



## CSURMA AORMA

## POLICY AND PROCEDURE NO. W-3

(Formerly W-4)

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<b>SUBJECT:</b>	<b>WORKERS' COMPENSATION CLAIMS HANDLING PROCEDURES AND GUIDELINES</b>
<b>ADOPTED:</b>	<b>DECEMBER 8, 2009</b>
<b>EFFECTIVE:</b>	<b>DECEMBER 8, 2009</b>
<b>AMENDED:</b>	<b>SEPTEMBER 16, 2010 MARCH 20, 2014 SEPTEMBER 8, 2016 MARCH 8, 2018</b>

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### **PURPOSE:**

The purpose of this Policy & Procedure is to describe the roles and responsibilities of the Workers' Compensation Third Party Claims Administrator (**TPA**) and the participants in the CSURMA Auxiliary Organizations Risk Management Alliance (**AORMA**) in the reporting and handling of claims.

### **POLICY:**

It shall be the policy of the **AORMA** to ensure that Workers' Compensation claims are administered by the following general guidelines.

### **PROCEDURE:**

- In the event of a Workers' Compensation occurrence likely to involve **AORMA**, written notice regarding the occurrence shall be given by the Member to the **TPA** no later than five (5) calendar days from the date of the Member's knowledge. Such notice shall include the Employer's First Report of Occupational Injury or Illness (Form 5020). The form should include the circumstances of the occurrence, and the names and addresses of any injured parties, and witnesses. The five (5) day requirement to report injuries is a Labor Code requirement.
- The following will serve as the **AORMA** Workers' Compensation Program procedures and guidelines and are based upon the current contract with **TPA**.

### ***Claim Reporting Procedures***

The auxiliaries report all claims to **TPA** via e-mail or fax within five calendar days of notice as required by California Statute by completion of a Form 5020. The Claims Supervisor assigns new losses to appropriate handler for contact and investigation. After an initial investigation, the Claims Examiner makes a determination -as to the appropriate claim type.



Indemnity claims will be managed by the Claims Examiner. Medical First Aid Only claims will be managed by the Claims Support Associate. Medical First Aid Only claims are defined as claims estimated at less than \$3,000 in medical costs, no anticipated permanent disability and with no loss of work.

Record Only claims in the Juris (Sedgwick claims system) are considered “Incident Only” claims. This claim type does not have a claims status attached to it. It is neither open nor closed. It serves as a reporting function only.

All new indemnity claims will be reviewed by the Claims Supervisor within 5 (five) working days of receipt by **TPA** or within 5 (five) days of conversion to indemnity claim.

### ***Initial Investigation***

The Claims Examiner will conduct a thorough investigation to determine compensability immediately upon receipt of the claim. The Claims Examiner makes all the initial contacts necessary to make this determination and will follow the question format provided by **TPA** management which outlines the information to be requested for each of the contacts. The Claims Examiner **TPA** will contact the Auxiliary Organization Workers’ Compensation Claim Coordinator (**Coordinator**), the injured employee, and the injured employee’s supervisor and physician. Physician contact is not necessary if (1) a Doctor’s First Report of Occupation Injury or Illness (Form 5021) is in the file, (2) there is no lost time, and (3) there are no disputes.

### ***3-Point Contact – Employee, Employer and Physician***

The Claims Examiner will make 3-Point Contact on all “pending” claims within one business day after receiving notice of the claim. Communication with the injured employee will be available in the employee’s primary language or with translation upon request.

Notice of claim is defined as:

- Notice of a pending claim in Juris.
- Phone call, fax or e-mail from the **Coordinator** (Form 5020)
- Doctor’s First Report of Occupational Injury or Illness (Form 5021)
- Notice of Representation (no contact with injured employee)
- Application of Adjudication of Claim (no contact with injured employee)
- DWC-1 Claim Form

If the **TPA** receives the first notice of claim, **TPA** will notify the **Coordinator** of the details of the claim, request additional information from the **Coordinator** as needed and set up the claim in Juris. The **Coordinator** will complete the Form 5020.

If it is determined after initial contact that a claim is a First Aid, the claim will be closed. If later a bill is received, the file will be reopened for payment of the bill and closed.



If the Claims Examiner/Claims Support Assistant is unable to complete all the initial contacts, the Claims Examiner will continue contact attempts for three days. Should the contact attempts be unsuccessful a “Call Me Card” or e-mail will be sent to contact the respective party. All attempts at communication will be documented in Notepad. Documentation of a “Call Me Card” will be stored in Correspondence. Assistance from the **Coordinator** must be requested if contact with the injured employee cannot be made after three unsuccessful attempts. The work and home telephone number of the injured employee is a required field for a “pending” claim and therefore needs to be made available to the Claims Examiner. Alternative contact numbers, email addresses or a mailing address can be requested if the Claims Examiner is unable to make contact.

***No claim will be accepted without completion of the 3-point contact unless there is concurrence from the Coordinator.***

3-Point Contact will be documented in Juris on the day the contact occurs.

The **Claims Supervisor** review of all new claims at five days will ensure that contact is completed and documented. If contact is complete, the **Claims Supervisor** will so note in Notepad. If contact is not complete, the **Claims Supervisor** will document in Notepad the contacts that need completion and require that the Claims Examiner continue contacts until all have been completed. The **Claims Supervisor** will keep the file on close diary until all contacts are made.

#### ***Acceptance/Denial Issues***

If the Claims Examiner determines that a claim should be denied, the Claims Examiner will notify the **Coordinator** of the investigation results and recommendation to deny benefits prior to notifying the injured employee. All recommendations for denials must be approved by the **Claims Supervisor** and documented in Notepad. All denied claims will have a reason for the denial entered in the claim system.

If the injured worker does not pursue a claim, **TPA** will not delete the claim. The Claims Examiner/Claims Support Assistant will notify the employee in writing of Sedgwick’s confirmation and understanding that the employee does not wish to pursue the claim. The claim will be coded with an appropriate claim type (e.g., Record Only, Medical Only, Indemnity, etc.)

The Claims Examiner has fourteen (14) days to determine if a claim will be delayed. Medical treatment will continue to be provided during the ninety (90) day discovery period up to a limit of \$10,000, per labor code statute, or until the case is denied.

The Claims Examiner has up to ninety (90) days to make a compensability decision. The ninety (90) days starts with the employer’s knowledge of injury.



### ***Initial Documents***

The DWC-1, 5020 and 5021 forms are required documents in the claim file. If the DWC-1 is not in the file, evidence of attempts to solicit the DWC-1 form must be in the file. All are required in every claim file prior to closure.

If the **Claims Examiner/Claims Support Assistant** does not have the DWC-1 form when completing set-up of the claim, a claim form will be forwarded to the employee's home address immediately upon receipt of the notice of injury unless it is noted that a DWC-1 claim form was not provided by the **Coordinator**.

If the DWC-1 is not received within sixty days, the **Claims Examiner/Claims Support Assistant** will notify the **Coordinator** via email. This process applies to accepted claims only.

A copy of the 5020 DWC-1, and the 5021 will be clearly documented in SIR (Scanned Information Retrieval system). If a 5021 has not been submitted, the file must contain a copy of a request for the 5021. The 5021 request will be saved to the claim in Juris Correspondence.

A claim must not be closed without these documents, or proof that the DWC-1 was provided to the employee, in the claim file.

### ***Medical Releases***

**TPA** will request Medical Releases within five (5) working days of file make-up on all files. If the signed release is not returned within fourteen (14) days, and the injury has not resolved (such as in a Medical Only claim), the **Claims Examiner/Claims Support Assistant** will contact the **Coordinator** and request assistance. The process applies to Indemnity files as well as Medical Only files where treatment is continuing beyond the fourteen days.

Upon receipt of the medical release, **TPA** will order appropriate medical records as needed.

### ***Medical Direction and Control***

The **Claims Examiner/Claims Support Assistant** is responsible for coordinating the provision of prompt, appropriate and effective medical treatment for auxiliary employees. The **Claims Examiner/Claims Support Assistant** will exercise all reasonable efforts to obtain current physician reports in accordance with CCR 9785 (California Code of Regulations concerning treating physicians) on all claims where medical treatment is active.

Within fourteen (14) calendar days of notification of change of treating physician, the **Claims Examiner/Claims Support Assistant** will send the complete medical file with CCR 9785 notification to the treating physician.

If the injured employee is absent from work, notification of the auxiliary organization's return to work policy, and the injured worker's job description, if necessary, will be sent to the treating physician. Notification will be by letter and available in Correspondence.



A copy of CCR 9785 will be sent to the treating physician within five (5) working days upon any request made by the workers' compensation auxiliary **Coordinator**.

The Claims Examiner will request updated medical reports on Future Medical (FM) claims where treatment is being sought. On non-active FM claims, the Claims Examiner will document a strategy for administrative closure.

The Claims Examiner will document requests for authorization of treatment procedures in the Juris Notepad. The **Claims Examiner/Claims Support Assistant** will respond to requests for authorization of treatment and surgery on accepted cases in accordance with Utilization Review guidelines and requirements.

The treatment plan will be documented in Juris Notepad including the next treatment date. The **Claims Examiner/Claims Support Assistant** will document any medication, by name, which has been authorized by the physician for the employee in Juris Notepad. Updates will be requested as medication changes.

No agreement to utilize an AME will be made without the approval of the Claims Examiner. In litigated cases, the Claims Examiner will notify the defense attorney of this requirement.

All bills will be paid or objected to within thirty (30) calendar days from date-stamp receipt.

### ***Documentation***

**TPA** will caption all Juris Notepad entries using appropriate Juris system-defined headings. All entries will contain documentation with appropriate detail, identify the issues of the claim, and describe the plan of action being taken to resolve these issues. An Action Plan will be documented in Juris Notepad every ninety (90) days on Indemnity files and every one hundred eighty (180) days on Future Medical files.

Medically authorized restrictions will be documented in the Juris Notepad and updated every time the restrictions are modified by the physician.

Medical records that are received via medical release or subpoena must be summarized in Juris Notepad.

### ***Diary***

#### **CLAIMS EXAMINER DIARY**

Every active indemnity file will be reviewed at least once every thirty (30) days. Diary activity will include contact with unrepresented injured employees, at minimum, every sixty (60) days. Claims with ongoing temporary disability benefits will be reviewed every fourteen (14) calendar days. Review includes a phone call to the treating physician to determine return to work capability. Documentation of the review and verification of disability will appear in Notepad.



Future medical diary is no less than one hundred eighty (180) days as warranted by activity on the claim. Future Medical cases are defined as claims where the only benefit obligations are the payment of awarded permanent disability and undisputed future medical care.

*Follow-up telephone contact will be made with unrepresented injured employees who are losing time from work every fourteen (14) calendar days. Follow-up telephone contact with all other unrepresented injured employees must occur at a minimum every sixty (60) days (Future Medical file excluded).*

#### CLAIMS SUPPORT ASSISTANT DIARY

Medical Only claims will be reviewed at minimum at sixty days. At ninety (90) days, the Claims Support Assistant will review for conversion to Indemnity or closure.

#### SUPERVISOR DIARY

Claims Supervisor will review all new indemnity claims five (5) days after receipt. The Claims Supervisor will re-set a diary on each new claim as appropriate depending on the severity of the issues or medical treatment but no less than one hundred eighty (180) days. Delayed claims will be reviewed at forty-five (45) and eighty (80) days within the first ninety (90) days. Acceptance after delay and denials will be reviewed and approved by the manager. These reviews will be documented under the Management Review heading in the claim Notepad.

Supervisors will effectively manage assignments of **Claims Examiner/Claims Support Assistant** personnel to ensure caseloads are meeting the claims handling standards. An inventory count by claim type will be kept for each Claims Examiner's caseload on a monthly basis.

#### *Temporary Disability*

Temporary disability is paid every two weeks.

Verification of the employee's disability is the responsibility of the Claims Examiner. The Claims Examiner must verify with the treating physician that the employee is unable to work his/her customary job duties, or able to return to work either in a modified position, or at his/her regular job duties.

The Claims Examiner should contact the physician, if necessary, and/or confirm through medical reporting medical verification of disability every two weeks to coincide with the temporary disability check issuance. Potential for return to work must be discussed and documented. Restrictions will be clarified and discussed with the **Coordinator** for return to work possibilities.

#### *Litigation*

**TPA** is to utilize approved auxiliary organization defense counsel in every case. The Claims Examiner will make the selection of counsel on each claim in coordination with the **Coordinator**. **TPA** recommends use of defense counsel as required by its defense counsel referral criteria.



However, referrals will be made at the request of the **Coordinator** as well. **TPA** requires that defense counsel adhere to **AORMA**'s Defense Counsel Guidelines. These guidelines will be included with each litigation referral.

**TPA** will notify the **Coordinator** upon receipt of an Application for Adjudication of Claim within five (5) working days. **TPA** will assign claims to Counsel within five days after receipt of notice of approval from the **Coordinator**. **TPA** will notify the **Coordinator** by telephone or email of assignment to Counsel on a claim, and confirm by sending the **Coordinator** a copy of the letter to the selected Counsel confirming engagement.

Case analysis is to be provided by counsel within thirty days of referral. A copy of the initial case analysis will be sent to the **Coordinator** and documented in the Juris Notepad. The Claims Examiner will follow up with the defense attorney if a case analysis is not received within thirty (30) calendar days from date of referral. Subsequent reports will be sent to **TPA** and the **Coordinator** depending on the activity of the claim, but no less frequently than ninety (90) days.

The Claims Examiner will continue to manage the file, including performing administrative tasks, such as setting medical appointments, appointment letters and medical record requests. These tasks are to be completed by **TPA** staff with few exceptions.

The Claims Examiner will audit all attorney bills for appropriateness of payment.

The Claims Examiner and the **Coordinator** will determine who should attend hearings.

#### ***Mandatory Settlement Conference at WCAB***

Upon notification of the Mandatory Settlement Conference (MSC) date, the following procedure will occur:

In litigated cases, a request for authority will be sent to **AORMA** thirty (30) days prior to defense counsel filing a Declaration of Readiness to proceed, or five (5) days after receipt of the Declaration of Readiness to proceed from applicant's counsel. Thirty (30) days prior to defense counsel filing a Declaration of Readiness to Proceed, **TPA** will provide **AORMA** and Member with a comprehensive case review and/or SAR (settlement authorization request).

**TPA** will attend an MSC as deemed necessary.

Subrogation will be pursued when appropriate unless otherwise indicated by the **Coordinator**. If any legal action must be filed in any court other than the Workers' Compensation Appeals Board on behalf of the auxiliary organization, **TPA** must have approval from the CSURMA **AORMA** Committee.



### ***Communications***

**TPA** Supervisor and Claims Examiner for **TPA** will utilize professional, courteous and effective communication skills at all times and will respond to telephone and email inquiries within one (1) working day. All e-mail communications that are pertinent to a particular claim should be placed in the Juris Notepad.

### ***Index System***

**TPA** will index all disputed or lost time injury claims at claim setup and annually thereafter relying on Sedgwick's account number with the Index System.

### ***Reserving***

The initial reserve will be set up within five (5) working days of the receipt of the claim. Claims are to be reserved on a "most probable ultimate cost" basis from the date the claim is set up. Reserve amounts will be evaluated and adjusted on a regular basis, but at a minimum, within thirty (30) days of any event or change in medical prognosis that will affect the ultimate outcome of the claim. Reserves should also be reviewed concurrent with Diary and Action Plan review. "Stair-stepping" is to be avoided. All reserve calculations will be clearly reflected in the claim file.

Sedgwick Claims Supervisors will review all reserve changes above the authority of each Claims Examiner.

Reserves will be reviewed with each action plan.

### ***Investigations***

**TPA** recommends use of outside investigators as required by their claim investigation criteria and best practices. In addition to manager or supervisor approval, assignment of an outside investigator requires prior contact, approval and coordination with the **Coordinator**.

***OSHA Reporting –The members bear the responsibility to complete a manual OSHA log as required by California law.***

### ***Resolution***

Upon receipt of any permanent and stationary report, the Claims Examiner will determine if the disability described in the report is appropriate for the circumstances of the injury. The Claims Examiner may self-rate if the disability is clear. However, **AORMA** prefers that the Claims Examiner solicit an independent rating prior to issuing advances. Based on what is learned from the rating, additional clarification may be needed from the physician. The Claims Examiner will seek clarification from the physician or object as appropriate.

Upon receipt of the supplemental report with the clarifying information, the Claims Examiner may need to solicit an additional independent rating in order to ensure that the Claims Examiner is confident of the total value of permanent disability. If the dollar amount of the rating and/or the



dollar value of the total amount of permanent disability advance to be made exceed(s) \$25,000, the Permanent Disability Benefit letter requires approval from a supervisor.

Within five (5) calendar days after the Claims Examiner has determined that the report is appropriate, the Claims Examiner will submit the report to the Disability Evaluation Unit (DEU) for a Summary Rating.

A Settlement Authority Request (SAR) must be submitted to the Operations Manager at **TPA**, the **CSURMA AORMA** Workers' Compensation Committee or the **CSURMA AORMA** Committee depending on the level of the settlement value requested in accordance with the Claims Settlement Policy and Procedure. This requires timeliness in getting the independent rating in order to avoid penalties for not issuing a timely permanent disability advance.

Upon receipt of the Summary Rating from the Disability Evaluation Unit (DEU), the Claims Examiner verify the rating used in the SAR and amend the SAR, if necessary.

If the claim is litigated, the Claims Examiner must notify the defense attorney that negotiations cannot begin without authority. The Claims Examiner is responsible for getting that authority to the attorney within two (2) working days of receipt of authority. If applicant's attorney files the Declaration of Readiness to Proceed (DOR) for settlement purposes, the SAR must be submitted within five (5) days of receipt of the notification.

### ***Settlement Authority***

Various levels of settlement authority have been established as respects this **AORMA** coverage under **AORMA** Policy & Procedure W-5. The Member has no authority to settle claims.

All settlement authority requests must be presented using the Settlement Authorization Request (SAR) form.

The **SAR** must be complete and thorough. It must include a brief history of the injury, a description of the permanent disability and its dollar value, the medical prognosis and its dollar value, and any other costs that are included in the proposed settlement. It must include a complete outline of all issues and defenses. All ratings, both applicant and defense must be stated. It must state the Claims Examiner opinion regarding settlement versus taking the case to trial.

Managers must approve all requests for authority.

If a response from the authorizing body is not received in thirty (30) days, the Claims Examiner will notify the Claims Consultant via email. If timing is **urgent**, this will be indicated in the email along with a deadline date, as well as notifying the Claims Consultant by voicemail.

### ***Return to Work Issues***

The Claims Examiner will provide all information to the **Coordinator** regarding return to work restrictions and permanent modifications immediately upon knowledge.

### ***Excess Carrier Reporting and Settlement Requirements***

Any claim with a date of injury after May 1, 2004 must be reported by **TPA** to the respective excess carrier immediately, but in no event later than ten (10) calendar days from the date the **Coordinator** is notified or becomes reasonably aware of such accident or disease which may involve the excess carrier or includes any of the following:

- a. Injuries to spinal cord (including Cauda Equina), paraplegia, or quadriplegia;
- b. Fatality;
- c. Amputation of a major extremity;
- d. Blindness;
- e. Second degree burns on 25% or more of the body or third degree burns on 10% or more of the body
- f. Serious head or brain injuries (including skull fracture);
- g. Multiple fractures – involving more than one member or any non union of any part of the body;
- h. Nerve damage causing paralysis and loss of sensation in arm and hand (brachial plexus nerve damage);
- i. Massive internal injuries affecting body organs;
- j. Any occurrence which causes serious injury or death to two or more employees
- k. Any occurrence, which results in disability exceeding one (1) year.
- l. Any occurrence that results in permanent and total disability 100% - (including but not limited to 100% by statute: loss of both eyes/sight, loss of both hands (or the use thereof), “practically total paralysis,” brain injury resulting in incurable imbecility or insanity.
- m. Any occurrence that involves unusual exposure to the coverage—examples include sexual molestation, HIV, AIDS, rape, class actions and bad faith allegations, or other serious violation, which may involve excess;

Total incurred in excess of 50% of the Self Insured Retention or per Excess reporting requirements. Attachments to the first report will include:

- Face sheet to include summary of case, pertinent claimant information such as claim number, date of injury, date of birth, date of hire, average weekly wages, TTD, PD rate. The Claims Examiner must list all the issues and the plan of action recommended in order resolving these issues. Any subrogation aspects must be described and discussed.
- Reserve breakdown
- Printout of all payments, sorted by category
- AME, QME, P&S and/or current medical reports advising status of claim (AME = Agreed Medical Evaluator; QME = Qualified Medical Evaluator; P&S= Permanent and Stationary)
- Copies of all Applications filed, Workers’ Compensation Appeals Board (WCAB) Awards & Findings & Awards (F&As)



- Defense attorney evaluation
- Copies of investigation reports
- All notices and legal papers relating to the claim or suit
- Any other pertinent data

Subsequent reports will be made on a quarterly basis (unless excess carrier advises otherwise). Attachments to the subsequent reports will include:

- Face sheet to include summary of case, pertinent claimant information such as claim number, Date of Injury, Date of Birth, Date of Hire, Average Weekly Wage, Total Temporary Disability and Permanent Disability Rate. The report must provide the status of the case and the steps proposed to resolve all the remaining issues.
- Reserve breakdown
- Printout of all payments, sorted by category
- Current medical report(s)
- Any of the prior reporting requirements that occur subsequent to the initial excess report.

The Claims Manager and/or Supervisor will review and authorize all excess reports. The reports will be submitted to the Excess carrier with a hard copy of all attachments. The hard copy attachments are to be submitted only to Excess carrier.

The process is the same for interim status reports and final reporting.

Once confirmation is received from Excess carrier, the Claims Examiner will make a copy of the confirmation for the claim file and update the system that confirmation was received from the Excess Carrier.

If the employee files a Serious and Willful claim, defense costs are not reimbursable by the Excess Carrier. Requests for reimbursement must exclude these costs.

### ***Fraud Claims***

Suspected fraudulent activity (material misrepresentation by the employee) must be reviewed with the Claims Supervisor, the **Coordinator** and the **AORMA** Claims Consultant to determine the merits of the case. The case will also be discussed with the CSURMA SIU manager, J.D Wesson, who serves as the Investigation and SIU oversight manager for AORMA and CSU. The case will be prepared for submission to the District Attorney and Department of Insurance once a decision to refer the case to the authorities has been made. Fraud referral activity will be documented on the claim in Juris Management Review Notepad.

### ***Balance Sheet***

**TPA** will complete a Balance Sheet on all open files at one year from date of injury, annually at the anniversary of claim set up and annually thereafter on each file at SAR evaluation and at closing of the claim. The Balance Sheet will be kept in Correspondence or a hard copy in the claims file.



### ***Escrow Fund***

Changes have been made to the Trustee Account as a result of the transition to Sedgwick's Juris claims system effective July 1, 2016. Sedgwick Claims Management administers benefit payments and expense payments on behalf of AORMA. The account utilized is an AORMA owned account through Wells Fargo. Sedgwick will issue all payments on claims linked to this account. The Client Banking department located in Memphis, TN will prepare monthly reconciliations.

Checks issued over \$50,000.00 require funding verification. Such requests should be forwarded to the **AORMA** Accountant at the CSU Chancellor's Office, along with supporting documentation.

**TPA** will submit replenishment requests **biweekly**.

### ***Check Issuance***

All checks for claims that are linked to this account are issued by Sedgwick. Joey House, Managing Director Accounting and Financial Service and Kevin Hawkins, Sr. Vice President Finance are the facsimile signatures that will be used for all checks. There will be no manual checks under any circumstances.

### ***Reports***

The Claims Manager will provide a monthly report of **TPA** and **AORMA** penalties no later than the 10<sup>th</sup> of each month.

**TPA** will also provide reports to the **Coordinator** for each Member as follows:

Quarterly claim summary report - inception to date

- Claim summary report of all claims created in the last quarter
- Ad hoc reports by client request