

SERVICES AGREEMENT BETWEEN THE CITY OF VERNON AND ADMINSURE, INC.
FOR WORKERS' COMPENSATION THIRD PARTY CLAIMS ADMINISTRATION
SERVICES

COVER PAGE

Contractor:	AdminSure, Inc.
Responsible Principal of Contractor:	Alithia Vargas-Flores, President
Notice Information - Contractor:	AdminSure, Inc. 3380 Shelby Street Ontario, CA 91764 Attention: Alithia Vargas-Flores, President Telephone: (909) 396-5814
Notice Information - City:	City of Vernon 4305 Santa Fe Avenue Vernon, CA 90058 Attention: Lisette M. Grizzelle Interim Director of Human Resources Telephone: (323) 583-8811 ext. 166
Commencement Date:	January 1, 2025
Termination Date:	December 31, 2027
Consideration:	Total not to exceed \$257,415 (includes all applicable sales tax); and more particularly described in Exhibit B
Records Retention Period	Three (3) years, pursuant to Section 11.20

SERVICES AGREEMENT BETWEEN THE CITY OF VERNON AND ADMINSURE, INC. FOR WORKERS' COMPENSATION THIRD PARTY CLAIMS ADMINISTRATION SERVICES

This Agreement is made between the City of Vernon, a California charter City and California municipal corporation ("City"), and AdminSure, Inc., a California corporation ("Contractor").

The City and Contractor agree as follows:

1.0 EMPLOYMENT OF CONTRACTOR. City agrees to engage Contractor to perform the services as hereinafter set forth as authorized by the City Council on November 19, 2024.

2.0 SCOPE OF SERVICES.

2.1 Contractor shall perform all work necessary to complete the services set forth in the City's Request for Proposals issued on or about April 25, 2024, and titled Request for Proposals (RFP) Worker's Compensation Third Party Claims Administration Services, and Contractor's proposal to the City ("Proposal") dated May 14, 2024, Exhibit "A", a copy which is attached to and incorporated into this Agreement by reference.

2.2 All services shall be performed to the satisfaction of City.

2.3 All services shall be performed in a competent, professional, and satisfactory manner in accordance with the prevailing industry standards for such services.

3.0 PERSONNEL.

3.1 Contractor represents that it employs, or will employ, at its own expense, all personnel required to perform the services under this Agreement.

3.2 Contractor shall not subcontract any services to be performed by it under this Agreement without prior written approval of City.

3.3 All of the services required hereunder will be performed by Contractor or by City approved subcontractors. Contractor, and all personnel engaged in the work, shall be fully qualified and authorized or permitted under State and local law to perform such services and shall be subject to approval by the City.

4.0 TERM. The term of this Agreement shall commence on January 1, 2025, and it shall continue until December 31, 2027, unless terminated at an earlier date pursuant to the provisions thereof.

5.0 COMPENSATION AND FEES.

5.1 Contractor has established rates for the City of Vernon which are comparable to and do not exceed the best rates offered to other governmental entities in and around Los Angeles County for the same services. For satisfactory and timely performance of

the services, the City will pay Contractor in accordance with the payment schedule set forth in Exhibit "B" attached hereto and incorporated herein by reference.

5.2 Contractor's grand total compensation for the entire term of this Agreement, shall not exceed \$257,415 without the prior authorization of the City, as appropriate, and written amendment of this Agreement.

5.3 Contractor shall, at its sole cost and expense, furnish all necessary and incidental labor, material, supplies, facilities, equipment, and transportation which may be required for furnishing services pursuant to this Agreement. Materials shall be of the highest quality. The above Agreement fee shall include all staff time and all clerical, administrative, overhead, insurance, reproduction, telephone, air travel, auto rental, subsistence, and all related costs and expenses.

5.4 City shall reimburse Contractor only for those costs or expenses specifically approved in this Agreement, or specifically approved in writing in advance by City. Unless otherwise approved, such costs shall be limited and include nothing more than the following costs incurred by Contractor:

5.4.1 The actual costs of subcontractors for performance of any of the services that Contractor agrees to render pursuant to this Agreement, which have been approved in advance by City and awarded in accordance with this Agreement.

5.4.2 Approved reproduction charges.

5.4.3 Actual costs and/or other costs and/or payments specifically authorized in advance in writing and incurred by Contractor in the performance of this Agreement.

5.5 Contractor shall not receive any compensation for extra work performed without the prior written authorization of City. As used herein, "extra work" means any work that is determined by City to be necessary for the proper completion of the Project, but which is not included within the Scope of Services and which the parties did not reasonably anticipate would be necessary at the time of execution of this Agreement. Compensation for any authorized extra work shall be paid in accordance with the payment schedule as set forth in Exhibit "B," if the extra work has been approved by the City.

5.6 Licenses, Permits, Fees, and Assessments. Contractor shall obtain, at Contractor's sole cost and expense, such licenses, permits, and approvals as may be required by law for the performance of the services required by this Agreement. Contractor shall have the sole obligation to pay for any fees, assessments, and taxes, plus applicable penalties and

interest, which may be imposed by law and which arise from or are necessary for the performance of the Services by this Agreement.

6.0 PAYMENT.

6.1 As scheduled services are completed, Contractor shall submit to the City an invoice for the services completed, authorized expenses, and authorized extra work actually performed or incurred according to said schedule.

6.2 Each such invoice shall state the basis for the amount invoiced, including a detailed description of the services completed, the number of hours spent, reimbursable expenses incurred and any extra work performed.

6.3 Contractor shall also submit a progress report with each invoice that describes in reasonable detail the services and the extra work, if any, performed in the immediately preceding calendar month.

6.4 Contractor understands and agrees that invoices which lack sufficient detail to measure performance will be returned and not processed for payment.

6.5 City will pay Contractor the amount invoiced within thirty (30) days after the City approves the invoice.

6.6 Payment of such invoices shall be payment in full for all services, authorized costs, and authorized extra work covered by that invoice.

7.0 CITY'S RESPONSIBILITY. City shall cooperate with Contractor as may be reasonably necessary for Contractor to perform its services; and will give any required decisions as promptly as practicable so as to avoid unreasonable delay in the progress of Contractor's services.

8.0 COORDINATION OF SERVICES. Contractor agrees to work closely with City staff in the performance of Services and shall be available to City's staff, consultants, and other staff at all reasonable times.

9.0 INDEMNITY. Contractor agrees to indemnify City, its officers, elected officials, employees and agents against, and will hold and save each of them harmless from, any and all actions, suits, claims, damages to persons or property, losses, costs, penalties, obligations, errors, omissions or liabilities (herein "claims or liabilities"), including but not limited to professional negligence, that may be asserted or claimed by any person, firm or entity arising out of or in connection with the work, operations or activities of Contractor, its agents, employees, subcontractors, or invitees, provided for herein, or arising from the acts or omissions of Contractor hereunder, or arising from Contractor's performance of or failure to perform any term, provision, covenant or condition of this Agreement, except to the extent such

claims or liabilities arise from the gross negligence or willful misconduct of City, its officers, elected officials, agents or employees.

10.0 INSURANCE. Contractor shall procure and maintain for the duration of the Agreement insurance against claims for injuries to persons or damage to property that may arise from or in connection with the performance of the work hereunder by the Contractor, its agents, representative, or employees. The policies shall state that they afford primary coverage.

10.1 Commercial General Liability Insurance – Contractor shall carry General Liability Insurance covering all operations performed by or on behalf of the Contractor providing coverage for bodily injury and property damage with a single limit of not less than one million dollars (\$1,000,000) per occurrence and two million dollars (\$2,000,000) general aggregate limit written on an Insurance Services Office (ISO) Comprehensive General Liability "occurrence" Form CG 00 01 or its equivalent for coverage on an occurrence basis. The City of Vernon, its directors, commissioners, officers, employees, agents, and volunteers must be endorsed on the policy as additional insureds with respect to liability arising out of the Contractor's performance of this Agreement. The additional insured coverage under the Contractor's policy shall be primary and non-contributory and will not seek contribution from the City's insurance. The policy shall be endorsed to include a waiver of subrogation.

10.1.1 If Contractor intends to employ other contractors as part of the services rendered, the City must approve and will establish the appropriate insurance requirements.

10.1.2 Contractor agrees to subrogate General Liability resulting from performance under this agreement by agreeing to defend, indemnify, and hold harmless, the City, and its respective employees, agents, and City Council from and against all claims, liabilities, suits, losses, damages, injuries and expenses, including all costs and reasonable attorney's fees ("Claims"), which are attributable to any act or omission by the Contractor under the performance of the services.

10.2 Professional Errors and Omissions Coverage in a sum of not less than one million dollars (\$1,000,000), where such risk is applicable. Applicable aggregate must be identified and claims history provided to determine amounts remaining under the aggregates. Contractor shall maintain such coverage for at least one (1) year after the termination of this agreement.

10.3 Umbrella Liability Insurance – An umbrella (over primary) may be used to comply with limits or other primary coverage requirements. When used, the umbrella policy shall apply to bodily injury/property damage and personal injury/advertising injury and shall include a

“dropdown” provision providing primary coverage for any liability not covered by the primary policy. The umbrella policy shall have no additional exclusion or coverage difference from the primary policy. The coverage shall also apply to automobile liability.

10.4 Workers' Compensation/Employers Liability - Contractor shall comply with the applicable sections of the California Labor Code concerning workers' compensation for injuries on the job. Compliance is accomplished in one of the following manners:

10.4.1 Provide a copy of the permissive self-insurance certificate approved by the State of California; or

10.4.2 Secure and maintain in force a policy of workers' compensation insurance with statutory limits and Employer's Liability Insurance with a limit of one million dollars (\$1,000,000) per accident. The policy shall be endorsed to waive all rights of subrogation against City, its directors, commissioners, officers, employees, and volunteers for losses arising from performance of this Agreement or

10.4.3 If Contractor has no employees, it may certify or warrant to the City that it does not currently have any employees or individuals who are defined as “employees” under the Labor Code, and the requirement for Workers' Compensation coverage will be waived by completing the waiver form provided by the City.

10.5 If Contractor maintains broader coverage and/or higher limits than the minimums shown above, City requires and shall be entitled to the broader coverage and/or the higher limits maintained by the Contractor. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to the City.

10.6 Each insurance policy included in this clause shall be endorsed to state that coverage shall not be cancelled except after thirty (30) days prior written notice to City.

10.7 Insurance shall be placed with insurers with an A.M. Best rating of no less than A-VIII. Any self-insured retention or deductible in excess of \$25,000 must be approved in advance by the City. Any policies written on a claims-based basis must include a minimum of a 3-year tail.

10.8 Prior to the commencement of performance, Contractor shall furnish City with a certificate of insurance for each policy. Each certificate is to be signed by a person authorized by that insurer to evidence coverage on its behalf. The certificate(s) must be in a form approved by City. City may require complete, certified copies of any or all policies upon request.

10.9 Failure to maintain required insurance at all times shall constitute a default and material breach. In such event, Contractor shall immediately notify City and cease all performance under this Agreement until further directed by the City. In the absence of satisfactory insurance coverage, City may, at its option: (a) procure insurance with collection rights for premiums, attorney's fees, and costs against Contractor by way of set-off or recoupment from sums due to Contractor, at City's option; (b) immediately terminate this Agreement and seek damages from the Agreement resulting from said breach; or (c) self-insure the risk, with all damages and costs incurred, by judgment, settlement or otherwise, including attorney's fees and costs, being collectible from Contractor, by way of set-off or recoupment from any sums due to Contractor.

11.0 GENERAL TERMS AND CONDITIONS.

11.1 INDEPENDENT CONTRACTOR.

11.1.1 It is understood that in the performance of the services herein provided for, Contractor shall be, and is, an independent contractor, and is not an agent, officer or employee of City and shall furnish such services in its own manner and method except as required by this Agreement, or any applicable statute, rule, or regulation. Further, Contractor has and shall retain the right to exercise full control over the employment, direction, compensation and discharge of all persons employed by Contractor in the performance of the services hereunder. City assumes no liability for Contractor's actions and performance, nor assumes responsibility for taxes, bonds, payments, or other commitments, implied or explicit, by or for Contractor. Contractor shall be solely responsible for, and shall indemnify, defend and save City harmless from all matters relating to the payment of its employees, subcontractors and independent contractors, including compliance with social security, withholding and all other wages, salaries, benefits, taxes, exactions, and regulations of any nature whatsoever.

11.1.2 Contractor acknowledges that Contractor and any subcontractors, agents or employees employed by Contractor shall not, under any circumstances, be considered employees of the City, and that they shall not be entitled to any of the benefits or rights afforded employees of City, including, but not limited to, sick leave, vacation leave, holiday pay, Public Employees Retirement System benefits, or health, life, dental, long-term disability or workers' compensation insurance benefits.

11.2 CONTRACTOR NOT AGENT. Except as the City may authorize in writing, Contractor and its subcontractors shall have no authority, express or implied, to act on behalf of or bind the City in any capacity whatsoever as agents or otherwise.

11.3 OWNERSHIP OF WORK. All documents and materials furnished by the City to Contractor shall remain the property of the City and shall be returned to the City upon termination of this Agreement. All reports, drawings, plans, specifications, computer tapes, floppy disks and printouts, studies, memoranda, computation sheets, and other documents prepared by Contractor in furtherance of the work shall be the sole property of City and shall be delivered to City whenever requested at no additional cost to the City. Contractor shall keep such documents and materials on file and available for audit by the City for at least three (3) years after completion or earlier termination of this Agreement. Contractor may make duplicate copies of such materials and documents for its own files or for such other purposes as may be authorized in writing by the City.

11.4 CORRECTION OF WORK. Contractor shall promptly correct any defective, inaccurate or incomplete tasks, deliverables, goods, services and other work, without additional cost to the City. The performance or acceptance of services furnished by Contractor shall not relieve the Contractor from the obligation to correct subsequently discovered defects, inaccuracy, or incompleteness.

11.5 RESPONSIBILITY FOR ERRORS. Contractor shall be responsible for its work and results under this Agreement. Contractor, when requested, shall furnish clarification and/or explanation as may be required by the City, regarding any services rendered under this Agreement at no additional cost to City. In the event that an error or omission attributable to Contractor occurs, then Contractor shall, at no cost to City, provide all necessary design drawings, estimates and other Contractor professional services necessary to rectify and correct the matter to the sole satisfaction of City and to participate in any meeting required with regard to the correction.

11.6 WAIVER. The City's waiver of any term, condition, breach, or default of this Agreement shall not be considered to be a waiver of any other term, condition, default or breach, nor of a subsequent breach of the one waived. The delay or failure of either party at any time to require performance or compliance by the other of any of its obligations or agreements shall in no way be deemed a waiver of those rights to require such performance or compliance. No waiver of any provision of this Agreement shall be effective unless in writing and executed by a duly authorized representative of the party against whom enforcement of a waiver is sought.

11.7 SUCCESSORS. This Agreement shall inure to the benefit of, and shall be binding upon, the parties hereto and their respective heirs, successors, and/or assigns.

11.8 NO ASSIGNMENT. Contractor shall not assign or transfer this Agreement or any rights hereunder without the prior written consent of the City and approval by the City Attorney, which may be withheld in the City's sole discretion. Any unauthorized assignment or transfer shall be null and void and shall constitute a material breach by the Contractor of its obligations under this Agreement. No assignment shall release the original parties from their obligations or otherwise constitute a novation.

11.9 COMPLIANCE WITH LAWS. Contractor shall comply with all Federal, State, County and City laws, ordinances, rules and regulations, which are, as amended from time to time, incorporated herein and applicable to the performance hereof. Violation of any law material to performance of this Agreement shall entitle the City to terminate the Agreement and otherwise pursue its remedies. Further, if the Contractor performs any work knowing it to be contrary to such laws, rules, and regulations Contractor shall be solely responsible for all costs arising therefrom.

11.10 ATTORNEY'S FEES. If any action at law or in equity is brought to enforce or interpret the terms of this Agreement, the prevailing party shall be entitled to reasonable attorney's fees, costs, and necessary disbursements in addition to any other relief to which such party may be entitled.

11.11 INTERPRETATION.

11.11.1 Applicable Law. This Agreement shall be deemed an agreement and shall be governed by and construed in accordance with the laws of the State of California. Contractor agrees that the State and Federal courts which sit in the State of California shall have exclusive jurisdiction over all controversies and disputes arising hereunder, and submits to the jurisdiction thereof.

11.11.2 Entire Agreement. This Agreement, including any exhibits attached hereto, constitutes the entire agreement and understanding between the parties regarding its subject matter and supersedes all prior or contemporaneous negotiations, representations, understandings, correspondence, documentation, and agreements (written or oral).

11.11.3 Written Amendment. This Agreement may only be changed by written amendment executed by Contractor and the City Administrator or other authorized representative of the City, subject to any requisite authorization by the City Council. Any oral representations or modifications concerning this Agreement shall be of no force or effect.

11.11.4 Severability. If any provision in this Agreement is held by any court of competent jurisdiction to be invalid, illegal, void, or unenforceable, such portion shall be

deemed severed from this Agreement, and the remaining provisions shall nevertheless continue in full force and effect as fully as though such invalid, illegal, or unenforceable portion had never been part of this Agreement.

11.11.5 Order of Precedence. In case of conflict between the terms of this Agreement and the terms contained in any document attached as an Exhibit or otherwise incorporated by reference, the terms of this Agreement shall strictly prevail. The terms of the City's Request for Proposals shall control over the Contractor's Proposal.

11.11.6 Construction. In the event an ambiguity or question of intent or interpretation arises with respect to this Agreement, this Agreement shall be construed as if drafted jointly by the parties and in accordance with its fair meaning. There shall be no presumption or burden of proof favoring or disfavoring any party by virtue of the authorship of any of the provisions of this Agreement.

11.12 TIME OF ESSENCE. Time is strictly of the essence of this agreement and each and every covenant, term, and provision hereof.

11.13 AUTHORITY OF CONTRACTOR. The Contractor hereby represents and warrants to the City that the Contractor has the right, power, legal capacity, and authority to enter into and perform its obligations under this Agreement, and its execution of this Agreement has been duly authorized.

11.14 ARBITRATION OF DISPUTES. Any dispute for under \$25,000 arising out of or relating to the negotiation, construction, performance, non-performance, breach, or any other aspect of this Agreement, shall be settled by binding arbitration in accordance with the Commercial Rules of the American Arbitration Association at Los Angeles, California and judgment upon the award rendered by the Arbitrators may be entered in any court having jurisdiction thereof. The City does not waive its right to object to the timeliness or sufficiency of any claim filed or required to be filed against the City and reserves the right to conduct full discovery.

11.15 NOTICES. Any notice or demand to be given by one party to the other must be given in writing and by personal delivery or prepaid first-class, registered or certified mail, addressed as follows. Notice simply to the City of Vernon or any other City department is not adequate notice.

If to the City:

City of Vernon
Attention: Lisette M. Grizzelle, Interim Director of Human Resources
4305 Santa Fe Avenue
Vernon, CA 90058

If to the Contractor:

AdminSure, Inc.
Attention: Alithia Vargas-Flores, President
3380 Shelby Street
Ontario, CA 91764

Any such notice shall be deemed to have been given upon delivery, if personally delivered, or, if mailed, upon receipt, or upon expiration of three (3) business days from the date of posting, whichever is earlier. Either party may change the address at which it desires to receive notice upon giving written notice of such request to the other party.

11.16 NO THIRD PARTY RIGHTS. This Agreement is entered into for the sole benefit of City and Contractor and no other parties are intended to be direct or incidental beneficiaries of this Agreement and no third party shall have any right or remedy in, under, or to this Agreement.

11.17 TERMINATION FOR CONVENIENCE (Without Cause). City may terminate this Agreement in whole or in part at any time, for any cause or without cause, upon fifteen (15) calendar days' written notice to Contractor. If the Agreement is thus terminated by City for reasons other than Contractor's failure to perform its obligations, City shall pay Contractor a prorated amount based on the services satisfactorily completed and accepted prior to the effective date of termination. Such payment shall be Contractor's exclusive remedy for termination without cause.

11.18 DEFAULT. In the event either party materially defaults in its obligations hereunder, the other party may declare a default and terminate this Agreement by written notice to the defaulting party. The notice shall specify the basis for the default. The Agreement shall terminate unless such default is cured before the effective date of termination stated in such notice, which date shall be no sooner than ten (10) days after the date of the notice. In case of default by Contractor, the City reserves the right to procure the goods or services from other sources and to hold the Contractor responsible for any excess costs occasioned to the City thereby. Contractor shall not be held accountable for additional costs incurred due to delay or default as a result of Force Majeure. Contractor must notify the City immediately upon knowing that non-performance or delay will apply to this Agreement as a result of Force Majeure. At that time Contractor is to submit in writing a Recovery Plan for this Agreement. If the Recovery Plan is not acceptable to the City or not received within 10 days of the necessary notification of Force Majeure default, then the City may cancel this order in its entirety at no cost to the City, owing only for goods and services completed to that point.

11.19 TERMINATION FOR CAUSE. Termination for cause shall relieve the terminating party of further liability or responsibility under this Agreement, including the payment of money, except for payment for services satisfactorily and timely performed prior to the service of the notice of termination, and except for reimbursement of (1) any payments made by the City for service not subsequently performed in a timely and satisfactory manner, and (2) costs incurred by the City in obtaining substitute performance. If this Agreement is terminated as provided herein, City may require, at no additional cost to City, that Contractor provide all finished or unfinished documents, data, and other information of any kind prepared by Contractor in connection with the performance of Services under this Agreement. Contractor shall be required to provide such document and other information within fifteen (15) days of the request.

11.19.1 Additional Services. In the event this Agreement is terminated in whole or in part as provided herein, City may procure, upon such terms and in such manner as it may determine appropriate, services similar to those terminated.

11.20 MAINTENANCE AND INSPECTION OF RECORDS.

The City, or its authorized auditors or representatives, shall have access to and the right to audit and reproduce any of the Contractor's records to the extent the City deems necessary to insure it is receiving all money to which it is entitled under the Agreement and/or is paying only the amounts to which Contractor is properly entitled under the Agreement or for other purposes relating to the Agreement.

The Contractor shall maintain and preserve all such records for a period of at least three (3) years after termination of the Agreement.

The Contractor shall maintain all such records in the City of Vernon. If not, the Contractor shall, upon request, promptly deliver the records to the City of Vernon or reimburse the City for all reasonable and extra costs incurred in conducting the audit at a location other than the City of Vernon, including, but not limited to, such additional (out of the City) expenses for personnel, salaries, private auditors, travel, lodging, meals, and overhead.

11.21 CONFLICT. Contractor hereby represents, warrants, and certifies that no member, officer, or employee of the Contractor is a director, officer, or employee of the City of Vernon, or a member of any of its boards, commissions, or committees, except to the extent permitted by law.

11.22 HEADINGS. Paragraphs and subparagraph headings contained in this Agreement are included solely for convenience and are not intended to modify, explain or to be

a full or accurate description of the content thereof and shall not in any way affect the meaning or interpretation of this Agreement.

11.23 ENFORCEMENT OF WAGE AND HOUR LAWS. Eight hours labor constitutes a legal day's work. The Contractor, or subcontractor, if any, shall forfeit twenty-five dollars (\$25) for each worker employed in the execution of this Agreement by the respective Contractor or subcontractor for each calendar day during which the worker is required or permitted to work more than 8 hours in any one calendar day and 40 hours in any one calendar week in violation of the provisions of Sections 1810 through 1815 of the California Labor Code as a penalty paid to the City; provided, however, work performed by employees of contractors in excess of 8 hours per day, and 40 hours during any one week, shall be permitted upon compensation for all hours worked in excess of 8 hours per day at not less than 1½ times the basic rate of pay.

11.24 EQUAL EMPLOYMENT OPPORTUNITY PRACTICES. Contractor certifies and represents that, during the performance of this Agreement, it and any other parties with whom it may subcontract shall adhere to equal employment opportunity practices to assure that applicants, employees and recipients of service are treated equally and are not discriminated against because of their race, religion, color, national origin, ancestry, disability, sex, age, medical condition, sexual orientation or marital status. Contractor further certifies that it will not maintain any segregated facilities. Contractor further agrees to comply with The Equal Employment Opportunity Practices provisions as set forth in Exhibit "C".

[Signatures Begin on Next Page].

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the Commencement Date stated on the cover page.

City of Vernon, a California charter City
and California municipal corporation

By: _____
Daniel E. Calleros, Interim City
Administrator

ATTEST:

Yonnie Parker, Deputy City Clerk

APPROVED AS TO FORM:

Zaynah N. Moussa, City Attorney

AdminSure, Inc., a California corporation

By: Alithia Vargas-Flores
Name: Alithia Vargas-Flores

Title: President

By: Ashley Sells

Name: Ashley Sells

Title: Corporate Secretary

EXHIBIT A
CONTRACTOR'S PROPOSAL

Workers' Compensation
Third Party Claims Administration Services

-RFP RESPONSE-



May 14, 2024

**Third Party Administrators of Workers' Compensation and Liability
Self-Insurance Programs in California since 1982**

**3380 Shelby Street
Ontario, California 91764
Alithia Vargas-Flores
909.396.5814**



3380 Shelby Street
Ontario, California 91764

Telephone (909) 861-0816
Fax (909) 978-1131

May 14, 2024

Lisa Wirtz
Human Resources Analyst
City of Vernon
lwirtz@cityofvernon.org

Re: Request for Proposal Response
Workers' Compensation Third Party Claims Administration Services

Cover Letter

Dear Lisa Wirtz:

AdminSure Inc., a California Corporation, is submitting a proposal response to provide for Workers' Compensation Claims Administration Services, Utilization Review Services, and Bill Review Services for the City of Vernon. Our services are both comprehensive and flexible, which will allow us to conform to the City's specific and overall needs as described in the Request for Proposal (RFP).

Since 1982 we have been a leading service provider of performance-based Workers' Compensation Program Services for numerous full-service cities with Police Departments (safety members) like the City of Vernon. This is truly our specialty as nearly 100% of our client base is comprised of full-service cities with safety members – Police and Fire. We have a very longstanding and secure client base as we have administered many of our municipality clients, specifically cities, Workers' Compensation Programs for more than 20 years. Please refer to Attachment 1 for our Workers' Compensation Program Client List.

We administer claims in a professional, proactive and consistent manner, and we are very knowledgeable with regard to all aspects involved with the Workers' Compensation system. Specifically, we are extremely well versed in the Workers' Compensation Laws of California (Labor Codes, California Code of Regulations (CCRs), Government Codes, Case Laws, and Senate Bills (SB), et cetera) that govern Workers' Compensation claims. We are also very knowledgeable of the presumptions for safety members and their impact on CalPERS Retirement Benefits (Industrial Disability Retirement (IDR) Benefits) as well as matters involving the coordination of State and Federal disability benefits, i.e., Americans with Disabilities Act (ADA).

Our services are performed with a clear purpose in mind – to see that claims are handled properly, quickly, and economically. At the same time, we pride ourselves in maintaining strong lines of communication with our clients, their injured workers, and all other interested parties. Our goal is to provide the City's injured workers with all the benefits they are entitled to that is specific to the City's approach; this is our core competency.

In addition, we believe our following approaches/services are key elements in order to maintain a successful Workers' Compensation Program:

- Goals: Results-based; timelines are set and met; progress is followed; outcomes are reviewed.
- Claims Handling Approach: We are assertive and professional; we communicate and document.
- App – Injured Worker and Claims Adjuster Advocacy Solution: The App will help injured workers return to health and work, while increasing our productivity. The App is in addition to our voice-to-voice communications as it is not meant to dehumanize the claims process or take the place of telephone calls with injured workers. Specifically, in addition to their assigned claims adjuster, the App will also guide injured workers throughout their entire Workers' Compensation claim – from inception to closure. Injured workers will also be able to securely communicate with their assigned claims adjuster in over 100 different languages through in-App messaging/texting, and email, et cetera. Moreover, the App is very user friendly and ideal for injured workers who prefer to obtain quick answers to their questions, provide us with information, and for those injured workers who are not able to easily communicate through telephone calls during their workday (anticipated to be finalized by 7/31/24).
- Efforts: We are proactive not reactive; specifically, our experience assists us in anticipating when certain occurrences are truly a forewarning, example: A non-litigated injured worker fails to attend a scheduled doctor's appointment (exam) that we initially reminded them about; we immediately contact the injured worker to discuss why they failed to attend the exam and will reschedule the exam. Our immediate contact with the injured worker is a proactive effort to remind them that the City and we care about them, their health, et cetera, and bottom line – we take their claim file very seriously.
- Return-to-Work Program: When applicable, we will work as a team with the City and each individual department to ensure a "not-able-to-accommodate" response is the exception, not the rule.
- Investigations: With prior City notice and approval, we investigate all "red flags" and clearly document our computer notes in a very timely manner to ensure the City is completely aware of the investigation aspect of each claim file.
- Customized Training: We will offer ongoing training in all areas such as technology, data, and reports, as well as industry best practices and State of California requirements, industry standards, et cetera. Per the City's discretion, training may be extended to certain or all City employees on a quarterly or yearly basis. We will offer our assistance with creating policies specific to Workers' Compensation, and we will coordinate training in other areas such as safety, ergonomics, ADA, et cetera, which may arise out of or impact a claim file.
- File Reviews and Meetings: Accurate, timely and consistent communication is vital. We offer to meet with our City clients along with all Department Heads to provide a current status of each



claim file and to ensure everyone is “on the same page.” We also recommend the financial component of the claim files be discussed with each department as we have found that most City Department Heads have little to no idea as to what their department’s costs are relative to the City’s overall Workers’ Compensation costs. We have found that there is a larger “buy in” from them when they are aware of the associated costs.

- *Reports: We will provide the City with unlimited standard, ad hoc, customized, et cetera reports that provide current claims’ statuses on a monthly basis to reports that provide decades’ worth of data. Our reports are purposeful, accurate and timely; thereby ensuring that all parties are well informed.*

We have found that these approaches and services streamline the Workers’ Compensation claims process for all interested parties as they are both comprehensive yet flexible. We have proven success in tailoring each of our clients’ Workers’ Compensation Programs to meet their individual needs; therefore, we are very capable of conforming to the City’s specific and overall needs as described in the RFP.

In addition to providing Workers’ Compensation Claims Administration Services, we provide Utilization Review Services and Bill Review Services through our wholly owned subsidiary, MedReview Inc. – which is located in-house, on AdminSure’s premises. It is important to note that nearly 100% of our clients have selected us to provide them with Utilization Review Services and Bill Review Services in addition to Claims Administration Services as they have found that tightly integrating these services results in greater cost savings, timeliness, efficiency, and reliability. This is particularly important in view of the deadlines, penalties, and Electronic Data Interchange (EDI) requirements associated with these activities.

We are able to ensure we are in full compliance with the Workers’ Compensation Laws of California and the Workers’ Compensation industry’s best practices by adhering to our Workers’ Compensation Claims Administration Standards (Attachment 2) and our State of California approved Utilization Review Plan (Attachment 3), as well as other client-specific and pool/excess standards, i.e., Excess Standards. It is important to note that City/Excess Standards shall supersede any/all other Standards.

Adhering to the above-noted Standards has resulted in our following most recent 2023 State of California Audit Scores:

- *Our Workers’ Compensation Department’s score is over three times better than the passing score*
- *Our Utilization Review Department’s score is 100%*

Please refer to Attachment 4 for our 2023 State of California Audit Scores/Findings.



It is important to note that the cost of administering the City's Workers' Compensation Program and the handling of the City's existing open files is included in our proposed Workers' Compensation Claims Administration fee. In addition, we considered the City's caseload volume and the economic challenges the public sector continues to experience when quoting our proposed fee. Therefore, our proposed guaranteed fee is guaranteed throughout the term of the Contract Agreement.

We believe these good faith gestures demonstrate our ability to provide professional services for a competitive fee as well as our commitment to creating and maintaining a long-term business relationship with the City of Vernon. Please refer to Attachment 5 for our Fee Proposal, thank you.

Closing

Given the opportunity, we believe the City of Vernon will find that we have the overall experience, technical expertise, and qualifications in order to administer the City of Vernon's Workers' Compensation Program in a very professional and cost-effective manner.

We promise to provide the City with customized "boutique" care and attention – wherein everyone and everything matters. We will be adaptable and flexible to the City's needs and requests. We will also provide a high level of service, responsiveness, and communication with our City contacts, injured workers, and all interested parties.

Based on our entire proposal response, our proposed cost for services, our years of experience related to successfully administering complex claims for Cities with Police Departments, we are confident that AdminSure will provide the City of Vernon with the greatest overall cost-benefit advantages for its Self-Insured Workers' Compensation Program.

Should you have any questions or would like to further discuss our services, please contact me directly at (909) 396-5814, or by way of e-mail at avargas-flores@adminsire.com as I am fully authorized to bind our proposal, execute a Contract Agreement, and act on behalf of AdminSure Inc. Our proposal response shall remain valid for a period of not less than ninety (90) days from the date of submittal.

Thank you for your time and consideration.

Respectfully submitted,



Alithia Vargas-Flores, President
MBA, SIA, WCCP, WCCA



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ATTACHMENTS

Attachment 1	Workers' Compensation Client List
Attachment 2	Workers' Compensation Claims Administration Standards
Attachment 3	Utilization Review: Plan, Claims Authorization Criteria, and Workflows
Attachment 4	2023 State of California Audit Scores/Findings
Attachment 5	Fee Proposal
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Attachment 9	Affidavit of Non-Collusion

Introduction

Since 1982, AdminSure Inc., a California Corporation, has been a leading service provider of performance-based Workers' Compensation Program Services for numerous cities with police and/or fire departments (safety members). In addition to providing Workers' Compensation Claims Administration Services, we provide Utilization Review Services and Bill Review Services.

Administering Workers' Compensation Program Services for Southern California cities with police and/or fire departments is truly our specialty as the great majority of our client base is comprised of cities like the City of Vernon. Specifically, our public entity/sector clients are comprised of Cities, Fire Districts, and one County – of which, the great majority have public safety (police and/or fire); therefore, we are a proven service provider.

We are a financially strong and stable company with a very longstanding and secure client base as we have administered many of our clients' Workers' Compensation Programs for more than 20 years. Please refer to Attachment 1 for our Workers' Compensation Program Client List.

We are able to achieve the objectives of this project as we currently provide the exact services described in the City's Request for Proposal (RFP). We are a top-tier service provider with decades' worth of experience in City – public entity/sector – Workers' Compensation Self-Insurance Claims Administration, and we also promote a proactive approach to manage and administer benefits in accordance with applicable laws and City-specific policies. Therefore, we have very current, on-point experience to achieve all of the City of Vernon's RFP objectives.

We are able to meet each specified timeline as described in the RFP by establishing City-approved standards and protocols. We will assign qualified, best-fit Claims Adjusting Staff (with prior City approval), as well as all necessary support Staff. We will also dedicate the required resources during the transition period and throughout the entire business relationship in order to meet and exceed the City's needs and expectations.

It is important to reiterate that for nearly 42 years, our focus has been and remains to provide performance-based Workers' Compensation Program Services for California cities with Police and/or Fire Departments (safety members). This is truly our specialty as the great majority of our client base is comprised of cities – like the City of Vernon. Our continued focus and commitment to this sector specifically – California Cities with Police and/or Fire Departments – significantly differentiates us from our competitors.

The following are key attributes and additional areas of our focus that collectively distinguish us from our competitors and also point as to why we are the best qualified TPA to partner with the City of Vernon:

- Our most recent 2023 State of California Audit Scores:
 - Workers' Compensation Department: over three times better than the passing score
 - Utilization Review Department: 100%
- We encourage City involvement, whatever is possible and practical for the City

- We provide tailored training sessions and assistance on the claim submission process, forms, Risk Management Information System (RMIS), industry standards and best practices, etc. We are also able to assist with creating policies specific to Workers' Compensation and assist with coordinating training in other areas such as ergonomics, ADA, etc.
- The City's Claims Team will customize their claims handling approach to meet the City's requirements and needs so that they are specific to the City's approach
- Quality assurance and professionalism – we truly humanize the claims process by treating each injured worker as a “person,” not a “problem”
- Communication and documentation – we will establish and maintain a professional relationship and effective communication process with our City contact(s) and injured workers; as well as all interested parties (physicians, attorneys, etc.)
- We are assertive. We communicate and document. We are mindful of the genuine injured worker and maintain the integrity of the claims process by utilizing both our heads and hearts when making informed decisions
- Return-to-Work (RTW Program) – with prior client review and approval, we will ensure a “not-able-to-accommodate” response is the exception not the rule
- Claim notes – “If it's not in writing, it never happened,” we will document all interactions and efforts – and a plan of action towards settlement/closure will be noted
- File Reviews and meetings – on a quarterly basis and along with all Client Department Heads – should our City Contact(s) agree, we will discuss and provide a current status of claim files to ensure everyone is “on the same page”
- Real-time software and City access – everyone (City contact(s) and Claims Staff) works on the same system, at the same time, sharing information in real-time. The City will be provided access for an unlimited number of authorized read-only users
- Reports, Analytics, and Data – if “it” is captured, we can create it. We are able to provide the City with an unlimited number of reports as well as analytics and data
- Results based – timelines are set and met, progress is followed, outcomes are reviewed. We will provide kind customer service while focusing on extending cost-effective services
- App – Injured Worker and Claims Adjuster Advocacy Solution. The App will help injured workers return to health and work, while increasing our productivity. The App is in addition to our voice-to-voice communications as it is not meant to dehumanize the claims process or take the place of telephone calls with injured workers. Specifically, in addition to their assigned claims adjuster, the App will also guide injured workers throughout their entire Workers' Compensation claim – from inception to closure. Injured workers will also be able to securely communicate with their assigned claims adjuster in over 100 different languages through in-App messaging/texting, and email, etc. Moreover, the App is very user friendly and ideal for injured workers who prefer to obtain quick answers to their questions, provide us with

information, and for those injured workers who are not able to easily communicate through telephone calls during their workday (anticipated to be finalized by 7/31/24)

We promise to provide the City with customized “boutique” care and attention – wherein everyone and everything matters. We are adaptable and flexible to the City’s needs and requests. We will provide a high level of service, responsiveness, and communication with our City contact(s), injured workers, and all interested parties.

Truly, our ultimate goal is to provide considerate and consistent services in order to positively impact claim outcomes. Given the opportunity, we are confident the City will experience that we have the knowledge and qualifications in order to professionally administer its Workers’ Compensation Program in both an effective and cost-benefit sensitive manner.

Therefore, it would merely be a matter of continuously working closely with our City Contacts to perfect the desired claims handling approach and process that is specific to the City’s requirements and expectations. We are also able to adjust our internal standards accordingly to meet the City’s needs so that we provide the City and all of their injured workers with the services they expect and deserve.

General Scope of Work & Work Plan

The following is a detailed description of our approach when providing services based on the City’s Scope of Work and service requirements as noted/discussed within the Request for Proposal (RFP). We have found that explaining exactly how we will comply is best answered by summarizing what can be expected of us, in general, when administering a Workers’ Compensation claim on behalf of the City of Vernon. In doing so will concisely demonstrate that we have a unique understanding of the City’s needs based on the RFP.

We strive to respond to the City’s and injured workers’ questions, requests, etc. within one workday by way of e-mail, telephone, etc. Specifically, phone calls, faxes and electronic transmissions (e-mails) will be responded to within one workday from when they were received, and all mailed correspondence will be responded to within five workdays of receipt.

Specific to injured workers, as previously shared, the App will help injured workers return to health and work, while increasing our productivity. The App is in addition to our voice-to-voice communications as it is not meant to dehumanize the claims process or take the place of telephone calls with injured workers. Specifically, in addition to their assigned claims adjuster, the App will also guide injured workers throughout their entire Workers’ Compensation claim – from inception to closure. Injured workers will also be able to securely communicate with their assigned claims adjuster in over 100 different languages through in-App messaging/texting, and email, etc. Moreover, the App is very user friendly and ideal for injured workers who prefer to obtain quick answers to their questions, provide us with information, and for those injured workers who are not able to easily communicate through telephone calls during their workday (anticipated to be finalized by 7/31/24).

We operate in a paperless environment wherein all mail, documents, etc. received/created is scanned/saved in our computer system on a real-time basis so that the City has access to review all claims information on a real-time basis. Correspondence will be electronically date stamped on the day received and will be “matched” to the appropriate claim file and given (assigned) to the

assigned claims adjusters. Claims Staff will review unmatched mail, if any, and appropriate action will be taken.

Claims are reported to us in various ways depending on client preference. We prefer claims to be electronically reported to us by way of our on-line 5020 reporting module (real-time) which allows for the proper electronic forms to be attached (system entries: Employer's Report of Occupational Injury or Illness (Form 5020), Workers' Compensation Claim Form (DWC 1), Supervisor's Report of Injury or Illness, etc.). Specifically, at no additional cost, the City is able to directly and securely report new claims (and pertinent new claim information) to us in a completely electronic (paperless) manner through our company website utilizing our On-Line Services Module.

Upon receipt of an Employer's Report of Occupational Injury or Illness (Form 5020) and/or a Workers' Compensation Claim Form (DWC 1), we will open/prepare a claim file. We will contact the City and request the appropriate forms from both the injured worker and the City be provided to us when notification of an injury/illness or incident by any source is first received in our office, i.e., Application of Adjudication, Notice of Legal Representation, Doctor's First Report of Injury (DFR, Form 5021). We will document said contact in our computer notepad after the claim has been created in our Risk Management Information System (RMIS).

If there is no evidence that the DWC 1 Form was provided to the injured worker, we will provide the injured worker with the DWC 1 Form within one workday of knowledge of the injury. Should we receive a request for a DWC 1 Form, we will advise the sender (if the sender is a non-litigated injured worker) to notify the City and we will also immediately contact the City to advise that the documentation provision of the DWC 1 Form is maintained within our RMIS.

Once a claim file is opened and/or we have knowledge of a possible or imminent claim, we make immediate 3-point contact with the City, the injured worker, and the treating medical facility (physician) – all communications are documented in our computer notepad. In the event a party is non-responsive, there will be evidence of at least three documented attempts to reach the individual by phone, email or in writing (mail). Medical-Only claim files will also have this three-point contact requirement as well. Contact with opposing counsel will also be made when an Application is our first notice.

On all non-litigated, lost time cases where the injured worker is temporarily disabled (has not returned to work), telephone contact will be established with the injured worker upon receipt of notice of a claim and will continue as often as necessary, but not less than twice a month until the injured worker returns to work. We will also provide ongoing information, guidance, and assistance to injured workers at every stage of the claims process: compensability, the delay process, conditional denial process, all statutory benefits, permanent disability ratings (potential apportionment, modified/alternative/permanent work, etc.), the Qualified/Agreed Medical Examiner (QME/AME)/Independent Medical Review (IMR) process, and settlement of claims, etc. All contact will be documented in our computer notepad.

When making the initial phone contact, we will ask the injured worker to make contact with us as well whenever they may have any questions, concerns, comments, etc. We will maintain contact with all non-litigated injured workers from the inception to disposition (closure) of their claim file(s). All contact will be documented in our computer notepad. Our goal is to provide exceptional, timely, and appropriate services for the City and their injured workers as in doing so will assist us

in developing and maintaining a professional and trusting rapport with the City and their injured workers.

Within 14 calendar days of receipt of a claim form (DWC 1), a proper notice will be sent to the injured worker notifying them of the decision reference their claim (acceptance, delay or denial), and their rights under the Workers' Compensation Laws of California. If a decision is made to delay a claim file (benefits), an AOE/COE (arose out of employment/in the course of employment) investigation will be initiated with prior City approval.

Based on all the information present at that time, we determine which medical facility and/or physician will be best to examine and/or provide medical treatment to the injured worker. A Qualified Medical Examination (QME), Agreed Medical Examination (AME), or Independent Medical Examination (IME), etc. may also be options depending on the facts/specifics of each claim.

We also have many investigative techniques in place to identify and investigate questionable or fraudulent industrial injury claims. We will work closely with the City and their injured workers/employees to obtain all pertinent information on each claim file so that the most appropriate decisions are made in a timely manner. Based on all the information present at that time, we determine whether or not investigation, surveillance, fraud, litigation, and/or subrogation efforts are necessary or applicable.

We obtain Index Claim Searches on all lost time claims and all claims wherein any disability benefit is due, as well as when it is appropriate (i.e., all new claims, and at necessary intervals on continuing active claims). The purpose of an Index Claim Search is to obtain a history of any previous (or current) claim filings the injured worker may have that may impact the claim(s) against the City and/or wherein the City may be in a position to receive a credit (apportionment). All index searches are at no additional cost to the City.

In addition, with prior City authorization, we immediately assign (refer) an investigator to a claim when any identified issue arises that may impact the nature, extent, or scope of the City's liability. Referrals will include specific instructions regarding the scope of the investigation and the City will be kept informed of the costs and results of all investigations. Also, when a claim is believed to be fraudulent ("red flags" are identified), we will refer the claim to the appropriate law enforcement agency for further investigation – of course, with prior authorization from the City.

For all denied and contested (delayed) claims, we will contact the City to discuss the claim in its entirety, including "red flags," etc., before any notice is sent or communication is made with the injured worker. The claims adjuster will document the factual, medical, and/or legal basis for the delay or denial that is in accordance with the Workers' Compensation Laws of California. Reference questionable claims that should be or may be accepted, we will contact the City to discuss claims such as these in their entirety.

Once a claim is entered into our system and the decision to accept, delay or deny the claim has been made, we set appropriate reserves and place the claim on an appropriate diary cycle. Compensability determination and reasons for same will be clearly documented in our computer notepad upon receipt of the claim. It is important to reiterate that we will discuss our recommendation to delay or deny a claim with our City contact(s) prior to sending any notices, and we will also discuss acceptance of any questionable claims prior to sending notices.

All open claim files will have an assigned diary date on an ongoing basis until the date of closure. Our regular diary reviews are clearly distinguished in our computer notepad from routine file documentation. All open claim files are on an active diary for review of current work status, medical status, review of reserves, investigation/litigation/subrogation status, and plan of action towards claim resolution and closure, etc.

The initial plan of action will be clearly documented in our computer notepad within 14 calendar days of the initial claim set-up. Lost time claims are reviewed at least every 14 days, medical-only claims are reviewed at least every 30–45 days, and Awarded Future Medical claims are reviewed for Compromise and Release (C&R) settlement potential (with prior City approval) and/or administrative closure no less than twice a year. We will also monitor the diary reviews by utilizing a “No Activity” report every month to identify any files that have fallen off diary, if any.

Initial claim reserves will be posted electronically and will reflect the most probable value of the claim file (life of the claim). Reserves are based on the information available at the time of the claim opening and are adjusted accordingly based on medical, legal, etc. facts that develop as the claim file matures, as well as per Self-Insurance Plan (SIP) Regulations, Labor Codes, California Code of Regulations (CCRs), etc. Initial claim reserves and subsequent reserve changes will be reviewed and approved by the assigned claims manager.

As claim values increase and decrease, claim reserves will be reviewed and adjusted, if necessary, on a regular basis and on each diary date (at least every 45 workdays). Future medical claim reserves are reviewed at least every 180 days. The rationale for reserves will be documented in our file notes and the amounts allocated to each reserve category will be documented. We also establish and maintain indemnity, medical, and allocated expense reserves as separate line items to ensure each expense is being properly reserved and paid.

Physicians’ offices will be contacted within one to two workdays of notice on all new indemnity claims. Such contact will continue as needed during the continuation of temporary disability (lost time benefits) to ensure that treatment is related to the compensable injury or illness. All contact will be documented in our computer notepad. On all non-litigated, lost time cases where the injured worker has not returned to work, telephone contact will be established with the injured worker within one to two workdays of receipt of notice of a claim and will continue as often as necessary, but no less than twice a month until the injured worker (employee) returns to work.

We will also proactively obtain work restrictions and/or a release to work/duty on all cases in order to facilitate a return to temporary modified work/hours, full duty work, etc. All efforts will be documented in our computer notepad. In cases where an injured worker’s restrictions are permanent, we will immediately contact the City so that a determination can be made as to the availability of alternative, modified, or regular work (different position), etc.

If we do not receive a response from the City within one to two weeks, we will follow up with the City. We will work as a team with the City in order to comply with laws preventing disability discrimination, including Government Code Section 12926.1. We will also assist our City contacts to the fullest extent to ensure they are meeting their obligations under State and Federal Disability Laws, etc.

With regard to disability benefit payments, we will determine eligibility for disability benefits through medical documentation and City confirmation. The following is our process for issuing

benefit payments (both live checks and vouchers (paper transactions) reference salary continuation, if any), including settlements: accurate and timely indemnity benefit payments; notices (including Division of Workers' Compensation (DWC) benefit notices) and Awards will be calculated, processed, and transmitted (mailed) to injured workers as required by California Labor Codes, California Code of Regulations (CCRs), etc.

Initial indemnity benefit payments and/or notices will be processed and mailed to injured workers within 14 days of the first day of compensable disability. Payments reference undisputed Awards, computations, or Compromise and Release agreements, etc. will be issued within 10 workdays or sooner if necessary to ensure payment is made within 20 calendar days of the WCAB's approval date (following receipt of the appropriate documentation).

All subsequent and final indemnity benefit payments and notices will be verified and issued in compliance with the Workers' Compensation Laws of California. Settlements will be approved by the City's claims manager prior to payment being issued and will be documented in our computer notepad. Late payments, if any, will include a self-imposed penalty in accordance with the Labor Code. All benefit notices, notices, correspondence, etc. are saved in our computer system and may be accessed at any time by the City.

Any and all fines/penalties incurred as a result of our failure to comply with statutory laws and/or administrative regulations, if any, shall be our sole responsibility. We will reimburse the City no later than 30 days from the event causing the penalty assessment. We will also provide the City with a Penalty Report every month, if any. Reference overpayments, we will request reimbursement of overpaid funds from the party that received the funds. If necessary, a credit will be sought as part of any resolution of the claim.

We also balance all benefits paid in our computer system whenever a benefit ends, a new benefit begins, receipt of an Award, when there is a change in benefit type or benefit rate, etc., and we will also balance each applicable claim file on a semi-annual basis.

With regard to litigation management, in the event the claims adjuster and the City determine a claim warrants legal service/referral, the claims adjuster will retain primary responsibility of the claim file. Defense Counsel will not be used to perform routine activities that are the responsibility of the claims adjuster. The claims adjuster will also carefully evaluate and monitor the attorney's aggressiveness in resolving claims, ability to identify issues, responsiveness, timeliness, and billing practices. The claims adjuster will also provide the City with advance notice of depositions, hearings, trials, etc., so they may attend, if necessary or desired.

Our general criteria for referring cases for legal defense services include, but are not limited to when a deposition of the injured worker is warranted and/or when there are components of the claim that require legal review/analysis, i.e., personnel issues, other pending litigation, global settlement, etc. City approval will be obtained prior to any request for legal service and/or referral to the City's choice of attorney and we will adhere to all City protocols regarding litigation. We will also cooperate fully with all attorneys selected by the City including City attorneys, in-house attorneys, etc.

The City's choice of Defense Counsel will provide the City and us with an initial case analysis and plan of action within 10 workdays of the assignment. In addition, all preparation for trial will

involve the City so that all material evidence and possible witnesses are utilized in order to obtain the most favorable outcome for the City.

We will also maintain a litigation management budget for each litigated file and provide litigation status reports on a monthly basis for each litigated file, if necessary. Should an attorney near or exceed the previously stated/agreed-upon litigation budget, we will immediately review the claim and provide the City with an analysis as to the reason(s) and legitimacy for same; thereafter, we will recommend a plan of action, i.e., contact the attorney, obtain a new budget, etc. We also thoroughly review all attorney bills and confirm the services were performed prior to approving for payment.

All settlement proposals will be presented to the City in sufficient time to obtain authority, City Council authority (if applicable), etc. All settlement proposals will be in a format deemed acceptable to the City.

With regard to subrogation management, we actively pursue recovery in all subrogation claims. We will identify and seek recovery from any individual, agency/entity (public or private), or State Fund that may be a party to a claim. Upon recognition of subrogation potential, we will place the at-fault party (parties) on notice that we will pursue maximum recovery reference all benefits and payments made on the claim file.

Whenever possible, in a civil action, we attempt to settle by means of a Third Party Compromise and Release. If this is not possible, we will make every effort to offset the Workers' Compensation expenses through a credit against the proceeds from the injured worker's civil action.

Subrogation claims will also be monitored to determine the need to file a Lien or a Complaint in Intervention (in a civil action) to preserve/protect the Statute of Limitations. If the injured worker brings an action against the party responsible for the injury, we will consult with the City reference the value of the subrogation claim and recommend a plan of action.

If necessary, upon City authorization, Subrogation Counsel may be assigned to file a Lien or a Complaint in Intervention. Upon assignment of the case, Subrogation Counsel will be required to provide a "not-to-exceed" estimate of fees. The fees will be authorized by the City prior to commencement of any work by Subrogation Counsel. Should Subrogation Counsel near the "not-to-exceed" fees, we will obtain continuing authority from the City prior to incurring additional costs and said authority will be clearly documented in our computer notepad.

The City will have real-time access to all claim information which includes all claims that may have subrogation potential. We will also provide a projection of the possibility of recovery and the probable recovery amount. Thereafter, we will provide subsequent statuses to the City and all interested parties.

With regard to medical care, our approach for maintaining the Utilization Review process is to adhere to: the Medical Treatment Utilization Schedule (MTUS)/the American College of Occupational and Environmental Medicine's (ACOEM) Guidelines, all applicable California Labor Codes, California Code of Regulations (CCRs), etc. reference Utilization Review in order to approve, modify, or deny Request for Authorization (RFA) treatment requests. Although all medical care information will be accessible to City-approved Staff, we are able to create protocols wherein we notify the City when medical care is denied or modified, etc.

Upon receipt of a Utilization Review Request for Authorization (RFA) that cannot be approved at the claims adjusting level, we will immediately forward (e-mail or place in the proper “workflow”) the scanned request along with pertinent medical reports (scanned) to our Utilization Review department so that a decision is made within the strict mandatory timelines.

Utilization Review referrals are also made when a modification or denial of requested medical treatment/service (RFA) is necessary, a Peer Review is necessary, or when a non-examining medical opinion is needed. All of our Utilization Review actions, efforts, documents, etc. are noted and stored in our computer system for our City contact(s) to review on a 24/7/365 basis.

Requests for medical treatment/service (RFA) that may be referred for Utilization Review include, but are not limited to requests for questionable medical treatment or services, overuse of medications or certain types of treatment such as chiropractic care, and treatment/service that appears to be medically inappropriate for the injured worker based on their medical history, and/or the claim file’s accepted body part(s) and/or diagnoses, etc.

We will manage all medical care by remaining in constant contact with all medical service providers including the City’s choice of Nurse Case Managers (NCM), if any. We are also able to assist the City in developing, or recommending, a panel of preferred physicians for the initial and ongoing treatment of employee injuries/illnesses. We would also be able to assist by including medical specialists for treatment requiring long-term or specialty care, ancillary providers, etc.

It is important to note that preferred physicians and facilities will have experience in occupational medicine, historically and consistently produce successful treatment results with corresponding medical reports, and overall – each provider/facility will have a high level of experience in treating workplace injuries and have a respectable reputation within the medical community and Workers’ Compensation industry.

In the event a claim warrants referral to a Nurse Case Manager (NCM) provider, we will contact the City for approval and to discuss the intent, scope and cost of the services needed. Cases that may benefit from NCM services include, but are not limited to catastrophic injuries or illnesses, complex surgeries or procedures, severe diagnoses, and problematic medical cases/claims. Claims that simply reach a certain lost time or “days opened” threshold, i.e., 30 days of lost time, or 120 days opened, etc., with no other factors present, are not appropriate cases for NCM services. However, there are cases with unique circumstances that will warrant NCM services perhaps on day one of the claim; therefore, it is best to consider NCM services on a case-by-case basis.

NCM providers work in close collaboration with the injured workers’ physicians and all interested parties in order to return the injured worker to their usual and customary occupation, modified duties, a rehabilitation program, etc. They also assist claims staff in ensuring medical treatment and medical procedures lead to quantifiable results instead of unnecessary and/or excessive medical treatment or procedures that have no possible value. NCM providers may also assist in ensuring that injured workers receive quality and appropriate care that is both cost-benefit sensitive and effective.

When a NCM provider is assigned to a claim, we will continue to evaluate the injured worker’s physical capacity specific to their ability to return to work (modified/light duty – work restrictions; full duty – usual and customary occupation/U&C, etc.). We will work alongside the NCM provider

and treating physician(s) to ensure that the City's injured workers receive all the benefits they are entitled to that is specific to the City's approach.

We will utilize whomever the City selects as their choice of NCM provider; and although we are able to recommend various NCM providers, the final selection rests with the City. It is also important to note that, as with all vendors, we do not receive and are not entitled to any commissions, fees or any other type of compensation from any vendor the City selects.

We will continuously review all open claims and provide a current plan of action towards closure in our computer notepad. As previously noted, our goal is to provide the injured worker with all the benefits they are entitled to that is specific to the City's approach. Therefore, all benefits are paid appropriately and timely, and all medical bills are reviewed for reductions per the Official Medical Fee Schedule (OMFS), Inpatient Hospital Fee Schedule (IHFS), and Preferred Provider Organizations' (PPO) discounts, if applicable, as well as other network organization discounts, and/or negotiated rates, etc.

With regard to medical benefit payments, we will authorize payment of medical benefits as follows: prior to any payment, all bills will be reviewed for accuracy and appropriateness by claims adjusting staff. Medical bills submitted without supporting documentation will be objected to within 30 days of receipt and will not be reviewed for payment until such documentation is obtained, if applicable. Medical bills will be paid, objected to, or denied in accordance with State Statutes.

Medical-legal bills/costs will also be reviewed for appropriateness and necessity. Medical-legal bills/costs that do not qualify as valid medical-legal expenses will be objected to in a timely manner according to the Workers' Compensation Laws of California. As required by Senate Bill (SB) 899, payment of medical treatment regarding delayed (AOE/COE) claims will be processed through utilization review and bill review but will not exceed \$10,000.

We are also mindful that an injured worker may hinder progression of their claim(s) due to nefarious or non-industrial reasons. If we anticipate or have knowledge that this is occurring or may occur, we will work closely with the City, and all parties involved, to ensure that the claim does not become stagnant. We will schedule conference calls and roundtable meetings with all parties involved which may include the claims adjuster, claims manager, our City contact(s), the injured worker, physician, and if applicable, the defense attorney, so that there is constant action occurring on the claim file, not just "movement."

Once an injured worker's initial/final medical diagnosis is determined, we address all issues that may arise thereof, which include, but are not limited to: medical treatment/service requests, ergonomic studies, lost time benefits (Temporary Disability, Salary Continuation, Labor Code 4850, etc.), return to work/modified (light) duty, permanent disability (Permanent Disability Rating(s) and Permanent Disability Benefits), rehabilitation (Vocational Rehabilitation/Supplemental Job Displacement Benefits (SJDB)), and Americans with Disabilities Act (ADA) Interactive Meetings, etc. Also, when necessary and/or appropriate, we will obtain and utilize the City's "essential job functions" analysis and/or Job Description (Job Analysis).

We will assist with ensuring the City's injured employees, personnel, and other agencies address and/or provide rehabilitation, and/or reassignment of injured employees with physical or

performance limitations arising out of industrial injuries. This may include assisting with the Americans with Disabilities Act (ADA) Interactive Process.

Upon receipt of a medical report that requires a permanent disability rating, we will review and internally rate the report within 10 workdays of receipt. When necessary, we also request an informal/outside rating or board rating. We will also address any potential apportionment, credits, penalties, etc.

When required and/or necessary, Permanent disability (PD) advances are issued timely along with appropriate Division of Workers' Compensation (DWC) benefit notices no later than 14 calendar days of receipt of the qualifying report. Should the City/we object to the report's permanent disability findings, we will mail the appropriate objection notice reference the report/PD findings within 14 calendar days as required by State law. We will also re-review the reserves and set/re-set PD reserves accordingly, if necessary, at that time.

Once the above-noted final issues/matters are determined, we would be in a position to resolve and/or negotiate a settlement which will be based on all medical/legal and factual findings. Within 10 workdays of receiving all the necessary information, we will provide the City with our written settlement recommendation (Stipulations with Request for Award, Compromise and Release, etc.) prior to offering or agreeing to any settlement. Our settlement recommendation will include a brief history of the injury, the rating(s) of all pertinent medical reports, the amounts paid and reserved on the claim, the proposed settlement, the pros and cons of the proposed settlement which will include an estimate of future cost or consequences if the City were to reject the proposed settlement. We will also provide the City with any and all pertinent information that is available so that the most appropriate and cost-effective settlement may be agreed upon and offered.

Reference excess and excess reporting, applicable claim files wherein incurred reserves are nearing/at 50% of the City's self-insured retention (SIR) level (amount), or may have the potential to exceed the City's self-insured retention level, will be reported in accordance with the reporting criteria established by the City and the City's excess insurance carrier's policies within five workdays, or sooner if necessary, from the day on which it is known that any criteria is met.

When a claim nears/reaches one-half of the SIR, we are able to report to the client every 90 calendar days (on a quarterly basis) regarding the status of the claim. Our report will be on an approved form and will include a current status of the claim, our plan of action for the future handling of the claim, and the current paid-to-date and total incurred amounts listed by all payment categories.

Our process for reporting claims other than "at/near 50% incurred" to the City's excess insurance carrier (e.g., death, cerebral injury, one year of lost time, etc.) will be in accordance with the reporting criteria established by the City and the excess insurance carrier's policies. From the day on which the claim occurs/is made, or when it is known that any criteria is met, there will be no delay in reporting such claims to the excess insurance carrier.

The City will have real-time, online access to all excess correspondence prepared or received by our office. Requests for reimbursement will be made within 30 days of exceeding the SIR and every six months or sooner thereafter. The requests for reimbursement will be made on the form prescribed by the excess insurance carrier. Upon receipt of excess reimbursements, we will

immediately mail/provide the check to the City for deposit. Also, when applicable, we will send the City a closing report upon resolution of a claim involving excess insurance coverage.

In addition, reference qualifying settlements, we will effectively assist the City's choice of Medicare Set-Aside Allocation (MSA) service provider. We will also attend all WCAB/Rehab Hearings, Conferences, Proceedings, Trials, depositions, etc., as requested and at no additional cost. We will obtain City approval prior to settling any claim, lien, etc. as final settlement authority shall always rest with the City.

Furthermore, as the City's designated Reporting Agent (RA), we will provide reporting to CMS regarding Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA). Initial and Subsequent Reporting includes initial and subsequent reporting as required by law, at no additional cost. At this time, we are the RA for 100% of our clients.

With regard to reducing/resolving "older" claims, we will review all claim files in their entirety to identify all pending items that may be prohibiting the file from moving forward/being closed. After we review the "older" claims in detail, we will create a plan of action/strategy to resolve all outstanding issues that may be delaying the claim from moving towards disposition (settlement)/closure. Outstanding issues may include obtaining a current medical report, resolving liens, preparing a Stipulations with Request for Award, offering a C&R, etc. We will identify all areas that require attention to ensure "older" claims are resolved in a timely, professional, and cost-effective manner.

It is also important to note that our claims managers review all open claims on an ongoing basis as well as review/audit a minimum of 10% of each of their claims adjusters' caseloads on a continuous basis to ensure we are meeting and/or exceeding all standards. The purpose of our internal audits is to ensure proper claims handling procedures are being adhered to and that a current plan of action towards settlement and/or closure is documented in every open claim file. All claim files will be available for review by City staff or by an auditor at any time.

We are also able to conduct quarterly claim file review meetings to discuss the overall case management of the claims, coordination of Workers' Compensation related activities, medical treatment, litigation, and any topics, issues, concerns, etc. related to the City's Workers' Compensation Program. These meetings may take place virtually, on-site at the City's location, our office, or however/wherever else the City prefers.

Also, at no additional charge, we will provide the City with any and all printed and electronic (with the ability to amend) Workers' Compensation Posters, Forms, Pamphlets, etc., as required by law. With regard to assisting non-English speaking claimants, we are able to obtain multi-lingual speaking assistance from translating firms should a claimant prefer to verbally communicate with us in a language other than English.

Financial Management & Positive Pay Services

Per the RFP, the funding arrangement for issuing checks and vouchers (paper transactions), if any, on behalf of the City's Workers' Compensation Program is for the City to maintain a Trust Account (City owned trust account) from which all Workers' Compensation Benefits and Payments are to be paid. We will prepare and mail checks (our work product) directly to payees without delay. We

will sign checks with a facsimile signature. The City would continue to maintain an adequate balance in the Trust Account to meet all of its Workers' Compensation obligations without delay.

We will process payments/checks (our work product) for all approved expenses and statutory benefits by way of the City's (Workers' Compensation) Trust Account. We will adhere to all City financial management specifications and requirements. We will facilitate this task with a "transparent" approach in that we are able to provide daily, weekly, monthly, yearly, ad hoc, special, etc. reports to maintain the integrity of the Trust Account. We are also able to provide daily electronic check registers.

In addition to the above, we are able to administer Positive Pay Services alongside the City's choice of bank at no additional cost. Our Positive Pay Services provide protection against the potential of theft and fraudulent or tampered checks from being created, cashed, or deposited.

We are also able to provide the City with a daily report listing all transactions: checks, voided checks, vouchers (paper transactions), etc., that we issue on behalf of the City. Reports illustrating all bank transactions, such as check registers, can also be provided to the City on a daily, weekly, monthly, etc. basis. All Positive Pay Services that we provide directly to the City, including reports, are at no additional cost.

In summary, we are able to provide the City with live check, voided check, voucher (paper transaction), and positive pay, etc., information on a daily, weekly, monthly, etc. basis.

Loss Prevention Services – IDR & ADA

We are also able to assist the City with coordinating safety training and other loss prevention services with the assistance of organizations that specialize in many areas such as ergonomics ("ergonomic evaluations"), biomechanics and injury causation, environmental and industrial hygiene, and ADA compliance, etc. Our involvement will be at no cost and the services provided by the City's choice of service providers/outside vendors will always be at-cost as we will never add on any additional fees.

Also, considering that the great majority of our clients are cities with police and/or fire departments, we are very well versed regarding the presumptions for safety members, specifically police and/or fire, and their impact on CalPERS Retirement Benefits – Industrial Disability Retirement (IDR).

In addition, we are extremely knowledgeable and experienced with Workers' Compensation claims that involve the coordination of municipal claims administration, Labor Code 4850 Benefits, IDR/CalPERS, and Americans with Disabilities Act (ADA), etc. matters.

Client Training

The field of Workers' Compensation is constantly changing due to new information, case law, proposed changes, newly enacted Statutes and California Code of Regulations, etc. Constant change requires analysis and possible implementation of adjustments to our clients' Workers' Compensation Programs. Therefore, we are committed to continuously educating and providing training for our clients so that they are aware of the requirements that need to be met and the efforts that need to be made in order to ensure that they/we are in compliance with the Workers'

Compensation Laws of California and the Workers' Compensation industry's best practices and standards.

At no additional cost, we are able to provide the City with ongoing training, including all training materials/handouts, as well as conduct presentations and provide written communications to ensure that the Workers' Compensation procedures in place are proper and purposeful, and to ensure that all areas of the Workers' Compensation process are being adhered to.

Training involves providing information and guidance (review and discussion) regarding specific claims, general procedures, as well as positive and negative trends. The training subject matter will also include recent WCAB decisions, case law updates, and emerging trends in the Workers' Compensation industry. This type of training will also ensure the City's Workers' Compensation Program is administered in a professional and lawful manner.

We are also able to assist the City with coordinating safety training and other loss prevention services with the assistance of organizations that specialize in many areas such as ergonomics ("ergonomic evaluations"), biomechanics and injury causation, environmental and industrial hygiene, and ADA compliance, etc. Our involvement will be at no cost and the services provided by the City's choice of service providers/outside vendors will always be at-cost as we will never add on any additional fees.

In addition to the above, we are able to assist the City with staying current on the legal requirements and best practices of risk management in the Workers' Compensation arena by providing all pertinent information we receive from all channels throughout the Workers' Compensation industry, such as: the State of California, attorneys, conferences we attend, etc. We are also able to advise the City of industry meetings and conferences that would be beneficial to attend.

We are also able to keep the City updated on their Workers' Compensation financial trends by providing useful reports that may illustrate areas of the City's Workers' Compensation Program that deserve "kudos," or may require immediate attention and/or action.

At no additional cost, we are also able to provide assistance in developing policies and procedures relating to City's Workers' Compensation Program which will be created based on the information we gather through administering/handling and auditing the City's claims. We will also incorporate industry best practices and standards, as well as our internal standards, with the understanding that City Standards shall supersede ours.

Medical Provider Network (MPN) Services

We recommend the MedEx MPN to our clients. Per the RFP, the City currently utilizes MedEx. Nevertheless, should the City decide to change MPNs, each of our clients has the option of utilizing their choice of Medical Provider Network (MPN). MPNs are to consist of medical experts, including specialists, who may be utilized to review and/or provide treatment. Should the City opt to utilize a MPN, same will be at-cost as we do not add on any additional fee, or receive any commission, or any other type of compensation from any MPN for the internal MPN Services we provide.

Pharmacy Card (Benefit) Network Services

We recommend MyMatrixx to our clients for Pharmacy Card (Benefit) Network Services in order to contain pharmacy costs. These services are at cost as we do not add on any additional fee, or receive any commission, or any other type of compensation from any service provider. However, should the City prefer a particular vendor regarding any Pharmacy Benefit Network Services, we will utilize whomever the City prefers. Should the City's choice of vendor charge a fee/cost, it will be at-cost as we do not add on any additional fee, or receive any commission, or any other type of compensation from any service provider.

Utilization Review Services

Since 2004, we have provided Utilization Review Services for our self-insured clients through our wholly owned subsidiary, MedReview, Inc. We do not provide Utilization Review Services for any Third Party Administrator (TPA) or entity other than our Workers' Compensation clients.

Each of our clients is able to customize their Utilization Review approach from the number of physical therapy sessions to prior authorizations, etc. We carefully tailor a customized Utilization Review approach for each of our clients based on their needs and requirements. Please refer to Attachment 1 for a list of our Workers' Compensation clients for which we provide Utilization Review Services.

Our Utilization Review Department is located in-house on AdminSure, Inc.'s premises, and is fully integrated with our claims adjusters and bill review personnel. The integration of these services has enabled our claims adjusters to promptly and accurately expedite the entire claims and utilization review process within the complex timeframes mandated by the Workers' Compensation system.

What distinguishes our utilization review approach from all others is our commitment to providing fair, timely, and professional services while achieving cost efficiencies. We are unique in that although we rely upon the Medical Treatment Utilization Schedule (MTUS)/American College of Occupational and Environmental Medicine's (ACOEM) Guidelines to determine utilization review decisions, we are mindful of the genuine injured worker in that we make great efforts to render appropriate decisions as quickly as possible as we are very aware that no one appreciates waiting to hear whether their requested medical treatment or service, etc. is approved.

Bill Review Services (Medical Billing Reviews)

Since 1998, we have provided Bill Review Services for our self-insured clients through our wholly owned subsidiary, MedReview, Inc. Please refer to Attachment 1 for a list of our Workers' Compensation clients for which we provide Bill Review Services. We do not provide Bill Review Services for any Third Party Administrator (TPA) or entity other than our Workers' Compensation clients.

Our Bill Review Department is located in-house on AdminSure, Inc.'s premises, and is fully integrated with our claims adjusters and utilization review personnel. The integration of these services results in a very prompt and interactive relationship between our claims adjusters and bill review personnel; thereby, ensuring only approved bills are reviewed and paid timely. This approach definitely distinguishes our organization from other bill review providers as we have

found that tightly integrating these services results in greater cost savings, timeliness, efficiency, and reliability; this is particularly important in view of the deadlines, penalties, and Electronic Data Interchange (EDI) requirements associated with these activities.

Our Bill Review Department's sole purpose is to obtain the greatest savings for our clients by comprehensively reviewing medical bills, reducing every medical bill per the Official Medical Fee Schedule (OMFS), Inpatient Hospital Fee Schedule (IHFS), and maximizing Preferred Provider Organizations (PPO) discounts, network organization discounts, and/or negotiated rates, etc. We provide an Explanation of Benefits (EOB) with every bill we review and complete. In addition, all EOBs are saved in our Risk Management Information System (RMIS) for review by the City, claims adjusters, etc.

We are truly committed to providing purposeful medical management services that ensure positive outcomes. We do not believe in over-promoting medical management services that exaggerate actual claim outcomes or overreach by suggesting self-serving, unrealistic savings through affiliated or outsourced service providers to our clients.

We prefer to focus on and provide prompt, assertive, and professional claims handling services along with applying reasonable Utilization Review and every Medical Management Service, Provider Network Savings, Preferred Provider Organization (PPO) Savings, and Fee Schedule (OMFS/IHFS) Savings, Negotiated Rates, etc. to the fullest extent allowed by law so that we may provide the City's injured workers with all the medical treatment and services they are medically and legally entitled to in the most timely and cost-effective and cost-sensitive manner.

Risk Management Information System (RMIS)

Our in-house Team of IS/IT Staff utilize and manage our Risk Management Information System (RMIS). Our RMIS system operates seamlessly in a "best practices" claims environment. Our RMIS is integrated with our Bill Review, Bill Payment, Check Processing (our work product), and Utilization Review, etc. systems.

Our RMIS is a 100% web-based claims administration system that can be accessed anywhere, at any time, through just a browser. At no additional cost, we will provide the City with read-only access to all claim files/data via a secure website. Read-only (includes report writing module) access to our RMIS will be at no additional cost for an unlimited number of City users. There are no restrictions to the read-only data. Should the City decide to have read-write access, the fee will be a pass-through fee as we would not add any cost/fee.

Our City contacts will have 24/7/365 internet-based access and services available at all times in order to manage, review, audit, etc., claim files and to retrieve information and create reports through our report writing module. Again, there are no fees associated with read-only access to our RMIS or when utilizing the report writing module. We will also provide system training for our City users (contacts) at no additional cost.

Our user-friendly RMIS provides very current, effective, and dependable technological capabilities that result in managing claims in a more informed and timely manner; thereby, providing our claims adjusting staff with more time to problem solve, administer claims, and settle/close claims.

Our system is a “one system” approach that encompasses all the functionality that is required/necessary to link/tie in the following Services: Claims Administration, Risk Management, Bill Review (Bill Payments), Utilization Review, Medical Management, Work Status Coordination, and Litigation Management, etc. This enables complete collaboration among all parties involved in the claims administration and risk management process.

Collaboration extends to online access to our claim notes, correspondence, diary, payment history, and much more. Everyone works on the same system, at the same time, sharing information in real time. The system empowers the City and us to make better, more informed decisions in a much shorter timeframe; thereby, ultimately lowering the costs associated with the City’s Workers’ Compensation Program.

Of the many capabilities our RMIS provides, one specific capability is producing ad hoc reports (specialized, custom, etc.). Our reports are useful from both a risk management and data management perspective and will be tailored to the City’s specific needs. At no additional cost, we are able to provide hundreds of reports such as OSHA Forms (Logs/Summaries/Reports), and reports that illustrate pertinent claim information, loss history (paid losses), incurred costs, cost drivers and savings, as well as reports that track all information and payments made on each individual claim; claims losses showing severity, frequency and statistics in graph or other visual charts showing accident (injury) trends by type of injury, body part, days lost, etc.

Our computer system tracks all lost time scenarios within the “Work Status Tab” – please refer to Attachment 6 for a sample (screenshot). This “Tab” allows us to track all types of lost time benefits such as temporary modified duty and temporary partial disability such as: full time/full duty; full time/modified duty; part time/full duty; part time/modified duty; permanent modified duty; temporary total disability, etc.

In addition, our system tracks Labor Code 4850 benefits separately in that it applies the temporary disability rate as one transaction and the remaining balance as a Labor Code 4850 benefit transaction. This is especially important reference annual State reporting as the City’s assessments are calculated based on the temporary disability rate amounts, not the entire Labor Code 4850 benefit amounts.

We are able to provide reports on a daily, weekly, monthly, quarterly, annual, etc. basis for and on behalf of the City, including those required by State and Federal law. Reports include a complete record of all financial transactions, including, but not limited to check registers that enumerate check issuance data, and/or voucher (paper transaction) data, whatever is appropriate for the City; as well as management summaries, claim listings and loss analyses (paid losses and incurred costs), etc. At no additional cost, we are able to provide the City with any/all requested reports/loss runs (loss run analysis, summary report, etc.) typically within five workdays, or sooner, of the request.

In summary, we will provide all requested/required monthly reports by no later than the 10th (usually within five workdays) day of the following month, or sooner. We will also provide read-only online access to our computer system (RMIS), which includes report writing capability, for an unlimited number of City users at no charge.

Please refer to Attachment 6 for a summary of reports we are able to provide as well as sample claims reports (computer-generated reports)/analytics that illustrate our reporting capabilities

which include standard/regular monthly, quarterly, semi-annual, and annual computer loss runs, etc.

Data Conversion – Transition & Implementation Plan

Should we be selected, we will timely and accurately convert the City's claims data from its current Risk Management Information System (RMIS) to our RMIS. We expect that the data conversion will be completed within 30 workdays of receipt of the City's complete and final (exit) data. We have found that when a realistic data conversion plan is in place, transferring electronic claim files and data/documentation from one RMIS to another by a contract agreement start date is possible.

Please refer to Attachment 7 for our Transition and Implementation Plan (Data Conversion) that outlines the anticipated activities associated with the transition of claims and implementing all required services. Our proven approach ensures the least disruption during the transfer of electronic data, transfer of physical files (if any), and the service of required notices upon transition, etc.

It is important to note that we expect the City to have full access to all claim files we are assigned once we receive final (exit) data on July 1, 2024 (sample date) from the City's current RMIS provider so that we may finalize the entire data conversion. This is imperative in order to ensure all data is transferred correctly and to ensure claim files are coded as Indemnity, Future Medical, or Medical-Only, etc. and that each claim file is properly assigned to the appropriate claims adjuster for handling.

Data Integrity & Confidentiality – Disaster Recovery Plan

We are a Certified Service Organization Controls (SOC) Organization with a Disaster Recovery Plan. This designation is meaningful as it signifies that we undergo yearly, in-depth examinations of our control objectives and control activities, which includes controls over information technology and related processes such as security, data integrity, and confidentiality measures. This matters because you do not need to take our "word" for it – we are a proven, secure service provider.

Fees and Costs

Please refer to Attachment 5 for our Fee Proposal, thank you.

Ability of the Proposer to Perform

Our City of Vernon Team assigned to handle claims will be comprised of professional staff that includes our Workers' Compensation Claims Directors. Their broad role includes transitioning the City's claims to us, selecting (with prior City approval) and assigning all necessary best-fit Claims Adjusting Staff, and non-Claims Adjusting Staff, to perform each service required per the RFP. Please refer to Attachment 8 for their resumes which detail their education, experience, years with our firm, etc.

It is important to note that our Workers' Compensation Claims Directors have successfully completed numerous Third Party Administrator (TPA) transitions; moreover, they have sufficient time and resources to devote to the City of Vernon's transition should we be selected. They will

also oversee the entire Project alongside the City's assigned Workers' Compensation Claims Manager to ensure we meet and exceed the City's needs and expectations.

As previously noted, our Workers' Compensation Claims Directors will – along with our City contact(s) – assign the best-fit Workers' Compensation Claims Manager and Claims Team to the City's account as it is absolutely imperative to the success of the City's Self-Insured Workers' Compensation Program that the City's assigned Claims Adjusting Staff are compatible with our City contact(s) and that our business relationship is based on mutual goals and shared philosophies.

It is important to reiterate that our Workers' Compensation Claims Directors and City's assigned Workers' Compensation Claims Manager will oversee the City's account to ensure the City of Vernon's Team administers and manages the services requested in the RFP in such a way that meets and exceeds the City's needs and expectations.

In addition, the City's assigned Workers' Compensation Claims Manager will have the authority to resolve client issues immediately including increasing staffing (should workloads increase over the life of the Agreement), or reassigning Staff to the City's satisfaction. If/when necessary, we will provide a qualified back-up claims adjuster in the event of any absence of the City's Claims Adjusting Staff. Should the City request/require a different approach, we will adhere accordingly.

It is also important to note that we have more than sufficient resources to provide the requested professional services in the timeframe required by looking to our 100+ Workers' Compensation Professional Staff to assist the assigned City of Vernon Workers' Compensation Team as follows:

- Staff – City of Vernon's Claims Team:
 - Directors of Operations
 - Workers' Compensation Claims Manager
 - Workers' Compensation Claims Adjusters
 - Workers' Compensation Claims Assistants
 - Workers' Compensation Office Assistants
- Clerical Support Staff
- Utilization Review Staff
- Bill Review Staff
- Bill Pay Staff
- Check Processing Staff
- Information Systems/Technology (IS/IT) Support Staff

Our staffing backup plan when a City of Vernon team member is not available is achieved through our PTO (personal time off) "Buddy System." Each claims adjuster has a claims adjuster assigned to them to assist when they are on PTO and/or not available. This ensures all clients and injured workers receive the necessary attention and care at all times.

By appropriately staffing the City's account, the City's Claims Team will be able to consistently communicate with injured workers throughout the entire claims process. Our responsive, meaningful communication approach to claims handling results in good, injured worker relations and should result in claim cost reductions and claims settling/closing sooner.

Client References

As requested in the RFP, the following are three references similar in size and character to the City of Vernon:

- City of Huntington Park – Client since October 1, 2004
- City of South Gate – Client since July 1, 2005
- City of Lynwood – Client since March 1, 2004

Please refer to Attachment 1 for our Workers' Compensation Program Client List, thank you.

Affidavit of Non-Collusion

Please refer to Attachment 9 for our fully executed Affidavit of Non-Collusion.

Closing

Thank you for the opportunity to potentially partner with the City of Vernon. We believe we will best serve as the City's choice of service provider based on our:

- Entire proposal response
- Proposed cost for services
- Technical expertise
- Qualifications
- Years of specialized experience related to successfully administering complex claims in a considerate and consistent manner for Cities with Police Departments (safety members) – like the City of Vernon

We are confident we will provide the City of Vernon with the greatest overall cost-benefit advantages for its Self-Insured Workers' Compensation Program (Claims Administration Services, Utilization Review Services, and Bill Review Services). We sincerely hope we are extended the opportunity.

Should you have any questions or would like to further discuss our services, please contact me directly at 909.396.5814, or by way of e-mail at avargas-flores@adminsire.com, as I am the contact person for this Request for Proposal (RFP) and am fully authorized to negotiate and contractually bind AdminSure Inc. Our proposal response shall remain valid for a period of not less than ninety (90) days from the date of submittal.

Thank you for your time and consideration.

Respectfully submitted,



Alithia Vargas-Flores, President
MBA, SIA, WCCP, WCCA



Workers' Compensation Client List

The following is a list of our Workers' Compensation clients for which we provide various Services as follows: Claims Administration, Utilization Review, and Bill Review:

Alpine Fire Protection District
Antelope Valley Union High School District (AVUHSD)
Bonita-Sunnyside Fire Protection District
California Insurance Pool Authority (CIPA)
City of Adelanto
City of Anaheim
City of Arcadia
City of Baldwin Park
City of Barstow
City of Bell
City of Buena Park
City of Burbank
City of Canyon Lake
City of Carlsbad
City of Carson
City of Cathedral City
City of Coachella
City of Colton
City of Corona
City of Costa Mesa
City of Covina
City of Cypress
City of Desert Hot Springs
City of Downey
City of El Monte
City of El Segundo
City of Encinitas
City of Escondido
City of Fullerton
City of Garden Grove
City of Glendale
City of Glendora
City of Hawthorne
City of Hermosa Beach

City of Holtville
City of Hope National Medical Center
City of Huntington Park
City of Imperial Beach
City of Inglewood
City of Irvine
City of La Habra
City of Laguna Beach
City of Los Alamitos
City of Lynwood
City of Manhattan Beach
City of Montclair
City of Monterey Park
City of Moreno Valley
City of Murrieta
City of National City
City of Newport Beach
City of Norco
City of Oceanside
City of Ontario
City of Orange
City of Palm Springs
City of Placentia
City of Pomona
City of Rancho Mirage
City of Redlands
City of Redondo Beach
City of Rialto
City of San Bernardino
City of San Bernardino Water Department
City of San Clemente
City of San Fernando
City of San Jacinto
City of San Marcos
City of San Marino
City of Santa Ana
City of Santa Barbara
City of Santa Maria
City of South Gate
City of Tustin
City of Victorville
City of Vista
City of Westminster
City of Westmorland
City of Yorba Linda
Goodwill Industries of Southern California

Goodwill Retail Services
Hemet Unified School District (HUSD)
Independent Cities Risk Management Authority (ICRMA)
Kern County Hospital Authority
Lakeside Fire Protection District
Local Agency Workers' Compensation Excess (LAWCX)
Los Angeles Community College District (LACCD)
Los Angeles Department of Water and Power (LADWP)
Mariposa County
North County Fire Protection District
Out of the Shell, LLC
Palmdale School District
Pomona Valley Hospital Medical Center (PVHMC)
PRISM (Public Risk Innovation, Solutions, and Management) – Formerly:
California State Association of Counties – Excess Insurance Authority (CSAC-
EIA) – Primary Workers' Compensation (PWC) Program
Public Entity Risk Management Authority (PERMA)
Rancho Santa Fe Fire Protection District
San Miguel Fire Protection District
South Coast Air Quality Management District (SCAQMD)
SunLine Transit Agency
Tarzana Treatment Centers
Taylor-Dunn Corporation
Trademark Construction Co., Inc. DBA J.M.W. Truss and Components
Yum Yum Donut Shops, Inc. (Winchell's)

WORKERS' COMPENSATION CLAIMS ADMINISTRATION STANDARDS (CALIFORNIA)

The following standards are intended to foster a professional, best practices approach to Workers' Compensation claims administration. Under no circumstances are they to be construed as having precedence over any new or existing statute, regulation or case law.

1. Caseload

An ideal caseload is 150-165 open indemnity claims, with each future medical claim (settled; no pending issues other than the payment of the approved Award, medical treatment, liens and excess) or medical-only claim being counted as one-half of an indemnity claim.

2. New Claim Set Up

Upon receipt of the Employer's Report of Occupational Injury or Illness (Form 5020), Workers' Compensation Claim Form (DWC 1), or Application for Adjudication of Claim, the claims administrator will create a claim file within two workdays.

In the event a DWC 1 Form is not received by the claims administrator within one to two workdays after receiving Form 5020, the claims administrator will contact the employer to ensure that a DWC 1 Form was provided to the injured worker within one workday of the employer's date of knowledge of the injury. If a DWC 1 Form was not provided, the claims administrator will immediately send a DWC 1 Form directly to the injured worker.

The claims administrator will immediately request Form 5020 from the employer when the Doctor's First Report of Occupational Injury or Illness (Form 5021) is received first.

All coding fields will be accurate and complete.

3. Compensability

The initial compensability determination (accept claim, deny claim, or delay acceptance pending the results of additional investigation or medical documentation) and the reasons for such a determination will be made and documented in the claims administrator's file notes no later than fourteen (14) calendar days of the filing of the claim with the employer.

Upon knowledge of preexisting medical conditions which may be pertinent to a claim, medical records will be explored and obtained as necessary and/or approved by the employer.

When medical causation is unclear, a medical evaluation will be scheduled with a physician by way of a State Panel Qualified Medical Exam, Defense Qualified Medical Exam, or Agreed Medical Exam (AME). A cover letter, when appropriate, will be provided to the physician outlining the specific issues, concerns and questions. All relevant medical reports, investigation reports, and information will be provided to the physician for review prior to the examination date.

Delayed claims will clearly document the reason for the delay, the information needed to determine compensability and the anticipated date of the final decision. If a claim was initially delayed pending a physician's report and/or other medical, legal, or investigation report, a decision will be made within five workdays from receipt of such reporting, or sooner, if any delay will result in a penalty situation.

For all denied claims, the claims administrator will document the factual, medical, and/or legal basis for the denial, in accordance with the Workers' Compensation Laws of California.

The claims administrator will notify the employer of all claims where a delay or denial is recommended. The claims administrator will also notify the employer before any questionable claim is accepted. Thereafter, a proper notice will be sent to the injured worker notifying him/her of the decision and their rights under the Workers' Compensation Laws of California.

In no case will a compensability decision be made more than ninety (90) days from the employer's date of knowledge of the injury and/or the employer's receipt of the Workers' Compensation Claim Form (DWC 1).

4. ISO ClaimSearch® and EDEX

The claims administrator will request a report from ISO ClaimSearch® and/or EDEX on all new indemnity claims. Thereafter, requests will be submitted if the possibility of other injuries is suspected, it appears permanent disability may be paid, or a claim file becomes litigated.

5. Three-Point Contact

- a. Employers will be contacted within two workdays of receipt of a claim to discuss and verify compensability, disability, clarify issues, and request additional information, if necessary. Contact will be made sooner if any delay will result in a late payment, late notice, or any penalty situation.

- b. All injured workers will be contacted by telephone within two workdays of receipt of a claim. During this initial contact, injured workers will be provided with an explanation of their benefits and will be asked whether they have any questions or concerns regarding their claim.

Injured workers who have not returned to work will be contacted by telephone within two workdays of receipt of a lost time claim unless the injured worker is represented by an attorney. During this initial contact, injured workers will be provided with an explanation of their benefits and will be asked whether they have any questions or concerns regarding their claim.

Injured workers will continue to be contacted at least twice a month while they are disabled from working, unless they are represented by an attorney, or their claim has been finalized.

- c. Treating physicians will be contacted within two workdays of notice or receipt of a lost time claim to verify the diagnosis, compensability, duration of disability, proposed treatment and other issues, as appropriate. Contact will be made sooner if any delay will result in a late payment, late notice or any penalty situation. Thereafter, the claims administrator will maintain contact at least every thirty (30) days with the treating physician to monitor the disability status and the progress of medical treatment, facilitate an early return to work, and obtain medical reports.

6. Telephone and Written Communication

Telephone calls will be returned within one workday. If the designated claims administrator is not available within this time frame, another claims administrator will return the telephone call.

Written communications from the employer, defense counsel and injured workers requiring acknowledgment or action will be responded to within five workdays. Written communications from all other parties will be responded to within thirty (30) days or sooner, if an immediate response is necessary or required. All incoming written communication will have the date of receipt clearly date stamped.

The claims administrator will respond to the employer's request for verbal status reports on claim files within twenty-four (24) to forty-eight (48) hours.

In lieu of written status reports, the employer will be provided with online computer access to claim status information.

7. Investigation Management

With prior authorization from the employer, the claims administrator will immediately assign an investigator, as needed, when any identified issue arises that may impact the nature, extent, or scope of the employer's liability.

Referrals will be made within five workdays from the employer's approval and will include specific, written instructions regarding the scope of the investigation. The employer will be kept informed of the results of all investigations.

8. Fraudulent Claims

Any claim that is believed to be fraudulent will be referred to an investigator for additional investigation, and with the employer's prior approval, the claim will be referred to the appropriate law enforcement agency for further investigation.

9. Subrogation Management

Whenever practical, the claims administrator will aggressively pursue recovery in all subrogation claims. The claims administrator will attempt to maximize the recovery for benefits and payments made and assert credit against an injured worker's net recovery for future benefit payments.

Subrogation potential will be identified and appropriate steps will be taken to initiate an investigation within ten (10) workdays after information is available that subrogation may exist. In all cases where it appears a third party is responsible for the injury to the injured worker(s), and once the responsible party has been identified, the third party will be contacted within ten (10) workdays with notification of the employer's right to subrogation and the recovery of claim expenses.

The claim will be monitored to determine the need to file a complaint in order to preserve the statute of limitations. If the injured worker brings an action against the party responsible for the injury, the claims administrator will consult with the employer about the value of the subrogation claim and other considerations. Upon employer authorization, subrogation counsel will be assigned to file a Lien or a Complaint in Intervention in the action. The claims administrator will identify and seek recovery from a state fund, entity, or individual that may be a party to the claim.

The employer will be kept informed of the results of all subrogation efforts and findings.

Should an employer request that we not pursue subrogation efforts and/or the claims administrator recommends subrogation efforts not be made for whatever reason(s), we shall document all discussions, decisions, etc. in our computer notepad.

10. Litigation Management

When a defense attorney is not necessary, the claims administrator will work closely with the applicant's attorney towards disposition of the claim.

In the event the claims administrator and the employer determine a claim warrants referral to a workers' compensation defense attorney, the claim administrator will retain primary responsibility. Defense counsel will not be used to perform routine activities that are the responsibility of the claims administrator. Exceptions will be approved by the employer.

The claims administrator will communicate with the defense attorney to provide a complete overview of the claim. The claims administrator will also prepare a complete copy of the claim file for transmission to the defense attorney with a transmittal form or cover letter outlining the status of the case, results of investigations and discovery completed to date, primary issues, requested action and plan of action. Ongoing documentation will be sent to the defense attorney timely.

The claims administrator will carefully evaluate and monitor the defense attorney's aggressiveness in resolving claims, ability to identify issues, responsiveness, timeliness, and billing practices. The claims administrator will also provide the employer with advance notice of hearings and trials so they may attend, if necessary or desired.

11. Claim Reserves

Initial claim reserves will reflect the most probable value of the claim based on the information available at the time and the facts developed to date.

Initial claim reserves and subsequent reserve changes are reviewed and approved by a supervisor except under the following circumstance:

Claims administrators who possess the necessary Workers' Compensation experience and knowledge may have authority to establish initial reserves up to \$75,000.00 and each subsequent reserve change up to \$50,000.00.

As claim values increase and decrease, claim reserves will be reviewed on a regular basis and on each diary date, but not less than twice a year. The rationale for reserves will be documented in the file notes and the amounts allocated to each reserve category will be documented.

12. Claim Reconciliation

Claim files will be reconciled to ensure all medical, indemnity, vocational

rehabilitation, legal, and other expense payments are appropriate, were made to the correct individual/provider in the correct amount and were paid from the correct claim file. The physical file will be verified with the computer information.

All open claim files will be reconciled annually or when there is a change from one benefit to another. Proof of the reconciliation will be documented by way of a file note and a completed reserve worksheet, when applicable.

13. Payments

Prior to payment, all bills will be reviewed for accuracy and appropriateness. All medical bills will be reviewed for reduction in accordance with the California Official Medical Fee Schedule (OMFS), InPatient Hospital Fee Schedule (IHFS), Preferred Provider Organization (PPO) discounts, and/or negotiated rates.

Medical bills submitted without supporting documentation will be objected to within thirty (30) days from receipt and will not be reviewed for payment until such documentation is obtained, if applicable. Medical bills will be paid, objected to, or denied no later than thirty (30) days from receipt and/or in accordance with state statutes.

Medical-legal costs will be reviewed for appropriateness and necessity. Bills that do not qualify as valid medical-legal expenses will be objected to on a timely basis according to the Workers' Compensation Laws of California.

As required by SB 899, payment of medical treatment regarding delayed AOE/COE claims will be processed through Utilization Review and Bill Review but will not exceed \$10,000.00.

Mileage reimbursement requests from injured workers will be processed and mailed to the injured worker within ten (10) workdays of receipt of the request. Advance travel expense payments will be mailed to the injured worker no later than seven days prior to the anticipated date of travel.

14. Diary

Indemnity claims that are not on a benefit payment schedule will be reviewed on diary every thirty (30) to sixty (60) days as activity warrants, or more frequently when needed, for resolution of any and all issues and closure.

Indemnity claims on a benefit payment schedule will be reviewed on diary every fourteen (14) days, or more frequently when needed, for resolution of any and all issues and closure.

Medical-Only claims will be reviewed on diary every thirty (30) days for closure, or more frequently when needed. A medical-only claim will be converted to an indemnity claim when disability benefits are due, compensability becomes an issue, or litigation is initiated by either the injured worker or the employer.

Future-Medical claims will be reviewed on diary at least twice a year, or more frequently when needed, for the monitoring of future-medical care, Compromise and Release settlement and closure.

15. Indemnity Benefits

Accurate and timely indemnity benefit payments and notices will be computed, processed, and transmitted to injured workers as required by California Labor Codes, Statutes and Regulations.

Initial indemnity benefit payments and notices will be processed and mailed to the injured worker within fourteen (14) days of the first day of compensable disability. All subsequent and final indemnity benefits payments and notices will be verified and issued in compliance with the Workers' Compensation Laws of California.

Late indemnity payments due directly to the injured worker will include a self-imposed 10% penalty in accordance with the Labor Code.

16. Penalties

Late payments of all undisputed bills, benefits, Awards, Commutations, or Compromise and Releases will include the appropriate self-imposed penalty in accordance with the Workers' Compensation Laws of California.

The employer will be advised of the assessment of any penalty for late payment, the reason, and the responsible party within ten (10) workdays of the assessment. In the event the claims administrator is the responsible party, the claims administrator will submit a reimbursement check to the employer within fifteen (15) workdays of the assessment.

17. Return to Work

The claims administrator will assist the employer in establishing a modified-work (light-duty) plan that is appropriate and accommodating for injured workers while they are recovering from their injury or illness and prior to their return to regular duties.

The claims administrator will immediately consult with the employer in those cases where the injury or illness residuals might involve permanent work restrictions and/or

retirement potential.

18. Medical Management

The claims administrator's Utilization Review process will monitor treatment recommendations and medical treatment to ensure it is appropriate, medically necessary, and consistent with the recommended standards set forth in the American College of Occupational and Environmental Medicine Occupational Medical Practice Guidelines (ACOEM).

For all conditions and injuries/illnesses not covered by the ACOEM Practice Guidelines, authorized treatment will be in accordance with other evidence-based medical treatment guidelines that are relevant to the request, generally recognized by the national medical community, and scientifically based.

The claims administrator will monitor the medical treatment to ensure it is related to the compensable injury or illness. The claims administrator will timely object to inappropriate medical reports.

When appropriate, the claims administrator will arrange a medical evaluation by way of a Labor Code Section §4050 Exam, State Panel Qualified Medical Exam, Defense Qualified Medical Exam, or Agreed Medical Exam (AME) to address the necessity and/or reasonableness of care for litigated and non-litigated injured workers and injured workers who have a valid predesignated physician. A cover letter, when appropriate, will be provided to the physician outlining the specific issues, concerns, and questions. All relevant medical reports, investigation reports, and information will be provided to the physician for review prior to the examination date.

If the employer has an approved Medical Provider Network (MPN) in place, all medical evaluations, determinations, and disputes shall be governed per California Labor Codes and Regulations, specifically Labor Code Sections §4616 through §4616.4, Regulations §9767.1 through §9767.14, and pertinent Workers' Compensation Laws of California.

In the event a claim warrants referral to an outside nurse case manager or any other outside medical management service, the employer will be contacted for prior approval and to discuss the intent and scope of services requested.

19. Resolution of Claims

The employer will be notified within ten (10) workdays after receipt of the treating physician's or other relevant physician's Maximum Medical Improvement (Permanent and Stationary) report.

The claims administrator will determine the extent of permanent disability by completing a disability rating, arranging for an informal disability rating, or requesting a Summary Rating Determination (DEU Form 102) from the Disability Evaluation Unit. The claims administrator will also determine and take credit for legally permissible apportionment, if any.

The claims administrator will telephone the injured worker, if not represented by legal counsel, and mail a notice outlining permanent disability, future-medical care, and if applicable, provide a Qualified Medical Examination request form, within ten (10) workdays from receipt of a Maximum Medical Improvement (Permanent and Stationary) report. The purpose of the telephone call and notice is to explain the process and answer the injured worker's question(s). The claims administrator will take appropriate action(s) to finalize the claim.

20. Rehabilitation Management

All notifications, determinations, and referrals regarding Vocational Rehabilitation Benefits or Supplemental Job Displacement Benefits, and Qualified Injured Worker or Non-Qualified Injured Worker status will be made timely in accordance with the Workers' Compensation Laws of California in place at the time of injury. The claims administrator will:

- a. Notify the employer of the injured worker's permanent work restrictions so the employer may determine the availability of permanent modified or alternate work.
- b. Notify the injured worker of their potential rehabilitation rights.
- c. With prior employer approval, assign an outside rehabilitation counselor or other service vendor when the need is identified for a formal job analysis, essential function job analysis, ergonomic evaluation, or a 90-Day QRR intervention.
- d. Attempt to secure the prompt conclusion of vocational rehabilitation benefits, and settle rehabilitation where appropriate.
- e. Monitor rehabilitation programs on an ongoing basis to verify appropriateness and progress.
- f. Monitor and control rehabilitation benefits and costs through conclusion. In addition, the claims administrator will work with the employer to assist in the coordination of experts in complying with Americans with Disabilities Act (ADA) and AB 2222 interactive accommodation requirements.

21. Approval of Settlements

The claims administrator and/or defense attorney, if applicable, will submit settlement requests to the employer for approval on all settlement requests. Settlement requests will be clear and concise and will consist of a verbal and/or written analysis of the claim/issue(s), and monetary recommendations. After supervisory approval, settlement requests will be presented to the employer in this manner so as to ensure receipt of a response in sufficient time to process the settlement.

If the settlement exceeds, or may have the potential to exceed, the employer's self-insured retention, the claims administrator will immediately submit a written analysis of the claim/issues(s) and contact the excess carrier by telephone to discuss the settlement and obtain approval.

Overpayments will be identified on all settlement requests and where appropriate, the claims administrator will pursue credit for the overpayment, if any.

22. Award Payments

Following receipt of the appropriate, fully executed document(s), payments on undisputed Awards, Commutations, or Compromise and Releases will be issued within ten (10) workdays or sooner, if necessary to ensure payment within twenty (20) calendar days of the Workers' Compensation Appeals Board (WCAB) approval date, or if any delay will result in a late payment, late notice, or any penalty situation.

23. Excess Insurance

Claims that have the potential to exceed the employer's self-insured retention will be reported in accordance with the reporting criteria established by the employer's excess insurance carrier's policies.

Claims that meet the established reporting criteria will be reported to the excess carrier in accordance with the applicable policy but in no event will the claim be reported to the excess carrier more than thirty (30) days from the day on which it is known the criteria are met.

Excess reporting correspondence prepared by the claims administrator will be copied to the employer. Correspondence received by the claims administrator involving excess claims will be sent to the employer and responded to by the claims administrator within ten (10) workdays of receipt.

Requests for reimbursement on active claims will be made at least twice a year. For less active claims, reimbursement will be requested when reimbursement exceeds \$2,500.00, but in no event less frequently than on an annual basis.

24. File Documentation

Any significant development will be documented in the file notes. All file notes will have a “Plan of Action” that includes time frames for completing tasks or activities. The progress of the “Plan of Action” will be documented as will the reasons for any delays or modifications to the “Plan of Action.”

File documentation also includes all information that relates to the direction, value, and active claim strategy towards closure of the claim.

All files will be in chronological order with correspondence in the designated section. All handwritten correspondence, if any, will be legible. All file notes, actions, or tasks completed on a claim will identify the date and the person(s) who completed it.

25. Supervisory Review

Supervisors do not have a caseload. Their primary role is to direct, monitor and review the work of claims administrators. All supervisory reviews will be documented in the file notes and labeled “Supervisory Review.” All claims will be reviewed by a supervisor:

- a. At file creation.
- b. Before cases are delayed or denied.
- c. Before referral to outside investigation, subroa, medical case management or defense counsel.
- d. When reserve increases, proposed settlements or payments exceed the claims administrator’s limit of authority.
- e. Before mandatory settlement conferences or trials.

In addition, supervisors will audit 10% of the claims administrator’s caseload each month to evaluate the work product of the claims administrator, provide direction and review significant activities to ensure adherence to claims administration standards.

Finally, supervisors will review all incoming mail on a daily basis with an eye for anything that might portend a problem or require special attention.

26. Internal Auditing

In addition to supervisory audits, claim files are also randomly selected and reviewed by an internal auditor to further ensure compliance with performance standards outlined herein and to identify any areas of needed improvement in overall claims

handling and reserving.

27. Closure

Indemnity and medical-only claims will be reviewed for closure and closed within thirty (30) days from the date all issues, including those involving benefits, payments and notices, have been resolved.

Future-Medical claims will be reviewed for settlement not less than twice a year. When future-medical benefits are the only remaining benefit due to the injured worker, and the claim is inactive for a period of two years, it will be closed no later than two years from the date of the last provision of Workers' Compensation benefits, flagged as "do not destroy" and placed in permanent storage.

28. Record Retention

The claims administrator will retain all claim files for five years after the closure date. The claims administrator will retain all future-medical claim files for the entire life of the claim file.

Thereafter, the claims administrator will contact the employer to determine if the employer wishes to retain the claim file.

29. Personnel and Availability

Personnel who handle claim files will be well trained, appropriately certified and will receive continuing education and training.

The claims administrator, or a supervisor, will be available by telephone Monday through Friday, 8:00 a.m. to 4:30 p.m.

30. Client Services

The claims administrator will provide the employer with all necessary workers' compensation claim forms in an electronic format with printed forms available at cost.

The claims administrator will provide on-site training, attend on-site meetings, and complete file reviews for the employer on an as needed basis.

The claims administrator will participate in events pertaining to the employer's Workers' Compensation Program and will meet with injured workers to resolve issues that arise from claims on an as needed basis.

The claims administrator will meet with the employer on an as needed basis to provide information, opinions and direction regarding proposed changes to the Workers' Compensation Laws of California and to meet with the employer's designated personnel to ensure they are effectively processing the employer's Workers' Compensation claims as required by law.

MEDREVIEW

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Utilization Review Plan

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Introduction

MedReview's utilization review process is pursuant to and in compliance with Labor Code Sections 4610, 4610.5, and title 8, California Code of Regulations (CCR), Sections 9792.6.1 through 9792.10.1.

MedReview's utilization review process is governed by written policies and procedures that ensure decisions are based on medical necessity to cure and relieve treatment recommendations by physicians. All decisions are consistent with the California Medical Treatment Utilization Schedule (MTUS), including the drug formulary, adopted pursuant to Labor Code Section 5307.27. MedReview updates and reviews the treatment guidelines per CCR Section 9792.25.1(a) MTUS Methodology for Evaluating Medical Evidence.

Pursuant to CCR 9792.6.1(v), "Reviewer" means a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any state or the District of Columbia, competent to evaluate the specific clinical issues involved in medical treatment services, where these services are within the scope of the reviewer's practice.

Pursuant to Labor Code Section 4610(g)(3)(B)(i), MedReview shall neither offer nor provide any financial incentive or consideration to a physician based on the number of modifications or denials made by the physician under this section.

A "utilization review decision" means a decision pursuant to Labor Code Section 4610 to approve, modify, or deny a treatment recommendation or recommendations by a physician prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Labor Code Sections 4600 or 5402(c).

This Utilization Review Plan is available to the public upon request. The claims administrator may charge reasonable copying and postage expenses related to disclosing the complete utilization review plan. Such charge shall not exceed \$0.25 per page plus actual postage costs.

Medical Director and Personnel

MedReview's Medical Director is William Logan Tontz, Jr., M.D. Dr. Tontz is a practicing physician and surgeon who holds an unrestricted license to practice medicine in the State of California. Dr. Tontz's specialty is Orthopedic Surgery.

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The Medical Director ensures that the process by which MedReview prospectively, retrospectively, or concurrently reviews and approves, modifies, or denies treatment recommendations by physicians complies with the requirements of Labor Code Section 4610. Pursuant to CCR Section 9792.6.1(o), the Medical Director is a physician and surgeon licensed by the Medical Board of California or the Osteopathic Board of California who holds an unrestricted license to practice medicine in the State of California.

The Medical Director is responsible for all utilization review decisions. In addition to his duties as a reviewer, he is available to suggest courses of action to secure the medical information necessary to complete a review; available to provide additional resources of information to aid the non-physician reviewers with the primary review process; provides input and guidance to the other reviewers where appropriate; communicates with the requesting physicians when appropriate; reviews policies regarding the utilization review process; and provides educational information to the non-physician reviewers.

MedReview's Utilization Review is comprised of contracted physician reviewers licensed to practice in any state or the District of Columbia by their appropriate licensing boards, non-physician reviewers, consisting of licensed, certified, and trained health professionals, and assisting clerical personnel.

MedReview's physician reviewers are competent to evaluate the specific clinical issues involved in medical treatment services and, where these services are within the reviewer's scope of practice, may approve, modify, or deny requests for authorization of medical treatment for reasons of medical necessity to cure or relieve the effects of the industrial injury. Reviewers function as a secondary review when the non-physician reviewer is unable to approve medical treatment per appropriate guidelines.

MedReview's non-physician reviewers are comprised of individuals who possess an active, professional license or certification to practice as a health professional (Registered Nurse (RN), Certified Medical Assistant (MA) and Licensed Vocational Nurse (LVN)). MedReview's non-physician reviewers function as a primary reviewer applying specific criteria to requests for authorization for medical services. The non-physician reviewer may approve requests for authorization of medical services. The non-physician reviewer may discuss applicable criteria with the requesting physician, should the treatment for which authorization is sought appears to be inconsistent with the criteria. In such instances, the requesting physician may voluntarily withdraw a portion or all of the treatment in question and submit an amended request for treatment authorization. The non-physician reviewer may reasonably request appropriate additional information that is necessary to render a decision, but in no event, shall this exceed the time limitations per regulations. The non-physician reviewer shall not modify or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve or due to incomplete or insufficient information

MedReview's clerical personnel assist in the utilization review process by assigning received requests for authorization of medical treatment for initial review by a non-physician reviewer. Additionally, the clerical personnel are available to answer telephone calls between the hours of 9:00 a.m. to 5:30 p.m., on business days, for healthcare providers to request authorization for medical services.

MedReview's transcription personnel proofreads and formats the reviewers' typed decisions and drafts MedReview letters.

Utilization Review Process

Receipt of Request for Authorization

MedReview personnel are available by telephone from 9:00 a.m. to 5:30 p.m., on business days, to receive treatment requests. A facsimile number is maintained for after-hours treatment requests. The utilization review process for responding to a treatment request begins when the request for authorization is first received by mail, facsimile, or electronic mail.

Pursuant to CCR Section 9792.9.1(c)(2)(A), upon receipt of a request for authorization as described in subdivision (c)(2)(B), or a DWC Form RFA that does not identify the employee or provider, does not identify a recommended treatment, is not accompanied by documentation substantiating the medical necessity for the requested treatment, or is not signed by the requesting physician, a non-physician reviewer, as allowed by Section 9792.7, or reviewer must either regard the request as a complete DWC Form RFA and comply with the timeframes for decision set forth in this section or return it to the requesting physician marked "not complete," specifying the reasons for the return of the request no later than five (5) business days from receipt. The timeframe for a decision on a returned request for authorization shall begin anew upon receipt of a completed DWC Form RFA.

Utilization review of a medical treatment request may be deferred if the claims administrator disputes liability for either the occupational injury for which the treatment is recommended or the recommended treatment itself on grounds other than medical necessity.

Unless additional information is requested necessitating an extension, the utilization review process shall meet the required timeframes.

The first day in counting any timeframe requirement is the day after the receipt of the DWC Form RFA, except when the timeline is measured in hours. Whenever the timeframe requirement is stated in hours, the time for compliance is counted in hours from the time of receipt of the DWC Form RFA, pursuant to CCR Section 9792.9.1(c)(1).

Pursuant to Labor Code Section 4610(b)-(c), for all dates of injury occurring on or after January 1, 2018, any request(s) for authorization received for emergency treatment services and medical treatment rendered, for a body part or condition that is accepted as compensable by the employer, within the 30 days following the initial date of injury shall be authorized without prospective utilization review, except as provided in subdivision (c).

Unless authorized by the employer or rendered as emergency medical treatment, the following medical treatment services, as defined in rules adopted by the administrative director, that are rendered through a member of the medical provider network or health care organization, a predesignated physician, an employer-selected physician, or an employer-selected facility, within the 30 days following the initial date of injury, shall be subject to prospective utilization review under this section:

- ~ Pharmaceuticals, to the extent they are neither expressly exempted from prospective review nor authorized by the drug formulary adopted pursuant to Section 5307.27.
- ~ Nonemergency inpatient and outpatient surgery, including all presurgical and postsurgical services.
- ~ Psychological treatment services.
- ~ Home health care services.
- ~ Imaging and radiology services, excluding X-rays.
- ~ All durable medical equipment, whose combined total value exceeds two hundred fifty dollars (\$250), as determined by the official medical fee schedule.
- ~ Electrodiagnostic medicine, including, but not limited to, electromyography and nerve conduction studies.
- ~ Any other service designated and defined through rules adopted by the administrative director.

Timeframes and Notification

Prospective or concurrent utilization review decisions will not exceed five (5) business days from the date of receipt of the request for authorization. During the utilization review process, the reviewer or non-physician reviewer shall request information reasonably necessary to make a determination from the treating physician within five (5) business days from the date of receipt of the request for authorization.

Prospective decisions regarding requests for treatment covered by the MTUS Drug Formulary shall be made no more than five working days from the date of receipt of the medical treatment request.

Prospective or concurrent decisions related to an expedited review will not exceed 72 hours after the receipt of the written information reasonably necessary to make the determination. A request

for expedited review must be supported by evidence establishing that the injured worker faces an imminent and serious threat to his or her health, or that the timeframe for utilization review would be detrimental to the injured worker's condition.

Retrospective decisions shall be made within 30 days of receipt of the request for authorization and medical information that is reasonably necessary to make a determination.

All decisions to approve a request for authorization shall specify the following:

- ~ The date the request for authorization was first received.
- ~ The medical treatment service requested.
- ~ The medical treatment service approved.
- ~ The date of the decision.

Prospective, concurrent, or expedited approvals shall be communicated to the requesting physician within 24 hours of the decision, initially by telephone, facsimile, or, if agreed to by the parties, secure email. Telephone communication of the decision shall be followed with a written notice to the requesting physician within 24 hours of the decision for concurrent review and within two (2) business days for prospective review. For retrospective approvals, the written decision shall be communicated to the requesting physician, the injured worker, and his or her attorney/designee, if applicable.

Pursuant to CCR Section 9792.6.1(a), 'Authorization' means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury.

Payment, or partial payment, of a medical bill for services requested, within the 30-day timeframe, shall be deemed a retrospective approval.

Pursuant to CCR Section 9792.9.1(e)(1), the review and decision to deny or modify a request for medical treatment must be conducted by a reviewer, who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the individual's practice.

Prospective, concurrent, or expedited decisions to modify or deny shall be communicated to the requesting physician within 24 hours of the decision, initially by telephone, facsimile, or, if agreed to by the parties, secure email. Telephone communication of the decision shall be followed with a written notice to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney, within 24 hours of the decision for concurrent review and within two (2) business days for prospective review.

For retrospective decisions to deny part or all of the requested medical treatment, the written decision shall be communicated to the requesting physician, the injured worker, and his or her attorney/designee, if applicable, within 30 days of receipt of request for authorization and medical information that is reasonably necessary to make a determination.

Written decisions to modify or deny requests for authorization shall be provided to the requesting physician, the injured worker, the injured worker's representative, and if the injured worker is represented by counsel, the injured worker's attorney. The written decision shall be signed by either the claims administrator or the reviewer, and shall only contain the following information specific to the request, pursuant to CCR Section 9792.9.1(e)(5):

- ~ The date on which the request for authorization was first received.
- ~ The date on which the decision is made.
- ~ A description of the specific course of proposed medical treatment for which authorization was requested.
- ~ A list of all medical records reviewed.
- ~ A specific description of the medical treatment service approved, if any.
- ~ A clear, concise, and appropriate explanation of the reasons for the reviewing physician's decision, including the clinical reasons regarding medical necessity and a description of the relevant medical criteria or guidelines used to reach the decision pursuant to Section 9792.8. If a utilization review decision to modify or deny a medical service is due to incomplete or insufficient information, the decision shall specify the reason for the decision, the specific information that is needed, the date(s) and time(s) of attempts made to contact the physician to obtain the necessary information, and a description of the manner in which the request was communicated.
- ~ The Application for Independent Medical Review, DWC Form IMR, with all fields, except for the signature of the employee, to be completed by the claims administrator. The application, set forth in Section 9792.10.2, and the written decision provided to the injured worker shall include an addressed envelope, which may be postage-paid for mailing to the Administrative Director or his or her designee.
- ~ A clear statement advising the injured employee that any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code Section 4610.5 and 4610.6, and that an objection to the utilization review decision must be communicated by the injured worker, the injured worker's representative, or the injured worker's attorney on behalf of the injured worker on the enclosed Application for Independent Medical Review, DWC Form IMR, within 10 days after service of the utilization review decision(s) for formulary disputes and 30 days after service of the utilization review decision(s) for all other medical treatment disputes.

~ The following mandatory language:

- ~ “You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me (insert claims adjuster's name in parentheses) at (insert telephone number). However, if you are represented by an attorney, please contact your attorney instead of me.

and

- ~ “For information about the workers' compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. For recorded information and a list of offices, call toll-free 1-800-736-7401.”
- ~ Details about the claims administrator’s internal utilization review appeals process for the requesting physician and a clear statement that the internal appeals process is a voluntary process that neither triggers nor bars use of the dispute resolution procedures of Labor Code Section 4610.5 and 4610.6, but may be pursued on an optional basis.
- ~ The written decision modifying or denying treatment authorization provided to the requesting physician containing the name and specialty of the reviewer or expert reviewer, and the telephone number in the United States of the reviewer or expert reviewer. The written decision discloses the hours of availability of either the reviewer, the expert reviewer, or the medical director for the treating physician to discuss the decision which is, at a minimum, four (4) hours per week during normal business hours, 9:00 a.m. to 5:30 p.m., Pacific Time, or an agreed upon scheduled time to discuss the decision with the requesting physician. In the event the reviewer is unavailable, the requesting physician may discuss the written decision with another reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services.

Emergency Health Care Services and Concurrent Decisions to Deny

Pursuant to CCR Section 9792.6.1(i), “Emergency health care services” means health care services for a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to place the patient’s health in serious jeopardy. Emergency health care services do not require prior authorization and may be subjected to retrospective review. Pursuant to CCR Section 9792.9.1 (e)(2), failure to obtain authorization prior to providing emergency health care services shall not be an acceptable basis for refusal to cover medical services provided to treat and stabilize an injured worker presenting for emergency health care services. Emergency health care services

may be subjected to retrospective review. Documentation for emergency health care services shall be made available to the claims administrator upon request.

A concurrent decision to deny authorization for medical treatment must meet the following requirements prior to discontinuation of medical care:

- ~ The requesting physician shall be notified of the decision.
- ~ A care plan has been agreed upon by the requesting physician that is appropriate for the medical needs of the employee.
- ~ Medical care provided during the review shall be treatment that is medically necessary to cure or relieve from the effects of the industrial injury.

Timeframe Extension

Except for treatment requests made pursuant to the MTUS Drug Formulary, when additional information reasonably necessary to make a determination is requested necessitating a timeframe extension, a reviewer or non-physician reviewer shall request the information from the treating physician within five (5) business days from the date of receipt of the request for authorization.

If the requested information is not received within fourteen (14) days from the receipt of the completed request for authorization for prospective or concurrent review, or within thirty (30) days of the request for retrospective review, the reviewer shall deny the request with the stated condition that the request will be reconsidered upon receipt of the information.

A reviewer may ask for the following:

- ~ An additional examination or test be performed upon the injured worker that is reasonable and consistent with professionally recognized standards of medical practice.
- ~ A specialized consultation and review of medical information by an expert reviewer.

When a reviewer asks for the above, the reviewer shall, within five (5) business days from the date of receipt of the request for authorization, notify the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney, in writing, that the reviewer cannot make a decision within the required timeframe. The written notification will include the anticipated date on which a decision will be rendered.

If the results of the additional examination or test are not received within thirty (30) days from the receipt of the completed request for authorization for prospective, concurrent, or retrospective review, the reviewer shall deny the request with the stated condition that the request will be reconsidered upon receipt of the information.

Upon receipt of the requested information:

- ~ For prospective and concurrent review:

- a non-physician reviewer shall make the decision to approve the request for authorization within five (5) business days of receipt of the information
- or
- a reviewer shall make the decision to approve, modify, or deny the request for authorization within five (5) business days of receipt of the information.

The requesting physician shall be notified by telephone, facsimile, or, if agreed to by the parties, secure email within 24 hours of making the decision. The written decision shall include the date the information was received and the decision shall be communicated in the manner set out in Section 9792.9.1(d) or (e), whichever is applicable.

- ~ For prospective and concurrent decisions related to an expedited review:
 - a non-physician reviewer shall make the decision to approve the request for authorization within 72 hours of receipt of the information
 - or
 - a reviewer shall make the decision to approve, modify, or deny the request for authorization within 72 hours of receipt of the information.

The requesting physician shall be notified by telephone, facsimile, or, if agreed to by the parties, secure email within 24 hours of making the decision. The written decision shall include the date the information was received and the decision shall be communicated in the manner set out in Section 9792.9.1(d)(2) or (e)(3), whichever is applicable.

- ~ For retrospective review:
 - a non-physician reviewer shall make the decision to approve the request for authorization within thirty (30) calendar days of receipt of the information
 - or
 - a reviewer shall make the decision to approve, modify, or deny the request for authorization within thirty (30) calendar days of receipt of the information.

The written decision to approve shall include the date it was made and shall be communicated to the requesting physician who provided the medical services and to the individual who received the medical services, and his or her attorney/designee, if applicable.

The written decision to deny part or all of the requested medical treatment shall include the date it was made and shall be communicated to the requesting physician who provided the medical services and to the individual who received the medical services, and his or her attorney/designee, if applicable, within 30 days of receipt of request for authorization and medical information that is reasonably necessary to make a determination.

Documentation

Pursuant to CCR Section 9792.9.1(g), whenever a reviewer issues a decision to deny a request for authorization based on the lack of medical information necessary to make a determination, the claims administrator's file must document the attempt by the claims administrator or reviewer to obtain the necessary medical information from the physician either by facsimile, mail, or e-mail.

Pursuant to Labor Code Section 4610(k), a utilization review decision to modify or deny a treatment recommendation shall remain effective for 12 months from the date of the decision without further action by the employer with regard to a further recommendation by the same physician, or another physician within the requesting physician's practice group, for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

Utilization Review Decision-Making Process

Pursuant to Labor Code Section 4610(h), the criteria or guidelines used in MedReview's utilization review process to determine whether to approve, modify, or deny medical treatment services are all of the following:

- ~ Developed with involvement from actively practicing physicians.
- ~ Consistent with the schedule for medical treatment utilization, including the drug formulary, adopted pursuant to Section 5307.27.
- ~ Evaluated at least annually and updated if necessary.
- ~ Disclosed to the physician and the employee, if used as the basis of a decision to modify or deny services in a specified case under review.
- ~ Available to the public upon request (no copying fees apply).

Non-physician reviewers and reviewers conduct the following medical evidence search sequence for the evaluation and treatment of injured workers:

- ~ Search the recommended guidelines set forth in the current MTUS to find a recommendation applicable to the injured worker's medical condition or injury.
- ~ In the limited situation where a medical condition or injury is not addressed by the MTUS or if the MTUS' presumption of correctness is being challenged, then:
 - Search the most current version of ACOEM or ODG to find a recommendation applicable to the injured worker's medical condition or injury. Choose the recommendation that is supported with the best available evidence according to the MTUS Methodology for Evaluating Medical Evidence set forth in Section 9792.25.1.
- ~ If no applicable recommendation is found in ACOEM or ODG, or if the reviewing physician believes there is another recommendation supported by a higher quality and strength of evidence, then:
 - Search the most current version of other evidence-based medical treatment guidelines that are recognized by the national medical community and are scientifically based to find a recommendation applicable to the injured worker's medical condition or injury. Medical treatment guidelines can be found in the National Guideline Clearinghouse. Choose the recommendation that is supported with the best available evidence according to the MTUS Methodology for Evaluating Medical Evidence set forth in Section 9792.25.1.
- ~ If no applicable recommendation is found in the National Guideline Clearinghouse, then:
 - Search for current studies that are scientifically-based, peer-reviewed, and published in journals that are nationally recognized by the medical community to find a recommendation applicable to the injured worker's medical condition or injury. Choose the recommendation that is supported with the best available evidence according to the MTUS Methodology for Evaluating Medical Evidence set forth in Section 9792.25.1. A search for peer-reviewed published studies may be conducted by accessing the U.S. National Library of Medicine's database of biomedical citations and abstracts.

IMR Appeals Process

Any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code Section 4610.5 and 4610.6. An objection to the utilization review decision(s) must be communicated by the injured worker, the injured worker's representative, or the injured worker's attorney on the injured worker's behalf on the Application for Independent Medical Review, DWC Form IMR, enclosed with the Utilization Review decision, within 10 days after service of the utilization review decision(s) for formulary disputes and 30 days after service of the utilization review decision(s) for all other medical treatment disputes.

Pursuant to Labor Code section 4610.5(h)(1)(A)-(B), the employee may submit a request for independent medical review to the division. The request may be made electronically under rules adopted by the administrative director.

The request shall be made no later than as follows:

- (A) For formulary disputes, 10 days after the service of the utilization review decision to the employee.
- (B) For all other medical treatment disputes, 30 days after the service of the utilization review decision to the employee.

Workers' Compensation Alternative Dispute Resolution Programs

Some clients have employees that belong to Police Officers' Associations and Fire Fighters' Associations. A portion of these associations have agreed upon Alternate Dispute Resolution (ADR) programs. These ADR processes replace the Independent Medical Review (IMR) procedures.

Utilization Review Appeals Process

The Internal Utilization Review Appeals Process (Appeal) is as follows:

It is a voluntary process that neither triggers nor bars use of the dispute resolution procedures of Labor Code Sections 4610.5 and 4610.6, but may be pursued on a voluntary basis. The injured worker or the treating physician must request an Appeal of the decision(s) within 10 days after receipt of the utilization review decision(s) by submitting additional information. The determination of the Appeal will be issued within 30 days of receipt of the Appeal. An Appeal shall be considered complete upon the issuance of a final Independent Medical Review (IMR) determination.

For information about the Workers' Compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. For recorded information and a list of offices, call toll free 1-800-736-7401.

Confidentiality Policy

Due to the nature of our work, it is imperative that employees maintain strict confidentiality when it comes to our clients' matters as well as our own policies and procedures. A breach of confidentiality will result in disciplinary action, including possible termination of employment.

Confidentiality Policy (Physician Reviewers)

Consultant agrees to maintain the confidentiality provisions of the materials reviewed and discussions conducted hereunder. Consultant understands and agrees that all information or data that Consultant receives from Administrator, or at the direction of Administrator, in connection with the process of providing services hereunder will be deemed confidential and may not be disclosed to anyone other than Administrator or its employees directly responsible for working with Consultant.

Definitions

Concurrent Review: Utilization review conducted during an inpatient stay. CCR Section 9792.6.1(c).

Expedited Review: Utilization review or independent medical review conducted when the injured worker's condition is such that the injured worker faces an imminent and serious threat to his or her health, including, but not limited to the potential loss of life, limb, or other major bodily functions, or the normal timeframe for the decision-making process would be detrimental to the injured worker's life or health or could jeopardize the injured worker's permanent ability to regain maximum function. CCR Section 9792.6.1(j).

Prospective Review: Any utilization review conducted, except for utilization review conducted during an inpatient stay, prior to the delivery of the requested medical services. CCR Section 9792.6.1(s).

Retrospective Review: Utilization review conducted after medical services have been provided and for which approval has not already been given. CCR Section 9792.6.1(u).

Physician Review Services

MedReview Inc. contracts with the following physicians/companies for Physician Review services:

Neil S. Ghodadra, M.D.
Orthopedic Surgery
License No. A 116163

Roman A. Shulze, D.O.
Family Practice and Occupational Medicine
License No. 8047

Aaron Emil McCoy, D.O.
Anesthesiology
License No. 15451

Scott McElmeel, M.D.
Anesthesiology
License No. C 153971

John V. Flores, PhD, MBBS, D.C.
Chiropractic and Sports Medicine
License No. 25215

William L. Tontz, M.D.
Orthopedic Surgery
License No. A 69746

Leslie R. Cadet, M.D.
Occupational Medicine
License No. A 164363

Advanced Medical Reviews, Inc.
Medical Director: Charles Totaro Carnel, M.D.
Medical Director Specialty: Physical Medicine & Rehabilitation
Medical Director License No. MD.27631 (Alabama)

MedReview Inc. contracts with the following physicians/companies for Expert Review services:

Network Medical Review Co. Ltd.
Medical Director: Robert C. Porter, M.D.
Medical Director Specialty: Occupational Medicine
Medical Director License No. 33237

Utilization Review – Claims Adjuster Authorization Criteria

Claims adjusters may approve the following Request(s) for Authorization (RFAs). All RFAs outside of the authorization criteria listed below must be referred to and processed by Utilization Review. Please note: Only a Physician may modify or deny RFA(s).

Claim Adjusters should adhere to the MTUS Treatment Guidelines. These guidelines are located in L-Drive (*UR Education for Claims > Guideline Folder*).

Treatment Requests - first 30 days of injury or illness	
Treatment Request	Claims Adjuster Authorization Criteria
<i>Per Labor Code 4610 (c)</i> <i>First 30 days of injury or illness</i> <i>(Starts January 1, 2018)</i>	<p><i>Unless authorized by the employer or rendered as emergency medical treatment, the following medical treatment services shall be subject to prospective utilization review:</i></p> <ul style="list-style-type: none"> <i>Pharmaceuticals that are non-exempt in the drug formulary</i> <i>Nonemergency inpatient and outpatient surgeries, including all pre-surgical and post-surgical services</i> <i>Psychological treatment services</i> <i>Home health care services</i> <i>Imaging and radiology services excluding x-rays</i> <i>All DME that exceeds \$250</i> <i>Electrodiagnostic testing</i>
Treatment Requests - after 30 days of injury or illness	
Treatment Request	Claims Adjuster Authorization Criteria
<i>Physical Methods:</i> <ul style="list-style-type: none"> <i>Occupational therapy</i> <i>Physical therapy</i> <i>Chiropractic treatment</i> <i>Acupuncture</i> 	<p><i>May have 24 visits for the life of the claim.</i></p> <p><i>Initial request – up to 4-6 visits.</i></p> <p><i>Additional requests (sets of 4-6 visits) may be approved if provider documents functional improvement.</i></p>
<i>Office Visits:</i> <ul style="list-style-type: none"> <i>Initial evaluation</i> <i>Consultation</i> <i>Second opinion</i> <i>Transfer of care</i> <i>Office visits</i> 	<p><i>May be approved by the claims adjuster.</i></p> <p><i>Send the RFA to UR when questioning whether or not the consultation, second opinion, or transfer of care is medically necessary.</i></p>

Injections: <ul style="list-style-type: none"> • Steroid 	<i>Injections are recommended based on body part accepted and injury/illness.</i> <i>Initial steroid injections for diagnostic and pain management can be approved by claims adjuster. Additional requests should be processed by Utilization Review. Not recommended for therapeutic use.</i>		
Injections: <ul style="list-style-type: none"> • ESI • Facet • Hyaluronic • PRP • SI joint 	<i>Injections are recommended based on body part and injury and must meet criteria outlined in the MTUS Treatment Guidelines.</i>		
Surgery	<i>All surgery requests must be processed by Utilization Review.</i>		
Pre-operative Testing/ Pre-operative Medical Clearance	<i>Upon approval of surgery, claims adjuster may approve the following requests: CBC, CMP, PT/PTT, EKG and Chest X-Ray.</i>		
Radiology/Diagnostic: <ul style="list-style-type: none"> • X-rays • CT-scans • MRI • EMG/NCV 	<i>May be approved by the claims adjuster.</i> <i>See above for directions for the time period "first 30 days."</i>		
Home Health Care	<i>The claims adjuster may approve home health care up to 7 days.</i> <i>All requests for home health care greater than 7 days must be processed by Utilization Review.</i>		
Weight Loss/Gym Membership	<i>Weight loss and gym membership will be reviewed on a case-by-case basis to determine the necessity for utilization review.</i>		
Transportation	<i>The claims adjuster may approve transportation when appropriate.</i>		
Medication: <ul style="list-style-type: none"> • Per MTUS Formulary • Adhere to MTUS treatment guidelines for injury/illness • FDA approved • Generic drug 	Situation	NO UR	Yes UR
	Ongoing drugs	Exempt	Non-Exempt
	Off-label drugs	Exempt	Non-Exempt
	Brand-name drugs		Brand-name drugs
	Physician-dispensed drugs	First 7 days of injury, Exempt/Non-Exempt drugs, 4-day supply	After first 7 days of injury, all medications Exempt/Non-Exempt
	Compound drugs		Compound
	Special fill drugs	First 7 days of injury, Exempt/Non-Exempt, 4-day supply	
	Peri-operative fill drugs	Exempt/Non-Exempt 4 days before/4 days after surgery 4-day supply	
	Health and safety post-exposure prophylaxis (PEP)	Responsibility of the employer to provide urgent PEP after an exposure to bloodborne pathogens	
Detox Programs	<i>All requests for detox programs will be processed by Utilization Review.</i>		

<i>Psychiatric</i>	<i>Requests for psychiatric/neuro-psych or counseling may be approved by the claims adjuster.</i>
<i>Cancer Treatment</i>	<i>All specialized cancer treatment/therapy will require utilization review.</i>
<i>Durable Medical Equipment</i>	<i>Claims adjuster may approve all DME purchases and/or rentals. See above for directions for the time period "first 30 days."</i>

UTILIZATION REVIEW WORKFLOW

CLAIMS ADJUSTER REVIEW

UR

- All Utilization Review is in accordance with CCR 9792.9.1, Utilization Review Standards - Timeframes, Procedures and Notice - On or After January 1, 2013

Intake

- Receipt of Request for Authorization (RFA) (Received by Email, Facsimile or U.S. Mail - Electronically Assigned to Claim File)
- Per Adjuster Authorization Criteria sheet, Intake confirms with Claims Adjuster to continue UR review

Claims Adjuster

- Per Adjuster Authorization Criteria sheet, Claims Adjuster confirms with Intake to continue UR review
- Claims Adjuster faxes/mails approval determinations to the provider, injured worker and applicant attorney, when applicable

UTILIZATION REVIEW WORKFLOW

NON-PHYSICIAN REVIEW

UR

- All Utilization Review is in accordance with CCR 9792.9.1, Utilization Review Standards - Timeframes, Procedures and Notice - On or After January 1, 2013

Intake

- Receipt of Request for Authorization (RFA) (Received by Email, Facsimile or U.S. Mail - Electronically Assigned to Claim File)
- Per Adjuster Authorization Criteria sheet, Intake confirms with Claims Adjuster to continue UR review
- RFA(s) are directly assigned to UR, when applicable

Claims Adjuster

- Per Adjuster Authorization Criteria sheet, Claims Adjuster confirms with Intake to continue UR review
- Claims Adjuster submits RFA(s) to UR when the RFA does not meet guideline standards and/or Adjuster Authorization Criteria sheet

UR

- UR applies the MTUS, ACOEM and ODG guidelines to determine the medical necessity for the RFA
- UR faxes/mails request for information/approval determinations to the provider, injured worker and applicant attorney, when applicable

Intake

- Receipt of response to request for information (Received by Email, Facsimile or U.S. Mail - Electronically Assigned to Claim File)
- Intake notifies of response to request for information

UR

- UR faxes/mails approval determinations to the provider, injured worker and applicant attorney, when applicable
- UR submits response to request for information to Physician Reviewer for UR determination (See MD Review Workflow)

UTILIZATION REVIEW WORKFLOW

PHYSICIAN REVIEW

UR

- All Utilization Review is in accordance with CCR 9792.9.1, Utilization Review Standards - Timeframes, Procedures and Notice - On or After January 1, 2013

Intake

- Receipt of Request for Authorization (RFA) (Received by Email, Facsimile or U.S. Mail - Electronically Assigned to Claim File)
- Per Adjuster Authorization Criteria sheet, Intake confirms with Claims Adjuster to continue UR review
- RFA(s) are directly assigned to UR, when applicable

Claims
Adjuster

- Per Adjuster Authorization Criteria sheet, Claims Adjuster confirms with Intake to continue UR review
- Claims Adjuster submits RFA(s) to UR when the RFA does not meet guideline standards and/or Adjuster Authorization Criteria sheet

UR

- UR submits RFA(s) to a Physician Reviewer when the RFA does not meet guideline standards
- The review and decision to deny or modify a RFA must be conducted by a Physician Reviewer

Physician
Reviewer

- The Physician Reviewer makes the UR determination

Tran-
scription

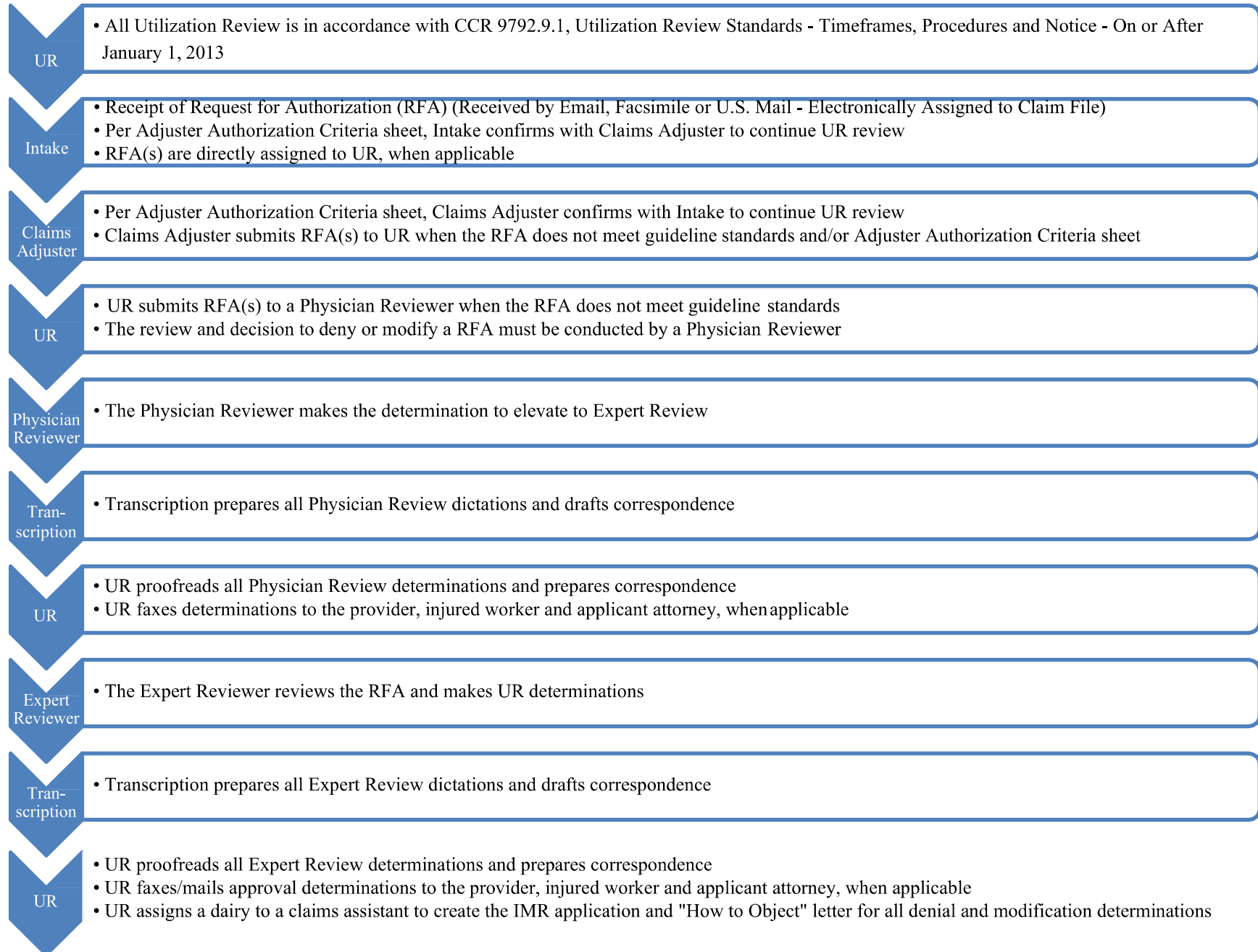
- Transcription prepares all Physician Review dictations and drafts correspondence

UR

- UR proofreads all Physician Review determinations and prepares correspondence
- UR faxes/mails approval determinations to the provider, injured worker and applicant attorney, when applicable
- UR assigns a dairy to a claims assistant to create the IMR application and "How to Object" letter for all denial and modification determinations

UTILIZATION REVIEW WORKFLOW

EXPERT REVIEW



Calendar Year: 2023

Utilization Review Performance Rating of Investigation of a Claims Administrator

Investigation No: URA -S11-23 R1-5

Claims Administrator: AdminSure, Inc.

Location: Ontario

Utilization Review Management: MedReview

Number of Requests for Authorization:

Prospective	56
Concurrent	0
Retrospective	1

Decisions by Type:

Approval	40
Modification	4
Delay	0
Denial	13

1. FACTOR FOR UNTIMELY RESPONSE TO REQUEST

# late prospective responses	0	divide by # of prospective requests	56	
# late concurrent responses	0	divide by # of concurrent requests	0	
# late retrospective responses	0	divide by # of retrospective requests	1	
Totals	0	divide by	57	=
				0.00000

2. FACTOR FOR FAULTY NOTICE CONTENT

# faulty prospective responses	0	divide by # of prospective requests	56	
# faulty concurrent responses	0	divide by # of concurrent requests	0	
# faulty retrospective responses	0	divide by # of retrospective requests	1	
Totals	0	divide by	57	-
				0.00000

3. FACTOR FOR IMPROPER DISTRIBUTION OF NOTICE

# prospective w/ improper distribution	0	divide by # of prospective requests	56	
# concurrent w/ improper distribution	0	divide by # of concurrent requests	0	
# retrospective w/ improper distribution	0	divide by # of retrospective requests	1	
Totals	0		57	
				=
				0.00000

UTILIZATION REVIEW PERFORMANCE RATING

A Utilization Review Performance Rating of 0.85000 or greater is a passing score.

100.0%

Calendar Year: 2023

Individual Exhibit 1A

Profile Audit Review Performance Rating of Randomly Selected Claims

Audit No: LAO-11-23-R1-5

Subject: AdminSure, Inc.

Location: Ontario

1. FACTOR FOR FAILURE TO PAY ACCRUED AND UNDISPUTED INDEMNITY

A. Frequency Rate

claims with unpd indem 5 divide by # claims with payable indem 59 = 0.08475

B. Average Amount of Unpaid Indemnity per Claim with Obligation to Pay Indemnity

Total unpd indem. = \$ 4,767.71 divide by # of claims with obligation to pay indem. 59
Avg Unpd Ind = \$ 80.81

C. Severity Rate

Avg Unpd Indem \$ 80.81 divide by avg unpd indem 2019-2021 of \$129.35 = 0.62473

D. Factor for Failure to pay Undisputed Accrued Indemnity

Frequency rate 0.08475 X Severity rate 0.62473 X modifier of 2
= 0.10589

2. FACTOR FOR LATE FIRST PAYMENT OF TEMPORARY DISABILITY / VIOLATION FOR FIRST NOTICE OF SC

# claims with late 1st TD	1	divide by # with TD payments	10	
# claims with first SC notice violations	20	divide by # with salary continuation	48	
Totals	21	divide by	Totals	58
				=
				0.36207

3. FACTOR FOR LATE FIRST PAYMENT OF PERMANENT DISABILITY AND DEATH BENEFITS

# claims with late first PD	0	divide by # with first PD	10	
# claims with late first DB	0	divide by # with first DB paid	0	
Totals	0	divide by	Totals	10
				=
				0.00000

4. FACTOR FOR LATE SUBSEQUENT INDEMNITY PAYMENTS

claims with late subsequent payments 0 divide by # with subsequent payments 13 =
0.00000

5. FACTOR FOR PROVISION OF AME/QME NOTICES

claims with AME/QME notice violation 5 divide by # requiring notices 59 =
0.08475

PROFILE AUDIT REVIEW PERFORMANCE RATING - 2023

Profile Audit Review Performance Rating of 1.76323 or greater is a failing score

0.55270

Fee Proposal

Our proposed guaranteed Fee Proposal is made in good faith and demonstrates our ability to provide professional services for a competitive fee, as well as our commitment to creating and maintaining a long-term business relationship with the City of Vernon.

Our enclosed Fee Proposal is based on a straightforward fee structure that covers all Workers' Compensation Program Services; specifically, Claims Administration Services, Utilization Review Services, and Bill Review Services. Our Services are outlined within our entire proposal response which includes, but is not limited to, the following:

- *24/7/365 online access to our Risk Management Information System (RMIS) – includes report writing capabilities and an unlimited number of “read-only” City users at no additional cost*
- *Financial Management/Manage the City's Workers' Compensation Trust Account (internal)*
- *Manage Positive Pay Services (internal)*
- *City of Vernon's Workers' Compensation Team:*
 - *Workers' Compensation Claims Supervisor/Manager*
 - *Workers' Compensation Indemnity Claims Adjuster*
 - *Workers' Compensation Medical-Only Claims Adjuster*
 - *Workers' Compensation Claims Assistant*
 - *Workers' Compensation Office Assistant*
 - *Support Staff:*
 - *Directors of Operations*
 - *Workers' Compensation Claims Supervisors/Managers*
 - *Workers' Compensation Claims Leads*
 - *Workers' Compensation Indemnity Claims Adjusters*
 - *Workers' Compensation Medical-Only Claims Adjusters*
 - *Workers' Compensation Claims Assistants*
 - *Workers' Compensation Office Assistants*
 - *Clerical Support Staff*
 - *Utilization Review Staff*
 - *Bill Review Staff*
 - *Bill Pay Staff*
 - *Check Processing Staff (our work product)*
 - *Information Systems/Technology (IS/IT) Support Staff*
- *Training – Claims Administration and Computer Software, Including Training Materials and Handouts (no additional cost)*
- *Meetings (includes meeting with ancillary service providers/vendors)*
- *Presentations and Materials*
- *Quarterly File Reviews (any on-site location, virtual, and telephonic) with corresponding Claim Narratives/Management Reports*
- *Educational Seminars*
- *All Reports: Standard and Special/Ad Hoc//Customized Reports; State/Federal Reports (no additional cost; at-cost when data is not captured)*

- *Mandatory reporting to CMS regarding Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) – Initial and Subsequent Reporting will be at no additional cost*
- *As the City's choice of Bill Review Provider, we will complete the Workers' Compensation Information System (WCIS) Reporting at no additional cost, i.e., Medical Bill Review EDI (Electronic Data Interchange) Reporting and Services*
- *As the City's choice of Utilization Review Provider, we will provide and manage all Utilization Review Services*
- *Printed and Electronic (with the ability to amend) Workers' Compensation Posters, Forms, and Pamphlets*
- *Printed Checks – our work product (benefits and payments)*
- *Stamped Envelopes for Mailing Workers' Compensation Checks and Correspondence (our work product)*
- *Index Claim Searches (ISO) at no additional cost*
- *Preparation of the Public Self-Insurer's Annual Report*
- *OSHA Forms (logs/summaries/reports)*
- *Preparation and Issuance of Federal Form 1099 Notices*
- *Storage for Closed Claim Files – At no cost, we will provide storage for all claim files closed within the last five years/fiscal years and all closed Future Medical files regardless of the date of closure*

In addition, we will accomplish the work and satisfy the City's service objectives as described in the Request for Proposal (RFP) by performing the following Claims Administration Services, Utilization Review Services, and Bill Review Services, which includes, but is not limited to:

- *AOE/COE Determination*
- *Investigation, Sub-Rosa (Surveillance), and Fraud Management*
- *Consultation Services*
- *Litigation Management*
- *Subrogation Management*
- *Benefit Administration (Indemnity, Medical, etc.), Management and Execution*
- *Utilization Review Management and Services*
- *Bill Review Management and Services*
- *If applicable, Medical Provider Network (MPN) – we shall not add on any additional fee/cost to the City's choice of MPN's Service Provider's fee/cost, if any*
- *Medical Management*
- *Return-to-Work (RTW) Program and Permanent Modified Duty Program Management*
- *Industrial Disability Retirement Management (IDR/CalPERS)*
- *ADA Interactive Process Meetings (compliance)*
- *Supplemental Job Displacement Benefits (SJDB)/Vocational Rehabilitation Management*
- *Settlement Management*
- *Medicare Set-Aside Allocation (MSA) Assistance*
- *Excess Reporting and Management*
- *Cost Containment/Loss Control Management*
- *ADR adherence, if any, and Assist with Incentive Programs, if any*

It is important to reiterate that we do not provide Utilization Review Services or Bill Review Services for any Third Party Administrator (TPA) or entity other than our Workers' Compensation Clients as we are committed to dedicating our time and efforts to only our Clients.

Regarding Bill Review Services, should we not be selected to provide Bill Review Services for the claims we administer/handle, there will be a \$8 per-bill fee for our partial bill review services/our direct costs; specifically, for the obtaining/receiving of electronic files from the City's choice of Bill Review provider (their work product), and for the processing/handling (our Staff's efforts/time) of same, as well as the printing (our paper/toner) and mailing (our envelope/stamp) of each check/EOB (Explanation of Benefits document – their work product) on behalf of the City's choice of Bill Review provider.

As previously noted, nearly 100% of our clients utilize us for Bill Review Services. We believe this is so for the following very important reasons:

- *Cost Efficiencies*
- *Transparency*
- *Control*
- *Accountability*
- *Trust*

We are truly committed to providing purposeful medical management services that ensure positive outcomes. We do not believe in over-promoting medical management services that exaggerate actual claim outcomes or overreach by suggesting self-serving, unrealistic savings through affiliated and/or outsourced service providers to our clients.

We prefer to focus on and provide prompt, assertive, and professional claims handling services along with applying reasonable Utilization Review and every Medical Management Service, Provider Network Savings, Preferred Provider Organization (PPO) Savings, and Fee Schedule (OMFS/IHFS) Savings, Negotiated Rates, etc. to the fullest extent allowed by law so that we may provide the City's injured workers with all the medical treatment and services they are medically and legally entitled to in the most timely and cost-effective and cost-sensitive manner.

We believe this proven approach will produce meaningful results, real savings, and will truly strengthen the City's position in maintaining a professional and well-managed Workers' Compensation Program.

In closing, based on our:

- *Qualifications*
- *Technical Expertise*
- *Proposal Response*
- *Fee Proposal*
- *Years of specialized experience related to successfully administering complex claims in a considerate and consistent manner for Cities with Police Departments (safety members) – like the City of Vernon*

We truly believe we are the best suited Third Party Administrator (TPA) to administer the City of Vernon's Self-Insured Workers' Compensation Program (Claims Administration Services, Utilization Review Services, and Bill Review Services).

It is important to note that the cost of administering the City's Workers' Compensation Program and the handling of the City's existing open files is included in our proposed Workers' Compensation Claims Administration fee. In addition, we considered the City's caseload volume and the economic challenges the public sector continues to experience when quoting our proposed fee. Therefore, our proposed guaranteed fee is guaranteed throughout the term of the Contract Agreement.

We believe these good faith gestures demonstrate our ability to provide professional services for a competitive fee as well as our commitment to creating and maintaining a long-term business relationship with the City of Vernon.

Should you have any questions or would like to further discuss our services, please contact me directly at (909) 396-5814, or by way of e-mail at avargas-flores@adminsire.com as I am fully authorized to bind our proposal, execute a Contract Agreement, and act on behalf of AdminSure Inc. Our proposal response shall remain valid for a period of not less than ninety (90) days from the date of submittal.

Thank you for your time and consideration.

Respectfully submitted,



Alithia Vargas-Flores, President
MBA, SIA, WCCP, WCCA

<u>Fee Proposal</u>	
<u>Claims Administration Services</u> <i>(Includes Internal Support Staff)</i> Flat Fee	<ul style="list-style-type: none"> ▪ Year 1: \$6,940 per month. ▪ 3% annual increase.
<u>Bill Review Services</u> Flat Fee	<ul style="list-style-type: none"> ▪ \$10 per bill for all Official Medical Fee Schedule (OMFS), In-Patient Hospital Fee Schedule (IHFS) and Out-Patient, etc., reviews; and when applicable, plus .75 cents for State of California required E-Bill/OCR Services; or \$8 per bill for partial bill review services. ▪ When applicable, up to 25% Preferred Provider Organization (PPO)/Negotiated Savings fee, if there are no applicable savings, there are no fees. ▪ No additional fees for transmitting medical billing information on behalf of the City to the Workers' Compensation Information System (WCIS) as required by State Law, i.e., Medical Bill Review EDI (Electronic Data Interchange) Reporting and Services. ▪ 3% annual increase.
<u>Utilization Review Services</u> Flat Fee	<ul style="list-style-type: none"> ▪ Physician (includes Peer and Expert)/Non-Physician Review & Decision: \$300 per hour billed in 10-minute increments/ approximately 4% of total charges; \$85 adjuster/\$125 utilization review. ▪ 3% annual increase.
Transition Fee	<ul style="list-style-type: none"> ▪ No fee.
Data Conversion Fee	<ul style="list-style-type: none"> ▪ No fee.
CMS/MMSEA – Internal Services	<ul style="list-style-type: none"> ▪ No fee.
City On-Line Access (All Data)	<ul style="list-style-type: none"> ▪ No fee for City read-only users; at-cost fee for read and write.
All Reports: Standard & Custom/Ad Hoc Reports	<ul style="list-style-type: none"> ▪ No fee. At-cost when data is not captured.
Index Claim Search & 1099s	<ul style="list-style-type: none"> ▪ No fee.
Training & Development of Special Account Instructions/Procedures & Banking	<ul style="list-style-type: none"> ▪ No fee. Reference any "Banking" fees, if any, please make note that any fees charged by the bank shall be at cost as we will not add on any feed for our internal services.
Trainings, Meetings, Quarterly Claim Reviews, Forms, Posters & Pamphlets	<ul style="list-style-type: none"> ▪ No fee.

Summary

Workers' Compensation Program Reports

The following list of reports illustrates a sample of our reporting capabilities which includes daily, weekly, monthly, quarterly, semi-annual, and annual reports and loss runs:

Sample Standard Reports:

- *Work Status Tab (Screen Shot)*
- *Active Claims Listed by Allocation*
- *Reserve Report*
- *Claims Voucher (Paper Transaction)/Check Register*
- *Claims Detail Summary*
- *Claims by Nature of Injury*
- *Claims by Claim Cause*
- *Claims by Body Part*
- *Claims Closed this Month*
- *Claims Closed by Month*
- *Claims Opened this Month*
- *Claims Opened by Month*
- *Claim Lag Time*
- *Litigated Claims by Claimant Type*
- *Work Status*
- *Claims Settled Last Month*
- *Claims Summary by Year*
- *Claims Transaction Report*
- *Balance Sheet Report*
- *Check Reconciliation Report*
- *OSHA's Form 300 Report*
- *OSHA's Form 300A Report*
- *OSHA's Form 301 Report*
- *Comparison Report*
- *Frequency and Severity by Nature of Injury*
- *Claims Handling Analysis*
- *Claim Ratios*
- *Average Claim Costs/Data Analysis—Metrics*
- *Cost of All Claims*
- *Batch Pay Sample Check*
- *Batch Pay Sample Report*

Sample Detailed/Analytical Reports:

- *Five-Year New Claims Opened*
- *Five-Year New Claims Opened and Claims Closed*
- *Percentage of New Claims Opened – Indemnity*

- *Average Cost Per New Claim Added by Department*
- *Police, Five-Year New Claims Opened by Claim Type*
- *Fire, Five -Year Claims Opened by Claim Type*
- *All Other Departments, Five-Year Claims Opened by Claim Type*
- *Police, Total Incurred = Paid & Reserved*
- *Fire, Total Incurred = Paid & Reserved*
- *All Other Departments, Total Incurred = Paid & Reserved*
- *Citywide, Total Incurred = Paid & Reserved*
- *Police, Stratification Loss*
- *Fire, Stratification Loss*
- *All Other Departments, Stratification Loss*
- *All Departments, Litigated Claims*
- *Safety (Police & Fire) Litigated Claims*
- *Non-Safety Litigated Claims*
- *All Departments, Litigated Expenses vs. Total Paid*
- *Five-Year Top 10 New Claim Distribution by Department (Bar)*
- *Five-Year Top 10 New Claim Distribution by Department (Pie)*
- *Five-Year Claim Distribution by Top 10 Cause of Loss (Bar)*
- *Five-Year Claim Distribution by Top 10 Cause of Loss (Pie)*
- *Claim Distribution by Cause of Loss Reference*
- *Five-Year Claim Distribution by Top 10 Nature of Injury (Bar)*
- *Five-Year Claim Distribution by Top 10 Nature of Injury (Pie)*
- *Claim Distribution by Nature of Injury Reference*
- *Five-Year Claim Distribution by Top 10 Body Part (Bar)*
- *Five-Year Claim Distribution by Top 10 Body Part (Pie)*
- *Claim Distribution by Body Part Reference*
- *Modified Duty Days - All Departments*
- *Modified Duty Days - Safety (Police & Fire)*
- *Modified Duty Days - None-Safety*
- *Metrics*
- **Comparisons - Percentage of New Claims Added*
- **Comparisons - Closing Ratio*
- **Comparisons - Frequency Rate (Per 100 Employees)*
- **Comparisons - Percentage of Annual Medical Only Claims*
- **Comparisons - Percentage Litigated for New Claims Added*
- **Comparisons - Percentage of Total Paid (All Claims)*

We have also included snapshots of our Dashboard which is currently being updated. It is important to reiterate that there are literally hundreds of reports we are able to create for the City of Vernon at no additional cost. Thank you for your time and consideration.



Alithia Vargas-Flores, President
MBA, SIA, WCCP, WCCA



WORK STATUS TAB

SCREEN SHOT

Step 1

Claim

Insured Allocation

Post Injury Benefit Data

Medicare

SIU

Correspondence

Attachment

Reserve

Payment

Scheduled Payment

Litigation

Asset To Vehicle

Contacts

Utilization Review

Work Status

Compensation Payment History

Work Status Overview

Exam Date:

Modified Release Date:

Modified Through Date:

Next Appointment Date:

Release to Begin Days:

Days:

Hours:

*Work Status Type:

Full Time / Full Duty

Full Time / Modified Duty

Full Time / Modified Duty - Not Accom - Lost Time

Part Time / Full Duty

Part Time / Full Duty - Not Accom - Lost Time

Part Time / Modified Duty

Part Time / Modified Duty - Not Accom - Lost Time

Permanent Modified Duty

Temporary Total Disability

Claims Assistant:

Other Information:

Assigned by Physician:

Work Status/Restrictions:

Date	End Date	Days	Release To Begin Days	Work Status Type	Next Appointment Date	Hours	Amount	Location	Supervisor	First Name	Phone	Job Description	Assigned	Comment
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Workers' Compensation Active Claims Listed by Allocation

Employee's Name Cause of Injury Description of Injury	Case No. Status	Claim Type Department	Injury Date Days Lost Closing Date		Paid this Period	Paid	Outstanding	Incurred	Recovery
Org1 Desc: Administrative Services									
Developed discomfort in the base of her left Left hand/fingers and Right hand	14-120112 Open	Future Med-Lim ADMSRV 160	04/30/2014 0.00	Medical	0.00	2,339.88	2,160.12	4,500.00	0.00
				TD	0.00	0.00	0.00	0.00	0.00
				PD	0.00	0.00	0.00	0.00	0.00
				Rehab	0.00	0.00	0.00	0.00	0.00
				Other Indemnity	0.00	0.00	0.00	0.00	0.00
				Legal Expense	0.00	0.00	0.00	0.00	0.00
				Other Expense	0.00	195.78	389.22	585.00	0.00
				Total	0.00	2,535.66	2,549.34	5,085.00	0.00
		Org1 Desc	1	Medical	0.00	2,339.88	2,160.12	4,500.00	0.00
				TD	0.00	0.00	0.00	0.00	0.00
				PD	0.00	0.00	0.00	0.00	0.00
				Rehab	0.00	0.00	0.00	0.00	0.00
				Other Indemnity	0.00	0.00	0.00	0.00	0.00
				Legal Expense	0.00	0.00	0.00	0.00	0.00
				Other Expense	0.00	195.78	389.22	585.00	0.00
				Org1 Desc	0.00	2,535.66	2,549.34	5,085.00	0.00

Workers' Compensation Active Claims Listed by Allocation

Employee's Name Cause of Injury Description of Injury	Case No. Status	Claim Type Department	Injury Date Days Lost Closing Date		Paid this Period	Paid	Outstanding	Incurred	Recovery		
Developed severe pain in his right foot when walking Right Foot Pain	13-115343 Open	Future Medical PUBSAF 471	02/10/2013 3.00	Medical	0.00	1,438.01	11,892.10	13,330.11	0.00		
				TD	0.00	905.31	0.00	905.31	0.00		
				PD	0.00	1,381.85	0.00	1,381.85	0.00		
				Rehab	0.00	0.00	0.00	0.00	0.00		
				Other Indemnity	0.00	0.00	0.00	0.00	0.00		
				Legal Expense	0.00	0.00	0.00	0.00	0.00		
				Other Expense	0.00	414.63	1,100.00	1,514.63	0.00		
				Total	0.00	4,139.80	12,992.10	17,131.90	0.00		
CONTINUOUS TRAUMA TO NECK STRAIN DISC NECK	2008001048 Open	Future Medical PUBSAF 471	09/25/2006 117.00	Medical	0.00	45,273.61	35,051.76	80,325.37	0.00		
				TD	0.00	32,336.97	0.00	32,336.97	0.00		
				PD	0.00	21,342.62	0.00	21,342.62	0.00		
				Rehab	0.00	0.00	0.00	0.00	0.00		
				Other Indemnity	0.00	0.00	0.00	0.00	0.00		
				Legal Expense	0.00	0.00	0.00	0.00	0.00		
				Other Expense	0.00	121.59	7,128.41	7,250.00	0.00		
				Total	0.00	99,074.79	42,180.17	141,254.96	0.00		
				Org1 Desc	196	Medical	54,662.69	5,355,484.38	6,028,742.58	11,384,226.96	-12,500.00
						TD	52,037.44	3,817,187.62	358,027.23	4,175,214.85	-12,500.00
						PD	6,289.54	2,559,240.47	1,508,352.59	4,067,593.06	0.00
						Rehab	0.00	144,601.00	61,752.20	206,353.20	0.00
						Other Indemnity	10,351.21	436,632.69	499,336.95	935,969.64	-1,024,875.44
						Legal Expense	2,039.10	435,963.74	48,775.32	484,739.06	0.00
						Other Expense	7,411.88	292,394.04	798,209.34	1,090,603.38	-15,000.00
						Org1 Desc	132,791.86	13,041,503.94	9,303,196.21	22,344,700.15	-1,064,875.44
				Grand Total:	244	Medical	66,469.92	6,510,797.23	7,656,584.54	14,167,381.77	-20,000.00
						TD	74,718.64	4,381,846.79	535,402.19	4,917,248.98	-12,500.00
						PD	935.86	3,008,507.24	1,847,677.43	4,856,184.67	0.00
						Rehab	0.00	172,745.31	81,752.20	254,497.51	0.00
						Other Indemnity	10,351.21	485,862.51	518,936.20	1,004,798.71	-1,137,644.57
						Legal Expense	2,811.15	679,960.35	119,307.77	799,268.12	0.00
						Other Expense	16,199.60	498,626.92	1,024,196.14	1,522,823.06	-15,000.00
						Grand Total:	171,486.38	15,738,346.35	11,783,856.47	27,522,202.82	-1,185,144.57

Reserve Total

Processed	Claim Number	Claimant	Incident	Transaction Type	Reason	Examiner	Amount
Claim Number: 02IRV00684							
03/17/2015	02IRV00684		02/09/2002	Other Expense		Barrile, Ronece	5,767.88
03/25/2015	02IRV00684		02/09/2002	Permanent Disability		Barrile, Ronece	9,749.00
03/25/2015	02IRV00684		02/09/2002	Permanent Disability		Barrile, Ronece	-9,749.01
Claim Number Total 3							5,767.87
Claim Number: 04IRV00895							
03/09/2015	04IRV00895		04/03/2004	Other Indemnity		Barrile, Ronece	750.00
Claim Number Total 1							750.00
Claim Number: 05IRV01027							
03/26/2015	05IRV01027		03/01/2005	Medical	Auto	Cuevas, Diana	-58,000.00
03/26/2015	05IRV01027		03/01/2005	Other Expense	Auto	Cuevas, Diana	-5,959.29
03/26/2015	05IRV01027		03/01/2005	Rehab	Auto	Cuevas, Diana	-1,000.00
Claim Number Total 3							-64,959.29
Claim Number: 06IRV01238							
03/12/2015	06IRV01238		11/16/2006	Medical	Auto	Barrile, Ronece	-6,163.68
03/12/2015	06IRV01238		11/16/2006	Other Expense	Auto	Barrile, Ronece	-1,246.40
Claim Number Total 2							-7,410.08
Claim Number: 11-110195							
03/11/2015	11-110195		01/19/2011	Other Expense		Barrile, Ronece	-7,057.80
03/11/2015	11-110195		01/19/2011	Permanent Disability		Barrile, Ronece	-27,100.97
03/11/2015	11-110195		01/19/2011	Permanent Disability		Barrile, Ronece	457.17
03/11/2015	11-110195		01/19/2011	Rehab		Barrile, Ronece	-4,000.00
03/11/2015	11-110195		01/19/2011	Temporary Disability		Barrile, Ronece	-457.17
Claim Number Total 5							-38,158.77
Claim Number: 11-110691							
03/30/2015	11-110691		03/25/2011	Medical	Auto	Cuevas, Diana	-9,304.84
03/30/2015	11-110691		03/25/2011	Other Expense	Auto	Cuevas, Diana	-1,860.00
Claim Number Total 2							-11,164.84

Processed	Claim Number	Claimant	Incident	Transaction Type	Reason	Examiner	Amount
Claim Number: 9603140027							
03/31/2015	9603140027		10/24/1995	Medical		Barrile, Ronece	-104,417.36
03/31/2015	9603140027		10/24/1995	Other Expense		Barrile, Ronece	-11,996.15
03/31/2015	9603140027		10/24/1995	Other Indemnity		Barrile, Ronece	-129.94
03/31/2015	9603140027		10/24/1995	Permanent Disability		Barrile, Ronece	-88,550.00
			Claim Number Total		4		-205,093.45
			Grand Total		142		-60,285.97

Workers' Compensation Claims Voucher/Check Register

For Month Ending

Number	Date	Amount	Payee	Description	Claimant	Code	Claim Number
Payment Method Desc: Check							
74814	03/04/2015	330.08	Higuera, Ron J. D.C., M.S.	Chiropractic Treatment		PUBSAF	11-112189
74815	03/04/2015	168.00	Team Makena, LLC	Medical Appliance		PUBSAF	13-117025
74816	03/04/2015	119.12	National Ambulatory Hernia Ins	Medical Treatment		PUBSAF	14-121165
74817	03/04/2015	102.08	Ortho Med Group & ARC	Physical Therapy		PUBWRK	15-121376
74818	03/04/2015	102.08	Ortho Med Group & ARC	Physical Therapy		PUBWRK	15-121376
74819	03/04/2015	102.08	Ortho Med Group & ARC	Physical Therapy		PUBWRK	15-121376
74820	03/04/2015	81.97	Nicholas E Rose M.D	Medical Treatment		PUBSAF	14-117523
74821	03/04/2015	92.05	National Ambulatory Hernia Ins	Medical Treatment		PUBSAF	13-117103
74822	03/04/2015	123.37	Pacific Cardiovascular Association	Medical Treatment		PUBSAF	06IRV01207
74823	03/04/2015	751.98	Stone River Pharmacy Solutions **	Medical Prescription		PUBSAF	9503140060
74824	03/04/2015	104.21	California Rehabilitation & Sports	Physical Therapy		COMDEV	15-121330
74825	03/04/2015	163.31	Michael P. Weinstein M.D.	Medical Treatment		PUBSAF	06IRV01178
74826	03/04/2015	49.98	Sand Canyon Medical Group	Medical Treatment		PUBSAF	13-117422
74827	03/04/2015	73.91	Sand Canyon Urgent Care	Medical Treatment		COMSRV	15-121612
74828	03/04/2015	82.36	Sand Canyon Urgent Care	Medical Treatment		COMSRV	15-121557
74829	03/04/2015	283.67	Cindy I Chen Md Apc	Medical Treatment		PUBSAF	07IRV01299
74830	03/04/2015	93.77	California Rehabilitation & Sports	Physical Therapy		PUBSAF	14-120290
74831	03/04/2015	105.69	Align Networks, Inc.	Physical Therapy		PUBSAF	12-114633
74832	03/04/2015	125.26	Elite Orthopedics	Medical Treatment		PUBWRK	9303140078
74833	03/04/2015	8,642.87	Saddleback Memorial Medical Center *	Medical Treatment		PUBSAF	14-120344
74834	03/04/2015	90.12	ProCare Work Injury Center Irvine	Medical Treatment		PUBSAF	12-113561
74835	03/04/2015	69.02	Sand Canyon Medical Group	Medical Treatment		PUBSAF	14-120750
74836	03/04/2015	881.90	Newport Harbor Anesthesia Cons	Medical Treatment		PUBSAF	8403140001

Workers' Compensation Claims Voucher/Check Register

For Month Ending

Number	Date	Amount	Payee	Description	Claimant	Code	Claim Number
Payment	36	-30,135.11					
Payment Method Desc: Void							
75033	03/18/2015	-42.04	Stone River Pharmacy Solutions **	Medical Prescription		PUBSAF	13-116114
Payment	1	-42.04					
Grand Total:	766	60,599.94					

Claimant Name 12-114974

Status: Open
Incident Date: 12/03/2012

Type: Indemnity
Closed Date:
Insured Reported Date: 12/21/2012

Opened Date: 12/28/2012
Deductible: 0.00

Insured:
Public Safety

Claimant:
Claimant Address

SSN: XXX-XX-7262
Sex: Female

Rancho Santa Margarita, CA 92688

Birth Date: 02/07/1978 Examiner:

Hire Date: 12/30/2002 Weekly Wage: 1,658.00

Incident: During a simulation training, a tourniquet was applied to the left arm

Type:

Cause: Miscellaneous Strain

Body Part: Multiple Body Parts

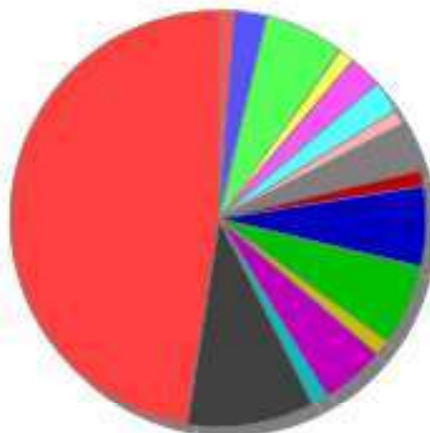
Nature of Injury: Multi Physical Injuries

	Total Incurred	Payments	Outstanding	Recovery
Medical	81,095.47	20,915.15	60,180.32	0.00
TD	90,784.14	90,784.14	0.00	0.00
PD	42,000.00	11,922.29	30,077.71	0.00
Rehab	8,000.00	0.00	8,000.00	0.00
Other Indemnity	2,156.25	656.25	1,500.00	0.00
Legal	15,000.00	10,339.45	4,660.55	0.00
Other Expense	35,225.33	26,599.33	8,626.00	0.00
Total:	274,261.19	161,216.61	113,044.58	0.00

Claims by Nature of Injury

Nature of Injury	Frequency	%	Total Incurred	%	Average/Claim	%	Total Paid	%
All Other Cumulative Trauma	1	1	12,763	2	12,763	156	337	100
Cancer	2	2	28,285	4	14,142	173	0	0
Contusion	5	6	3,110	0	622	8	1,375	80
Dermatitis	1	1	145	0	145	2	145	8
Foreign Body	2	2	1,317	0	658	8	281	13
Fracture	2	2	19,000	3	9,500	116	12,878	86
Hearing Loss (Cumulative)	1	1	9,550	1	9,550	117	0	0
Hernia	3	4	71,900	11	23,967	293	9,854	40
Inflammation	1	1	174	0	174	2	174	1
Laceration	5	6	2,017	0	403	5	2,017	7
Miscellaneous	5	6	1,032	0	206	3	1,032	4
Multi Physical Injuries	1	1	4,200	1	4,200	51	311	1
Puncture	4	5	858	0	215	3	858	3
Respiratory Disorders	1	1	12,735	2	12,735	156	0	0
Sprain	8	10	89,889	14	11,236	137	8,609	23
Strain	38	48	397,836	61	10,469	128	120,550	76

Claims By Nature Of Injury

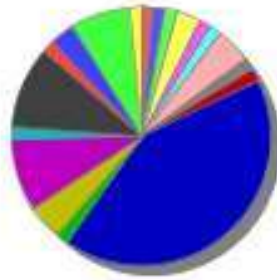


● All Other Cumulative Trauma = 1 ● Cancer = 2 ● Contusion = 5
● Dermatitis = 1 ● Foreign Body = 2 ● Fracture = 2
● Hearing Loss (Cumulative) = 1 ● Hernia = 3 ● Inflammation = 1
● Laceration = 5 ● Miscellaneous = 5 ● Multi Physical Injuries = 1
● Puncture = 4 ● Respiratory Disorders = 1 ● Sprain = 8
● Strain = 38

Claims by Claim Cause

Claim Cause	Frequency	%	Total Incurred	%	Average/Claim	%
Cut/Scraped by Broken Glass	1	1	37,469	3	37,469	198
Cut/Scraped by Other Object	1	1	143	0	143	1
Fall on Same Level	1	1	16,750	1	16,750	89
Fall on Stairs	2	3	1,959	0	979	5
Foreign Matter/Object in Eye	1	1	377	0	377	2
Hit by Falling/Flying Object	1	1	0	0	0	0
Hit/Injured by Animal/Insect	3	4	23,606	2	7,869	42
Holding or Carrying	1	1	9,000	1	9,000	48
Lifting	1	1	57,063	5	57,063	302
Miscellaneous Cause	28	42	848,061	67	30,288	160
Miscellaneous Exposure/Contact	1	1	430	0	430	2
Miscellaneous Fall or Slip	3	4	54,542	4	18,181	96
Miscellaneous Strain	6	9	61,517	5	10,253	54
Miscellaneous Vehicle Accident	1	1	2,944	0	2,944	16
Other Cumulative Trauma	7	10	110,382	9	15,769	83
Pushing or Pulling	1	1	1,772	0	1,772	9
Reaching	2	3	14,950	1	7,475	40
Repetitive Motion	5	7	15,286	1	3,057	16
Vehicle Upset	1	1	9,859	1	9,859	52

Claims By Claim Cause

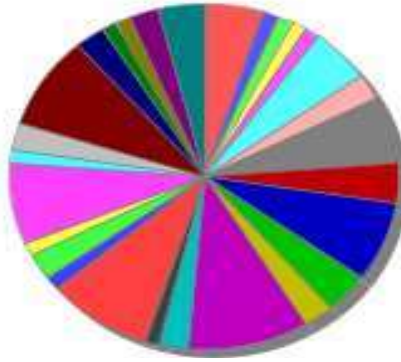


- Cut/Scraped by Broken Glass = 1 ● Cut/Scraped by Other Object = 1
- Fall on Same Level = 1 ● Fall on Stairs = 2
- Foreign Matter/Object in Eye = 1 ● Hit by Falling/Flying Object = 1
- Hit/Injured by Animal/Insect = 3 ● Holding or Carrying = 1
- Lifting = 1 ● Miscellaneous Cause = 28
- Miscellaneous Exposure/Contact = 1
- Miscellaneous Fall or Slip = 3 ● Miscellaneous Strain = 6
- Miscellaneous Vehicle Accident = 1 ● Other Cumulative Trauma = 7
- Pushing or Pulling = 1 ● Reaching = 2 ● Repetitive Motion = 5
- Vehicle Upset = 1

Claims by Body Part

Body Part	Frequency	%	Total Incurred	%	Average/Claim	%
Abdomen/Groin	4	5	72,427	11	18,107	221
Ankle	1	1	915	0	915	11
Buttock(s)	1	1	198	0	198	2
Chest (Ribs/Sternum/Other)	1	1	280	0	280	3
Ear(s)	1	1	9,550	1	9,550	117
Elbow	4	5	7,208	1	1,802	22
Eye(s)	2	2	1,317	0	658	8
Facial Soft Tissue	5	6	41,556	6	8,311	102
Finger(s)	3	4	921	0	307	4
Foot	6	8	22,054	3	3,676	45
Hand	3	4	462	0	154	2
Head Injury	2	2	1,345	0	673	8
Knee	8	10	98,508	15	12,313	150
Lower Arm	2	2	4,436	1	2,218	27
Lower Leg	1	1	145	0	145	2
Lumbar/Sacral Vertebrae	7	9	197,357	30	28,194	344
Lung(s)	1	1	12,735	2	12,735	156
Miscellaneous	2	2	761	0	381	5
Mouth	1	1	0	0	0	0
Multiple Body Parts	6	8	53,555	8	8,926	109
Multiple Trunk	1	1	11,215	2	11,215	137
Neck	2	2	2,589	0	1,294	16
Shoulder(s)	7	9	28,002	4	4,000	49
Thoracic and Lumbar	2	2	1,101	0	551	7
Thumb	1	1	95	0	95	1
Upper Arm/Clavicle/Scapula	1	1	81,435	12	81,435	995
Upper Leg	2	2	476	0	238	3
Wrist	3	4	4,167	1	1,389	17

Claims By Body Part



● Abdomen/Groin = 4	● Ankle = 1	● Buttock(s) = 1
● Chest (Ribs/Sternum/Other) = 1	● Ear(s) = 1	● Elbow = 4
● Eye(s) = 2	● Facial Soft Tissue = 5	● Finger(s) = 3
● Foot = 6	● Hand = 3	● Head Injury = 2
● Knee = 8	● Lower Arm = 2	● Lower Leg = 1
● Lumbar/Sacral Vertebrae = 7	● Lung(s) = 1	● Miscellaneous = 2
● Mouth = 1	● Multiple Body Parts = 6	● Multiple Trunk = 1
● Neck = 2	● Shoulder(s) = 7	● Thoracic and Lumbar = 2
● Thumb = 1	● Upper Arm/Clavicle/Scapula = 1	● Upper Leg = 2
● Wrist = 3		

Workers' Compensation Claims Closed this Month

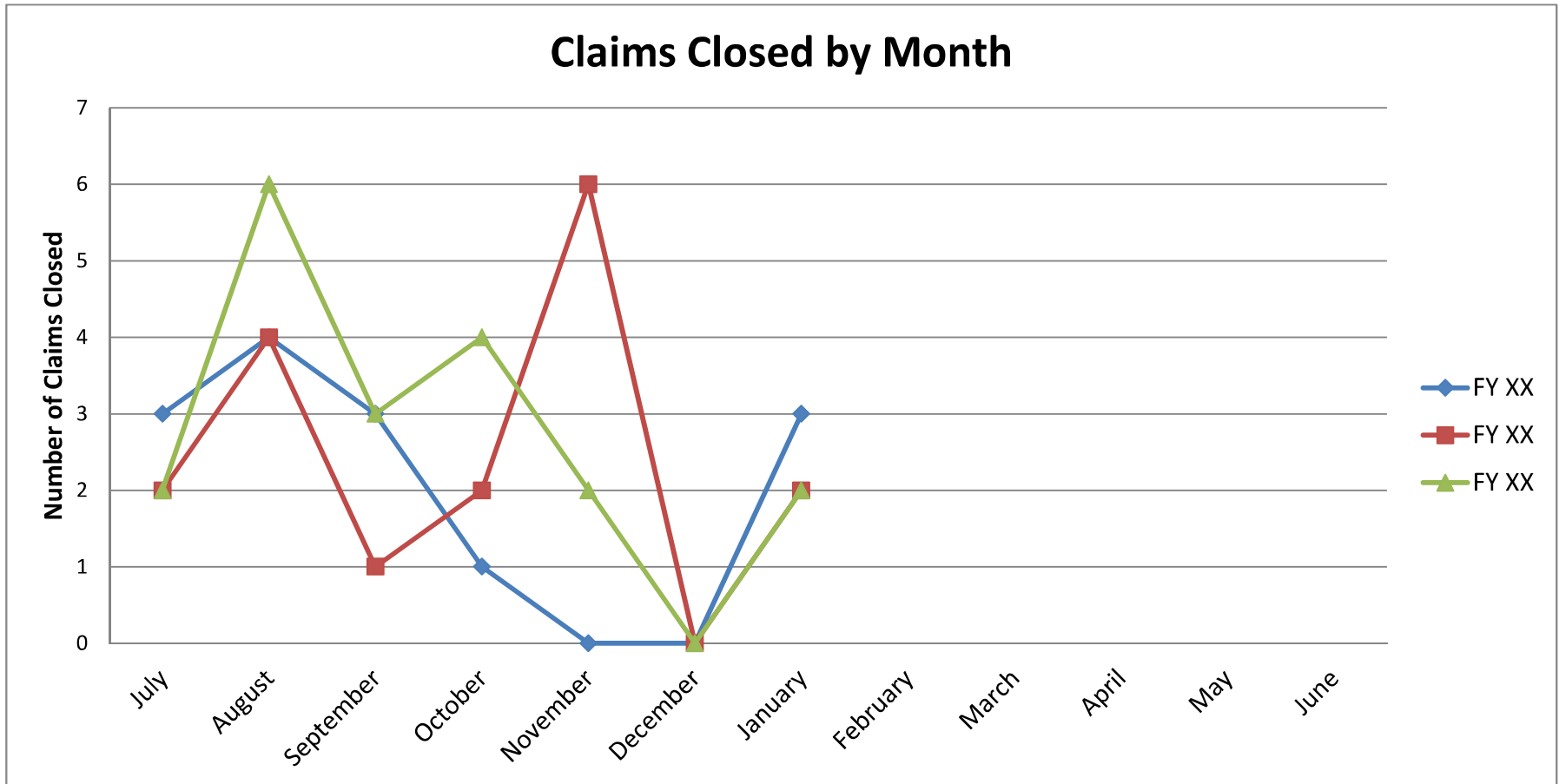
For Month Ending

Employee's Name Cause of Injury Description of Injury	Case No. Status	Department Claim Type	Injury Date Closing Date Days Lost		Paid this Period	Paid	Outstanding	Incurred	Recovery
He rolled his ankle on uneven ground when jumping over a fence Right ankle fracture	14-119454 Closed	PUBSAF 411 Indemnity	05/25/2014 03/23/2015 44.00	Medical	0.00	2,307.97	0.00	2,307.97	0.00
				TD	0.00	9,023.68	0.00	9,023.68	0.00
				PD	0.00	0.00	0.00	0.00	0.00
				Rehab	0.00	0.00	0.00	0.00	0.00
				Other Indemnity	0.00	0.00	0.00	0.00	0.00
				Legal Expenses	0.00	0.00	0.00	0.00	0.00
				Other Expenses	0.00	158.97	0.00	158.97	0.00
				Total	0.00	11,490.62	0.00	11,490.62	0.00
Stepped on curb and right ankle rolled off curb while walking back to police Right ankle / Right foot strain	14-120530 Closed	PUBSAF 471 Medical Only	06/09/2014 03/12/2015 0.00	Medical	0.00	1,619.67	0.00	1,619.67	0.00
				TD	0.00	0.00	0.00	0.00	0.00
				PD	0.00	0.00	0.00	0.00	0.00
				Rehab	0.00	0.00	0.00	0.00	0.00
				Other Indemnity	0.00	0.00	0.00	0.00	0.00
				Legal Expenses	0.00	0.00	0.00	0.00	0.00
				Other Expenses	0.00	143.89	0.00	143.89	0.00
				Total	0.00	1,763.56	0.00	1,763.56	0.00
Continuous trauma; routine police duties contact with numerous people on course of TB Exposure	06IRV01238 Closed	PUBSAF Future Medical	11/16/2006 03/12/2015 0.00	Medical	0.00	452.59	0.00	452.59	0.00
				TD	0.00	0.00	0.00	0.00	0.00
				PD	0.00	0.00	0.00	0.00	0.00
				Rehab	0.00	0.00	0.00	0.00	0.00
				Other Indemnity	0.00	0.00	0.00	0.00	0.00
				Legal Expenses	0.00	0.00	0.00	0.00	0.00
				Other Expenses	0.00	9.00	0.00	9.00	0.00
				Total	0.00	461.59	0.00	461.59	0.00
Exposure to sun when responding to outdoor calls for service. Skin Cancer	11-110691 Closed	PUBSAF 481 Future Medical	03/25/2011 03/30/2015 4.00	Medical	0.00	695.16	0.00	695.16	0.00
				TD	0.00	563.84	0.00	563.84	0.00
				PD	0.00	0.00	0.00	0.00	0.00
				Rehab	0.00	0.00	0.00	0.00	0.00
				Other Indemnity	0.00	0.00	0.00	0.00	0.00
				Legal Expenses	0.00	0.00	0.00	0.00	0.00
				Other Expenses	0.00	344.65	0.00	344.65	0.00
				Total	0.00	1,603.65	0.00	1,603.65	0.00
(CONTINUOUS TRAUMA) Routine police duties, i.e., getting in and out of patrol car, Bilateral Shoulder Strain / Right Knee Strain	2009105552 Closed	PUBSAF 420 Future Medical	06/05/2009 03/12/2015 42.00	Medical	0.00	18,524.09	0.00	18,524.09	0.00
				TD	0.00	10,022.42	0.00	10,022.42	0.00
				PD	0.00	1,380.00	0.00	1,380.00	0.00
				Rehab	0.00	0.00	0.00	0.00	0.00
				Other Indemnity	0.00	0.00	0.00	0.00	0.00
				Legal Expenses	0.00	0.00	0.00	0.00	0.00
				Other Expenses	0.00	195.54	0.00	195.54	0.00
				Total	0.00	30,122.05	0.00	30,122.05	0.00

Workers' Compensation Claims Closed this Month

For Month Ending

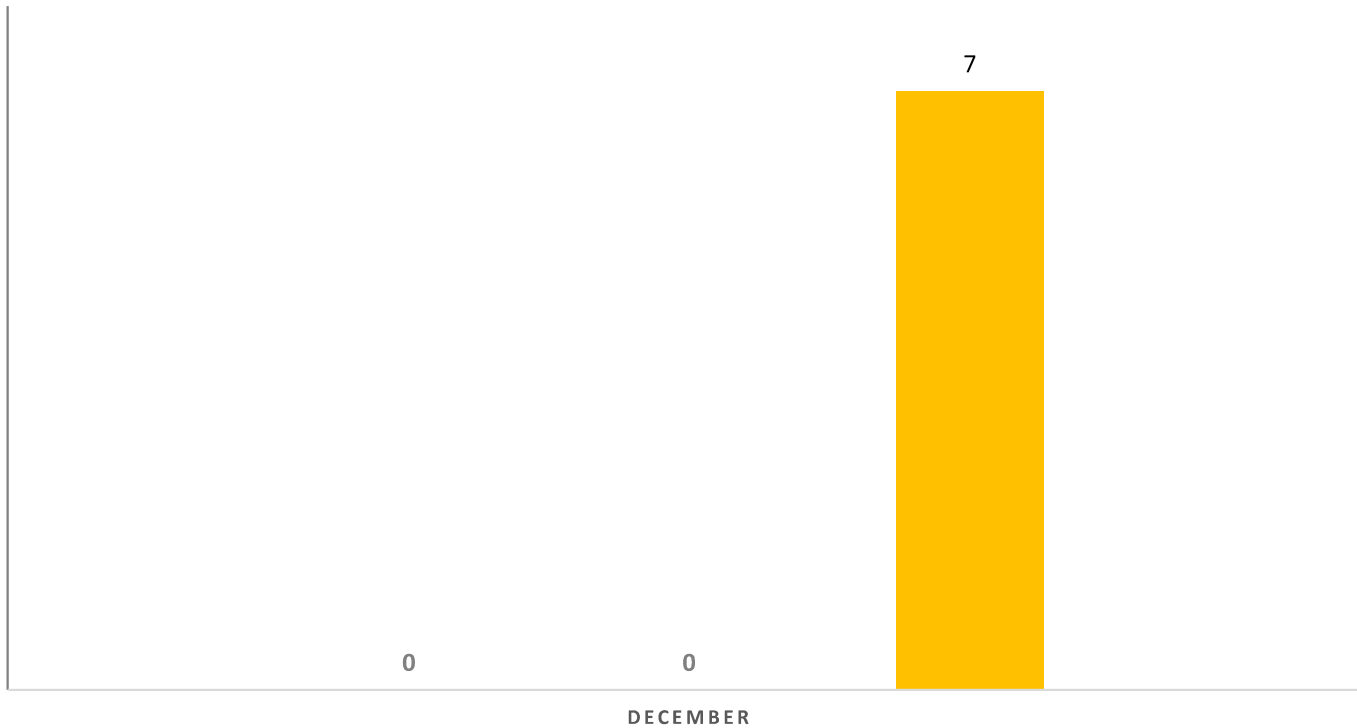
Employee's Name Cause of Injury Description of Injury	Case No. Status	Department Claim Type	Injury Date Closing Date Days Lost		Paid this Period	Paid	Outstanding	Incurred	Recovery
Strained low back, CT. wearing gunbelt, sitting in car, twisting in car to use Lower Back	05IRV01027 Closed	PUBSAF Future Medical	03/01/2005 03/26/2015 0.00	Medical	0.00	54,248.25	0.00	54,248.25	0.00
				TD	0.00	39,137.42	0.00	39,137.42	0.00
				PD	0.00	19,806.29	0.00	19,806.29	0.00
				Rehab	0.00	420.00	0.00	420.00	0.00
				Other Indemnity	0.00	0.00	0.00	0.00	0.00
				Legal Expenses	0.00	0.00	0.00	0.00	0.00
				Other Expenses	0.00	36.00	0.00	36.00	0.00
				Total	0.00	113,647.96	0.00	113,647.96	0.00
Developed pain in his right foot after participating in block training / baton use Right foot pain/plantar fascitis	14-121095 Closed	PUBSAF 471 Indemnity	10/07/2014 03/18/2015 0.00	Medical	0.00	952.51	0.00	952.51	0.00
				TD	0.00	0.00	0.00	0.00	0.00
				PD	0.00	0.00	0.00	0.00	0.00
				Rehab	0.00	0.00	0.00	0.00	0.00
				Other Indemnity	0.00	0.00	0.00	0.00	0.00
				Legal Expenses	0.00	0.00	0.00	0.00	0.00
				Other Expenses	0.00	191.47	0.00	191.47	0.00
				Total	0.00	1,143.98	0.00	1,143.98	0.00
Strained his lower abdominal area while participating in physical training at the police Lower abdomen / groin strain	14-121165 Closed	PUBSAF 411 Medical Only	11/20/2014 03/18/2015 0.00	Medical	119.12	491.16	0.00	491.16	0.00
				TD	0.00	0.00	0.00	0.00	0.00
				PD	0.00	0.00	0.00	0.00	0.00
				Rehab	0.00	0.00	0.00	0.00	0.00
				Other Indemnity	0.00	0.00	0.00	0.00	0.00
				Legal Expenses	0.00	0.00	0.00	0.00	0.00
				Other Expenses	10.25	36.08	0.00	36.08	0.00
				Total	129.37	527.24	0.00	527.24	0.00
Grand Total: 18				Medical	1,552.81	89,732.90	0.00	89,732.90	0.00
				TD	0.00	66,841.79	0.00	66,841.79	0.00
				PD	0.00	21,186.29	0.00	21,186.29	0.00
				Rehab	0.00	420.00	0.00	420.00	0.00
				Other Indemnity	0.00	0.00	0.00	0.00	0.00
				Legal Expenses	0.00	0.00	0.00	0.00	0.00
				Other Expenses	148.09	3,404.18	0.00	3,404.18	0.00
				Grand Total:	1,700.90	181,585.16	0.00	181,585.16	0.00



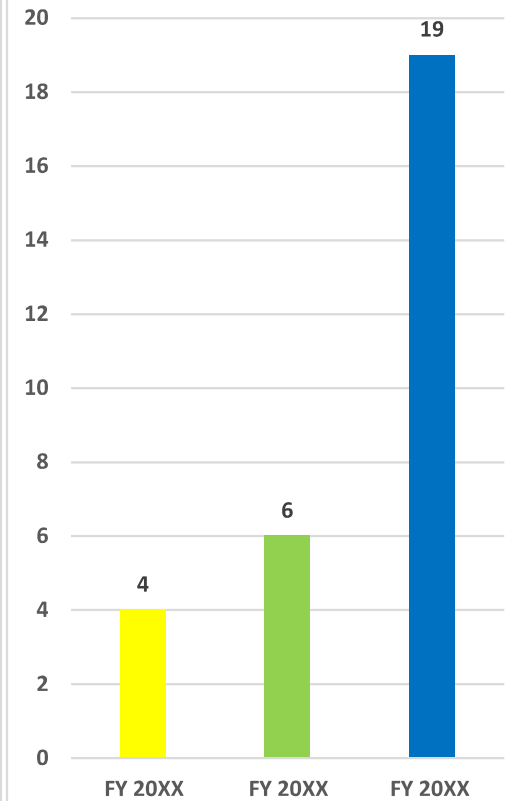
Measures the total number of claims that are closed in a month period. Ideally, we want to close more claims than are opened in a month. Closing the claims is an important factor in mitigating the overall cost of claims. The higher the number, the better.

CLAIMS CLOSED BY MONTH DECEMBER 20XX

■ FY XX ■ FY XX ■ FY XX



Claims Closed YTD Comparison



Measures the total number of claims that are closed in a month period. Ideally, we want to close more claims than are opened in a month. Closing the claims is an important factor in mitigating the overall cost of claims. The higher the number the better.

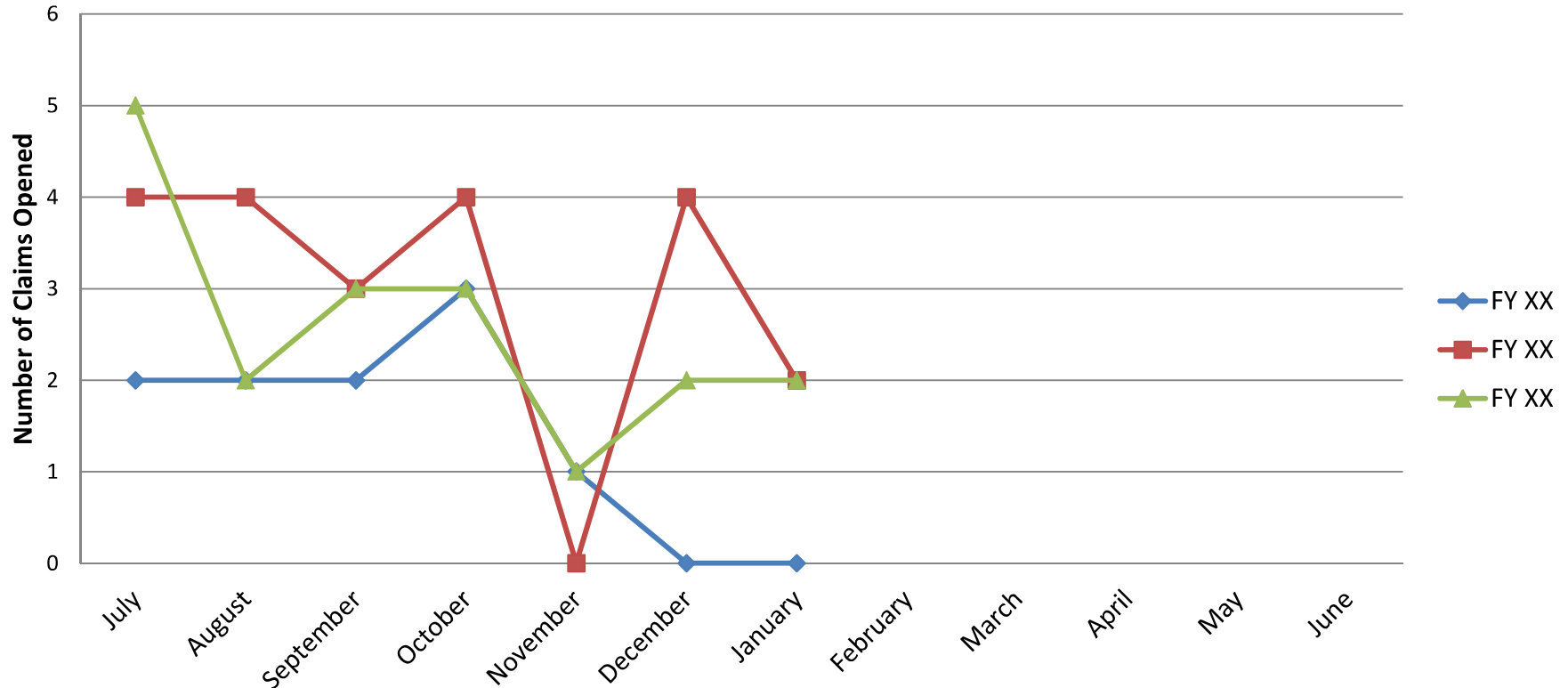
Workers' Compensation Claims Opened this Month

Employee's Name Cause of Injury Description of Injury	Case No. Status	Claim Type Department	Injury Date Days Lost		Paid this Period	Paid	Outstanding	Incurred	Recovery
Developed a hernia after his motorcycle struck a curb and Left Abdominal hernia	15-122031 Open	Indemnity PUBSAF 471	03/12/2015 0.00	Medical	0.00	0.00	10,000.00	10,000.00	0.00
				TD	0.00	0.00	11,006.40	11,006.40	0.00
				PD	0.00	0.00	0.00	0.00	0.00
				Rehab	0.00	0.00	0.00	0.00	0.00
				Other Indemnity	0.00	0.00	0.00	0.00	0.00
				Legal Expenses	0.00	0.00	0.00	0.00	0.00
				Other Expenses	0.00	0.00	1,150.00	1,150.00	0.00
				Total	0.00	0.00	22,156.40	22,156.40	0.00
While struggling with a combative mental health Left shoulder strain	15-122032 Open	Medical Only PUBSAF 411	03/19/2015 0.00	Medical	0.00	0.00	2,100.00	2,100.00	0.00
				TD	0.00	0.00	0.00	0.00	0.00
				PD	0.00	0.00	0.00	0.00	0.00
				Rehab	0.00	0.00	0.00	0.00	0.00
				Other Indemnity	0.00	0.00	0.00	0.00	0.00
				Legal Expenses	0.00	0.00	0.00	0.00	0.00
				Other Expenses	0.00	0.00	190.00	190.00	0.00
				Total	0.00	0.00	2,290.00	2,290.00	0.00
Sustained injury to his right wrist while digging post holes Right wrist sprain	15-122008 Open	Medical Only PUBWRK 551	03/20/2015 0.00	Medical	0.00	0.00	2,500.00	2,500.00	0.00
				TD	0.00	0.00	0.00	0.00	0.00
				PD	0.00	0.00	0.00	0.00	0.00
				Rehab	0.00	0.00	0.00	0.00	0.00
				Other Indemnity	0.00	0.00	0.00	0.00	0.00
				Legal Expenses	0.00	0.00	0.00	0.00	0.00
				Other Expenses	0.00	0.00	225.00	225.00	0.00
				Total	0.00	0.00	2,725.00	2,725.00	0.00
Exposure to sun during the course of work caused her to Left ear skin cancer	15-121893 Open	Indemnity PUBSAF 411	03/09/2015 0.00	Medical	0.00	0.00	10,000.00	10,000.00	0.00
				TD	0.00	0.00	9,500.00	9,500.00	0.00
				PD	0.00	0.00	0.00	0.00	0.00
				Rehab	0.00	0.00	0.00	0.00	0.00
				Other Indemnity	0.00	0.00	0.00	0.00	0.00
				Legal Expenses	0.00	0.00	0.00	0.00	0.00
				Other Expenses	0.00	0.00	1,350.00	1,350.00	0.00
				Total	0.00	0.00	20,850.00	20,850.00	0.00
EE was reaching for keys when his left thumb hit a Left Thumb Puncture Wound	15-121829 Closed	Medical Only PUBSAF 411	02/15/2015 0.00	Medical	83.26	83.26	0.00	83.26	0.00
				TD	0.00	0.00	0.00	0.00	0.00
				PD	0.00	0.00	0.00	0.00	0.00
				Rehab	0.00	0.00	0.00	0.00	0.00
				Other Indemnity	0.00	0.00	0.00	0.00	0.00
				Legal Expenses	0.00	0.00	0.00	0.00	0.00
				Other Expenses	11.94	11.94	0.00	11.94	0.00
				Total	95.20	95.20	0.00	95.20	0.00

Workers' Compensation Claims Opened this Month

Employee's Name Cause of Injury Description of Injury	Case No. Status	Claim Type Department	Injury Date Days Lost		Paid this Period	Paid	Outstanding	Incurred	Recovery
While cleaning the range area / walking in the parking lot on a Left eye irritation	15-121948 Open	Medical Only PUBSAF 411	03/12/2015 0.00	Medical	0.00	0.00	950.00	950.00	0.00
				TD	0.00	0.00	0.00	0.00	0.00
				PD	0.00	0.00	0.00	0.00	0.00
				Rehab	0.00	0.00	0.00	0.00	0.00
				Other Indemnity	0.00	0.00	0.00	0.00	0.00
				Legal Expenses	0.00	0.00	0.00	0.00	0.00
				Other Expenses	0.00	0.00	86.00	86.00	0.00
				Total	0.00	0.00	1,036.00	1,036.00	0.00
EE injured her left knee while walking and then colliding with Left knee contusion	15-121993 Open	Indemnity PUBSAF 423	12/12/2014 0.00	Medical	0.00	0.00	1,500.00	1,500.00	0.00
				TD	0.00	0.00	0.00	0.00	0.00
				PD	0.00	0.00	0.00	0.00	0.00
				Rehab	0.00	0.00	0.00	0.00	0.00
				Other Indemnity	0.00	0.00	0.00	0.00	0.00
				Legal Expenses	0.00	0.00	0.00	0.00	0.00
				Other Expenses	0.00	0.00	235.00	235.00	0.00
				Total	0.00	0.00	1,735.00	1,735.00	0.00
Grand Total: 7				Medical	83.26	83.26	27,050.00	27,133.26	0.00
				TD	0.00	0.00	20,506.40	20,506.40	0.00
				PD	0.00	0.00	0.00	0.00	0.00
				Rehab	0.00	0.00	0.00	0.00	0.00
				Other Indemnity	0.00	0.00	0.00	0.00	0.00
				Legal Expenses	0.00	0.00	0.00	0.00	0.00
				Other Expenses	11.94	11.94	3,236.00	3,247.94	0.00
				Grand Total:	95.20	95.20	50,792.40	50,887.60	0.00

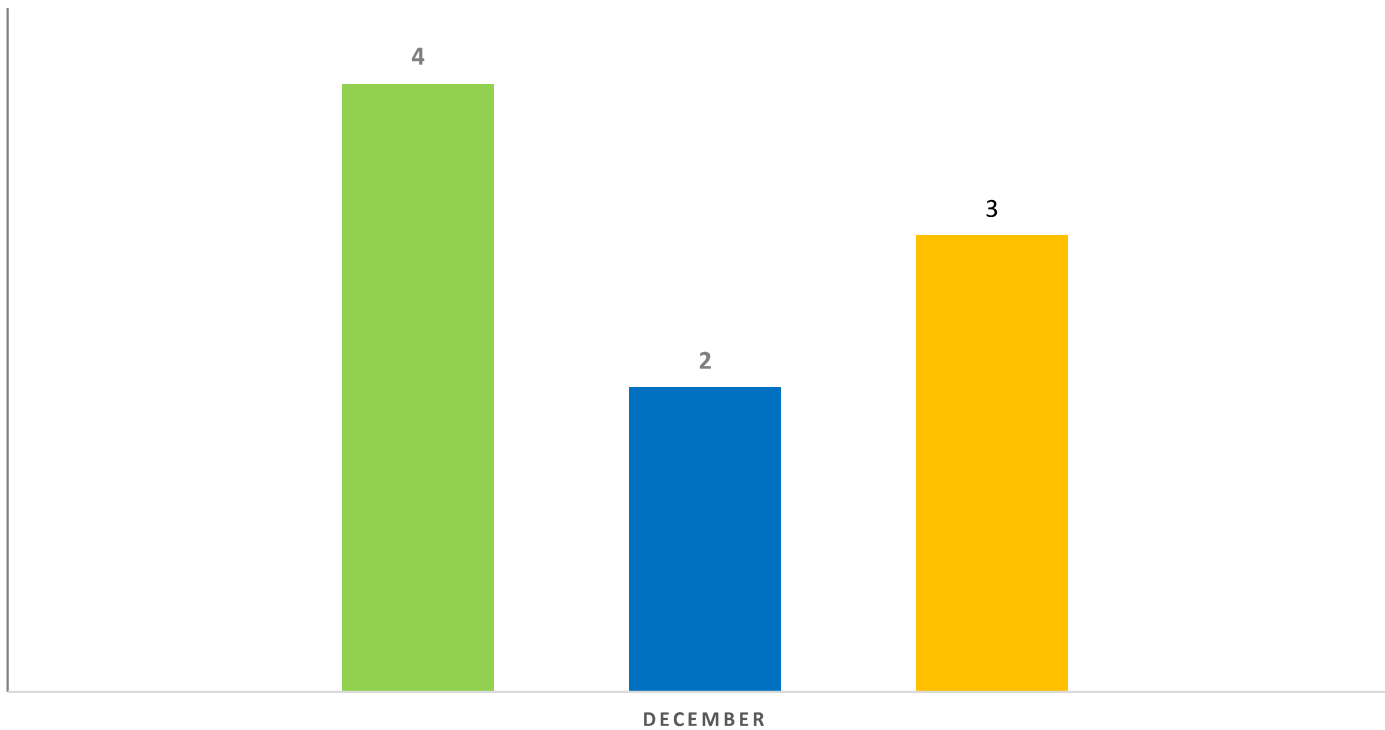
Claims Opened by Month



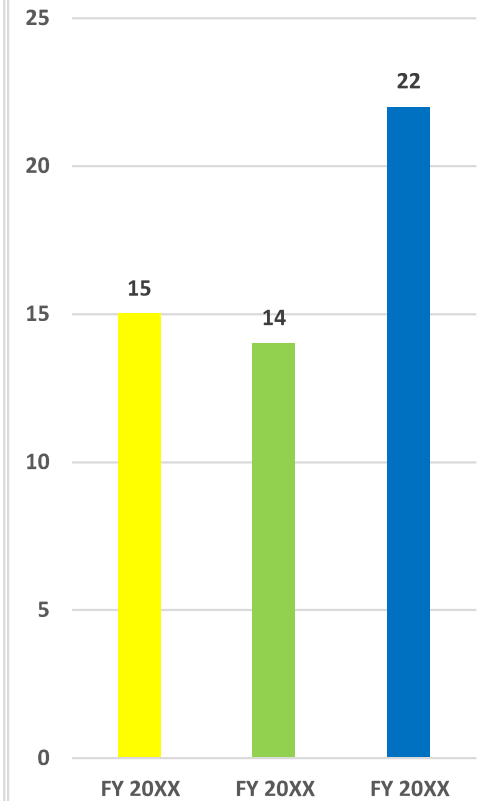
Measures the total number of new claims filed in a month. This number includes claims that have been or may be denied. This number may reflect unsafe work practices or morale problems. Typically the cost associated with these claims become most prevalent two years later. The lower the number the better.

CLAIMS OPENED BY MONTH DECEMBER 20XX

■ FY XX ■ FY XX ■ FY XX



Claims Opened YTD Comparison



Measures the total number of new claims filed in a month. This number includes claims that have been or may be denied. This number may reflect unsafe work practices or morale problems. Typically the cost associated with these claims become most prevalent two years later. The lower the number the better.

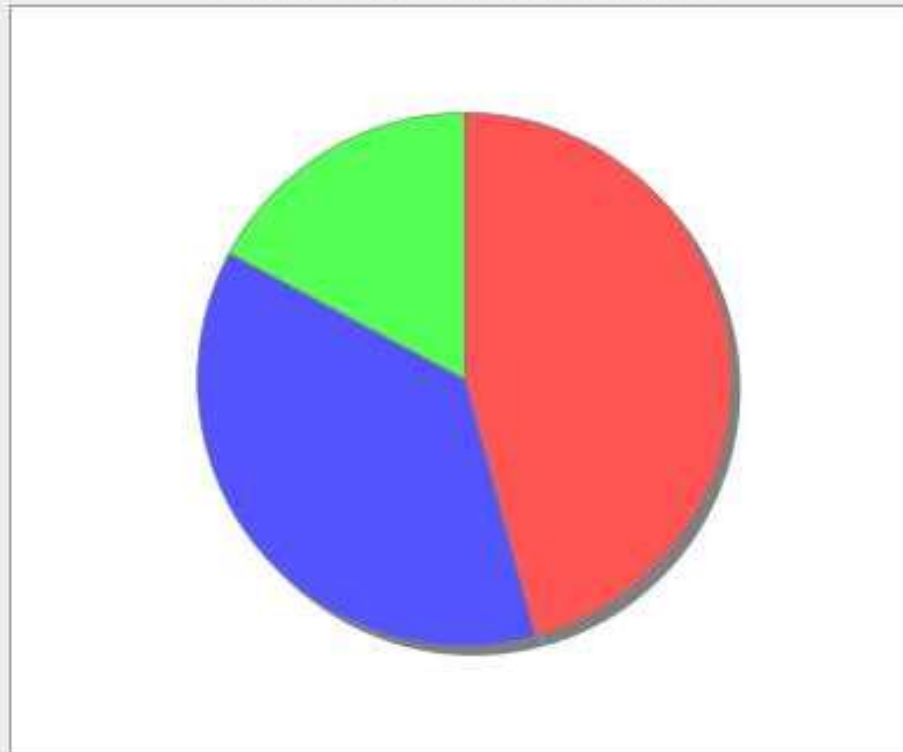
Claim Lag Time

Claim Number	Claimant	Incident Date	Insured Reported	Days between Incident/Reported	Adjusting Loc. Received	Days between Reported/Received	Days between Incident/Received
15-121829		02/15/2015	02/20/2015	5	03/03/2015	11	16
15-121893		03/09/2015	03/09/2015	0	03/09/2015	0	0
15-121948		03/12/2015	03/12/2015	0	03/16/2015	4	4
15-121993		12/12/2014	03/19/2015	97	03/23/2015	4	101
15-122008		03/20/2015	03/20/2015	0	03/24/2015	4	4
15-122031		03/12/2015	03/27/2015	15	03/27/2015	0	15
15-122032		03/19/2015	03/26/2015	7	03/27/2015	1	8
Grand Total: 7			Median Lag Time:	5.00		4.00	8.00
			Average Lag Time:	17.71		3.43	21.14

Litigated Claims by Claimant Type

Claimant Type	Open Count	Closed Count	Frequency	%	Total Incurred	%	Average/Claim	%
Future Medical	32	0	32	46	5,585,257	34	174,539	74
Indemnity	26	0	26	37	5,117,056	31	196,810	83
Indemnity/Future Medical	12	0	12	17	5,883,500	35	490,292	207
Grand Total:			70		16,585,813		236,940	

Claims By Claimant Type



● Future Medical = 32
 ● Indemnity = 26
● Indemnity/Future Medical = 12

Work Status

Claim Number	Claimant	Injury Date	Exam Date	Next Appointment Date	Work Status	Accepted Delayed Denied	Work Status/Restrictions
11-110678		03/12/2011	12/29/2014	03/22/2015	Temporary Total Disability	Y N N	TTD
14-119529		06/03/2014	01/27/2015	03/10/2015	Full Time / Modified Duty	N N N	No squatting/kneeling; No climbing ladders greater than 6 feet
14-119538		03/31/2014	01/19/2015	03/12/2015	Part Time / Modified Duty	N N N	continue working 4 hours per day
14-120344		08/07/2014	03/03/2015	03/31/2015	Full Time / Modified Duty	Y N N	40 hours per week; limited pushing, pulling reaching and overhead use
14-120784		10/15/2014	02/13/2015	03/09/2015	Full Time / Modified Duty	N N N	No heavy lifting greater than 25 lbs.; No repetitive lifting greater than 15 lbs.
14-120940		10/30/2014	01/22/2015	03/19/2015	Full Time / Modified Duty	N N N	No repetitive reaching, pushing, and pulling. Restricted to desk-type work and/or detective-type work; she should not be out in the field interacting with suspects where she may have to do takedowns, etc.
14-121112		11/30/2014	01/05/2015	03/04/2015	Full Time / Modified Duty	Y N N	NO FORCEFUL OR REP PUSH/PULLING WITH RIGHT HAND; NO LIFTING/PULLING/PUSHING OVER 10 LBS
15-121893		03/09/2015	03/10/2015	03/23/2015	Full Time / Modified Duty	N N N	
15-121993		12/12/2014	02/27/2015	03/27/2015	Full Time / Modified Duty	N Y N	Limited kneeling
15-122008		03/20/2015	03/20/2015	03/27/2015	Part Time / Modified Duty	Y N N	Must use splint or brace, no use of right hand.

Grand Total: 11

Claims Settled Last Month

Claimant	Claim Number	Injury - Date	Claim Type	Litigated	Examiner	Settle - Date	Settlement Type	Settlement Amount
	12-113827	06/28/2012	Future Medical	N	RBARRILE	03/06/2015	Stipulated Award	0.00

Workers' Compensation Claims Summary by Year

For Month Ending

Policy Period by Date of Injury	Open	Total Claims	Days Lost	Paid This Period	Incurred This Period	Paid	Outstanding	Incurred	Recovery	Net Incurred
1965-1966	0	1	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1975-1976	0	1	0.00	0.00	0.00	2,090.75	0.00	2,090.75	0.00	2,090.75
1976-1977	0	1	0.00	0.00	0.00	14,876.35	0.00	14,876.35	0.00	14,876.35
1977-1978	0	4	0.00	0.00	0.00	38,799.00	0.00	38,799.00	0.00	38,799.00
1978-1979	0	11	0.00	0.00	0.00	76,978.34	0.00	76,978.34	0.00	76,978.34
1979-1980	0	71	0.00	0.00	0.00	49,930.23	0.00	49,930.23	0.00	49,930.23
1980-1981	0	83	0.00	0.00	0.00	59,062.56	0.00	59,062.56	0.00	59,062.56
1981-1982	0	86	0.00	0.00	0.00	267,454.57	0.00	267,454.57	129,444.76	138,009.81
1982-1983	0	85	0.00	0.00	0.00	470,412.11	0.00	470,412.11	54,895.72	415,516.39
1983-1984	1	76	0.00	0.00	0.00	407,527.67	24,733.32	432,260.99	0.00	432,260.99
1984-1985	0	81	0.00	0.00	0.00	85,430.78	0.00	85,430.78	0.00	85,430.78
1985-1986	0	99	0.00	0.00	0.00	316,736.66	0.00	316,736.66	0.00	316,736.66
1986-1987	0	117	0.00	0.00	0.00	479,259.74	0.00	479,259.74	0.00	479,259.74
1987-1988	0	90	0.00	0.00	0.00	274,088.14	0.00	274,088.14	0.00	274,088.14
1988-1989	0	135	0.00	0.00	0.00	394,446.77	0.00	394,446.77	0.00	394,446.77
1989-1990	1	115	0.00	102.01	0.00	698,313.80	103,577.75	801,891.55	210.00	801,681.55
1990-1991	2	120	0.00	0.00	0.00	1,298,327.03	123,252.72	1,421,579.75	0.00	1,421,579.75
1991-1992	1	108	0.00	230.82	0.00	740,442.90	12,122.18	752,565.08	0.00	752,565.08
1992-1993	2	159	0.00	378.54	0.00	1,010,352.31	98,804.44	1,109,156.75	0.00	1,109,156.75
1993-1994	1	141	0.00	0.00	0.00	1,082,444.32	91,424.43	1,173,868.75	37,132.79	1,136,735.96
1994-1995	3	124	0.00	2,074.48	0.00	1,073,590.83	170,078.06	1,243,668.89	97,654.52	1,146,014.37
1995-1996	3	105	1498.00	2,462.06	-205,093.45	1,846,429.19	182,414.93	2,028,844.12	170,769.13	1,858,074.99
1996-1997	0	118	0.00	0.00	0.00	582,548.68	0.00	582,548.68	14,370.10	568,178.58
1997-1998	4	112	0.00	18.00	0.00	1,053,564.84	289,142.08	1,342,706.92	3,000.00	1,339,706.92

Workers' Compensation Claims Summary by Year

For Month Ending

Policy Period by Date of Injury	Open	Total Claims	Days Lost	Paid This Period	Incurred This Period	Paid	Outstanding	Incurred	Recovery	Net Incurred
1998-1999	2	123	0.00	0.00	0.00	1,182,484.06	72,249.67	1,254,733.73	16,500.00	1,238,233.73
1999-2000	3	106	0.00	0.00	0.00	1,943,619.07	75,846.55	2,019,465.62	84,632.72	1,934,832.90
2000-2001	8	110	419.00	2,216.45	0.00	2,540,887.38	821,560.28	3,362,447.66	195,693.10	3,166,754.56
2001-2002	9	121	10.00	1,930.14	5,767.87	2,270,590.18	666,566.48	2,937,156.66	15,000.00	2,922,156.66
2002-2003	9	117	2882.00	848.01	0.00	1,537,003.04	557,801.03	2,094,804.07	23,643.00	2,071,161.07
2003-2004	5	132	412.00	3,975.29	750.00	1,323,512.19	244,294.66	1,567,806.85	18,146.75	1,549,660.10
2004-2005	7	128	620.00	4,039.84	-64,959.29	2,602,584.01	1,254,260.33	3,856,844.34	584,164.00	3,272,680.34
2005-2006	11	130	1093.00	3,015.26	0.00	1,902,690.49	641,943.25	2,544,633.74	39,545.22	2,505,088.52
2006-2007	8	121	2009.00	1,210.54	-7,410.08	1,260,739.15	238,993.83	1,499,732.98	6,716.04	1,493,016.94
2007-2008	5	118	1867.00	34.25	-100.00	877,640.41	143,009.65	1,020,650.06	1,194.34	1,019,455.72
2008-2009	10	135	4125.00	5,519.15	-18,387.14	2,390,267.05	1,188,804.22	3,579,071.27	187,328.09	3,391,743.18
2009-2010	14	108	2558.00	5,320.26	0.00	1,505,808.30	789,623.48	2,295,431.78	1,844.10	2,293,587.68
2010/2011	17	113	3190.00	17,747.45	-49,323.61	1,446,772.17	573,167.48	2,019,939.65	50,717.86	1,969,221.79
2011/2012	22	115	1866.00	23,030.56	6,000.13	1,249,010.86	1,019,303.82	2,268,314.68	1,858.23	2,266,456.45
2012/2013	26	111	2455.00	13,295.06	5,174.53	1,030,373.67	1,043,377.25	2,073,750.92	2,190.65	2,071,560.27
2013/2014	35	142	2153.00	37,601.33	15,198.37	987,335.96	860,877.02	1,848,212.98	0.00	1,848,212.98
2014/2015	35	80	248.00	49,237.36	252,096.70	158,420.27	496,390.80	654,811.07	0.00	654,811.07
Grand Total:	244	4053		174,286.86	-60,285.97	38,532,845.83	11,783,619.71	50,316,465.54	1,736,651.12	48,579,814.42

Workers' Compensation Claims Transaction Report

For Month Ending

Number	Date	Amount	Payee	From	Thru	Claimant	Code	Claim Number
Payment Transaction Desc: Chiropractic Treatment								
74840	03/04/2015	165.66	Ideal Chiropractic	01/29/2015	02/12/2015		PUBSAF	03IRV00765
74814	03/04/2015	330.08	Higuera, Ron J. D.C., M.S.	01/28/2015	02/06/2015		PUBSAF	11-112189
74866	03/11/2015	172.30	Higuera, Ron J. D.C., M.S.	02/11/2015	02/11/2015		PUBSAF	11-112189
75020	03/18/2015	150.80	Higuera, Ron J. D.C., M.S.	02/18/2015	02/20/2015		PUBSAF	11-112189
75073	03/25/2015	138.63	Higuera, Ron J. D.C., M.S.	02/20/2015	02/25/2015		PUBSAF	11-112189
Payment	5	957.47						
Payment Transaction Desc: Court Reporter Expense								
75132	03/25/2015	508.90	Peranich Reporting	11/21/2014	11/21/2014		COMSRV	01IRV00531
75130	03/25/2015	958.75	BARRETT REPORTING INC	02/13/2015	02/13/2015		PUBSAF	04IRV00895
Payment	2	1,467.65						
Payment Transaction Desc: Medical Appliance								
74815	03/04/2015	168.00	Team Makena, LLC	01/09/2015	01/09/2015		PUBSAF	13-117025
74978	03/18/2015	83.95	Recovery Medical Services, LLC	02/20/2015	02/20/2015		PUBSAF	14-117491
75086	03/25/2015	131.16	Team Makena, LLC	02/23/2015	02/23/2015		PUBWRK	14-119045
75084	03/25/2015	145.86	South Coast Medical	02/27/2015	02/27/2015		COMSRV	9303140150
75087	03/25/2015	150.00	A+ Medical Supplies	02/23/2015	02/23/2015		PUBSAF	14-117468
75062	03/25/2015	400.00	Advanced Hearing Services	03/10/2015	03/10/2015		PUBSAF	9603140097
Payment	6	1,078.97						
Payment Transaction Desc: Medical Case Management								
74852	03/04/2015	1,881.00	Comp Nurse Solutions	01/12/2015	02/20/2015		PUBSAF	14-119538
75047	03/18/2015	671.00	CNS LLC	02/07/2015	03/04/2015		PUBWRK	13-116144
75138	03/25/2015	836.00	CNS LLC	01/10/2015	03/13/2015		PUBWRK	14-119045
Payment	3	3,388.00						

Workers' Compensation Claims Transaction Report

For Month Ending

Number	Date	Amount	Payee	From	Thru	Claimant	Code	Claim Number
75121	03/25/2015	104.21	Prosport Physical Therapy RSM	02/27/2015	02/27/2015		PUBSAF	2009105542
75114	03/25/2015	107.25	The Kinetic Chain Physical Therapy	02/24/2015	02/24/2015		PUBSAF	14-120344
75112	03/25/2015	184.20	Gateway Rehab and Wellness	02/25/2015	02/27/2015		PUBSAF	14-120865
75113	03/25/2015	219.27	The Kinetic Chain Physical Therapy	02/26/2015	03/03/2015		PUBSAF	14-120344
75115	03/25/2015	303.68	Gateway Rehab and Wellness	02/13/2015	02/19/2015		PUBSAF	14-120865
75116	03/25/2015	624.83	ACIC Physical Therapy	01/07/2015	01/29/2015		PUBSAF	14-117491
75068	03/25/2015	104.21	Prosport Physical Therapy RSM	02/20/2015	02/20/2015		PUBSAF	14-120940
75069	03/25/2015	104.21	Prosport Physical Therapy RSM	02/18/2015	02/18/2015		PUBSAF	14-120940
75070	03/25/2015	104.21	Prosport Physical Therapy RSM	02/11/2015	02/11/2015		PUBSAF	14-120940
75071	03/25/2015	104.21	Prosport Physical Therapy RSM	02/26/2015	02/26/2015		PUBSAF	14-121237
75072	03/25/2015	105.69	Fairbanks Power Physical Therapy	02/23/2015	02/23/2015		PUBSAF	8403140001
75067	03/25/2015	110.29	California Rehabilitation & Sports	03/02/2015	03/02/2015		COMDEV	15-121330
75083	03/25/2015	242.68	MSC Group, Inc	01/05/2015	01/05/2015		PUBSAF	2009105542
Payment	60	8,219.82						
Grand Total:	257	68,369.03						

Client Name
Bank Name

Bank Statement Balance:	\$180,273.84
Less: Outstanding Checks:	(\$21,373.82)
Reconciled Bank Balance:	\$158,900.02
Less: Bank Adjustments & Errors	\$0.00
Adjusted Checkbook Balance:	\$158,900.02

Difference	\$0.00
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Bank Adjustment & Error Detail:	\$0.00
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Minimum Trust Amount:	\$0.00
Reconciled Bank Balance:	\$0.00
Funding Amount Needed:	\$0.00

Prior Month Funds Request Balance:	\$0.00
Disbursements Made This Period:	\$0.00
Less: Voids	\$0.00
Less: Interest Paid	\$0.00
Less: Credits Received This Period:	\$0.00

Funding Amount Due:	\$0.00
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CHECK RECONCILIATION REPORT

Check Date	Check Number	Payee	Check Amount	Cleared Amount	Outstanding Check Amount
12/19/14	19497	Hooman Rastegar, M.D.	\$146.91	\$0.00	\$146.91
01/05/15	19585	Peranich Reporting	\$620.50	\$0.00	\$620.50
02/10/15	19807	MedReview Inc.	\$41.02	\$41.02	\$0.00
02/11/15	19813	MedReview Inc.	\$1,020.16	\$1,020.16	\$0.00
02/11/15	19814	MedReview Inc.	\$146.34	\$146.34	\$0.00
02/12/15	19826	MedReview Inc.	\$187.25	\$187.25	\$0.00
02/12/15	19827	MedReview Inc.	\$60.00	\$60.00	\$0.00
02/12/15	19828	MedReview Inc.	\$1,466.65	\$1,466.65	\$0.00
02/13/15	19838	Apex Healthcare Medical Center, Inc.	\$219.59	\$219.59	\$0.00
02/13/15	19840	MedReview Inc.	\$1,231.34	\$1,231.34	\$0.00
02/13/15	19841	MedReview Inc.	\$69.06	\$69.06	\$0.00
02/13/15	19845	New Age Translations, Inc.	\$177.00	\$177.00	\$0.00
02/17/15	19851	MedReview Inc.	\$88.09	\$88.09	\$0.00
02/18/15	19869	Apex Healthcare Medical Center, Inc.	\$162.44	\$162.44	\$0.00
02/18/15	19870	Apex Healthcare Medical Center, Inc.	\$211.05	\$211.05	\$0.00
02/18/15	19871	Apex Healthcare Medical Center, Inc.	\$116.49	\$116.49	\$0.00
02/18/15	19875	B. Richard Burke DPM *	\$141.91	\$141.91	\$0.00
02/18/15	19877	MedReview Inc.	\$2,745.34	\$2,745.34	\$0.00
02/18/15	19878	MedReview Inc.	\$29.59	\$29.59	\$0.00
02/19/15	19885	Foundation Medical Group, Inc	\$130.19	\$130.19	\$0.00
02/19/15	19886	Alliance Urgent Care	\$72.24	\$72.24	\$0.00
02/19/15	19896	MedReview Inc.	\$215.85	\$215.85	\$0.00
02/19/15	19897	MedReview Inc.	\$110.81	\$110.81	\$0.00
02/19/15	19898	MedReview Inc.	\$11.30	\$11.30	\$0.00
02/20/15	19901	University Spine and Orthopedics	\$178.66	\$178.66	\$0.00
02/20/15	19903	San Bernardino Medical Orthopedic Group	\$235.22	\$235.22	\$0.00
02/20/15	19904	MedReview Inc.	\$636.44	\$636.44	\$0.00
02/23/15	19907	San Bernardino Medical Orthopedic Group	\$211.42	\$211.42	\$0.00
02/23/15	19908	SOUTH COAST DME	\$182.51	\$182.51	\$0.00
02/23/15	19909	Mh Express Pharmacy	\$119.34	\$119.34	\$0.00
02/23/15	19911	MedReview Inc.	\$288.62	\$288.62	\$0.00
02/23/15	19913	ISYS	\$384.00	\$384.00	\$0.00
02/24/15	19914	EA Integrated Health Services	\$96.90	\$96.90	\$0.00
02/24/15	19915	San Bernardino Medical Orthopedic Group	\$11.91	\$11.91	\$0.00
02/24/15	19916	MedReview Inc.	\$9.69	\$9.69	\$0.00
02/25/15	19917	John G. Ellis, M.D. Inc.	\$162.44	\$162.44	\$0.00

CHECK RECONCILIATION REPORT

Check Date	Check Number	Payee	Check Amount	Cleared Amount	Outstanding Check Amount
03/26/15	20169	Walgreens	\$16.57	\$0.00	\$16.57
03/26/15	20170	University Spine and Orthopedics	\$546.88	\$546.88	\$0.00
03/26/15	20171	Physical Medicine Institute	\$2,250.00	\$0.00	\$2,250.00
03/26/15	20172	Walgreens	\$13.63	\$0.00	\$13.63
03/26/15	20173	MedReview Inc.	\$1,031.55	\$0.00	\$1,031.55
03/26/15	20174	MedReview Inc.	\$86.47	\$0.00	\$86.47
03/27/15	20177	Arrowhead Evaluation Services, Inc.	\$5,000.00	\$0.00	\$5,000.00
03/27/15	20178	CompToday	\$9.14	\$0.00	\$9.14
03/27/15	20179	CompToday	\$8.74	\$0.00	\$8.74
03/27/15	20180	CompToday	\$28.38	\$0.00	\$28.38
03/27/15	20181	Healthpointe Med Grp dba SCOSMC	\$15.21	\$0.00	\$15.21
03/27/15	20182	Southern Calif Permanente Med Grp**	\$144.94	\$0.00	\$144.94
03/27/15	20183	CA Emerg Phys Med Grp	\$202.50	\$0.00	\$202.50
03/27/15	20184	Align Networks, Inc.	\$129.41	\$0.00	\$129.41
03/27/15	20185	Align Networks, Inc.	\$76.30	\$0.00	\$76.30
03/27/15	20186	Align Networks, Inc.	\$674.20	\$0.00	\$674.20
03/27/15	20187	Fairbanks Power Physical Therapy	\$112.11	\$0.00	\$112.11
03/27/15	20188	Fairbanks Power Physical Therapy	\$112.11	\$0.00	\$112.11
03/27/15	20189	Align Networks, Inc.	\$56.41	\$0.00	\$56.41
03/27/15	20190	Align Networks, Inc.	\$399.25	\$0.00	\$399.25
03/27/15	20191	Southland Spine & Rehab Med Ctr	\$39.18	\$0.00	\$39.18
03/27/15	20192	Fairbanks Power Physical Therapy	\$296.67	\$0.00	\$296.67
03/27/15	20193	Align Networks, Inc.	\$98.02	\$0.00	\$98.02
03/27/15	20194	MedReview Inc.	\$755.88	\$0.00	\$755.88
03/27/15	20195	MedReview Inc.	\$2,408.26	\$0.00	\$2,408.26
03/30/15	20196	CompToday	\$19.70	\$0.00	\$19.70
03/30/15	20197	MedReview Inc.	\$129.48	\$0.00	\$129.48
03/31/15	20199	Economy Transport LLC	\$648.00	\$0.00	\$648.00
03/31/15	20200	KAISER FOUNDATION HOSPITAL	\$487.53	\$0.00	\$487.53
03/31/15	20201	Southland Spine & Rehab Med Ctr	\$152.13	\$0.00	\$152.13
03/31/15	20202	Healthpointe Med Grp dba SCOSMC	\$1,898.43	\$0.00	\$1,898.43
03/31/15	20203	MedReview Inc.	\$329.34	\$0.00	\$329.34
03/31/15	20204	MedReview Inc.	\$998.44	\$0.00	\$998.44
GRAND TOTALS:			\$127,757.43	\$87,875.21	\$39,882.22

OSHA's Form 300

Log of Work-Related Injuries and Illnesses

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

You must record information about every work-related death and about every work-related injury or illness that involves loss of consciousness, restricted work activity or job transfer, days away from work, or medical treatment beyond first aid. You must also record significant work-related injuries and illnesses that are diagnosed by a physician or licensed health care professional. You must also record work-related injuries and illnesses that meet any of the specific recording criteria listed in 29 CFR Part 1904.8 through 1904.12. Feel free to use two lines for a single case if you need to. You must complete an Injury and Illness Incident Report (OSHA Form 301) or equivalent form for each injury or illness recorded on this form. If you're not sure whether a case is recordable, call your local OSHA office for help.

Form approved OMB no. 1218-0176

Establishment name

City State

Identify the person			Describe the case			Classify the case											
(A) Case no.	(B) Employee's name	(C) Job title <i>(e.g. Welder)</i>	(D) Date of injury or onset of illness	(E) Where the event occurred <i>(e.g. Loading dock north end)</i>	(F) Describe injury or illness, parts of body affected, and object/substance that directly injured or made person ill <i>(e.g. Second degree burns on right forearm from acetylene torch)</i>	CHECK ONLY ONE box for each case based on the most serious outcome for that case:				Enter the number of days the injured or ill worker was:		Check the "Injury" column or choose one type of illness:					
						Remained at Work				Away from work (K)	On job transfer or restriction (L)	(M) See The Legend Below					
						Death (G)	Days away from work (H)	Job Transfer or restriction (I)	Other record-able cases (J)			(1) (2) (3) (4) (5) (6)					
XXXXX	XXXXX	Police Department	03/12/2015	Other/unknown	Hernia Abdomen/Groin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	0.00 days	0.00 days	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
XXXXX	XXXXX	Police Department	03/19/2015	Other/unknown	Strain Shoulder(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	0.00 days	0.00 days	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
XXXXX	XXXXX	Public Works	03/20/2015	Other/unknown	Sprain Wrist	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	0.00 days	11.00 days	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
XXXXX	XXXXX	Police Department	03/09/2015	Other/unknown	Cancer Facial Soft Tissue	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	0.00 days	13.00 days	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
XXXXX	XXXXX	Police Department	02/15/2015	Other/unknown	Puncture Thumb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	0.00 days	0.00 days	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
XXXXX	XXXXX	Police Department	03/12/2015	FBI Range	Foreign Body Eye(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	0.00 days	0.00 days	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
XXXXX	XXXXX	Police Department	12/12/2014	Office	Contusion Knee	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	0.00 days	28.00 days	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grand Total						0	0	3	4	0.00	52.00	6	1	0	0	0	0
						(1)	(2)	(3)	(4)	(5)	(6)	(1)	(2)	(3)	(4)	(5)	(6)

Public reporting burden for this collection of information is estimated to average 14 minutes per response, including time to review the instructions, search and gather the data needed, complete and review the collection of information. Persons are not required to respond to the collection of information unless it displays a currently valid OMB control number. If you have any comments about these estimates or any other aspects of this data collection, contact: US Department of Labor, OSHA Office of Statistical Analysis, Room N-3644, 200 Constitution Avenue, NW, Washington, DC 20210. Do not send the completed forms to this office

Be sure to transfer these totals to the Summary page (Form 300A) before you post it.

Legend: 1- injury 2- Skin disorder 3- Respiratory condition 4- Poisoning 5- Hearing loss 6- All other illness

Summary of Work-Related Injuries and Illnesses



All establishments covered by Part 1904 must complete this Summary page, even if no work-related injuries or illnesses occurred during the year. Remember to review the Log to verify that the entries are complete and accurate before completing this summary.

Using the Log, count the individual entries you made for each category. Then write the totals below, making sure you've added the entries from every page of the Log. If you had no cases, write "0".

Employees, former employees, and their representatives have the right to review the OSHA Form 300 in its entirety. They also have limited access to the OSHA Form 301 or its equivalent. See 29 CFR Part 1094.35, in OSHA's recordkeeping rule, for further details on the access provisions for these forms

Number of Cases

Total number of deaths	Total number of cases with days away from work	Total number of cases with job transfer or restriction	Total number of other recordable cases
0	0	3	4
(G)	(H)	(I)	(J)

Number of Days

Total number of days away from work	Total number of days of job transfer or restriction
0.00	52.00
(K)	(L)

Injury and Illness Types

Total number of ... (M)			
(1) Injuries	6	(4) Poisonings	0
		(5) Hearing loss	0
(2) Skin disorders	1	(6) All other illnesses	0
(3) Respiratory conditions	0		

Post this Summary page from February 1 to April 30 of the year following the year covered by the form.

Public reporting burden for this collection of information is estimated to average 50 minutes per response, including time to review the instructions, search and gather the data needed, and complete and review the collection of information. Persons are required to respond to the collection of information unless it displays a currently valid OMB control number. If you have any comments about these estimates or any other aspects of this data collection, contact: US Department of Labor, OSHA Office of Statistical Analysis, Room N-3644, 200 Constitution Avenue, NW, Washington, DC 20210. Do not send the completed forms to this office.

Establishment information

Your establishment name

Street

CityStateCAZIP

Industry description (e.g., Manufacture of motor truck trailers)

Standard Industrial Classification (SIC), if known (e.g.,3715)

9229SC

OR

North American Industrial Classification (NAICS), if known (e.g.,336212)

Employment information (if you don't have these figures, see the Worksheet on the back of this page to estimate.)

Annual average number of employees

Total hours worked by all employees last year

Sign here

Knowingly falsifying this document may result in a fine.

Company executiveTitle

() - /

PhoneDate

OSHA's Form 301

Injury and Illnesses Incident Report

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes

Form approved OMB no. 1218-0176

This *Injury and illness Incident Report* is one of the first forms you must fill out when a recordable work-related injury or illness has occurred. Together with the *Log of Work-Related Injuries and Illnesses* and the accompanying *Summary*, these forms help the employer and OSHA develop a picture of the extent and severity of work-related incidents.

Within 7 calendar days after you receive information that a recordable work-related injury or illness has occurred, you must fill out this form or an equivalent. Some state workers' compensation, insurance, or other reports may be acceptable substitutes. To be considered an equivalent form, any substitute must contain all the information asked for on this form.

According to Public Law 91-596 and 29 CFR 1904, OSHA's recordkeeping rule, you must keep this form on file for 5 years following the year to which it pertains.

If you need additional copies of this form, you may photocopy and use as many as you need.

Completed by _____

Title _____

Phone (____) _____ - _____ Date ____/____/____

Information about the employee

- 1) Full name XXXXX
- 2) Street XXXXX
- City XXXXX State CA ZIP 92860
- 3) Date of birth 06/21/1960
- 4) Date hired 02/22/1996
- 5) ☒ Male ☐ Female

Information about the physician or other health care professional

- 6) Name of Physicians or other health care professional Sand Canyon Urgent Care
- 7) If treatment was given away from the worksite, where was it given?
- Facility _____
- Street _____
- City _____ State _____ ZIP _____

8) Was employee treated in an emergency room?

- ☐ Yes
- ☒ No

9) Was employee hospitalized overnight as an in-patient?

- ☐ Yes
- ☒ No

Information about the case

- 10) Case number from the Log XXXXX (Transfer the case number from the Log after you record the case.)
- 11) Date of injury or illness 02/15/2015
- 12) Time employee began work 6:00 AM
- 13) Time of event 6:00 PM ☐ check if time cannot be determined
- 14) What was the employee doing just before the incident occurred? Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. Examples: "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry."
Reaching for keys when thumb hit wooden storage box.
- 15) What happened? Tell us how the injury occurred. Examples: "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."
EE was reaching for keys when his left thumb hit a wooden storage box located in his patrol car and he received puncture wound from a splinter
- 16) What was the injury or illness? Tell us the part of the body that was affected and how it was affected; be more specific than "hurt," "pain," or score." Examples: "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."
Left Thumb Puncture Wound
- 17) What object or substance directly harmed the employee? Examples: "concrete floor"; "chlorine"; "radial arm saw." If this question does not apply to the incident, leave it blank.
N/A
- 18) If the employee died, when did death occur? Date of death _____

OSHA's Form 301

Injury and Illnesses Incident Report

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes

Form approved OMB no. 1218-0176

This *Injury and illness Incident Report* is one of the first forms you must fill out when a recordable work-related injury or illness has occurred. Together with the *Log of Work-Related Injuries and Illnesses* and the accompanying *Summary*, these forms help the employer and OSHA develop a picture of the extent and severity of work-related incidents.

Within 7 calendar days after you receive information that a recordable work-related injury or illness has occurred, you must fill out this form or an equivalent. Some state workers' compensation, insurance, or other reports may be acceptable substitutes. To be considered an equivalent form, any substitute must contain all the information asked for on this form.

According to Public Law 91-596 and 29 CFR 1904, OSHA's recordkeeping rule, you must keep this form on file for 5 years following the year to which it pertains.

If you need additional copies of this form, you may photocopy and use as many as you need.

Completed by _____

Title _____

Phone (____) _____ - _____ Date __/__/__

Information about the employee

1) Full name XXXXX

2) Street XXXXX

City XXXXX State CA ZIP 92705

3) Date of birth 04/27/1979

4) Date hired 12/27/1999

5) ☒ Male ☐ Female

Information about the physician or other health care professional

6) Name of Physicians or other health care professional Sand Canyon Urgent Care

7) If treatment was given away from the worksite, where was it given?

Facility _____

Street _____

City _____ State _____ ZIP _____

8) Was employee treated in an emergency room?

☐ Yes ☒ No

9) Was employee hospitalized overnight as an in-patient?

☐ Yes ☒ No

Information about the case

10) Case number from the Log XXXXX (Transfer the case number from the Log after you record the case.)

11) Date of injury or illness 03/19/2015

12) Time employee began work 6:00 AM

13) Time of event 1:13 PM ☐ check if time cannot be determined

14) **What was the employee doing just before the incident occurred?** Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. *Examples:* "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry."
Struggling with combative mental health patient

15) **What happened?** Tell us how the injury occurred. *Examples:* "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."
While struggling with a combative mental health patient, he injured his left shoulder

16) **What was the injury or illness?** Tell us the part of the body that was affected and how it was affected; be more specific than "hurt," "pain," or score." *Examples:* "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."
Left shoulder strain

17) **What object or substance directly harmed the employee?** *Examples:* "concrete floor"; "chlorine"; "radial arm saw." *If this question does not apply to the incident, leave it blank.*
N/A

18) **If the employee died, when did death occur?** Date of death _____

**WORKERS' COMPENSATION CLAIMS
CLIENT COMPARISON REPORT AS
OF**

Client	# of Employees	Total Paid This Quarter	Outstanding Reserves	Outstanding Reserves Per Total # of Employees	Total Incurred in Q1 2015 Total Pd Q1 + Outstanding	#of Open Claims	# of Open Litigated Claims
Client X	2,986	\$920,366.80	\$10,026,752.09	\$3,357.92	\$10,947,118.89	191	59
Client Y	4,623	\$988,715.96	\$13,758,746.45	\$2,976.15	\$14,747,462.41	231	80
AVERAGES	3,805	\$954,541.38	\$11,892,749.27	\$3,167.04	\$12,847,290.65	211	70

**WORKERS' COMPENSATION CLAIMS
FREQUENCY & SEVERITY BY NATURE OF INJURY
TOP TEN LISTED BY FREQUENCY
as of**

Client X

Nature of Injury	# of Claims	Total Incurred	Average Per Claim
Strain	88	\$9,244,148.00	\$114,620.00
Miscellaneous	24	\$731,037.00	\$30,460.00
Sprain	20	\$2,079,150.00	\$103,957.00
All Other Cumulative Trauma	13	\$1,464,653.00	\$112,666.00
Contusion	12	\$3,023,302.00	\$251,942.00
Fracture	8	\$531,734.00	\$66,467.00
Multi Physical Injuries	6	\$481,307.00	\$80,218.00
Mental Stress	6	\$123,189.00	\$20,531.00
All Other Specific Injury	4	\$62,769.00	\$15,692.00
Puncture	2	\$200,934.00	\$100,467.00
TOTAL	183	\$17,942,223.00	\$897,020.00

Client Y

Nature of Injury	# of Claims	Total Incurred	Average Per Claim
Strain	94	\$14,197,761.00	\$151,040.00
Miscellaneous	36	\$1,902,197.00	\$52,839.00
All Other Cumulative Trauma	25	\$4,789,022.00	\$191,561.00
Sprain	20	\$1,504,961.00	\$75,248.00
Contusion	19	\$2,104,025.00	\$110,738.00
Carpal Tunnel Syndrome	10	\$571,972.00	\$57,197.00
Fracture	7	\$597,706.00	\$85,387.00
Multi Physical/Mental injuries	5	\$470,084.00	\$94,017.00
Mental Stress	4	\$1,171,495.00	\$292,874.00
Contagious Disease	3	\$264,424.00	\$88,141.00
TOTAL	223	\$27,573,647.00	\$1,199,042.00

CLAIMS HANDLING ANALYSIS

# OF CLAIMS REPORTED PER YEAR						
	2010	2011	2012	2013	2014	2015
Future Medical	13	15	13	9	1	0
Indemnity	49	59	45	60	65	9
Medical Only	70	66	60	60	60	15
TOTAL	132	140	118	129	126	24

# OF LITIGATED CLAIMS						
	2010	2011	2012	2013	2014	2015
TOTAL	2	20	8	18	7	0

DAYS FROM EMPLOYEE'S INJURY TO DATE EMPLOYER NOTIFIED						
	2010	2011	2012	2013	2014	2015
Average Lag Time	9.38	94.23	18.77	23.39	58.61	12.17

DAYS FROM EMPLOYERS DATE OF KNOWLEDGE TO DATE REPORTED TO TPA						
	2010	2011	2012	2013	2014	2015
Average Lag Time	6.75	58.82	15.98	8.14	11.18	9.67

AVERAGE DAYS OPEN PER CLAM						
	2010	2011	2012	2013	2014	2015
Future Medical	1279	1203	967	614	434	37
Indemnity	432	460	481	338	205	39
Medical Only	78	97	54	71	78	38
Litigated	1663	1012	1064	619	351	0

AVERAGE # OF DAYS LOST PER CLAM						
	2010	2011	2012	2013	2014	2015
Future Medical	99	274	65	15	0	0
Indemnity	67	49	74	55	33	9
Medical Only	0	0	0	0	0	0
Litigated	122	299	304	136	43	0

CLAIM RATIOS

RATIO OF MEDICAL ONLY CLAIMS TO INDEMNITY CLAIMS											
	2010	2011	%	2012	%	2013	%	2014	%	2015	%
Medical Only	70	66	-6%	60	-9%	60	0%	60	0%	15	-75%
Indemnity	49	59	20%	45	-24%	60	33%	65	8%	9	-86%
TOTAL	119	125		105		120		125		24	

RATIO OF LITIGATED TO NON-LITIGATED CLAIMS											
	2010	2011	%	2012	%	2013	%	2014	%	2015	%
Litigated	2	20	900%	8	-60%	18	125%	7	-61%	0	-100%
Non-Litigated	130	120	-8%	110	-8%	111	1%	119	7%	24	-80%
TOTAL	132	140		118		129		126		24	

RATIO OF FUTURE MEDICAL TO NON-FUTURE MEDICAL CLAIMS											
	2010	2011	%	2012	%	2013	%	2014	%	2015	%
Future Medical	13	15	15%	13	-13%	9	-31%	1	-89%	0	-100%
Non-Future Medical	119	125	5%	105	-16%	120	14%	125	4%	24	-81%
TOTAL	132	140		118		129		126		24	

RATIO OF OPEN TO CLOSED CLAIMS											
	2010	2011	%	2012	%	2013	%	2014	%	2015	%
OPEN	7	13	86%	27	108%	30	11%	39	30%	18	-54%
CLOSED	125	127	2%	91	-28%	99	9%	87	-12%	6	-93%
TOTAL	132	140		118		129		126		24	

CLIENT X
AVERAGE CLAIM COSTS

AVERAGE COST PER CLAIM PER YEAR - MEDICAL ONLY											
	2010	2011	%	2012	%	2013	%	2014	%	2015	%
Medical	\$820.75	\$834.81	2%	\$662.51	-21%	\$924.85	40%	\$1,154.63	25%	\$1,266.40	10%
Temporary Disability	\$0.00	\$0.00	0%	\$0.00	0%	\$0.00	0%	\$0.00	0%	\$17.15	0%
Permanent Disability	\$0.00	\$0.00	0%	\$0.00	0%	\$0.00	0%	\$23.00	0%	\$0.00	0%
Voc Rehab	\$0.00	\$0.00	0%	\$0.00	0%	\$0.00	0%	\$0.00	0%	\$0.00	0%
Other Indem	\$0.00	\$0.00	0%	\$0.00	0%	\$0.00	0%	\$0.00	0%	\$0.00	0%
Legal	\$0.00	\$0.00	0%	\$0.00	0%	\$0.00	0%	\$0.00	0%	\$0.00	0%
Other	\$10.39	\$23.01	0%	\$2.43	0%	\$48.84	1910%	\$317.21	0%	\$134.58	-58%
TOTAL	\$831.14	\$857.82	3%	\$664.94	-22%	\$973.69	46%	\$1,494.84	54%	\$1,418.13	-5%

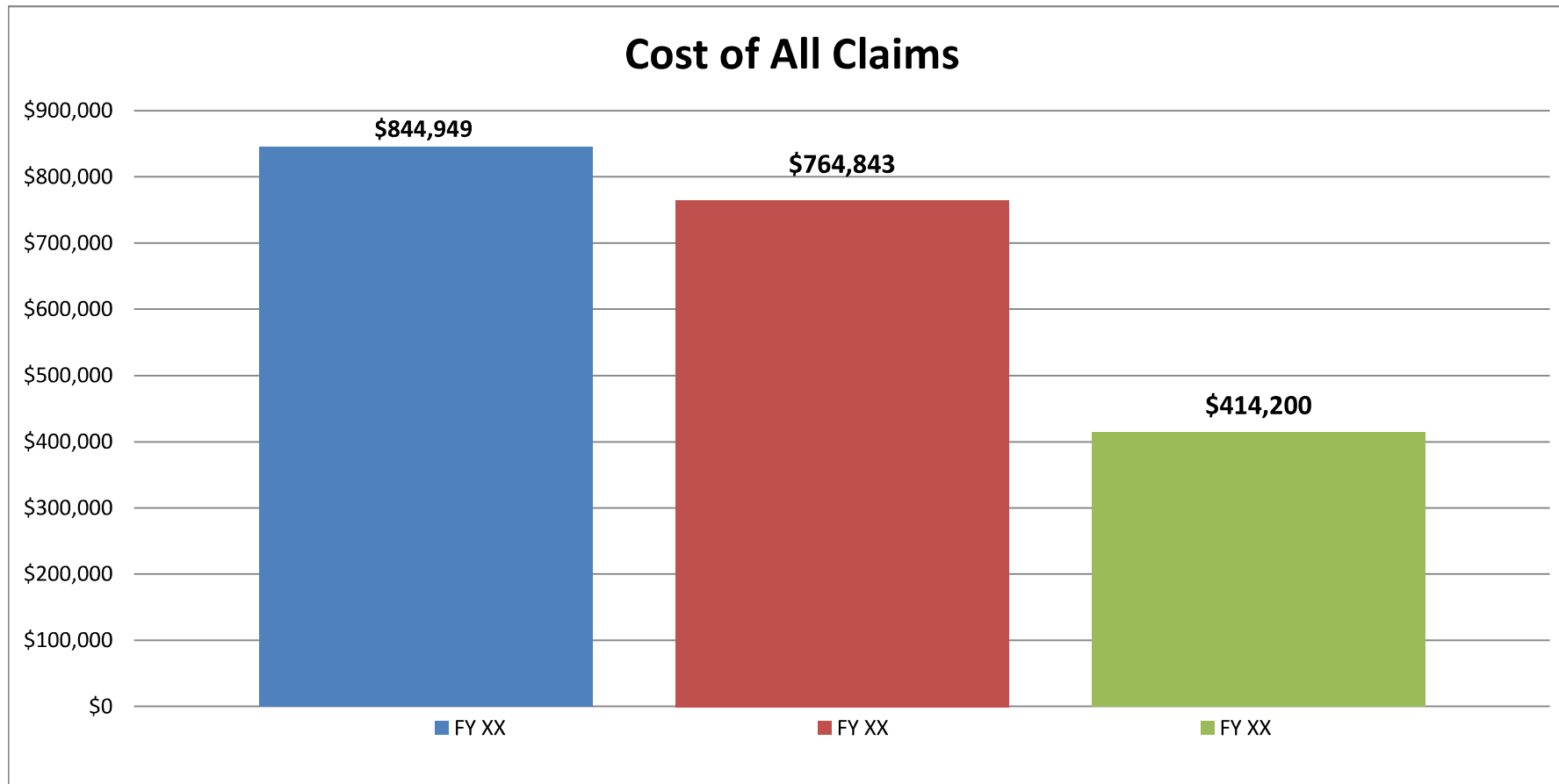
AVERAGE COST PER CLAIM PER YEAR - INDEMNITY											
	2010	2011	%	2012	%	2013	%	2014	%	2015	%
Medical	\$6,030.82	\$14,747.98	145%	\$24,543.37	66%	\$17,994.69	-27%	\$13,153.71	-27%	\$4,988.17	-62%
Temporary Disability	\$3,668.03	\$4,638.96	26%	\$6,747.29	45%	\$8,063.74	20%	\$4,622.25	-43%	\$1,187.92	-74%
Permanent Disability	\$2,450.32	\$2,932.67	20%	\$4,926.23	68%	\$5,437.97	10%	\$2,272.97	-58%	\$0.00	-100%
Voc Rehab	\$275.76	\$376.84	37%	\$761.14	102%	\$532.08	-30%	\$223.08	-58%	\$0.00	-100%
Other Indem	\$372.41	\$561.43	51%	\$265.00	-53%	\$1,014.48	283%	\$384.82	-62%	\$0.00	-100%
Legal	\$608.21	\$2,569.56	322%	\$2,378.80	-7%	\$3,271.26	38%	\$1,380.52	-58%	\$0.00	-100%
Other	\$1,473.05	\$2,344.97	59%	\$3,314.84	41%	\$4,270.26	29%	\$2,747.17	-36%	\$900.85	-67%
TOTAL	\$14,878.60	\$28,172.41	89%	\$42,936.67	52%	\$40,584.48	-5%	\$24,784.52	-39%	\$7,076.94	-71%

AVERAGE COST PER CLAIM PER YEAR - FUTURE MEDICAL											
	2010	2011	%	2012	%	2013	%	2014	%	2015	%
Medical	\$31,927.33	\$20,616.91	-35%	\$29,596.32	44%	\$21,682.14	-27%	\$18,000.00	-17%	\$0.00	0%
Temporary Disability	\$10,049.74	\$3,707.97	-63%	\$6,302.72	70%	\$1,091.19	-83%	\$0.00	-100%	\$0.00	0%
Permanent Disability	\$10,934.61	\$6,480.68	-41%	\$5,824.81	-10%	\$542.35	-91%	\$0.00	-100%	\$0.00	0%
Voc Rehab	\$810.35	\$0.00	-100%	\$1,017.63	-5%	\$0.00	0%	\$0.00	0%	\$0.00	0%
Other Indem	\$514.27	\$975.30	90%	\$964.14	-1%	\$0.00	0%	\$0.00	0%	\$0.00	0%
Legal	\$1,884.64	\$3,922.62	108%	\$2,562.18	-35%	\$0.00	0%	\$0.00	0%	\$0.00	0%
Other	\$4,113.53	\$4,077.15	-1%	\$4,552.03	12%	\$2,719.67	-40%	\$3,600.00	32%	\$0.00	0%
TOTAL	\$60,234.47	\$39,780.63	-34%	\$50,819.83	28%	\$26,035.35	-49%	\$21,600.00	-17%	\$0.00	-100%

AVERAGE CLAIM COSTS

AVERAGE COST PER CLAIM PER YEAR - LITIGATED											
	2010	2011	%	2012	%	2013	%	2014	%	2015	%
Medical	\$50,634.41	\$42,421.63	-16%	\$101,044.34	138%	\$39,654.15	-61%	\$25,818.39	-35%	\$0.00	-100%
Temporary Disability	\$12,725.85	\$10,973.56	-14%	\$28,670.94	161%	\$20,160.95	-30%	\$7,953.51	-61%	\$0.00	-100%
Permanent Disability	\$11,962.68	\$11,558.06	-3%	\$23,627.14	104%	\$15,303.58	-35%	\$10,416.74	-32%	\$0.00	-100%
Voc Rehab	\$2,279.05	\$1,105.63	-51%	\$5,828.87	427%	\$1,713.85	-71%	\$1,714.29	0%	\$0.00	-100%
Other Indem	\$3,157.66	\$2,332.68	-26%	\$2,567.22	10%	\$3,338.43	30%	\$1,744.57	-48%	\$0.00	-100%
Legal	\$14,750.14	\$9,402.56	-36%	\$14,620.26	55%	\$10,618.56	-27%	\$9,247.69	-13%	\$0.00	-100%
Other	\$12,074.76	\$6,794.71	-44%	\$12,836.64	89%	\$10,919.29	-15%	\$8,583.62	-21%	\$0.00	-100%
TOTAL	\$107,584.55	\$84,588.83	-21%	\$189,195.41	124%	\$101,708.81	-46%	\$65,478.81	-36%	\$0.00	-100%

AVERAGE COST PER CLAIM PER YEAR - CLOSED											
	2010	2011	%	2012	%	2013	%	2014	%	2015	%
Medical	\$2,272.59	\$2,100.43	-8%	\$1,130.23	-46%	\$1,740.15	54%	\$872.71	-50%	\$548.25	-37%
Temporary Disability	\$1,428.07	\$567.07	-60%	\$336.43	-41%	\$743.19	121%	\$487.90	-34%	\$4.91	-99%
Permanent Disability	\$728.58	\$341.90	-53%	\$130.17	-62%	\$62.72	-52%	\$205.71	228%	\$0.00	-100%
Voc Rehab	\$50.09	\$0.95	0%	\$0.00	-100%	\$10.87	#DIV/0!	\$0.00	0%	\$0.00	0%
Other Indem	\$92.50	\$53.92	-42%	\$0.00	-100%	\$27.39	#DIV/0!	\$34.48	0%	\$0.00	0%
Legal	\$170.42	\$493.32	189%	\$99.82	-80%	\$151.48	52%	\$94.13	0%	\$0.00	0%
Other	\$397.99	\$377.22	-5%	\$177.06	-53%	\$411.23	132%	\$400.00	-3%	\$116.70	-71%
TOTAL	\$5,140.24	\$3,934.81	-23%	\$1,873.71	-52%	\$3,147.03	68%	\$2,094.93	-33%	\$669.86	-68%

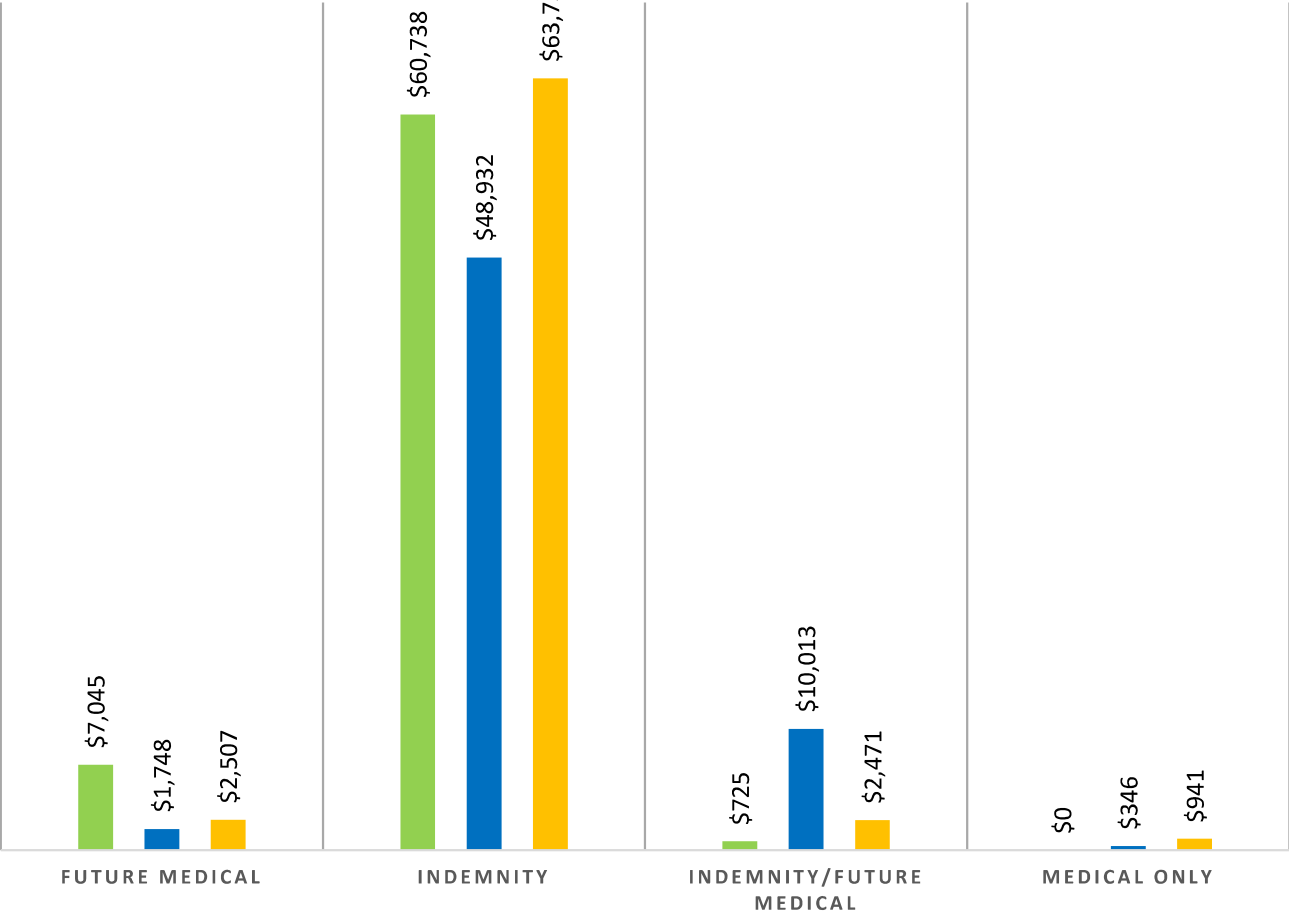


Measures the total liability of claims. This number indicates how well Client is at controlling costs through reduced claims, return to work, and claim closure. This number will directly correlate to increases in annual deposits that must be paid. The lower the number the better.

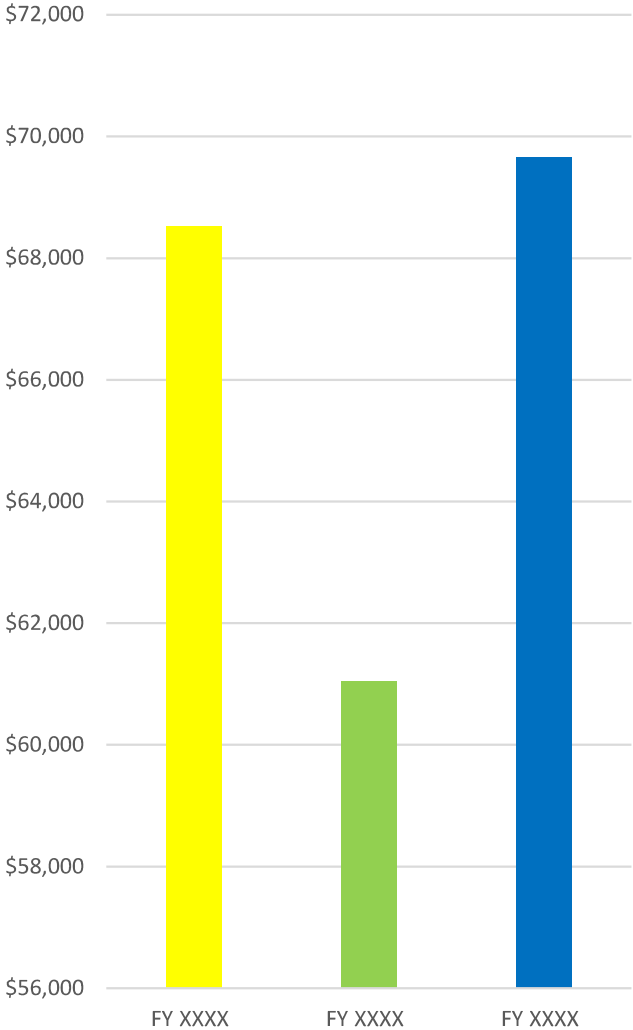
COST OF ALL CLAIMS

DECEMBER 20XX

FY XXXX FY XXXX FY XXXX



YTD Comparison





1470 South Valley Vista Drive, Suite 230
Diamond Bar, California 91765

Telephone (909) 861-0816
Fax (909) 860-3995

BATCH PAY SAMPLE CHECK

Employer	Client Name	Payee Name	MedReview Inc.
Check Number	81468	Payee Address	Post Office Box 5108
Check Date	04/09/20XX		Diamond Bar CA 91765

Claimant Name	Incident Date	Claim Number	From	Through	Description	Document #	Amount
XXXXX	03/25/2015	15-122054	03/25/2015	03/25/2015	Medical Review	413197P	3.90
XXXXX	03/25/2015	15-122054	03/25/2015	03/25/2015	Medical Review	413197O	21.67
XXXXX	12/05/2014	14-121177	03/16/2015	03/16/2015	Medical Review	413198F	4.33
XXXXX	12/05/2014	14-121177	03/16/2015	03/16/2015	Medical Review	413198P	0.95
XXXXX	12/05/2014	14-121177	03/16/2015	03/16/2015	Medical Review	413198O	6.50
Number of Claims:		2			Check Total:	5	37.35

CLIENT NAME

Workers' Compensation

Administered by AdminSure (909) 861-0816

BANK OF AMERICA

222 North Catalina Avenue
Redondo Beach, CA 90277

DATE

16-66
1220

CHECK
NUMBER **81468**

AMOUNT

*******37.35**

PAY Thirty Seven Dollars And 35/100

TO
THE
ORDER
OF MedReview Inc.
Post Office Box 5108
Diamond Bar, CA 91765

THIS CHECK EXPIRES AND IS VOID
90 DAYS FROM CHECK DATE

BATCH PAY SAMPLE REPORT

Workers' Compensation Claims Check Register

For Month Ending XXXXXX

Number	Date	Amount	Payee	Description	Claimant	Code	Claim Number
81468	04/09/2015	0.95	MedReview Inc.	Medical Review Services	XXXXXX	L0054	XXXXXX
81468	04/09/2015	3.90	MedReview Inc.	Medical Review Services	XXXXXX	L0060	XXXXXX
81468	04/09/2015	4.33	MedReview Inc.	Medical Review Services	XXXXXX	L0054	XXXXXX
81468	04/09/2015	6.50	MedReview Inc.	Medical Review Services	XXXXXX	L0054	XXXXXX
81468	04/09/2015	21.67	MedReview Inc.	Medical Review Services	XXXXXX	L0060	XXXXXX
Grand Total:	5	37.35					

City of X

Workers' Compensation Analytics

AdminSure

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2 - Five-Year New Claims Opened
3 - Five-Year New Claims Opened and Claims Closed
4 - Percentage of New Claims Opened - Indemnity
5 - Average Cost Per New Claim Added by Department
6 - Police, Five-Year New Claims Opened by Claim Type
7 - Fire, Five-Year Claims Opened by Claim Type
8 - All Other Departments, Five-Year Claims Opened by Claim Type
9 - Police, Total Incurred = Paid & Reserved
10 - Fire, Total Incurred = Paid & Reserved
11 - All Other Departments, Total Incurred = Paid & Reserved
12 - Citywide, Total Incurred = Paid & Reserved
13 - Police, Stratification Loss
14 - Fire, Stratification Loss
15 - All Other Departments, Stratification Loss
16 - All Departments, Litigated Claims
17 - Safety (Police & Fire) Litigated Claims
18 - Non-Safety Litigated Claims
19 - All Departments, Litigated Expenses vs. Total Paid
20 - Five-Year Top 10 New Claim Distribution by Department (Bar)
21 - Five-Year Top 10 New Claim Distribution by Department (Pie)
22 - Five-Year Claim Distribution by Top 10 Cause of Loss (Bar)
23 - Five-Year Claim Distribution by Top 10 Cause of Loss (Pie)
24 - Claim Distribution by Cause of Loss Reference

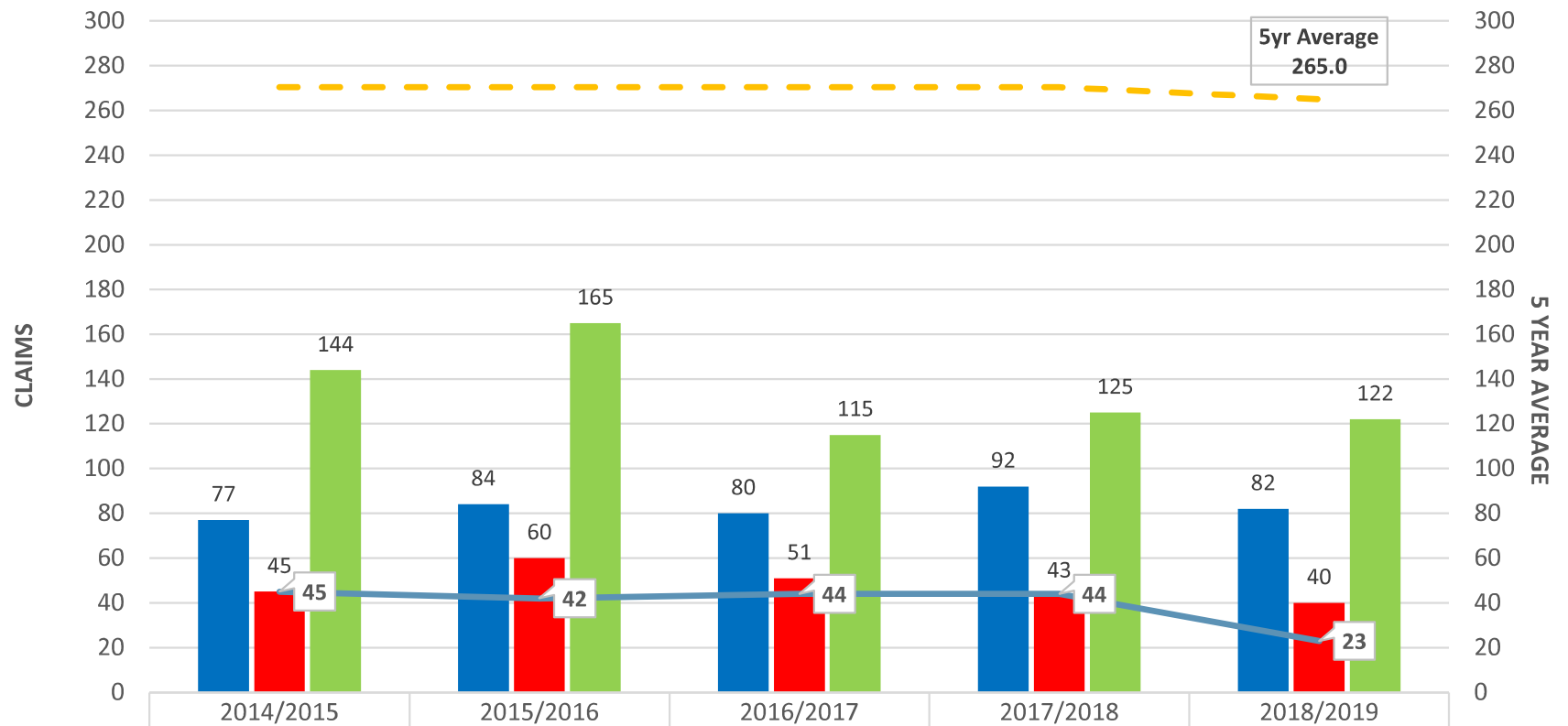
Page

25 - Five-Year Claim Distribution by Top 10 Nature of Injury (Bar)
26 - Five-Year Claim Distribution by Top 10 Nature of Injury (Pie)
27 - Claim Distribution by Nature of Injury Reference
28 - Five-Year Claim Distribution by Top 10 Body Part (Bar)
29 - Five-Year Claim Distribution by Top 10 Body Part (Pie)
30 - Claim Distribution by Body Part Reference
31 - Modified Duty Days - All Departments
32 - Modified Duty Days - Safety (Police & Fire)
33 - Modified Duty Days - None-Safety
34 - Metrics
35 - *Comparisons - Percentage of New Claims Added
36 - *Comparisons - Closing Ratio
37 - *Comparisons - Frequency Rate (Per 100 Employees)
38 - *Comparisons - Percentage of Annual Medical Only Claims
39 - *Comparisons - Percentage Litigated for New Claims Added
40 - *Comparisons - Percentage of Total Paid (All Claims)

CITY OF *Sample*

5YR NEW CLAIMS OPENED

FISCAL YEARS 2014/2015 THROUGH 2018/2019

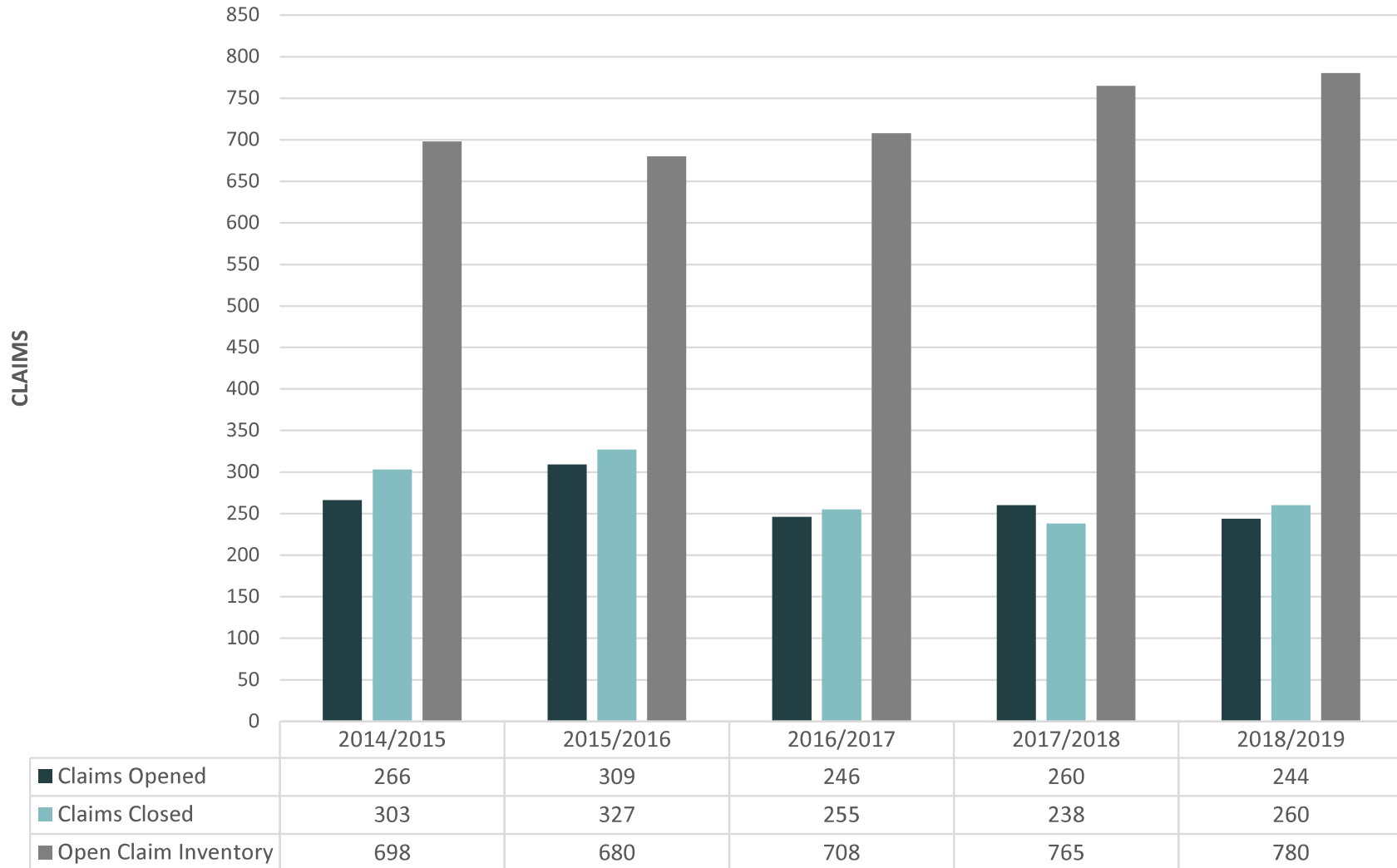


Police	77	84	80	92	82
Fire	45	60	51	43	40
All Other	144	165	115	125	122
Total Claims	266	309	246	260	244
5yr Average	270.3	270.3	270.3	270.3	265.0
Litigated	45	42	44	44	23

CITY OF *Sample*

5YR NEW CLAIMS OPENED AND CLAIMS CLOSED

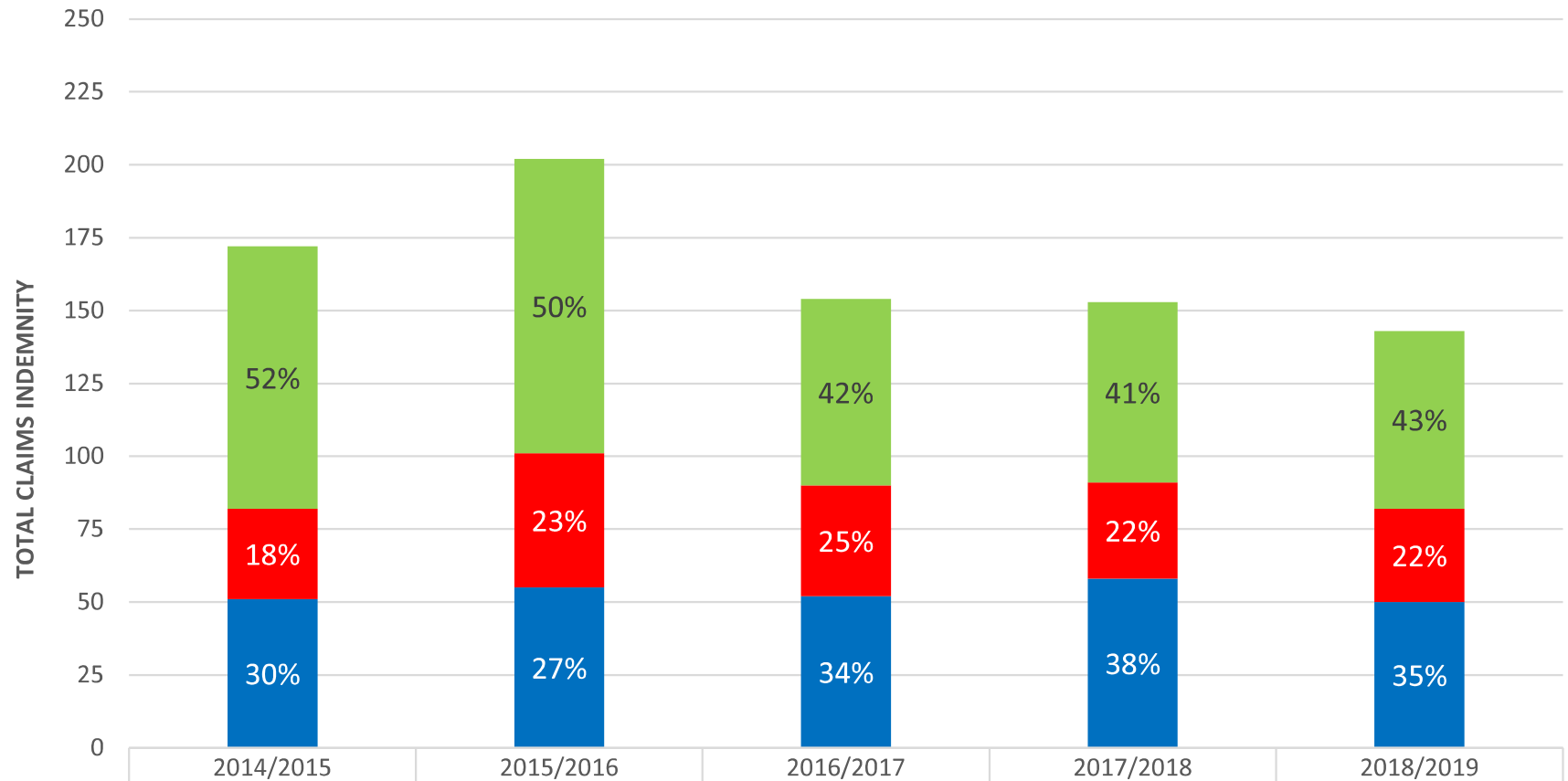
FISCAL YEARS 2014/2015 THROUGH 2018/2019



CITY OF *Sample*

PERCENTAGE OF NEW CLAIMS OPENED - INDEMNITY

VALUATION DATE 6-30-2019

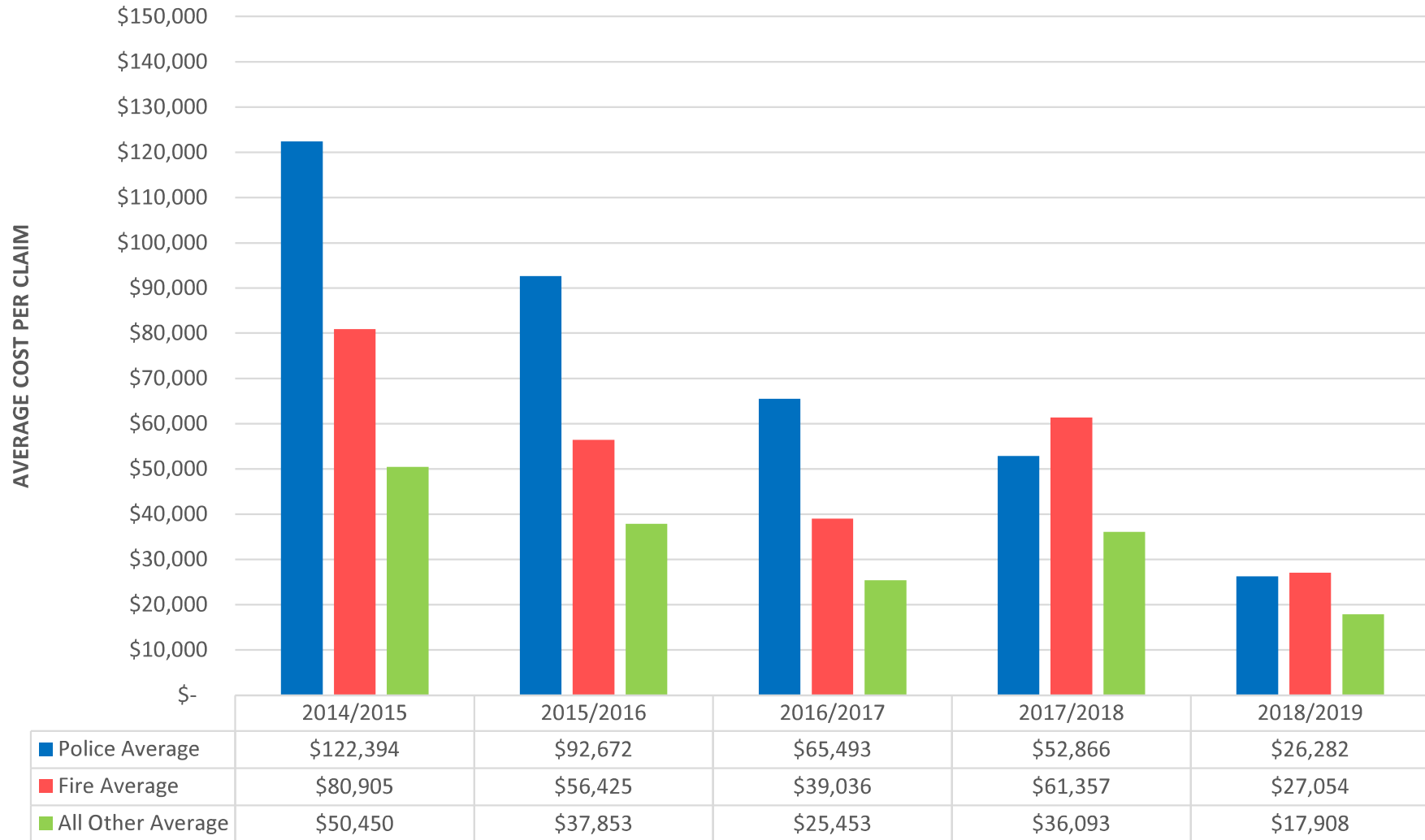


	2014/2015	2015/2016	2016/2017	2017/2018	2018/2019
Total Claims Indemnity	172	202	154	153	143
All Other	90	101	64	62	61
Fire	31	46	38	33	32
Police	51	55	52	58	50

CITY OF *Sample*

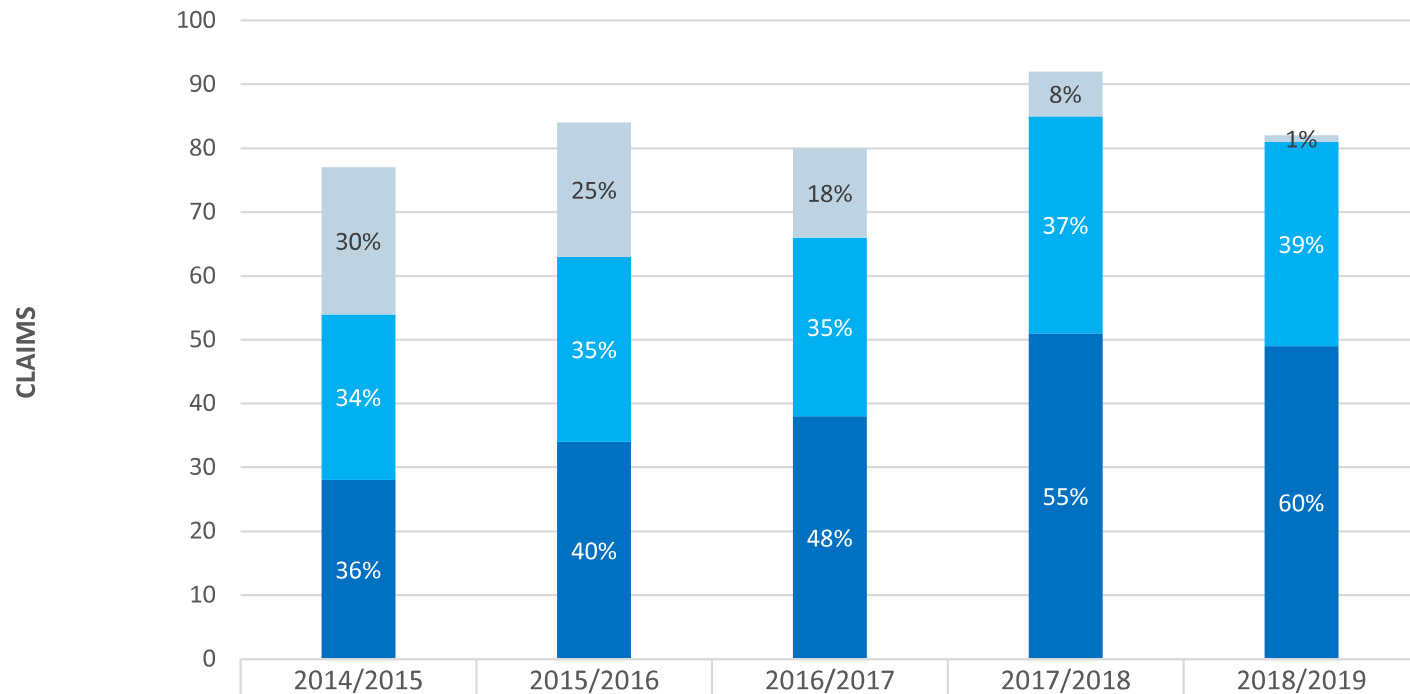
AVERAGE COST PER NEW CLAIM ADDED BY DEPARTMENT

VALUATION DATE 6-30-2019



CITY OF *Sample* – POLICE DEPARTMENT 5YR NEW CLAIMS OPENED BY CLAIM TYPE

FY 2014/2015 THROUGH 2018/2019

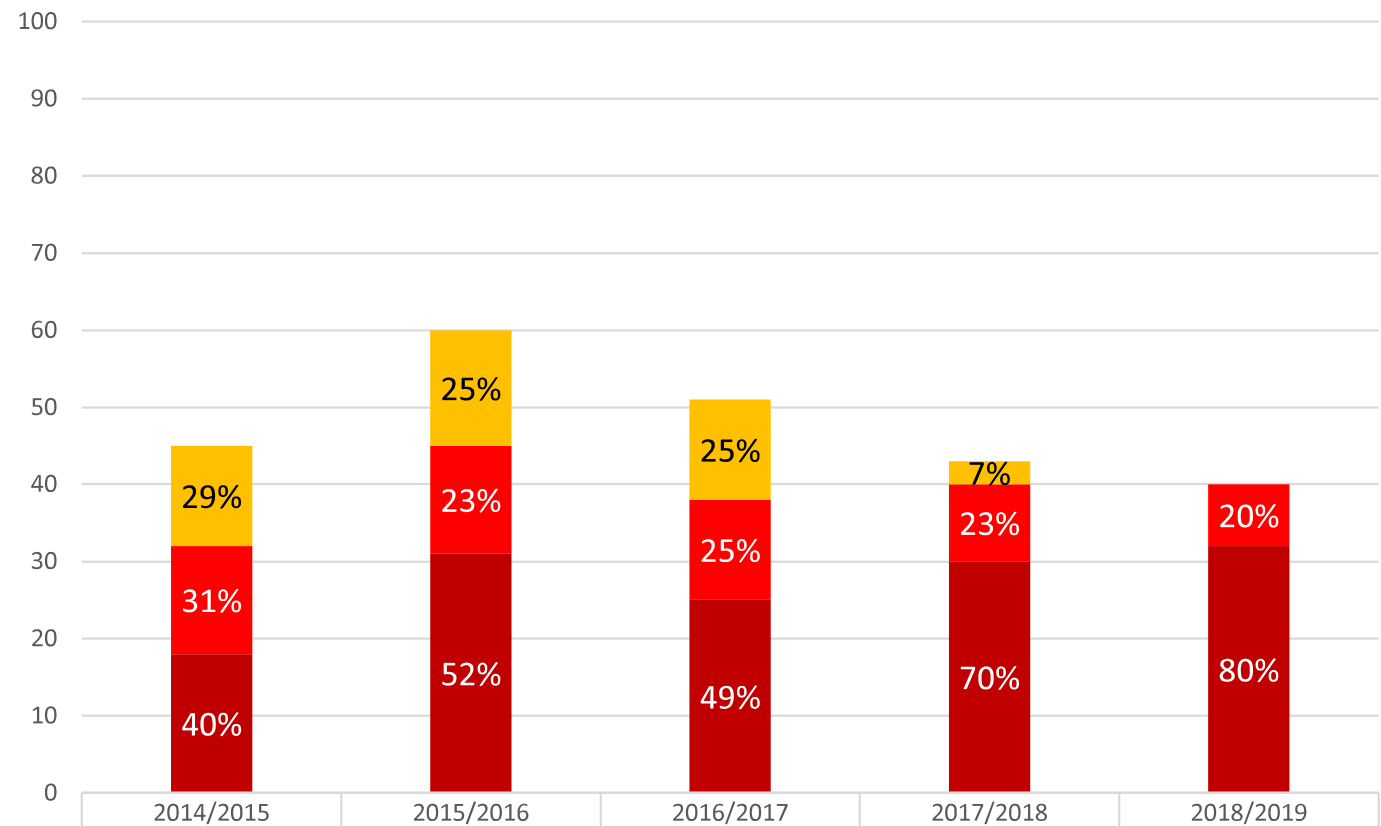


Police - FM, Indem / FM, FM-Lim	23	21	14	7	1
Police - Medical Only	26	29	28	34	32
Police - Indemnity	28	34	38	51	49
Total New Claims Reported (Police)	77	84	80	92	82
Total New Reportable Claims (Citywide)	266	309	246	260	244
Police to Citywide Ratio	29%	27%	33%	35%	34%

CITY OF *Sample* – FIRE DEPARTMENT 5YR NEW CLAIMS OPENED BY CLAIM TYPE

FY 2014/2015 THROUGH 2018/2019

CLAIMS

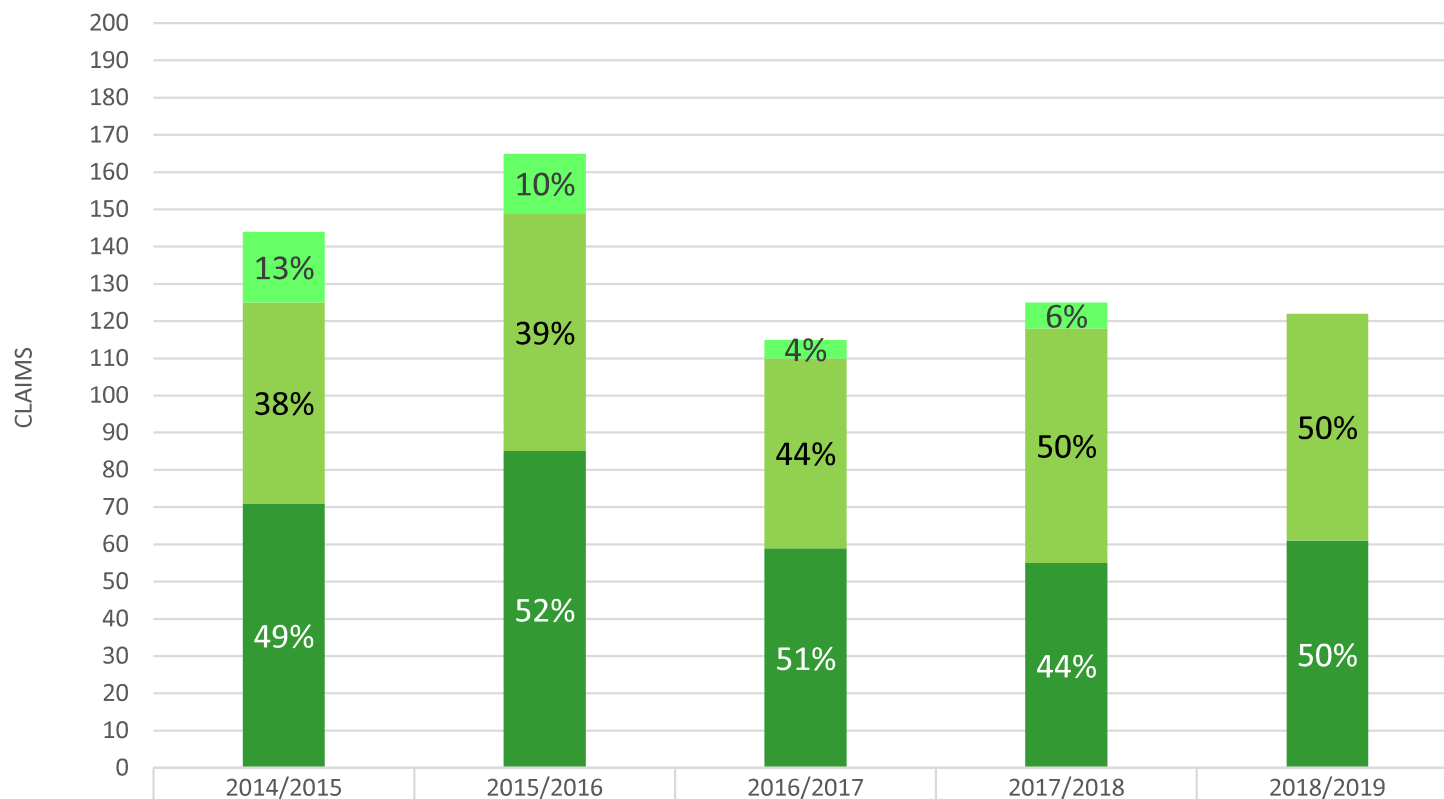


■ Fire - FM, Indem / FM, FM-Lim	13	15	13	3	0
■ Fire - Medical Only	14	14	13	10	8
■ Fire - Indemnity	18	31	25	30	32
Total New Claims Reported (Fire)	45	60	51	43	40
Total New Reportable Claims (Citywide)	266	309	246	260	244
Fire to Citywide Ratio	17%	19%	21%	17%	16%

CITY OF *Sample* – ALL OTHER DEPARTMENTS

5YR NEW CLAIMS OPENED BY CLAIM TYPE

FY 2014/2015 THROUGH 2018/2019



All Others - FM, Indem / FM, FM-Lim	19	16	5	7	0
All Others - Medical Only	54	64	51	63	61
All Others - Indemnity	71	85	59	55	61
Total New Claims Reported (All Others)	144	165	115	125	122
Total New Reportable Claims (Citywide)	266	309	246	260	244
All Others to Citywide Ratio	54%	53%	47%	48%	50%

CITY OF *Sample* – POLICE DEPARTMENT

TOTAL INCURRED = PAID & RESERVED

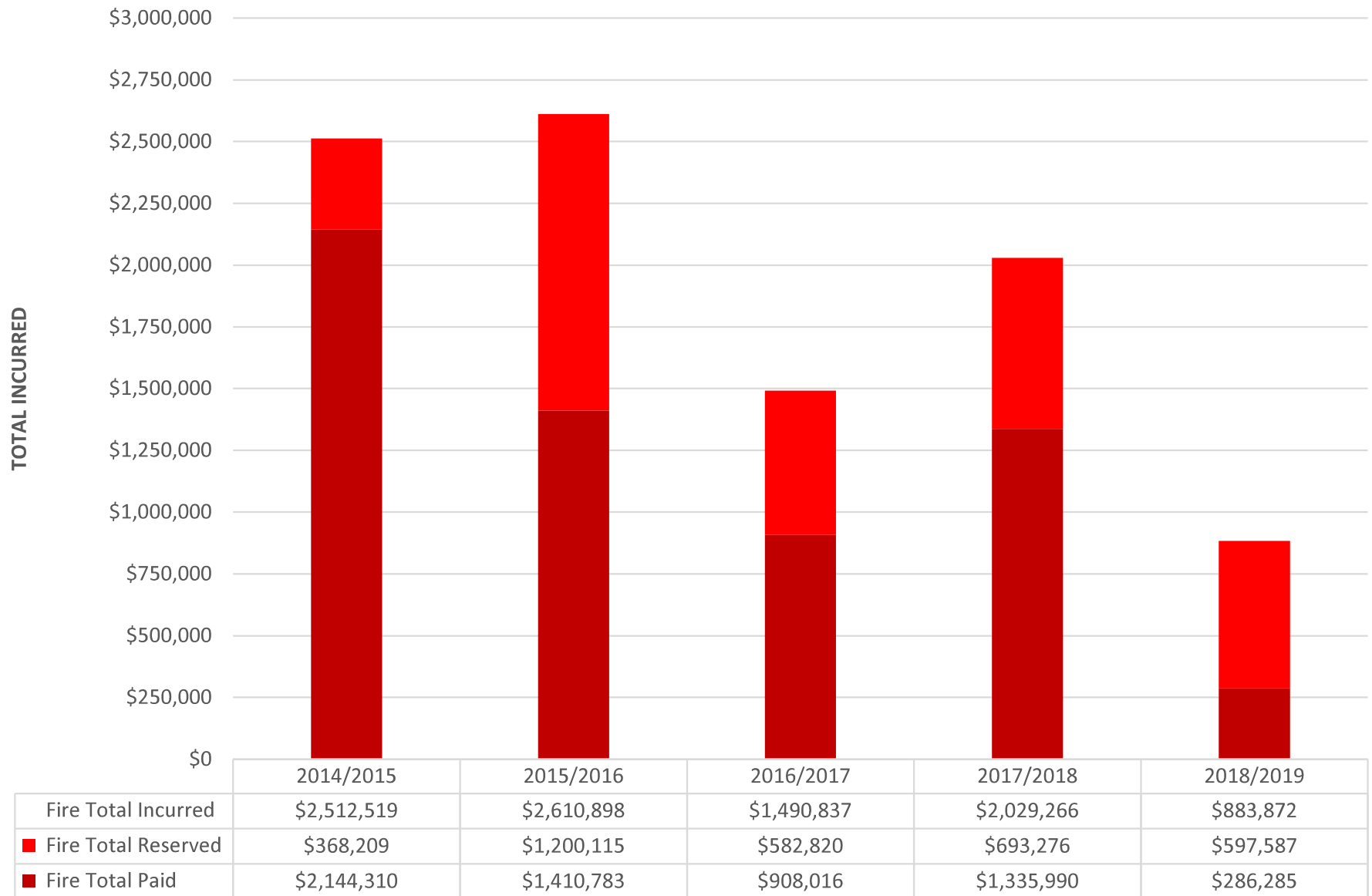
VALUATION DATE 6-30-2019



CITY OF *Sample* – FIRE DEPARTMENT

TOTAL INCURRED = PAID & RESERVED

VALUATION DATE 6-30-2019



CITY OF *Sample* – ALL OTHER DEPARTMENTS

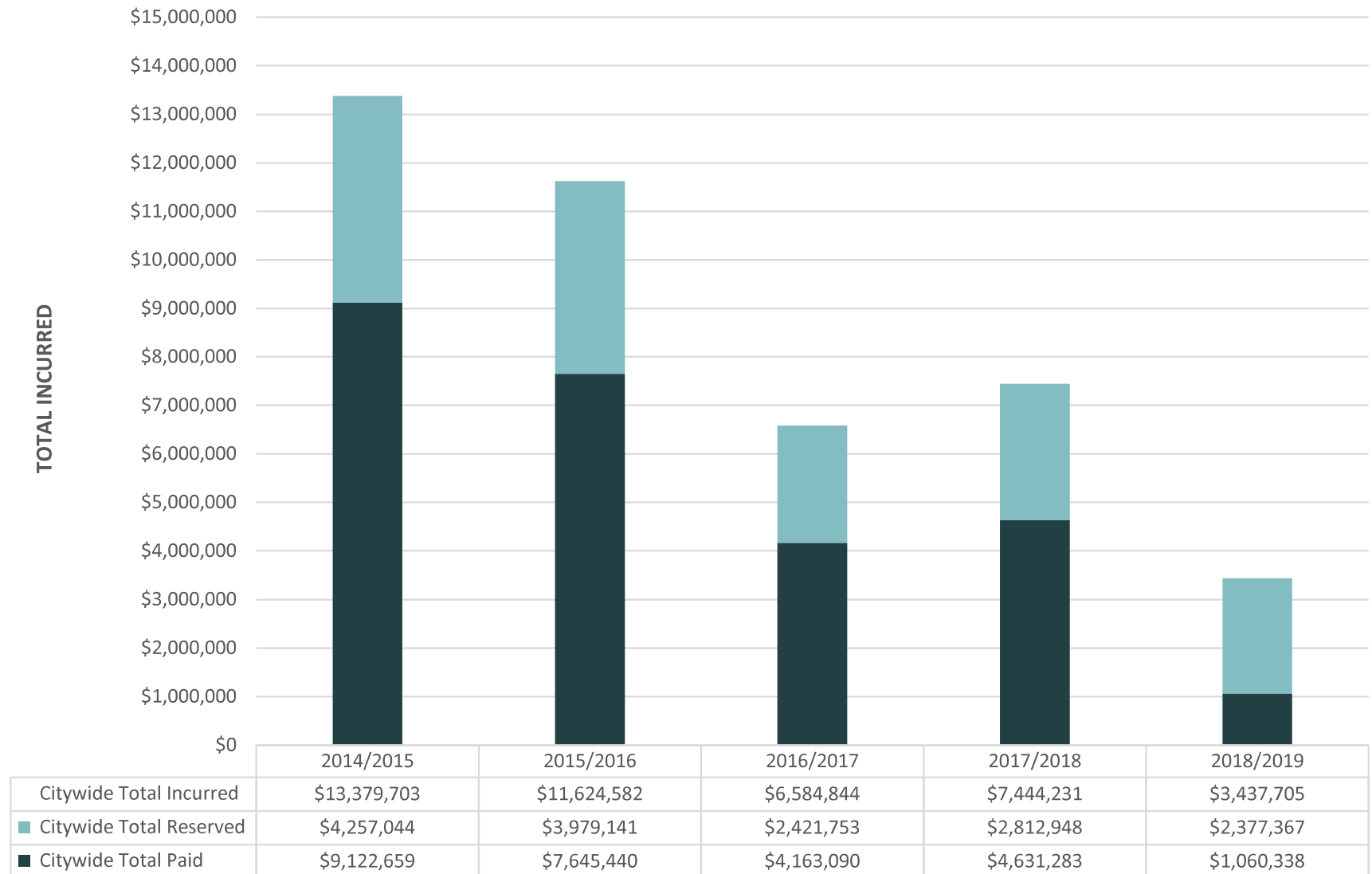
TOTAL INCURRED = PAID & RESERVED

VALUATION DATE 6-30-2019



CITY OF *Sample* – CITYWIDE TOTAL INCURRED = PAID & RESERVED

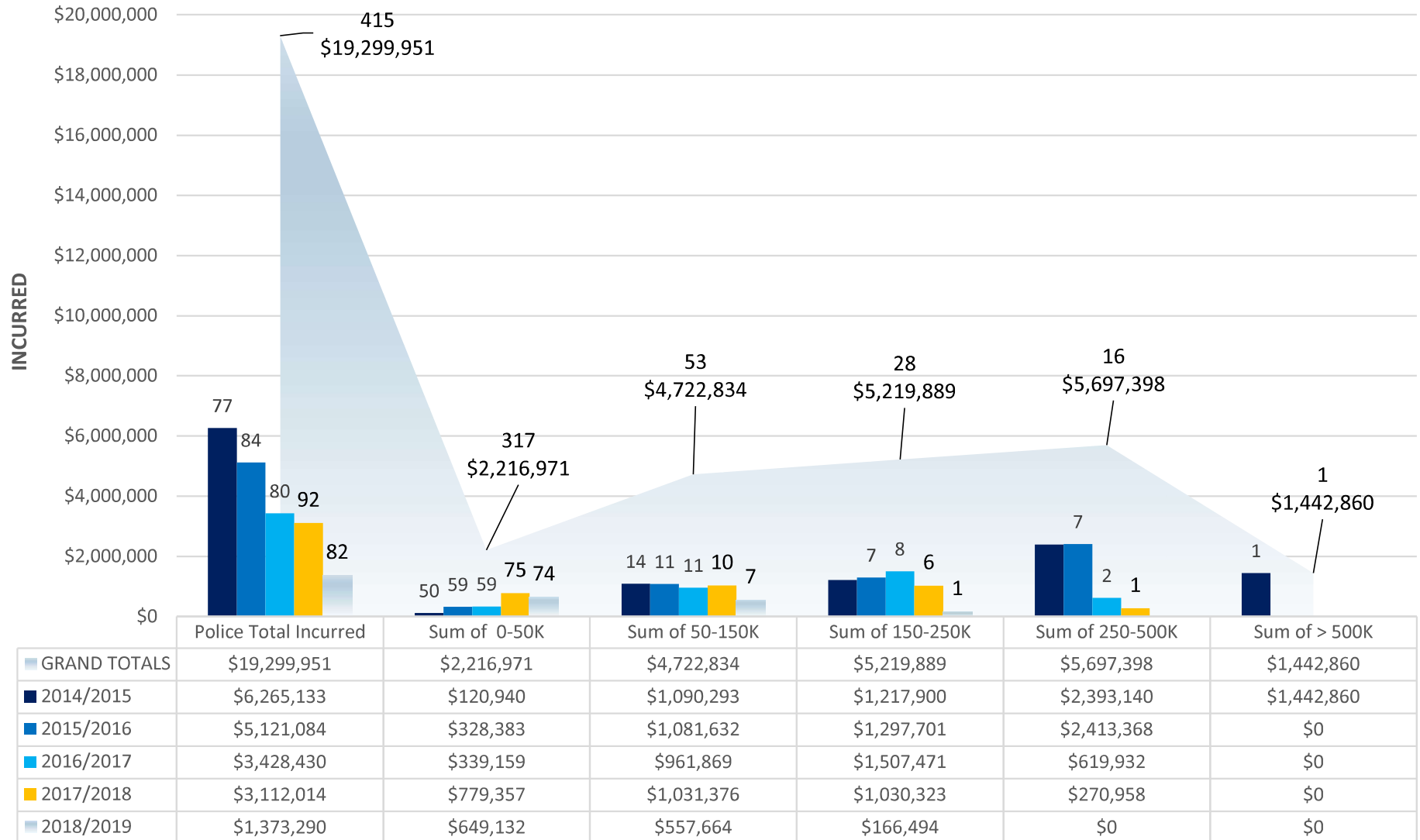
VALUATION DATE 6-30-2019



CITY OF *Sample*

STRATIFICATION LOSS - POLICE DEPARTMENT

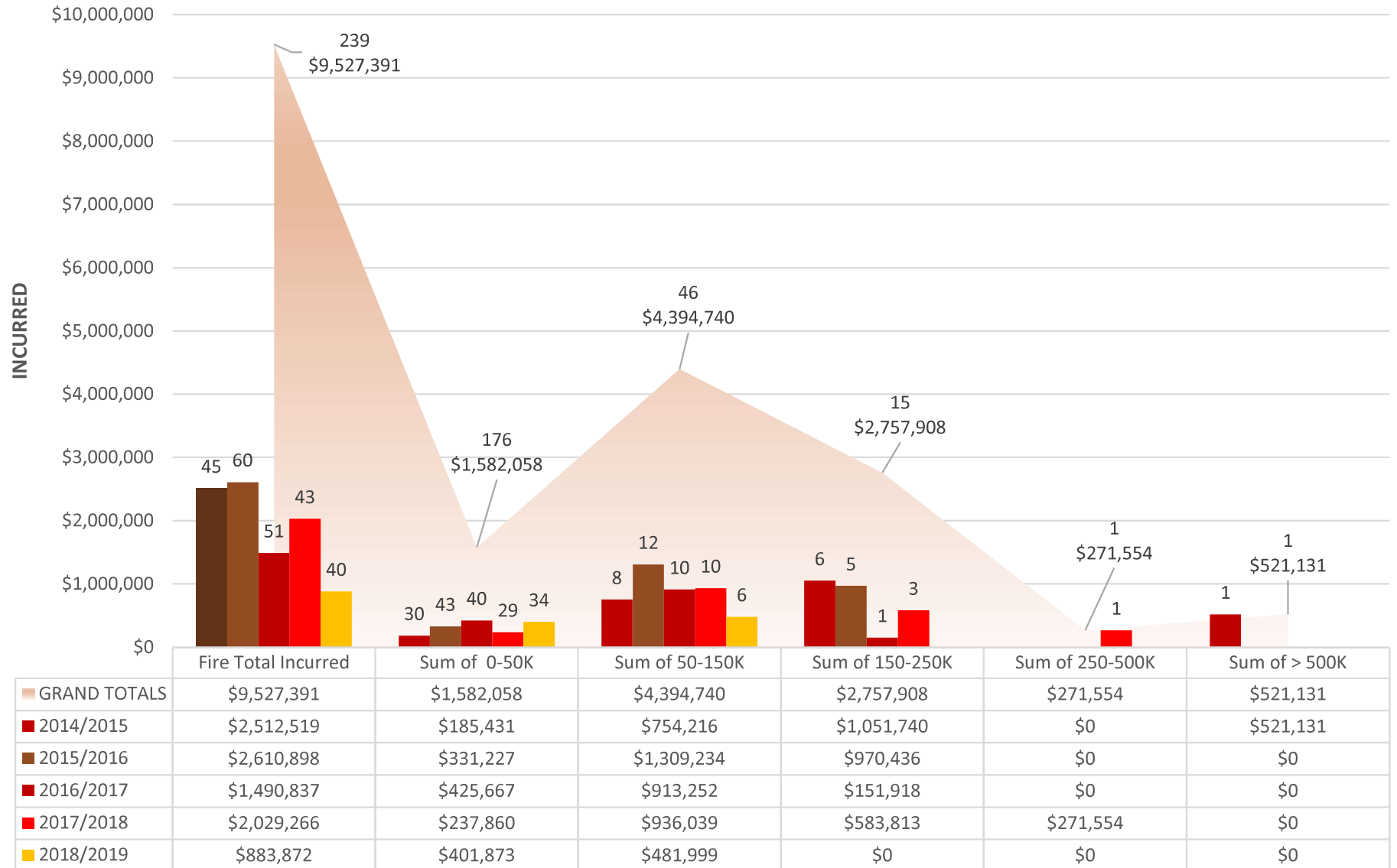
VALUATION DATE 06-30-2019



CITY OF *Sample*

STRATIFICATION LOSS - FIRE DEPARTMENT

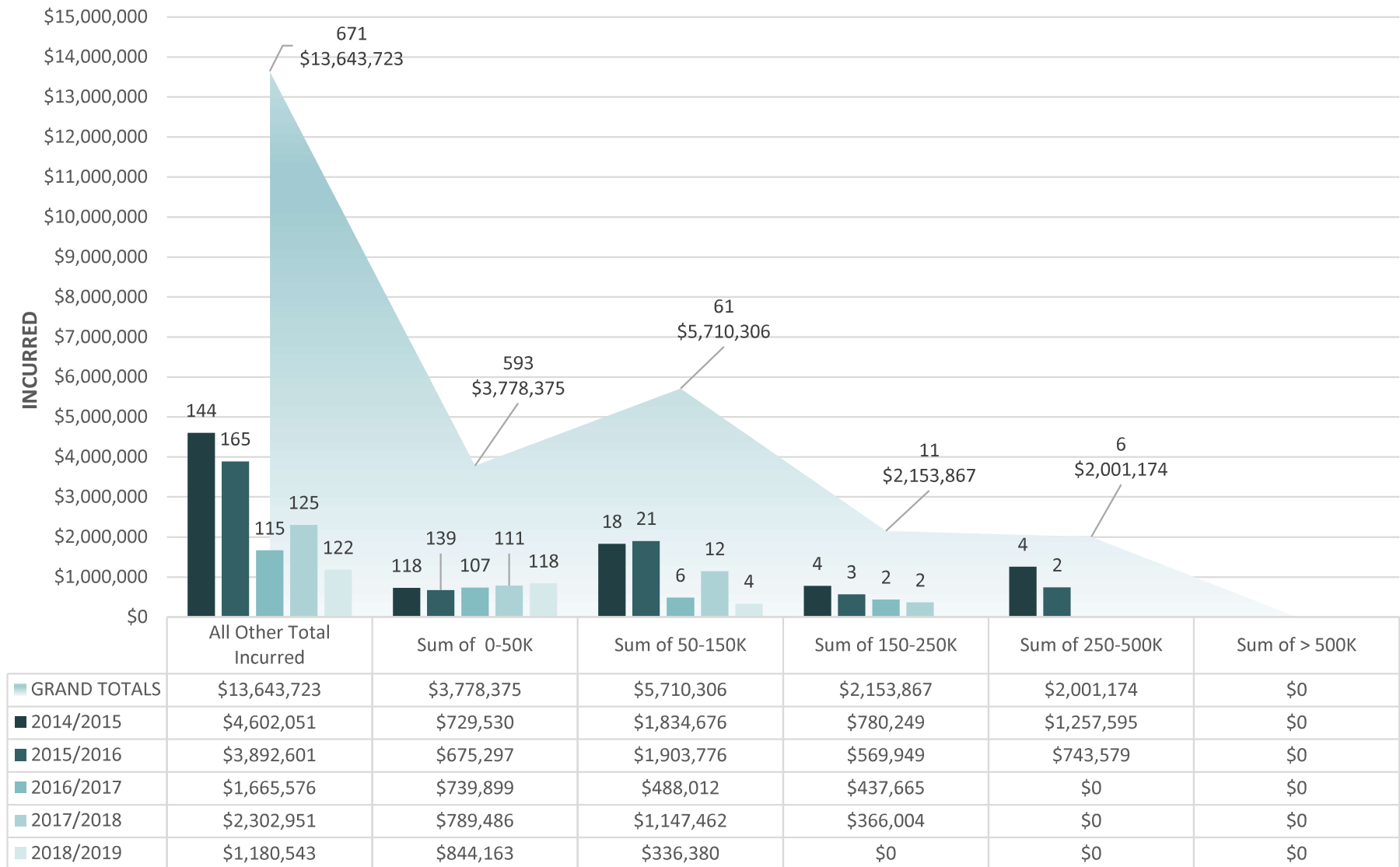
VALUATION DATE 06-30-2019



CITY OF *Sample*

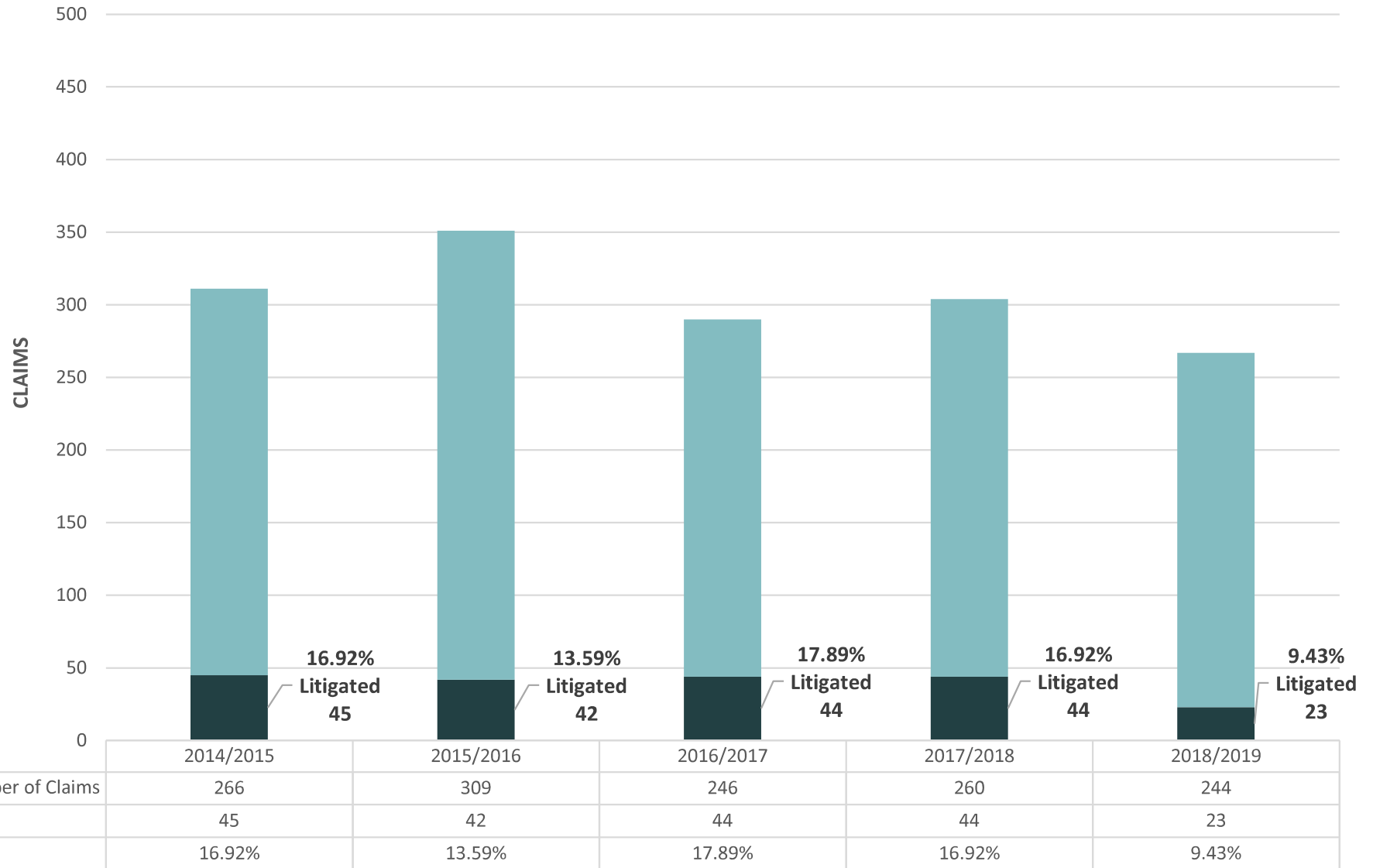
STRATIFICATION LOSS – ALL OTHER DEPARTMENTS

VALUATION DATE 06-30-2019



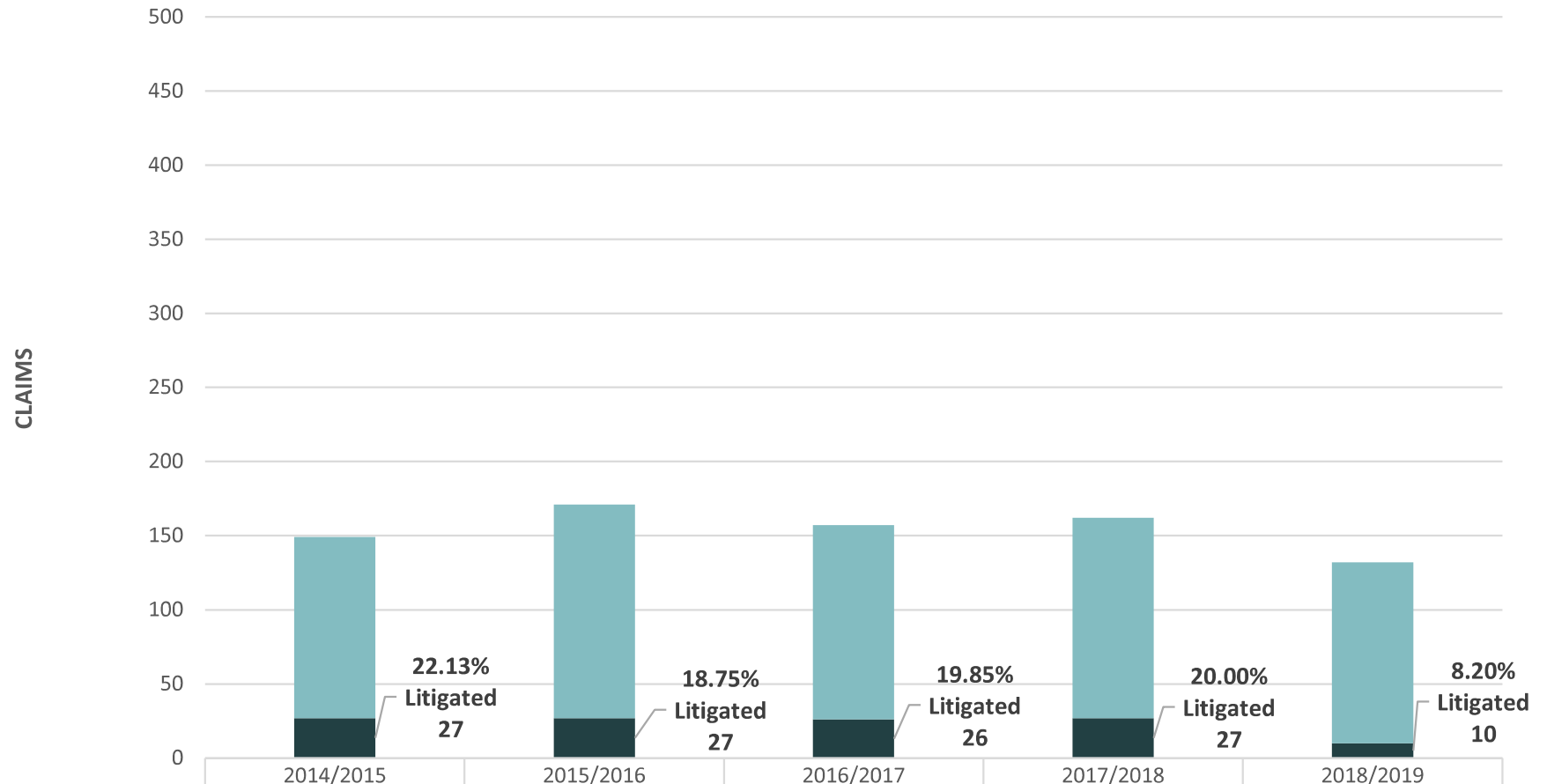
CITY OF *Sample* – ALL DEPARTMENTS LITIGATED CLAIMS

FISCAL YEARS 2014/2015 TO 2018/2019



CITY OF *Sample* - SAFETY (POLICE & FIRE) LITIGATED CLAIMS

FISCAL YEARS 2014/2015 TO 2018/2019

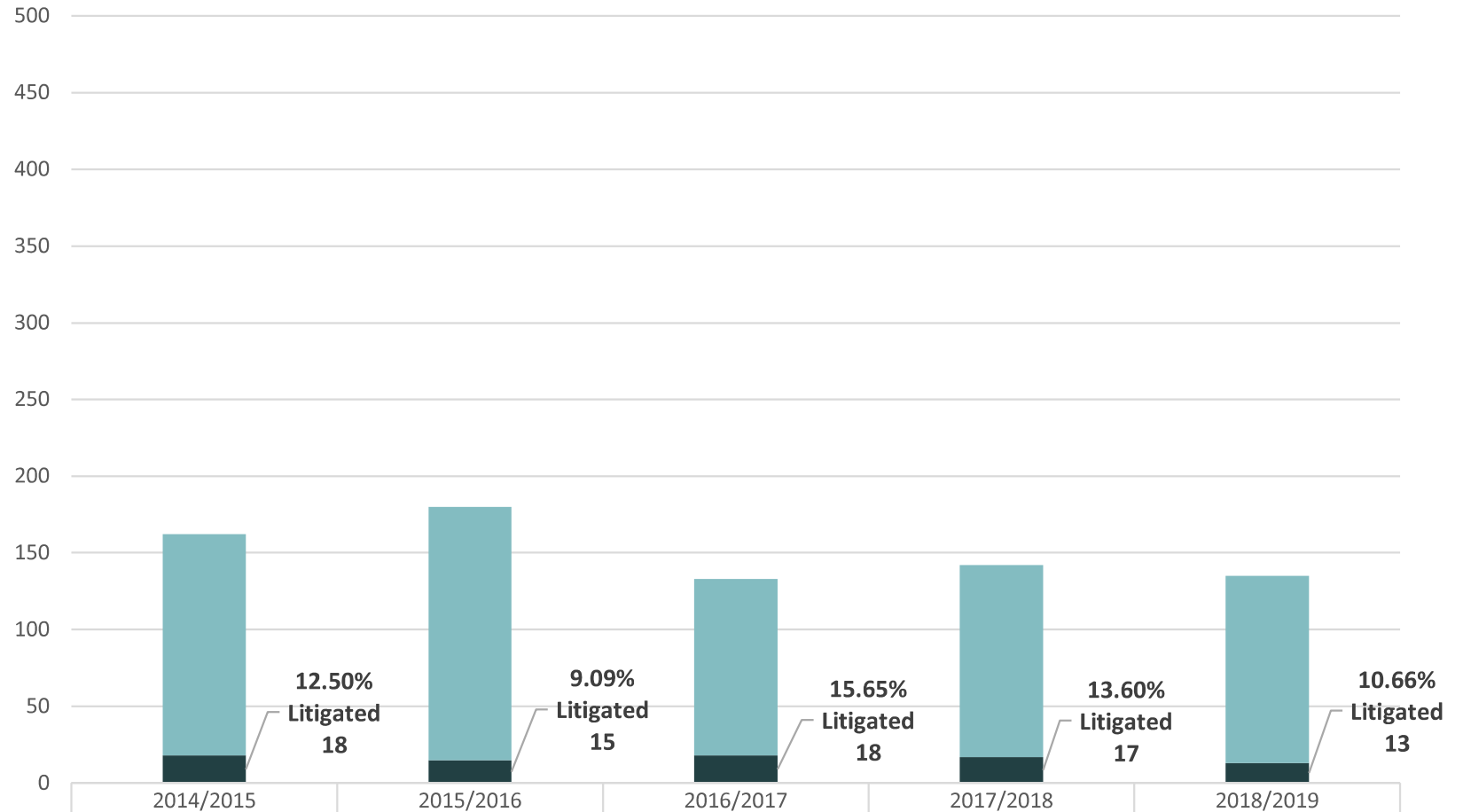


Total Number of Claims	122	144	131	135	122
Litigated	27	27	26	27	10
% Litigated	22.13%	18.75%	19.85%	20.00%	8.20%

CITY OF *Sample* – NON-SAFETY LITIGATED CLAIMS

FISCAL YEARS 2014/2015 TO 2018/2019

CLAIMS

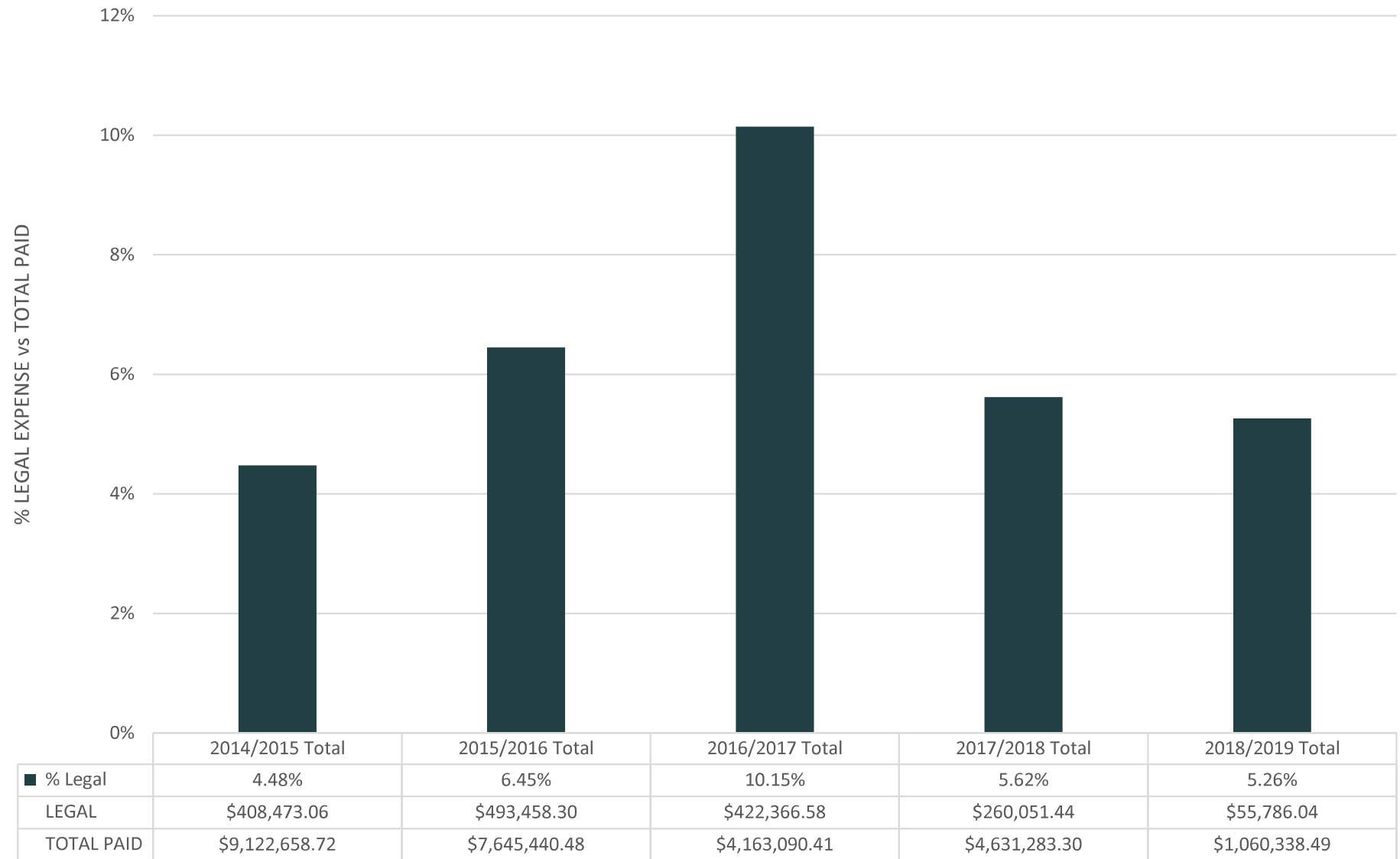


Total Number of Claims	2014/2015	2015/2016	2016/2017	2017/2018	2018/2019
	144	165	115	125	122
Litigated	18	15	18	17	13
% Litigated	12.50%	9.09%	15.65%	13.60%	10.66%

CITY OF *Sample* – ALL DEPARTMENTS

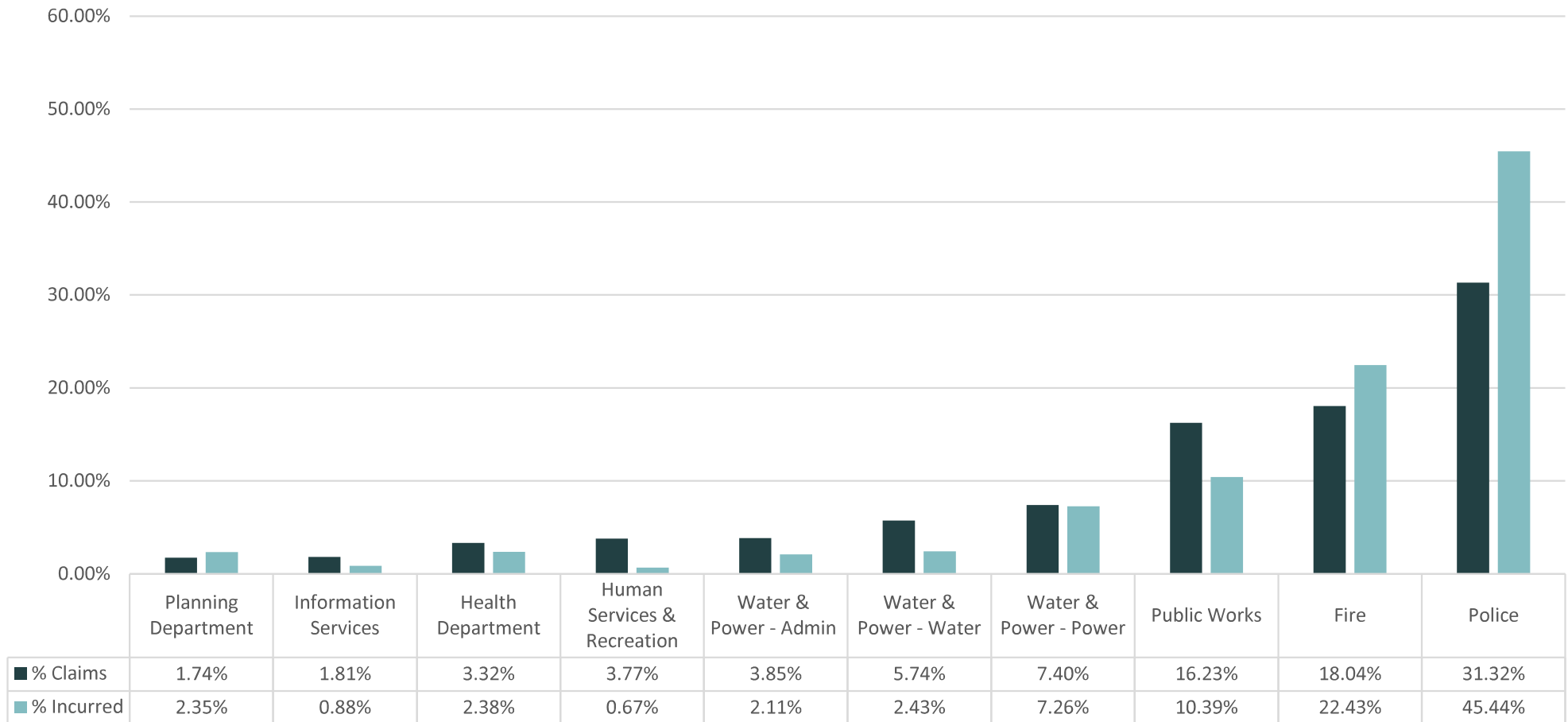
LITIGATED EXPENSES vs TOTAL PAID

CLAIMS OPENED FY 14/15 TO 18/19 – VALUED AS OF 6-30-2019



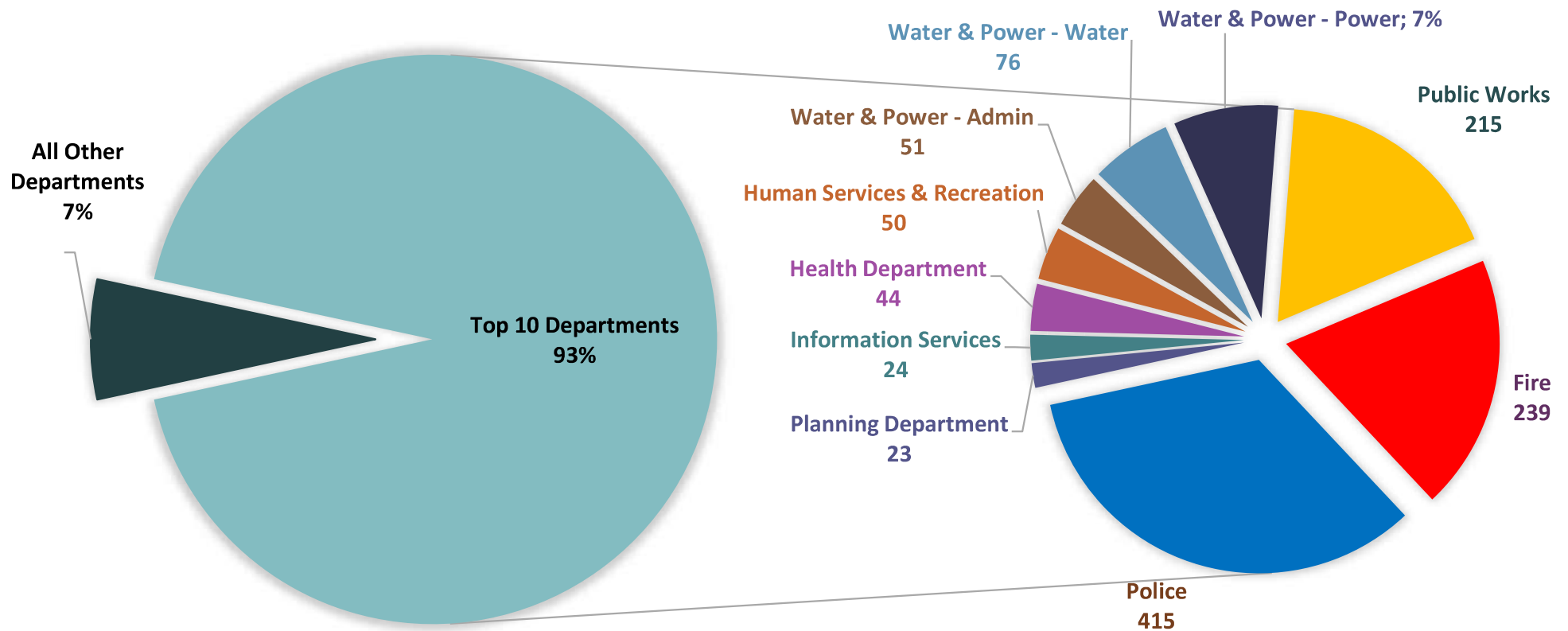
CITY OF *Sample* WORKERS' COMPENSATION 5YR TOP 10 NEW CLAIM DISTRIBUTION BY DEPARTMENT

FY 2014/2015 THROUGH 2018/2019



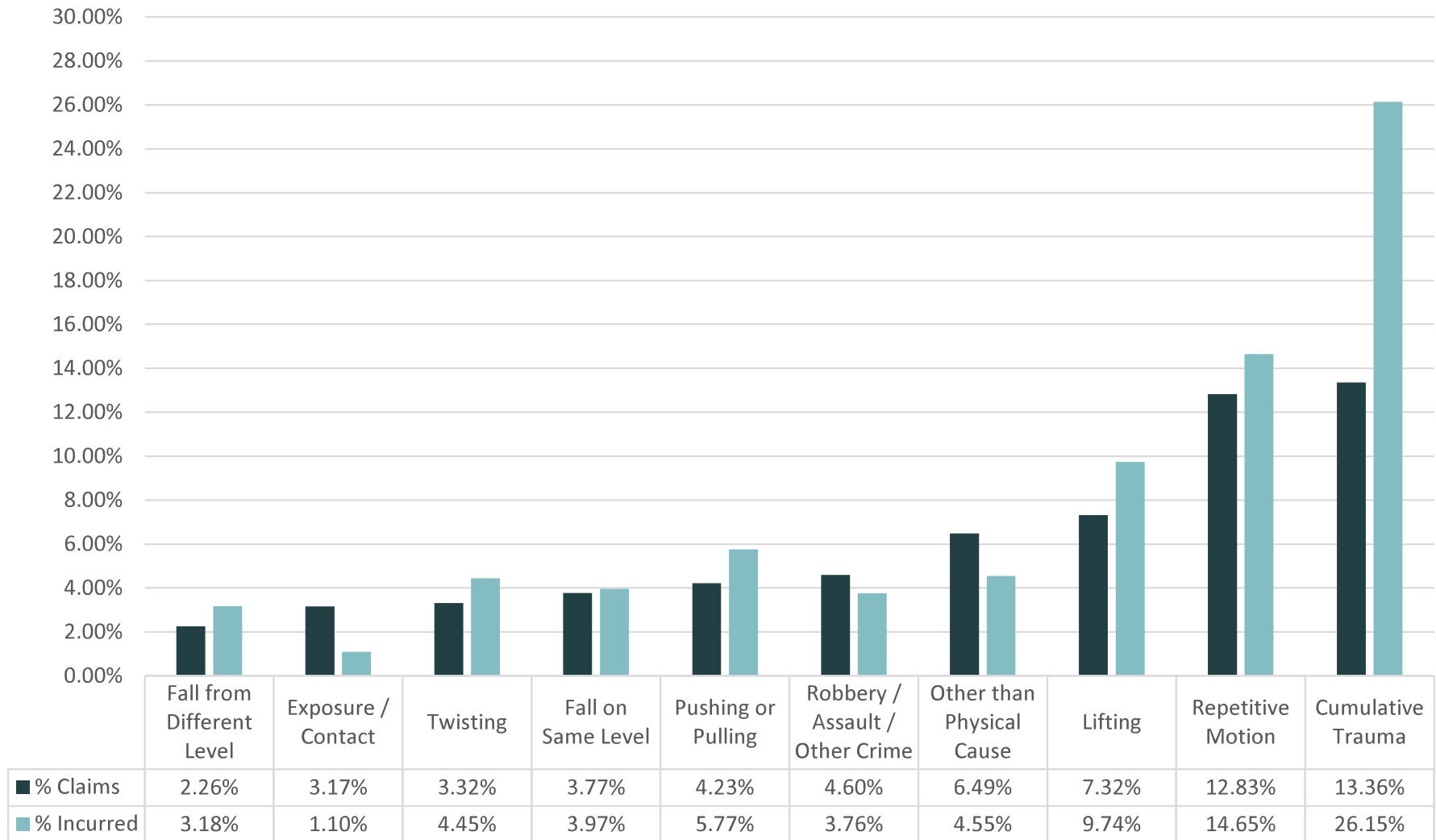
CITY OF *Sample* WORKERS' COMPENSATION 5YR TOP 10 NEW CLAIM DISTRIBUTION BY DEPARTMENT

FY 2014/2015 THROUGH 2018/2019



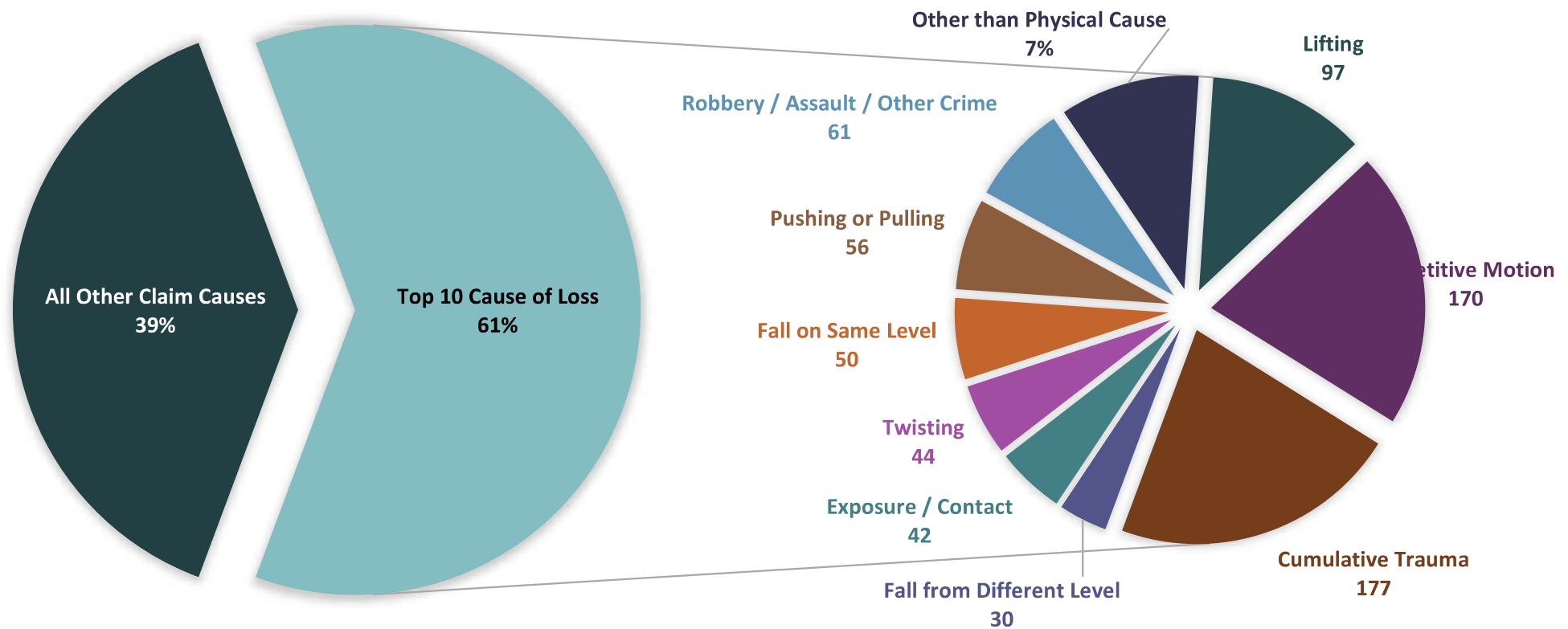
CITY OF *Sample* WORKERS' COMPENSATION 5YR CLAIM DISTRIBUTION BY TOP 10 CAUSE OF LOSS

FY 2014/2015 THROUGH 2018/2019



CITY OF *Sample* WORKERS' COMPENSATION 5YR CLAIM DISTRIBUTION BY TOP 10 CAUSE OF LOSS

FY 2014/2015 THROUGH 2018/2019



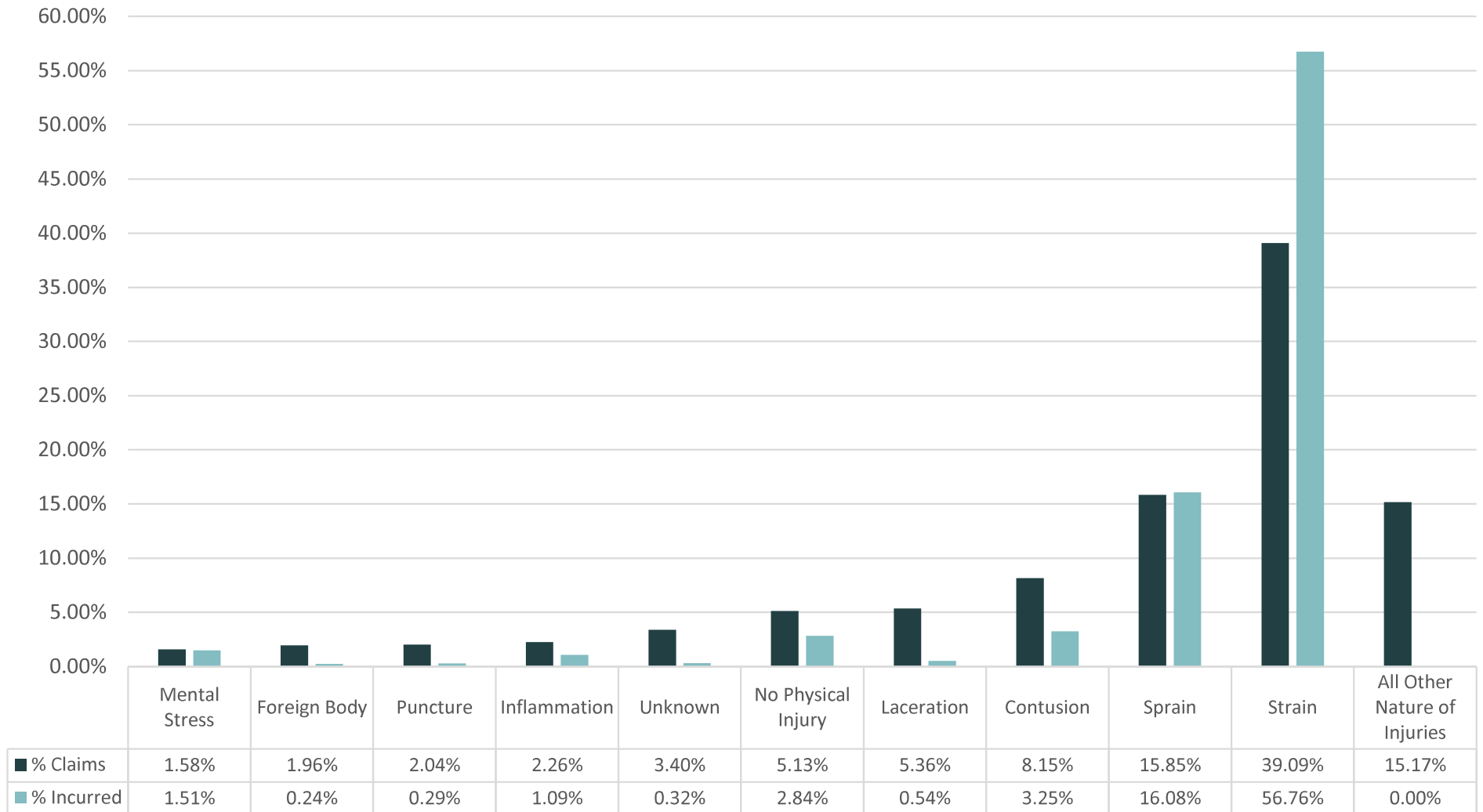
CLAIM DISTRIBUTION BY CAUSE OF LOSS REFERENCE

VALUATION DATE 6-30-2019

Cause Description	Claims	Total Incurred	Avg/Claim	Cause Description	Claims	Total Incurred	Avg/Claim
Abnormal Air Pressure Exposure	1	\$69,410	\$69,410	Reaching	12	\$242,973	\$20,248
Fire / Flame Contact	1	\$2,335	\$2,335	Hit by Falling / Flying Object	13	\$111,663	\$8,589
Hit by Explosion / Flareback	1	\$966	\$966	Abrasive Repetitive Motion	14	\$403,732	\$28,838
Hot Object / Substance Contact	1	\$800	\$800	Absorbed / Ingested / Inhaled	14	\$121,166	\$8,655
Caught in Machine	2	\$979	\$489	Caught in Handled Object	14	\$67,445	\$4,817
Cut / Scraped by Hand Tool	2	\$236	\$118	Climbing	14	\$540,191	\$38,585
Fall from Ladder / Scaffolding	2	\$3,950	\$1,975	Hit by Miscellaneous Object	14	\$371,716	\$26,551
Hit by Moving Parts / Machine	2	\$35,944	\$17,972	Multi-Vehicle Accident	14	\$1,677,423	\$119,816
Hit by Object Handled by Other	2	\$80,438	\$40,219	Struck Stationary Object	14	\$58,093	\$4,150
Hot Fluid / Steam Contact	2	\$1,266	\$633	Bending / Stooping	15	\$266,115	\$17,741
Vehicle hit Fixed Object	2	\$392,043	\$196,022	Dust / Gas / Fume / Vapor Exposure	15	\$24,739	\$1,649
Continual Noise	3	\$26,517	\$8,839	Foreign Matter / Object in Eye	16	\$32,771	\$2,048
Fall into Opening	3	\$14,176	\$4,725	Trip did not fall	16	\$261,332	\$16,333
Struck / Stepped on Sharp Object	3	\$3,378	\$1,126	Holding or Carrying	18	\$902,784	\$50,155
Struck Moving Parts of Machine	4	\$33,363	\$8,341	Running	19	\$191,671	\$10,088
Cut / Scraped by Broken Glass	5	\$5,353	\$1,071	Slip did not fall	19	\$519,832	\$27,360
Cut / Scraped by Powered Tool	5	\$3,386	\$677	Using Tool or Machine	22	\$705,798	\$32,082
Extreme Temperature Exposure	5	\$11,771	\$2,354	Hit / Injured by Animal / Insect	23	\$19,542	\$850
Struck Miscellaneous Object	5	\$149,831	\$29,966	Cut / Scraped by Other Object	27	\$60,026	\$2,223
Fall on Slippery Substance	6	\$192,439	\$32,073	Hit by Handled Object	27	\$249,053	\$9,224
Struck Handled / Lifted Object	6	\$8,049	\$1,342	Miscellaneous Fall or Slip	29	\$362,002	\$12,483
Vehicle Accident	6	\$321,209	\$53,535	Fall from Different Level	30	\$1,352,057	\$45,069
Caught by Miscellaneous Object	7	\$103,619	\$14,803	Exposure / Contact	42	\$466,592	\$11,109
Strain	7	\$41,450	\$5,921	Twisting	44	\$1,889,636	\$42,946
Hit by Hand Tool / Machine	8	\$5,937	\$742	Fall on Same Level	50	\$1,684,917	\$33,698
Hit by Co-Worker / Patient	9	\$159,203	\$17,689	Pushing or Pulling	56	\$2,448,577	\$43,725
Hit by Motor Vehicle	10	\$210,335	\$21,033	Robbery / Assault / Other Crime	61	\$1,595,643	\$26,158
Jumping	10	\$444,269	\$44,427	Other than Physical Cause	86	\$1,930,650	\$22,449
Fall on Stairs	11	\$29,582	\$2,689	Lifting	97	\$4,136,148	\$42,641
Cut / Scraped by Handled Object	12	\$98,729	\$8,227	Repetitive Motion	170	\$6,221,434	\$36,597
				Cumulative Trauma	177	\$11,104,381	\$62,737
GRAND TOTALS		Claims:	1325	Incurred:	\$42,471,065	Average:	\$32,053.63

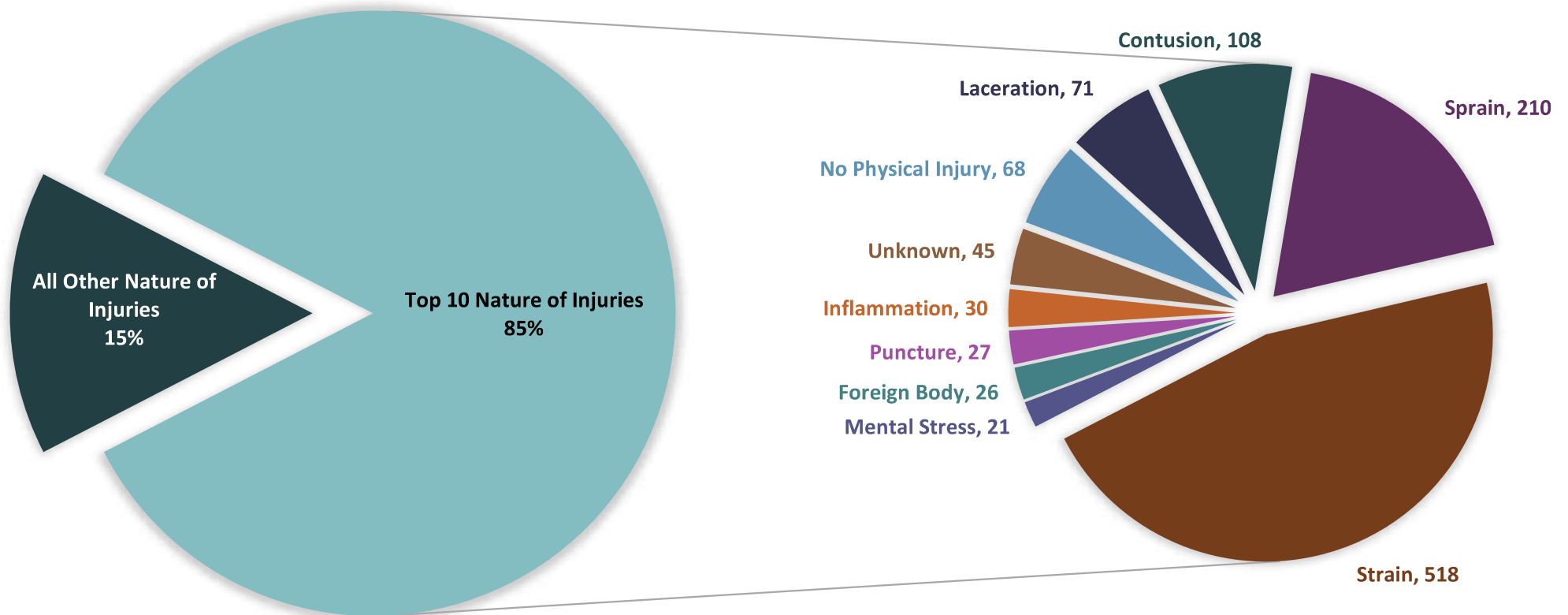
CITY OF *Sample* WORKERS' COMPENSATION 5YR CLAIM DISTRIBUTION BY TOP 10 NATURE OF INJURY

FY 2014/2015 THROUGH 2018/2019



**CITY OF *Sample* WORKERS' COMPENSATION
5YR CLAIM DISTRIBUTION BY TOP 10 NATURE OF INJURY**

FY 2014/2015 THROUGH 2018/2019



CLAIM DISTRIBUTION BY NATURE OF INJURY REFERENCE

VALUATION DATE 6-30-2019

Nature of Injury	Claims	Total Incurred	Avg/Claim	Nature of Injury	Claims	Total Incurred	Avg/Claim
Cardiovascular Disease	1	\$36,820	\$36,820	Dizziness	8	\$18,009	\$2,251
Concussion	1	\$222	\$222	Heart Trouble	8	\$385,561	\$48,195
Pneumonia	1	\$42,160	\$42,160	Hypertension	8	\$257,074	\$32,134
Poisoning - General	1	\$864	\$864	Dermatitis	10	\$111,090	\$11,109
Tinnitus Cumulative	1	\$83,448	\$83,448	Abrasion	11	\$95,676	\$8,698
Tinnitus Specific	1	\$704	\$704	Asbestosis	12	\$193,348	\$16,112
Vision Loss	1	\$1,546	\$1,546	Cancer	12	\$999,048	\$83,254
Amputation	2	\$57,516	\$28,758	Fracture	13	\$2,707,139	\$208,241
Electric Shock	2	\$774	\$387	Infection	15	\$40,532	\$2,702
Elevated Heart Rate	2	\$27,471	\$13,735	Carpal Tunnel Syndrome	16	\$635,787	\$39,737
Myocardial Infarction	2	\$327,231	\$163,616	Hernia	16	\$483,179	\$30,199
Syncope	2	\$3,241	\$1,620	Mental Stress	21	\$640,260	\$30,489
Hearing Loss (Cumulative)	3	\$95,530	\$31,843	Foreign Body	26	\$103,976	\$3,999
Hearing Loss (Specific Trauma)	3	\$101,660	\$33,887	Puncture	27	\$123,567	\$4,577
Contagious Disease	4	\$4,671	\$1,168	Inflammation	30	\$461,111	\$15,370
Dislocation	4	\$73,075	\$18,269	Unknown	45	\$134,521	\$2,989
Exposure Bloodborne Pathogen	4	\$1,813	\$453	No Physical Injury	68	\$1,205,505	\$17,728
Smoke Inhalation	4	\$15,610	\$3,903	Laceration	71	\$227,683	\$3,207
Rupture	5	\$241,193	\$48,239	Contusion	108	\$1,379,646	\$12,775
Respiratory Disorders	6	\$142,387	\$23,731	Sprain	210	\$6,828,444	\$32,516
Crushing	7	\$36,204	\$5,172	Strain	518	\$24,105,724	\$46,536
Heat Prostration	7	\$28,706	\$4,101				
Burn	8	\$11,338	\$1,417				

GRAND TOTALS

Claims:

1325

Incurred:

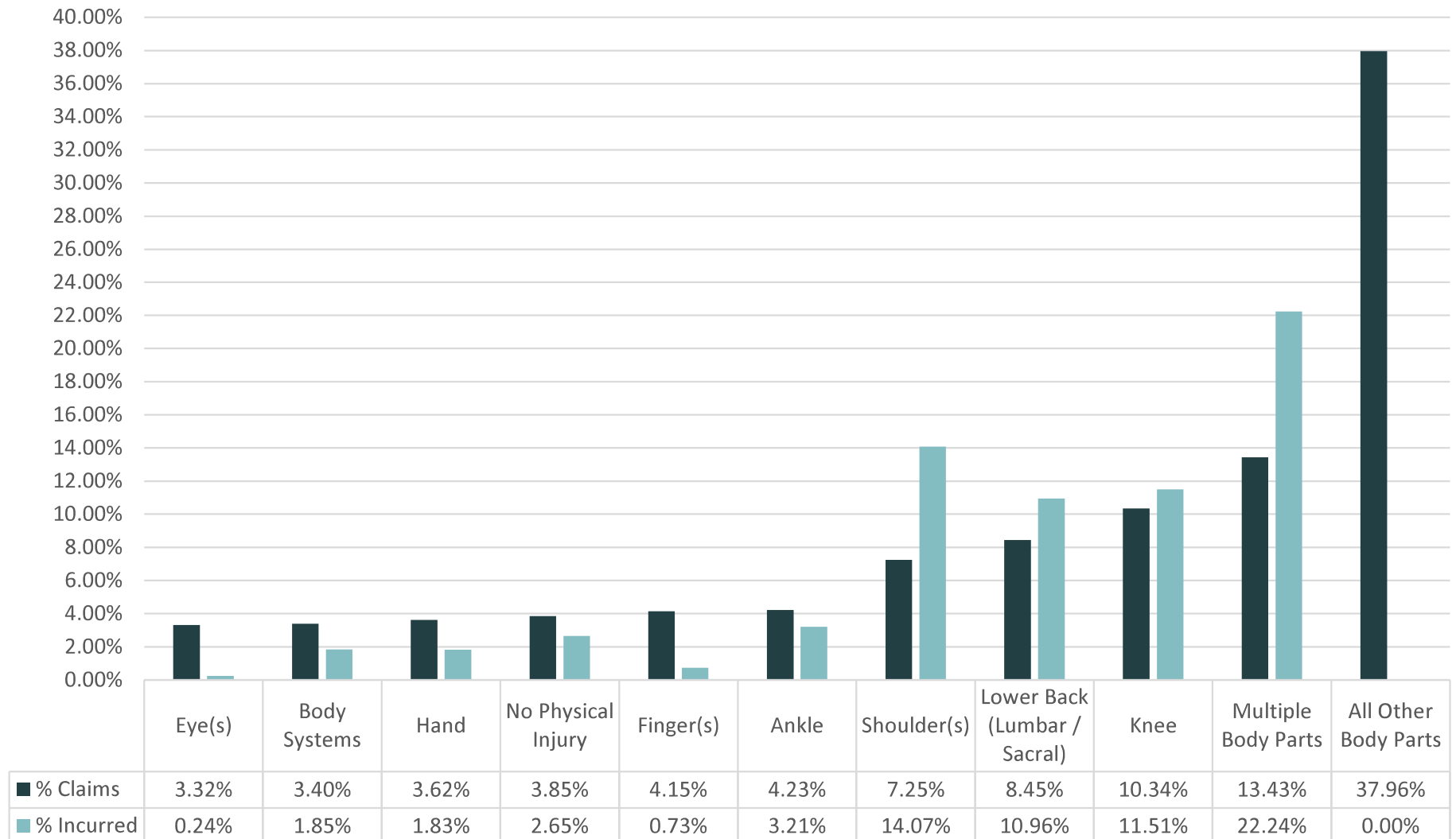
\$42,471,065

Average:

\$32,053.63

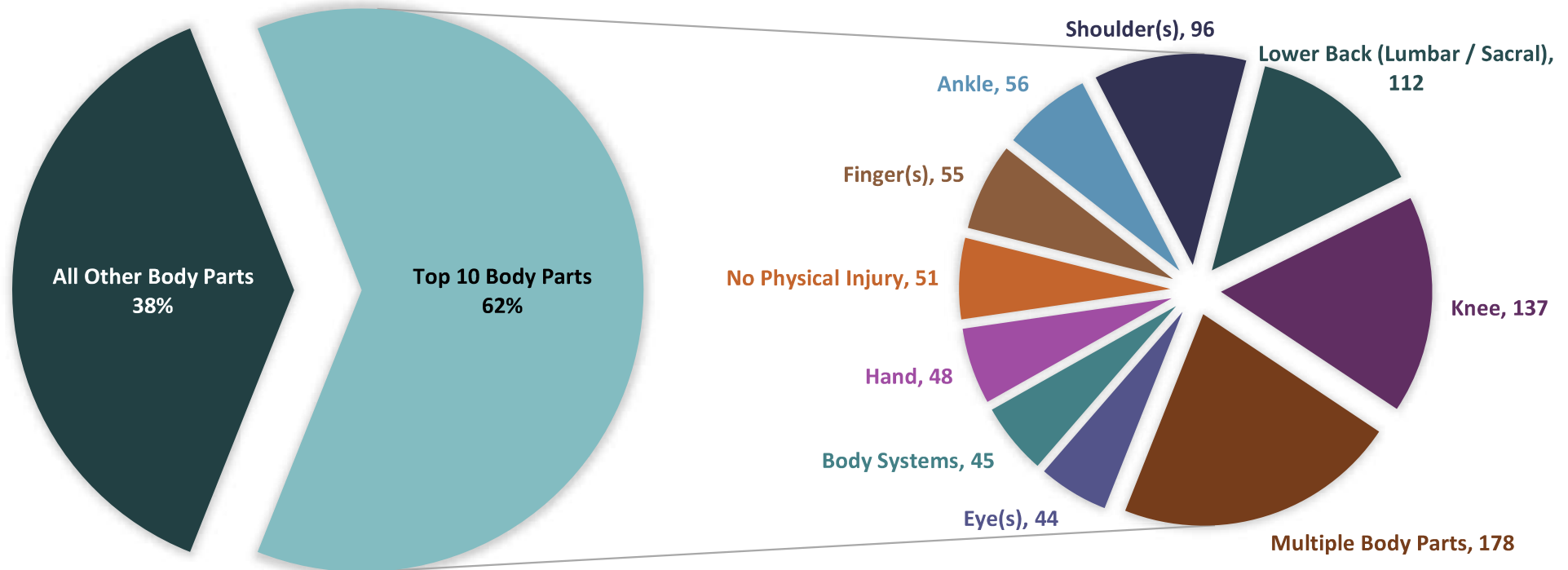
CITY OF *Sample* WORKERS' COMPENSATION 5YR CLAIM DISTRIBUTION BY TOP 10 BODY PART

FY 2014/2015 THROUGH 2018/2019



**CITY OF *Sample* WORKERS' COMPENSATION
5YR CLAIM DISTRIBUTION BY TOP 10 BODY PART**

FY 2014/2015 THROUGH 2018/2019



CLAIM DISTRIBUTION BY BODY PART REFERENCE

VALUATION DATE 6-30-2019

Body Part	Claims	Total Incurred	Avg/Claim	Body Part	Claims	Total Incurred	Avg/Claim
Buttock(s)	1	\$1,538	\$1,538	Head Injury	16	\$65,852	\$4,116
Miscellaneous	1	\$1,498	\$1,498	Facial Soft Tissue	17	\$134,165	\$7,892
Pelvis	1	\$3,800	\$3,800	Upper Arm / Clavicle / Scapula	18	\$519,321	\$28,851
Cervical and Thoracic	2	\$4,965	\$2,482	Thumb	20	\$186,901	\$9,345
Great Toe	2	\$1,322	\$661	Internal Organs	21	\$551,201	\$26,248
Unknown	3	\$17,095	\$5,698	Upper Extremity(s)	21	\$567,255	\$27,012
Neck Soft Tissue	3	\$982	\$327	Elbow	24	\$611,642	\$25,485
Facial Bones	4	\$5,700	\$1,425	Lumbar / Sacral Vertebrae	24	\$954,209	\$39,759
Mouth	4	\$23,895	\$5,974	Abdomen / Groin	27	\$579,422	\$21,460
Cervical and Lumbar	7	\$263,477	\$37,640	Lower Arm	30	\$87,661	\$2,922
Lower Extremity(s)	7	\$810,804	\$115,829	Lower Leg	35	\$704,027	\$20,115
Nose	7	\$216,413	\$30,916	Foot	38	\$713,907	\$18,787
Skull	7	\$5,522	\$789	Wrist	40	\$828,052	\$20,701
Toe(s)	7	\$14,409	\$2,058	Eye(s)	44	\$100,964	\$2,295
Wrist(s) and Hand(s)	7	\$131,559	\$18,794	Body Systems	45	\$783,701	\$17,416
Thoracic and Lumbar	8	\$842,103	\$105,263	Hand	48	\$775,311	\$16,152
Upper Leg	9	\$158,331	\$17,592	No Physical Injury	51	\$1,126,438	\$22,087
Hip	11	\$1,031,185	\$93,744	Finger(s)	55	\$310,320	\$5,642
Upper Back (Thoracic)	11	\$420,751	\$38,250	Ankle	56	\$1,363,822	\$24,354
Lung(s)	12	\$187,327	\$15,611	Shoulder(s)	96	\$5,975,342	\$62,243
Heart	13	\$738,090	\$56,776	Lower Back (Lumbar / Sacral)	112	\$4,653,406	\$41,548
Chest (Ribs / Sternum / Other)	15	\$698,113	\$46,541	Knee	137	\$4,889,507	\$35,690
Ear(s)	15	\$282,727	\$18,848	Multiple Body Parts	178	\$9,447,509	\$53,076
Neck	15	\$679,525	\$45,302				

GRAND TOTALS

Claims:

1325

Incurred:

\$42,471,065

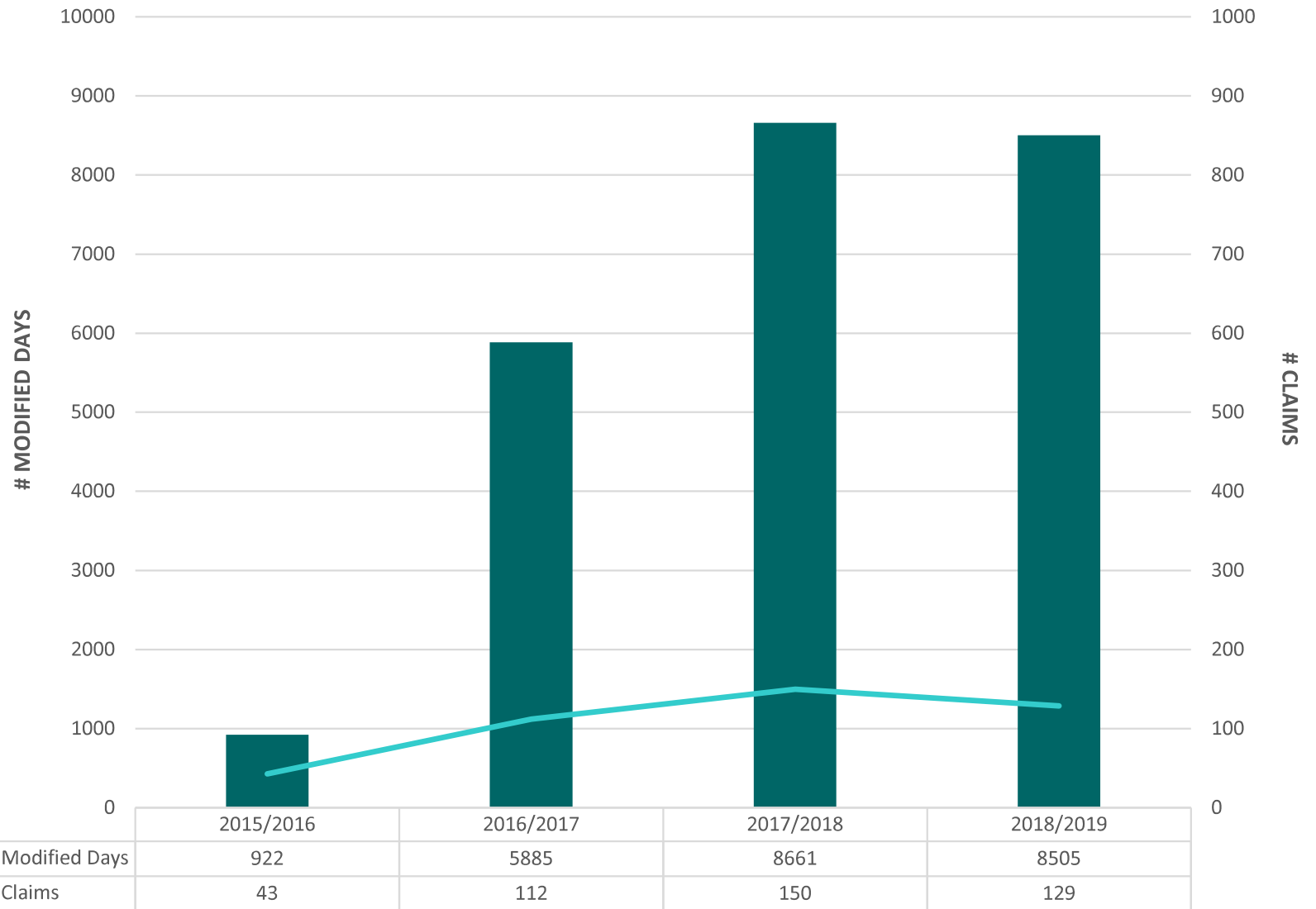
Average:

\$32,053.63

CITY OF *Sample*

MODIFIED DUTY DAYS - ALL DEPARTMENTS

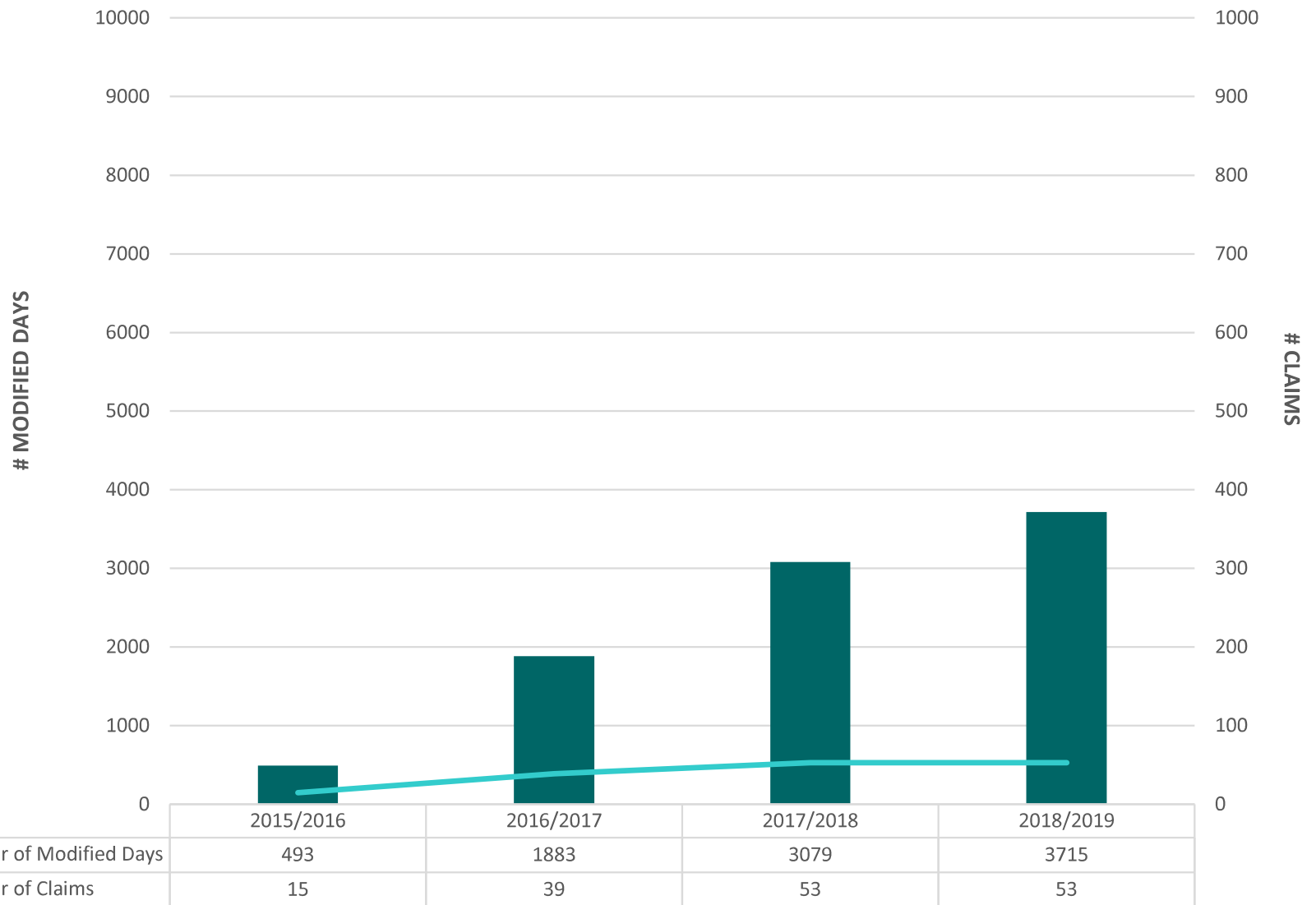
ACROSS ALL CLAIMS WITH MOD. DAYS > 0 AT FY END – REGARDLESS OF DOI/OPEN DATE



CITY OF *Sample*

MODIFIED DUTY DAYS - SAFETY (POLICE & FIRE)

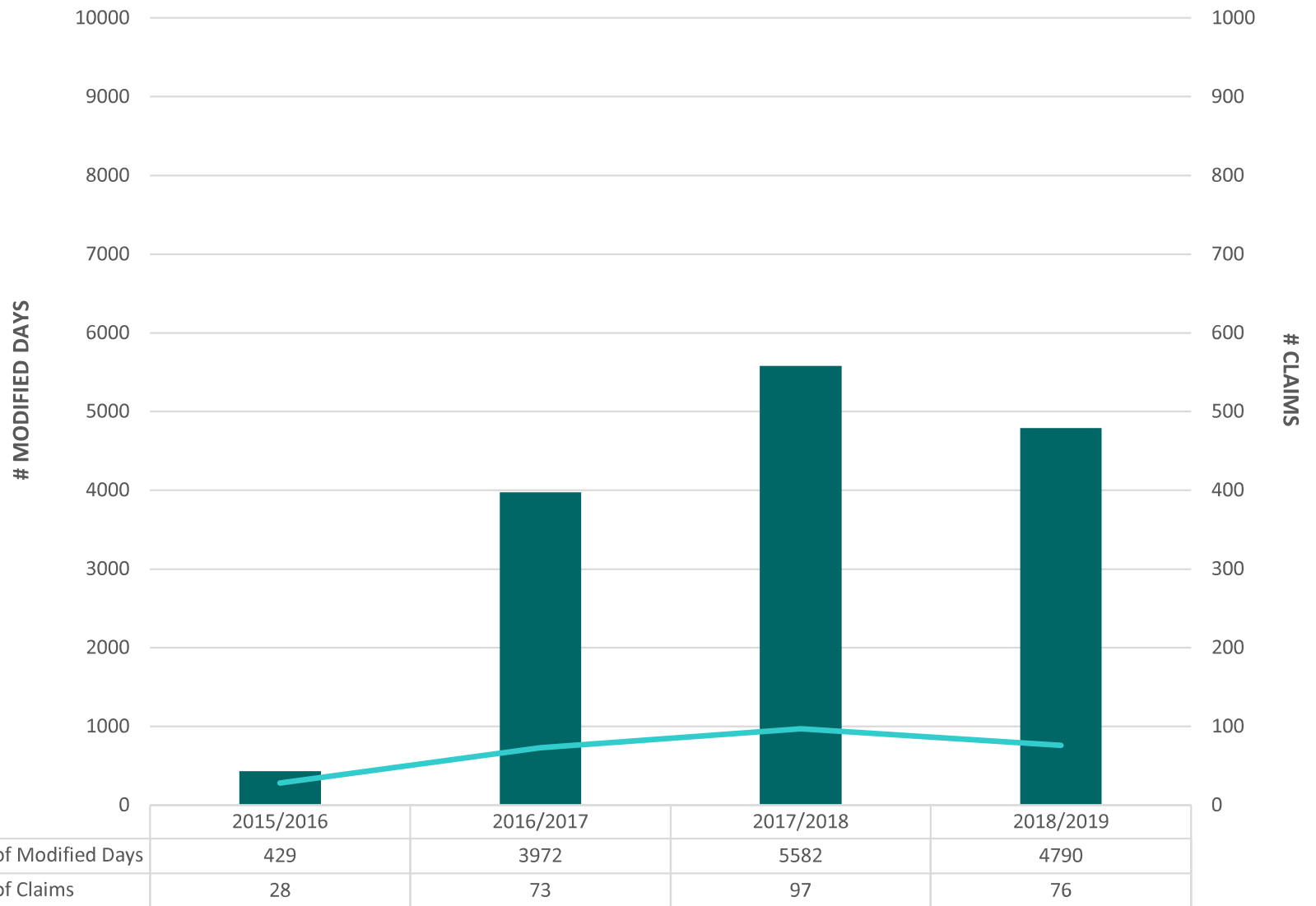
ACROSS ALL CLAIMS WITH MOD. DAYS > 0 AT FY END – REGARDLESS OF DOI/OPEN DATE



CITY OF *Sample*

MODIFIED DUTY DAYS - NON-SAFETY

ACROSS ALL CLAIMS WITH MOD. DAYS > 0 AT FY END – REGARDLESS OF DOI/OPEN DATE

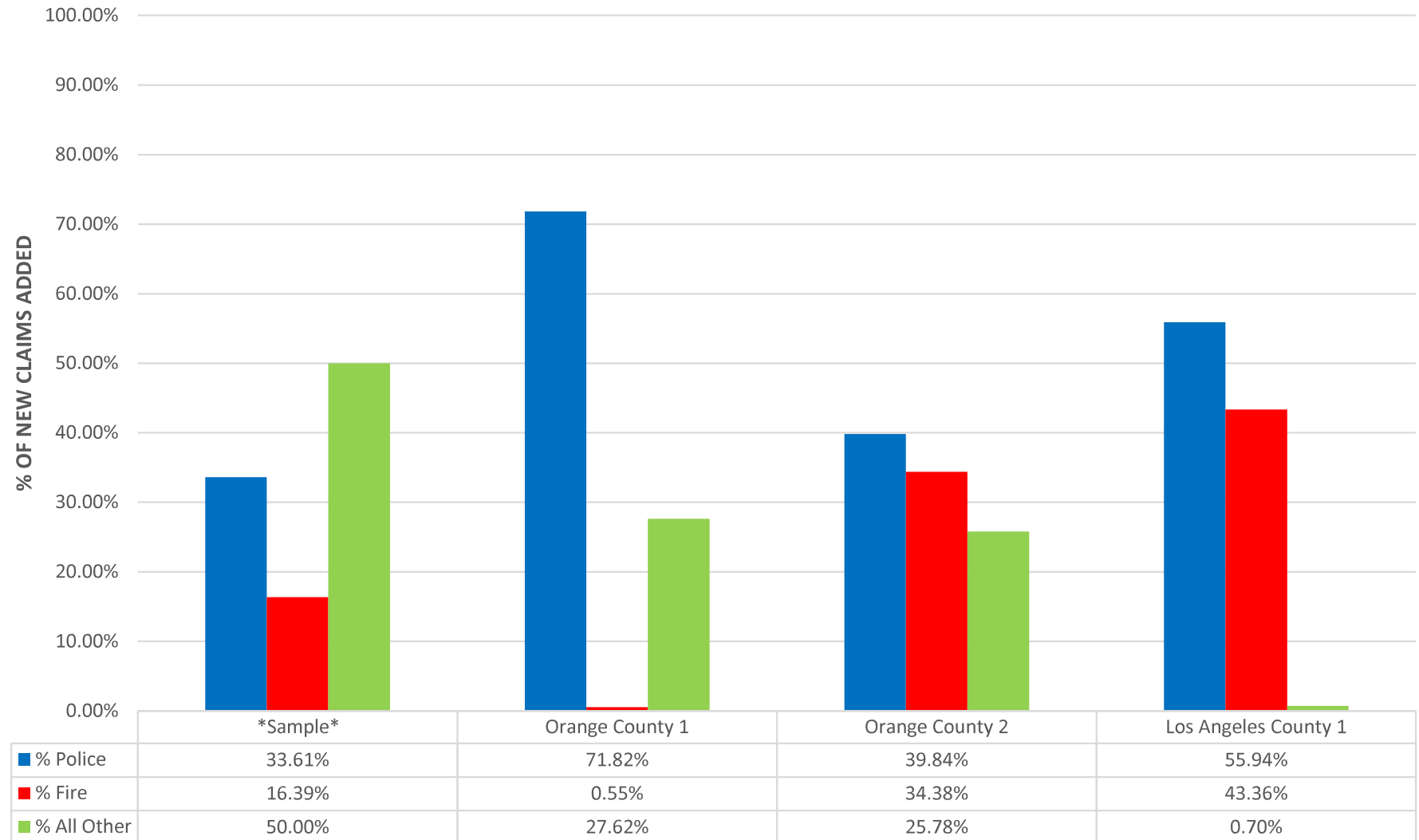


CITY OF *Sample* METRICS

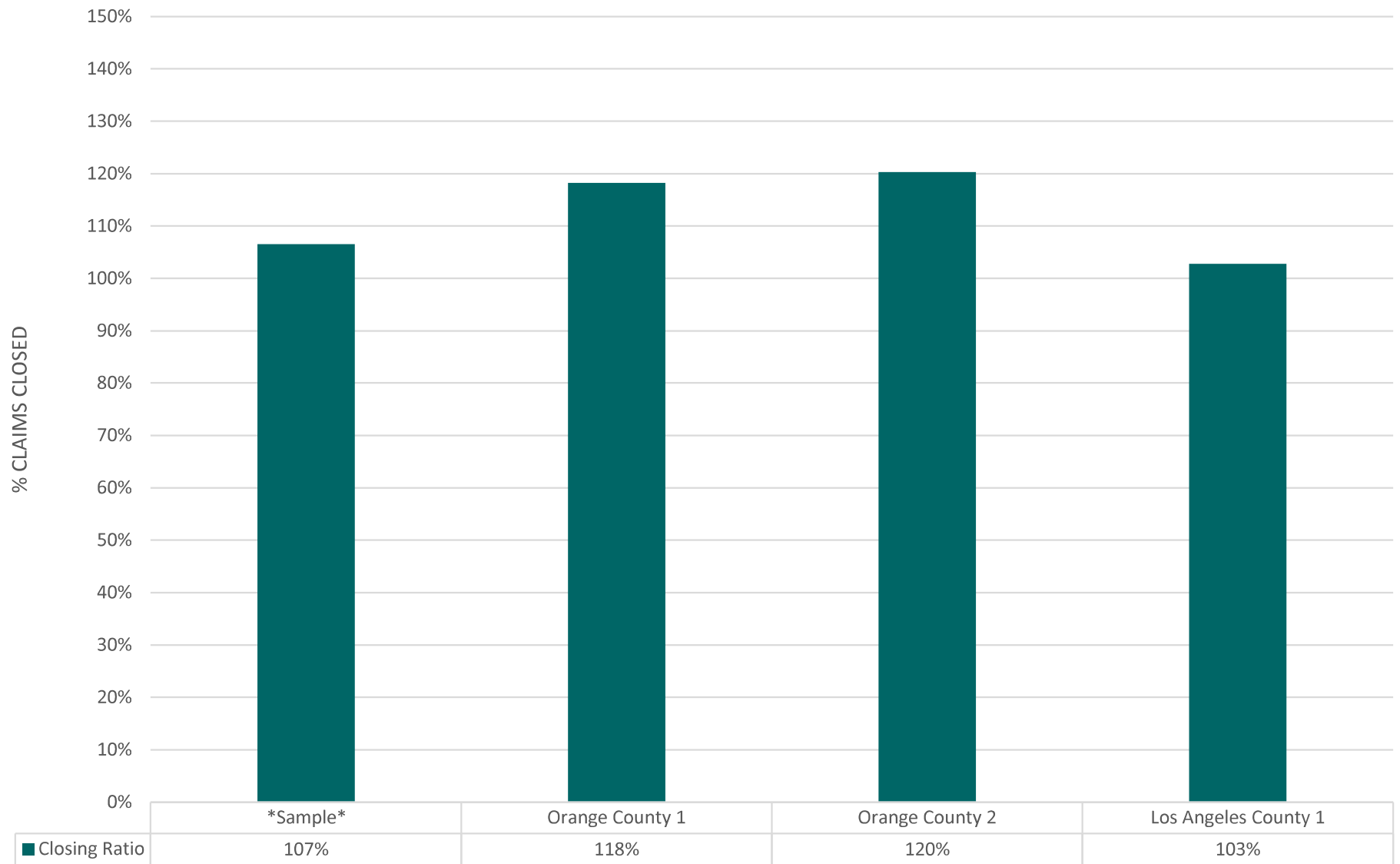
	2014/2015	2015/2016	2016/2017	2017/2018	4yr. Avg.	2018/2019
1. Average Cost Per Claim	\$6,593	\$5,679	\$6,160	\$7,812	\$6,561	\$4,346
Total Claim Costs (Total Paid) @ End of Fiscal Year	\$1,753,750	\$1,754,658	\$1,515,292	\$2,031,136		\$1,060,338
Total # of Reported Claims	266	309	246	260		244
	2014/2015	2015/2016	2016/2017	2017/2018	4yr. Avg.	2018/2019
	\$34,296	\$24,743	\$16,923	\$17,813	\$23,443	\$4,346
Total Claim Costs as of 6/30/2019	\$9,122,659	\$7,645,440	\$4,163,090	\$4,631,283		\$1,060,338
Total # of Reported Claims	266	309	246	260		244
	2014/2015	2015/2016	2016/2017	2017/2018	4yr. Avg.	2018/2019
2. Annual Cost Per FTE	\$930	\$918	\$793	\$1,092	\$933	\$496
Total Claim Costs (Total Paid) @ End of Fiscal Year	\$1,753,750	\$1,754,658	\$1,515,292	\$2,031,136		\$1,060,338
Total # of FTE's Covered Under WC	1886	1912	1912	1860		2138
	2014/2015	2015/2016	2016/2017	2017/2018	4yr. Avg.	2018/2019
	\$4,837	\$3,999	\$2,177	\$2,490	\$3,376	\$496
Total Claim Costs as of 6/30/2019	\$9,122,659	\$7,645,440	\$4,163,090	\$4,631,283		\$1,060,338
Total # of FTE's Covered Under WC	1886	1912	1912	1860		2138
	2014/2015	2015/2016	2016/2017	2017/2018	4yr. Avg.	2018/2019
3. Frequency Rate (per 100 employees)	14.10%	16.16%	12.87%	13.98%	14.28%	11.41%
Total # of Reported Claims	266	309	246	260		244
Total # of FTE's Covered Under WC	1886	1912	1912	1860		2138
	2014/2015	2015/2016	2016/2017	2017/2018	4yr. Avg.	2018/2019
4. Percentage of Annual Indemnity Claims	58.65%	62.46%	59.76%	53.85%	58.68%	58.20%
# of New Indemnity Claims	156	193	147	140		142
Total # of Reported WC Claims	266	309	246	260		244
	2014/2015	2015/2016	2016/2017	2017/2018	4yr. Avg.	2018/2019
5. WC Costs as Percentage of Payroll	1.05%	1.02%	0.85%	1.12%	1.01%	0.56%
Total Claim Costs (Total Paid) @ End of Fiscal Year	\$1,753,750	\$1,754,658	\$1,515,292	\$2,031,136		\$1,060,338
Total Payroll	\$167,628,100	\$171,675,261	\$178,726,586	\$181,973,165		\$190,299,253
	2014/2015	2015/2016	2016/2017	2017/2018	4yr. Avg.	2018/2019
	5.44%	4.45%	2.33%	2.55%	3.69%	0.56%
Total Claim Costs as of 6/30/2019	\$9,122,659	\$7,645,440	\$4,163,090	\$4,631,283		\$1,060,338
Total Payroll	\$167,628,100	\$171,675,261	\$178,726,586	\$181,973,165		\$190,299,253

CITY COMPARISON PERCENTAGE OF NEW CLAIMS ADDED

FISCAL YEAR 2018/2019

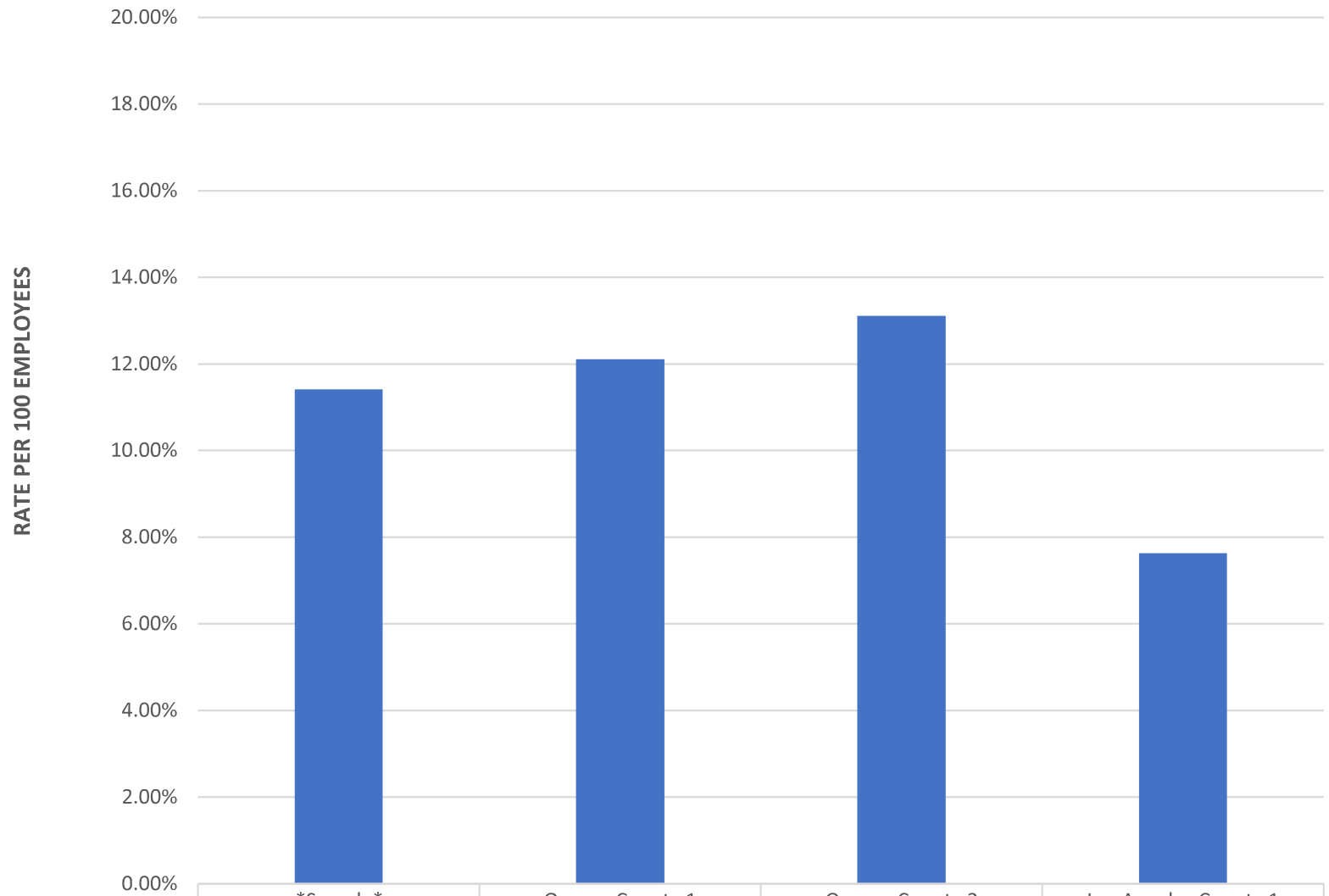


CITY COMPARISON
CLOSING RATIO
FISCAL YEAR 2018/2019



CITY COMPARISON FREQUENCY RATE (PER 100 EMPLOYEES)

FISCAL YEAR 2018/2019



■ FREQUENCY RATE (PER 100 EMPLOYEES)

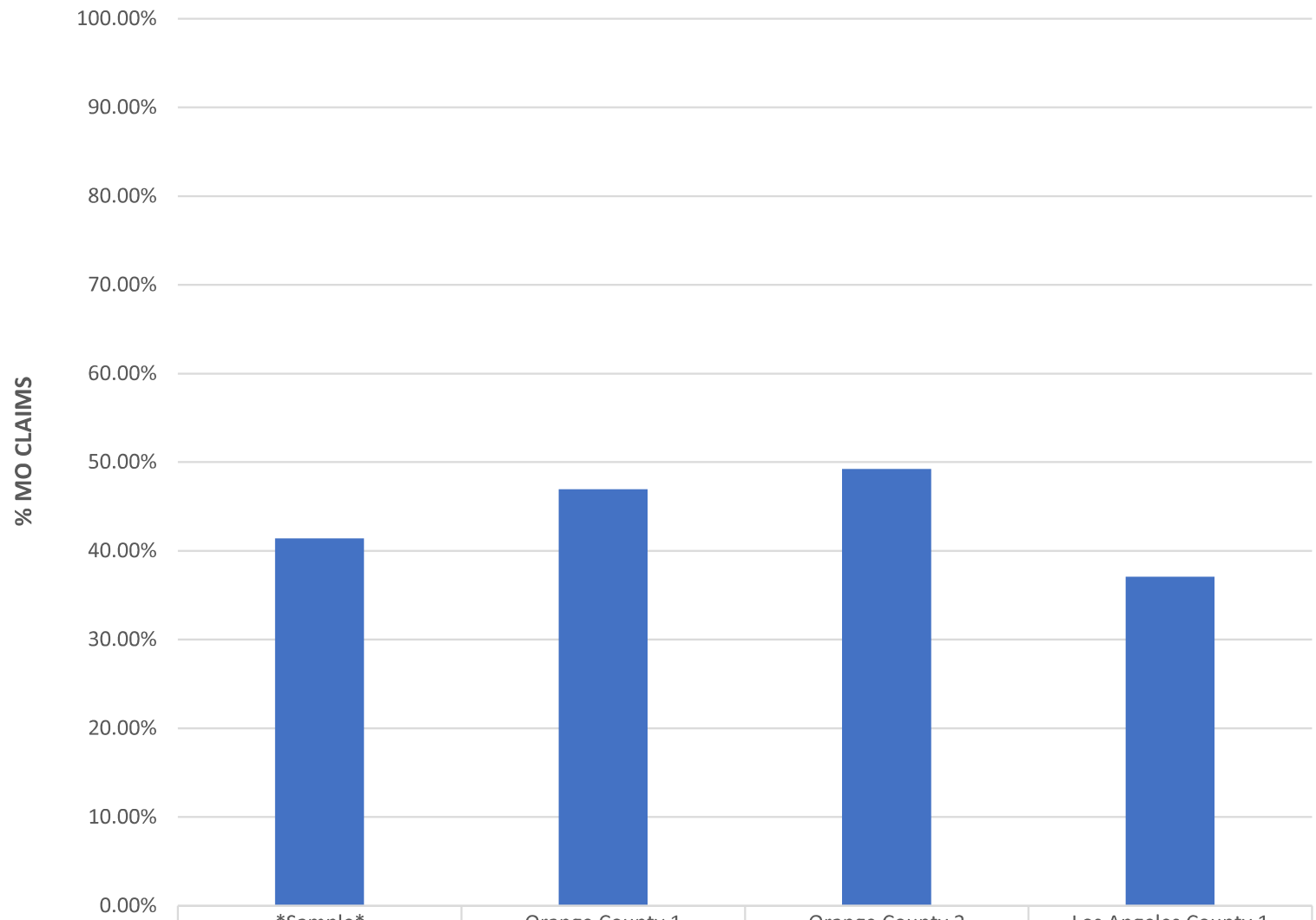
11.41%

12.11%

13.11%

7.63%

CITY COMPARISON
PERCENTAGE OF ANNUAL MEDICAL ONLY CLAIMS
FISCAL YEAR 2018/2019



■ Percentage of Annual Medical Only Claims

Sample

41.39%

Orange County 1

46.96%

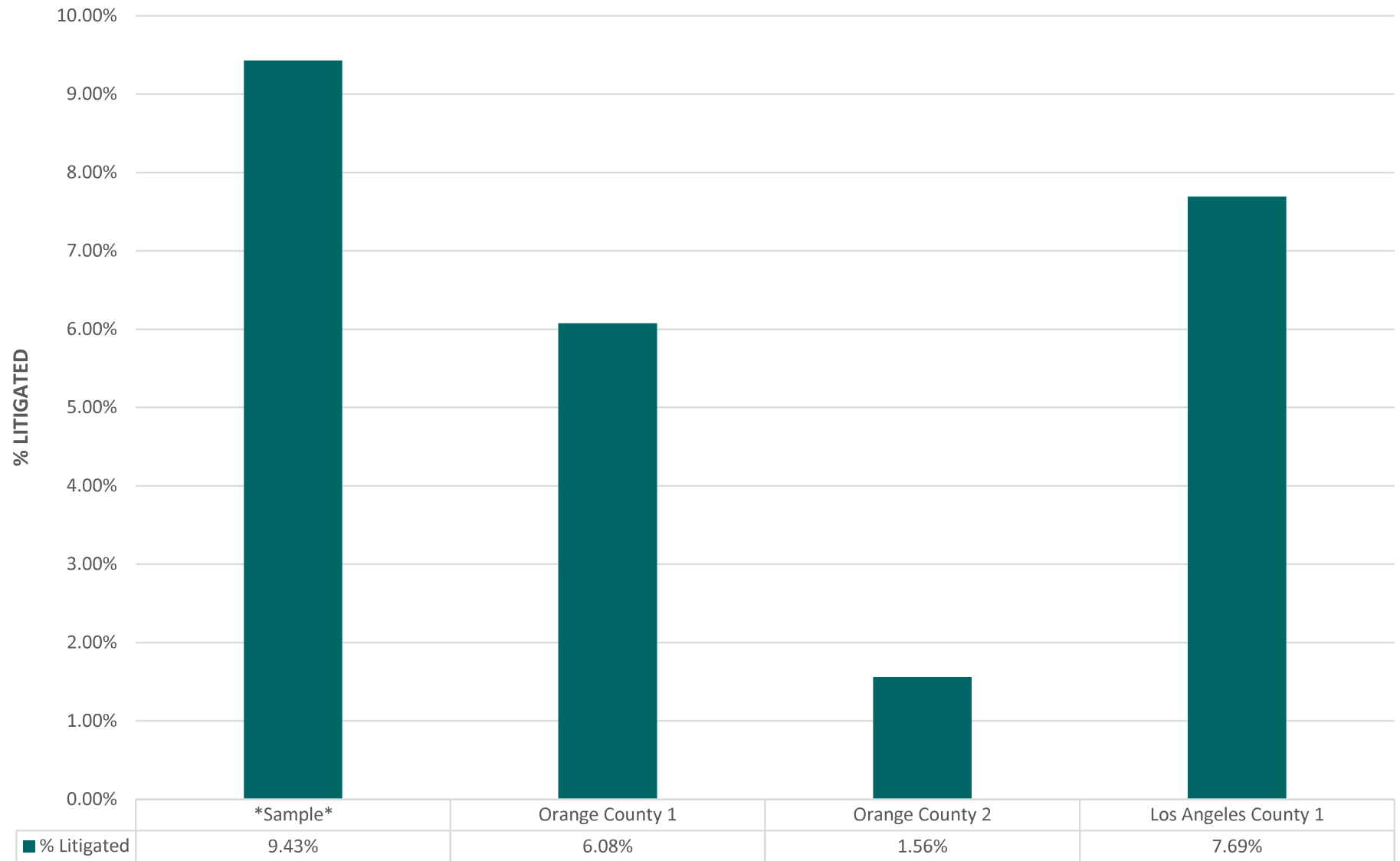
Orange County 2

49.22%

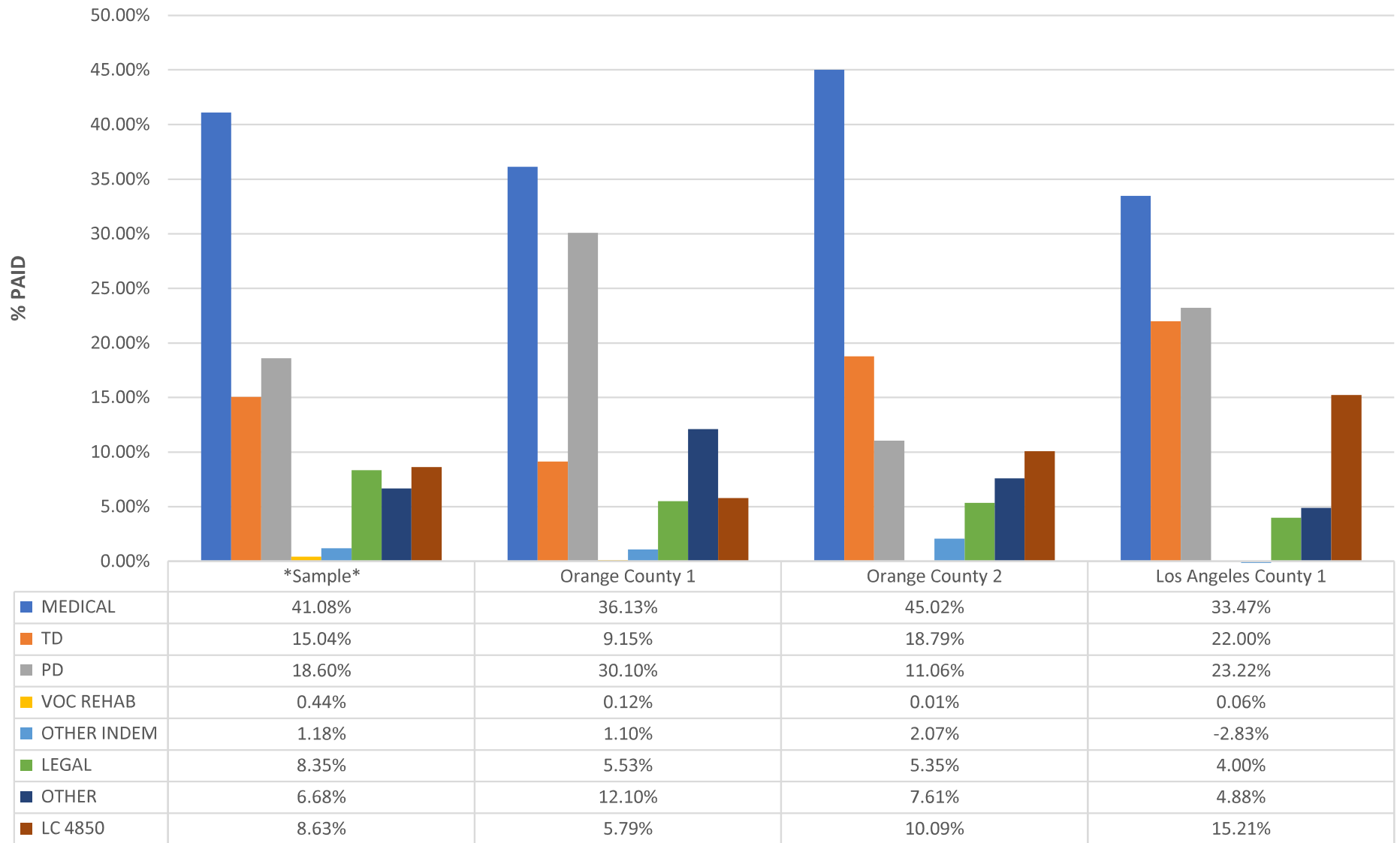
Los Angeles County 1

37.06%

CITY COMPARISON
PERCENTAGE LITIGATED FOR NEW CLAIMS ADDED
FISCAL YEAR 2018/2019



CITY COMPARISON
PERCENTAGE OF TOTAL PAID (ALL CLAIMS)
 FISCAL YEAR 2018/2019



Test Savings and Fee Summary

Client: Total:Total

Metric	Amount	Percentage
Bill Count	1,073	
Work Units	0	
Additional Charge	\$0.00	
Total Charges	\$1,967,720.48	
Dup Red	\$487,414.40	
BR Reg Red	\$1,068,235.51	
PPO Red	\$26,635.81	
OSR Red	\$275.35	
All Other Red	\$296.92	
Total Red	\$1,582,857.99	80.44%
Red Less Dups	\$1,095,443.59	74.00%
OCR Fee	\$502.20	
eBill Fee	\$141.60	
BR Fee	\$9,279.00	
IPFS Fee	\$0.00	
UR Advisor Fee	\$0.00	
Nurse Fee	\$0.00	
Neg Fee	\$0.00	
AP Fee	\$0.00	
PPO Fee	\$4,610.75	
OSR Fee	\$49.56	
SR Fee	\$0.00	
All Other Fee	\$0.00	
Total Fee	\$14,583.11	
Net Savings	\$1,080,860.48	73.02%
ROI	109:1	

Savings by Service Class

Client: Total:Total

Service Class	Bill Count	Total Charges	Additional Charge	Dup Red	BR Reg Red	PPO Red	OSR Red	All Other Red	Total Red	Total Red %	Total Allowance
ANESTHESIOLOGY	4	\$12,912.00	\$0.00	\$0.00	\$10,751.28	\$314.14	\$0.00	\$0.00	\$11,065.42	85.70%	\$1,846.58
DRUGS	196	\$107,274.56	\$0.00	\$10,786.91	\$46,654.57	\$463.15	\$163.74	\$8.98	\$58,077.35	54.14%	\$49,197.21
DURABLE MEDICAL EQUIPMENT	17	\$13,085.72	\$0.00	\$1,082.92	\$3,630.41	\$607.80	\$0.00	\$117.41	\$5,438.54	41.56%	\$7,647.18
EVALUATION AND MANAGEMENT	380	\$145,977.91	\$0.00	\$13,988.33	\$61,942.08	\$8,057.66	\$0.00	\$0.00	\$83,988.07	57.53%	\$61,989.84
FACILITY-ASC	12	\$115,315.92	\$0.00	\$0.00	\$100,233.47	\$705.45	\$0.00	\$0.00	\$100,938.92	87.53%	\$14,377.00
FACILITY-INPATIENT HOSPITAL	5	\$1,114,694.73	\$0.00	\$429,717.45	\$599,103.32	\$1,375.34	\$0.00	\$0.00	\$1,030,196.11	92.42%	\$84,498.62
FACILITY-OUTPATIENT HOSPITAL	11	\$106,550.34	\$0.00	\$1,538.34	\$80,311.86	\$42.31	\$0.00	\$0.00	\$81,892.51	76.86%	\$24,657.83
HEARING SERVICES	1	\$6,175.00	\$0.00	\$0.00	\$6,175.00	\$0.00	\$0.00	\$0.00	\$6,175.00	100.00%	\$0.00
HOME HEALTH	18	\$19,967.64	\$0.00	\$0.00	\$1,027.80	\$0.00	\$0.00	\$0.00	\$1,027.80	5.15%	\$18,939.84
MEDICAL AND SURGICAL SUPPLIES	11	\$5,397.40	\$0.00	\$84.92	\$3,162.52	\$249.65	\$0.00	\$4.97	\$3,502.06	64.88%	\$1,895.34
MEDICAL-LEGAL	18	\$37,318.86	\$0.00	\$9,444.93	(\$251.62)	\$0.00	\$0.00	\$0.00	\$9,193.31	24.63%	\$28,125.55
MEDICINE	24	\$19,032.99	\$0.00	\$0.00	\$11,878.52	\$531.65	\$0.00	\$0.00	\$12,410.17	65.20%	\$6,622.82
NON MEDICAL	9	\$1,548.85	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	0.00%	\$1,548.85
ORTHODIC PROCEDURES AND DEVICES	6	\$9,541.27	\$0.00	\$0.00	\$2,169.92	\$1,012.74	\$0.00	\$165.56	\$3,348.22	35.09%	\$6,193.05
PATHOLOGY	24	\$64,007.92	\$0.00	\$1,087.44	\$58,162.20	\$371.60	\$42.81	\$0.00	\$59,664.05	93.21%	\$4,343.87
PHYSICAL MEDICINE AND REHAB	259	\$85,310.17	\$0.00	\$4,161.78	\$31,932.24	\$4,731.49	\$0.00	\$0.00	\$40,825.51	47.86%	\$44,484.66
RADIOLOGY	35	\$25,400.24	\$0.00	\$1,554.00	\$18,083.28	\$777.45	\$68.80	\$0.00	\$20,483.53	80.64%	\$4,916.71
SURGERY	26	\$48,838.32	\$0.00	\$2,591.13	\$29,382.15	\$1,990.00	\$0.00	\$0.00	\$33,963.28	69.54%	\$14,875.04
TRANSPORTATION	5	\$5,657.26	\$0.00	\$3,876.25	\$640.28	\$0.00	\$0.00	\$0.00	\$4,516.53	79.84%	\$1,140.73
Unknown	12	\$23,713.38	\$0.00	\$7,500.00	\$3,246.23	\$5,405.38	\$0.00	\$0.00	\$16,151.61	68.11%	\$7,561.77
Total	1,073	\$1,967,720.48	\$0.00	\$487,414.40	\$1,068,235.51	\$26,635.81	\$275.35	\$296.92	\$1,582,857.99	80.44%	\$384,862.49

PPO/OSR Penetration

Bill.Jurisdiction State	PPO/OSR	Bill Count	Total Charges	BR Allowance*	Billed To PPO/OSR	PPO/OSR Red	PPO/OSR Fee	PPO/OSR Savings	PPO/OSR Penetration	PPO/OSR Efficiency
AZ	PrimeHealth Pend And Transmit	1	\$60.75	\$46.90	\$46.90	\$9.38	\$1.69	20.00%	100.00%	200.00
	Total	1	\$60.75	\$46.90	\$46.90	\$9.38	\$1.69	20.00%	100.00%	200.00
CA	Anthem Blue Cross Pend and Transmit	236	\$4,574,189.43	\$1,334,886.56	\$1,334,886.56	\$353,573.92	\$84,628.67	26.49%	24.50%	64.90
	Coventry Pend And Transmit	8	\$766,650.02	\$114,752.08	\$114,752.08	\$406.09	\$101.54	0.35%	2.11%	0.07
	HealthSmart Pend And Transmit	471	\$697,440.32	\$497,226.39	\$497,226.39	\$4,755.56	\$1,283.46	0.96%	9.13%	0.88
	IQ Analysis FS	253	\$659,480.04	\$221,512.40	\$221,512.40	\$6,862.63	\$1,503.66	3.10%	4.07%	1.26
	No PPO	2,661	\$2,844,808.26	\$1,061,182.86	\$0.00	\$0.00	\$0.00			
	PrimeHealth Pend And Transmit	7,130	\$4,740,985.70	\$2,218,774.65	\$2,218,774.65	\$193,643.08	\$44,438.25	8.73%	40.72%	35.55
	Total	10,759	\$14,283,553.77	\$5,448,334.94	\$4,387,152.08	\$559,241.28	\$131,955.58	12.75%	80.52%	102.67
ID	Coventry Pend And Transmit	1	\$2,162.00	\$825.13	\$825.13	\$8.25	\$2.06	1.00%	100.00%	10.00
	Total	1	\$2,162.00	\$825.13	\$825.13	\$8.25	\$2.06	1.00%	100.00%	10.00
MS	No PPO	1	\$3,748.00	\$1,629.11	\$0.00	\$0.00	\$0.00			
	Total	1	\$3,748.00	\$1,629.11	\$0.00	\$0.00	\$0.00			
TX	PrimeHealth Pend And Transmit	1	\$1,798.00	\$1,427.12	\$1,427.12	\$168.52	\$30.33	11.81%	100.00%	118.10
	Total	1	\$1,798.00	\$1,427.12	\$1,427.12	\$168.52	\$30.33	11.81%	100.00%	118.10
Total		10,763	\$14,291,322.52	\$5,452,263.20	\$4,389,451.23	\$559,427.43	\$131,989.66	12.74%	80.51%	102.57

DASHBOARD SAMPLE 1 of 2

AdminSure

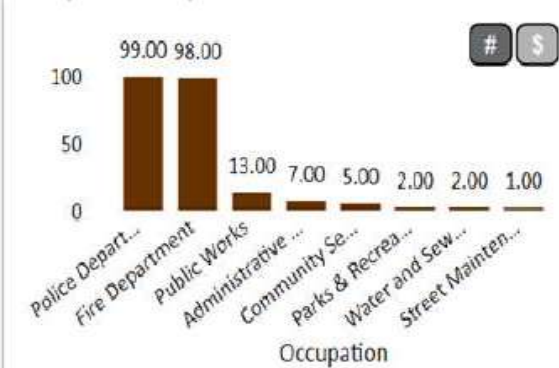
- Risk Management
- RM Dashboard
- Loss Stratification
- My Report
- Claim Management
- Claim Search

Applied Filters: Calendar Year: All, Fiscal Year - Quarter: All, Claim Status: Multiple selections, Claim Type: All, Organization: All, Location: All

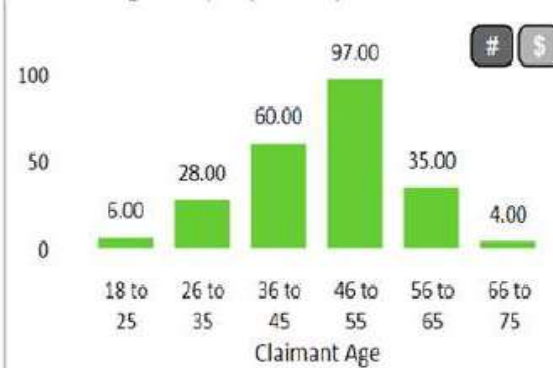
Claim Count # 230	Total Incurred (\$) \$54.83M	Total Paid (\$) \$23.22M	Outstanding Reserve (\$) \$31.61M
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Demographic Analysis

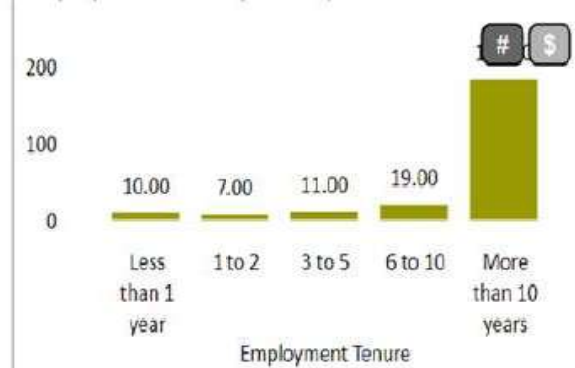
Occupation Analysis



Claimant Age Analysis (In Years)



Employment Tenure (In Years)

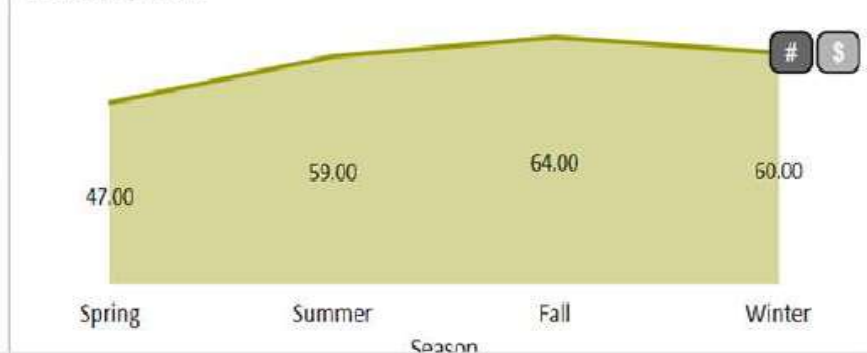


Reporting Statistics

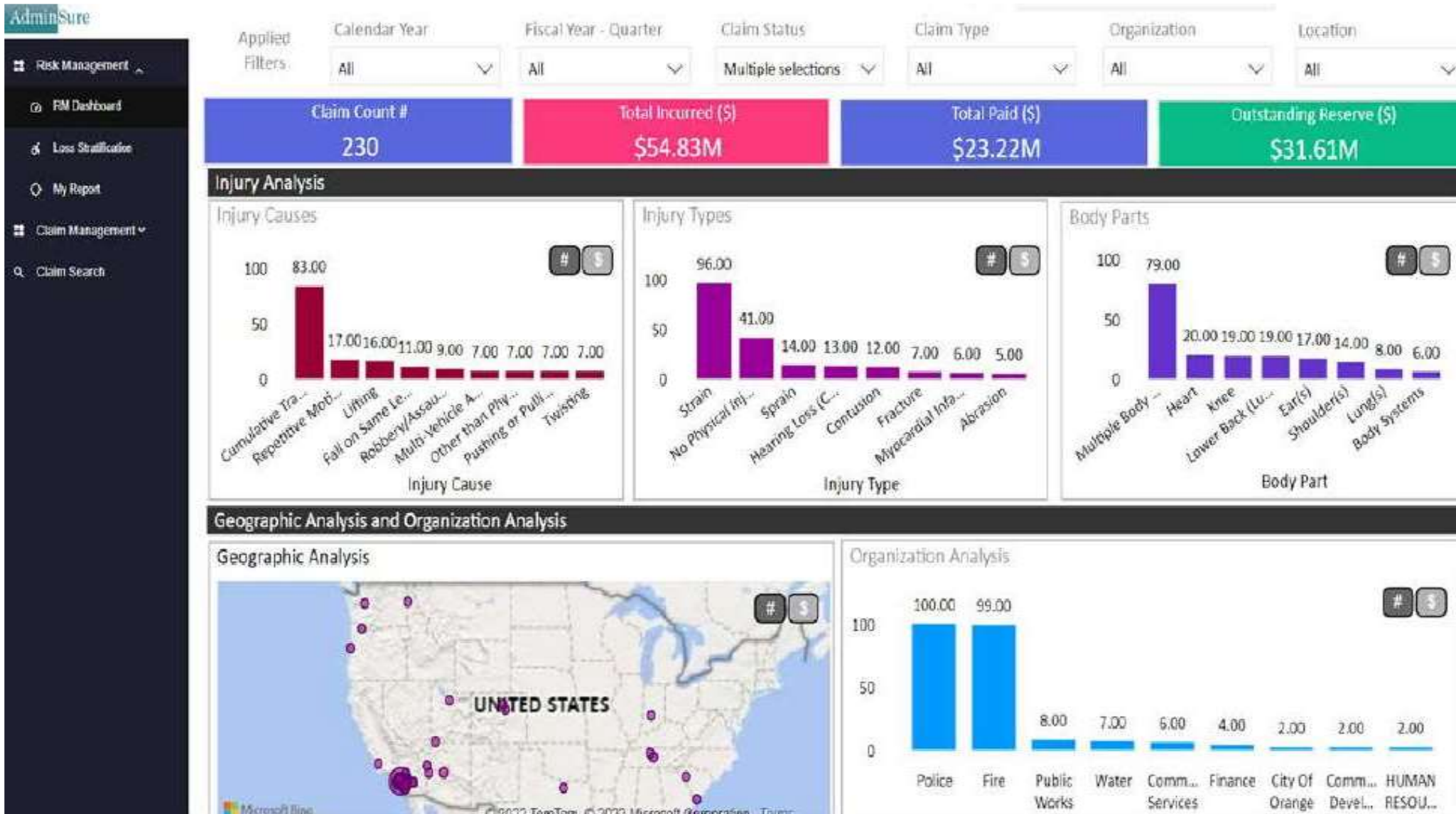
Report Lag Analysis (In Days)



Seasonality Trend



DASHBOARD SAMPLE 2 of 2



Transition Plan***Sample Start Date: July 1, 2024***

<u>TASKS</u>	<u>TIMEFRAME</u>	<u>DATE OF COMPLETION</u>	<u>KEY PERSONNEL</u>
<i>Begin the data conversion and discuss with City Contacts the transition and timeline</i>	<i>Approximately 2 Hours</i>	<i>The day after, or within the same week, approval of our Services</i>	<i>AdminSure (IT/IS and Claims Team), City's current RMIS, and City Contacts</i>
<i>Begin and complete the setup process for the City's Workers' Compensation Trust Account, and Positive Pay Services, if applicable</i>	<i>Approximately 2 Weeks</i>	<i>By July 1, 2024</i>	<i>The City, AdminSure (IT/IS Department), and the City's choice of Bank</i>
<i>Provide the City with a sample letter for their current employees that advises them of the change and the contact information of their new Claims Adjuster (our direct contact info)</i>	<i>Less than 1 Hour</i>	<i>By June 1, 2024</i>	<i>AdminSure (WC Directors)</i>
<i>Meet with City Contacts to discuss reporting requirements, forms, workflow, expectations, goals, et cetera</i>	<i>Approximately 2 Hours</i>	<i>By June 15, 2024</i>	<i>AdminSure (Claims Team)</i>
<i>Schedule Orientation and/or Training Sessions with each Department, and may include certain/all City employees (optional)</i>	<i>Approximately 1 Hour for each Department</i>	<i>By August 1, 2024</i>	<i>AdminSure (Claims Team)</i>
<i>Meet with designated City Clinics/Facilities to discuss protocols, expectations, goals, et cetera</i>	<i>Approximately 1 Hour for each Clinic/Medical Facility</i>	<i>By June 15, 2024</i>	<i>AdminSure (Claims Team)</i>
<i>Complete the Notice of Change of Administrator (Regulations §15402-§15402.4) to the State, SIP Manager</i>	<i>Less than 1 Hour</i>	<i>Before July 1, 2024</i>	<i>AdminSure (WC Directors)</i>
<i>Receive/pick up all hard open/closed files from the City, if applicable</i>	<i>1 Day</i>	<i>By July 1, 2024</i>	<i>AdminSure</i>
<i>Complete the City's "Client Profile"</i>	<i>Approximately 2 Hours</i>	<i>By July 1, 2024</i>	<i>AdminSure (Claims Team)</i>
<i>Mail all injured workers with open claim files a letter reminding them of the change and their new Claims Adjuster's direct contact information. We will also send a similar letter to all interested parties involved in the claim files</i>	<i>Approximately 4 Hours</i>	<i>By August 1, 2024</i>	<i>AdminSure (IT/IS and Claims Team, if applicable)</i>
<i>Data Conversion and Software Training</i>	<i>This is a collaborative effort between the City's current RMIS provider and AdminSure</i>	<i>By July 15, 2024 for Software Training and by July 31, 2024 for the fully executed Data Conversion. Both are dependent on the date we receive the final (exit) data</i>	<i>The City's current RMIS provider and AdminSure</i>



ID	% Complete	Task Name	Responsible	Duration	Start	Finish	Actual Finish
1	0%	Collect data from City's RMIS Provider	City's RMIS	7 days	Mon 06/17/24	Sun 06/23/24	
2	0%	Data Mapping / Creation of Scripts	AdminSure	7 days	Mon 06/24/24	Sun 06/30/24	
3	0%	Upload Data into Test Environment / Data Validation	AdminSure	7 days	Mon 07/01/24	Sun 07/07/24	
4	0%	Receive Final (Exit) Data / Exit Reports	City's RMIS	7 days	Mon 07/08/24	Sun 07/14/24	
5	0%	Run Scripts & Upload Data into Test / Data Validation	AdminSure	7 days	Mon 07/15/24	Sun 07/21/24	
6	0%	Upload Data into Production / Final Data Validation	AdminSure	10 days	Mon 07/22/24	Wed 07/31/24	

[illegible]

Transition & Implementation Plan

(Data Conversion)



June 2024 – July 2024



Transition & Implementation Plan (Data Conversion)

We have found that when a realistic transition and implementation plan (data conversion) timeline and plan is in place, transferring claim files and data/documentation by a specific Contract Agreement start date is possible. Our following Transition and Implementation Plan (data conversion) summarizes the necessary actions required for an efficient transition with a sample start date of July 1, 2024.

We understand the importance of a seamless transition for you and your injured workers (employees) while undergoing a transition and data conversion. Our proven, detailed and comprehensive approach to conducting transitions and data conversions ensures completion in such a manner that causes the least amount of disruption or delay for all parties involved.

The entire data conversion process is accomplished through a proven, very well-thought-out plan that involves the following main six steps:

1. We obtain/collect sample data from the City's current Risk Management Information System (RMIS) provider
2. Data is analyzed; field and code mapping scripts are compiled
3. Data is uploaded into our test environment and scrutinized for accuracy
4. We receive final (exit) data and final (exit) reports from the City's current RMIS provider
5. Final (exit) data set is uploaded to our test environment; accuracy and consistency with final (exit) loss runs are verified
6. Final (exit) data set is moved into production; final (exit) data validation is conducted

Collecting Sample Data

At least 30-45 days before the takeover date (ideally), we obtain test data and record layouts from the City's current RMIS provider. It is absolutely necessary that we receive data in CSV format only.

Data Analysis

Data integrity is valued with the utmost importance as it is vital to the success of a Risk Management Information System (RMIS). With this in mind, data mapping and code scripts are carefully compiled. The data mapping process will identify all the data elements that are to be

converted. We then assign each data element to a specific database field and govern/set rules and/or logic that applies to the data.

Initial Data Testing

The sample data will be uploaded to our test environment and scrutinized for accuracy. All day-to-day functions are tested and executed. Reports are generated and compared to the sample data received. If any anomalies are discovered, they are corrected and documented. The data validation and testing of the sample data will continue until we are confident we are ready to proceed with the final (exit) data set.

Collecting Final (Exit) Data Set

On/about the date the City's hard claim files, if any, are transferred from to us, or no later than on our first day of our Contract/Agreement effective date with the City, we obtain the final (exit) data set. At this point, it is imperative that any and all fundamental changes that may have been made to the data structure that we previously received in the sample data be communicated to us. The final (exit) data set is uploaded into our test environment and validated for accuracy and consistency by comparing same with the final (exit) loss runs. This data validation and testing will continue until we are confident we are ready to move this into our live production database.

"Going Live" with Final (Exit) Data Set

The final (exit) data set will then be uploaded into our production database and made available to the Claims Adjusting Staff assigned to your Workers' Compensation Program. A final (exit) data validation will take place while both the Information Systems/Technology (IS/IT) and Claims Adjusting Staff review the imported claims information. Once the data is verified, we will notify all interested parties of the completion of the data conversion/implementation project and provide an unlimited number of City users (City contacts) and our assigned Claims Adjusting Staff with their online user account credentials (login/password).

We will also provide our City contacts training at no additional cost.

Closing

We are very confident in our proven ability to successfully complete the proposed Transition and Implementation Plan (data conversion) within the timeline provided (30 workdays or sooner).

Thank you for your time and consideration and we truly look forward to having the opportunity to partner with the City of Vernon.

AdminSure Inc.

Nerissa Burnside, SIA, WCCP, WCCA

Senior Workers' Compensation Claims Director

Professional Experience

2017–Present AdminSure Inc. – Senior WC Claims Director

2004–2017 AdminSure Inc.

Workers' Compensation Claims Supervisor/Manager

- Performs an extensive range of claims services which includes supervising management staff; communication with employers, injured workers, medical providers (medical management and return-to-work program management), and attorneys (litigation and subrogation management); oversees managers' coordination of lost time/monetary benefits (i.e. TD, LC4850, CalPERS, SJDB/vocational rehabilitation, and settlements) and medical benefits (benefit administration as well as excess reporting; utilization review and bill review management), as well as the investigation of questionable claims, and when required, attends various meetings WCAB conferences, et cetera.
- Assists with conducting claims reviews, training sessions, and educational seminars; and coordinates various outside expert service providers reference ADA accommodation meetings, MSA reviews, ergonomic assessments, et cetera.

2001–2004 AdminSure Inc.

Workers' Compensation Senior Claims Adjuster

- Performed an extensive range of claims services including communication with employers, injured workers, medical providers, and attorneys; coordinated accurate and timely delivery of benefits; investigated questionable claims, and when required, attended various WCAB conferences.

1997–2001 Liberty Mutual Insurance Company

Case Manager/Senior Case Manager

- Responsible for assisting team members with claims administration education and achieving office objectives. Performed an extensive range of claims services including communication with employers, injured workers, medical providers, and attorneys; coordinated accurate and timely delivery of benefits; investigated questionable claims, and when required, attended various WCAB conferences.

Education

- Graduated from California Polytechnic University, Pomona with a Bachelor's Degree in Business Administration.
- State Certified Self-Insurance Workers' Compensation Administrator.
- Workers' Compensation Claims Professional Designation (WCCP).
- Workers' Compensation Claims Administration Certification (WCCA).

References

Please refer to our Client List.

Nicolas Bowers, SIA, WCCP, WCCA

Workers' Compensation Claims Director

Professional Experience

2022–Present AdminSure Inc.

Workers' Compensation Claims Director

- Performs many of the Supervisor/Manager tasks and assists with an extensive range of claims services including communication with clients/employers, attorneys, service providers, and coordinates/participates in training as well as marketing efforts. Attends file reviews, conferences and when requested, client file reviews.

2020–2021 AdminSure Inc.

Workers' Compensation Claims Supervisor/Manager

- Performed an extensive range of claims services which included supervising accounts and claims staff; communication with employers, injured workers, medical providers (medical management and return-to-work program management), and attorneys (litigation and subrogation management); coordinated accurate and timely delivery of lost time/monetary benefits (i.e. TD, LC4850 benefits, CalPERS, SJDB/vocational rehabilitation, and settlements, et cetera) and medical benefits (benefit administration as well as excess reporting; utilization review and bill review management); investigated questionable claims, and when required, attended various meetings, WCAB conferences, et cetera.
- Assisted with conducting claims reviews, training sessions, and educational seminars; and coordinated various outside expert service providers reference ADA accommodation meetings, MSA reviews, ergonomic assessments, et cetera.

2011–2019 AdminSure Inc.

Workers' Compensation Senior Claims Adjuster

- Performed an extensive range of claims services including communication with employers, injured workers, medical providers, and attorneys; coordinated accurate and timely delivery of benefits; investigated questionable claims, and when required, attended various WCAB conferences.

Education

- State Certified Self-Insurance Workers' Compensation Administrator.
- Bachelor of Science Degree, Business Management and HR.
- Workers' Compensation Claims Professional Designation (WCCP).
- Workers' Compensation Claims Administration Certification (WCCA).

STATE OF CALIFORNIA)
) ss
COUNTY OF LOS ANGELES)

March 2013

EXHIBIT B

SCHEDULE

<u>Fee Proposal</u>	
Claims Administration Services <i>(Includes Internal Support Staff)</i> Flat Fee	<ul style="list-style-type: none"> ▪ Year 1: \$6,940 per month. ▪ 3% annual increase.
<u>Bill Review Services</u> Flat Fee	<ul style="list-style-type: none"> ▪ \$10 per bill for all Official Medical Fee Schedule (OMFS), In-Patient Hospital Fee Schedule (IHFS) and Out-Patient, etc., reviews; and when applicable, plus .75 cents for State of California required E-Bill/OCR Services; or \$8 per bill for partial bill review services. ▪ When applicable, up to 25% Preferred Provider Organization (PPO)/Negotiated Savings fee, if there are no applicable savings, there are no fees. ▪ No additional fees for transmitting medical billing information on behalf of the City to the Workers' Compensation Information System (WCIS) as required by State Law, i.e., Medical Bill Review EDI (Electronic Data Interchange) Reporting and Services. ▪ 3% annual increase.
<u>Utilization Review Services</u> Flat Fee	<ul style="list-style-type: none"> ▪ Physician (includes Peer and Expert)/Non-Physician Review & Decision: \$300 per hour billed in 10-minute increments/ approximately 4% of total charges; \$85 adjuster/\$125 utilization review. ▪ 3% annual increase.
Transition Fee	<ul style="list-style-type: none"> ▪ No fee.
Data Conversion Fee	<ul style="list-style-type: none"> ▪ No fee.
CMS/MMSEA – Internal Services	<ul style="list-style-type: none"> ▪ No fee.
City On-Line Access (All Data)	<ul style="list-style-type: none"> ▪ No fee for City read-only users; at-cost fee for read and write.
All Reports: Standard & Custom/Ad Hoc Reports	<ul style="list-style-type: none"> ▪ No fee. At-cost when data is not captured.
Index Claim Search & 1099s	<ul style="list-style-type: none"> ▪ No fee.
Training & Development of Special Account Instructions/Procedures & Banking	<ul style="list-style-type: none"> ▪ No fee. Reference any "Banking" fees, if any, please make note that any fees charged by the bank shall be at cost as we will not add on any feed for our internal services.
Trainings, Meetings, Quarterly Claim Reviews, Forms, Posters & Pamphlets	<ul style="list-style-type: none"> ▪ No fee.

EXHIBIT C

EQUAL EMPLOYMENT OPPORTUNITY

PRACTICES PROVISIONS

- A. Contractor certifies and represents that, during the performance of this Agreement, the contractor and each subcontractor shall adhere to equal opportunity employment practices to assure that applicants and employees are treated equally and are not discriminated against because of their race, religious creed, color, national origin, ancestry, handicap, sex, or age. Contractor further certifies that it will not maintain any segregated facilities.
- B. Contractor agrees that it shall, in all solicitations or advertisements for applicants for employment placed by or on behalf of Contractor, state that it is an "Equal Opportunity Employer" or that all qualified applicants will receive consideration for employment without regard to their race, religious creed, color, national origin, ancestry, handicap, sex or age.
- C. Contractor agrees that it shall, if requested to do so by the City, certify that it has not, in the performance of this Agreement, discriminated against applicants or employees because of their membership in a protected class.
- D. Contractor agrees to provide the City with access to, and, if requested to do so by City, through its awarding authority, provide copies of all of its records pertaining or relating to its employment practices, except to the extent such records or portions of such records are confidential or privileged under state or federal law.
- E. Nothing contained in this Agreement shall be construed in any manner as to require or permit any act which is prohibited by law.