WORKERS' COMPENSATION CLAIMS ADMINISTRATOR

REQUEST FOR PROPOSALS

ISSUE DATE: OCTOBER 2022
RESPONSES DUE: NOVEMBER 2022

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EXHIBITS

1. INTRODUCTION

The Northern California Cities Self Insurance Fund (NCC) is soliciting proposals from qualified third-party administrators (TPAs) for claims administration of NCC's Workers' Compensation Program. This request is for comprehensive claims administration services to include managed care, information systems, computer hardware and office supplies appropriate for the management of the Program.

NCC requires a TPA partner who demonstrates an innovative and effective claims management process that is streamlined and user-friendly, has strong customer service focus, solid reporting capabilities, effective technological capabilities, proactive and consistent management of employee occupational absences, competitive rates and fees, and the ability and willingness to comply with NCC's performance standards. The proposing firm's staff should have proper licensing to perform claims administration services. The proposing firm should have a strong regional presence in Northern California and depth of staff necessary to perform the claims administration services requested now and into the future.

This Request for Proposals (RFP) contains specifications covering the administration of NCC's WC program. The RFP shall not be construed to create an obligation on the part of NCC to contract with any firm or serve as the basis of a claim for reimbursement for expenditures related to the development of a proposal. This RFP is an informal solicitation of proposals only. It is not intended nor is it to be construed as engaging in formal competitive bidding pursuant to any statute, ordinance, policy, or regulation.

The proposal should include your ability to perform the desired services and agreement to binding client specific service procedures and contract requirements. Attached as Exhibit A are NCC's Claims Management Procedures and Guidelines. The proposal should address all areas of the claims management requirements, including experience levels for technical claims staff, caseload levels, authority levels, reporting requirements, claim file documentation format, and examiner and manager file reviews. The selected TPA must also follow all standards outlined within PRISM's Addendum A Claims Administration Standards, attached as Exhibit B.

The proposal should also provide pricing for claims administration on a flat fee basis with a breakdown of charges for managed care or any additional services and expenses. Please indicate your willingness to agree to a performance guarantee subject to mutual agreement between your company and NCC, including your suggestions regarding the performance areas to be measured, how they will be measured and at what intervals.

2. BACKGROUND

Northern California Cities Self Insurance Fund is a Joint Powers Authority formed in 1979. Originally a Workers' Compensation (WC) group purchase pool, the JPA began shared risk programs for both liability and WC in 1991. Please see www.nccsif.org for more information including the most recent Annual Report.

NCC's Workers' Compensation Program is comprised of twenty-two member cities ranging from Galt in the south to Anderson in the north, with many of the cities in the Sacramento area as members, including Folsom and Elk Grove, the two largest members by payroll. All but two members have police departments, with most also having fully staffed fire departments. Each member has a $100,000 retention with payments made from their NCC Banking Layer assets, and all members have a $500,000 retention paid from the NCC Shared Layer reserves.

Alliant Insurance Services, Inc. is retained to provide Pool Administration and Consulting Services to NCC. Alliant has extensive experience with California Workers' Compensation JPA administration along with a unique knowledge of NCC, having worked with the group since its very beginnings. Alliant assists NCC members in reducing financial losses and managing the performance of the JPA and its independent contractors to assure success in meeting the organization's goals. James Marta and Company provide accounting services to NCC and works closely with the current TPA for financial reporting and cash management.

NCC has been a member of the PRISM Excess Workers' Compensation (EWC) program since 7/1/2003, and currently contracts with Sedgwick to manage new and existing claims. The JPA was the first Workers' Compensation client of Gregory Bragg & Associates, later purchased by York and more recently purchased by Sedgwick.

Key service benchmarks and goals for this process include:

- Engaged service team
- Focused management of the Return to Work (RTW) process
- Prompt access to treaters
- Responsiveness – within 24 hours
- Manageable caseload of no more than 125 Indemnity or 300 Med Only
- Management support
- System support
- Knowledge of CA public safety 4850 benefits

NCC does not cover 4850 Temporary Disability or Salary Continuation benefits, however,

the TPA computes and tracks those amounts separately and issues vouchers to the member for their records. Some members offer Salary Continuation for non-safety employees that are also tracked with vouchers issued by the TPA.

This Request for Proposals covers the administration of all Workers' Compensation claims since the inception of NCC. We are open to creative solutions, including options for improving communication and resolving issues, particularly those impeding modified duty return to work efforts. Of particular concern is the lack of qualified medical professionals, so any solutions that may increase treatment options are welcome.

3. GENERAL CONDITIONS

3.1 Proposal Documents

RFP Response shall be sent by email to the Program Administrator no later than 5 p.m. PDT on November 1, 2022. Any proposal not meeting this requirement will be returned to the Contractor unopened.

NCC's Program Administrator will be your sole point of contact during the RFP process. Questions pertaining to the proposal shall be emailed to the Program Administrator no later than 5:00 p.m. PDT on October 11, 2022. Emailed questions will be replied to by October 18, 2022, with copy to ALL firms that express an interest in proposing by that date. It is the proposer's responsibility to ensure the documents are received. If the file size is over 45 MB please send via secure link.

Proposals shall be delivered to:
Marcus Beverly
NCC Program Administrator
Alliant Insurance Services, Inc.
marcus.beverly@alliant.com
(916) 643-2704
With copy to:
Jenna Wirkner
jenna.wirkner@alliant.com

3.2 Signature

The proposal must be signed in the name of the Contractor and must bear the signature of the person authorized to sign Proposals on behalf of the Contractor. Contractor must agree to the contract terms specified in this RFP or cite exceptions in their response, including modifications to any insurance requirements.

3.3 Completion of Proposals

Proposals may be rejected if conditional or incomplete, or if it contains alterations of any kind.

3.4 Examination of Contract Documents

The failure or omission of any Contractor to receive or examine any contract document, form, instrument, addendum, or other document, shall in no way relieve any Contractor

from obligations with respect to this RFP or to the contract. The submission of a proposal shall be taken as evidence of compliance with this Section.

3.5 **Addenda**

NCC may modify this RFP before the date scheduled for submission of proposals by issuance of an addendum to all parties who have been furnished the RFP for the purpose of submitting a proposal.

3.6 **Modification of RFP Response**

A Contractor may modify the proposal after its submission by written notice of withdrawal and resubmission before the time and the date specified for submission of proposals. Modifications will not be considered if offered in any other manner.

3.7 **Withdrawal of Proposals**

A Contractor may withdraw their proposal by submitting a written request for its withdrawal to NCC at any time before the date scheduled for proposal submission. Proposals may not be withdrawn after the proposal submission date.

3.8 **Rejection of Proposals**

NCC reserves the right to reject any or all proposals or to negotiate separately with any Contractor when it is determined to be in the best interest of NCC.

3.9 **Cost of Preparation of Proposals**

Costs for developing responses to this RFP are entirely the responsibility of the Contractor and shall not be the responsibility of NCC.

3.10 **Award of Contract**

If the contract is awarded, it will be to the responsible Contractor whose proposal is deemed to be the best proposal and whose proposal best meets the requirements of the RFP documents and any addenda thereto, except for irregularities waived by NCC.

It is anticipated that award of the contract will be made per the Tentative Schedule of Events in Section 3.13. If award cannot be made per the schedule, the Contractor will be requested to extend the time during which the Contractor agrees to be bound by their proposal. Written notification will be made to unsuccessful Contractors.

3.11 **Errors in Proposal**

Contractors shall be bound by the terms and conditions of their proposals, notwithstanding the fact that errors are contained therein. However, if immaterial

errors are found in a proposal, NCC may notify the Contractor that the submitted proposal contains errors and require the Contractor to correct the errors.

3.12 **References**

Each Contractor shall submit with their proposal a list of other California public entity clients and the following:

- A minimum of four clients for whom similar work has been performed in the past two (2) years.
- The last two CA public agency clients who have discontinued a contract for similar work and their reasons for doing so.

The reference list shall include the names and addresses of the client, the name, title and telephone number of each client's primary manager, and the dates the work was performed. Preference will be given to experience with municipalities with public safety exposure. During the evaluation and selection process NCC may contact each of the referenced clients.

3.13 **Tentative Schedule of Events**

Issue RFP	October 3, 2022
Questions Due	October 11, 2022
Answers Provided	October 18, 2022
Proposal due date	November 1, 2022
Interview with Selected Firms (if needed)	December 7
Committee Meeting to Recommend Firm	By December 9, 2022
Board of Directors Meeting/Approve Firm	December 15, 2022
Contract and Transition Plan as needed	By January 30, 2023
Services Begin Under New Contract	July 1, 2023

3.14 **Record Retention and Inspection**

The Contractor agrees that NCC shall have access to and the right to examine, audit, excerpt, copy, or transcribe any pertinent records pertaining to the Agreement.

3.15 **Assignment**

This Agreement, or any interest therein, may not be assigned without the prior written consent of NCC.

3.16 **Compliance with Laws**

Contractor agrees to comply with all applicable Federal, State, and local laws, rules, regulations, ordinances, policies, and procedures in the conduct of the program as specified herein.

3.17 **Termination of Agreement**

This Agreement may be terminated by either party by providing written notification of same ninety (90) days prior to the date of termination. Notice shall be given by certified mail.

3.18 **Termination for Non-performance**

If the Contractor refuses or fails to perform services as required by NCC, including furnishing properly trained personnel, or if adjudged as bankrupt or insolvent, or is otherwise in substantial violation of the Agreement, then NCC may, without prejudice, serve written notice of intention to terminate the Agreement.

Such notice shall contain the reasons for termination, and unless within fifteen (15) days after service of such notice the reasons are satisfactorily addressed, the Agreement shall cease and terminate. The foregoing provisions are in addition to and not in limitation of any other rights or remedies available to NCC.

3.19 **Independent Contractor**

While performing services under the Agreement, Contractor is an independent contractor and not an officer, agent, or employee of NCC.

3.20 **Confidentiality**

The Contractor shall hold in strict confidence all medical reports, records, employment records, claim forms and other data pertaining to NCC and its members, except as may be required for the performance of duties as specified in the Agreement.

3.21 **Hold Harmless Agreement**

The Agreement shall include the following hold harmless language and shall not include any special limitation of liability on the part of the Contractor, including a cap tied to the service fee or limitation on consequential damages. Any proposal containing a special limit of liability is subject to rejection.

If Contractor, its Agents, Employees, Representatives, or Assigns, negligently or intentionally violate any Law or Regulation, or any Provision of the Agreement, Contractor shall Indemnify, Defend, and Hold Northern California Cities Self-

Insurance Fund harmless from and against all Loss and Damage, including any reasonable Costs or Expenses (including Attorney's Fees), incurred by NCC in connection with such conduct.

The Contractor shall hold harmless and indemnify Northern California Cities Self-Insurance Fund, its members, their officers and employees from every claim or demand made by reason of:

a. Any injury to person or property sustained by the Contractor or by any person, contractor, or corporation employed directly or indirectly by the Contractor upon or in connection with performance under the Agreement, however caused;

b. Any injury to person or property sustained by any person, firm, or corporation, caused by any act, neglect, default, or omission of the Contractor, or by any person, firm or corporation directly or indirectly employed by the contractor upon or in connection with performance under the Agreement; and,

c. The Contractor at its own expense and risk shall defend any legal proceeding that may be brought against NCC, its members, their officers, agents, and employees on any such claim or demand as set forth in paragraph a. and b. above of this subsection and pay and satisfy any judgment that may be rendered against NCC and the Contractor as it pertains to this subsection.

The Contractor will indemnify NCC for payment of any penalties incurred because of claims management related errors and omissions. This includes but is not limited to errors incurred because of failure to properly comply with reporting under Medicare section 111, failure to timely provide benefits to injured workers, or the inappropriate or unnecessary overpayment of benefits.

3.22 **Term of Agreement**

The initial term of the Agreement will be for a minimum period of three (3) years. Proposals with options for longer terms will also be considered.

3.23 **Permits and Licenses**

The Contractor, its employees, and agents, shall secure and maintain valid permits and licenses as required by law for the execution of services pursuant to this Agreement.

3.24 **Insurance Requirements**

The successful bidder(s) must maintain the insurance as required in Exhibit **C.**

3.25 **Conflict of Interest**

The Contractor warrants there are no business or financial interests which conflict with their obligations to NCC under this Agreement and further agrees to disclose any such interest which may be acquired during the life of this Agreement.

Please limit the proposal to 40 pages, with any additional information such as bios, sample reports, etc. included as exhibits.

4. STATEMENT OF WORK

Contractor shall perform all services required to supervise and administer the Workers' Compensation program for NCC and to act as NCC's representative in matters relating to NCC's obligations under the Workers' Compensation laws of the State of California. Contractor shall perform but is not limited to the following services on behalf of NCC:

4.1 Program Administration

4.1.1 Provide staff, professional and clerical, as required to administer NCC's Workers' Compensation program in compliance with all rules and regulations governing the administration of self-insurance pursuant to Section 3700 et, seq., of the Labor Code and the California Administrative Procedures Act (Government Code, Title 8).

4.1.2 Prepare a Claims Manual for use by NCC and its members. This manual shall specify claims activities and processing, organization of claims files, and procedures for reporting industrial injury claims. Contractor shall conduct or assist in conducting orientation meetings for the personnel directly involved in processing such claims not less than one time per year.

4.1.3 Provide to NCC information on changes or proposed changes in statutes, rules, and regulations affecting NCC's responsibility and the responsibilities of its members under a self-insured Workers' Compensation program.

4.1.4 Review with NCC the program progress, including identification of problem areas, and recommend solutions. Provide consultative services as required to assure success of the program.

4.1.5 Provide the necessary staff to effectively manage NCC's existing open Workers' Compensation claims to the satisfaction of the members.

4.2 Claims Administration

4.2.1 Review and process all claims for Workers' Compensation benefits in accordance with the requirements of the Industrial Relations Department for reporting and notification.

4.2.2 Determine the compensability of claimed injuries and illnesses in accordance with the State of California Workers' Compensation Laws.

4.2.3 Determine eligibility for and recommend payment of medical benefits and authorize examinations to determine the nature and extent of disability when appropriate.

4.2.4 Obtain and evaluate medical expert opinion as to the nature, extent and duration of temporary disability and the amount of any residual permanent disability to be anticipated.

4.2.5 Review, compute, recommend and authorize payment of temporary disability and permanent disability benefits due an injured employee whether paid voluntarily or under Decisions, Orders, or Findings and Awards of Workers' Compensation Appeals Board. Relative to permanent disability, this includes Informal Advisory Ratings and Consultative Evaluations.

4.2.6 Refer litigated cases to attorneys acceptable to NCC. Assist the attorneys in the preparation of litigated cases, negotiations of compromise and release settlements, and subrogation actions. Contractor shall not hire attorneys without the approval of NCC. See section 4.4 for more information related to Legal Services.

4.2.7 As necessary and appropriate investigate, or arrange for investigation of, questionable cases and the status of disabled employees.

4.2.8 Review claims which involve a suspicion of Fraud with NCC. Maintain special investigation unit panel for oversight of these claims.

4.2.9 Represent NCC at hearings which involve Workers' Compensation claims against NCC and/or its members.

4.2.10 Report claims, maintain records on, and effect collections from, excess reinsurers on behalf of NCC.

4.2.11 Administer claims promptly to avoid self-imposed penalties and penalties for unreasonable delays. NCC reserves its right to be reimbursed for all administrator-caused penalties and interest. Such payments shall be reported to NCC monthly.

4.2.12 Notify NCC of reserve increases at or above $100,000.

4.2.13 Prepare and file, in a timely manner, all reports which are now, or will be, required by the State of CA or other governmental agencies with respect to self-funded programs.

4.2.14 Calculate and maintain accurate records for 4850 TD and SC benefits and issue vouchers to members in lieu of payments.

4.3 Medical Administration and Control

4.3.1 Provide and maintain a comprehensive medical provider network and recommend a panel of specialists as may be required for special treatment.

4.3.2 Monitor treatment programs for injured employees, including review of all "Doctor's First Report of Work Injury" to assure that treatment is related to a compensable injury or illness.

4.3.3 Maintain close liaison with treating physicians to assure that employees receive proper care and to avoid over-treatment situations. Utilize telephonic and field nurse case management with approval of NCC to obtain reasonable treatment plan and targets for return to work and medical improvement.

4.3.4 Authorize hospitalization, surgery and any other types of approved treatment as required after determination of liability in conformance with Labor Code Sections 4600 and 4601.

4.3.5 Review, audit, compute and authorize payment of all medical bills in conformance with the Recommended Minimum Fee Schedule as set forth by the Division of Workers' Compensation.

4.3.6 Provide liaison with any cost containment services with whom NCC chooses to utilize.

4.3.7 Complete administration and processing of all lifetimes medical cases awarded or ordered by the Workers' Compensation Appeals Board.

4.4 Legal Services

4.4.1 Retain a panel of attorneys approved by NCC who specialize in the defense of Workers' Compensation litigation. Monitor all litigated cases from the time an application is filed with the Appeals Board until final disposition is rendered.

4.4.2 Consult with NCC and attorneys as required to ensure that all facts and investigations necessary will be available on a timely basis.

4.4.3 Ensure that necessary subpoenas for records and/or witnesses are issued and depositions taken.

4.4.4 Ensure timely filing and serving of Answers to Applications and of medical records.

4.4.5 Review and consult with NCC and its member on ALL proposed settlements. Approval of all settlements on claims that exceed a Member's Banking Layer (retained layer) must be secured from NCC before a Compromise and Release is filed with the Appeals Board for approval.

4.4.6 Protect the interests of NCC in third party cases, including filing of Complaints in Subrogation, where appropriate.

4.5 Employee Services

4.5.1 Provide information and guidance to the employees of NCC members regarding Workers' Compensation benefits, inquiries on specified injuries and permanent disability ratings.

4.5.2 Assist in resolving employee problems related to an industrial injury claim.

4.5.3 Assist in the development of policies and procedures as needed to accommodate an employee's temporary or permanent restrictions.

4.6 Reporting Services and Record Retention

4.6.1 Provide NCC and its members with regular monthly and periodic reports in the format and number requested. Consideration will be given to the format and availability of reports including charts, graphs, dashboard, etc. Such reports include, but are not limited to, the following:

- Loss Experience Report
- Location Report
- Trend Analysis
- Loss Narrative Report
- Management Summary Report
- Monthly Claims Summary Report
- Monthly Incurred Change Report

- Monthly Claims Register Report
- Annual Report to State
- Annual Tax Statements Including Federal Form 1099 and State Form 599 as Appropriate
- Review of Large and Litigated Claims
- Penalty and Interest Payment Report

4.6.2 The claims administrator is responsible for working closely with NCC's accountant in reconciling the loss runs in total and current activity to the cash activity. Claims administrator will provide:

1. Weekly claim payment registers so that claim clearing bank accounts may be adequately funded.
2. Quarterly activity reconciliations by line of coverage of claims paid, voids, refunds, recoveries, vouchers, and any other adjustments that are needed to reconcile the loss run reporting to the cash transactions.
3. Maintain a listing of excess recoveries outstanding by claim and line of coverage including a listing of amounts that are calculated but not recoverable. Any amounts not recoverable should be brought to the claim committee for review and approval.
4. Quarterly loss report in excel format period to date (all) that summarize by
    a. Line of coverage
    b. Banking
    c. Shared
    d. Excess
    e. Remove vouchers (WC Section 4850)
    f. The above reports will be provided both by policy year and also by member.
5. Annual loss run reports for the actuary similar to item 3.

You may contact NCC's accountant, James Marta, 916-993-9494 ext. 111 jmarta@jpmcpa.com for examples of reporting provided by the claims administrator

4.6.3 Any recoveries or refunds must be sent intact to the NCC accountant. The claims administrator shall not deposit these amounts into any accounts (this provides better separation of duties).

4.6.4 All claim files, records, reports, and other documents or materials pertaining to NCC's claims shall be the property of NCC, shall be available for NCC's use at any time, and shall be delivered to NCC, or its designee, upon termination of the Agreement. During

the term of the Agreement, the administrator is responsible to maintain and store open and closed claims.

4.7 Trust Fund Checking Accounts

4.7.1 NCC shall establish trust fund checking accounts to cover payments and reimbursements applicable to the self-insured Workers' Compensation program and any other programs as necessary.

4.7.2 The trust fund checking account shall be established in the name of the Contractor as agent of NCC. Deposits shall be made to the account as required to ensure that funds are available for payment of claims for settlement and allocated loss expenses upon presentation of check or warrant. Contractor shall not draw on the trust fund checking account for any purpose other than adjustment of claims and payment of allocated loss expenses. Contractor payments shall be submitted separately for review, approval, and payment.

4.7.3 The Contractor shall monitor the trust fund account and make recommendations to NCC as to the appropriate level of funding to comply with established laws.

4.7.4 The contractor shall be responsible for uploading transactions for each check run for positive pay and be responsible for monitoring and following up on positive pay exceptions on a timely basis

4.7.5 The Contractor shall provide NCC with a detailed accounting of all benefits and allocated loss expenses paid from the fund on at least a monthly basis by line of coverage. The detailed accounting shall include the date and check number of all benefit and allocated loss payments and shall also include appropriate supporting documentation for allocated loss expense payments. A monthly check register summary shall be provided. Contractor is responsible for erroneous payments made from the account by their error and any such payments shall be reimbursed separately by the contractor.

4.7.6 Contractor shall develop, implement, and maintain security procedures to ensure safeguard of funds in the account and the bank checks.

4.7.7 The Contractor agrees that NCC shall have access to and the right to examine, audit, excerpt, copy, or transcribe any pertinent records pertaining to the agreement.

4.7.8 All records shall be kept and maintained by the Contractor and made available to NCC during the term of the agreement and for a period of three (3) years thereafter. All such records shall be delivered to NCC in the format and media specified upon termination of the agreement.

5. PROPOSAL RESPONSE REQUIREMENTS

Each proposal submitted will be evaluated to determine if the firm meets the following minimum qualifications. Proposals that do not meet these minimum qualifications may not advance for further evaluation.

5.1 **General**

Each Contractor shall complete this portion of the Request for Proposals by discussing each item in the order presented. The responses must be legible, clear, accurate, complete, and must be signed by an authorized representative.

5.2 **Title Page**

Indicate the name of the firm, the local address, the name of the firm's contact person, the telephone number of the contact person and the date.

5.3 **Table of Contents**

Include a clear identification of the material submitted by your firm by section and by page number.

5.4 **Profile of Firm**

5.4.1 Please describe your firm and outline your experience in performing Workers' Compensation claims and managed care services in California, including agencies with public safety services.

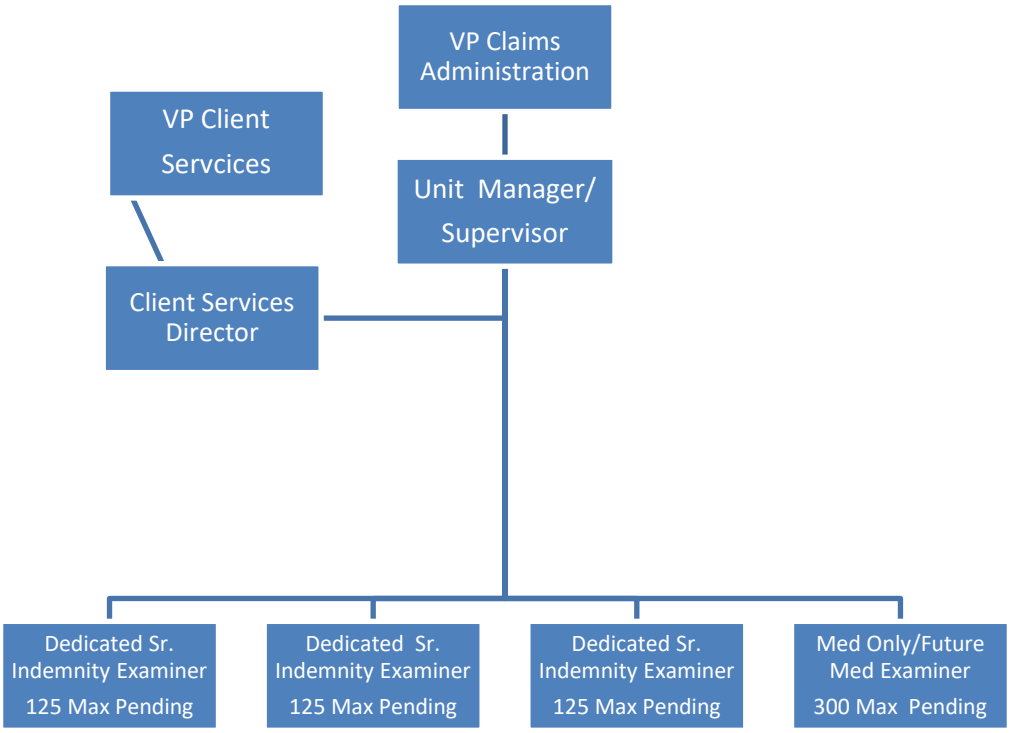
5.4.2 State the location of the office from which the work will be done if your firm is awarded the contract, the number and type of staff employed at this office and the number and type of staff working remotely.

5.5 **Contractor's Qualifications and Staffing**

See current staffing chart below for core team. All proposals must include this staffing model and *maximum* pending levels per examiner for comparison purposes and as the preferred NCC model. *However, alternate models that address NCC's needs will be considered.*

5.5.1 Indicate the name of the person who will manage the claims administration activities as specified in this Request for Proposals. Provide a brief resume of the manager's background training and experience. Specifically discuss the individual's experience in

managing a claims administration program of the size and scope of the program described herein.



5.5.2 Indicate the claims unit manager/supervisor who will be assigned to NCC's Workers' Compensation program. Include a brief resume of the individual's background training and experience. Indicate whether the supervisor is licensed by the State of California.

5.5.3 Indicate the examiners or the level of examiners to be assigned based on the staffing model currently in place, with three *dedicated* indemnity examiners and one medical examiner. Describe the support staff structure, including the examiner to claim assistant ratio that will be proposed for NCC. Indicate the minimum qualifications of examiners. Specifically address the proposed team's experience with public entities, familiarity with the local WCAB, attorney and medical community in the Northern California area. Please describe their experience in calculating TD benefits, coordinating benefits, and working with cities in Northern California that have a Labor Code 4850 exposure, offer other salary continuation, and use a voucher system in lieu of issuing checks.

5.5.4. If you have not designated staff to service the account, provide your criteria and recruitment strategy for selecting qualified personnel.

5.5.5. Provide annual totals, starting 1/1/2019, for examiners and supervisors/managers handling CA workers' comp: total number of employees, the number of new hires, and the number of separations/retirements. Include the turnover ratio for examiners and supervisors during the same period and explain how you ensure continuity of service in the event of turnover or extended leave.

5.6 **References**

Provide a list of public sector clients for whom your firm has provided Workers' Compensation administration services in the past two years. Also provide:

A minimum of four clients for whom similar work (as outlined in the scope of work) has been performed in the past two years.

The last two CA public agency clients who have discontinued a contract for similar work and their reasons for doing so.

Indicate the scope of the work performed for each of the referenced clients; the name of the client; address and telephone number; and the name of each client's primary manager. Please provide public agency references in the Northern California region (Monterey County to Oregon Border) where possible.

Disclose and submit with proposal a description of any pending lawsuit, litigation, or proceedings with clients that you are or were contracted with for Worker's Compensation claims administration

5.7 **Training**

Describe procedures you will utilize to provide training to staff of NCC in the following areas:

- Claims administration and processing, including the roles and responsibilities of member cities, TPA, and injured employee.
- Program implementation
- Legal responsibilities of NCC and its member districts.
- Safety/Loss Control.

5.8 **Claim File Reviews and Reports**

What is your firm's policy on providing claim reviews? Will you conduct claim reviews with each NCC member and if so, how often? Who will provide and in what format?

Preference is given to a standard "Claims Management Report" that is updated with each diary or significant development, accessible in the claim file, and focused on a plan of action to resolve the remaining issues toward closure. Please provide a sample of your firm's report.

5.9 **Reserving and Future Medical Claims**

How do you determine or calculate future medical reserves? What is your practice for administrative closure?

5.10. **Customer Service Standards**

Describe your standards for customer service, including response times, reporting standards, three-point contact and follow up. Refer to the NCC and PRISM standards included as exhibits and indicate where your standards exceed or differ from them.

5.11 **Litigation Management**

Describe your approach to litigation management, including the continued role of the examiner, counsel, and client. What strategies do you employ to resolve litigated claims in a cost-effective manner? What percentage of your Northern California public agency claims are litigated?

5.12 **Claim Processing System**

Describe your claim processing system, including client access and features. Describe the process and options for reporting claims and receiving acknowledgements. Describe your experience in working with Company Nurse, used by several NCC members.

5.13 **Security and Control Procedures**

Discuss procedures utilized by your firm to ensure the security of the trust fund account.

5.14 **Managed Care Services**

NCC reserves the right to bundle managed care services with claims administration services or to unbundle any or all the services. This may include use of a consultant to provide oversight of all managed care services, including bill review, utilization review and nurse case management. Please describe how your firm would work with outside vendors to provide effective and efficient service to program members, specifically noting any limitations you may have in working with outside vendors.

5.14.1 **Bill Review**

Describe your qualifications in providing bill review services, including features of your system, unique capabilities, and ability to customize the delivery of your services.

Provide the average savings achieved for your clients. Discuss what distinguishes your organization from other bill review providers. Indicate if the services are in-house or outsourced and if outsourced indicate any financial interest or other fees received from the provider.

5.14.2 **Utilization Review**

Describe your qualifications in providing utilization review services, including standards and guidelines used to review treatment requests. Indicate the percentage of requests for authorization that are sent to UR. Describe any unique capabilities or approaches your firm has for reviewing medical treatment requests. Discuss any methods you employ to help your clients reduce utilization review costs and whether you charge for adjuster pass-throughs. Note: NCC's customized UR criteria to increase pass-through approvals and a letter to providers explaining what is pre-approved is included in Exhibit D.

For your Northern California clients, provide the average turnaround time on treatment requests, average denial rate, and average modified or overturned denial rate. Describe your recommended panel of medical experts, including specialists who may be utilized for peer review

5.14.3 **Nurse Case Management Services**

Describe your qualifications in providing nurse case management services, including guidelines and expectations regarding those services. What percentage of indemnity claims have a Nurse Case Manager assigned? Discuss what distinguishes your organization from other nurse case management providers.

Provide a summary of the qualifications and experience of each proposed team member, including their length of service with your firm and their resume. Indicate the office location nurses would be working from.

5.14.4 **Medical Provider Network**

Describe your firm's Medical Provider Network, including if it is leased or owned. If leased, please identify the provider, outline related fees, and negotiated discounts.

How will your firm assist NCC with a customized MPN providing sufficient coverage in the geographic area? Describe your process for adding new providers and monitoring for providers that should be removed from the network.

5.14.5 **Other Ancillary Services**

NCC members utilize Company Nurses' first call injury triage program. The successful bidder(s) will be required to work cooperatively with this service provider. Please describe any experience you have had with this organization or similar providers.

5.15 **Inquiry Assistance**

Discuss the extent that you will assist NCC and its staff with Workers' Compensation inquiries, questions, and problems. What is your internal standard for response time to client messages and emails? Please describe the responsibilities of staff dedicated to client services.

5.16 **Recordkeeping**

Describe record-keeping procedures to be utilized for all aspects of the self-insurance administration program. Include a plan for closed claims storage and retrieval. Please also discuss any cost associated with claim storage or retrieval.

5.17 **Ownership of Records**

Please confirm that all claim files, electronic data processing/management information system records, and all records generated on behalf of NCC are owned by NCC and that claim files will be available to NCC upon request.

5.18 **Fee Structure**

Please describe your proposed fee structure, including your proposed pricing to administer the claims count as provided in the sample reports in Exhibit D. The proposed fee should encompass the total compensation paid to your firm for the administration of the number of claims listed. Please also include your proposed fee structure for additional claims, including a proposed annual not to exceed maximum fee. Please indicate any difference in the claims administration fee with bundled v. unbundled managed care services.

Please also outline fees not included in claims administrator fees (*including fees charged to the claims file)*, if any, such as but not limited to:

1. Subrogation fees
2. Bill Review
3. Utilization Review, including if a fee applies for pass-throughs
4. Nurse Case Management
5. Medical network access fees
6. Case management fees:
    a. Telephonic

b. Field

7. Pharmacy program fees
8. Investigation fees:
    a. AOC/COE face to face
    b. Activity check and sub-rosa
9. Claims Index Bureau fees – *free to NCC through PRISM*
10. Client access fees
    a. Startup
    b. Special report
    c. Data transfer
    d. Data storage/maintenance
    e. Monthly reports
    f. OSHA reporting
    g. Acknowledgments
    h. System access

TPA should outline all fees that would be paid as an ancillary expense of the claim file and the cost of those fees whether they are paid to the TPA or an outside vendor, including bill review, PPO, MPN, ISO, and Medicare reporting fees, copy service charges, storage, etc. Please provide any maximum not to exceed fees for these services.

<u>The fee structure should be quoted on an annual basis with a 3-year term at a minimum. A longer term and/or optional years or will also be considered.</u>

5.18.1 Discuss the additional cost, if any, if a new claims administrator is selected and open claims are transferred to the new administrator for processing to their conclusion. What is your communication plan and strategy for a successful transition?

5.19 **Experience of Firm**

What does your firm offer that makes you unique and the best qualified to meet the needs and goals of NCC?

6. EVALUATION OF RESPONSES

During the evaluation, validation, and selection process, NCC may request meetings with a contractor's representative to request answers to specific questions or may request firm representative answer specific questions in writing. NCC may require that the Contractor make presentations that are pertinent to the evaluation process. If a question and/or questions are asked by NCC in a meeting and these questions and the answers thereto are pertinent to the proposal and the contract to be awarded, the question(s) and the answer(s) will be sent to the Contractor in writing for verification before they are included in the proposal documents.

The selection criteria to be used to select the successful bidder will include, but is not limited to, the following:

1. An established record of consistent professional service and reputation within the industry, with specific emphasis on public entities and knowledge of public safety benefits.

2. High quality references from clients, particularly from other self-insured groups, either public or private.

3. Staffing and experience levels.

4. Overall responses in addressing the ability to perform the statement of work.

5. Overall cost-benefit advantages to NCC.

EXHIBIT A

APPENDIX A

NORTHERN CALIFORNIA CITIES SELF INSURED FUND (NCCSIF)

CLAIMS MANAGEMENT PROCEDURES & GUIDELINES

In the event of a Workers' Compensation occurrence likely to involve NCCSIF, written or verbal notice regarding the occurrence shall be given by the Member to the NCCSIF Third Party Administrator (TPA) no later than five calendar days from the date of the Member's knowledge. Such notice shall include the Employer's First Report of Occupational Injury or Illness (Form 5020). Be sure to include circumstances of the occurrence, and the names and addresses of any injured parties, and witnesses.

Failure to report occurrences as required may be cause for denial of coverage if NCCSIF is prejudiced due to the lack of timely reporting. The following will serve as the NCCSIF Workers' Compensation Program procedures and guidelines and are based upon the current TPA contract.

Claim Reporting Procedures

The Members report all claims to TPA within five calendar days of notice as required by California Statute by completion of a Form 5020. After an initial investigation, the Claims Examiner decides to enter the claim as a record only, medical only or indemnity.

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

Record only claims will be closed by the Claims Examiner as soon as all the appropriate claim information is completed.

All new claims will be reviewed by the supervisor within five working days of assignment.

Initial Investigation

The Claims Examiner will conduct a thorough investigation to determine compensability immediately upon receipt of the claim. The Claims Examiner makes all the initial contacts necessary to make this determination and will follow the question format provided by TPA management which outlines the information to be requested for each of the contacts. TPA will contact the workers' compensation claim Member Contact at the Member organization, the injured worker, the supervisor, and the physician. Physician contact is not necessary if a Doctor's First Report of Occupation Injury or Illness (Form 5021) is in the file, there is no lost time, and there are no disputes.

3-Point Contact – Employee, Employer and Physician

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

Notice of claim is defined as:

- Notice of a pending claim in TPA's Claims Management System (CMS)
- Notice of claim reported through Company Nurse
- Phone call, fax, or e-mail from the Member Contact (Form 5020)
- Doctor's First Report of Occupational Injury or Illness (Form 5021)
- Notice of Representation (no contact with injured worker)
- Application of Adjudication of Claim (no contact with injured worker)
- DWC-1 Claim Form

If TPA receives the first notice of claim, TPA will notify the workers' compensation claim Member Contact at the Member organization (the Member Contact) of the details of the claim, request additional information from the Member Contact as needed and set up the claim in TPA CMS. The Member Contact will complete the Form 5020.

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

If the Claims or Med Only Examiner is unable to complete all the initial contacts, the Claims Examiner will continue contact attempts for three days. Should the contact attempts be unsuccessful a "Call Me Card" or e-mail will be sent to contact the respective party. All attempts at communication will be documented in the claim file.

Assistance from the Member Contact must be requested if contact with the injured employee cannot be made after three unsuccessful attempts. The work and home telephone number of the injured employee is a required field for a "pending" claim and therefore needs to be made available to the Claims Examiner. Alternative contact numbers, email addresses or a mailing address can be requested if the Claims Examiner is unable to make contact.

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

The supervisor will review all new claims at five days to ensure that contact is completed and documented. The supervisor will document the contacts that need completion and require that the Claims Examiner continue contacts until all have been completed. The supervisor will keep the file on close diary until all contacts are made.

Acceptance/Denial Issues

If the Claims Examiner determines that a claim should be denied, the Claims Examiner will notify the Member Contact of the investigation results and recommendation to deny benefits prior to notifying the injured employee. All recommendations for denials must be approved by the TPA

supervisor and documented in the claim. All denied claims will have a reason for the denial entered in the claim system.

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

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

The Claims Examiner has up to ninety days to make a compensability decision. The ninety days starts with the employer's knowledge of injury. The Examiner will make a determination regarding compensability once enough information is received to reasonably do so.

Initial Documents

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

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

If the DWC-1 is not received within sixty days, the Claims Examiner will notify the Member Contact via email. This process applies to accepted claims only.

A copy of the 5020 and the DWC-1 will be retained in each claim file. The 5021 will also be in the file or, if a 5021 has not been submitted, the file must contain a copy of a request for the 5021.

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

Medical Releases

TPA will request Medical Releases within five working days of claim receipt. If the signed release is not returned within fourteen days, and the injury has not resolved (such as in a Medical Only claim), the Claims Examiner will contact the Member Contact and request assistance. The process applies to Indemnity files as well as Medical Only files where treatment is continuing beyond the fourteen days.

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

Medical Direction and Control

The Claims Examiner is responsible for coordinating the provision of prompt, appropriate and effective medical treatment for Member employees. The Examiner is responsible for authorizing treatment and notifying medical treaters of NCCSIF's custom Utilization Review criteria.

The Claims Examiner will exercise all reasonable efforts to obtain current physician reports in accordance with California Code of Regulations (CCR) 9785 on all claims where medical treatment is active.

Within fourteen calendar days of notification of change of treating physician, the Claims Examiner will send the complete medical file with CCR 9785 notification to the treating physician.

If the injured employee is absent from work, the Examiner will request physical restrictions from the treating physician. Notification of the Member organization's return to work policy and the injured worker's job description, if necessary, will be sent to the treating physician. Request will be documented in the claim file and repeated as needed during temporary disability.

A copy of CCR 9785 will be sent to the treating physician within five working days upon any request made by the workers' compensation Member Contact.

The Claims Examiner will request updated medical reports on Future Medical (FM) claims where treatment is being sought. On non-active FM claims, the Claims Examiner will monitor for possible administrative closure based on no treatment for two years with no future treatment reasonably anticipated.

The Claims Examiner will document requests for authorization of treatment procedures in the claim file. The Claims Examiner will respond to requests for authorization of treatment and surgery on accepted cases in accordance with NCCSIF's custom Utilization Review guidelines and requirements.

The treatment plan and next treatment date will be documented in the TPA's claim file. The Claims Examiner will document any medication, by name, which has been authorized or denied by the physician for the employee in the claim file. . Updated status reports will be requested as medication changes.

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

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

Documentation

TPA will caption all entries using appropriate CMS defined headings. All entries will contain documentation with appropriate detail, identify the issues of the claim, and describe the plan of action being taken to resolve these issues. An Action Plan will be documented in the CMS within the first fourteen (14) days of receipt and at least every ninety (90) days on Indemnity files and every one hundred eighty (180) days on Future Medical files.

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

Medical records that are received via medical release or subpoena must be summarized in the CMS.

Diary

<u>INDEMNITY CLAIMS EXAMINER DIARY</u>

Every active indemnity file will be reviewed at least once every thirty (30) days. Diary activity will include contact with unrepresented injured employees, at minimum, every sixty (60) days

Claims with ongoing temporary disability benefits will be reviewed every fourteen (14) calendar days. Review includes a phone call to the treating physician to determine return to work capability. Documentation of the review and verification of disability will appear in the claim file.

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

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

MEDICAL ONLY CLAIMS EXAMINER DIARY

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

MANAGER/ SUPERVISOR DIARY

Managers/Supervisor will review all new claims five (5) days after set-up. At that time, the manager will re-set a diary on each new claim as appropriate depending on the severity of the issues or medical treatment. Delayed claims will be reviewed at thirty (30), sixty (60) and ninety (90) day intervals. All denials will be reviewed and approved by the manager. Active cases will be reviewed every ninety (90) days (or sooner if requested). Caseloads for each claim examiner assigned to NCCSIF will be reviewed by the supervisor every ninety (90) days. These reviews will be documented as Management Review in the claim system.

Managers will effectively manage assignments to Examiners to ensure caseloads are meeting the claims handling standards. A count of Future Medical Claims will be kept for each Claims Examiner's caseload.

Temporary Disability

Temporary disability is paid every two weeks.

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

The Claims Examiner should contact the physician every two weeks. Potential for return to work must be discussed and documented. Restrictions will be clarified and discussed with the Member Contact for return to work possibilities.

Litigation

TPA is to utilize approved Member defense counsel in every case. The Claims Examiner will make the selection of counsel on each claim in coordination with the Member Contact. Supervisors must approve referrals. TPA requires that defense counsel adhere to NCCSIF's Defense Counsel Guidelines. These guidelines will be included with each litigation referral.

TPA will notify the Member Contact upon receipt of a Notice of Representation or an Application for Adjudication of Claim within five (5) working days.

TPA will assign claims to Counsel within five days after receipt of notice of approval from the Member Contact. TPA will notify the Member Contact by telephone or email of assignment to Counsel on a claim and confirm by sending the Member a copy of the letter to the selected Counsel confirming engagement.

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

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

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

The Claims Examiner and the Member Contact will determine who should attend hearings.

Mandatory Settlement Conference at WCAB

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

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

TPA will attend an MSC as deemed necessary.

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

Communications

TPA Supervisor and Examiner will utilize professional, courteous, and effective communication skills at all times and will respond to telephone and email inquiries within one (1) working day. All email communications that are pertinent to a particular claim are stored in the CMS claim file.

Index System

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

Reserving

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

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

Reserves will be reviewed with each action plan.

Investigations

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

Cal/OSHA Reporting

The members bear the responsibility to complete a Cal/OSHA log as required by California law. The TPA will provide an annual record of claims in Cal/OSHA Log formats (Forms 300 and 301) by January 15 each year to assist members in posting the Form 300A by February 1.

Resolution

Upon receipt of any permanent and stationary report, the Claims Examiner will determine if the disability described in the report is appropriate for the circumstances of the injury. The Claims Examiner may self-rate if the disability is clear or submit to independent rater or DEU within five business days. If not clear, NCCSIF prefers that the Claims Examiner solicit an independent rating prior to issuing advances. Based on what is learned from the rating, additional clarification may be needed from the physician. The Claims Examiner will seek clarification from the physician or object as appropriate.

Upon receipt of the supplemental report with the clarifying information, the Claims Examiner may need to solicit an additional independent rating in order to ensure that the Claims Examiner is confident of the total value of permanent disability. If the dollar amount of the rating and/or the dollar value of the total amount of permanent disability advance to be made exceed(s) $25,000, the Permanent Disability Benefit letter requires approval from a supervisor.

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

A Settlement Authority Request (SAR) must be submitted to the TPA Supervisor, Member and/or the NCCSIF Claims or Executive Committee, depending on the level of the settlement value requested. This requires timeliness in getting the independent rating in order to avoid penalties for not issuing a timely permanent disability advance.

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

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

Settlement Authority

Various levels of settlement authority have been established as respects this NCCSIF coverage under NCCSIF Policy & Procedure A-6b.

These levels are as follows:

1. $0 to $100,000 (or Member's Banking Layer) - Member with the Claims Administrator (TPA)

   The TPA, with the approval of the member, shall have authority to settle claims up to and including $100,000 per occurrence.

2. $100,000 to $250,000 – NCCSIF Claims Committee

   If the ultimate net loss is or will be in excess of the Member's Banking Layer, the Claims Committee has authority to authorize claims settlement up to $250,000 per occurrence.

3. $250,000 to Shared Risk Layer Limit (currently $500,000) —NCCSIF Executive Committee

   The Executive Committee has authority to approve settlements up to the Shared Risk Layer limit per occurrence. The excess carrier will be involved as needed in accordance with the policy reporting and settlement requirements.

All of the foregoing notwithstanding, if time is of the essence for a specific claim, the President and Claims Committee Chairperson, on the advice of the Claims Administrator, shall have the authority to approve settlement, subject to $100,000 limitation within the Shared Risk Layer. If the President or Chairperson's City is involved in the claim, then the authority is delegated to two non-involved Members of the Claims Committee.

Authority requests must be presented using a Settlement Authority Request (SAR) form.

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

Claims Managers must approve all requests for authority.

If a response from the authorizing body is not received in thirty (30) days, the Claims Examiner will notify the Program Manager via email. If timing is ***urgent***, this will be indicated in the email along with a deadline date and followed up with voicemail.

Return to Work Issues

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

Excess Carrier Reporting and Settlement Requirements

Any claim that meets the criteria for excess reporting must be reported by TPA to the appropriate excess carrier immediately, but in no event later than ten (10) calendar days from the date the TPA is notified or becomes reasonably aware of such accident or disease which may involve the excess carrier or includes any of the following:

a. Injuries to spinal cord (including Cauda Equina), paraplegia, or quadriplegia;
b. Fatality;
c. Amputation of a major extremity;
d. Blindness;
e. Second degree burns on 25% or more of the body or third degree burns on 10% or more of the body
f. Serious head or brain injuries (including skull fracture);
g. Multiple fractures – involving more than one member or any nonunion of any part of the body;
h. Nerve damage causing paralysis and loss of sensation in arm and hand (brachial plexus nerve damage);
i. Massive internal injuries affecting body organs;
j. Any occurrence which causes serious injury or death to two or more employees
k. Any occurrence, which results in disability exceeding one (1) year.
l. Any occurrence that results in permanent and total disability 100% - (including but not limited to 100% by statute: loss of both eyes/sight, loss of both hands (or the use thereof), "practically total paralysis," brain injury resulting in incurable imbecility or insanity.
m. Any occurrence that involves unusual exposure to the coverage—examples include sexual molestation, HIV, AIDS, rape, class actions and bad faith allegations, or other serious violation, which may involve excess;
n. Total incurred in excess of 50% of the Self-Insured Retention (currently $500,000)

Attachments to the first report will include:

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

- All notices and legal papers relating to the claim or suit
- Any other pertinent data

Subsequent reports will be made on a quarterly basis (unless excess carrier advises otherwise).

Attachments to the subsequent reports will include:

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

The Claims Manager will review and authorize all excess reports. The reports will be submitted to the Excess carrier with a copy of all attachments.

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

The Claims Examiner will document confirmation of receipt and requests for information from the Excess Carrier.

If the employee files a Serious and Willful claim, defense costs *directly* related to such claim may not be reimbursable by the Excess Carrier. If counsel is solely completing defense work for the Serious and Willful and it is clear the charges are for the S&W only, then PRISM has not reimbursed those defense costs. Requests for reimbursement should separate these costs where they are clearly identifiable.

Fraud Claims

Suspected fraudulent activity (material misrepresentation by the employee) must be reviewed with the Claims Manager and the Member Contact to determine the merits of the case and further action. Assignment to SIU, Sub Rosa or other special investigation must be approved by the member and TPA. The case will be prepared for submission to the District Attorney and Department of Insurance if a decision to refer the case to the authorities has been made.

Balance Sheet

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

Escrow Fund

The TPA administers a trustee account on behalf of NCCSIF from which benefit payments and expenses will be made. The TPA's Claims Accounting Department will issue all checks and prepare monthly bank reconciliations.

Checks issued over $100,000 require funding verification. Such requests should be forwarded to the NCCSIF Accountant, along with supporting documentation.

TPA will submit replenishment requests **monthly or as needed.**

Check Issuance

All checks are issued by TPA. NCCSIF staff are not authorized to sign checks. There will be no manual checks under any circumstances.

Reports

The TPA will provide a monthly report of TPA and NCCSIF penalties no later than the 10th of each month.

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

Monthly Reports
- New Claims
- Open Claims
- Closed Claims
- Incurred Changes
- Payment Register

Quarterly claim summary reports with rolling three-year data for comparison and trending

Ad hoc reports by member request

Financial & Regulatory Reports
- 1099 Reports
- Medicare Reporting
- OSIP Annual Report
- Managed Care Reports

CLIENT CONTACT(S): *LIST PROVIDED BY PROGRAM ADMINISTRATOR*

Program Administrator

Marcus Beverly Marcus.Beverly@alliant.com (916) 643-2704 (916) 660-2725 Alliant Insurance Services 2180 Harvard St. Ste 460 Sacramento, CA 95815	**Jenna Wirkner** Jenna.Wirkner@alliant.com (916) 643-2741 Alliant Insurance Services 2180 Harvard St. Ste 460 Sacramento, CA 95815

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

ADDENDUM A
WORKERS' COMPENSATION
CLAIMS ADMINISTRATION STANDARDS

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

I. CLAIMS HANDLING - ADMINISTRATIVE

A. Case Load

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

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

B. Case Review and Documentation

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

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

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

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

5. Medical Only Claims

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

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

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

C. Communication

1. Telephone Inquiries

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

2. Incoming Correspondence

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

3. Return Correspondence

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

4. Ongoing Claimant Contact

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

D. Fiscal Handling

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

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

E. Medicare Reporting

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

II. CLAIM CREATION

A. Three-Point Contact

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

B. Compensability

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

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

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

C. AOE/COE Investigation

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

D. Reserves

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

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

E. Indexing

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

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

III. CLAIM HANDLING – TECHNICAL

A. Payments

1. Initial Temporary and Permanent Disability Indemnity Payment

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

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

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

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

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

2. Subsequent Temporary and Permanent Disability Payments

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

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

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

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

3. Final Temporary and Permanent Disability Payments

a. All final indemnity payments shall be issued timely.

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

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

4. Award Payments

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

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

5. Medical Payments

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

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

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

6. Injured Worker Reimbursement Expense

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

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

7. Penalties

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

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

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

B. Medical Treatment

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

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

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

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

C. Apportionment

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

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

D. Disability Management

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

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

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

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

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

E. Supplemental Job Displacement Benefits

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

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

F. Reserving

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

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

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

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

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

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

G. Resolution of Claim

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

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

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

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

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

H. Settlement Authority

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

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

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

IV. LITIGATED CASES

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

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

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

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

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

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

V. SUBROGATION

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

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

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

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

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

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

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

VI. EXCESS COVERAGE

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

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

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

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

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

Following is the history of amendments to this document:

Amended: March 4, 1988
Amended: October 7, 1988
Amended: October 6, 1995
Amended: October 1, 1999
Amended: June 6, 2003
Amended: March 2, 2007
Amended: July 1, 2009
Amended: July 1, 2011
Amended: March 2, 2012
Amended: October 4, 2013
Amended: July 1, 2019

EXHIBIT C

Insurance Requirements for Professional Services

Consultant shall procure and maintain for the duration of the contract insurance against claims for injuries to persons or damages to property which may arise from or in connection with the performance of the work hereunder by the Consultant, its agents, representatives, or employees.

MINIMUM SCOPE AND LIMIT OF INSURANCE

Coverage shall be at least as broad as:

1. **Commercial General Liability** (CGL): Insurance Services Office Form CG 00 01 covering CGL on an "occurrence" basis, including products and completed operations, property damage, bodily injury and personal & advertising injury with limits no less than **$2,000,000** per occurrence. If a general aggregate limit applies, either the general aggregate limit shall apply separately to this project/location (ISO CG 25 03 or 25 04) or the general aggregate limit shall be twice the required occurrence limit.
2. **Automobile Liability:** Insurance Services Office Form Number CA 0001 covering, Code 1 (any auto), or if Consultant has no owned autos, Code 8 (hired) and 9 (non-owned), with limit no less than **$1,000,000** per accident for bodily injury and property damage.
3. **Workers' Compensation** insurance as required by the State of California, with Statutory Limits, and Employer's Liability Insurance with limit of no less than **$1,000,000** per accident for bodily injury or disease.
4. **Professional Liability** (Errors and Omissions) Insurance appropriates to the Consultant's profession, with limit no less than **$2,000,000** per occurrence or claim, **$4,000,000** aggregate.
5. **Crime Insurance (**Fidelity Bond**)** covering the Consultant's officers, employees, and volunteers with a minimum limit of **$2,000,000**.

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

Other Insurance Provisions

The insurance policies are to contain, or be endorsed to contain, the following provisions:

Additional Insured Status

NCCSIF and its members, including officers, officials, employees, and volunteers are to be covered as additional insureds on the CGL policy with respect to liability arising out of work or operations performed by or on behalf of the Consultant including materials, parts, or equipment furnished in connection with such work or operations. General liability coverage can be provided in the form of an endorsement to the Consultant's insurance (at least as broad as ISO Form CG 20 10 11 85 or current equivalent).

Primary Coverage

For any claims related to this contract, the **Consultant's insurance coverage shall be primary and non-contributory** and at least as broad as ISO CG 20 01 04 13 as respects NCCSIF and its members, its officers, officials, employees, and volunteers. Any insurance or self-insurance maintained by NCCSIF and members' officers, officials, employees, or volunteers shall be excess of the Consultant's insurance and shall not contribute with it. This requirement shall also apply to any Excess or Umbrella liability policies.

EXHIBIT C

Notice of Cancellation
Each insurance policy required above shall provide that coverage shall not be canceled, except with notice to NCCSIF.

Waiver of Subrogation
Consultant hereby grants to NCCSIF and its members a waiver of any right to subrogation which any insurer of said Consultant may acquire against them by virtue of the payment of any loss under such insurance. Consultant agrees to obtain any endorsement that may be necessary to affect this waiver of subrogation, but this provision applies regardless of whether NCCSIF has received a waiver of subrogation endorsement from the insurer.

Self-Insured Retentions

Self-insured retentions must be declared to and approved by NCCSIF. NCCSIF may require the Consultant to purchase coverage with a lower retention or provide proof of ability to pay losses and related investigations, claim administration, and defense expenses within the retention. The policy language shall provide, or be endorsed to provide, that the self-insured retention may be satisfied by either the named insured or Entity.

Acceptability of Insurers
Insurance is to be placed with insurers authorized to conduct business in California with a current A.M. Best's rating of no less than A:VII, unless otherwise acceptable to NCCSIF.

Claims Made Policies
If any of the required policies provide claims-made coverage:

1. The Retroactive Date must be shown and must be before the date of the contract or the beginning of contract work.
2. Insurance must be maintained, and evidence of insurance must be provided ***for at least three (3) years after completion of the contract of work.***
3. If coverage is canceled or non-renewed, and not replaced ***with another claims-made policy form with a Retroactive Date prior to*** the contract effective date, the Consultant must purchase "extended reporting" coverage for a minimum of ***three (3)*** years after completion of work.

Verification of Coverage

Consultant shall furnish NCCSIF with original certificates and amendatory endorsements or copies of the applicable policy language effecting the coverage required. All certificates and endorsements are to be received and approved by NCCSIF before work commences. However, failure to obtain the required documents prior to the work beginning shall not waive the Consultant's obligation to provide them. NCCSIF reserves the right to require complete copies of required insurance policies, including endorsements required by these specifications, at any time.

Subcontractors
Consultant shall require and verify that all subcontractors maintain insurance meeting all the requirements stated herein.

Special Risks or Circumstances
NCCSIF reserves the right to modify these requirements, including limits, based on the nature of the risk, prior experience, insurer, coverage, or other special circumstances.

NCCSIF

Summary by Program Year As Of: 07/31/2022

	Indemnity	Medical	Expense	Total	Ind	Med	FA	Totals	Legal	Life
2022 - 2023										
Incurred	26,056.06	57,115.00	4,604.40	87,775.46	11	30	0	41	0	0
Paid	0.00	214.78	123.60	338.38						
Outstanding	26,056.06	56,900.22	4,480.80	87,437.08						
2021 - 2022										
Incurred	3,735,565.82	2,892,402.04	499,303.81	7,127,271.67	394	204	1	599	18	0
Paid	1,657,956.12	943,105.53	130,923.09	2,731,984.74						
Outstanding	2,077,609.70	1,949,296.51	368,380.72	4,395,286.93						
2020 - 2021										
Incurred	6,050,498.62	3,635,523.93	884,692.13	10,570,714.68	273	120	4	397	38	0
Paid	2,099,412.22	1,104,074.12	432,769.32	3,636,255.66						
Outstanding	3,951,086.40	2,531,449.81	451,922.81	6,934,459.02						
2019 - 2020										
Incurred	4,125,111.57	3,205,794.13	896,213.32	8,227,119.02	211	127	3	341	29	15
Paid	2,824,167.89	1,525,889.94	536,830.53	4,886,888.36						
Outstanding	1,300,943.68	1,679,904.19	359,382.79	3,340,230.66						
2018 - 2019										
Incurred	4,139,333.43	14,230,022.84	1,976,787.86	20,346,144.13	205	166	3	374	28	36
Paid	3,437,088.75	2,405,224.56	636,353.84	6,478,667.15						
Outstanding	702,244.68	11,824,798.28	1,340,434.02	13,867,476.98						
2017 - 2018										
Incurred	3,411,879.96	2,772,023.14	843,622.59	7,027,525.69	200	164	10	374	27	39
Paid	3,038,450.11	1,693,537.04	655,775.23	5,387,762.38						
Outstanding	373,429.85	1,078,486.10	187,847.36	1,639,763.31						
2016 - 2017										
Incurred	3,226,574.51	3,742,377.57	1,192,157.69	8,161,109.77	197	192	16	405	28	34
Paid	3,149,189.07	2,865,112.99	1,036,911.65	7,051,213.71						
Outstanding	77,385.44	877,264.58	155,246.04	1,109,896.06						
2015 - 2016										
Incurred	3,068,767.09	3,023,527.02	1,008,538.29	7,100,832.40	168	145	22	335	21	46
Paid	2,746,997.08	1,885,518.67	837,138.16	5,469,653.91						
Outstanding	321,770.01	1,138,008.35	171,400.13	1,631,178.49						
2014 - 2015										
Incurred	6,067,829.11	3,445,537.98	1,011,328.87	10,524,695.96	197	166	22	385	32	46
Paid	3,770,548.98	2,466,216.35	843,930.23	7,080,695.56						
Outstanding	2,297,280.13	979,321.63	167,398.64	3,444,000.40						
2013 - 2014										
Incurred	3,357,158.78	3,657,093.36	941,723.80	7,955,975.94	168	205	18	391	20	42
Paid	3,347,215.32	2,563,211.15	796,727.15	6,707,153.62						
Outstanding	9,943.46	1,093,882.21	144,996.65	1,248,822.32						
2012 - 2013										
Incurred	2,319,461.91	2,301,012.23	841,931.55	5,462,405.69	194	183	7	384	27	38
Paid	2,310,664.41	1,929,322.93	786,121.66	5,026,109.00						
Outstanding	8,797.50	371,689.30	55,809.89	436,296.69						

NCCSIF

Summary by Program Year As Of: 07/31/2022

	Indemnity	Medical	Expense	Total	Ind	Med	FA	Totals	Legal	Life
2011 - 2012										
Incurred	3,356,429.53	4,452,099.63	852,301.35	8,660,830.51	209	143	3	355	32	44
Paid	2,631,145.07	2,349,053.27	772,760.95	5,752,959.29						
Outstanding	725,284.46	2,103,046.36	79,540.40	2,907,871.22						
2010 - 2011										
Incurred	1,636,285.65	1,915,080.85	508,570.20	4,059,936.70	186	173	8	367	35	35
Paid	1,636,234.33	1,583,834.57	472,857.92	3,692,926.82						
Outstanding	51.32	331,246.28	35,712.28	367,009.88						
2009 - 2010										
Incurred	2,138,483.85	2,826,312.20	678,018.39	5,642,814.44	193	163	10	366	37	44
Paid	2,080,185.97	2,389,923.96	613,704.53	5,083,814.46						
Outstanding	58,297.88	436,388.24	64,313.86	558,999.98						
2008 - 2009										
Incurred	1,833,652.32	2,366,563.47	675,696.32	4,875,912.11	227	208	21	456	55	39
Paid	1,833,652.32	2,062,009.58	630,906.09	4,526,567.99						
Outstanding	0.00	304,553.89	44,790.23	349,344.12						
2007 - 2008										
Incurred	2,213,711.28	2,292,549.58	532,133.45	5,038,394.31	201	204	16	421	38	36
Paid	1,984,700.62	1,985,115.93	487,817.65	4,457,634.20						
Outstanding	229,010.66	307,433.65	44,315.80	580,760.11						
2006 - 2007										
Incurred	2,295,431.65	3,322,541.86	905,752.91	6,523,726.42	207	174	14	395	59	47
Paid	2,295,275.64	3,111,018.50	873,509.81	6,279,803.95						
Outstanding	156.01	211,523.36	32,243.10	243,922.47						
2005 - 2006										
Incurred	1,960,681.61	4,103,396.73	778,444.52	6,842,522.86	204	206	7	417	58	34
Paid	1,778,840.23	2,853,350.12	631,685.64	5,263,875.99						
Outstanding	181,841.38	1,250,046.61	146,758.88	1,578,646.87						
2004 - 2005										
Incurred	1,974,862.76	2,373,454.78	578,604.50	4,926,922.04	187	189	14	390	67	36
Paid	1,967,159.92	1,856,270.08	528,335.21	4,351,765.21						
Outstanding	7,702.84	517,184.70	50,269.29	575,156.83						
2003 - 2004										
Incurred	2,217,120.64	2,205,583.13	410,745.31	4,833,449.08	223	196	6	425	64	33
Paid	2,217,120.64	2,044,329.23	382,225.70	4,643,675.57						
Outstanding	0.00	161,253.90	28,519.61	189,773.51						
2002 - 2003										
Incurred	3,766,840.50	4,002,751.59	710,830.82	8,480,422.91	271	183	7	461	74	37
Paid	3,680,077.34	3,708,574.10	653,413.81	8,042,065.25						
Outstanding	86,763.16	294,177.49	57,417.01	438,357.66						
2001 - 2002										
Incurred	2,459,057.76	2,521,386.65	408,849.93	5,389,294.34	180	196	0	376	50	30
Paid	2,459,056.76	2,451,716.92	391,456.67	5,302,230.35						
Outstanding	1.00	69,669.73	17,393.26	87,063.99						

NCCSIF

Summary by Program Year As Of: 07/31/2022

	Indemnity	Medical	Expense	Total	Ind	Med	FA	Totals	Legal	Life
2000 - 2001										
Incurred	3,246,123.24	4,313,414.66	641,123.33	8,200,661.23	216	178	0	394	52	40
Paid	2,852,858.86	3,717,845.46	556,953.61	7,127,657.93						
Outstanding	393,264.38	595,569.20	84,169.72	1,073,003.30						
1999 - 2000										
Incurred	2,349,900.00	3,516,386.62	618,357.83	6,484,644.45	203	173	0	376	55	38
Paid	2,349,899.00	3,087,451.41	536,950.05	5,974,300.46						
Outstanding	1.00	428,935.21	81,407.78	510,343.99						
1998 - 1999										
Incurred	1,824,531.78	3,474,847.46	697,497.45	5,996,876.69	181	143	0	324	37	23
Paid	1,417,214.96	2,195,284.18	472,953.81	4,085,452.95						
Outstanding	407,316.82	1,279,563.28	224,543.64	1,911,423.74						
1997 - 1998										
Incurred	2,259,343.12	3,017,358.72	447,851.88	5,724,553.72	197	203	0	400	50	23
Paid	2,242,037.01	2,857,113.26	402,640.02	5,501,790.29						
Outstanding	17,306.11	160,245.46	45,211.86	222,763.43						
1996 - 1997										
Incurred	1,450,428.33	2,217,270.21	409,291.37	4,076,989.91	208	161	0	369	57	23
Paid	1,430,167.78	2,035,178.02	387,986.17	3,853,331.97						
Outstanding	20,260.55	182,092.19	21,305.20	223,657.94						
1995 - 1996										
Incurred	2,490,593.13	1,995,152.96	653,187.63	5,138,933.72	206	206	1	413	57	19
Paid	2,457,095.28	1,844,785.63	639,179.09	4,941,060.00						
Outstanding	33,497.85	150,367.33	14,008.54	197,873.72						
1994 - 1995										
Incurred	1,026,999.63	2,168,651.62	544,460.88	3,740,112.13	183	225	0	408	37	19
Paid	1,026,999.63	1,526,343.30	506,647.67	3,059,990.60						
Outstanding	0.00	642,308.32	37,813.21	680,121.53						
1993 - 1994										
Incurred	997,236.06	1,709,199.77	671,980.42	3,378,416.25	166	256	0	422	43	15
Paid	982,087.40	1,573,674.00	653,061.55	3,208,822.95						
Outstanding	15,148.66	135,525.77	18,918.87	169,593.30						
1992 - 1993										
Incurred	1,833,578.71	2,300,542.86	825,149.79	4,959,271.36	235	226	0	461	54	17
Paid	1,833,575.71	2,248,580.38	821,927.59	4,904,083.68						
Outstanding	3.00	51,962.48	3,222.20	55,187.68						
1991 - 1992										
Incurred	1,361,443.45	1,438,714.48	644,732.00	3,444,889.93	174	253	0	427	41	13
Paid	1,361,443.45	1,295,815.93	622,760.76	3,280,020.14						
Outstanding	0.00	142,898.55	21,971.24	164,869.79						
1990 - 1991										
Incurred	1,065,533.00	992,346.41	536,087.53	2,593,966.94	188	269	0	457	42	8
Paid	1,065,533.00	992,346.41	536,087.53	2,593,966.94						
Outstanding	0.00	0.00	0.00	0.00						

NCCSIF

Summary by Program Year As Of: 07/31/2022

	Indemnity	Medical	Expense	Total	Ind	Med	FA	Totals	Legal	Life
1989 - 1990										
Incurred	889,997.20	713,170.93	436,146.26	2,039,314.39	154	247	0	401	27	5
Paid	889,997.20	674,363.47	430,850.43	1,995,211.10						
Outstanding	0.00	38,807.46	5,295.83	44,103.29						
1988 - 1989										
Incurred	1,064,315.78	1,190,152.35	440,146.55	2,694,614.68	142	233	0	375	31	5
Paid	1,064,315.78	1,052,861.87	419,577.33	2,536,754.98						
Outstanding	0.00	137,290.48	20,569.22	157,859.70						
1987 - 1988										
Incurred	1,042,293.31	683,536.23	337,998.73	2,063,828.27	110	299	0	409	27	3
Paid	1,042,293.31	683,536.23	337,998.73	2,063,828.27						
Outstanding	0.00	0.00	0.00	0.00						
1986 - 1987										
Incurred	521,923.87	705,762.74	353,330.22	1,581,016.83	82	284	0	366	31	6
Paid	521,923.87	637,805.53	341,786.12	1,501,515.52						
Outstanding	0.00	67,957.21	11,544.10	79,501.31						
1985 - 1986										
Incurred	828,886.17	1,489,796.20	308,664.46	2,627,346.83	97	235	0	332	28	3
Paid	828,886.17	1,489,796.20	308,664.46	2,627,346.83						
Outstanding	0.00	0.00	0.00	0.00						
1984 - 1985										
Incurred	1,072,804.78	1,455,769.55	310,925.06	2,839,499.39	118	262	0	380	41	4
Paid	1,072,804.78	1,455,769.55	310,925.06	2,839,499.39						
Outstanding	0.00	0.00	0.00	0.00						
1983 - 1984										
Incurred	828,831.85	712,438.36	232,266.10	1,773,536.31	86	219	0	305	54	2
Paid	828,831.85	712,438.36	232,266.10	1,773,536.31						
Outstanding	0.00	0.00	0.00	0.00						
1982 - 1983										
Incurred	665,599.00	1,024,894.49	201,292.32	1,891,785.81	71	188	0	259	46	4
Paid	665,599.00	1,024,894.49	201,292.32	1,891,785.81						
Outstanding	0.00	0.00	0.00	0.00						
1981 - 1982										
Incurred	226,273.32	164,361.64	80,610.29	471,245.25	50	60	0	110	27	2
Paid	226,273.32	164,361.64	80,610.29	471,245.25						
Outstanding	0.00	0.00	0.00	0.00						
1980 - 1981										
Incurred	128,595.18	109,328.41	68,014.52	305,938.11	38	62	1	101	21	0
Paid	128,595.18	109,328.41	68,014.52	305,938.11						
Outstanding	0.00	0.00	0.00	0.00						
1979 - 1980										
Incurred	175,426.22	254,330.97	55,350.70	485,107.89	39	72	0	111	16	1
Paid	175,426.22	254,330.97	55,350.70	485,107.89						
Outstanding	0.00	0.00	0.00	0.00						

NCCSIF

Summary by Program Year As Of: 07/31/2022

	Indemnity	Medical	Expense	Total	Ind	Med	FA	Totals	Legal	Life
1978 - 1979										
Incurred	59,556.21	42,406.34	17,458.42	119,420.97	8	4	0	12	10	0
Paid	59,556.21	42,406.34	17,458.42	119,420.97						
Outstanding	0.00	0.00	0.00	0.00						
1977 - 1978										
Incurred	10.10	0.00	1,631.56	1,641.66	1	2	0	3	1	0
Paid	10.10	0.00	1,631.56	1,641.66						
Outstanding	0.00	0.00	0.00	0.00						
1976 - 1977										
Incurred	0.00	0.00	186.79	186.79	0	1	0	1	1	0
Paid	0.00	0.00	186.79	186.79						
Outstanding	0.00	0.00	0.00	0.00						
1975 - 1976										
Incurred	0.00	0.00	63.84	63.84	1	0	0	1	0	0
Paid	0.00	0.00	63.84	63.84						
Outstanding	0.00	0.00	0.00	0.00						
1974 - 1975										
Incurred	0.00	758.64	1,324.20	2,082.84	1	1	0	2	0	0
Paid	0.00	758.64	1,324.20	2,082.84						
Outstanding	0.00	0.00	0.00	0.00						
1961 - 1962										
Incurred	0.00	0.00	0.00	0.00	1	0	0	1	0	0
Paid	0.00	0.00	0.00	0.00						
Outstanding	0.00	0.00	0.00	0.00						
Grand Total										
Incurred	**92,791,017.85**	**111,034,742.33**	**26,675,982.14**	**230,501,742.32**	**7,662**	**8,199**	**214**	**16,075**	**46**	**40**
Paid	**79,468,563.86**	**77,453,694.00**	**22,077,427.16**	**178,999,685.02**						
Outstanding	**13,322,453.99**	**33,581,048.33**	**4,598,554.98**	**51,502,057.30**						

NCCSIF

Claim Analysis Summary

Measurement Period from 7/1/21 to 7/31/22 as of Each Month End

Filters Selected:

New Defined: By Date Claim Opened Reporting Level: Claim Closed Claim Option: Excluding Reopened and Closed Indemnity Claim Defined: By System Code Line Type: WC Financial Indicator: Gross Financial Option: No Cap Duration Option: By

Pending Claims by Loss Year	2021 Jul	2021 Aug	2021 Sep	2021 Oct	2021 Nov	2021 Dec	2022 Jan	2022 Feb	2022 Mar	2022 Apr	2022 May	2022 Jun	2022 Jul	Change From Prior Month	Change From Last Year Month
1984	1	1	1					1	1	1					(1)
1986	1	1	1	1	1	1	1	1	1	1	1	1	1	0	0
1987	1	1	1	1	1	1	1	1	1	1	1	1	1	0	0
1989	2	2	2	2	2	2	2	2	2	2	2	2	2	0	0
1990	1	1	1	1	1	1	1	1	1	1	1	1	1	0	0
1991	3	3	3	3	3	3	3	3	3	3	3	3	3	0	0
1992	4	4	4	4	4	4	4	4	4	4	4	4	3	(1)	(1)
1993	1	1	1	1	1	1	1	1	1	1	1	1	1	0	0
1994	4	4	4	4	4	4	4	4	4	4	4	4	4	0	0
1995	2	2	2	2	2	2	2	2	2	2	2	2	2	0	0
1996	4	4	4	4	4	4	4	4	4	4	4	4	4	0	0
1997	1	1	1	1	1	1	1	1	1						(1)
1998	3	3	3	3	3	3	3	3	3	3	3	3	3	0	0
1999	7	7	7	7	6	6	6	6	6	5	5	5	5	0	(2)
2000	6	6	6	6	6	6	6	6	6	6	6	6	6	0	0
2001	7	7	7	7	7	7	7	7	8	8	8	8	8	0	1
2002	6	7	7	7	7	7	7	7	8	9	9	9	9	0	3
2003	3	3	3	3	3	3	3	3	3	3	3	3	3	0	0
2004	7	7	7	8	8	8	8	8	8	8	8	8	8	0	1
2005	5	5	5	5	5	5	5	5	5	5	5	5	5	0	0
2006	10	10	10	10	9	9	9	9	9	9	9	9	10	1	0
2007	5	5	5	4	4	4	4	4	4	4	4	4	4	0	(1)
2008	5	5	5	5	5	5	6	6	6	6	6	6	5	(1)	0
2009	11	11	11	11	10	10	10	8	8	8	8	8	8	0	(3)
2010	10	10	10	10	10	10	10	11	11	11	11	11	10	(1)	0
2011	11	10	10	10	9	9	9	9	9	9	9	9	9	0	(2)
2012	10	10	10	10	9	9	9	9	10	10	10	10	11	1	1
2013	15	15	15	15	15	15	15	15	15	15	15	15	15	0	0
2014	20	20	20	20	20	19	19	19	20	20	20	20	20	0	0
2015	22	20	21	21	21	21	21	21	21	22	22	22	22	0	0
2016	32	34	33	33	31	30	30	30	29	29	29	29	29	0	(3)
2017	34	33	33	33	31	30	30	30	31	29	29	30	29	(1)	(5)
2018	40	37	37	37	37	34	35	35	32	32	32	32	32	0	(8)
2019	73	73	71	70	68	67	68	68	67	64	63	63	63	0	(10)
2020	91	86	86	83	82	79	80	80	79	77	75	73	68	(5)	(23)
2021	112	130	170	185	191	207	218	207	177	148	129	115	106	(9)	(6)
2022							77	170	193	184	172	156	182	26	182
Total	**570**	**579**	**617**	**627**	**621**	**627**	**719**	**801**	**793**	**748**	**713**	**682**	**692**	**10**	**122**

NCCSIF

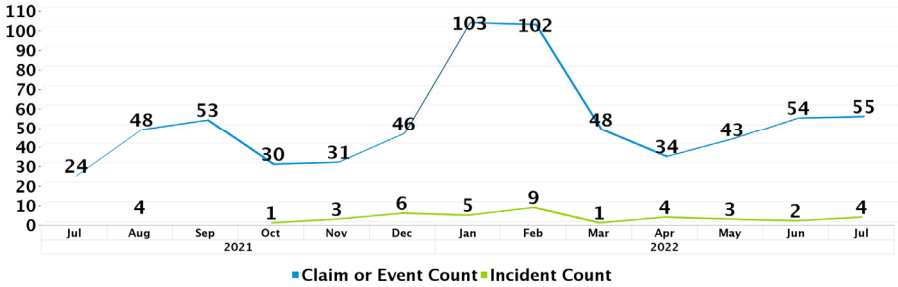
Claim Analysis Summary

Measurement Period from 7/1/21 to 7/31/22 as of Each Month End

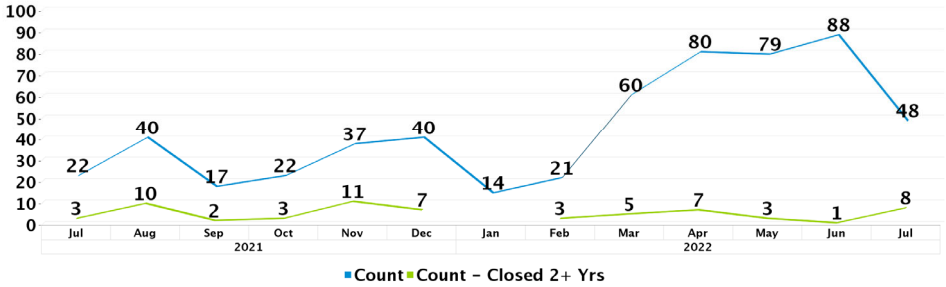
Filters Selected:

New Defined: By Date Claim Opened Reporting Level: Claim Closed Claim Option: Excluding Reopened and Closed Indemnity Claim Defined: By System Code Line Type: WC Financial Indicator: Gross Financial Option: No Cap Duration Option: By Date Opened Duration Selection: Include Reopened Days

New Incident and Claim Count by Opened Month and Year

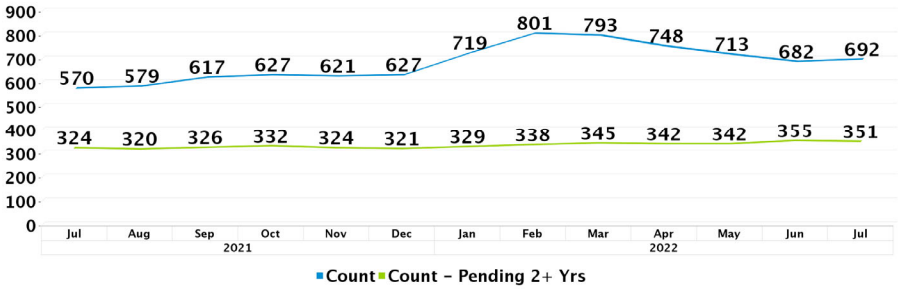


Closed Claim Count by Closed Month and Year

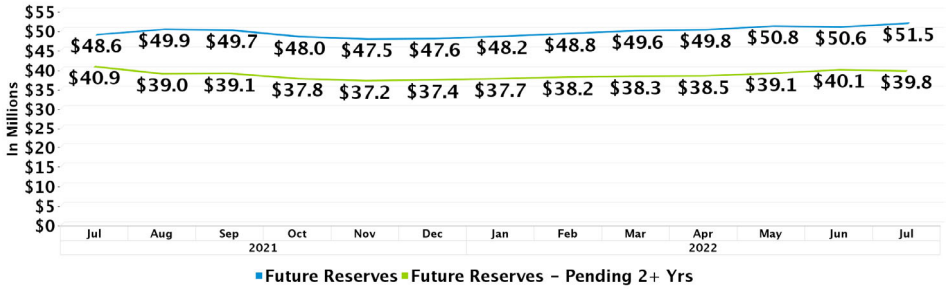


Count and Ratio	2021 Jul	2021 Aug	2021 Sep	2021 Oct	2021 Nov	2021 Dec	2022 Jan	2022 Feb	2022 Mar	2022 Apr	2022 May	2022 Jun	2022 Jul
New Incidents and Claims	24	52	53	31	34	52	108	111	49	38	46	56	59
New Claims	24	48	53	30	31	46	103	102	48	34	43	54	55
Reopened Claims	4	1	2	2			3	1	4	1	1	3	3
Closed Claims	22	40	17	22	37	40	14	21	60	80	79	88	48
Closed Claims 2+ Yrs	3	10	2	3	11	7		3	5	7	3	1	8
Closing Ratio by Claim	78.6%	81.6%	30.9%	68.8%	119.4%	87.0%	13.2%	20.4%	115.4%	228.6%	179.5%	154.4%	82.8%
Pending Claims	570	579	617	627	621	627	719	801	793	748	713	682	692
Pending Claims 2+ Yrs	324	320	326	332	324	321	329	338	345	342	342	355	351

Pending Claim Count by As of Month and Year



Pending Future Reserves by As of Month and Year



Medical Bill Review Summary: 7/1/21 - 6/30/22

NCCSIF

Medical Bill Review Summary	7/1/21 - 6/30/22
Number of Bills	7,545
Number of Lines	16,093
Bill Charges	$7,871,559
Bill Allowance	$2,779,777
Average Allowance/Bill	$368
PPO Penetration*	**7/1/21 - 6/30/22**
PPO Bill Penetration	94.1%
PPO Charge Penetration	92.0%
Savings	**7/1/21 - 6/30/22**
Bill Review Savings	$4,041,292
PPO Savings	$1,041,600
Other Savings	$6,989
Total Savings	$5,089,882
Gross Savings %	64.7%
Average Savings/Bill	$675
ROI	45 : 1
Fees	**7/1/21 - 6/30/22**
Bill Review Fees	$113,203
PPO Fees	$0
Other Fees	$0
Total Fees	$113,203
Net Performance	**7/1/21 - 6/30/22**
Net Savings	$4,976,679
Net Savings %	63.2%
Average Net Savings/Bill	$660
Net ROI	44 : 1

**PPO metrics excludes bills not eligible for network participation.*

Report excludes full duplicate denials.

NCCSIF

Utilization Review Summary

7/1/21 - 6/30/22

Review Status	Procedures Reviewed	% of Procedures
Approved	1,305	55.7%
Denied	1,001	42.8%
Negotiated	6	0.3%
Withdrawn	29	1.2%
Total	**2,341**	**100%**

Savings and Fees Summary	
Medical Savings	$336,662
UR Fees	$60,895
Physician Fees	$60,930
Total Fees	$121,825
Net Savings | ROI	$214,837 | 3 to 1

Review By Level	Procedures Reviewed	% of Procedures
Approved by Coordinator	181	8%
Clinical Nurse/Physician Review	1,276	55%
Clinical Nurse Review	884	38%
Total	**2,341**	**100%**

Appeal Summary	Count Procedures	% Appealed Procedures
Appeal Upheld	52	78%
Appeal Overturned	15	22%
Appeal Negotiated	0	-
Total	**67**	**100%**

Procedure Category	Procedures Reviewed	Approved Count	Denied/Modified Count	% Denied/Modified	Medical Savings	UR Fees	Physician Fees	Total Fees
Acupuncture/Chiro	141	52	81	57%	$25,202	$2,131	$3,943	$6,073
Diagnostic/Labs	360	223	128	36%	$16,728	$7,953	$9,499	$17,452
Home Health/DME	152	101	50	33%	$50,825	$3,314	$4,580	$7,894
Inpatient	8	0	8	100%	$3,379	$88	$195	$282
Miscellaneous	49	27	22	45%	$5,407	$2,130	$3,538	$5,668
Office Visit/Consult/Referral	129	116	13	10%	$5,635	$1,595	$1,381	$2,976
Outpatient Surgery	94	47	47	50%	$21,895	$1,186	$2,175	$3,361
Pain Management	270	105	154	57%	$27,652	$5,226	$8,431	$13,658
Pharmacy	751	473	278	37%	$110,239	$30,909	$16,561	$47,470
Psych	25	20	5	20%	$4,560	$1,128	$745	$1,873
PT/OT	361	141	220	61%	$65,139	$5,213	$9,833	$15,045
RTW	1	0	1	100%	$0	$22	$50	$72
Total	**2,341**	**1,305**	**1,007**	**43%**	**$336,662**	**$60,895**	**$60,930**	**$121,825**

MEDICAL PROVIDER NETWORK

NCCSIF

7/1/21 - 6/30/22 valued at 6/30/22

Summary	Claims	
	New Losses Accessing MPN	217
	Existing Claims Accessing MPN	479
	Allowable Charges	$1,307,639
Savings Detail	Savings	
	Contract Savings	$112,662
	Average Discount	8.6%
	Net Savings	$112,662

✓ Represents Adjuster Authorization - Non Clinical Review

Consultation/Treatment

- ✓ ***Initial Consultations/Second Opinions***
- ✓ ***Consultation/Rule Out Evals***
- ✓ Psychiatric Treatment
- ✓ Neuro-psyche Consults
- ✓ Multi-Disciplinary Pain Program
- ✓ Weight Loss Programs
- ✓ CTS Secondary Diagnosis
- ✓ RSD/CRPS Consultation/Diagnosis
- ✓ Pain Management

Pharmaceutical

- ✓ ***Exempt Initial RX***
- ✓ ***Formulary Medication (Optum)***
- ✓ Non-Exempt Medication (Optum)
- ✓ Oral RX outside of CA RX Formulary
- ✓ IV Narcotics
- ✓ Detox Programs
- ✓ Botox Injections

Durable Medical Equipment

- ✓ ***Therapy Kits***
- ✓ ***Swiss Ball***
- ✓ ***Non-Custom Bracing***
- ✓ ***Post-Op DME***
- ✓ DME Purchase beyond $500.00
- ✓ DME Rental post 90 days
- ✓ Custom DME/Bracing
- ✓ H-Wave purchase/rental
- ✓ Tear Tech/Tri-Wave/RS4i
- ✓ Bone Growth Stimulator

Diagnostic Testing

- ✓ ***Initial X-Rays***
- ✓ ***Initial MRI/CT Scan/Bone Scan***
- ✓ ***Range of Motion/Muscle Testing***
- ✓ ***Ultrasound/Doppler***
- ✓ ***Multiple Diagnostics***
- ✓ ***Repeat Diagnostics***
- ✓ Thermo/Heat Testing
- ✓ Experimental Testing
- ✓ EMG/NCV for CTS w/out prior labs
- ✓ Shockwave Therapy
- ✓ Disco grams/Myelograms

Physical Medicine (PT/OT & Chiro)

- ✓ ***Initial 18 Physical Therapy/Occupational/Chiropractic Visits***
- ✓ ***18 Post Surgical PT/OT/Chiropractic visits***
- ✓ ***Initial 6 Acupuncture/Aquatic Therapy visits***
- ✓ Aquatic Therapy beyond 6 visits
- ✓ Physical Therapy/Occupational Therapy beyond 18 visits*
- ✓ Post Surgical Physical Therapy/Occupational Therapy beyond 18 visits
- ✓ Post Surgical Chiropractic treatment beyond 6 visits 18
- ✓ Acupuncture beyond 6 visits
- ✓ Home Health Care
- ✓ Pilates/Gym Membership
- ✓ Holistic Medicine
- ✓ All Work Hardening

* Physical Medicine: Post 24 Limitations (No SX) - Refer to Medical Director for Determination

Surgical/Invasive Procedures

- ✓ ***Initial Trigger Point/Cortisone/Orthovisc (w/Panels***
- ✓ ***Nerve Blocks***
- ✓ ***Facet Injections***
- ✓ All Surgical Requests
- ✓ Chemonucleolysis
- ✓ Multi-Level ESI's
- ✓ Spinal Cord Stimulators
- ✓ Bone Growth Stimulators
- ✓ Pain Pumps
- ✓ IDET

Other

- ✓ Adjuster/Nurse Drive Requests
- ✓ Client Specified Reviews
- ✓ Experimental Services
- ✓ Unrecognized/Unknown Treatment
- ✓ Non-FDA approved treatment
- ✓ All Custodial Care
- ✓ Medical Transportation
- ✓ All treatment Requests that Exceed The MTUS Guidelines

Date

Preferred Provider
Notice – Sent to Provider by Company Nurse and sent by Sedgwick to the Injured Worker
Address
Address

Re: NCCSIF: Preferred Network Provider Pre-Authorization Program

You are receiving this notice as you are a select preferred provider within the Northern California Cities Self Insurance Fund (NCCSIF) medical provider community and work closely with the pool members and workers' compensation claims administrator Sedgwick.

To ease access and expedite appropriate medical treatment related to industrial injuries, the members of NCCSIF have implemented a pre-authorization program. To ensure that you have immediate access and information regarding the NCCSIF Workers' Compensation Program, we offer the following:

As part of this program the members of NCCSIF have established a set of pre-authorized treatment/testing guidelines that require no prospective or concurrent notification to Sedgwick/CareWorks prior to administration. Treatment rendered in line with these guides must be followed up by a PR-2 indicating treatment provided and work status.

Consultation/Treatment
- ✓ Initial Consultations/Second Opinions
- ✓ Consultation/Rule Out Evaluations

Diagnostic Testing
- ✓ Initial and Repeat X-Rays
- ✓ Initial and Repeat MRI/CT Scan/Bone Scan

Durable Medical Equipment
- ✓ Therapy Kits
- ✓ Swiss Ball
- ✓ Non-Custom Bracing
- ✓ Post-Op DME

Physical Medicine (PT/OT & Chiro)
- ✓ Initial 18 PT/OT/Chiropractic Visits
- ✓ 18 Post Surgical PT/OT/Chiro Visits
- ✓ Initial 6 Acupuncture Visits

Please direct all treatment requests falling outside of the pre-authorized treatment guides to Sedgwick/CareWorks Managed Care Services to 800.922.5020 or fax your request to 877.922.7236.

Should you have any questions and or concerns, please feel free to contact me at 951.231.6825.

Sincerely,

Devora Brainard
Vice President, Client Services I Sedgwick

c: Marcus Beverly
Alliant Insurance Services, Inc.