Adopted: December 6, 1985
Last Amended: July 1, 2019

ADDENDUM A
WORKERS' COMPENSATION
CLAIMS ADMINISTRATION STANDARDS

The following Standards have been adopted by Public Risk Innovation, Solutions, and Management (hereinafter PRISM) in accordance with Article 18(b) of the PRISM Joint Powers Agreement. It is the intent of these Standards to ensure compliance with all applicable Labor Code and California Code of Regulations Sections. In the event that there exists a conflict between the Standards, the Labor Code or the Code of Regulations, the most stringent requirement shall apply.

I. CLAIMS HANDLING - ADMINISTRATIVE

A. Case Load

1. Each claims examiner assigned to the Member should handle a targeted caseload of 150 but not to exceed 165 claims. In situations where caseloads include future medical and medical only claims, these claims shall be counted as 2:1 in the caseload limit.

2. Supervisory personnel should not handle a caseload, although they may handle specific issues or a small number of conflict claims.

B. Case Review and Documentation

1. Documentation shall reflect any significant developments in the file and include a plan of action. Plan of action statements shall be updated at the time of examiner diary review.

2. The examiner shall review indemnity and medical-only files at intervals not to exceed 45 calendar days. Future medical files shall be reviewed at intervals not to exceed 90 calendar days.

3. The supervisor shall review all new claims within 60 calendar days of initial set up and subsequently monitor activity on indemnity files at intervals not to exceed 120 calendar days. Future medical files shall be reviewed by the supervisor at intervals not to exceed 180 calendar days.

4. File contents shall comply with Code of Regulations Sections 10101, 10101.1 and 15400, and be kept in a neat and orderly fashion. If claims are maintained in a paperless system, documents shall be clearly identified (e.g., medical report, WCAB Orders, legal, etc.).

5. Medical Only Claims

   a. If a medical-only claim is still open at 90 calendar days, it shall be transferred to an indemnity examiner.

   b. If, at any time, it is anticipated there will be indemnity benefits paid, the claim shall be transferred to an indemnity claim type.

   c. If the medical-only claim remains open at 180 days, the claim shall be converted to an indemnity claim type, unless there is documentation showing that medical treatment will be ending and the claimant will be discharged from care within the next 30 days, or the claimant is only seeking treatment for a blood-borne pathogen exposure protocol.

C. Communication

1. Telephone Inquiries

   Return calls shall be made within 1 working day of the original telephone inquiry. All documentation shall reflect these efforts.

2. Incoming Correspondence

   All correspondence received shall be clearly stamped with the date of receipt.

3. Return Correspondence

   All correspondence requiring a written response shall have such response completed and transmitted within 5 working days of receipt.

4. Ongoing Claimant Contact

   On cases involving unrepresented injured workers who are off work, telephone contact shall be made at a minimum of once every 30 days and within 3 working days after discharge from the hospital or outpatient facility following a surgical procedure. This is in addition to nurse case management involvement on claims where nurse case managers are assigned.

D. Fiscal Handling

1. Fiscal handling for indemnity benefits on active cases shall be balanced with appropriate file documentation on a semi-annual basis and prior to sending a benefit termination notice to verify that statutory benefits are paid appropriately. Balancing is defined as, “an accounting of the periods and amounts due in comparison with what was actually paid”.

2. In cases of multiple losses with the same person, payments shall be made on the appropriate claim file.

E. Medicare Reporting

Mandatory reporting to the Center for Medicaid Services (CMS) shall be completed directly or through a reporting agent in compliance with Section 111 of the Medicare Medicaid and SCHIP Extension Act of 2007 (“MMSEA”). Medicare eligibility shall be documented in the claim file at time of settlement evaluation.

II. CLAIM CREATION

A. Three-Point Contact

Three-point contact shall be conducted on all claims with the non-represented injured worker, employer representative and treating physician within 3 working days of receipt of the claim by the third party administrator or self-administered entity. If a nurse case manager is assigned to the claim, initial physician contact may be conducted by either the claims examiner or the nurse case manager. This initial contact should be substantive and clearly documented in the claim file. In the event a party is non-responsive, there shall be evidence of at least three documented attempts to reach the individual.

B. Compensability

1. The initial compensability determination (accept claim, deny claim or delay acceptance pending the results of additional investigation) and the reasons for such a determination shall be made and documented in the file within 14 calendar days of the filing of the claim with the employer. In the event the claim is not received by the third party administrator or self-administered entity within 14 calendar days of the filing of the claim with the employer, the third party administrator or self-administered entity shall make the initial compensability determination within 7 calendar days of receipt of the claim.

2. Delay of benefit letters shall be mailed in compliance with the Division of Workers' Compensation (DWC) guidelines. In the event the employer does not provide notice of lost time to the third party administrator or self-administered entity timely to comply with DWC guidelines, the third party administrator or self-administered entity shall mail the benefit letters within 7 calendar days of notification.

3. The final compensability determination shall be made by the claims examiner or supervisor within 90 calendar days of employer receipt of the claim form.

C. AOE/COE Investigation

If a decision is made to delay benefits on a claim, an AOE/COE investigation shall be initiated within 3 working days of the decision to delay. This may include, but is not limited to, assigning out for witness/injured worker statements, initiating the QME/AME process, requesting medical records, etc.

D. Reserves

1. Using the information available at claim file set up, an initial reserve shall be established for the most probable case value.

2. The initial reserve shall be electronically posted to the claim within 14 calendar days of receipt of the claim.

E. Indexing

All claims shall be reported to the Index Bureau at time of initial set up and re-indexed on an as needed basis thereafter. Blood borne pathogen exposure claims are an exception to this requirement.

PRISM maintains membership with the Index Bureau that members can access.

III. CLAIM HANDLING – TECHNICAL

A. Payments

1. Initial Temporary and Permanent Disability Indemnity Payment

a. The initial indemnity payment shall be issued to the injured worker within 14 calendar days of knowledge of the injury and disability. In the event the third party administrator or self-administered entity is not notified of the injury and disability

within 14 calendar days of the employer's knowledge, the third party administrator or self-administered entity shall make payment within 7 calendar days of notification. Initial permanent disability payments shall be issued within 14 calendar days after the date of last payment of temporary disability. Effective 1/1/2013, permanent disability payments shall be issued upon approval of an Award pursuant to Labor Code Section 4650(b)(2). Prior to a PD Award, advances may be due if the employer has not offered the employee a position paying at least 85% of their wages and compensation at time of injury or the employee is not employed in a position paying at least 100% of their wages and compensation at time of injury. This shall not apply with salary continuation.

b. The properly completed DWC Benefit Notice shall be mailed to the employee within 14 calendar days of the first day of disability. In the event the third party administrator or self-administered entity is not notified of the first day of disability until after 14 calendar days, the DWC Benefit Notice shall be mailed within 7 calendar days of notification.

c. Self-imposed penalty shall be paid on late payments in accordance with Section III. A.7 of this document.

d. Overpayments shall be identified and reimbursed timely where appropriate. The third party administrator or self-administered entity shall request reimbursement of overpaid funds from the party that received the funds. If necessary, a credit shall be sought as part of any resolution of the claim.

2. Subsequent Temporary and Permanent Disability Payments

a. Eligibility for indemnity payments subsequent to the first payment shall be verified, except for established long-term disability.

b. Ongoing indemnity payments shall be paid in accordance with Labor Code Section 4650(c).

c. Subsequent DWC benefit notices shall be issued in accordance with CCR 9812.

d. Self-imposed penalty shall be paid on late payments in accordance with Section III. A.7 of this document.

3. Final Temporary and Permanent Disability Payments

a. All final indemnity payments shall be issued timely.

b. The appropriate DWC benefit notices shall be issued in accordance with CCR 9812.

c. Self-imposed penalty shall be paid on late payments in accordance with Section III. A.7. of this document.

4. Award Payments

a. The claim file shall reflect demonstrated efforts to initiate/batch payments on undisputed Awards, Commutations, or Compromise and Release agreements within 10 working days following receipt of the appropriate document, unless the Award indicates payment is due sooner.

b. For all claims in the Primary Workers' Compensation (PWC) Program and/or excess reportable claims, copies of all Awards shall be provided to PRISM at time of payment.

5. Medical Payments

a. Medical treatment billings (physician, pharmacy, hospital, physiotherapist, etc.) shall be reviewed for correctness, approved for payment and paid within 60 days of receipt.

b. The medical provider shall be notified in writing within 30 days of receipt of an itemized bill if a medical bill is contested, denied or incomplete.

c. A bill review process should be utilized whenever possible. There should be participation in a PPO and/or MPN whenever possible.

6. Injured Worker Reimbursement Expense

a. Reimbursements to injured workers shall be issued within 15 working days of the receipt of the claim for reimbursement.

b. Advance travel expense payments shall be issued to the injured worker 10 working days prior to the anticipated date of travel.

7. Penalties

a. Penalties shall be coded so as to be identified as a penalty payment.

b. If the Member utilizes a third party administrator, the Member shall be advised of the assessment of any penalty for delayed payment and the reason thereof, and the administrator's plans for payment of such penalty, on a monthly basis.

c. If the Member utilizes a third party administrator, the Member, in their contract with the administrator, shall specify who is responsible for specific penalties.

B. Medical Treatment

1. Each Member shall have in place a Utilization Review process as set forth in Labor Code Section 4610.

2. Disputes regarding utilization review determinations shall be resolved using the Independent Medical Review process set forth in Labor Code Section 4610.5.

3. Nurse case managers shall be utilized where appropriate. Rationale for assignment and continued necessity shall be documented in the claim notes at each regular diary review.

4. If enrolled in a Medical Provider Network, the network shall be utilized whenever appropriate.

C. Apportionment

1. Investigation into the existence of apportionment shall be documented.

2. If potential apportionment is identified, all efforts to reduce exposure shall be pursued.

D. Disability Management

1. The third party administrator or self-administered entity shall work proactively to obtain work restrictions and/or a release to full duty on all cases. The TPA or self-administered entity shall notify a designated Member representative immediately upon receipt of temporary work restrictions or a release to full duty, and work closely with the Member to establish a return to work as soon as possible.

2. The third party administrator or self-administered entity shall notify a designated Member representative immediately upon receipt of an employee's permanent work restrictions so that the Member can determine the availability of alternative, modified or regular work.

3. If there is no response within 20 calendar days, the third party administrator or self-administered entity shall follow up with the designated Member representative.

4. Members shall have in place a process for complying with laws preventing disability discrimination, including Government Code Section 12926.1, which requires an interactive process with the injured worker when addressing a return to work particularly with permanent work restrictions.

5. Third party administrators or self-administered claims professional shall cooperate with members to the fullest extent, in providing medical and other information the member deems necessary for the member to meet its obligations under federal and state disability laws.

E. Supplemental Job Displacement Benefits

1. Supplemental Job Displacement Benefits – Dates of injury on or after 1/1/04 and before 1/1/13: Benefits pursuant to Labor Code Section 4658.5 shall be timely provided. Dates of injury on or after 1/1/13: Benefits pursuant to Labor Code 4658.7 shall be timely provided.

2. The third party administrator or self-administered entity shall secure the prompt conclusion of SJDB.

F. Reserving

1. Reserves shall be reviewed at regular diary and at time of any significant event, e.g. - surgery, P&S/MMI, return to work, etc., and adjusted accordingly. This review shall be documented in the file regardless of whether a reserve change was made. Where the SIP model does not apply, claims shall be reserved for the most probable value.

2. Indemnity reserves shall reflect actual temporary disability indemnity exposure with 4850 differential listed separately.

3. Permanent disability indemnity exposure shall include life pension reserve if appropriate.

4. Future medical claims shall be reserved in compliance with CCR 15300 (b)(4) allowing adjustment for reductions in the approved medical fee schedule, undisputed utilization review, medically documented non-recurring treatment costs and medically documented reductions in life expectancy.

5. Allocated expense reserves shall include medical cost containment, legal, investigation, copy service and other related fees.

6. A reserve worksheet shall be utilized and/or detailed rationale substantiating reserve levels shall be documented within the claim file.

G. Resolution of Claim

1. Within 10 working days of receiving medical information indicating that a claim can be finalized, the claims examiner shall begin appropriate action to finalize the claim.

2. Follow up finalization efforts shall continue and be documented at regular diary reviews until resolution is complete.

3. Settlement value shall be documented appropriately utilizing all relevant information.

4. Where settlement includes resolution of future medical for a Medicare beneficiary or an expected Medicare beneficiary, the settlement shall document the strategy to protect Medicare's secondary payer status.

5. Pursuant to CCR15400.2, claim files with awards for future benefits shall be reviewed for administrative closure two years after the last provision of benefits.

H. Settlement Authority

1. No agreement shall be authorized involving liability, or potential liability, of PRISM without the advance written consent of PRISM. The member shall be notified of any settlement request submitted to PRISM.

2. The third party administrator shall obtain the Member's authorization on all settlements or stipulations in excess of the settlement authority provided in any provision of the individual contract between the Member and the claims administrator.

3. Proof of settlement authorization(s) shall be maintained in the claim file.

IV. LITIGATED CASES

The third party administrator or self-administered entity shall establish written guidelines for the handling of litigated cases. The guidelines should, at a minimum, include the points below, which may be adopted and incorporated by reference as "the Guidelines".

1. The third party administrator or self-administered entity shall promptly initiate investigation of issues identified as material to potential litigation. The Member shall be alerted to the need for in-house investigation, or the need for a contract investigator who is acceptable to the Member. The Member shall be kept informed on the scope and results of investigations.

2. The third party administrator or self-administered entity shall, in consultation with the Member, assign defense counsel from a list approved by the Member. Initial referral and ongoing litigation management shall be timely and appropriate. The third party administrator or self-administered entity shall maintain control of the ongoing claim activities.

3. Settlement proposals directed to the Member shall be forwarded by the third party administrator, self-administered entity or defense counsel in a concise and clear written form with a reasoned recommendation. Settlement proposals shall be presented to the Member as directed so as to insure receipt in sufficient time to process the proposal.

4. Knowledgeable Member personnel shall be involved in the preparation for medical examinations and trial, when appropriate or deemed necessary by the Member so that all material evidence and witnesses are utilized to obtain a favorable result for the defense.

5. The third party administrator or self-administered entity shall comply with any reporting requirement of the Member.

V. SUBROGATION

1. In all cases where a third party (other than a Member employee or agent) is responsible for the injury to the employee, attempts to obtain information regarding the identity of the responsible party shall be made within 14 calendar days of recognition of subrogation potential.

2. Once identified, the third party shall be contacted within 14 calendar days with notification of the Member's right to subrogation and the recovery of certain claim expenses.

3. If the third party is a governmental entity, a claim shall be filed with the governing board (or State Board of Control as to State entities) within 6 months of the injury or notice of the injury. If the third party is a non-governmental entity, a complaint shall be filed in civil court within two years in order to preserve the statute of limitations.

4. Periodic contact shall be made with the responsible party and/or insurer to provide notification of the amount of the estimated recovery to which the Member shall be entitled.

5. If the injured worker brings a civil action against the party responsible for the injury, the claims administrator shall consult with the Member about the value of the subrogation claim and other considerations. Upon Member authorization, subrogation counsel shall be assigned to file a Lien or a Complaint in Intervention in the civil action.

6. Whenever practical, the claims administrator shall aggressively pursue recovery in any subrogation claim. They should attempt to maximize the recovery for benefits paid, and assert a credit against the injured worker's net recovery for future benefit payments.

7. Member (and PRISM if applicable) approval is required to waive pursuit of subrogation or agree to a settlement of a third party recovery. This approval shall be documented in the claim file. In cases of self-administered entities, a process shall be documented noting the authority levels within the member organization to waive pursuit of subrogation or agree to a settlement of a third party recovery.

VI. EXCESS COVERAGE

A. Claims meeting the definition of reportable excess workers' compensation claims as defined by the Memorandum of Coverage Conditions Section shall be reported to PRISM within five working days of the day on which it is known the criterion is met. Utilize the Excess Workers' Compensation First Report Form available through PRISM's website.

B. Subsequent reports shall be transmitted to PRISM on a quarterly basis on all indemnity claims and on a semi-annual basis on all future medical claims or sooner if claim activity warrants, or at such other intervals as requested by PRISM, in accordance with Underwriting and Claims Administration Standards. Utilize the Excess Workers' Compensation Status Report Form

available through PRISM's website, or a comparable form to be approved by PRISM.

C. Reimbursement requests shall be submitted in accordance with PRISM's reporting and reimbursement procedures on a quarterly or semi-annual basis depending on claims payment activity. Utilize the Excess Workers' Compensation Claim Reporting and Reimbursement Procedures available through PRISM's website.

D. A closing report with a copy of any settlement documents not previously sent shall be sent to PRISM.

Following is the history of amendments to this document:

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