications.

***Funding to Pay Claims***

It goes without saying that unless sufficient money exists to pay claims, the speed at which victims get help will be severely compromised. Some programs have found that even after they have made their processes substantially more efficient in making eligibility decisions, their claims bog down because they cannot pay them. (In some cases, backlogs have resulted from the efficiencies themselves, since funding that was once ample enough to pay a prior volume of claims no longer is enough. Outreach success also can result in an increase in claims that results in demand outstripping supply.)

The point for managers to keep in mind is to be aware that improving the ability to pay claims must be matched by increases in resources to keep pace.

***Program Performance Measures***

Many managers are required to create performance measures for their programs in annual budgeting processes. Other managers set them simply to try to improve or maintain performance.

No national standard exists for the time it should take to process a claim. Too many individual program variations preclude such a numerical one-size-fits-all measurement. Nevertheless, for each individual program, setting a goal for processing the majority of claims within a set time period makes a lot of sense, since it certainly is an indicator of program performance, and the value of speedy claims adjudication is appreciated by victims and providers.

Some programs try to process their claims within 90 days, or even 30 days, acknowledging that there always will be claims that fall outside these parameters for reasons beyond the program’s control. (In calculating program speed, managers should be cognizant of how particularly long claims can affect averages; working with medians may be a better approach, since the very long claims don’t upset the mid-point of work as much.)

Programs can measure other aspects of a program than claims-processing speed. The number of training sessions held per year could be set as a goal and checked at the end of that period. Programs also could try to reduce the number of claims that are decided inaccurately, as determined through quality control and review.

***Performance Measures for Staff***

Most programs have developed at least some expectations of the amount of work claims staff should perform, as measured by claims completed in a week, a month, or some other period, and some programs have established performance measures based on the volume of work accomplished. Again, managers must be able to balance speed and quality in setting any goals for efficiency in processing claims. Automated reports that provide measurements of individual staff can be helpful in evaluating each staff members’ performance.

***Quality Control***

A periodic review of cases has become established procedure in many programs. Some programs accomplish quality control through the director reviewing staff work on all claims – indeed, this may be a necessity if it is the director’s formal duty to make decisions on all claims, or to be the one to make recommendations to a decision-making board. Other programs make use of a quality control specialist below the level of the director to check up on the work of claims staff.

Some programs have found that reviewing only a representative sample of claims, rather than all, is sufficient to maintain quality in case processing. Other programs may only want to review claims that involve difficult decisions, such as denials involving contributory conduct.

With thorough training of staff, and some measure of oversight of staff work, quality control can be achieved, but the precise level and means must be determined by each program manager individually.