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2020 ANNUAL AUDIT OF CLAIMS ADMINISTRATION & CASE MANAGEMENT SERVICES PROVIDERS

JUDICIAL BRANCH WORKERS' COMPENSATION PROGRAM

JANUARY 18, 2021

MARSH

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Executive Summary

The Judicial Council of California (JCC) contracted with Marsh USA, Inc. (Marsh) to provide various claim auditing services over the period extending from May 1, 2020 through June 30, 2021. One such requested service was the completion of annual audits of The Judicial Branch Workers' Compensation Program's (JBWCP) two primary program vendors:

- Acclamation Insurance Management Services (AIMS) (i.e., Third Party Administrator); and
- Allied Managed Care (AMC) (i.e., Managed Care Provider).

The purpose of the audits was to provide a broad baseline of operational performance for both vendors to allow The JBWCP to: (1) identify potential opportunities to enhance Program performance and key outcomes; as well as (2) support future business decisions. Claim auditing activities were completed between September 21, 2020 and October 30, 2020. A total of 180 and 80 claim files were audited in conjunction with the AIMS and AMC audits respectively. The following is a high-level summary of the outcomes achieved for both audits.

AIMS Audit: (Composite Audit Score Achieved = 94.45)

Scores for the fourteen audit categories evaluated are as follows:

AUDIT CATEGORY	# OF APPLICABLE CLAIMS	AUDIT SCORES
• JBWCP Member Loss Reporting	26	(Not Scored)
• Claim Setup & Assignment/Reassignment	31	97.33
• Three-Point Contacts	28	82.61
• Investigation	142	91.43
• Medical Cost Containment	151	99.61
• Disability Management	47	85.61
• Litigation Management	82	97.86
• Subrogation, Apportionment, Contribution	47	96.88
• Reserving	179	89.84
• Communication	134	88.76
• Payments	170	98.90
• Settlement/Resolution	89	89.88
• Strategic Plans & Documentation	180	96.18
• Supervisory Review	180	94.00
AIMS COMPOSITE AUDIT SCORE		**94.45**

The AIMS overall composite score achieved for the 2020 annual audit is **94.45**. This score is indicative of strong overall management of JBWCP's Workers' Compensation Program.

AIMS received scores of 90.00 or more in eight of the scored categories audited. Scores in the range of 90.00–100.00 suggest strong operational performance. Observed exceptions are typically extremely limited and are not suggestive of larger adverse trends in performance and do not require corrective actions to be undertaken.

AIMS received scores ranging from 85.00–89.99 in four of the five remaining, scored categories audited (i.e., Disability Management, Reserving, Communication, and Settlement/Resolution). Scores falling within this range generally reflect sound operational performance with some minor number of observed exceptions. As a result, recommendations have been offered, but we view the vast majority of these recommendations to be "fine-tuning" opportunities that are not indicative of larger systemic concerns.

The final audit category evaluated (i.e., Three-Point Contact) received a score of **82.61**. Scores falling within the range of 70.00–84.99 are indicative of one or more systemic breakdowns in performance. As a result, corrective actions are required by AIMS to address these process and execution-related deficiencies. With respect to three-point contacts, both initial and follow-up attempts to communicate with required parties were observed to be inconsistently performed.

Overall, AIMS' claim files demonstrate sound technical acumen and managerial oversight. The audited claim files also demonstrate generally consistent communications and collaboration with JBWCP Members with limited exceptions.

Reserving practices also appeared to be generally sound. A comparison of AIMS' total incurred claim values against our comparative claim value estimates found that aggregate total incurred claim values were under-reserved by approximately 4.5%. A variance of +/- 10% is common in the industry. However, we note that the under-reserving was more prevalent regarding medical reserves – particularly on future medical claims. This suggests to us that a further evaluation of reserve practices regarding this sub-category of claims is warranted.

Finally, we observed further opportunities to enhance JBWCP Program performance and/or outcomes through: (1) amendments to the current AIMS Services Guidelines; and (2) adoption of industry best practices. These recommendations are separately documented as "Additional Best Practices Considerations". A detailed discussion of AIMS audit findings and associated recommendations can be found in **Section 3** of this report. Associated Scoring Reports can be found in **Appendices C-F** of this report.

AMC Audit: (Composite Audit Score Achieved = 87.54)
Scores for the five audit categories evaluated are as follows:

AUDIT CATEGORY	# OF APPLICABLE CLAIMS	AUDIT SCORES
• Nurse Triage	16	70.77
• Nurse Case Management & Compliance With Protocols	35	88.17
• Medical Provider Network	42	100.00
• Pharmacy Benefits Program	52	85.04
• Closure Criteria	27	98.00
AMC COMPOSITE AUDIT SCORE		**87.54**

The AMC overall composite score achieved for the 2020 annual audit is **87.54**. This score is indicative of generally sound overall management of JBWCP's Workers' Compensation Managed Care Program with the presence of some minor opportunities to "fine-tune" performance.

AMC received scores of 90.00 or more in two of the scored categories audited. Scores in the range of 90.00–100.00 suggest strong operational performance. Observed exceptions are typically extremely limited and are not suggestive of larger adverse trends in performance and do not require corrective actions to be undertaken.

AMC received scores ranging from 85.00–89.99 in two of the three remaining, scored categories audited (i.e., Nurse Case Management & Compliance With Protocols and Pharmacy Benefits Program). Scores falling within this range generally reflect sound operational performance with some minor number of observed exceptions. As a result, recommendations have been offered, but we view the vast majority of these recommendations to be "fine-tuning" opportunities that are not indicative of larger systemic concerns.

The final audit category evaluated (i.e., Nurse Triage) received a score of **70.77**. Scores falling within the range of 70.00–84.99 are indicative of one or more systemic breakdowns in performance. The observed score barely met the minimum threshold score of 70.00. As a result, immediate corrective actions are required by AMC to address these process and execution-related deficiencies. With respect to Nurse Triage, significant issues were observed regarding consistently:

- Communicating with Treating Physicians and Claimants within the required three-day timeframe;
- Obtaining availability of transitional work and/or employee's duty statements; and
- Forwarding Triage reports to assigned Adjusters within 3 business days.

Overall, AMC's claim file documentation demonstrates favorable impacts on claim outcomes. We also observed consistent utilization of preferred medical provider and pharmacy benefit networks by Claimants.

We observed further opportunities to enhance JBWCP's Managed Care Program performance and/or outcomes through: (1) amendments to the current AIMS Services Guidelines; and (2) adoption of industry best practices. These recommendations are separately documented as "Additional Best Practices Considerations". A detailed discussion of AMC audit findings and associated recommendations can be found in **Section 4** of this report. Associated Scoring Reports can be found in **Appendices G-H** of this report.

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Methodology

Maria Walsh, Senior Vice President and Relationship Manager led the 2020 annual audits of AMC and AIMS on the JBWCP Account. Senior Vice Presidents Kelly Byrkit and Alan Turnipseed were responsible for project managing the AMC and AIMS audits respectively. Both Kelly and Alan were also responsible for preparing this written report. Marsh Colleagues Urvi Sutariya, James Baker and Ryan Kielhorn provided auditing support on both audits.

AMC Auditing Methodology:

At the inception of the AMC audit, JBWCP and Marsh collaboratively developed audit categories and associated metrics. Five audit categories were developed included:

1. Nurse Triage;
2. Nurse Case Management & Compliance With Protocols;
3. Medical Provider Network;
4. Pharmacy Benefits Program; and
5. Closure Criteria.

A total of 30 associated audit metrics were developed across all five audit categories.

Once audit categories and metrics were finalized, a loss run was requested from AMC containing all workers' compensation claims in which AMC had billed services between November 1, 2019 and the valuation date of the loss run (i.e., August 28, 2020). A total of 139 claims were identified on the loss run. Claims were stratified into three distinct categories:

1. Claims with large payments (43 total);
2. Claims with multiple payments (31 total); and
3. Single small payments (65 total).

A claim sample was constructed consisting of 80 workers' compensation claims. All claims with managed care payments from categories 1 and 2 were selected for the audit. The remaining six claims were randomly selected from category 3. The final AMC claim sample can be found in **Appendix B** of this report.

The audit was conducted remotely via on-line access to AIMS' "Ventiv" claim system. Auditing activities were completed during the weeks of September 21st and September 28th, 2020. The following types of information were utilized by the Marsh project team to complete the audit:

- Claim/loss information;
- Claim notes;
- Financial transactions (i.e., payments and reserve histories);
- Images/documents (e.g., forms, emails, correspondence, reports); and

- AMC Managed Care Guidelines (Effective November 1, 2018).

The audit was performed using Marsh's proprietary software "*Performer*". The Performer audit software was configured with JBWCP's specific audit categories and metrics for the AMC audit. Each of the five audit categories were equally weighted and contained one or more metrics with multiple-choice type answers. The maximum score for any one metric was **100**. Some metrics have simple "*Yes*", "*No*" or "*Not Applicable*" answers. These are scored **100** for "*Yes*" and **0** for "*No*". "*Not Applicable*" answers were automatically removed from scoring by the software. Other metrics may have 4 or more different choices with various scores assigned to each answer that range between **0** and **100**. Based upon auditor responses captured within the software, scores/grades were calculated for:

- Each individual audit metric;
- Each audit category; and
- The overall audit.

All audit metrics and categories were tabulated to arrive at an overall composite score relating to the performance of AMC.

At the conclusion of our auditing activities, preliminary scoring reports, auditor findings and supporting commentary were provided to AMC for their review and rebuttal. In instances where audit findings (and associated comments) were demonstrated to be factually inaccurate, corresponding adjustments were made to our work papers and scoring. In instances where a professional difference of opinion existed between Marsh and AMC, adjustments were negotiated and ultimately, mutually agreed upon by both AMC and Marsh. Our work papers and scoring reports were subsequently adjusted and form the basis for our findings and conclusions set forth within this report.

Final AMC scoring reports can be found in:

- **Appendix G – Scoring By Category** and
- **Appendix H – Scoring By Question** of this report.

AIMS Auditing Methodology:

At the inception of the AIMS audit, JBWCP and Marsh collaboratively developed audit categories and associated metrics. Fourteen audit categories were developed included:

1. JBWCP Member Loss Reporting;
2. Claim Set-up & Assignment/Reassignment;
3. Three-Point Contact;
4. Investigation;
5. Medical Cost Containment;
6. Disability Management;
7. Litigation Management;
8. Subrogation, Apportionment, Contribution;
9. Reserving;

10. Communication;
11. Payments;
12. Settlement/Resolution;
13. Strategic Plans & Documentation; and
14. Supervisory Review.

A total of 91 associated audit metrics were developed across all fourteen audit categories.

Once audit categories and metrics were finalized, a loss run was requested from AIMS containing all open workers' compensation indemnity claims as of the valuation date of the loss run (i.e., August 31, 2020). A total of 905 claims were identified on the loss run. Marsh was requested to review an equal number of claims for the ten (10) current AIMS Indemnity Adjusters assigned to the JBWCP Account.

A total claim sample was constructed consisting of 180 workers' compensation claims. 18 claims were randomly selected across JBWCP's Judiciary Members including:

- Supreme Court;
- District Courts of Appeal;
- Habeas Corpus Resource Center;
- Commission on Judicial Performance;
- Judicial Council of California; and
- Trial Court Judges.

The remaining 162 claims were randomly selected across JBWCP's Trial Court Members. With respect to the Trial Court portion of the claim sample (where possible), claim selections were made from each of the three strata of Trial Court Members:

- Large Members (i.e., Headcounts => 500 employees);
- Medium Members (i.e., Headcounts ranging from 101 to 499 employees);
- Small Members (i.e., Headcounts <= 1-- employees).

The final AIMS claim sample can be found in **Appendix A** of this report.

The audit was conducted remotely via on-line access to AIMS' "Ventiv" claim system. Auditing activities were completed during the weeks of September 21st and September 28th, 2020. The following types of information were utilized by the Marsh project team to complete the audit:

- Claim/loss information;
- Claim notes;
- Financial transactions (i.e., payments and reserve histories);
- Images/documents (e.g., forms, emails, correspondence, reports); and
- AMC Managed Care Guidelines (Effective November 1, 2018).

The audit was performed using Marsh's proprietary software "*Performer*". The Performer audit software was configured with JBWCP's specific audit categories and metrics for the AIMS audit. Each of the fourteen audit categories were equally weighted and contained one or more metrics

with multiple-choice type answers. The maximum score for any one metric was **100**. Some metrics have simple "*Yes*", "*No*" or "*Not Applicable*" answers. These are scored **100** for "*Yes*" and **0** for "*No*". "*Not Applicable*" answers were automatically removed from scoring by the software. Other metrics may have 4 or more different choices with various scores assigned to each answer that range between **0** and **100**. Based upon auditor responses captured within the software, scores/grades were calculated for:

- Each individual audit metric[1];
- Each audit category[2]; and
- The overall audit.

All audit metrics and categories were tabulated to arrive at an overall composite score relating to the performance of AIMS.

At the conclusion of our auditing activities, preliminary scoring reports, auditor findings and supporting commentary were provided to AIMS for their review and rebuttal. In instances where audit findings (and associated comments) were demonstrated to be factually inaccurate, corresponding adjustments were made to our work papers and scoring. In instances where a professional difference of opinion existed between Marsh and AIMS, adjustments were negotiated and ultimately, mutually agreed upon by both AIMS and Marsh. Our work papers and scoring reports were subsequently adjusted and form the basis for our findings and conclusions set forth within this report.

Final AIMS scoring reports can be found in:

- **Appendix C – Scoring By Category**;
- **Appendix D – Scoring By Question**;
- **Appendix E – Scoring By Adjuster**; and
- **Appendix F – Claim Value Roster** of this report.

[1] Metrics that are indicators (limited to Subrogation category) were not scored.

Additional metrics (though separately scored) were not factored into AIMS overall audit composite score. The reason for excepting these metrics from scoring consideration is that current AIMS Service Guidelines do not require compliance by AIMS. Accordingly, these metrics were separately tracked to provide baseline data. All such metrics have been identified in Section 3 of this report.

[2] The JBWCP Member Loss Reporting audit category was not factored into AIMS overall audit composite score. The reason for excluding this audit category is that the required actions involve Members exclusively, and are therefore out of the control of AIMS and its Adjusters/Supervisors. Accordingly, these metrics were separately tracked to provide information baseline data to JBWCP.

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Audit Findings & Recommendations – Third Party Administration Services Provider

An audit of 180 claims was completed in October 2020 of JBWCP's Third Party Administrator (TPA) – Acclamation Insurance Management Services (AIMS). A total of 14 audit categories were evaluated during the audit to provide a broad baseline of performance regarding JBWCP's Workers' Compensation Program. For purposes of developing an overall composite performance score for AIMS, thirteen of the fourteen categories were scored. The remaining category (i.e., JBWCP Member Loss Reporting) was excluding from scoring as performance of required activities was outside the control of AIMS.

Within each of the fourteen audit categories evaluated, one or more metrics were evaluated and scored. Unless otherwise indicated, each metric outcome was factored into an overall composite score for the associated audit category.[3] Our scoring methodology is as follows:

OBSERVED SCORE	INTERPRETATION OF PERFORMANCE
90.00 - 100.00	High performance warranting no associated recommendations
85.00 - 89.00	Overall performance is sound with minor fine-tuning opportunities
70.00 - 84.99	Systemic process inconsistencies exist presenting opportunities for improvement
0.00 - 69.99	Systemic breakdowns in performance exist warranted immediate corrective action

For any metric scoring less than **90.00**, recommendations have been provided for JBWCP's consideration. Additionally, we evaluated audit observations and JBWCP's current Claim Services Guidelines with AIMS (i.e., AIMS Service Guidelines) against industry best practices to provide additional opportunities to further enhance overall program performance.

AIMS' achieved a final composite audit score of **94.45**. While the overall score reflects favorable performance, multiple opportunities for improvement were identified. The remainder of this section provides granular detail relating to the observed performance of AIMS, the identification of opportunities for enhancing Program performance, and recommendations as to how those opportunities can be successfully achieved. Detailed scoring reports by category, question, Adjuster and financials are located in **Appendices C**, **D**, **E** and **F** respectfully of this report.

[3] Individual audit metrics were tracked to provide a broad baseline of AIMS performance. However, in instances where the activity identified within a metric was not required on AIMS in the current AIMS Service Guidelines, it has been excluding from the observed audit category score.

Audit Category #1: JBWCP Member Loss Reporting
Composite Score = 65.38

Audit Metric	Audit Category #1 - Metric Descriptions	Final Score	Metric Scored
1.1	JBWCP Member submitted Employer's First Report of Injury Form 5020 to AIMS within 5 calendar days of notification of injury	65.38	Not Scored

Findings:

Section IV.B of the Judicial Branch Workers' Compensation Program (JBWCP) Claims Manual outlines the requirement for Members to complete and provide an Employer's Report of Occupational Injury or Illness (i.e., 5020) to AIMS within five calendar days of the date of knowledge of a reported injury or illness.[4] A total of 26 of the 180 claims audited had dates of loss that fell within the audit review period (i.e., dates of loss on or after November 1, 2019).

Of these 26 applicable claims, a total of 17 or **65.38** of claims were observed to have been timely reported by Members. The remaining 9 claims were reported beyond the current five calendar day requirement identified within the JBWCP Claims Manual. Note: As the timely reporting of losses by Members is outside the control of AIMS, the reported score of **65.38** has been excluded from the overall AIMS composite audit score.

Recommendations:

Prompt reporting of losses by Members is critical to: (1) ensure the timely provision of benefits to Claimants; (2) to provide AIMS with the ability to maintain maximum control over claim-related activities; as well as (3) to avoid unnecessary litigation. The overall score represents a significant opportunity for improvement within the Program. To address the observed deficiencies in timely reporting by Members, we recommend:

1. We recommend that the Member reporting requirements involving Form 5020 be harmonized between the AIMS Service Guidelines and JBWCP Claims Manual. (See Footnote #4). Further, we would advocate for a Member loss reporting requirement not to exceed 2 business days.
2. That a general reminder or refresher be provided to all Members periodically relating to both the requirement and its overall importance to the Program. Ideally, reminders/ refreshers should be circulated every 6-12 months to all Members.
3. JBWCP should partner with AIMS to track ongoing compliance by individual Members. Where issues are observed with timely reporting, one-on-one follow-up by JBWCP leadership with identified members would be appropriate including the need to provide additional training to Member staff.

[4] This requirement appears to be at odds with the reporting requirement contained within the current AIMS Services Guidelines, which requires Member reporting on Form 5020 within 24 hours of injury or notification of injury (Claim Set-up, first paragraph found on page #3).

Additional Best Practices Considerations:

Cost allocation mechanisms can be a valuable tool to drive or otherwise incent desired behaviors among responsible parties to ensure the prompt reporting of losses. While it appears that JBWCP utilizes a cost allocation methodology to allocate program costs among Members, the methodology appears to be focused on Member loss experience.

It may be worthwhile for JBWCP to consider modifying the current cost allocation methodology to include other performance-based requirements on the part of Members including the timely reporting of losses. These types of cost allocation methodologies are commonly observed in high-performing workers' compensation programs and if properly designed, drive desired behavior by tying compliance to incentives built into a cost allocation methodology.

Audit Category #2: Claim Set-up & Assignment/Reassignment

Composite Score = 97.33

Audit Metric	Audit Category #2 - Metric Descriptions	Final Score	Metric Scored
2.1	Total days required to assign to Adjuster (i.e., Assignment Date - AIMS Date of Knowledge)	96.77	✓
2.2	Initial claim classification appropriate (i.e., indemnity, medical only)	96.55	✓
2.3	Claims meeting escalation criteria were timely and appropriate reassigned to indemnity Adjuster	100.00	✓

Findings:

The timely set-up and assignment of claims by a claim services provider is critical to ensure Adjusters can promptly initiate necessary activities to address compensability, and when warranted, provide necessary medical and/or indemnity benefits. AIMS' overall composite audit score for this category is **97.33**, which is consistent with a high-performing claims organization. A total of 31 of the 180 claims audited had claim set-ups and assignments within the audit review period (i.e., On or after November 1, 2019).

Of these 31 applicable claims, a total of 30 claims were observed to have been set-up and assigned to Adjusters within one calendar day from the date claims were received by AIMS resulting in a score is **96.77**.[5] The remaining claim (200000435JUD) required 8 days to be set-up and assigned. Though eight days represents a significant delay on the part of AIMS relating to the set-up and assignment of a claim, only one such instance was observed. As such, this does not suggest any systemic concerns.

Additionally, the initial classification of claims was generally observed to be appropriate. Out of a total of 29 applicable claims, 28 or **96.55** of claims were observed to have been classified

[5] For purposes of scoring, claims set-up and assigned within: (i) 0-1 calendar days received a score of 100.00; (ii) 2 calendar days received a score of 50.00; (iii) 3 calendar days received a score of 25.00; and (iv) 4 or more calendar days received a score of 0.00.

appropriately (i.e., indemnity of medical only) at the inception of the claim. The one remaining claim (200000411JUD) was initially established as a lost time claim even though the Claimant was initially reported to have been working full duty.

The final audit criteria evaluated involved the timely and appropriate re-assignment of claims from medical only to last time adjuster based upon claim file developments. A total of 15 applicable claims were identified. All 15 claims were observed to have been appropriately re-assigned resulting in a score of **100.00**.

Recommendations:

Though the initial classification of claims was generally observed to be appropriate, we note that the current AIMS Service Guidelines do not specify the criteria for determining when a claim should be categorized as indemnity versus medical only. Memorialization of these criteria would be valuable to ensure that claim classification protocols are mutually agreed upon between AIMS and JBWCP, and that billing for claims administration services is accurate.

Additional Best Practices Considerations:

No additional considerations are offered.

Audit Category #3: Three-Point Contact

Composite Score = 82.61

Audit Metric	Audit Category #3 - Metric Descriptions	Final Score	Metric Scored
3.1	Attempt to contact JBWCP Member was made within 1 business day of assignment	81.48	✓
3.2	Where initial JBWCP Member contact was unsuccessful, a minimum of 2 additional follow-up attempts were made within 2 business days of assignment	71.43	✓
3.3	Attempt to contact Claimant was made within 1 business day of assignment	87.50	✓
3.4	Where initial Claimant contact was unsuccessful, a minimum of 2 additional follow-up attempts were made within 2 business days of assignment	81.82	✓
3.5	Where Claimant contact attempts were unsuccessful, an attempt was made to contact the JBWCP Member to obtain alternate contact information within 3 business days of assignment	33.33	Not Scored
3.6	Attempt to contact Medical Provider was made within 1 business day of assignment	85.71	✓
3.7	Where initial Medical Provider contact was unsuccessful, a minimum of 2 additional follow-up attempts were made within 2 business days of assignment	50.00	✓

Findings:

Prompt attempts to communicate with Claimants, Medical Providers and Members is a key activity in the overall investigation process. Industry best practices typically require initial attempts to communicate with all three parties within one business day of assignment to an Adjuster. While best practices relating to follow-up communications varies by claim services

provider, typically multiple attempts (i.e., 2-3) will be required over a two to five-day timeframe. AIMS' overall composite audit score for this category is **82.61**, which warrants corrective actions to be undertaken by AIMS to address performance-related concerns.

In the case of the current AIMS Service Guidelines, a 24-hour contact requirement exists as to Members (i.e., see Contact). However, the Service Guidelines do not specifically require initial 24-hour contact with either Claimants or Medical Providers, nor do they provide guidance relating to required follow-up communications in the event initial attempts were unsuccessful.[6]

As a result, observed performance relating to AIMS' Adjusters communication attempts were mixed. Scores relating to initial communication attempts with Members, Claimants and Medical Providers were **81.48**, **87.50** and **85.71** respectively. Scores relating to follow-up communication attempts (i.e., a minimum of two additional attempts within two business days) with Members, Claimants and Medical Providers were **71.43**, **81.82** and **50.00** respectively and were observed to be more inconsistent across the board than initial communication attempts. These observed outcomes, particularly follow-up communications with Medical Providers, present significant opportunities to further enhance overall Program performance. They also demonstrate the importance of further memorializing communication expectations for all three parties to ensure greater overall consistency in the overall three-point contract process.

In addition to tracking overall Adjuster performance relating to communications, we additionally evaluated the degree to which Member communications occurred to obtain alternate contact information for Claimants in the event communications were unsuccessful (i.e., contacts made to Members within three business days following multiple unsuccessful attempts). In the three applicable claims audited, timely Member follow-up occurred in just one of the claims audited for a resulting score of **33.33**. While we view this requirement to be critical, it is not a current expectation that is specifically documented within the AIMS Service Guidelines. Accordingly, while AIMS performance was tracked regarding this specific requirement, the resulting score was excluded from AIMS overall composite score for the Three-Point Contact audit category.

Recommendations:

We recommend that the current AIMS Service Guidelines (specifically the "Contacts" section) be amended as follows:

1. Specifically require a 24-hour contact requirement for initial communications with Claimants and Medical Providers by AIMS Adjusters (similar to Member language).
2. Add additional language that specifically defines that expectations relating to follow-up communication attempts. We would suggest a minimum of two additional attempts for all three parties (i.e., total of three) within two business days of the assignment of the claim to an Adjuster.
3. Add additional language requiring Adjusters to communicate with Members no later than the third business day to secure alternate contact information for Claimants where initial/ subsequent communication attempts have proven unsuccessful.

[6] AIMS has separately indicated that they do in-fact interpret the language contained in the AIMS Service Guidelines to require 24-hour contact with all three parties (i.e., Member, Claimant and Medical Providers).

4. Add additional language requiring Adjusters to communicate with JBWCP's lead Trial Court and Judiciary contacts no later than the third business day to assist with contacting Members where initial/subsequent communication attempts have proven unsuccessful.

We further recommend that amended AIMS Service Guidelines be distributed to AIMS Adjusters for future reference. AIMS Account Manager and/or Supervisors should complete training (as required). Additionally, Supervisors should monitor for Adjuster compliance in conjunction with the initial supervisory review process.

Additional Best Practices Considerations:

No additional considerations are offered.

Audit Category #4: Investigations

Composite Score = 91.43

Audit Metric	Audit Category #4 - Metric Descriptions	Final Score	Metric Scored
4.1	Did the Adjuster take all necessary actions to evaluate compensability	96.77	✓
4.2	Was the claim appropriately accepted, delayed or denied within the 14-day statutory time period	100.00	✓
4.3	Were recorded statements taken where questions of compensability were raised	100.00	✓
4.4	Were claims timely reported to the Index Bureau and re-indexed every 12 months thereafter	88.03	✓
4.5	Where "hits" are identified through Index Bureau reports, was follow-up appropriate	86.21	✓
4.6	The need for field investigations (including surveillance) were appropriately recognized, authorized by JBWCP Member and managed	100.00	✓
4.7	Does a note exist within the claim file documenting both: (1) the final compensability decision made by the Adjuster; and (2) a supporting rationale/justification? Where claim denial issued, was denial discussed with the Member and all approvals were obtained and documented?	93.55	✓
4.8	Where a sub-rosa investigation was made by AIMS, the assignment (both scope and provided information) was thorough and timely	100.00	✓

Findings:

AIMS' overall composite audit score for this category is **91.43**. While above 90.00 in aggregate, certain fine-tuning opportunities exist to strengthen overall performance. Of the eight specific audit metrics evaluated, six scored **93.55** or higher. Specifically, investigations were observed to be sufficiently thorough to support compensability decisions. Decisions to initially accept, deny and/or delay claims were consistently rendered within the 14-day statutory requirement. Where questions relating to compensability were identified by a JBWCP Member or AIMS Adjuster, recorded statements were consistently secured. Approvals for field investigations (though limited in overall frequency) were consistently sought by Members and managed by Adjusters. Similarly, the use of sub-rosa investigations (though limited in frequency) were

appropriate in-scope and timely pursued by Adjusters. Finally, compensability decisions complete with supporting rationales were consistently documented within electronic claim notes.

Two potential areas of opportunity exist within the investigation category – both involving the claim indexing process. First, long-term claims were not consistently re-indexed on an annual basis by Adjusters or support personnel as is required by the AIMS Service Guidelines (i.e., **88.03**).[7] Moreover, where potential "hits" where identified within index bureau reports, appropriate follow-up by Adjusters to secure additional information was not consistently observed (i.e., **86.21**).[8]

Recommendations:

Indexing requirements identified within the AIMS Service Guidelines are consistent with commonly observed industry practices. As a result, current AIMS indexing processes do not provide the necessary safeguards to ensure consistency of execution by claim technical staff. Accordingly, we recommend AIMS review current process deficiencies and submit an action plan to the JBWCP addressing the corrective actions that will be undertaken to strengthen overall performance relating to indexing activities.

Additional Best Practices Considerations:

No additional considerations are offered.

Audit Category #5: Medical Cost Containment

Composite Score = 99.16

Audit Metric	Audit Category #5 - Metric Descriptions	Final Score	Metric Scored
5.1	In cases where the JBWCP Member elected to participate within the AIMS-AMC Medical Provider Network, did the Claimant actually treat within the Medical Provider Network	100.00	✓
5.2	Assuming the JBWCP Member elected to participate within the Medical Provider Network **AND** the Claimant elected to treat outside of the Medical Provider Network, did the Adjuster either: (1) appropriately re-directly care; or (2) document why re-direction of care within Medical Provider Network was not possible	100.00	✓
5.3	Where JBWCP Member did not elect to participate within the AIMS-AMC Medical Provider Network, did Adjuster direct or soft channel the Claimant to a preferred provider (primary or specialty) where possible	100.00	✓
5.4	Issues of causation, treatment plan and permanent and stationary status are timely addressed and appropriately documented	99.23	✓

[7] A total of 17 exceptions out of 142 applicable claims were identified during the audit.

[8] A total of 4 exceptions out of 25 applicable claims were identified during the audit.

5.5	Utilization review (e.g., surgical requests, medical diagnostics, treatment duration) referrals were timely made and the results were appropriately documented and acted upon	100.00	✓
5.6	Agreed Medical Examinations/Qualified Medical Examinations/Peer Reviews were timely made and utilization was appropriate	98.82	✓
5.7	Nurse case management (either telephonic or field) assignment was approved by the Member and was timely, for appropriate duration and added value	81.82	✓

Findings:

AIMS' overall composite audit score for this category is **99.16** which is consistent with a high-performing claims organization. Of the seven specific audit metrics evaluated, six scored **98.82** or higher. Specifically, Claimants were observed to ultimately participate within either the AIMS-AMC Medical Provider Network or the alternate medical networks (in the event Members elected to opt out). In instances where Claimants attempted to treat outside preferred Medical Provider Networks, Adjuster were generally able to re-directed care. In instances were efforts to re-direct care were unsuccessful, Adjusters appropriately documented why re-direction of care was not possible.

Medical issues relating to causation, treatment plans and permanent and stationary status were observed to be appropriately acted upon and documented by Adjusters. Utilization review was consistently employed by Adjusters to ensure the appropriateness of medical procedures, diagnostic testing, and treatment plans. Additionally, where medical disputes could be not reasonably resolved in a timely manner, Adjusters reasonably utilized a combination of agreed and/or qualified medical examinations to resolve all such disputes.

The only metric within the medical cost containment category that failed to score 90.00 or more involved utilization of nurse case managers (i.e., **81.82**). A total of 11 applicable claims were identified with two claims serving as exceptions. The primary issues identified involving both claims involved the under or non-utilization of nurse case management on claims.

Auditor comment relating to observed deficiencies are as follows:

Claim Number	Auditor comment
150000469JUD	Employee is not at MMI. Provides differing statements to the Claim Examiner & QME. NCM should be on file to assist with finding a MPN provider and push this provider for a new MMI report, which the QME can address as needed.
190000547JUD	TCM should have stayed on file until claimant reached full duty

Recommendations:

Utilization of nurse case management services by AIMS within the JBWCP appears conservative compared to other large California workers' compensation programs. We recommend JBWCP consider undertaking a specialized audit to evaluate the overall effectiveness of nurse case management services, and specifically, a comparison of the appropriateness of nurse case manager utilization versus disability duration outcomes. Based upon the findings of the audit, we further recommend that current nurse case management triggers identified in the AIMS Service Guidelines be evaluated and amended as necessary to further enhance disability outcomes.

Additional Best Practices Considerations:

No additional considerations are offered.

Audit Category #6: Disability Management

Composite Score = 85.61

Audit Metric	Audit Category #6 - Metric Descriptions	Final Score	Metric Scored
6.1	Where the Claimant's disability exceeds recognized industry standards, did the Adjuster/Nurse Case Manager request clarification from the treating physician	58.33	✓
6.2	Adjuster/Nurse Case Manager demonstrate proactive efforts to pursue return to work	93.10	✓
6.3	Where changes in temporary or permanent restrictions were provided, were those restrictions communicated to the JBWCP Member within 2 business days of receipt by the Adjuster	84.85	✓
6.4	Where necessary, were clarifications relating to specific temporary and/or permanent restrictions sought from the treating physician, Agreed Medical Examination &/or Qualified Medical Examination providing all evaluating physicians with all appropriate records and documentation prior to the evaluation	90.48	✓
6.5	Confirmation email received and documented from the JBWCP Member regarding ability or inability to accommodate	86.49	✓

Findings:

AIMS' overall composite audit score for this category is **85.61, which** warrants corrective actions to be undertaken by AIMS to address performance-related concerns. Of the five specific audit metrics evaluated, two scored **90.48** or higher. With respect to these two categories, Adjusters and/or Nurse Case Managers were observed to be proactive in efforts to return Claimants to work. To achieve return to work objectives, Adjusters and/or Nurse Case Managers were observed to be diligent in requesting and providing necessary information and/or clarifications regarding work restrictions to evaluating physicians.

Of the three remaining metrics audited, varying degrees of inconsistency were observed. The greatest area of concern involves the active management of disabilities against industry guidelines. Specifically, where Claimants' disabilities exceeded recognized industry standards, requests for clarification from the treating physician were not always requested (i.e., **58.33**). In essence, while initial estimates of disability durations were identified, claims were not actively and continuously managed against identified guidelines.

To a less degree, inconsistencies were also identified relating to timely communication of disability-related information to JBWCP Members. Specifically, once changes in either temporary or permanent restrictions were provided by medical providers, that information was not timely communicated (i.e., within 2 days) to JBWCP Members (i.e., **84.85**). Additionally, emails from JBWCP Members relating to their ability/inability to accommodate work restrictions

were not observed to be consistently documented in claim files – either notes or attachments (i.e., **86.49**). In general, we observed communication of disability-related information to JBWCP Members to be more consistently performed by Nurse Case Managers vs. Adjusters. Nevertheless, opportunities for improvement were identified among both roles.

Recommendations:

The AIMS Account Manager should review and reinforce current communication and documentation requirements with AIMS Adjusters as well AMC Nurse Case Managers. Additionally, existing processes, system access capabilities, and oversight mechanisms should be evaluated and modified as necessary to ensure consistency in the execution of disability-related activities – particularly when multiple roles are involved (i.e., Adjuster and Nurse Case Manager).

Additional Best Practices Considerations:

While Nurse Case Managers reference Official Disability Guidelines (ODG) for anticipated disability durations during the triage process, there are no corresponding requirements within the either the AIMS or Allied Managed Care (AMC) Service Guidelines for similar actions to be undertaken by Adjusters on claims where no Nurse Case Manager has been assigned. Moreover, where best practices industry benchmarks relating to disability durations are anticipated to be exceeded, current AIMS and AMC Service Guidelines fail to provide guidance relating to necessary follow-up activities.

We recommend JBWCP consider adding the following language within existing AIMS and AMC Service Guidelines:

1. Require ODG disability durations to be identified on all indemnity claims.
2. Ultimate responsibility for ensuring ODG disability guidelines should reside with Adjusters (whether a Nurse Case Manager has been assigned).[9]
3. Modified and full duty return to work target dates should be established on all indemnity claims featuring lost time as well as goals based on best practice benchmarks. If claim typical or maximum benchmarks are being utilized, justify should be provided as to why.
4. Where benchmarks are anticipated to be exceeded, Adjusters should include a plan of action as to how disabilities will be managed in the future to include the potential for triage and assignment of claims for telephonic Nurse Case Manager Intervention.

Where treating providers are found to be non-responsive or do not provide necessary justifications for ongoing disabilities, escalation to Field Case Management (FCM), peer review or QME should be considered to strategically manage claims.

[9] Questions exist if AMC Nurse Case Managers have access to the claims system utilized by AIMS to populate disability duration guidelines and key disability-based milestones. This issue should be addressed by AIMS and AMC to determine the solution(s) available to ensure the consistent capture and tracking of required disability information.

Audit Category #7: Litigation Management

Composite Score = 97.86

Audit Metric	Audit Category #7 - Metric Descriptions	Final Score	Metric Scored
7.1	Adjuster made a timely and appropriate referral to defense counsel	100.00	✓
7.2	Adjuster appropriately followed-up for required status reports when not provided by Defense Counsel on a timely basis	98.59	✓
7.3	Adjuster worked collaboratively with Defense Counsel to develop long term strategy and specific tasks to resolve litigation	96.25	✓
7.4	In the event the JBWCP Member provides direction to the Defense Counsel without involvement of the Adjuster, did the Adjuster take appropriate action to work with the Member and Defense Counsel to establish collaborative communication	100.00	✓
7.5	Defense Counsel activities were appropriately monitored by the Adjuster	97.47	✓
7.6	Assigned Defense Counsel activities represent an appropriate delegation of work	98.73	✓
7.7	Adjuster was responsive to all Defense Counsel requests for information, assistance and authority	97.33	✓

Findings:

AIMS' overall composite audit score for this category is **97.86**, which is consistent with a high-performing claims organization. Of the seven specific audit metrics evaluated, all scored **96.25** or higher. Specifically, referrals to Defense Counsel by Adjusters were observed to have been made on a timely basis. Where referrals were made, the scope of requested work reflected an appropriate delegation of activities.

Adjusters were observed to work collaboratively with defense counsel on ongoing litigation to jointly develop legal strategies, as well as to identify activities that needed to be performed on individual claims. Defense Counsel status reports were typically provided within reasonable timeframes on an ongoing basis. In instances where legal updates were not forthcoming on a timely basis, Adjusters were observed to have proactively followed-up for receipt of required information with Defense Counsel. Conversely, where Defense Counsel requested information, assistance, and/or authority from Adjusters, responses were observed to be both timely and sufficient in nature.

One particular area we were requested to evaluate were instances in which JBWCP Members interacted directly with defense counsel relating to ongoing legal activities without the knowledge of the assigned Adjuster. We were charged with evaluating the degree to which Adjusters took appropriate action to work with both Member and Defense Counsel to regain control of legal oversight responsibilities. A total of six applicable claims were observed during the audit. In all six instances, Adjusters were identified to have made timely efforts to regain control over the

legal relationship, as well as to collaborate with both Members and Defense Counsel on developing prospective litigation strategies and/or discussing required activities.[10]

Recommendations:

No recommendations are warranted.

Additional Best Practices Considerations:

No additional considerations are offered.

Audit Category #8: Subrogation, Apportionment, Contribution

Composite Score = 96.88

Audit Metric	Audit Category #8 - Metric Descriptions	Final Score	Metric Scored
8.1	Does subrogation potential exist	Indicator Only	Not Scored
8.1.1	Was subrogation potential identified by the Adjuster	100.00	✓
8.1.2	Was subrogation timely pursued, as authorized and directed by JBWCP Member or JBWCP Administrator	100.00	✓
8.1.3	Where subrogation potential exists and the JBWCP Member elects not to pursue, AIMS should bring the matter to the attention of the JBWCP Administrator for direction and assistance	N/A	✓
8.1.4	Was authority for compromised settlement of the Third Party Lien obtained from the JBWCP Administrator	100.00	✓
8.2	Does apportionment potential exist	Indicator Only	Not Scored
8.2.1	Was apportionment potential identified by the Adjuster	95.24	✓
8.2.2	Was apportionment appropriately pursued	97.14	✓
8.3	Does contribution potential exist	Indicator Only	Not Scored
8.3.1	Was contribution potential identified by the Adjuster	100.00	✓
8.3.2	Was contribution appropriately pursued	100.00	✓

Findings:

AIMS' overall composite audit score for this category is **96.88**, which is consistent with a high-performing claims organization. Of the eight specific audit metrics evaluated, seven scored **95.25** or higher. The eighth metric (i.e., **Metric 8.1.3** - Subrogation opportunities that JBWCP Members elected not to pursue requiring follow-up with the JBWCP Administrator by the Adjuster) was found to be non-applicable on the audit. We also note the fact that the overall

[10] The six identified claims involving Member intervention in the ongoing relationship between AIMS and Defense Counsel are as follows: (i) JC12020421; (ii) JC13020003; (iii) JC14020043; (iv) 180000021JUD; (v) 180000357JUD; and (vi) 210000046JUD.

number of claims audited presenting both subrogation and contribution potential and/or pursuit were limited (i.e., just 6 and 4 total respectively). Accordingly, the scores in these two sub-categories may not lend themselves to extrapolation to JBWCP's broader workers' compensation claims population.

On claims presenting subrogation opportunities, Adjusters were observed to appropriately identify recovery potential. Once identified, Adjusters were also observed to timely and appropriately pursue recovery opportunities on behalf the JBWCP. No performance-related deficiencies were detected.

Similarly, on claims presenting contribution opportunities, Adjusters were observed to appropriately detect offset potential. Once detected, Adjusters appropriately and timely pursued activities necessary to mitigate exposure on the part of JBWCP. No performance-related deficiencies were detected.

Finally, for claims presenting apportionment opportunities, Adjusters were generally observed to appropriately identify the potential for compensable impairment ratings to be mitigated based upon either pre-existing injuries and or medical conditions. Once identified, Adjusters were also generally observed to timely and appropriately pursue activities necessary to support the mitigation of exposure to JBWCP.

Auditor comment relating to observed deficiencies are as follows:

Claim Number	Auditor comment
210000078JUD	ISO reporting has "hits" on the report. No follow up for those records to send to PTP for apportionment. EE is not yet MMI but need to let PTP know about the potential for "baseline" medical. Furthermore, providing records prior to MMI will expedite the finalization of reporting once MMI/cut down on need for supplemental.
200000169JUD	While not yet MMI, there is an ISO report with a match. Apportionment potential has not been identified. May need these records for the PTP to address a baseline and/or apportionment.
200000169JUD	See above - unsure if there will be PD at this time but apportionment should be pursued now or at least commented on by the CE why not being pursued.

Recommendations:

No recommendations are warranted.

Additional Best Practices Considerations:

No additional considerations offered.

Audit Category #9: Reserving
Composite Score = 89.84

Audit Metric	Audit Category #9 - Metric Descriptions	Final Score	Metric Scored
9.1	Initial case reserves set by Adjuster within 5 business days of assignment	91.67	✓
9.2	Subsequent case reserve reviews for all *non-future medical claims* occurred at least every 90 days OR within 14 days of knowledge of a material claim file development impacting the claim's overall exposure. Subsequent case reserve reviews for *future medical claims* occurred at least every 180 days.	89.66	✓
9.3	Case reserves are sufficiently documented	92.70	✓
9.4	Current case reserves reflect "probable outcome" based upon currently known facts	86.71	✓
9.5	Is a reserve change (+/-) required? (If so, indicate required change(s)	**Table 1**	Not Scored

Findings:

AIMS' overall composite audit score for this category is **89.84** and warranted minor corrective actions on the part of AIMS. Observed discrepancies exist with respect to both timing as well as valuation of claim exposures.

For example, AIMS Service Guidelines provide that, initial (preliminary) reserves are to be set within five (5) business days from the date of claim receipt. Of the 36 applicable claims reviewed, three claims reflected initial case reserves being established more than five business days after the receipt of the loss (i.e., **91.67**). Similarly, the AIMS Service Guidelines require reserves to be subsequently reviewed at least every 90 calendar days (or a minimum of every 180 calendar days on future medical claims) or within 14 days of receipt of a material claim file development impacting a claim's projected exposure. Of the 174 applicable claims reviewed, 18 claims demonstrated case reserves being evaluated outside of timeframes identified in the required Service Guidelines (i.e., **89.66**).

Where reserves are established and updated, sufficiency of case reserve documentation including the rationales applied to each reserve category (i.e., medical, indemnity and expense) were not always consistent. A total of 178 applicable claims were evaluated in conjunction with the audit. Of these 178 claims, a total of 13 claims were identified where case reserves were not adequately documented resulting in a score of **92.70**. Issues regarding sufficient documentation were limited to insufficient case reserve rationales as opposed to reserve notes being devoid of a supporting rationale.

Finally, a total of 173 claims that were audited were open at the time of our review. Of these 173 claims, a total of 23 claims failed to reflect "probable outcome" which is the required standard set forth in the AIMS Service Guidelines resulting in a score of **86.71**. A Claim Value Roster is found in **Appendix F** of this report. The Claim Value Roster compares AIMS total incurred claim values at the time the audit was completed versus each auditor's corresponding comparative estimate of total incurred value for each open claim audited. Marsh's comparative estimates are based upon: (1) information known to AIMS at the time each file was audited; and (2) documented within the electronic claim file.

AIMS total incurred claim values on all claims subject to audit total **$16,328,199.62**. Marsh's comparative estimates of total incurred values on these same claims total **$17,057,866.52**. This results in an aggregate under-reserving of loss exposures by **($729,667.00)** or **(4.5%)**. On the 23 claims in which case reserves failed to reflect "probable outcome", 22 of the 23 claims were observed to be under-reserved. A more granular breakdown of aggregate case reserving discrepancies by reserve category is detailed in **Table 1** below.

TABLE 1

Reserve Category	Variances Based On Dollars	Variances Based On Count
- Medical Reserves	($404,600.00) or (55.4%)	19 of 23 claims or 82.6%
- Indemnity Reserves	($248,417.00) or (34.1%)	12 of 23 claims or 52.2%
- Expense Reserves	($76,650.00) or (10.5%)	11 of 23 claims or 60.9%

Overall, reserving of medical exposures appears to present the greatest opportunity to JBWCP – particularly on older claims transitioning to future medical status. As previously discussed, the AIMS Services Guidelines require reserving based upon "probable outcome". The Guidelines further state that, "*Self-Insured reserving guidelines are not a requirement of the JBWCP*".

In discussions with both JBWCP and AIMS representatives, there appears to be an understanding that lifetime reserves on older claims (including future medical claims) are not required. The inclusion of the language "probable outcome" within the AIMS Service Guidelines appears to be at odds with the parties understanding of reserve practices on these older losses and, in our opinion, is partially responsible for the observed variances in loss exposures. Greater specificity is required within the AIMS Service Guidelines on older losses unlikely to close.

Recommendations:

AIMS and JBWCP should memorialize their specific case reserving understanding relating to older loss that have no immediate prospects for closure – particularly future medical claims – within the AIMS Service Guidelines as current case reserving practices are inconsistent with existing "probable outcome" language.

Additional Best Practices Considerations:

While we understand that JBWCP is not subject to the same standards as a self-insured under California's Workers' Compensation Act, we would point out that the current case reserving practices involving the valuation of older losses with little or no likelihood of settling is inconsistent with commonly observed industry practices. Based upon our experiences and observations with other workers' compensation programs with similar practices, a by-product of the failure to appropriately value (i.e., undervalue) likely lifetime claim exposures is the adverse impact on claim resolution efforts and a corresponding build in claim inventories that results from distorting actual and perceived claim valuations.

Audit Category #10: Communications

Composite Score = 88.76

Audit Metric	Audit Category #10 - Metric Descriptions	Final Score	Metric Scored
10.1	During periods of total disability or modified duty or any change in status, the Adjuster maintained ongoing communication (verbal or written) with the Claimant at least every 14-calendar days. On all other non-represented claims, at least every 90 days	63.89	✓
10.2	Adjuster maintained appropriate communication with the JBWCP Member including responding to all telephonic or written requests within 1 business day	98.08	✓
10.3	Did the Adjuster keep the JBWCP Member informed of case status, significant changes and resolution plans without the Member initiating an inquiry	88.19	✓
10.4	With respect to 132(a) actions filed against a JBWCP Member, Adjuster communicated what is and is not covered by the JBWCP program	N/A	✓

Findings:

AIMS' overall composite audit score for this category is **88.76** and warrants corrective actions on the part of AIMS. A total of four audit metrics were evaluated. One of the four metrics, **Metric 10.4** (i.e., With respect to 132(a) actions filed against a JBWCP Member, Adjuster communicated what is and is not covered by the JBWCP program) was found to be non-applicable.

The most significant opportunity involved Adjusters failing to consistently maintain ongoing communications with Claimants during periods of either total disability or modified duty. Specifically, AIMS Service Guidelines require communications with Claimants every 14 calendar days during periods of total disability, modified duty or changes in work status. A total of 36 applicable claims were identified during the audit. Of these 36 claims, only 23 evidenced the required level of communications with Claimants resulting in a score of **63.89**.

Maintaining communications with Claimants in general is critical to achieving key program outcomes including mitigating loss costs, maintaining control of the claim and litigation avoidance. Given the relatively low caseloads maintained by AIMS Adjusters during the relevant audit period, capacity constraints do not appear to be a contributing factor leaving process breakdowns and/or lack of internal oversight as the likely contributors for these execution-related deficiencies.[11]

Responsiveness to JBWCP Member inquiries was found to be highly consistent (i.e., standard = one business day). A total of 104 applicable claims were identified during the audit of which 102 were found to demonstrate appropriate and timely communications with JBWCP members resulting in a score of **98.08**.

General status communications to JBWCP Members (i.e., case status, material developments, and resolution strategies) evidenced slight inconsistencies. A total of 127 applicable claims

[11] For more detail relating to AIMS Adjuster caseloads on the JBWCP program, please refer to Section #3 - Audit Category #13 of this report)

were identified during the audit of which 112 were found to demonstrate appropriate and timely communications with JBWCP members resulting in a score of **88.19**.

A sampling of Auditor comments relating to observed deficiencies are as follows:

Claim Number	Auditor comment
160000445JUD	IW had AA representation as of 10/19/19. Prior to that time period, there is no documentation of ongoing conversation taking place with IW every 14 days while working modified duty.
190000017JUD	Despite the EE's case being stipulated prior to the audit period the EE had surgery during the FM period. Auditor would recommend that contact with the EE occur during this time post op as EE is on mod duty.
200000137JUD	NCM maintained contact with IW while she is on modified duty; however, there is no documentation that Adjuster-maintained contact with IW while on modified duty.
200000195JUD	Prior to the case litigation, EE was on mod duty and no communication documented with the claimant
170000553JUD	Employer was not kept updated about claim status. There was employer contact to obtain authorization for surveillance, confirm if IW's employment status.
190000579JUD	There is no communication documented with employer to advise of the administrative closure in 2/2020 or the reopening of the claim in 6/2020.
200000257JUD	The adjuster did not keep the JBWCP member informed of current work restrictions.
200000360JUD	The adjuster did not keep the Member informed of current work restrictions from 1/28/2020 to full duty release on 5/29/2020.

Recommendations:

AIMS' Account Manager should address communication-related concerns arising from the audit with JBWCP Supervisors and Adjusters. To further enhance the likelihood of improved performance centered around JBWCP Member communications, the degree to which internal claim management practices and/or AIMS Service Guidelines fail to specifically address required claim information to be updated, those items should be memorialized in operational documentation to ensure clarity and enhance consistency across the AIMS claims organization.

Additional Best Practices Considerations:

No additional considerations offered.

Audit Category #11: Payments

Composite Score = 98.90

Audit Metric	Audit Category #11 - Metric Descriptions	Final Score	Metric Scored
11.1	Average weekly wage and workers' compensation benefit rates appropriately calculated and documented in claim file	96.91	✓
11.2	Initial and ongoing temporary total disability benefits were paid timely (i.e., no penalties/fines imposed)	100.00	✓
11.3	Initial and ongoing permanent partial disability benefits were paid timely (i.e., no penalties/fines imposed)	100.00	✓
11.4	Approved medical invoices were paid timely (i.e., no penalties/fines imposed)	100.00	✓
11.5	Payment of medical invoices were appropriate (i.e., no payments made for non-accepted body part or non-approved treatments)	100.00	✓

11.6	Legal invoices from Defense Counsel were paid timely (i.e., no evidence of defense counsel requesting payment on outstanding invoices)	100.00	✓
11.7	No evidence of 132(a) awards paid against the file (defense costs ok)	100.00	✓
11.8	Appropriate benefit notices were provided on all accepted and denied claims (e.g., initial, revised, final) including identification of any overpayment of benefits and a request for credit against future permanent partial disability benefits payable)	100.00	✓
11.9	Where an overpayment exists, was notification provided to the AIMS Program Manager and documented within the claim file by the Adjuster	66.67	✓
11.10	Where an overpayment exists, did the Adjuster attempt to recover or offset against future payments (**NOTE:** Neither AIMS or a JBWCP Member can agree to waive an overpayment or provide a future credit - only the JBWCP Administrator may do so)	75.00	✓
11.11	If an Employment Development Department notice was received, did the Adjuster proactively contact the organization to coordinate or negotiate benefits/reimbursement as opposed to waiting until the claim is ultimately settled?	94.74	✓

Findings:

AIMS' overall composite audit score for this category is **98.90**, which is largely consistent with a high-performing claims organization. Of the eleven specific audit metrics evaluated, nine scored **94.74** or higher. Specifically, average weekly wage and benefit rates were appropriately calculated and documented in the clean files. Adjusters paid both temporary total disability and permanent partial disability benefits timely. Payments made on submitted medical invoices were both appropriate and paid in a timely fashion. Finally, legal invoices submitted by defense counsel were also observed to have been paid in a timely fashion.

Appropriate benefit notices were provided on all claims (both accepted and denied). Where Section 132(a) awards were entered against Members, we observed no evidence of awards being paid against the claim files. Finally, where Employment Development Department (EDD) lien notices were received, AIMS Adjusters generally made proactive attempt to contact the organization to coordinate and/or negotiate benefits and/or reimbursements on the claim.

The two noted areas of opportunity involving scores relate to overpayments. Specifically, where overpayments were observed to exist, notifications were not always provided to the AIMS Account Manager and documented within the claim file notes (i.e., **66.67**). Additionally, where overpayments were observed to exist, attempts by the Adjuster to recover and/or offset against future payments were not consistently documented (i.e., **75.00**). It is important to note that despite the low scores involving these two-audit metrics, the absolute number of observed exceptions was relatively low (i.e., two and one respectively). Accordingly, despite the lower scores observed on these two-audit metrics, they appear to reflect one-off type events and are not indicative of an adverse trend that needs to be addressed by AIMS.

Recommendations:

No recommendations are warranted.

Additional Best Practices Considerations:

No additional considerations offered.

Audit Category #12: Settlement/Resolution

Composite Score = 89.88

Audit Metric	Audit Category #12 - Metric Descriptions	Final Score	Metric Scored
12.1	Adjuster recognized settlement opportunities early and approached settlement creatively including relevant methods and considerations to conclude the claim (i.e., global resolution, employment status, MSA, structures, arbitration, mediation)	89.87	✓
12.2	A Settlement Authority Request was completed (including rationale) and submitted to appropriate party/parties (i.e., Level) within 2 weeks of the occurrence of a "triggering" event by the assigned Adjuster	87.27	Not Scored
12.3	Adjuster adhered to the following settlement authority guidelines (new money to be paid out *but not money that has already been paid out or advanced against settlement*): **PRE 7/1/2020:** * **Level I** - **$0-$10,000** AIMS has full authority with notice to JBWCP Member 10 court days prior to finalizing the settlement offer * **Level II** - **$10,001-$75,000** JBWCP Member has full authority. * **Level III** - **$75,001 - $100,000** JBWCP Administrator in consultation with JBWCP Member. * **Level IV** - **$100,001-$150,000** Settlement Authority Panel (majority of 3 voting JBWCP Advisory Committee Members) in consultation with JBWCP Member * **Level V** - **$150,001+** Settlement Authority Panel (majority of 5 voting JBWCP Advisory Committee Members) in consultation with JBWCP Member **POST 7/1/2020:** * **Level I** - **$0-$10,000** AIMS has full authority with notice to JBWCP Member ten court days prior to finalizing the settlement offer * **Level II** - **$10,001-$100,000** JBWCP Member has full authority. * **Level III** - **$100,001+** Settlement Authority Panel (majority of 4 voting JBWCP Advisory Committee Members and the JBWCP Administrator/designee) in consultation with JBWCP Member.	100.00	✓
12.4	The Adjuster appropriately addressed Medicare Set-Aside and Medicare-related issues in the claim resolution strategy	88.46	✓
12.5	Adjuster conducted aggressive, strategic, and prompt settlement negotiations and follow-up	85.48	✓

12.6	Provider and Employment Development Department liens were/are being resolved in a timely and effective manner	81.25	✓
12.7	The file closed appropriately without delay, final bills were received and paid timely	87.50	✓
12.8	Administrative closure occurred on future medical claims with no treatment in excess of 12 months	50.00	✓

Findings:

AIMS' overall composite audit score for this category is **89.88**. Opportunities to improve execution of key settlement activities exist and corrective actions are warranted by AIMS to address various performance-related concerns. Of the seven scored audit metrics evaluated, only one scored more than **90.00**. The remaining six metric scores ranged between **50.00** and **89.87**.

Adjusters generally recognized settlement opportunities early on and demonstrated creative solutions to resolve both single claims as well as multiple open claims on a global basis (i.e., **89.87**). Adjusters consistently complied with settlement authority guidelines based upon settlement value for both pre-7/1/20 and post-7/1/ 20 protocols (i.e., **100.00**). When evaluating settlement opportunities, Adjusters were generally observed to appropriately address Medicare Set-Aside and other Medicare-related issues in conjunction with developing overall claim resolution strategies (i.e., **88.46**).

Adjusters were generally observed to conduct aggressive, strategic, and prompt settlement negotiations with appropriate follow-up (i.e., **85.48**). Some inconsistencies were observed regarding resolution of Provider and/or Employment Development Department liens. Specifically, liens were not consistently resolved in a timely and efficient manner with actions being deferred until resolution of the underlying claims had occurred (i.e., **81.25**). The net result of this practice is to extend the duration claims remain open thereby artificially inflating JBWCP's open claim inventory. In this regard, claims were not consistently closed in a timely and efficient manner (i.e., **87.50**). Moreover, future medical claims were not consistently administratively closed on a timely basis in instances where no treatment had occurred in the prior 12-month period (i.e., **50.00**). However, we would point out that the absolute number of observed exceptions regarding these latter two items were limited to one apiece.

An eighth metric was tracked but not scored because the audited activity was not required of AIMS under the current Service Guidelines. Specifically, claim files were evaluated to determine the number of claims in which the assigned Adjusters completed a settlement evaluation request within 2 weeks of a "triggering event". Even though this activity was not required under the Service Guidelines, AIMS nevertheless generally scored favorably regarding the timing of generating settlement authority requests to initiate resolution-related activities (i.e., **87.27**). On older losses where full and final settlements had been previously attempted and rejected, follow-up opportunities to again resolve claims on a full and final basis did not appear to be as aggressively pursued by Adjusters.

A sampling of Auditor comments relating to observed deficiencies are as follows:

Claim Number	Auditor comment
160000577JUD	The Adjuster should be discussing the possibility of an early nuisance settlement now that the Claimant appears to want to pursue claim
190000395JUD	Denial appears strong. However, given legal spend to date ($17K+) and future potential ($5k-$10K), opportunity for a nuisance settlement exists but not identified or pursued
JC 05001103	Claimant retired in 2013. There has been no review or discussion within the action plans to review for C&R
JC09000020	Stipulated settlement should have been drafted in September of 2019 and not completed until 4/15/2020
190000639JUD	PR4 is documented on 9/9/2020. It has been over 2 weeks and no settlement request/notification
190000669JUD	DEU rating of the disability was received in 2/2020. SAR for stips not completed until 7/2020
JC11000011	The clarification from the QME regarding the PD was received in early August 2020. Per the Supervisor notes, the SAR was to be completed on a different file for this individual but that note was from 10/1/2020. Therefore, auditor believes that at least 2 months have passed since the "triggering" event and the SAR being completed.
150000517JUD	Member denied authorization for MSA and recommend Adjuster provide other options for resolving claim. Settled below $25K, structure the settlement, explain FMC exposure vs resolving claim. Also confirming Claimant needed MSA as documented in SR claim note dated 1/17/20.
180000653JUD	On 4/15/20, Defense Attorney advised Claimant is interested in C&R and was going to send MSA releases. There is no further discussion with Defense Attorney and Adjuster to obtain MSA releases and pursue MSA to C&R the claim.
190000523JUD	Adjuster did recognize claim should be settled via C&R but this was after the claim was stipulated - recommend C&R be addressed from the beginning to resolve the claim.
JC05001103	No action taken regarding a C&R
JC09000020	There should be more diligent efforts to follow up with the claimant on stip signatures
JC13020480	Settlement should have been attempted again - during audit period it is referenced that Applicant Attorney declined offer, but no further efforts made
160000625JUD	There is no documentation that EDD lien was resolved. Last discussion about EDD lien was 10/11/19. There is no further documentation that EDD lien was resolved.
170000553JUD	EDD lien acknowledged in Action Plan strategy but no further action taken for resolution.
180000021JUD	It appears this file needs to be closed - defense bills have been paid, stipulation completed and no treatment
JC13020045	Last treatment was 1/2020. Claim was closed prior to the 12 months.

Recommendations:

We recommend the following:

- Amend AIMS Service Guidelines to require work-up and submission of a settlement authority request or SAR within two weeks of the occurrence of a “triggering event”. We would further suggest AIMS and JBWCP collaborate to jointly develop a list of triggering events that are documented within the AIMS Service Guidelines.
- AIMS Adjuster should continuously track outstanding liens (i.e., both EDD and Provider liens) within the electronic claim file. Attempts should be made to continuously resolve outstanding liens versus deferring such activities until after the underlying claim has been resolved to expedite the claim closure process. We note that the current AIMS Service Guidelines do not specify expectations surrounding this recommendation.

- Given the relatively low caseloads maintained by Adjusters (refer to Audit Category 13 Findings); a greater emphasis should be placed upon the identification, timing and pursuit of settlement activities (both initial attempts and subsequent attempts) by both Adjusters and Supervisors. A list of target claims should be identified and continuously pursued by Adjusters. Where impediments to resolution are encountered, we would further recommend the use of internal roundtables with Supervisors and Account Leadership to address impediments/objections and develop alternative strategies to resolving and/or closing claims. Where practical, defense counsel should be involved to leverage relationships with Applicants Attorneys be enhance resolution efforts.
- Consider developing strategic relationships with third-party vendors offering services tied to claim resolution (e.g., MSA administration providers, structured settlement providers) and seek to involve these vendors in internal roundtables to develop strategic resolution strategies.

Additional Best Practices Considerations:

In addition to the above recommendations, we would also consider working with AIMS to develop data mining capabilities within Ventiv to identify and prioritize open claims appropriate for resolution activities based upon pre-existing data points. If appropriately constructed, this functionality would allow AIMS to identify, pursue and close claims more efficiently. In turn, this capability on the part of AIMS will assist JBWCP to drive claim closures and ultimately reductions in actuarially derived IBNR.

Audit Category #13: Strategic Plans & Documentation

Composite Score = 96.18

Audit Metric	Audit Category 13 - Metric Descriptions	Final Score	Metric Scored
13.1	Initial claim file review completed by Adjuster within 30 days of claim assignment	100.00	✓
13.2	Claim file reviews completed at least every 90 days by Adjuster (2-week grace period to apply) on *non-future medical claims*. On *future medical claims*, at least every 180 days (two 2-week grace period to apply).	95.51	✓
13.3	Claim files are appropriately documented	96.11	✓
13.4	Target completion dates for key activities identified and documented by Adjuster	50.86	Not Scored
13.5	Claim notes reflect consistent and timely follow-up on key activities	94.44	✓
13.6	Diary functionality utilized, with timely diary completion	99.44	✓
13.7	Supervisor feedback/recommendations are appropriately responded to and acted upon by Adjuster	94.58	✓
13.8	Total number of assigned lost time Adjusters documented in claim file over the audit period	**Table 2**	Not Scored

Findings:

AIMS' Adjusters consistently performed strategic plans & documentation-related activities. AIMS' overall composite audit score for this category is **96.18** which is consistent with a high-performing claims organization. Of the six specific audit metrics evaluated (and scored) during the audit, all scored **94.44** or higher.

Specifically, initial claim file reviews were observed to have been completed by Adjusters within 30 days of claim assignment. Following completion of initial claim file reviews, subsequent reviews were generally completed a minimum of every 90 days by Adjusters on non-future medical claims. Similarly, with regard to future medical claims, subsequent reviews were generally completed a minimum of every 180 days.

Claim notes generally reflect timely follow-up (i.e., execution) of prospective activities identified in strategic plans. Adjusters generally utilized the diary functionality contained within AIMS' internal claims system (i.e., Ventiv) to manage existing caseloads. Where supervisory feedback and/or recommendations were provided, AIMS' Adjusters were generally observed to be responsive to those suggestions with follow-up being documented within the claim notes.

One additional metric was tracked during the audit to provide baseline data regarding Adjuster performance. Specifically, audited claims were evaluated to determine if Adjusters identified target completion dates for key activities identified within their strategic plans. Based upon our evaluation of the audited claim files, target completion dates were inconsistently utilized by AIMS' Adjusters resulting in a score of **50.86**. We note that use of target completion dates is not a requirement within the AIMS Service Guidleines. As a result, this additional audit metric outcome was not factored into the composite AIMS' score for the Strategic Plans & Documentation category.

Finally, we tracked one additional audit metric for informational purposes in conjunction with this audit category. This audit metric was also not scored. The audit metric tracked the total number of assigned lost time adjusters documented on each of the 180 audited files over the relevant audit period (i.e., November 1, 2019 or later). The average number of lost time adjusters observed was **1.17** lost time adjusters per claim file. **Table 2** below provided a breakdown of the actual number of lost time Adjusters observed across all the 180 claim files that were audited.

TABLE 2

# of Assigned Adjusters	Total Adjuster Count	% Of Audit Population
- 1 Lost Time Adjuster	154	85.5%
- 2 Lost Time Adjusters	21	11.7%
- 3 Lost Time Adjusters	5	2.8%
TOTALS	180	100.0%

In addition to the audit metrics evaluated through the auditing process, we were also requested to validate AIMS Indemnity Adjuster caseloads. The Service Guidelines require AIMS to maintain average monthly caseloads not to exceed 130 claims per Adjuster.

Caseload information was requested for the time period extending from November 2019 through September 2020. As a general observation, average Indemnity caseloads maintained by AIMS Adjusters on the JBWCP Program are significantly lower than industry averages in California. Excluding the indemnity Adjuster overseeing future medical claims, average annual indemnity caseloads ranged from a low of **67.57** claims per month (i.e., G Lopez over a seven-month timeframe) to a high of **120.55** claims per month (i.e., C VanCamp over an eleven-month timeframe). The average for all indemnity Adjusters over the eleven-month timeframe was **82.28** claims per indemnity Adjuster per month.

Results of the request are documented in **Table 3** below.

TABLE 3

Examiner	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
As of:	11/1/2019	12/3/2019	12/31/2019	2/3/2020	3/2/2020	4/1/2020	4/30/2020	6/1/2020	6/30/2020	7/29/2020	8/31/2020
CDankowski	103	94	*See JSandison*								
CHarris	73	85	82	71	69	60	60	59	59	63	70
CVanCamp	153	145	138	129	122	115	110	109	103	99	103
DBall	78	76	77	78	78	83	75	74	77	69	69
DCastanon	71	72	73	82	85	*See VMunroe*					
GLopez	*See JCappa*				54	54	52	76	77	80	80
JCappa	86	83	58	55	*See GLopez*						
JSandison	*See CDankowski*		98	98	95	96	88	86	90	89	62
MTaylor	72	71	92	88	89	94	95	69	68	61	60
NLegardye	93	86	84	84	79	83	82	80	76	74	83
NPalmer	95	89	86	80	82	81	80	79	77	83	81
RMcKinley (FM)	205	211	222	217	214	211	212	209	205	211	208
VMunroe	*See DCastanon*					84	76	73	73	77	80

Over the eleven-month period, two different Adjusters exceeded period, maximum caseloads. C. VanCamp exceeded the 130-claim target caseload from November 2019 through February 2020.[12] Additionally, the Adjuster assigned to manage future medical claims (i.e., R. McKinley) exceeded the 130claim maximum caseload target for all eleven months in question.[13] No other deviations were identified during the audit period.

Recommendations:

No recommendations are warranted.

[12] AIMS provided the following explanation for this deviation from the Service Guidelines. "*Carri VanCamp exceeded the Program's limit on claim files for several months in 2019. The Program was advised of this as soon as she passed the threshold and I offered a number of options to bring her numbers down, but none of the Members to which she was assigned wanted to be moved to a new examiner. We were eventually able to move some of the FM Judiciary claims to Rita McKinley which got Carri's number under the threshold, although she continues to be significantly above the other indemnity examiners' numbers.*"

[13] AIMS provided the following explanation for this deviation from the Service Guidelines. "*Rita McKinley is the FM examiner so the case count does not apply to her.*".

Additional Best Practices Considerations:

While overall compliance with respect to strategic plans and documentation by AIMS Adjusters Is appropriate under the current AIMS Service Guidelines, the lack of use of target completion dates represents an opportunity to further, add additional safeguards to the JBWCP Program to ensure prompt execution of required claim file activities.

An Adjuster's use of target completion dates provides AIMS' Supervisors and Account Leadership with an opportunity to assess the overall aggressiveness of an Adjuster's strategic plans, as well as to identify claims (through the oversight process) where timely execution is in question. It is noted that approximately one-half of the 180 claim files audited utilize some form of target completion dates. Amending the current AIMS Service Guidelines to incorporate the use of target completion dates would further drive consistency in the execution of Adjuster strategy plans across the JBWCP program.

Audit Category #14: Supervisory Review

Composite Score = 94.00

Audit Metric	Audit Category #14 - Metric Descriptions	Final Score	Metric Scored
14.1	Initial Supervisor review completed within 10 days of claim assignment	96.67	✓
14.2	Subsequent (initial) review completed within 90 days and then 180 days thereafter by Supervisor (2-week grace period to apply) on *non-future medical claims*. On *future medical claims*, at least every 180 days (2-week grace period to apply).	96.02	✓
14.3	Throughout the claim, the Supervisor provided timely, responsive and meaningful direction on the claim	93.89	✓
14.4	If the Adjuster(s) did not appropriately respond to Supervisor's direction, did the Supervisor provide the appropriate level of follow-up	80.65	✓
14.5	Total number of assigned Supervisors documented in the claim file over the audit period	**Table 3**	Not Scored

Findings:

AIMS' overall composite audit score for this category is **94.00**. With one notable exception, Supervisory review activities were generally observed to have been consistently performed by AIMS' Supervisors and Account Leadership Team. Of the four specific audit metrics evaluated (and scored) during the audit, three scored **93.89** or higher.

With respect to timing considerations, initial supervisor reviews were generally observed to have been completed within 10 days of claim assignment. Following completion of initial supervisor reviews, subsequent reviews were generally observed to have been completed within 90 days for the first subsequent review, and a minimum of every 180 days thereafter.

Supervisors' demonstrated sound technical expertise based upon feedback and/or recommendations documented within claim notes. Where Adjusters posed questions to

assigned Supervisors, feedback was observed to be timely in nature and on-point with the underlying questions/concerns posed by Adjusters.

The one area of opportunity identified in conjunction with the audit involved Supervisors properly following-up on prior feedback and/or recommendations. In instances where prior feedback/ recommendations had been offered, Supervisors did not consistently follow-up to ensure the assigned Adjusters had undertaken actions. Where Adjusters failed to implement Supervisor recommendations, documentation of appropriate supervisory follow-up was inconsistently observed (i.e., **80.65**). Given the fact that we a preponderance of the claims audited were more than one year old, the extended supervisory review period of 180 days is a contributing factor for this observed deficiency.

Finally, we tracked one additional audit metric for informational purposes in conjunction with this audit category. This audit metric was not scored. The audit metric tracked the total number of assigned Supervisors documented on each of the 180 audited files over the relevant audit period (i.e., November 1, 2019 or later). The average number of Supervisors observed was **1.08** Supervisors per claim file. **Table 4** below provided a breakdown of the actual number of Supervisors observed across all the 180 claim files that were audited.

TABLE 4

# of Supervisors	Total Supervisor Count	% Of Audit Population
- 1 Supervisors	168	93.3%
- 2 Supervisors	9	5.0%
- 3 Supervisors	3	1.7%
TOTALS	180	100.0%

Recommendations:

The AIMS Service Guidelines provide for an initial 90-day subsequent review followed by a 180-day review cycle thereafter throughout the life of an indemnity claim. Contrast this requirement to that of medical only claims that require an initial 90-day subsequent review followed by a 120-day review cycle. Given the significant exposures presented to JBWCP associated with indemnity claims, we strongly advocate that the AIMS Service Guidelines should be amended to require indemnity claims be subsequently reviewed by Supervisors (at a minimum) as often as medical only claims.

Additional Best Practices Considerations:

In addition to our above recommendation, we note that Industry best practices reflect supervisor reviews every 90-120 days throughout the lifetime of an indemnity claim. We see few carriers and or large third-party administrators (TPAs) that extend supervisor reviews out beyond 90-120 days with the limited exception of certain claim types (e.g., future medical claims, fatalities). Given the relatively low adjuster caseloads on the JBWCP program (and by extension, low Supervisor caseloads) we would further recommend that the AIMS Service Guidelines be amended to require Supervisor reviews at 90-day intervals throughout the lifetime of indemnity claims.

Additionally, the practice of having AIMS Supervisors review medical only claims is one that is not commonly observed in the workers' compensation industry. Due to the limited exposures posed by these losses, this practice represents an inefficient use of Supervisors' time. Rather, Supervisor time spent on the JBWCP program would be better served involved in active oversight of complex indemnity claims and/or claim resolution (closure) activities (see Audit Category #12 recommendations). We would recommend that the requirement for Supervisor review of medical only claims be eliminated. However, if oversight of medical only claims is important to JBWCP, we would alternatively recommend that system triggers be implemented notifying AIMS' Supervisors and/or Account Manager of all medial only claims that breach pre-defined timelines (i.e., 120-180 days) and/ or monetary thresholds (i.e., $3,500-$5,000) focusing on jut those claims posing the greatest risk exposure to the Program.

4

Audit Findings & Recommendations – Case Management Services Provider

An audit of 80 claims was completed in late September/early October 2020 of JBWCP's Managed Care Provider – Allied Managed Care (AMC). A total of 5 audit categories were evaluated during the audit to provide a broad baseline of performance regarding JBWCP's Workers' Compensation Program. For purposes of developing an overall composite performance score for AMC, all categories and associated metrics were scored.

Within each of the five audit categories evaluated, one or more metrics were evaluated and scored. Unless otherwise indicated, each metric outcome was factored into an overall composite score for the associated audit category. Our scoring methodology is as follows:

OBSERVED SCORE	INTERPRETATION OF PERFORMANCE
90.00 - 100.00	High performance warranting no associated recommendations
85.00 - 89.00	Overall performance is sound with minor fine-tuning opportunities
70.00 - 84.99	Systemic process inconsistencies exist presenting opportunities for improvement
0.00 - 69.99	Systemic breakdowns in performance exist warranted immediate corrective action

For any metric scoring less than **90.00**, recommendations have been provided for JBWCP's consideration. Additionally, we evaluated audit observations and JBWCP's current managed care guidelines with AMC (i.e., AMC Managed Care Guidelines) against industry best practices to provide additional opportunities to further enhance overall program performance.

AMC has achieved a final composite audit score of **87.54**. While the overall score generally reflects sound technical performance, multiple opportunities for improvement were identified. The remainder of this section provides granular detail relating to the observed performance of AMC, the identification of opportunities for enhancing Program performance, and recommendations as to how those opportunities can be successfully achieved. Detailed scoring reports by category and question, are found in **Appendices G** and **H** respectfully of this report.

Audit Category #1: Nurse Triage

Composite Score = 70.77

Audit Metric	Audit Category #1 - Metric Descriptions	Final Score	Metric Scored
1.1	Triage Nurse contacted Claimant and the Treating Doctor within 3 business days of the claim assignment and documented the file accordingly	57.14	✓
1.2	Triage Nurse completed AMC's Triage template outlining appropriate treatment and estimated return to work using Official Disability Guidelines and the American College of Occupational and Environmental Medicine guidance	91.67	✓

1.3	If Claimant is a judge, was approval first obtained to triage claim	100.00	✓
1.4	Triage Nurse obtained availability of transitional work and a copy of the employee's duty statement (job description)	20.00	✓
1.5	Triage Nurse documented activities in AlliedConnect Management software and the claims system	100.00	✓
1.6	Triage Nurse forwarded Triage report to Adjuster within 3 business days	66.67	✓

Findings:

AMC's overall composite audit score for this category is **70.77**. A total of six audit metrics were evaluated. Three of the audit metrics scored **91.67** or higher. The remaining three audit metrics scored **66.67** or less and warrant immediate corrective action by AMC.

According to the AMC Managed Care Guidelines, AIMS Adjusters are required to communicate with treating doctors and Claimants during three-point contacts that an AMC Nurse will contact them within three days to medically triage and assess the claim. The AMC Nurse is to then contact those individuals and complete triage reports to forward to Adjusters within three days. The AMC Nurse is also expected to recommend whether claims should be referred for nurse case management (NCM) and at what level (i.e., telephonic case management (TCM) vs. field case management (FCM)) based on pre-selected triggers.

AMC Nurses documented activities performed in the claim system as well as obtained the proper approvals for triage if the Claimant was a Judge. Triage reports were observed to be thorough and strategic in nature (see examples below in auditor comments). However, triage reports did not provide a comparison of medical treatment to ODG/ACOEM guidelines. It is a requirement within the AMC Managed Care Guidelines that treatment is to be outlined; however, not that the treatment be compared to guidelines and a plan of action developed if outside of guidelines.

ODG target dates were generally documented for expected return to work based on ICD9 or ICD10 code and comorbidities. Information regarding previous injuries was typically referenced. Potential barriers were outlined for AIMS' Adjusters to consider. Additionally, rationales for nurse case management referrals were appropriately documented.

Triage reports were not consistently completed within the required three-day timeframe (i.e., **66.67**). Moreover, triage reports did not include all requisite contact information – primarily with respect to treating doctors. Furthermore, it was noted that in some cases that AMC Nurses had attempted to contact Claimants, but were unable to achieve contacts before reports were due to Adjusters.

It is also a requirement for AMC Nurses to obtain the availability of transitional work and share a copy of Claimants' job descriptions with their treating providers. However, it is not clearly defined within the AMC Managed Care Guidelines where this information is to be obtained. Specifically, it is not clear whether an AMC Nurse is to contact Claimants' Supervisors, or the Member Program contacts. Therefore, it is unclear who at a Member is responsible for providing this information. As a result, consistency in execution is lacking (i.e., **20.00**).

A sampling of Auditor comments relating to observed deficiencies are as follows:

Claim Number	Auditor comment
200000420JUD	Contact with Claimant is documented in the triage report, but not the treating doctor
200000244JUD	There is evidence of the Claimant being contacted but not the treating doctor
200000137JUD	There is no documentation showing the Triage Nurse contacted the primary treating doctor within 3 days of claim assignment.
200000120JUD	Referral of case was on 8/31/19 and Claimant contact attempt was made timely; however, auditor sees no contact with the treating doctor.
200000137JUD	Triage report is completed; however, the auditor did not see evidence of ODG/ACOEM documented for treatment.
200000244JUD	ODG for disability duration is referenced but not whether treatment is within guidelines.
200000420JUD	The current treatment plan is documented but it is not referenced whether within guidelines - also, ODG for disability duration is not referenced.
210000007JUD	The availability of transitional work was not documented prior to delivery of the triage report.
200000420JUD	Attempts to obtain or document the availability of transitional work and copy of job description is not evident within the triage report.
200000276JUD	The auditor does not see evidence of the job description being obtained.
200000244JUD	The auditor did not see evidence of the AMC Nurse obtaining availability of transitional work or obtaining a copy of the job description
200000137JUD	There is no documentation that the Triage N (i.e., Nurse requested the job description.
180000447JUD	Initial case assessment dated 8/4/20 states no job description on file. There are no recommendations or comments to obtain one.
200000244JUD	Triage assigned on 10/31/19 and triage report completed and forwarded to Adjuster on 11/6/19. This is beyond the required 3 days.
200000231JUD	Per claim notes, triage report sent on 7/10/20, which is the 4th business day.
200000120JUD	Triage report sent on 9/5/19. Referral made on 8/30/19. This is 4 days.

Recommendations:

We recommend that AMC nurses be required to contact all parties as noted below during the initial triage. Proposed requirements for securing three-point contact should include:

- Making initial contact within one (1) business day of the case being assigned. If initial contact efforts fail, a contact letter should be sent.
- Continue to follow up every 24-48 hours to ensure three (3) attempts are made within the first five (5) business days.

Additionally, consider either:

- Refining the contact requirements with AMC for Nurses to specify contact with the Claimant's Supervisor and/or primary Member contact so that information may be more consistently received regarding transitional work and to obtain a job description; or
- Only require this activity for claims involving modified duty/lost time, or when referred for nurse case management.

Additional Best Practices Considerations:

Refine the AMC Managed Care Guidelines to require AMC Nurses to document whether medical treatment is within ODG/ACOEM guidelines. Despite most medical treatment being referred for utilization review (UR), AMC Nurses should consistently provide oversight of all

medical treatment, including referrals to specialty care and assuring the treatment is within evidenced-based guidelines. If medical treatment is not within evidenced-based guidelines, or if treatment is denied by utilization review, then AMC Nurses should intervene and develop plans of action with the assigned Adjusters, as well as communicate with Claimants on next steps.

Revise the criteria involving the triaging of all medical only and indemnity claims. Most medical only claims are self-limiting and do not require nurse intervention. Further, by more specifically defining referral criteria, AMC Nurses can be more appropriately utilized. Specifically:

- Draft criteria that includes medical only claims with protracted modified duty that is anticipated to (or exceeds) disability guidelines.
- Conduct an analysis of claims converting from medical only to indemnity status to determine characteristics that support additional triggers for nurse triage.
- Require AIMS and AMC to present proposed referral criteria, including any predictive modeling capabilities and/or business rules for those claims that should be referred for triage. At a minimum, refer claims wherein the proposed medical treatment and/or disability duration exceeds guidelines.

Audit Category #2: Nurse Case Management & Compliance With Protocols

Composite Score = 88.17

Audit Metric	Audit Category #2 - Metric Descriptions	Final Score	Metric Scored
2.1	If a Nurse Case Manager is assigned, is it consistent with case management protocols and by agreement of Adjuster and JBWCP Member	100.00	✓
2.2	Was case management initiated within 24 hours of referral	79.17	✓
2.3	3 point contact (i.e., Provider, Claimant and Adjuster) was completed by the Nurse Case Manager within 48 hours of assignment	39.13	✓
2.4	Nurse Case Manager progress reports contain medical treatment plan, next appointment date, work status, barriers to recovery and recommendations	94.12	✓
2.5	Nurse Case Manager integrated Official Disability Guidelines and American College of Occupational and Environmental Medicine guidance into progress reports	96.88	✓
2.6	Initial Nurse Case Manager evaluation completed within 7 business days of referral	96.00	✓
2.7	Nurse Case Manager Progress Reports completed every 30 days or upon significant activity	96.97	✓
2.8	Appointment updates provided to Adjuster within 24 hours of appointment	84.38	✓
2.9	Updates provided to Adjuster within 24 hours of significant file developments (return to work full or modified duty, anticipated surgery, etc.)	100.00	✓
2.10	Nurse Case Manager tracked lost time, modified and return to work dates in Ventiv	100.00	✓

2.11	If a Telephonic Case Management assignment exceeded 60 lost time days or other barriers to recovery or return to work are present, was Field Case Management considered	25.00	✓
2.12	Did Nurse Case Manager discuss the claim with Adjuster and Supervisor when the claim reached 90-days of service	81.82	✓
2.13	Claim notes appropriately documented in both the claim system and AlliedConnect	100.00	✓
2.14	A positive nurse case management impact was achieved on the claim	93.55	✓

Findings:

AMC's overall composite audit score for this category is **88.**17. A total of 14 audit metrics were evaluated. Nine of the audit metrics scored **93.55** or higher. The remaining five audit metrics scored **84.38** or less with two of the five scoring **39.13** or less warranting immediate corrective action by AMC.

Case management protocols are defined within the AMC Managed Care Guidelines, which include the ability to assign nurse case management throughout the life of the claim as well as how to determine which level to assign (i.e., TCM vs. FCM). Furthermore, required activities are outlined, including:

1. Timeframes for making three-point contacts;
2. Required information to be included within the nurse case management reports (and timeframes for supplying those reports to the Adjusters);
3. Utilization of standard of care guidelines to facilitate recovery/return to work; and
4. The tracking of lost time/modified duty within NavRisk.

Lastly, there are guardrails in place for TCM assignments, which include assessing claims at 60 days for possible task FCM assignments and for Adjusters and Supervisors to review files at 90 days to evaluate the need to continue ongoing case management.

Overall, AMC nurses performed well, and the auditors felt a positive case management impact was achieved. AMC Nurses were assigned consistent with the case management protocols. Progress reports were observed to be timely and contained the required level of information in accordance with the AMC Managed Care Guidelines (i.e., medical treatment plan, next appointment date, work status, barriers to recovery and recommendations).

Case management was however not consistently initiated within 24 hours after the case was referred (i.e., **79.17**). Furthermore, three-point contact with providers, Claimants and Adjusters were not consistently achieved within the 48-hour window (i.e., **39.13**).

Significant file developments such as surgical recommendations were communicated to Adjusters timely. However, medical updates were not consistently provided to Adjusters within 24 hours of each office visit. (i.e., **84.38**).

Lost time, modified duty and return to work dates were documented in the Ventiv claim system. However, it is unclear whether AMC Nurses or Adjusters were responsible for completing this task. During the rebuttal process, it was noted that AMC Nurses do not have access to the

Ventiv to track lost or restricted time - yet it is documented in the AMC Managed Care Guidelines that it is the responsible of the AMC Nurse for doing so.

Assessing the claim at 60 days for possible task FCM assignment and at 90 days for the continued need for ongoing case management (with Adjusters and Supervisors) were not adequately being documented and/or completed (i.e., **25.00** and **81.82** respectively).

During the rebuttal review process with AMC, it was noted the FCMs do not have access to the Ventiv to document case management activity. Furthermore, it is not a current requirement for Adjusters to document FCM progress reports into the claim file. Therefore, there was minimal progress reports or documentation of ongoing communication between FCMs and Adjusters to review.

Finally, there is a general statement in the AMC Managed Care guidelines that a nurse case management assignment can occur at any point in the life of the claim. However, there are no specific criteria for when referrals should be initiated.

A sampling of Auditor comments relating to observed deficiencies are as follows:

Claim Number	Auditor comment
200000169JUD	This claim was assigned 06/04/2020. The initial case management was not initiated until 06/10/2020.
190000575JUD	Case Management assigned on 2/20/2020. Activities did not incept until 2/26/2020 (> 24 hours)
200000044JUD	This claim was referred on 3/9/2020. Case management not initiated until 03/17/2020.
200000168JUD	Initiation required 2/5/20 (W). Actual initiation on 2/7/20 (F)
200000276JUD	Date of referral is 12/12/2019. First notice of case management activity is the initial report on 12/20/2019.
210000007JUD	Case Management assigned on 7/21/20 per claim file documentation. First activity not documented until 7/29/20.
200000301JUD	Contact with Adjuster and Claimant on 5/12/20, but no attempt to contact the treating physician within required timeline - actual 5/19/20
200000276JUD	Auditor does not note any contact to the treating provider.
200000044JUD	Claim was assigned 03/09/2020; Claimant and Adjuster contact not completed until 3/17/2020
200000120JUD	Auditor cannot locate any reach out within 48 hours to the Adjuster
190000575JUD	Case Management assigned on 2/20/2020. Activities did not incept until 2/26/2020 (> 24 hours)
190000237JUD	Referral made 11/5/19. Initial contacts not made until 11/13/19.
170000266JUD	Referral made 12/16 and contact with treating physician not made until 12/31/19.
170000266JUD	There is no documentation in the case management notes that the nurse provided updates to the Adjuster within 24 hours of appointment.
180000722JUD	There is no communication documented that the Nurse advised the Adjuster of medical updates within 24 hours of appointment.
190000539JUD	There is no documentation that the Adjuster was notified of appointment updates within 24 hours.
200000009JUD	There is no documentation of appointment updates provided to Adjuster.
200000137JUD	There is no documentation of the Nurse providing appointment updates to the Adjuster.
200000420JUD	There is no documented evidence that a task assignment to FCM was contemplated.
200000276JUD	The injured worker has been paid indemnity due to the inability to be accommodated for months and the auditor cannot locate any discussion regarding a possible escalation to a FCM to discuss the need to address the restrictions with the doctor.
200000023JUD	No evidence claim was evaluated for a possible FCM assignment at 60 days of lost time.
200000120JUD	Auditor cannot locate FCM being considered on the file despite ongoing lost time.
190000575JUD	No documentation exists that FCM appropriateness was discussed at 60th day.

160000626JUD	Auditor could not locate any discussion or consideration of FCM in the claim notes or the NCM progress reports. We are over 60 days lost time due to surgery in 3/2020 and injured workers continues to be paid indemnity.
190000362JUD	FCM was assigned from 9/11/2019 to 6/3/2020 - I did not see any discussion with Adjuster/Supervisor at 90 days to support justification for continued case management.
200000120JUD	Auditor cannot locate any discussion between Adjuster and Supervisor at 90 days regarding ongoing case management needs.
200000276JUD	Auditor cannot locate any discussions with the Adjuster or the Supervisor regarding need for ongoing case management at 90 days.
200000420JUD	A discussion on the need for ongoing case management occurred at 90 days between the AMC Nurse and the Adjuster but not the claim supervisor.
JC07000303	The auditor sees no discussions between the Adjuster and the Supervisor during audit period regarding the need for ongoing case management.
JC13020029	A discussion on the need for ongoing case management occurred between the AMC Nurse and the Adjuster but not the Supervisor.

Recommendations:

We recommend:

- Reiterating the requirement of initiating case management within 24 hours of assignment with AMC Nurses.
- Strengthening the requirements for initiating and following-up on three-point contact within the AMC Managed Care Guidelines (see suggested criteria below). Contact with the Claimants is important, as they will often share information with a Nurse they do not feel comfortable sharing with an Adjuster or as part of a recorded statement.
- Assure the AMC nurse asks about hobbies the Claimant may participate in, as well as previous injuries (either occupational or non-occupational) including motor vehicle accidents.
- Make initial contact within one (1) business day of the case being assigned. If initial contacts with Claimants are not successful, send contact letters.
- Continue to follow-up every 24-48 hours to ensure three (3) attempts are made within the first five (5) business days.
- Stress with AMC's nurses the importance of consistently reporting medical office visit updates to Adjusters within 24 hours.
- Provide role delineation between AMC nurses and AIMS Adjusters over who is responsible for tracking lost and restricted time. If it is the AMC Nurses' role, claim system access to Ventiv will be required.
- Require Adjusters to document claim files at 60 days of the AMC nurse assignment as to whether nurse case management is having a positive impact and should continue or be escalated to field case management for a task-based assignment. By transitioning this task to Adjusters, he/she will be better positioned to ensure proper medical oversight and cost over allocated loss expenses.
- Require Adjusters (rather than AMC Nurses) to document Ventiv with the outcome of discussions with Supervisors as to whether case management should continue and any justification for doing so at the required 90-day timeframe.

Additional Best Practices Considerations:

Additionally, we would recommend the following best practices to be adopted:

- Require Adjusters to document and comment on FCM progress reports as well as on-going communication and collaboration with TCM and FCM Nurses.
- Discuss the need for developing mid-case triggers with AMC and AIMS.
- While AMC Nurses reference ODG for disability durations, there are no requirement within the AMC Managed Care Guidelines for action to be taken where the best practice benchmark is anticipated to be exceeded. Consider adding the following language:
  - Establish modified and full duty return to work target dates as well as goals based on best practice benchmarks. If claim typical or maximum is being utilized, justify why.
  - Collaborate with the Adjuster on the plan of action when the benchmark is anticipated to be exceeded.
  - Escalate to a task FCM, Peer Review or QME if the treating provider is non-responsive or does not provide justification for on-going disability.

Audit Category #3: Medical Provider Network

Composite Score = 100.00

Audit Metric	Audit Category #3 - Metric Descriptions	Final Score	Metric Scored
3.1	Did the Nurse Case Manager attempt to influence the Claimant to treat within the preferred medical provider network relating to the choice of a primary or specialty provider (if applicable)	100.00	✓
3.2	Where a complaint regarding a physician in the Medical Provider Network was made by a JBWCP Member, was a response provided to the Adjuster (and documented in the claim file) acknowledging receipt of the complaint and demonstrating that the complaint has been acted upon by AMC.	N/A	✓
3.3	Did the Treating Physician in the Medical Provider Network appropriately diagnose the Claimant's injuries	100.00	✓
3.4	Where a misdiagnosis of the Claimant's injuries occurred, was there follow-up by the Adjuster or Nurse Case Manager with the Treating Physician as well as coordination/follow-up with the Claimant and JBWCP Member	N/A	✓

Findings:

AMC's overall composite audit score for this category is **100.00** which is consistent with a high-performing managed care organization. A total of four audit metrics were evaluated. Two of the audit metrics were found to be not applicable (N/A) as no observations were identified (i.e., **Metric 3.2** and **Metric 3.4** respectively). Both remaining audit metrics received perfect scores of **100.00**.

According to the AMC Managed Care Guidelines, JBWCP primarily utilizes the AIMS-AMC MPN. This is an elective network in which the Member may or may not participate (though it is

strongly encouraged for all Members to do so to minimize costs across the Program). AMC nurses are expected to attempt to influence Claimants to treat within the network, where possible. Claim file documentation reviewed evidenced Nurses complying with this requirement.

Additionally, we were also asked to evaluate the degree to which MPN treating physicians appropriately diagnosed Claimants' injuries. We observed no instances of improper diagnoses on the audited claims during the applicable review period (i.e., November 1, 2019 and after). Furthermore, we did not identify any instances of claims in which a JBWCP Member initiated a complaint against an MPN provider through either AIMS or AMC.

Recommendations:

No recommendations are warranted.

Additional Best Practices Considerations:

No additional considerations offered.

Audit Category #4: Pharmacy Benefits Program

Composite Score = 85.04

Audit Metric	Audit Category #4 - Metric Descriptions	Final Score	Metric Scored
4.1	Utilization of HealtheSystems pharmacy network program for prescription drugs	97.92	✓
4.2	Non-exempt medications falling outside of the California pharmacy formulary were sent to Pharmacy Nurse (as part of an early intervention program) to review for release and prevent addition issues	100.00	✓
4.3	Where a medication was held and not released, the Pharmacy Nurse contacted both Claimant and Adjuster to explain the rationale and what actions may be required before the medication can be released	46.67	✓
4.4	If a medication was determined to require utilization review before being released, did the Pharmacy Nurse first contact the prescribing physician and request a current Reasons For Assessment and medical report documenting the need for the medication, and then forward to the Adjuster	94.74	✓

Findings:

AMC's overall composite audit score for this category is **85.04**. A total of four audit metrics were evaluated. Three of the audit metrics evaluated scored **94.74** or higher. The remaining audit metric relating to required communications by Pharmacy Nurses if medications are held presents a significant opportunity to improve overall program performance and requires corrective action on the part of AMC.

According to the AMC Managed Care Guidelines, JBWCP utilize a pharmacy network program, which is proprietary, owned by HealtheSystems, and has been further customized by AIMS/AMC. Non-exempt medications falling outside of the formulary are to be sent to an AMC

Nurse to review for release to prevent addiction issues. If a medication is not released or held, the Pharmacy Nurse is to contact both Claimant and Adjuster to explain the rationale as to why the medication was held and provide guidance on what actions need to be taken for the medication to be released. Also, if a medication is determined to require utilization review before being released, the Pharmacy Nurse is required to contact the treating provider, request a current Reason for Assessment (RFA) and medical report documenting the need for the medication. Once received, the Pharmacy Nurse is then required to forward this report to the Adjuster.

Prescriptions were generally being filled correctly utilizing the HealtheSystems network. Any non-exempt medications that fell outside of the California pharmacy formulary were consistently sent to the Pharmacy Nurse for review and release. In the event medications were held and not released, Pharmacy Nurses did not consistently contact Claimants and Adjusters to provide the rationale for not releasing medications nor did they identify what actions were needed for the medication to be released. For medications determined to need utilization review before being released, Pharmacy Nurses were observed to generally contact prescribing physicians to request the supporting documentation and to subsequently provide supporting documentation to Adjusters.

A sampling of Auditor comments relating to observed deficiencies are as follows:

Claim Number	Auditor comment
JC02000176	The auditor saw evidence of an RFA being sent to the doctor but no contact with the claimant and Adjuster to explain the rationale for why medication held.
JC02000318	On 2/11/20, medication was held. In reviewing the claim notes, the Adjuster was notified; however, the auditor cannot locate any discussion with the Claimant.
JC07000324	There is no documentation of the nurse contacting the Claimant or Adjuster when the prescription was being held for further clarification.
JC06000186	The auditor was able to see evidence of an RFA to the provider but no evidence of a conversation or communication with the Adjuster or Claimant for medication held.
JC03000156	The auditor saw evidence of a RFA being sent for medications held but not a conversation with the Claimant and Adjuster.
JC04000593	On 12/11/2019, a review for medication was completed. In reviewing the claim notes, the Adjuster was notified that the medication was to be held; however, the Claimant was not contacted.
JC10000450	There is no documentation that the Nurse contacted the Claimant/Adjuster when the prescription was being held and not released.
JC09020540	On 12/13/19 and 12/17/19, medications were held. Auditor cannot locate any communication with the Claimant.
JC11000630	On 12/3/19, medication was not released. Auditor cannot locate any communication with the Claimant to explain reasoning.
JC11000027	When medication was held, I did not see evidence of the Claimant and/or Adjuster being contacted to explain rationale
JC13020132	On 7/6/20, the medication was not released. No communication with the Claimant can be located.
JC99000018	The auditor did not see evidence of the Pharmacy Nurse having conversations with the Claimant or Adjuster for medications held.
160000025JUD	Per 2/14/20 and 2/19/20 claim notes, medication request held as non-industrial from the treating provider; however, there is no documentation observed regarding communications with the Adjuster or Claimant about this.
160000528JUD	The auditor did not see evidence of the Pharmacy Nurse having conversations with the Adjuster or Claimant after medication was held on 12/3/2019.
160000626JUD	1/28/20 documentation holding medication due to no RFA. Adjuster notified by documentation but auditor can see no contact with the Claimant.

JC02000176	The auditor saw evidence of an RFA being sent to the doctor but no contact with the Claimant and Adjuster to explain the rationale for why medication held.
JC02000318	On 2/11/20, medication was held. In reviewing the claim notes, the Adjuster was notified; however, the auditor cannot locate any discussion with the Claimant.
JC07000324	There is no documentation of the Pharmacy Nurse contacting the Claimant or Adjuster when the prescription was being held for further clarification.
JC06000186	The auditor was able to see evidence of an RFA to the provider but no evidence of a conversation or communication with the Adjuster or Claimant for medication held.
JC03000156	The auditor saw evidence of a RFA being sent for medications held but not a conversation with the Claimant and Adjuster.
JC04000593	On 12/11/2019, a review for medication was completed. In reviewing the claim notes, the Adjuster was notified that the medication was to be held; however, the Claimant was not contacted.
JC10000450	There is no documentation that the Pharmacy Nurse contacted the Claimant / Adjuster when the prescription was being held and not released.
JC09020540	On 12/13/19 and 12/17/19, medications were held. Auditor cannot locate any communication with the Claimant.
JC11000630	On 12/3/19, medication was not released. Auditor cannot locate any communication with the Claimant to explain reasoning.
JC11000027	When medication was held, I did not see evidence of the Claimant and/or Adjuster being contacted to explain rationale
JC13020132	On 7/6/20, the medication was not released. No communication with the Claimant can be located.
JC99000018	The auditor did not see evidence of the Pharmacy Nurse having conversations with the Claimant or Adjuster for medications held.
160000025JUD	Per 2/14/20 and 2/19/20 claim notes, medication request held as non-industrial from the treating provider; however, there is no documentation observed regarding communications with the Adjuster or Claimant about this.
160000528JUD	The auditor did not see evidence of the Pharmacy Nurse having conversations with the Adjuster or Claimant after medication was held on 12/3/2019.
160000626JUD	1/28/20 documentation holding medication due to no RFA. Adjuster notified by documentation but auditor can see no contact with the Claimant.

Recommendations:

Assure that Pharmacy Nurses understands the importance of collaborating with the Adjusters and developing plans of action in scenarios where a prescribed medication will not be released. AMC also needs to reiterate the requirement of contacting Claimants to explain the rationale why a medication(s) is/are not being released as well as provide a corrective plan to address observed deficiencies in execution.

Additional Best Practices Considerations:

No additional considerations offered.

Audit Category #5: Closure Criteria

Composite Score = 98.00

Audit Metric	Audit Category #5 - Metric Descriptions	Final Score	Metric Scored
5.1	If one or more of the following criteria were met, was the nurse case management assignment timely closed out: (1) Claimant returned to work full duty (2) Claimant returned to work in a permanent modified position (3) Claimant was declared Permanent & Stationary (4) Claim was denied (5) No impact can be made on the file (6) Request made by Adjuster (7) Task assignment completed	100.00	✓
5.2	Closure report completed upon file closure within 5 days	95.65	✓

Findings:

AMC's overall composite audit score for this category is **98.00** which is consistent with a high-performing managed care organization. Both audit metrics evaluated scored more than **95.65**.

According to the AMC Managed Care Guidelines, there are closure criteria in place for when the case management assignment should be completed as well as a five-day requirement for the AMC Nurse to complete the closure report and submit to the Adjuster.

AMC Nurses completed and closed assignments as required, and well as submitting required closure reports timely on a timely based. It was noted during the rebuttal process that assignment for case management were not continued if Claimants were released to return to modified duty and were retired or terminated from employment with JBWCP.

Recommendations:

No recommendations are warranted.

Additional Best Practices Considerations:

We recommend amending the AMC Managed Care Guidelines to allow nurse case management to continue in the scenario that a Claimant is released to modified duty but elects to; (i) retire; or (ii) his/her employment is terminated by a JBWCP Member. The nurse case management assignment should continue until a full duty release is obtained to mitigate both temporary and permanent indemnity benefit exposures.

Appendix A: Claim Sample – Third Party Administrator Audit

Claim Count	JBWCP Segment	JCWCP Member	Claim Number	Date of Loss	Claimant Last Name	Claim Adjuster
1	Trial Courts	Tulare	0000006JUD	8/20/2014	Redacted	McKinley
2	Trial Courts	Contra Costa	0000059JUD	10/20/2014	Redacted	Palmer
3	Trial Courts	Santa Clara	0000152JUD	11/6/2014	Redacted	Sandison
4	Trial Courts	Orange	150000423JUD	3/22/2015	Redacted	Munroe
5	Trial Courts	Solano	150000454JUD	2/26/2015	Redacted	Lopez
6	Trial Courts	Orange	150000469JUD	4/22/2015	Redacted	Munroe
7	Trial Courts	Ventura	150000517JUD	4/27/2015	Redacted	Taylor
8	Judiciary	SC	150000535JUD	4/2/2015	Redacted	VanCamp
9	Trial Courts	Placer	160000003JUD	6/29/2015	Redacted	Lopez
10	Trial Courts	Fresno	160000029JUD	7/8/2015	Redacted	Harris
11	Trial Courts	San Joaquin	160000060JUD	6/12/2015	Redacted	Harris
12	Trial Courts	Alameda	160000239JUD	10/1/2015	Redacted	Harris
13	Trial Courts	Madera	160000260JUD	10/14/2015	Redacted	McKinley
14	Trial Courts	Alameda	160000310JUD	11/16/2015	Redacted	Harris
15	Trial Courts	Santa Clara	160000377JUD	12/21/2015	Redacted	Sandison
16	Trial Courts	Tulare	160000445JUD	1/22/2016	Redacted	Ball
17	Judiciary	JCC	160000577JUD	4/7/2016	Redacted	VanCamp
18	Trial Courts	Ventura	160000592JUD	3/24/2016	Redacted	Taylor
19	Trial Courts	San Francisco	160000602JUD	4/14/2016	Redacted	Taylor
20	Trial Courts	Santa Clara	160000625JUD	4/12/2016	Redacted	Sandison
21	Trial Courts	Humboldt	160000726JUD	5/20/2016	Redacted	McKinley
22	Trial Courts	Sonoma	170000068JUD	8/4/2016	Redacted	McKinley
23	Judiciary	JCC	170000152JUD	9/6/2016	Redacted	VanCamp
24	Trial Courts	Contra Costa	170000266JUD	6/15/2016	Redacted	Palmer
25	Trial Courts	Kern	170000267JUD	11/2/2016	Redacted	Lopez
26	Trial Courts	Kings	170000386JUD	12/15/2016	Redacted	McKinley
27	Trial Courts	San Diego	170000420JUD	1/16/2017	Redacted	Legardye
28	Trial Courts	San Diego	170000465JUD	2/16/2017	Redacted	Legardye
29	Trial Courts	Santa Clara	170000473JUD	1/3/2017	Redacted	Sandison
30	Trial Courts	Alameda	170000509JUD	2/28/2017	Redacted	Harris
31	Trial Courts	San Diego	170000553JUD	3/24/2017	Redacted	Legardye
32	Judiciary	JCC	170000588JUD	4/7/2017	Redacted	VanCamp
33	Trial Courts	Kern	170000628JUD	4/14/2017	Redacted	Lopez
34	Trial Courts	San Diego	170000701JUD	5/31/2017	Redacted	Legardye
35	Trial Courts	San Joaquin	170000754JUD	6/16/2017	Redacted	Harris
36	Judiciary	TC Judges	170000770JUD	12/5/2016	Redacted	VanCamp
37	Trial Courts	Orange	170000774JUD	6/22/2017	Redacted	Munroe
38	Trial Courts	Ventura	170000778JUD	5/23/2017	Redacted	Taylor
39	Trial Courts	San Francisco	180000021JUD	6/5/2017	Redacted	Taylor

Claim Count	JBWCP Segment	JCWCP Member	Claim Number	Date of Loss	Claimant Last Name	Claim Adjuster
40	Trial Courts	San Mateo	180000080JUD	8/1/2017	Redacted	Lopez
41	Trial Courts	Orange	180000084JUD	8/9/2017	Redacted	Munroe
42	Trial Courts	San Francisco	180000157JUD	9/12/2017	Redacted	Taylor
43	Trial Courts	Santa Clara	180000234JUD	10/20/2017	Redacted	Sandison
44	Trial Courts	Orange	180000250JUD	10/31/2017	Redacted	Munroe
45	Trial Courts	Sonoma	180000280JUD	7/3/2017	Redacted	Lopez
46	Trial Courts	San Bernardino	180000309JUD	11/9/2017	Redacted	Palmer
47	Trial Courts	Ventura	180000357JUD	12/21/2017	Redacted	Taylor
48	Trial Courts	San Bernardino	180000360JUD	12/29/2017	Redacted	Palmer
49	Trial Courts	Ventura	180000377JUD	11/14/2017	Redacted	Taylor
50	Trial Courts	Sonoma	180000413JUD	1/3/2018	Redacted	Lopez
51	Trial Courts	Siskiyou	180000418JUD	1/25/2018	Redacted	Ball
52	Trial Courts	San Bernardino	180000445JUD	2/2/2018	Redacted	Palmer
53	Trial Courts	Monterey	180000447JUD	2/9/2018	Redacted	Palmer
54	Trial Courts	Placer	180000496JUD	3/5/2018	Redacted	Lopez
55	Trial Courts	Orange	180000604JUD	4/30/2018	Redacted	Munroe
56	Trial Courts	San Francisco	180000653JUD	5/4/2018	Redacted	Taylor
57	Trial Courts	Ventura	180000688JUD	6/11/2018	Redacted	Taylor
58	Trial Courts	Shasta	180000705JUD	6/15/2018	Redacted	Ball
59	Trial Courts	Kings	180000716JUD	6/12/2018	Redacted	Harris
60	Trial Courts	Santa Clara	190000001JUD	5/1/2018	Redacted	Sandison
61	Trial Courts	Santa Clara	190000017JUD	7/2/2018	Redacted	Sandison
62	Trial Courts	Ventura	190000043JUD	1/3/2018	Redacted	Taylor
63	Trial Courts	Marin	190000068JUD	5/3/2018	Redacted	Harris
64	Trial Courts	San Francisco	190000126JUD	7/30/2018	Redacted	Taylor
65	Trial Courts	San Luis Obispo	190000216JUD	10/9/2018	Redacted	Ball
66	Trial Courts	Orange	190000224JUD	10/3/2018	Redacted	Munroe
67	Trial Courts	San Bernardino	190000262JUD	10/29/2018	Redacted	Palmer
68	Trial Courts	San Diego	190000308JUD	11/16/2018	Redacted	Legardye
69	Trial Courts	Tulare	190000392JUD	1/17/2019	Redacted	Ball
70	Trial Courts	San Bernardino	190000395JUD	10/26/2018	Redacted	Palmer
71	Trial Courts	San Bernardino	190000432JUD	10/22/2018	Redacted	Palmer
72	Trial Courts	San Diego	190000496JUD	12/14/2018	Redacted	Legardye
73	Trial Courts	Nevada	190000508JUD	3/22/2019	Redacted	Harris
74	Trial Courts	Orange	190000523JUD	3/14/2019	Redacted	Munroe
75	Trial Courts	Fresno	190000547JUD	4/11/2019	Redacted	Harris
76	Trial Courts	Merced	190000558JUD	4/19/2019	Redacted	Ball
77	Trial Courts	Yolo	190000577JUD	4/19/2019	Redacted	Ball
78	Trial Courts	Santa Clara	190000579JUD	12/3/2018	Redacted	Sandison
79	Trial Courts	Humboldt	190000584JUD	3/23/2019	Redacted	Ball
80	Trial Courts	Contra Costa	190000607JUD	6/26/2012	Redacted	Palmer
81	Trial Courts	Merced	190000624JUD	2/26/2019	Redacted	Ball
82	Trial Courts	Stanislaus	190000638JUD	12/3/2018	Redacted	Ball
83	Judiciary	DCAs	190000639JUD	5/3/2019	Redacted	VanCamp

Claim Count	JBWCP Segment	JCWCP Member	Claim Number	Date of Loss	Claimant Last Name	Claim Adjuster
84	Trial Courts	Ventura	190000660JUD	1/4/2016	Redacted	Taylor
85	Trial Courts	Orange	190000663JUD	6/11/2019	Redacted	Munroe
86	Trial Courts	Imperial	190000669JUD	6/18/2019	Redacted	Legardye
87	Judiciary	DCAs	190000686JUD	2/1/2019	Redacted	VanCamp
88	Trial Courts	San Joaquin	200000003JUD	6/26/2019	Redacted	Harris
89	Trial Courts	Kern	200000018JUD	7/10/2019	Redacted	Lopez
90	Trial Courts	San Bernardino	200000023JUD	7/11/2019	Redacted	Palmer
91	Trial Courts	Santa Clara	200000032JUD	7/10/2019	Redacted	Sandison
92	Trial Courts	Tulare	200000033JUD	7/16/2019	Redacted	Ball
93	Trial Courts	Solano	200000043JUD	7/23/2019	Redacted	Lopez
94	Trial Courts	Santa Clara	200000046JUD	5/22/2019	Redacted	Sandison
95	Trial Courts	Santa Clara	200000074JUD	8/5/2019	Redacted	Sandison
96	Trial Courts	Orange	200000084JUD	7/31/2019	Redacted	Munroe
97	Trial Courts	Contra Costa	200000108JUD	8/14/2019	Redacted	Palmer
98	Trial Courts	Contra Costa	200000111JUD	8/20/2019	Redacted	Palmer
99	Judiciary	JCC	200000126JUD	7/5/2019	Redacted	VanCamp
100	Judiciary	SC	200000137JUD	8/23/2019	Redacted	VanCamp
101	Trial Courts	Kern	200000144JUD	8/30/2019	Redacted	Lopez
102	Trial Courts	Imperial	200000152JUD	9/6/2019	Redacted	Legardye
103	Trial Courts	Monterey	200000169JUD	8/30/2019	Redacted	Palmer
104	Trial Courts	Ventura	200000180JUD	9/20/2019	Redacted	Taylor
105	Trial Courts	Santa Clara	200000181JUD	9/13/2019	Redacted	Sandison
106	Trial Courts	Nevada	200000187JUD	9/18/2019	Redacted	Harris
107	Trial Courts	San Diego	200000195JUD	8/1/2019	Redacted	Legardye
108	Judiciary	HCRC	200000257JUD	8/1/2019	Redacted	VanCamp
109	Trial Courts	Santa Clara	200000262JUD	9/18/2019	Redacted	Sandison
110	Judiciary	TC Judges	200000277JUD	11/27/2019	Redacted	VanCamp
111	Judiciary	DCAs	200000285JUD	12/5/2019	Redacted	VanCamp
112	Trial Courts	Santa Clara	200000306JUD	8/9/2019	Redacted	Sandison
113	Trial Courts	Santa Clara	200000316JUD	10/1/2019	Redacted	Sandison
114	Trial Courts	Orange	200000323JUD	12/19/2019	Redacted	Munroe
115	Trial Courts	Santa Barbara	200000343JUD	12/6/2019	Redacted	Lopez
116	Judiciary	JCC	200000360JUD	1/27/2020	Redacted	VanCamp
117	Trial Courts	Orange	200000391JUD	2/5/2020	Redacted	Munroe
118	Trial Courts	Monterey	200000411JUD	1/28/2020	Redacted	Palmer
119	Trial Courts	Alameda	200000435JUD	1/28/2020	Redacted	Harris
120	Trial Courts	Santa Barbara	200000485JUD	6/16/2017	Redacted	Lopez
121	Trial Courts	Shasta	200000496JUD	5/22/2020	Redacted	Ball
122	Trial Courts	Orange	200000509JUD	6/9/2020	Redacted	Munroe
123	Trial Courts	Alameda	200000514JUD	10/19/2017	Redacted	Harris
124	Trial Courts	Santa Clara	210000002JUD	6/30/2020	Redacted	Sandison
125	Trial Courts	Glenn	210000026JUD	7/3/2020	Redacted	Taylor
126	Trial Courts	Mono	210000035JUD	7/28/2020	Redacted	Harris

Claim Count	JBWCP Segment	JCWCP Member	Claim Number	Date of Loss	Claimant Last Name	Claim Adjuster
127	Trial Courts	Santa Clara	210000046JUD	5/1/2020	Redacted	Ball
128	Trial Courts	San Mateo	210000078JUD	7/1/2020	Redacted	Lopez
129	Trial Courts	Marin	210000085JUD	8/28/2020	Redacted	Harris
130	Trial Courts	Kern	JC02000716	2/15/2001	Redacted	Lopez
131	Trial Courts	Orange	JC04000385	6/3/2004	Redacted	Munroe
132	Trial Courts	Del Norte	JC04000583	1/17/2003	Redacted	McKinley
133	Trial Courts	Santa Clara	JC04000593	12/11/2003	Redacted	Sandison
134	Trial Courts	Imperial	JC04000915	8/15/2003	Redacted	Legardye
135	Trial Courts	Orange	JC04001034	3/24/2003	Redacted	Munroe
136	Trial Courts	Imperial	JC05000447	8/27/2004	Redacted	McKinley
137	Trial Courts	Yolo	JC05000841	6/1/2005	Redacted	McKinley
138	Trial Courts	Stanislaus	JC05001103	1/14/2004	Redacted	McKinley
139	Trial Courts	San Diego	JC05001126	1/30/2004	Redacted	Legardye
140	Trial Courts	Marin	JC06000658	3/10/2005	Redacted	McKinley
141	Trial Courts	Colusa	JC08000081	5/5/2008	Redacted	McKinley
142	Trial Courts	Orange	JC08000156	1/8/2007	Redacted	Munroe
143	Trial Courts	San Diego	JC08020070	6/27/2008	Redacted	Legardye
144	Judiciary	JCC	JC09000020	4/7/2008	Redacted	VanCamp
145	Trial Courts	Orange	JC09020691	4/8/2009	Redacted	Munroe
146	Judiciary	TC Judges	JC09020792	5/9/2009	Redacted	VanCamp
147	Trial Courts	Sutter	JC10000310	9/25/2009	Redacted	McKinley
148	Trial Courts	Santa Barbara	JC10000332	11/23/2009	Redacted	McKinley
149	Trial Courts	Imperial	JC10000706	5/10/2010	Redacted	Legardye
150	Trial Courts	Stanislaus	JC11000011	7/1/2010	Redacted	Ball
151	Trial Courts	Placer	JC11000027	7/14/2010	Redacted	McKinley
152	Trial Courts	Alameda	JC11000692	1/14/2011	Redacted	Harris
153	Trial Courts	San Joaquin	JC11000710	5/11/2011	Redacted	McKinley
154	Trial Courts	Kings	JC11000847	9/11/2010	Redacted	Harris
155	Trial Courts	San Diego	JC12020271	12/5/2011	Redacted	Legardye
156	Trial Courts	San Francisco	JC12020356	12/1/2011	Redacted	Taylor
157	Trial Courts	Madera	JC12020421	2/29/2012	Redacted	Ball
158	Trial Courts	San Francisco	JC12020558	4/18/2012	Redacted	Taylor
159	Trial Courts	San Luis Obispo	JC12020651	2/21/2012	Redacted	McKinley
160	Trial Courts	Contra Costa	JC12020768	7/13/2012	Redacted	Palmer
161	Trial Courts	Santa Cruz	JC13020003	7/9/2012	Redacted	Palmer
162	Judiciary	TC Judges	JC13020045	7/24/2012	Redacted	VanCamp
163	Trial Courts	Santa Clara	JC13020046	8/2/2012	Redacted	Sandison
164	Trial Courts	Mendocino	JC13020160	9/24/2012	Redacted	Ball
165	Trial Courts	Solano	JC13020465	12/12/2012	Redacted	Lopez
166	Trial Courts	Contra Costa	JC13020480	3/13/2013	Redacted	Palmer
167	Trial Courts	Butte	JC13020519	3/26/2013	Redacted	Ball
168	Trial Courts	Siskiyou	JC13020522	11/26/2012	Redacted	McKinley
169	Trial Courts	Monterey	JC13020612	5/14/2013	Redacted	McKinley
170	Trial Courts	Solano	JC13020707	6/17/2013	Redacted	Lopez

Claim Count	JBWCP Segment	JCWCP Member	Claim Number	Date of Loss	Claimant Last Name	Claim Adjuster
171	Trial Courts	Tuolumne	JC14020037	7/11/2013	Redacted	Ball
172	Trial Courts	San Diego	JC14020043	7/22/2013	Redacted	Legardye
173	Trial Courts	San Diego	JC14020297	12/11/2013	Redacted	Legardye
174	Trial Courts	Lake	JC14020448	3/18/2014	Redacted	Lopez
175	Trial Courts	Orange	JC14020503	4/17/2014	Redacted	Munroe
176	Trial Courts	San Francisco	JC15020031	7/21/2014	Redacted	Taylor
177	Trial Courts	San Diego	JC15020035	7/28/2014	Redacted	Legardye
178	Trial Courts	San Diego	JC15020064	8/15/2014	Redacted	Legardye
179	Judiciary	TC Judges	JC90000007	7/21/1989	Redacted	VanCamp
180	Judiciary	TC Judges	JC91000017	8/9/1990	Redacted	VanCamp

Appendix B: Claim Sample – Case Management Audit

Claim Count	JBWCP Segment	JCWCP Member	Claim Number	Date of Loss	Claimant Last Name	Claim Adjuster
1	Trial Courts	Alameda	160000025JUD	6/4/2015	Redacted	Harris
2	Trial Courts	Riverside	160000272JUD	10/27/2015	Redacted	VanCamp
3	Trial Courts	Santa Clara	160000528JUD	12/24/2015	Redacted	Sandison
4	Trial Courts	Tulare	160000626JUD	4/22/2016	Redacted	Ball
5	Trial Courts	Contra Costa	170000266JUD	6/15/2016	Redacted	Palmer
6	Trial Courts	Humboldt	170000280JUD	10/14/2016	Redacted	Ball
7	Trial Courts	San Diego	170000520JUD	2/23/2017	Redacted	McKinley
8	Trial Courts	San Diego	170000553JUD	3/24/2017	Redacted	Legardye
9	Trial Courts	Kern	170000762JUD	6/14/2017	Redacted	Lopez
10	Trial Courts	San Diego	170000775JUD	6/21/2017	Redacted	Legardye
11	Trial Courts	Kern	180000253JUD	10/31/2017	Redacted	Lopez
12	Trial Courts	Orange	180000296JUD	11/29/2017	Redacted	Munroe
13	Trial Courts	Kern	180000443JUD	2/5/2018	Redacted	Lopez
14	Trial Courts	Monterey	180000447JUD	2/9/2018	Redacted	Palmer
15	Trial Courts	San Francisco	180000722JUD	6/21/2018	Redacted	Taylor
16	Trial Courts	Riverside	190000237JUD	10/16/2018	Redacted	VanCamp
17	Trial Courts	San Diego	190000299JUD	10/1/2018	Redacted	Legardye
18	Trial Courts	San Diego	190000362JUD	10/4/2018	Redacted	Legardye
19	Trial Courts	Santa Clara	190000509JUD	3/15/2019	Redacted	Sandison
20	Trial Courts	Contra Costa	190000539JUD	4/8/2019	Redacted	Palmer
21	Trial Courts	San Diego	190000575JUD	1/30/2019	Redacted	Legardye
22	Trial Courts	San Diego	190000597JUD	5/2/2019	Redacted	Legardye
23	Trial Courts	Riverside	190000635JUD	5/31/2019	Redacted	VanCamp
24	Trial Courts	San Diego	190000640JUD	6/3/2019	Redacted	McKinley
25	Trial Courts	Orange	190000663JUD	6/11/2019	Redacted	Munroe
26	Trial Courts	Contra Costa	200000009JUD	6/26/2019	Redacted	Palmer
27	Trial Courts	San Bernardino	200000023JUD	7/11/2019	Redacted	Palmer
28	Trial Courts	San Bernardino	200000044JUD	7/23/2019	Redacted	Palmer
29	Trial Courts	Santa Cruz	200000086JUD	8/5/2019	Redacted	Palmer
30	Trial Courts	San Bernardino	200000120JUD	8/27/2019	Redacted	Palmer
31	Judiciary	SC	200000137JUD	8/23/2019	Redacted	VanCamp
32	Trial Courts	San Bernardino	200000168JUD	9/17/2019	Redacted	Palmer
33	Trial Courts	Monterey	200000169JUD	8/30/2019	Redacted	Palmer
34	Trial Courts	Orange	200000231JUD	10/21/2019	Redacted	Munroe
35	Trial Courts	Riverside	200000244JUD	10/28/2019	Redacted	VanCamp
36	Trial Courts	San Bernardino	200000276JUD	11/13/2019	Redacted	Palmer
37	Trial Courts	San Francisco	200000282JUD	11/19/2019	Redacted	Taylor
38	Trial Courts	San Bernardino	200000301JUD	12/12/2019	Redacted	Palmer

Claim Count	JBWCP Segment	JCWCP Member	Claim Number	Date of Loss	Claimant Last Name	Claim Adjuster
39	Trial Courts	San Bernardino	200000319JUD	1/2/2020	Redacted	Palmer
40	Trial Courts	Tulare	200000420JUD	2/18/2020	Redacted	Ball
41	Trial Courts	Sacramento	200000470JUD	3/6/2020	Redacted	Jones
42	Trial Courts	Butte	200000486JUD	4/2/2020	Redacted	Jones
43	Trial Courts	Imperial	200000492JUD	4/20/2020	Redacted	Legardye
44	Trial Courts	San Joaquin	200000494JUD	5/18/2020	Redacted	Jones
45	Trial Courts	San Joaquin	200000497JUD	5/28/2020	Redacted	Jones
46	Trial Courts	San Francisco	210000001JUD	6/12/2020	Redacted	Taylor
47	Trial Courts	Kern	210000007JUD	7/9/2020	Redacted	Lopez
48	Judiciary	TC Judges	JC00000033	11/9/1999	Redacted	McKinley
49	Trial Courts	Alameda	JC02000176	10/3/2002	Redacted	McKinley
50	Trial Courts	Alameda	JC02000318	9/19/2001	Redacted	McKinley
51	Trial Courts	Orange	JC02000713	7/1/2002	Redacted	McKinley
52	Trial Courts	Kern	JC02000722	11/19/2001	Redacted	McKinley
53	Trial Courts	Sacramento	JC020020083	10/5/2001	Redacted	VanCamp
54	Trial Courts	San Diego	JC03000156	7/22/2002	Redacted	McKinley
55	Trial Courts	Santa Clara	JC04000593	12/11/2003	Redacted	Sandison
56	Trial Courts	San Diego	JC04000950	8/18/2003	Redacted	McKinley
57	Trial Courts	Riverside	JC05001081	3/24/2004	Redacted	VanCamp
58	Trial Courts	San Mateo	JC05001124	9/2/2005	Redacted	McKinley
59	Trial Courts	Riverside	JC06000186	12/7/2005	Redacted	VanCamp
60	Trial Courts	Tulare	JC07000303	5/31/2006	Redacted	Ball
61	Trial Courts	Orange	JC07000324	4/18/2006	Redacted	McKinley
62	Trial Courts	San Francisco	JC07020001	9/15/2010	Redacted	McKinley
63	Trial Courts	Contra Costa	JC07020010	10/1/2006	Redacted	Palmer
64	Trial Courts	Orange	JC08000156	1/8/2007	Redacted	Munroe
65	Trial Courts	Solano	JC09020540	2/5/2009	Redacted	Lopez
66	Trial Courts	Alameda	JC10000450	1/11/2010	Redacted	McKinley
67	Trial Courts	Yolo	JC10000556	3/10/2010	Redacted	Ball
68	Trial Courts	Sacramento	JC10000721	4/13/2010	Redacted	VanCamp
69	Trial Courts	Placer	JC11000027	7/14/2010	Redacted	McKinley
70	Trial Courts	Santa Clara	JC11000287	11/10/2010	Redacted	Sandison
71	Trial Courts	San Mateo	JC11000630	4/18/2011	Redacted	Lopez
72	Trial Courts	Alameda	JC11000692	1/14/2011	Redacted	Harris
73	Trial Courts	Contra Costa	JC12020132	9/16/2011	Redacted	Palmer
74	Trial Courts	San Diego	JC12020360	1/27/2012	Redacted	Legardye
75	Trial Courts	Kern	JC13020029	7/12/2012	Redacted	Lopez
76	Trial Courts	Solano	JC13020132	9/11/2012	Redacted	Lopez
77	Trial Courts	Riverside	JC13020619	1/31/2013	Redacted	McKinley
78	Trial Courts	Alameda	JC14020402	2/7/2014	Redacted	McKinley
79	Trial Courts	Lake	JC14020448	3/18/2014	Redacted	Lopez
80	Judiciary	SC	JC99000018	1/4/1999	Redacted	McKinley

Appendix C: Scoring Summary By Category – Third Party Administrator Audit

CONSULTING SERVICES | MARSH ADVISORY

Auditing Solutions

Client: Judicial Branch Workers' Compensation Program
Audit: 2020 Annual TPA Audit - Acclamation Insurance Management Services ("AIMS")

Audit Scoring By Category

Services Provider	Coverage Line	Date of Review
Acclamation Ins. Mgmt. Svcs.	Workers' Compensation	10/05/2020 - 10/30/2020

Audit Category	Total Claims	Applicable Claims	Score
Member Loss Reporting	180	26	Not Scored
Claim Set-up & Assignment/Reassignment	180	31	97.33
Three-Point Contact	180	28	82.61
Investigations	180	142	91.43
Medical Cost Containment	180	151	99.16
Disability Management	180	47	85.61
Litigation Management	180	82	97.86
Subrogation, Apportionment, Contribution	180	47	96.88
Reserving	180	179	89.84
Communications	180	134	88.76
Payments	180	170	98.90

Audit Category	Total Claims	Applicable Claims	Score
Settlement/Resolution	180	89	89.88
Strategic Plans & Documentation	180	180	96.18
Supervisory Review	180	180	94.00

Composite Score	94.45

Notes: *The* ***Member Loss Reporting*** *audit category score has been excluded from the composite AIMS audit score (i.e., Not Scored). Scoring for this audit category is reported separately within Section #3 of this report.*

Any non-scoring questions (those with an assigned question weight of (0) are included in this report. A claim section score is the average of all the applicable questions within the section for a single claim. The audit section score shown in this report is the average of all the claim section scores.

Appendix D: Scoring Summary By Question – Third Party Administrator Audit

CONSULTING SERVICES | MARSH ADVISORY

Auditing Solutions

Client: Judicial Branch Workers' Compensation Program
Audit: 2020 Annual TPA Audit - Acclamation Insurance Management Services ("AIMS")

Audit Scoring By Question

Services Provider	Coverage Line	Date of Review
Acclamation Ins. Mgmt. Svcs.	Workers' Compensation	10/5/2020 - 10/30/2020

Audit Category	Total Claims	Applicable Claims	Score
Member Loss Reporting	180	26	Not Scored
JBWCP Member submitted Employer's First Report of Injury form 5020 to AIMS within 5 calendar days of notification of injury	180	26	Not Scored
Claim Set-up & Assignment/Reassignment	180	31	97.33
Total days required to assign to Adjuster (i.e., Assignment Date - AIMS Date of Knowledge)	180	31	96.77
Initial claim classification appropriate (i.e., indemnity, medical only)	180	29	96.55
Claims meeting escalation criteria were timely and appropriately reassigned to indemnity Adjuster	180	15	100.00
Three-Point Contact	180	28	82.61
Attempt to contact JBWCP Member was made within 1 business day of assignment	180	27	81.48
Where initial JBWCP Member contact was unsuccessful, a minimum of 2 additional follow-up attempts were made within 2 business days of assignment	180	7	71.43
Attempt to contact Claimant was made within 1 business day of assignment	180	24	87.50

Audit Category	Total Claims	Applicable Claims	Score
Where initial Claimant contact was unsuccessful, a minimum of 2 additional follow-up attempts were made within 2 business days of assignment	180	11	81.82
Where Claimant contact attempts were unsuccessful, an attempt was made to contact the JBWCP Member to obtain alternate contact information within 3 business days of assignment	180	3	Not Scored
Attempt to contact Medical Provider was made within 1 business day of assignment	180	21	85.71
Where initial Medical Provider contact was unsuccessful, a minimum of 2 additional follow-up attempts were made within 2 business days of assignment	180	2	50.00
Investigation	180	142	91.43
Did the Adjuster take all necessary actions to evaluate compensability	180	31	96.77
Was the claim appropriately accepted, delayed or denied within the 14-day statutory time period	180	30	100.00
Were recorded statements taken where questions of compensability were raised	180	8	100.00
Were claims timely reported to the Index Bureau and re indexed every 12 months thereafter	180	142	88.03
Where "hits" are identified through Index Bureau reports, was follow-up appropriate	180	29	86.21
The need for field investigations (including surveillance) were appropriately recognized, authorized by JBWCP Member and managed	180	5	100.00
Does a note exist within the claim file documenting both: (1) the final compensability decision made by the Adjuster; and (2) a supporting rationale/justification. Where claim denial issued, was denial discussed with the Member and all approvals were obtained and documented?	180	31	93.55
Where a sub-rosa investigation was made by AIMS, the assignment (both scope and provided information) was thorough and timely	180	4	100.00
Medical Cost Containment	180	151	99.16
In cases where the JBWCP Member elected to participate within the AIMS-AMC Medical Provider Network, did the Claimant actually treat within the Medical Provider Network	180	124	100.00
Assuming the JBWCP Member elected to participate within the Medical Provider Network **AND** the Claimant elected to treat outside of the Medical Provider Network, did the Adjuster either: (1) appropriately re-directly care; or (2) document why re-direction of care within Medical Provider Network was not possible	180	10	100.00

Audit Category	Total Claims	Applicable Claims	Score
Where JBWCP Member did not elect to participate within the AIMS-AMC Medical Provider Network, did Adjuster direct or soft channel the Claimant to a preferred provider (primary or specialty) where possible	180	8	100.00
Issues of causation, treatment plan and permanent and stationary status are timely addressed and appropriately documented	180	130	99.23
Utilization review (e.g., surgical requests, medical diagnostics, treatment duration) referrals were timely made and the results were appropriately documented and acted upon	180	107	100.00
Agreed Medical Examinations/Qualified Medical Examinations/Peer Reviews were timely made and utilization was appropriate	180	85	98.82
Nurse case management (either telephonic or field) assignment was approved by the Member and was timely, for appropriate duration and added value	180	11	81.82
Disability Management	180	47	85.61
Where the Claimant's disability exceeds recognized industry did the Adjuster/Nurse Case Manager request clarification from the treating physician	180	12	58.33
Adjuster/Nurse Case Manager demonstrate proactive efforts to pursue return to work	180	29	93.10
Where changes in temporary or permanent restrictions were provided, were those restrictions communicated to the JBWCP Member within 2 business days of receipt by the Adjuster	180	33	84.85
Where necessary, were clarifications relating to specific temporary and/or permanent restrictions sought from the treating physician, Agreed Medical Examination &/or Qualified Medical Examination providing all evaluating physicians with all appropriate records and documentation prior to the evaluation	180	21	90.48
Confirmation email received and documented from the JBWCP Member regarding ability or inability to accommodate	180	37	86.49
Litigation Management	180	82	97.86
Adjuster made a timely and appropriate referral to defense counsel	180	30	100.00
Adjuster appropriately followed-up for required status reports when not provided by Defense Counsel on a timely basis	180	71	98.59

Audit Category	Total Claims	Applicable Claims	Score
Adjuster worked collaboratively with Defense Counsel to develop long term strategy and specific tasks to resolve litigation	180	80	96.25
In the event the JBWCP Member provides direction to the Defense Counsel without involvement of the Adjuster, did the Adjuster take appropriate action to work with the Member and Defense Counsel to establish collaborative communication	180	7	100.00
Defense Counsel activities were appropriately monitored by the Adjuster	180	79	97.47
Assigned Defense Counsel activities represent an appropriate delegation of work	180	79	98.73
Adjuster was responsive to all Defense Counsel requests for information, assistance and authority	180	75	97.33
Subrogation, Apportionment, Contribution	180	47	96.88
Does subrogation potential exist	180	6	Not Scored
Was subrogation potential identified by the Adjuster	180	6	100.00
Was subrogation timely pursued, as authorized and directed by JBWCP Member or JBWCP Administrator	180	3	100.00
Where subrogation potential exists and the JBWCP Member elects not to pursue, AIMS should bring the matter to the attention of the JBWCP Administrator for direction and assistance	180	0	-
Was authority for compromised settlement of the Third Party Lien obtained from the JBWCP Administrator	180	2	100.00
Does apportionment potential exist	180	42	Not Scored
Was apportionment potential identified by the Adjuster	180	42	95.24
Was apportionment appropriately pursued	180	35	97.14
Does contribution potential exist	180	4	Not Scored
Was contribution potential identified by the Adjuster	180	4	100.00
Was contribution appropriately pursued	180	4	100.00
Reserving	180	179	89.84
Initial case reserves set by Adjuster within 5 business days of assignment	180	36	91.67

Audit Category	Total Claims	Applicable Claims	Score
Subsequent case reserve reviews for all *non-future medical claims* occurred at least every 90 days OR within 14 days of knowledge of a material claim file development impacting the claim's overall exposure. Subsequent case reserve reviews for *future medical claims* occurred at least every 180 days.	180	174	89.66
Case reserves are sufficiently documented	180	178	92.70
Current case reserves reflect "probable outcome" based upon currently known facts	180	173	86.71
Is a reserve change (+/-) required? (If so, indicate required change(s)	180	173	Not Scored
Communications	180	134	88.76
During periods of total disability or modified duty or any change in status, the Adjuster maintained ongoing communication (verbal or written) with the Claimant at least every 14 calendar days. On all other non-represented claims, at least every 90 days	180	36	63.89
Adjuster maintained appropriate communication with the JBWCP Member including responding to all telephonic or written requests within 1 business day (check on 24 hour standard)	180	104	98.08
Did the Adjuster keep the JBWCP Member informed of case status, significant changes and resolution plans without the Member initiating an inquiry	180	127	88.19
With respect to 132(a) actions filed against a JBWCP Member, Adjuster communicated what is and is not covered by the JBWCP program	180	0	-
Payments	180	170	98.90
Average weekly wage and workers' compensation benefit rates appropriately calculated and documented in claim file	180	97	96.91
Initial and ongoing temporary total disability benefits were paid timely (i.e., no penalties/fines imposed)	180	24	100.00
Initial and ongoing permanent partial disability benefits were paid timely (i.e., no penalties/fines imposed)	180	43	100.00
Approved medical invoices were paid timely (i.e., no penalties/fines imposed)	180	143	100.00
Payment of medical invoices were appropriate (i.e., no payments made for non-accepted body part or non-approved treatments)	180	143	100.00

Audit Category	Total Claims	Applicable Claims	Score
Legal invoices from Defense Counsel were paid timely (i.e., no evidence of defense counsel requesting payment on outstanding invoices)	180	71	100.00
No evidence of 132(a) awards paid against the file (defense costs ok)	180	9	100.00
Appropriate benefit notices were provided on all accepted and denied claims (e.g., initial, revised, final) including identification of any overpayment of benefits and a request for credit against future permanent partial disability benefits payable)	180	77	100.00
Where an overpayment exists, was notification provided to the AIMS Program Manager and documented within the claim file by the Adjuster	180	6	66.67
Where an overpayment exists, did the Adjuster attempt to recover or offset against future payments (**NOTE:** Neither AIMS or a JBWCP Member can agree to waive an overpayment or provide a future credit - only the JBWCP Administrator may do so)	180	4	75.00
If an Employment Development Department notice was received, did the Adjuster proactively contact the organization to coordinate or negotiate benefits/ reimbursement as opposed to waiting until the claim is ultimately settled?	180	19	94.74
Settlement/Resolution	180	89	89.88
Adjuster recognized settlement opportunities early and approached settlement creatively including relevant methods and considerations to conclude the claim (i.e., global resolution, employment status, MSA, structures, arbitration, mediation)	180	79	89.87
A Settlement Authority Request was completed (including rationale) and submitted to appropriate party/parties (i.e., Level) within 2 weeks of the occurrence of a "triggering" event by the assigned Adjuster	180	55	Not Scored

Audit Category	Total Claims	Applicable Claims	Score
Adjuster adhered to the following settlement authority guidelines (new money to be paid out *but not money that has already been paid out or advanced against settlement*): **PRE 7/1/2020:** * **Level I** - **$0-$10,000** AIMS has full authority with notice to JBWCP Member 10 court days prior to finalizing the settlement offer * **Level II** - **$10,001-$75,000** JBWCP Member has full authority. * **Level III** - **$75,001 - $100,000** JBWCP Administrator in consultation with JBWCP Member. * **Level IV** - **$100,001-$150,000** Settlement Authority Panel (majority of 3 voting JBWCP Advisory Committee Members) in consultation with JBWCP Member * **Level V** - **$150,001+** Settlement Authority Panel (majority of 5 voting JBWCP Advisory Committee Members) in consultation with JBWCP Member **POST 7/1/2020:** * **Level I** - **$0-$10,000** AIMS has full authority with notice to JBWCP Member ten court days prior to finalizing the settlement offer * **Level II** - **$10,001-$100,000** JBWCP Member has full authority. * **Level III** - **$100,001+** Settlement Authority Panel (majority of 4 voting JBWCP Advisory Committee Members and the JBWCP Administrator/designee) in consultation with JBWCP Member.	180	54	100.00
The Adjuster appropriately addressed Medicare Set-Aside and Medicare-related issues in the claim resolution strategy	180	26	88.46
Adjuster conducted aggressive, strategic and prompt settlement negotiations and follow-up	180	62	85.48
Provider and Employment Development Department liens were/are being resolved in a timely and effective manner	180	16	81.25
The file closed appropriately without delay, final bills were received and paid timely	180	8	87.50
Administrative closure occurred on future medical claims with no treatment in excess of 12 months	180	2	50.00
Strategic Plans & Documentation	180	180	96.18
Initial claim file review completed by Adjuster within 30 days of claim assignment	180	33	100.00

Audit Category	Total Claims	Applicable Claims	Score
Claim file reviews completed at least every 90 days by Adjuster (2 week grace period to apply) on *non-future medical claims*. On *future medical claims*, at least every 180 days (two 2 week grace period to apply).	180	178	95.51
Claim files are appropriately documented	180	180	96.11
Target completion dates for key activities identified and documented by Adjuster	180	175	Not Scored
Claim notes reflect consistent and timely follow-up on key activities	180	180	94.44
Diary functionality utilized, with timely diary completion	180	180	99.44
Supervisor feedback/recommendations are appropriately responded to and acted upon by Adjuster	180	166	94.58
Total number of assigned lost time Adjusters documented in claim file over the audit period	180	180	Not Scored
Supervisory Review	180	180	94.00
Initial Supervisor review completed within 10 days of claim assignment	180	30	96.67
Subsequent (initial) review completed within 90 days and then 180 days thereafter by Supervisor (2 week grace period to apply) on *non-future medical claims*. On *future medical claims*, at least every 180 days (2 week grace period to apply).	180	176	96.02
Throughout the claim, the Supervisor provided timely, responsive and meaningful direction on the claim	180	180	93.89
If the Adjuster(s) did not appropriately respond to Supervisor's direction, did the Supervisor provide the appropriate level of follow-up	180	31	80.65
Total number of assigned Supervisors documented in the claim file over the audit period	180	180	Not Scored

Composite Score **94.45**

Notes: *The* ***Member Loss Reporting*** *audit category score has been excluded from the composite AIMS audit score (i.e., Not Scored). Scoring for this audit category is reported separately within Section #3 of this report.*

Any non-scoring questions (those with an assigned question weight of (0) are included in this report. A claim section score is the average of all the applicable questions within the section for a single claim. The audit section score shown in this report is the average of all the claim section scores.

Appendix E: Scoring Summary By Claim Adjuster – Third Party Administrator Audit

CONSULTING SERVICES | MARSH ADVISORY

Auditing Solutions

Client: Judicial Branch Workers' Compensation Program
Audit: 2020 Annual TPA Audit - Acclamation Insurance Management Services ("AIMS")

Audit Scoring By Adjuster

Services Provider	Coverage Line	Date of Review
Acclamation Ins. Mgmt. Svcs.	Workers' Compensation	10/5/2020 - 10/30/2020

Audit Category	Total Claims	Applicable Claims	Score
C. Harris	18	18	97.26
C. VanCamp	18	18	87.53
D. Ball	18	18	95.49
G. Lopez	18	18	93.86
J. Sandison	18	18	94.22
M. Taylor	18	18	96.11
N. Legardye	18	18	95.08
N. Palmer	18	18	95.66
R. McKinley	18	18	98.11
V. Munroe	18	18	90.91
		Composite Score	**94.45**

Appendix F: Claim Value Roster – Third Party Administrator Audit

CONSULTING SERVICES | MARSH ADVISORY

Auditing Solutions

Client: Judicial Branch Workers' Compensation Program
Audit: 2020 Annual TPA Audit - Acclamation Insurance Management Services ("AIMS")

Claim Value Roster

Services Provider	Coverage Line	Date of Review
Acclamation Ins. Mgmt. Svcs.	Workers' Compensation	10/05/2020 - 10/30/2020

Claim Count	Claim Number	AIMS Total Inc.	Marsh Estimate	Total Inc. Variance	Medical Adjustment	Indemnity Adjustment	Expense Adjustment
1	0000006JUD	$ 16,065.93	$ 16,065.93	0.00	$0.00	$0.00	$0.00
2	0000059JUD	$ 79,034.83	$ 79,034.83	0.00	$0.00	$0.00	$0.00
3	0000152JUD	$ 37,107.30	$ 37,107.30	0.00	$0.00	$0.00	$0.00
4	150000423JUD	$ 26,353.59	$ 26,353.59	0.00	$0.00	$0.00	$0.00
5	150000454JUD	$ 96,493.80	$ 169,493.80	(73,000.00)	$53,000.00	$0.00	$20,000.00
6	150000469JUD	$ 49,608.99	$ 49,608.99	0.00	$0.00	$0.00	$0.00
7	150000517JUD	$ 183,348.71	$ 183,348.71	0.00	$0.00	$0.00	$0.00
8	150000535JUD	$ 195,478.99	$ 195,478.99	0.00	$0.00	$0.00	$0.00
9	160000003JUD	$ 246,257.02	$ 246,257.02	0.00	$0.00	$0.00	$0.00
10	160000029JUD	$ 30,486.84	$ 30,486.84	0.00	$0.00	$0.00	$0.00
11	160000060JUD	$ 80,348.40	$ 80,348.40	0.00	$0.00	$0.00	$0.00
12	160000239JUD	$ 94,461.40	$ 94,461.40	0.00	$0.00	$0.00	$0.00
13	160000260JUD	$ 38,930.02	$ 38,930.02	0.00	$0.00	$0.00	$0.00
14	160000310JUD	$ 178,109.93	$ 178,109.93	0.00	$0.00	$0.00	$0.00
15	160000377JUD	$ 155,108.78	$ 155,108.78	0.00	$0.00	$0.00	$0.00
16	160000445JUD	$ 104,990.84	$ 104,990.84	0.00	$0.00	$0.00	$0.00
17	160000577JUD	$ 88,695.54	$ 88,695.54	0.00	$0.00	$0.00	$0.00
18	160000592JUD	$ 12,897.61	$ 12,897.61	0.00	$0.00	$0.00	$0.00
19	160000602JUD	$ 372,971.25	$ 372,971.25	0.00	$0.00	$0.00	$0.00
20	160000625JUD	$ 101,775.84	$ 101,775.84	0.00	$0.00	$0.00	$0.00
21	160000726JUD	$ 87,082.09	$ 87,082.09	0.00	$0.00	$0.00	$0.00
22	170000068JUD	$ 81,642.40	$ 81,642.40	0.00	$0.00	$0.00	$0.00

Claim Count	Claim Number	AIMS Total Inc.	Marsh Estimate	Total Inc. Variance	Medical Adjustment	Indemnity Adjustment	Expense Adjustment
23	170000152JUD	$ 118,233.08	$ 151,233.08	(33,000.00)	$33,000.00	$0.00	$0.00
24	170000266JUD	$ 107,305.95	$ 107,305.95	0.00	$0.00	$0.00	$0.00
25	170000267JUD	$ 94,704.94	$ 94,704.94	0.00	$0.00	$0.00	$0.00
26	170000386JUD	$ 170,175.75	$ 170,175.75	0.00	$0.00	$0.00	$0.00
27	170000420JUD	$ 35,547.80	$ 35,547.80	0.00	$0.00	$0.00	$0.00
28	170000465JUD	$ 172,282.68	$ 172,282.68	0.00	$0.00	$0.00	$0.00
29	170000473JUD	$ 109,951.93	$ 109,951.93	0.00	$0.00	$0.00	$0.00
30	170000509JUD	$ 65,912.25	$ 65,912.25	0.00	$0.00	$0.00	$0.00
31	170000553JUD	$ 97,713.72	$ 97,713.72	0.00	$0.00	$0.00	$0.00
32	170000588JUD	$ 9,403.52	$ 9,403.52	0.00	$0.00	$0.00	$0.00
33	170000628JUD	$ 204,883.77	$ 298,883.77	(94,000.00)	$79,000.00	$0.00	$15,000.00
34	170000701JUD	$ 41,681.60	$ 41,681.60	0.00	$0.00	$0.00	$0.00
35	170000754JUD	$ 137,756.30	$ 137,756.30	0.00	$0.00	$0.00	$0.00
36	170000770JUD	$ 28,441.04	$ 28,441.04	0.00	$0.00	$0.00	$0.00
37	170000774JUD	$ 205,154.75	$ 205,154.75	0.00	$0.00	$0.00	$0.00
38	170000778JUD	$ 41,440.20	$ 41,440.20	0.00	$0.00	$0.00	$0.00
39	180000021JUD	$ 17,933.33	$ 17,933.33	0.00	$0.00	$0.00	$0.00
40	180000080JUD	$ 68,906.00	$ 68,906.00	0.00	$0.00	$0.00	$0.00
41	180000084JUD	$ 159,870.82	$ 159,870.82	0.00	$0.00	$0.00	$0.00
42	180000157JUD	$ 30,871.82	$ 30,871.82	0.00	$0.00	$0.00	$0.00
43	180000234JUD	$ 59,823.10	$ 59,823.10	0.00	$0.00	$0.00	$0.00
44	180000250JUD	$ 23,569.27	$ 23,569.27	0.00	$0.00	$0.00	$0.00
45	180000280JUD	$ 37,457.50	$ 37,457.50	0.00	$0.00	$0.00	$0.00
46	180000309JUD	$ 128,988.95	$ 128,988.95	0.00	$0.00	$0.00	$0.00
47	180000357JUD	$ 35,146.12	$ 35,146.12	0.00	$0.00	$0.00	$0.00
48	180000360JUD	$ 12,046.91	$ 12,046.91	0.00	$0.00	$0.00	$0.00
49	180000377JUD	$ 50,519.84	$ 71,319.84	(20,800.00)	$18,000.00	$0.00	$2,800.00
50	180000413JUD	$ 54,359.69	$ 54,359.69	0.00	$0.00	$0.00	$0.00
51	180000418JUD	$ 15,750.00	$ 39,250.00	(23,500.00)	$10,000.00	$11,200.00	$2,300.00
52	180000445JUD	$ 326.50	$ 326.50	0.00	$0.00	$0.00	$0.00
53	180000447JUD	$ 52,784.23	$ 52,784.23	0.00	$0.00	$0.00	$0.00
54	180000496JUD	$ 45,664.40	$ 45,664.40	0.00	$0.00	$0.00	$0.00
55	180000604JUD	$ 99,031.80	$ 99,031.80	0.00	$0.00	$0.00	$0.00
56	180000653JUD	$ 73,070.00	$ 73,070.00	0.00	$0.00	$0.00	$0.00
57	180000688JUD	$ 22,073.04	$ 22,073.04	0.00	$0.00	$0.00	$0.00
58	180000705JUD	$ 78,436.24	$ 78,436.24	0.00	$0.00	$0.00	$0.00
59	180000716JUD	$ 26,022.60	$ 26,022.60	0.00	$0.00	$0.00	$0.00
60	190000001JUD	$ 91,497.83	$ 91,497.83	0.00	$0.00	$0.00	$0.00
61	190000017JUD	$ 39,071.31	$ 39,071.31	0.00	$0.00	$0.00	$0.00
62	190000043JUD	$ 111,873.94	$ 111,873.94	0.00	$0.00	$0.00	$0.00

Claim Count	Claim Number	AIMS Total Inc.	Marsh Estimate	Total Inc. Variance	Medical Adjustment	Indemnity Adjustment	Expense Adjustment
63	190000068JUD	$ 40,097.98	$ 40,097.98	0.00	$0.00	$0.00	$0.00
64	190000126JUD	$ 110,191.32	$ 110,191.32	0.00	$0.00	$0.00	$0.00
65	190000216JUD	$ 88,921.67	$ 88,921.67	0.00	$0.00	$0.00	$0.00
66	190000224JUD	$ 32,618.31	$ 32,618.31	0.00	$0.00	$0.00	$0.00
67	190000262JUD	$ 26,678.71	$ 26,678.71	0.00	$0.00	$0.00	$0.00
68	190000308JUD	$ 23,237.89	$ 23,237.89	0.00	$0.00	$0.00	$0.00
69	190000392JUD	$ 12,676.23	$ 12,676.23	0.00	$0.00	$0.00	$0.00
70	190000395JUD	$ 35,814.35	$ 42,614.35	(6,800.00)	$0.00	$0.00	$6,800.00
71	190000432JUD	$ 9,678.14	$ 9,678.14	0.00	$0.00	$0.00	$0.00
72	190000496JUD	$ 10,000.00	$ 10,000.00	0.00	$0.00	$0.00	$0.00
73	190000508JUD	$ 72,404.17	$ 72,404.17	0.00	$0.00	$0.00	$0.00
74	190000523JUD	$ 80,294.87	$ 80,294.87	0.00	$0.00	$0.00	$0.00
75	190000547JUD	$ 58,343.95	$ 58,343.95	0.00	$0.00	$0.00	$0.00
76	190000558JUD	$ 29,202.83	$ 29,202.83	0.00	$0.00	$0.00	$0.00
77	190000577JUD	$ 11,354.85	$ 11,354.85	0.00	$0.00	$0.00	$0.00
78	190000579JUD	$ 16,941.14	$ 16,941.14	0.00	$0.00	$0.00	$0.00
79	190000584JUD	$ 22,125.00	$ 22,125.00	0.00	$0.00	$0.00	$0.00
80	190000607JUD	$ 5,292.00	$ 5,292.00	0.00	$0.00	$0.00	$0.00
81	190000624JUD	$ 11,300.00	$ 30,800.00	(19,500.00)	$5,500.00	$10,100.00	$3,900.00
82	190000638JUD	$ 12,709.52	$ 12,709.52	0.00	$0.00	$0.00	$0.00
83	190000639JUD	$ 19,301.80	$ 28,301.80	(9,000.00)	$9,000.00	$0.00	$0.00
84	190000660JUD	$ 61,880.00	$ 61,880.00	0.00	$0.00	$0.00	$0.00
85	190000663JUD	$ 63,695.99	$ 63,695.99	0.00	$0.00	$0.00	$0.00
86	190000669JUD	$ 25,548.40	$ 25,548.40	0.00	$0.00	$0.00	$0.00
87	190000686JUD	$ 17,958.29	$ 17,958.29	0.00	$0.00	$0.00	$0.00
88	200000003JUD	$ 44,357.49	$ 44,357.49	0.00	$0.00	$0.00	$0.00
89	200000018JUD	$ 27,302.82	$ 27,302.82	0.00	$0.00	$0.00	$0.00
90	200000023JUD	$ 59,881.07	$ 59,881.07	0.00	$0.00	$0.00	$0.00
91	200000032JUD	$ 48,638.97	$ 48,638.97	0.00	$0.00	$0.00	$0.00
92	200000033JUD	$ 27,023.98	$ 39,223.98	(12,200.00)	$0.00	$12,200.00	$0.00
93	200000043JUD	$ 11,617.07	$ 11,617.07	0.00	$0.00	$0.00	$0.00
94	200000046JUD	$ 30,688.66	$ 30,688.66	0.00	$0.00	$0.00	$0.00
95	200000074JUD	$ 10,908.61	$ 10,908.61	0.00	$0.00	$0.00	$0.00
96	200000084JUD	$ 9,247.18	$ 9,247.18	0.00	$0.00	$0.00	$0.00
97	200000108JUD	$ 32,562.03	$ 32,562.03	0.00	$0.00	$0.00	$0.00
98	200000111JUD	$ 20,777.37	$ 45,277.37	(24,500.00)	$24,500.00	$0.00	$0.00
99	200000126JUD	$ 5,800.00	$ 5,800.00	0.00	$0.00	$0.00	$0.00
100	200000137JUD	$ 21,454.06	$ 21,454.06	0.00	$0.00	$0.00	$0.00
101	200000144JUD	$ 6,094.56	$ 6,094.56	0.00	$0.00	$0.00	$0.00
102	200000152JUD	$ 11,364.92	$ 11,364.92	0.00	$0.00	$0.00	$0.00

Claim Count	Claim Number	AIMS Total Inc.	Marsh Estimate	Total Inc. Variance	Medical Adjustment	Indemnity Adjustment	Expense Adjustment
103	200000169JUD	$ 20,435.00	$ 34,135.00	(13,700.00)	$12,800.00	$0.00	$900.00
104	200000180JUD	$ 19,363.73	$ 19,363.73	0.00	$0.00	$0.00	$0.00
105	200000181JUD	$ 41,412.50	$ 41,412.50	0.00	$0.00	$0.00	$0.00
106	200000187JUD	$ 16,787.88	$ 16,787.88	0.00	$0.00	$0.00	$0.00
107	200000195JUD	$ 15,671.30	$ 15,671.30	0.00	$0.00	$0.00	$0.00
108	200000257JUD	$ 7,500.00	$ 25,500.00	(18,000.00)	$2,500.00	$12,500.00	$3,000.00
109	200000262JUD	$ 23,200.00	$ 23,200.00	0.00	$0.00	$0.00	$0.00
110	200000277JUD	$ 5,000.00	$ 24,500.00	(19,500.00)	$10,750.00	$7,500.00	$1,250.00
111	200000285JUD	$ 13,366.84	$ 13,366.84	0.00	$0.00	$0.00	$0.00
112	200000306JUD	$ 11,703.50	$ 11,703.50	0.00	$0.00	$0.00	$0.00
113	200000316JUD	$ 3,017.85	$ 22,422.85	(19,405.00)	$7,350.00	$11,055.00	$1,000.00
114	200000323JUD	$ 5,000.00	$ 5,000.00	0.00	$0.00	$0.00	$0.00
115	200000343JUD	$ 11,000.00	$ 11,000.00	0.00	$0.00	$0.00	$0.00
116	200000360JUD	$ 4,580.00	$ 4,580.00	0.00	$0.00	$0.00	$0.00
117	200000391JUD	$ 18,897.04	$ 18,897.04	0.00	$0.00	$0.00	$0.00
118	200000411JUD	$ 8,889.23	$ 8,889.23	0.00	$0.00	$0.00	$0.00
119	200000435JUD	$ 9,769.72	$ 9,769.72	0.00	$0.00	$0.00	$0.00
120	200000485JUD	$ 1,632.00	$ 1,632.00	0.00	$0.00	$0.00	$0.00
121	200000496JUD	$ 9,941.98	$ 14,941.98	(5,000.00)	$3,000.00	$1,500.00	$500.00
122	200000509JUD	$ 11,499.75	$ 45,999.75	(34,500.00)	$13,500.00	$21,000.00	$0.00
123	200000514JUD	$ 275.00	$ 275.00	0.00	$0.00	$0.00	$0.00
124	210000002JUD	$ 7,500.00	$ 7,500.00	0.00	$0.00	$0.00	$0.00
125	210000026JUD	$ 7,927.24	$ 7,927.24	0.00	$0.00	$0.00	$0.00
126	210000035JUD	$ 1,200.00	$ 1,200.00	0.00	$0.00	$0.00	$0.00
127	210000046JUD	$ 1,850.00	$ 1,850.00	0.00	$0.00	$0.00	$0.00
128	210000078JUD	$ 5,700.00	$ 5,700.00	0.00	$0.00	$0.00	$0.00
129	210000085JUD	$ -	$ -	0.00	$0.00	$0.00	$0.00
130	JC02000716	$ 931,670.29	$ 931,670.29	0.00	$0.00	$0.00	$0.00
131	JC04000385	$ 302,464.22	$ 345,464.22	(43,000.00)	$25,000.00	$11,000.00	$7,000.00
132	JC04000583	$ 269,172.90	$ 269,172.90	0.00	$0.00	$0.00	$0.00
133	JC04000593	$ 398,470.27	$ 398,470.27	0.00	$0.00	$0.00	$0.00
134	JC04000915	$ 119,654.28	$ 119,654.28	0.00	$0.00	$0.00	$0.00
135	JC04001034	$ 460,119.98	$ 460,119.98	0.00	$0.00	$0.00	$0.00
136	JC05000447	$ 95,136.65	$ 95,136.65	0.00	$0.00	$0.00	$0.00
137	JC05000841	$ 255,202.37	$ 376,202.37	(121,000.00)	$111,000.00	$0.00	$10,000.00
138	JC05001103	$ 15,356.64	$ 15,356.64	0.00	$0.00	$0.00	$0.00
139	JC05001126	$ 297,784.02	$ 297,784.02	0.00	$0.00	$0.00	$0.00
140	JC06000658	$ 83,872.88	$ 83,872.88	0.00	$0.00	$0.00	$0.00
141	JC08000081	$ 203,096.12	$ 203,096.12	0.00	$0.00	$0.00	$0.00
142	JC08000156	$ 187,113.05	$ 187,113.05	0.00	$0.00	$0.00	$0.00

Claim Count	Claim Number	AIMS Total Inc.	Marsh Estimate	Total Inc. Variance	Medical Adjustment	Indemnity Adjustment	Expense Adjustment
143	JC08020070	$ 156,732.49	$ 156,732.49	0.00	$0.00	$0.00	$0.00
144	JC09000020	$ 62,256.66	$ 62,256.66	0.00	$0.00	$0.00	$0.00
145	JC09020691	$ 19,735.05	$ 42,697.05	(22,962.00)	$7,100.00	$15,862.00	$0.00
146	JC09020792	$ 153,405.00	$ 153,405.00	0.00	$0.00	$0.00	$0.00
147	JC10000310	$ 106,810.85	$ 106,810.85	0.00	$0.00	$0.00	$0.00
148	JC100000332	$ -	$ -	0.00	$0.00	$0.00	$0.00
149	JC10000706	$ 285,609.22	$ 285,609.22	0.00	$0.00	$0.00	$0.00
150	JC11000011	$ 36,625.52	$ 36,625.52	0.00	$0.00	$0.00	$0.00
151	JC11000027	$ 86,316.45	$ 86,316.45	0.00	$0.00	$0.00	$0.00
152	JC11000692	$ 422,154.55	$ 422,154.55	0.00	$0.00	$0.00	$0.00
153	JC11000710	$ 23,639.90	$ 23,639.90	0.00	$0.00	$0.00	$0.00
154	JC11000847	$ 163,232.79	$ 163,232.79	0.00	$0.00	$0.00	$0.00
155	JC12020271	$ 477,218.54	$ 477,218.54	0.00	$0.00	$0.00	$0.00
156	JC12020356	$ 198,323.76	$ 198,323.76	0.00	$0.00	$0.00	$0.00
157	JC12020421	$ 373,381.59	$ 329,381.59	44,000.00	($44,000.00)	$0.00	$0.00
158	JC12020558	$ 140,616.69	$ 140,616.69	0.00	$0.00	$0.00	$0.00
159	JC12020651	$ 125,506.44	$ 125,506.44	0.00	$0.00	$0.00	$0.00
160	JC12020768	$ 294,041.29	$ 294,041.29	0.00	$0.00	$0.00	$0.00
161	JC13020003	$ 54,167.12	$ 79,967.12	(25,800.00)	$23,600.00	$0.00	$2,200.00
162	JC13020045	$ 65,850.71	$ 65,850.71	0.00	$0.00	$0.00	$0.00
163	JC13020046	$ 216,804.12	$ 266,804.12	(50,000.00)	$0.00	$50,000.00	$0.00
164	JC13020160	$ 89,863.64	$ 89,863.64	0.00	$0.00	$0.00	$0.00
165	JC13020465	$ 190,131.78	$ 190,131.78	0.00	$0.00	$0.00	$0.00
166	JC13020480	$ 187,523.85	$ 187,523.85	0.00	$0.00	$0.00	$0.00
167	JC13020519	$ 18,943.27	$ 18,943.27	0.00	$0.00	$0.00	$0.00
168	JC13020522	$ 87,303.79	$ 87,303.79	0.00	$0.00	$0.00	$0.00
169	JC13020612	$ 140,080.47	$ 140,080.47	0.00	$0.00	$0.00	$0.00
170	JC13020707	$ 86,973.76	$ 86,973.76	0.00	$0.00	$0.00	$0.00
171	JC14020037	$ 19,659.38	$ 19,659.38	0.00	$0.00	$0.00	$0.00
172	JC14020043	$ 69,253.09	$ 69,253.09	0.00	$0.00	$0.00	$0.00
173	JC14020297	$ 59,213.99	$ 59,213.99	0.00	$0.00	$0.00	$0.00
174	JC14020448	$ 110,743.17	$ 110,743.17	0.00	$0.00	$0.00	$0.00
175	JC14020503	$ 176,867.20	$ 261,367.20	(84,500.00)	$0.00	$84,500.00	$0.00
176	JC15020031	$ 10,138.58	$ 10,138.58	0.00	$0.00	$0.00	$0.00
177	JC15020035	$ 27,154.39	$ 27,154.39	0.00	$0.00	$0.00	$0.00
178	JC15020064	$ 126,502.65	$ 126,502.65	0.00	$0.00	$0.00	$0.00
179	JC90000007	$ 491,975.98	$ 491,975.98	0.00	$0.00	$0.00	$0.00
180	JC91000017	$ 472,286.84	$ 472,286.84	0.00	$0.00	$0.00	$0.00
		$ 16,328,199.62	**$ 17,057,866.62**	**($729,667.00)**	**$404,600.00**	**$248,417.00**	**$76,650.00**
				-4.5%			

Appendix G: Scoring Summary By Category – Case Management Audit

CONSULTING SERVICES | MARSH ADVISORY

Auditing Solutions

Client: Judicial Branch Workers' Compensation Program
Audit: 2020 Annual Case Management Audit - Allied ManagedCare ("AMC")

Audit Scoring By Category

Services Provider	Coverage Line	Date of Review
Allied Managed Care	Workers' Compensation	9/21/2020 - 10/2/2020

Audit Category	Total Claims	Applicable Claims	Score
Nurse Triage	80	16	70.77
Nurse Case Management & Compliance With Protocols	80	35	88.17
Medical Provider Network	80	42	100.00
Pharmacy Benefits Program	80	52	85.04
Closure Criteria	80	27	98.00
		Composite Score	**87.54**

Note: *Any non-scoring questions (those with an assigned question weight of (0) are included in this report. A claim section score is the average of all the applicable questions within the section for a single claim. The audit section score shown in this report is the average of all the claim section scores.*

Appendix H: Scoring Summary By Question – Case Management Audit

CONSULTING SERVICES | MARSH ADVISORY

Auditing Solutions

Client: Judicial Branch Workers' Compensation Program
Audit: 2020 Annual Case Management Audit - Allied ManagedCare ("AMC")

Audit Scoring By Question

Services Provider	Coverage Line	Date of Review
Allied Managed Care	Workers' Compensation	10/5/2020 - 10/30/2020

Audit Category	Total Claims	Applicable Claims	Score
Nurse Triage	80	16	70.77
Triage Nurse contacted Claimant and the Treating Doctor within 3 business days of the claim assignment and documented the file accordingly	80	14	57.14
Triage Nurse completed AMC's Triage template outlining appropriate treatment and estimated return to work using Official Disability Guidelines and the American College of Occupational and Environmental Medicine guidance	80	12	91.67
If Claimant is a judge, was approval first obtained to triage claim	80	1	100.00
Triage Nurse obtained availability of transitional work and a copy of the employee's duty statement (job description)	80	10	20.00
Triage Nurse documented activities in AlliedConnect Management software and the claims system	80	16	100.00
Triage Nurse forwarded Triage report to Adjuster within 3 business days	80	12	66.67

Audit Category	Total Claims	Applicable Claims	Score
Nurse Case Management & Compliance With Protocols	**80**	**35**	**88.17**
If a Nurse Case Manager is assigned, is it consistent with case management protocols and by agreement of Adjuster and JBWCP Member	80	28	100.00
Was case management initiated within 24 hours of referral	80	24	79.17
3-point contact (i.e., Provider, Claimant and Adjuster) was completed by the Nurse Case Manager within 48 hours of assignment	80	23	39.13
Nurse Case Manager progress reports contain medical treatment plan, next appointment date, work status, barriers to recovery and recommendations	80	34	94.12
Nurse Case Manager integrated Official Disability Guidelines and American College of Occupational and Environmental Medicine guidance into progress reports	80	32	96.88
Initial Nurse Case Manager evaluation completed within 7 business days of referral	80	25	96.00
Nurse Case Manager Progress Reports completed every 30 days or upon significant activity	80	33	96.97
Appointment updates provided to Adjuster within 24 hours of appointment	80	32	84.38
Updates provided to Adjuster within 24 hours of significant file developments (return to work full or modified duty, anticipated surgery, etc.)	80	23	100.00
Nurse Case Manager tracked lost time, modified and return to work dates in Ventiv	80	18	100.00
If a Telephonic Case Management assignment exceeded 60 lost time days or other barriers to recovery or return to work are present, was Field Case Management considered	80	12	25.00

Audit Category	Total Claims	Applicable Claims	Score
Did Nurse Case Manager discuss the claim with Adjuster and Supervisor when the claim reached 90-days of service	80	22	81.82
Claim notes appropriately documented in both the claim system and AlliedConnect	80	35	100.00
A positive nurse case management impact was achieved on the claim	80	31	93.55
Medical Provider Network	**80**	**42**	**100.00**
Did the Nurse Case Manager attempt to influence the Claimant to treat within the preferred medical provider network relating to the choice of a primary or specialty provider (if applicable)	80	11	100.00
Where a complaint regarding a physician in the Medical Provider Network was made by a JBWCP Member, was a response provided to the Adjuster (and documented in the claim file) acknowledging receipt of the complaint and demonstrating that the complaint has been acted upon by AMC.	80	0	-
Did the Treating Physician in the Medical Provider Network appropriately diagnose the Claimant's injuries	80	41	100.00
Where a misdiagnosis of the Claimant's injuries occurred, was there follow-up by the Adjuster or Nurse Case Manager with the Treating Physician as well as coordination/follow-up with the Claimant and JBWCP Member	80	0	-
Pharmacy Benefits Program	**80**	**52**	**85.04**
Utilization of HealtheSystems pharmacy network program for prescription drugs	80	48	97.92
Non-exempt medications falling outside of the California pharmacy formulary were sent to Pharmacy Nurse (as part of an early intervention program) to review formrelease and prevent addition issues	80	11	100.00

Audit Category	Total Claims	Applicable Claims	Score
Where a medication was held and not released, the Pharmacy Nurse contacted both Claimant and Adjuster to explain the rationale and what actions may be required before the medication can be released	80	30	46.67
If a medication was determined to require utilization review before being released, did the Pharmacy Nurse first contact the prescribing physician and request a current Reasons For Assessment and medical report documenting the need for the medication, and then forward to the Adjuster	80	38	94.74
Closure Criteria	**80**	**27**	**98.00**
If one or more of the following criteria were met, was the nurse case management assignment timely closed out: (1) Claimant returned to work full duty (2) Claimant returned to work in a permanent modified position (3) Claimant was declared Permanent & Stationary (4) Claim was denied (5) No impact can be made on the file (6) Request made by adjuster (7) Task assignment completed	80	27	100.00
Closure report completed upon file closure within 5 days	80	23	95.65
		Composite Score	**87.54**

Note: *Any non-scoring questions (those with an assigned question weight of (0) are included in this report. A claim section score is the average of all the applicable questions within the section for a single claim. The audit section score shown in this report is the average of all the claim section scores.*

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