

*Our claims administration services objective is to assist our clients in controlling losses and loss expense. Working closely with our clients, we promptly investigate loss reports, evaluate claims and take appropriate action in accordance with the client's requirements.*

## **Communication**

Upon receipt of a lost time claim report, our workers' compensation adjuster contacts the claimant, provider, and the employer within three business days. If the claim involves lost time, the adjuster contacts the claimant every two weeks while the claim is active. All telephone calls are returned within 24 hours. All correspondence requiring a response is answered within 10 days.

We believe in a partnership between our clients and the Pool. As claims administrators, we keep in contact with our clients on all pertinent issues, conducting periodic meetings with our clients to discuss more serious claims. As information develops through our investigation or because of changes in the case, we keep our client up-to-date and make recommendations for adjusting the claim.

Roundtable discussions are held regularly among Pool staff to ensure that our technical expertise can be brought to bear on any claim or issue that affects our clients.

## **Investigation**

Our objective is to administer benefits in a timely manner. This can only be done with a prompt and complete investigation. Losses can be significantly influenced by the initial investigation. A thorough investigation ensures that we pay the appropriate benefits and control losses whenever possible.

Written or recorded statements will be taken if a party offers information that might be used to deny a claim or reduce the exposure. Statements are obtained from the injured worker, employer, witnesses, or any other person who may have information relative to the claim. Statements will also be taken to determine liability on potential third party actions.

The manager reviews all employers' first report of injuries received and determines lost time or medical only status. Claims are entered into our database within 24 hours of receipt (working days). The assigned adjuster completes a setup sheet by contacting the claimant and the client, then sets the initial reserve on the file and returns the claim to the manager for review and reserve approval, if above his/her reserve autonomy.

The claimant is contacted within 24 hours of receipt of the claim to obtain information from the claimant regarding the circumstances of the injury, any pre-existing conditions and any subrogation information. The workers' compensation process and benefits are explained to the claimant at that time. The employer is contacted to confirm the facts and

to obtain additional information not included on the first report. If necessary, the claim may be referred to a medical management nurse.

The adjuster interviews the claimant, other employees and other witnesses as necessary to verify information or gather new information. Medical authorizations are executed in order to obtain documentation for review and verification of injury claims. If an attorney is involved, we work with the attorney to obtain documentation. Independent medical exams are arranged when necessary.

We determine the jurisdictional law applicable to the claim and make recommendations on compensation. Investigations are completed within statutory requirements.

After the investigation, the adjuster evaluates the claim on the basis of extent of injury, applicable laws and statutes, the facts, issues, client philosophy, and settlement alternatives.

## **File Documentation**

File documentation may be in the form of paper records and/or electronic records. All pertinent activity will be documented.

In addition to the Pool's generated reports, worksheets and notes, file documentation includes such items as medical reports, medical authorizations, independent expert reports, attorney correspondence, and all other supporting documentation pertaining to the claim.

## **Reserving**

The Pool reserves claims based on the adjuster's evaluation of the maximum probable exposure. Reserves are reviewed regularly for adjustments and an entry is made in the diary each time the file is reviewed. When the initial reserve is set, or when reserves are adjusted, the reasons why are documented in the file.

Upon receipt of information that affects the estimated outcome of the claim, all reserves are evaluated and adjusted accordingly. All reserve changes are made using a reserve worksheet. Within three working days of receipt, a reserve worksheet is completed on all lost time and serious medical-only cases. Every 90 days, the reserve will be reviewed by the manager with a confirming entry made in the file. If a reserve change is needed, a new reserve worksheet is completed. Changes exceeding an adjuster's individual authority are approved by the manager.

The reserve worksheet is completed on all lost time claims, and includes consideration of wages, medical loss, injury, potential permanent disability, claimant profile, outside expert needs and potential legal expense. After the claim adjuster analyzes the individual case, the claim adjuster will then justify the reserve by completing the comment section

or an additional report. Any reserves over the adjuster's autonomy are approved by the manager.

Generally, reserves worksheets are not completed on Medical Only Claims. These reserves are automatically set at \$250 but may be increased or decreased at the discretion of the adjuster.

## **Diary**

All open claims are kept on active diary by the adjuster assigned to the claim.

Active lost time claims are reviewed by the adjuster every 2 weeks. Some claims may be reviewed sooner if more frequent activity is needed and expected. Occasionally, a longer diary will be set if the claim is relatively inactive and work does not need to be done.

The manager maintains diaries on all cases above the adjuster's individual autonomy or on cases that have been open for more than six months. Occasionally, a longer diary will be set if the claim is relatively inactive and additional work is not needed.

## **Payments**

### **Indemnity**

Initial temporary total disability (TTD) payments are made within 14 days of the date of injury (or date lost time begins) and at 14 day intervals until the claimant is able to return to work, or in compliance with other statutory requirements.

Initial temporary partial disability (TPD) payments are made within 1 day of the return to partial duty date, and at 14 day intervals thereafter until the claimant is able to return to full duty, or in compliance with other statutory requirements.

Initial permanent partial disability (PPD) payments are made in compliance with statutory requirements.

Permanent total disability (PTD) payments are made at 14-day intervals, or in compliance with other statutory requirements.

Benefits due by order are made in compliance with statutory requirements.

### **Medical**

100% of all medical bills are paid within 30 days of receipt. If a bill cannot be paid (due to lack of proper documentation, fee schedule codes, etc.), it is returned to the provider within 10 days of receipt with an explanation.

## **Other**

100% of all other bills are paid within 30 calendar days of receipt. If a bill cannot be paid (due to lack of proper documentation, etc.), it is returned to the provider within 10 days of receipt with an explanation.

## **Supervision**

Pool believes that continuous supervision of all areas of claims handling and management ensures the highest quality work in claim's handling. In-house, The Pool ensures that each member of the claims' team receives support and supervision from other Pool professionals. Periodically, Pool brings in outside experts to audit our claims handling procedures and conduct file reviews. These audits and outside technical experts help us stay abreast of changes in the workers' compensation arena, as well as keeping our staff at the top of their profession.

## **Subrogation**

All claims are reviewed for subrogation potential. If there is potential subrogation, the file is flagged. A liability investigation is conducted to determine whether or not subrogation is feasible. If necessary, arrangements are made for evidence preservation, expert witnesses, accident reconstruction, etc. If subrogation is appropriate, the third party is put on notice in writing. Periodic follow-ups are made to obtain recovery. If attempts are unsuccessful, the case is reviewed with the client to determine whether or not formal action should be taken. All outstanding subrogation issues are resolved before a claim is closed.

## **Reinsurance/Excess Insurance Reporting Requirements**

All reinsurance/excess insurance reporting requirements shall be met.

## **Litigation**

The adjuster monitors the claim carefully to control legal expenses. The adjuster assigns the case to the defense firm, documents the issues in dispute and outlines the actions to be taken by the defense attorney. The claim adjuster coordinates work with the defense attorney and outlines a plan of defense for future handling. The defense attorney is required to return his initial evaluation of the claim within the time frames designated in the referral request.

If any further investigation is needed, the adjuster and manager coordinate that investigation. In most cases, the continued investigation is conducted by the adjuster, not the defense attorney. Pool requires defense counsel to obtain prior approval before

incurring expenses such as depositions, expert witnesses, extensive research or use of co-counsel. We advise the client of the merits of settlement options, if applicable. No settlement offers are made without authority.

## **Vocational Rehabilitation**

When a claim involves potential permanent total disability or when it seems likely that vocational rehabilitation would be beneficial in significantly reducing the costs of a claim, the adjuster assigns an independent vocational rehabilitation vendor, in accordance with statutory requirements. If the claim is under medical case management, the nurse assigned is also involved.

The adjuster documents exactly what work is to be performed when the initial assignment is made. The claim adjuster is responsible for monitoring the vendor's work and ensuring that the scope of work performed by the vendor is limited to the authorized vocational aspects of the claim.

## **Managed Care**

Pool associates with a network of contracting providers. The providers within the network provide health care services according to utilization management protocols in place, and additionally, may contract for discounted fees from the state workers' compensation fee schedule. By maintaining utilization protocols and accepting reduced fees, these providers deliver medical care to our clients with cost containment in mind.

Nurse consultants may be involved in case management for lost time or catastrophic medical cases. The nurse acts as coordinator and communicator to the claimant, provider(s), employer and other parties that may be involved in the case. The nurse consultants work closely with the adjusters and review case management on a periodic basis. Courses of treatment and referrals are reviewed to determine medical appropriateness and to make recommendations for more efficient treatment.

## **Claim Settlement, Evaluation**

Each adjuster has payment and settlement authorization limits. Payments and settlements that exceed their authorization are handled in accordance with the terms of the claims administration agreement with the client.

## **Other Recoveries, Offsets**

### **Subsequent Injury fund**

As soon as claim is identified as potential permanent total disability, the claim is reviewed for possible application to any subsequent injury fund.

## **Social Security Disability Insurance, Public Employees Retirement Administration and other disability offsets**

The adjuster investigates to determine whether or not the claimant is entitled to any disability benefits that could result in a reduced workers' compensation benefit. Notices are sent to such claimants explaining the disability offset coordination and requesting that they apply for the appropriate disability benefits. The adjuster follows up to determine the amount of disability benefits, to recalculate the workers' compensation benefit and to adjust the workers' compensation benefit accordingly. All claims involving disability over 30 days are reviewed for disability offsets. Claims involving disability of over 150 days are reviewed for SSDI disability potential.

### **Other Insurance**

If a claim involves more than one carrier, the adjuster monitors the claim to determine whether or not any benefits might be refundable from the other carrier.

## **Claims Handling Philosophy**

- ◆ Courtesy is extended to claimants, other service providers, and county contacts.
- ◆ A new claim may be a once-in-a-lifetime experience to the claimant. We treat it accordingly, providing necessary information
- ◆ We keep county contacts informed—if people have information, they are less likely to feel alienated and left out of the claims management picture.
- ◆ Case management is a team effort of adjusters, case managers and attorneys developing solutions, with the adjusters controlling the claim's handling.
- ◆ Early evaluation of claim exposure is essential—bad news doesn't get any better with age.
- ◆ We aggressively use medical and rehabilitation management practices to return injured employees to a productive work status as soon as possible.
- ◆ When an attorney is used, we give direction and monitor their activity, controlling legal costs.
- ◆ In a decision to settle, the cost of defense is not the only consideration.
- ◆ Subrogation—if there's money out there that's rightfully ours, we go after it.

- ◆ All bills are reviewed promptly to make sure they're properly invoiced and paid. We don't pay more than we have to.
- ◆ How much we pay on a claim isn't the ultimate measure of our success—how we make equitable payments is.