Judicial Branch Workers' Compensation Program
Sedgwick Claims Service Guidelines
(January 2025)

This document is a guideline for claims management staff at Sedgwick Claims (SC). It outlines specific claims administration expectations and requirements for the program's third-party administrator. SC's level of compliance with these guidelines is determined through the program's annual claims technical administration audit and spot checks.

SC will review the Service Guidelines with staff annually and newly assigned staff within 30 days[1] of assignment. SC will provide verification of review to JBWCP as completed.

132a, Serious and Willful, ADA, FMLA, and Good Faith Personnel Actions

The Judicial Branch Workers' Compensation Program (JBWCP) Administrator should be advised of claims that also entail 132a issues, Americans with Disabilities Act (ADA), Family and Medical Leave Act (FMLA), good faith personnel actions (GFPA), and/or terminations. Claims of 132a violations allege that an employee has been discriminated against for filing a workers' compensation claim or testifying on behalf of another employee's claim. Employer GFPAs entail personnel actions that may have a negative effect on an employee but are nonetheless undertaken in a lawful and nondiscriminatory manner during the course of business, such as a job transfer or suspension.

These matters often overlap with a workers' compensation claim and can have significant impacts on the outcome. When 132a, Serious and Willful, ADA, FMLA, or GFPA actions are suspected or alleged, Examiners must request from Members all potentially relevant documentation regarding the situation such as counseling memos, letters of instruction, personnel actions – adverse or otherwise – employment notices, or correspondence regarding return-to-work efforts.

As stated in the JBWCP Memorandum of Coverage (MOC):

> The JBWCP has the right and duty to defend at its expense any claim, proceeding or suit against the **Covered Party** for liabilities payable by [JBWCP] coverage. The JBWCP has the right to investigate and settle these claims, proceedings, or suits.

[1] Any usage of "day" throughout this document refers to calendar day, unless otherwise specified.

The JBWCP shall provide for the defense of, but not the indemnity for, serious and willful misconduct pursuant to Labor Code (LC) 4553 Serious and Willful misconduct, or discrimination or any other actions pursuant to LC 132a brought before the Workers' Compensation Appeals Board (WCAB). The JBWCP's duty to defend such claims shall cease upon the resolution of the underlying claim for disability.

Examiners will establish proactive diaries to manage LC 4553 and/or LC 132a issues.

Asbestos Claims

I. Each alleged asbestos exposure case should be reviewed case-by-case; the below process is not always the default process but simply a guide.
II. Report to Excess Carrier so they can track claim for future medical reporting/costs. For exposures that involved more than ONE claimant, these should be reported to the Excess/Carrier as ONE OCCURRENCE. Clearly document the reporting as well as any response from the Excess Carrier.

If an Employee files an alleged asbestos exposure claim (DWC 1), ensure the following is conducted:

I. Obtain the testing report for the file. If one has not been obtained, discuss with JBWCP Staff on the appropriateness of ordering one, depending upon the severity of the claimed injury/ies.
III. Verify if there was an industrial hygienist report or other investigative report and obtain a copy for the file. If no reports have been obtained, discuss with the JBWCP Staff on the appropriateness of obtaining reports, depending upon the severity of the claim's injury/ies.
IV. Obtain any other information needed regarding the alleged exposure and preserve it for possible use in the future.
V. The claims examiner (CE) will schedule a round table discussion with JBWCP to discuss findings.

If there is no asbestos finding(s) – Once testing/report is received, then determine if there were any asbestos findings. If no asbestos findings, the claim may be appropriate for denial based on no asbestos findings/medical evidence to support that they have sustained an industrial injury.

If there are asbestos finding(s) – Since it takes 5 – 30 years for an asbestosis diagnosis to develop, the CE should do the following:

I. Contact the Employee and explain that the findings, typically many years for the asbestosis to develop due to long exposure to asbestos and the Employee appears to have had limited exposure. The CE will find out:
   a. If the Employee will be going to the MPN/Occupational clinic or not. If they are, and it goes beyond the 14 days, then delay claim. If they already have been and the CE has received the medical within the 14 days, then a denial may be appropriate.
   b. After discussion with the JBWCP, where appropriate, denial wording may include "Your claim is denied because there is no factual or comprehensive medical evidence to support that you have sustained an industrial injury as a result of a possible exposure to asbestos at the Superior Court of California, County of XXXX. As asbestosis has a latency period of five years or more, if you are given this diagnosis by a physician in the future, you may contact the XXXX Superior Court, or the Judicial Council of California to re-open your claim and initiate additional discovery." (NOTE: This denial was based on positive findings of asbestos above the normal safe levels.)

Caseload

The third-party administrator (TPA) shall provide qualified staff such that those working with JBWCP claims will have manageable caseloads. To achieve this, the average monthly caseload of 120 claims per Examiner is desired. At no time shall the average caseload exceed 120 claims, unless requested by the Judicial Council and agreed upon by the TPA. The Claims Team Lead shall not carry a caseload.

Claim Review Protocols

Per contractual agreement, the TPA must conduct, at a minimum, one annual on-site claims file review with each Member, provided the Member has open claims and is open to participating on-site. Open claims, in this case, are only those that are active indemnity claims. It is recognized that an in-person file review may not be desired or necessary based on open claim volume or the Member's ability to participate. The TPA shall escalate any concerns regarding the scheduling of Members' file reviews to the JBWCP Administrator, if necessary.

Claim Review schedules will be confirmed with each Member, using the following protocols:

I. Team Leads are expected to schedule claim reviews directly with the respective Member in accordance with the required Claim Review Schedule and the Member's schedule.

II. The Team Lead or SC Client Service Manager is required to inform the JBWCP Administrator and the Risk Consultant via calendar invite of all claim reviews.
III. The Claim Status Reports shall include all outstanding issues and the plans to resolve all issues, including outstanding liens, and verify data elements/codes such as body part(s), causation, injury type, litigation, occupation, etc., are correct.
IV. The Claim Status Report will be emailed to the Member, JBWCP Administrator, and the Risk Consultant at least three business days prior to the scheduled review.
V. Information on companion cases may be included, even if the companion cases were not specifically referenced in the claim list (to be included in the count of 30 maximum files per review).
VI. Prior to the review date, the TPA will review the timely submission of new claim reporting by the Member and discuss late reporting issues and possible improvements, if necessary.
VII. Defense attorney participation is at the Member's discretion and should be on an as-needed basis and coordinated with the Member.
    a. Defense attorneys shall **not** bill either the claims file or the JBWCP for their participation in a claim review.
    b. The presentation of the claim review information remains the responsibility of the Examiner.
    c. The defense attorney's participation will be to provide subject matter expertise as requested.
    d. Member response time to review claim file list and communicate claims to be reviewed should be within five business days of receipt of open claims list.
    e. File reviews should be set for a **maximum** of 30 claims, which constitutes one full day. However, additional claims over 30 may be considered, and the file review may need to be set for an additional day, with agreement of SC.

Claim Set Up

All 5020 forms shall be maintained in the claim file in accordance with the TPA's standards for efficiency, documentation, and statutory requirements. The 5020 is privileged information and is beyond the power of subpoena. All claims will be set up in the SC Claims System within one working day of receipt of the file assignment.

The date of injury shall control the processing of the claim and benefits due.

I. Claims may be submitted via the SC's system, email, United States mail, or phone.
II. The Team Lead will review all new losses received for an initial assessment of severity, compensability, and subrogation issues.

Any deviation from the Service Guidelines must be pre-authorized by the JBWCP and the authorization clearly documented in the claims file.

III. The Examiner will complete the three-point contact per company policy and client requirements.
    a. The Examiner will review the Occupation Code with the Employer during the initial contact and make any necessary corrections.
    b. The Examiner will advise the IW that a Triage Nurse will be reaching out to them and why. If the IW does not agree, the examiner is to note the file why it is not being sent. If they agree, they will send the referral to the Triage Nurse.
        i. If the claim is for a Judge, the referral requires authorization from Jade Vu.

IV. The Team Lead will review the diary within 10 calendar days following claim entry to confirm that all contacts/issues on the claim have been addressed (e.g. benefit provisions, notices, subrogation, etc.).

V. All files will contain a request for Medical Releases and Medical Records documented in the Plan of Action. All records obtained will be reviewed on all claims.

VI. Medical Only claims will be transitioned to Indemnity status following management review when the claim has been open six months and/or has an Incurred value of $7,500 or 90 days if the IW has been on modified duty.

VII. Management review of the file supporting transition or the determination to remain at Medical only status will be clearly documented in the file notes.

VIII.

Closures

Team Leads will review the following claim files prior to closure:

I. Where a Settlement Authority Request/Notification (SAR) has been submitted; and
II. Where the injured worker has been non-responsive.

The Team Lead shall ensure that the appropriate Reynolds notice has been served upon the IW prior to consideration of case closure. All claims not administered by a Senior Examiner shall be reviewed by the Team Lead prior to closure to assure all issues have been resolved and appropriately documented. The review process will document the decision to either administratively close a file, or alternatively, proceed with an unsigned submission of settlement documents to the WCAB.

Conflict Files

Conflict files are files of claimants who are contributors and/or have authority for the Member's workers' compensation program and/or JBWCP oversight participation. Such

claims will be classified as conflict and access and administration of the claims will be determined by Program Administration in coordination with the TPA and the Member.

Contact

The Examiner will review all first reports of injury within one business day of reporting and make the initial contacts with the IW, Treating Doctor, and Member, documenting all contacts in the claims system. All claim notes will be entered in the claims system within one business day

Initial Contact

I. Member Contact - The Examiner shall contact the primary Member contact within one business day of receiving a new claim to confirm receipt of the claim and to review any concerns the Member may have regarding the claim, regardless of the claim type. Ongoing contact attempts will be made and documented in the claims system. Should subsequent attempts to contact the Member be unsuccessful, the Examiner shall contact the Team Lead of the Member Contact to gather necessary information.
II. Treating Doctor Contact – The Examiner shall contact the Treating Doctor or clinic within one business day of receiving the claim assignment to obtain medical status and advise the treating doctor they will be contacted within three business days by a Triage Nurse.
III. Employee Contact – The Examiner shall contact the IW within one business day of receiving the claim assignment to obtain the facts of the incident, confirm information, and explain benefits. In addition, the Employee will be notified that they will be contacted within three business days by a Triage Nurse. If the IW is initially unwilling to communicate with the Triage Nurse, the Examiner will discuss the value and benefit of the communication and attempt to encourage the IW to speak with the nurse. If the IW continues to refuse, the Examiner will document the claims file accordingly and notify the Triage Nurse. The IW will not be further contacted by the Triage Nurse. The Examiner will make two documented contact attempts within three business days of claim assignment.
IV. Should subsequent attempts to contact the IW be unsuccessful, the Examiner shall contact the Member to obtain alternate IW contact information.

Ongoing Contact

I. Continued IW contact by the Examiner will be conducted on all non-litigated Indemnity files and documented in the claim notes.

II. Indemnity files that have not been settled, subsequent contact with the injured worker shall occur as needed or at intervals not to exceed every 90 calendar days.

Examiners shall establish proactive diaries to follow up on contacts and maintain communication with all parties.

Coverage

Each year the JBWCP will provide a MOC to each Program Member.

The JBWCP does not file an annual report with Self-Insurance Plans (SIP) as they are permissibly uninsured per Labor Code (LC) 3700. For purposes of subsection (c) under LC 3700, the JBWCP has the same status as the state.

The Examiner shall verify the coverage period, and that coverage was provided to the member by JBWCP on the date of injury or illness in accordance with member program dates and governing documents. If applicable, Examiner shall exercise due diligence in joining applicable co-defendants. All activity to verify coverage and join co-defendants shall be clearly documented in the file notes.

For the majority of the Members, the JBWCP assumed liability for all injuries on or after January 1, 2001. Any issues of contribution between a court and a county are negotiated on a program-wide basis between the particular county and the JBWCP.

Decisions

Examiners are expected to make timely claim liability decisions in accordance with workers' compensation standards and state law.

I. The initial benefit notice informing the employee that the claim has been accepted, denied, or placed on delay, is due within 14 days of the claim date of knowledge (DOK). A claim note must document the decision contained in this initial notice.
II. If a claim has been on delay, a documented final compensability decision is due within 90 days of the DOK unless otherwise required.
III. A claim note must document both: (1) the final compensability decision made by the examiner; and (2) the supporting rationale/justification

Denials

All claims which are delayed or denied shall be done in keeping with all applicable statutory rules and regulations (and/or case law). All delays and denials should be reviewed and approved by the Claims Team Lead. Denials should be discussed with the Member prior to issuance. Reasons for denial shall be clearly documented on the claim. Member disputes or concerns regarding compensability decisions shall be escalated to the JBWCP Administrator, if necessary. Denial letters should be prepared by the Examiner and all necessary approvals should be documented on the original working document and the claim.

Examiners will establish proactive diaries to assure all delays and denials are managed within regulatory timelines.

Ergonomic Evaluation

Requests for ergonomic evaluations from the Primary Treating Physician, Panel Qualified Medical or Agreed Medical Evaluator will be referred to an outside consultant. The selection of the consultant will be discussed with the Member. All ergonomic evaluations will be referred to the JBWCP Approved Vendor list unless otherwise instructed.

ERGO EVALUATION REQUESTS AND ERGO EQUIPMENT ARE NOT TO BE SENT TO UTILIZATION REVIEW.

The Examiner will direct the consultant regarding the protocol for the assignment in terms of reporting instructions and recommendations for equipment. Requests for equipment will be reviewed by the Examiner to determine if approval will be granted and payment made from the claims file. The Examiner will discuss any equipment requests of concern with their Team Lead.

Basic office equipment such as pens, staplers, etc. (equipment to be used by other Court staff) should be paid directly by the Court. Equipment specific to the individual's injuries will be paid from the claim file. Questions regarding the appropriateness of payment of equipment will be escalated to the JBWCP Administrator.

Excess Recovery and Reporting

All excess reimbursements must be credited to the applicable file and include documentation in the activity notes to include the amount of recovery, additional recovery still owed by the excess carrier, and efforts undertaken to seek that recovery. Member concerns regarding

recovery reimbursements should be escalated to SC Team Lead staff for further discussion as necessary.

Excess reporting requirements may differ by coverage year. Please refer to the Excess Insurance schedule to ensure initial reports for the respective Member have been met in accordance with the appropriate policy period.

Examiners will establish proactive diaries to assure timely reporting of Excess files.

File Documentation

The following activities shall be documented: contacts (three-point, strategic claims discussion with any party-Member, administration, legal, medical, or internal staff), excess notification, reconciliations, referrals, verification, etc. A copy of written documentation (notices, letters, and reports) will be maintained in the applicable claim file.

All contacts with Members and IWs will be documented in the claims system. Updates to Members and IWs will be provided as needed and documented in the claims system.

This requirement shall apply to all standards contained in the guidelines.

Use of electronic claim files is appropriate only with the assurance that all claim file documentation can be re-created in hard copy as requested and access provided to the electronic claim files.

Fiscal Year

The state's fiscal year begins on July 1 and ends on June 30.

Future Medical (FM) Files

SC Examiners will review during their 180-day FM diaries, (include claims with permanent disability awards and FM) to determine the current employment status of IWs annually, the interest of the Member in settlement of Future Medical benefits for each IW, the feasibility of Future Medical Benefit settlements, and document in the file notes. SC will provide a report of FM Files closed and settled by C&R, and other relevant information in the Stewardship report at the annual Advisory Committee meeting.

With the exception of claims for Hearing Loss that include a requirement to provide Hearing Aids, claims that are awarded FM care, in which there has been no medical care or benefits provided, in the last 12 months can be administratively closed unless there is documentation of upcoming medical care expected within the next 12 months.

Claims for Hearing Loss in which there is a FM award requiring provision of Hearing Aids may be administratively closed if there is no medical care provided, or benefits paid in the last 24 months unless there is documentation of upcoming medical care or benefits expected within the next 12 months.

All FM claims must remain readily accessible and cannot be destroyed or deleted from the claims system.

Examiners will establish proactive diaries to manage future medical benefits and utilization review requirements.

Future medical claims will be evaluated every 180 calendar days to determine current employment and potential for settlement of the future medical award.

Index (ISO) Reporting

Indexing will be conducted for indemnity type claims and inception and every 180 days thereafter until closed. FM claims will be indexed annually. MO claims will be indexed every 180 days. All Index Reports will be reviewed and documented in the file notes.

Examiners will establish proactive diaries to assure timely request of Index Reports.

Investigations

All questionable claims shall be investigated in a prompt, thorough, and legal manner to determine compensability or to validate issues in question.

The Examiner is to identify the need for investigation and refer the case for same within five business days of receipt of claim or knowledge of questionable issues giving rise to the need for investigation. The Examiner is encouraged to conduct recorded statements on a case-by-case basis (excluding Judges) as some claims may involve more intensive statements required by an investigator. Should referral to an investigative vendor be necessary, this will be completed within five business days of receipt of member authorization.

Member authorization shall first be obtained before initiating any investigation. The authorization will be documented in the file notes of the claims file.

I. Coordination with the Member shall include discussing information on what vendor has been assigned, who will need to be interviewed, the next steps to be taken in the investigation, and the estimated timetable for completion.
II. All claims requiring an investigation shall be documented as such in the claim file, with an explanation of the issues, the reasons for the investigation, and the objective of the investigation.
III. All investigative assignments shall be documented in the file notes.
IV. All investigative assignments shall be made in accordance with any Member protocols or special procedures.
V. All investigative assignments will include a copy of the DWC 1, 5020, and all additional information (such as witness statements, accident reports, etc.) that will enable the investigator to prepare in advance for any statements or requests from witnesses.
VI. The investigative vendor is required to speak directly with the Examiner prior to initiating investigative activity to assure all available information has been provided. This documentation is to be clearly outlined in the file notes.

Sub rosa (surveillance) is designed to develop evidence to verify unsubstantiated facts or activities of IWs (e.g., the employer/client or other credible party advises that the IW is working somewhere else, engaging in activities that are in conflict with the injury or work restrictions, working while receiving temporary disability benefits, etc.).

I. Consideration of sub rosa investigations must be discussed with the Member prior to assignment.
II. All sub rosa assignments will require the Examiner to request and obtain a copy of the IW's court identification (badge) photo, if available, or other photo, which will be provided to the investigative vendor at assignment of the case.
III. All investigative assignments will include the specifics regarding the IW's work restrictions/abilities and the precise type of investigative activity required with a specific time limitation for the assignment.

To maintain the confidentiality of the investigative reports, distribution of these reports to any party must be done on a case-by-case basis and **ONLY AFTER** documented discussion with the Team Lead.

Examiners will establish proactive diaries to manage the investigation, vendor and resulting benefit decisions.

Issues/Concerns

It is REQUIRED, Examiners notify their Team Lead, and other key stakeholders such as the SC Client Services Manager, JBWCP Administrator, and Risk Consultant if a program issue arises.

The SC is responsible for notifying the JBWCP Staff if a Member is unresponsive to inquiries, including settlement requests.

Additional program issues may involve requests for loss control services, questions related to court charge-back costs, training for topics like ADA or FMLA, problems with their system access or report needs, and challenges with TPA staff.

Jurors

The Examiners should be aware of the distinction between Grand Jurors and Trial Court Jurors.

I. **Grand Jurors** are **not** covered under this program. Examiners are required to communicate to court contacts that Grand Jurors are not covered under the JBWCP and should be directed to the applicable county. Examiners should report related issues to the JBWCP Administrator and the Risk Consultant.
II. **Trial Court Jurors are** covered under the JBWCP and are associated with their respective trial court Member.

Legacy Claims

SC will review Open Unresolved Indemnity Claims with no companions, greater than five years from the date of injury, to finalize and settle. SC will provide a report of Legacy pending, settled, and closed claims, and other relevant information in the Stewardship report at the annual Advisory Committee meeting.

Liens

Examiners should continuously address and track outstanding liens (e.g., Opening EDD notifications/liens and Provider liens) in the POA and files notes. When a claim has been denied, then accepted, and if an EDD notice is received or bills denied, document these have been resolved/addressed. 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.

Use of the SC Lien Resolution Unit must be first consulted with the JBWCP and approved by the Member. The Member will be notified that there is an additional cost for this service.

Mail/Scanning

Incoming mail is opened, and electronically marked (or equivalent) with the date received.	Same business day as receipt	• Mail received outside of normal business hours may be marked as received on the next following business day.
Incoming mail is distributed by electronically indexing to an examiner or claim or through delivery to a specific office queue when initial indexing efforts are not successful.	Within one business day of receipt	• Legal mail is distributed to both the assigned examiner and their team lead for review, direction or discussion when needed. When appropriate, notify your team lead of other mail considered by office or client to be "priority". • Incoming physical mail or faxes are distributed on the same day as received. • Physical incoming checks should never be distributed to a colleague with "payment" authority in the claims system. • Regularly check SIR for receipt of new incoming claims information.
Continue efforts to index mail received in the office "queue" of SIR.	Several times daily	• Offices should establish, as appropriate, processes, responsibilities and schedules for retrieving mail delivered to the office "queue" of SIR. • Mail that cannot be successfully indexed is returned to the sender with a request letter for more information within five business days of receipt.
Review of SIR Inbox.	Several times daily	• Examiners and team leads should review their SIR queues several times daily, so they are aware of all incoming information. This helps to ensure claims colleagues are given the maximum amount of time to comply with

Any deviation from the Service Guidelines must be pre-authorized by the JBWCP and the authorization clearly documented in the claims file.

		jurisdictional and client requirements as well as Sedgwick Service Expectations.
Incoming correspondence received through SIR must be documented.	Within five business days of receipt However if the item is considered to be critical or legal/priority, the mail MUST be handled as soon as possible but no later than 1 business day after receipt.	• The following items are considered critical: o Requests for Medical Treatment (Utilization Review) o Maximal Medical Improvement o Impairment Ratings o Changes to Work Status and Restrictions, including Return To Work o Medicare Demand Letter o Notices from U.S. Department of Treasury • Examples of legal and priority mail for all offices are: o First Report of Injury / Loss o Awards and Orders o Notices of Hearing, Mediation, BRC or Arbitration o Summons and Complaints o Checks o Time sensitive documents such as interrogatory requests, requests to produce, subpoenas, applications for intercompany arbitration, etc..

Medical Exams

If an IW requests a Panel Qualified Medical Exam (PQME) but does not follow through in scheduling the PQME within the stated time frames, the Examiner will take no further action to prosecute the issue on behalf of the IW (unless it is deemed necessary for the Examiner to select a PQME to move issues forward or as required by state law).

The Examiner is responsible for obtaining/subpoenaing previous medical records and/or claims and forwarding the information to the Agreed Medical Evaluator (AME)/PQME prior to the examination.

If SC scheduled the PQME and it is cancelled, or the employee is a no-show, the Examiner will contact the IW to reschedule the appointment. Upon receipt of a medical report that provides work restrictions, permanent and stationary status, or discharge from care, the Examiner is required to provide this information to the Member contact within five business days.

Examiners will establish proactive diaries to manage the PQME process in a timely manner, assuring all applicable medical reports are provided to the evaluating physicians in advance of the exam date.

Examiners will also follow up on any items identified by the AME/QME that require additional action in order to complete the evaluation, such as sending the employee for additional diagnostic testing.

Medicare Set Aside

Use of SC Medicare Set Aside (MSA) services is required. The Examiner will request authority from the Member for referral of Medicare Set Aside (MSA) services and provide an estimate of cost for these services.

Examiners will establish proactive diaries to timely manage the MSA process, including the referral for MSA services, follow up on reports, and benefit decisions.

Nurse Case Management

Should the severity of the injury or illness warrant, the Examiner may obtain Nurse Case Management (NCM) or telephonic NCM services to aid in their management of the medical aspect of the claim as well as physician contact to ensure appropriate care is provided.

Authority from the Member must be obtained prior to referral for these services. The Examiner will advise the Member that there is an additional cost for NCM services and discuss the benefits and risks of utilizing NCM services. This discussion will be specifically noted in the claims file by the Examiner.

Examiners shall document claim files at 60 days of the SC 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. Examiners will consult with their Team Lead regarding continuing case management and document in the file.

Out-of-Office Notification

For the purpose of maintaining the continuity of claims administration, when out of office, all parties involved with the JBWCP should place an out-of-office message on their email and phone that informs when they will be away from their desk for a half day or more.

The out-of-office communication should include: the name and contact information for the person covering their desk. Key SC staff must inform Members and JBWCP Administration when they will be away from the office for more than 48 hours and provide an interim contact person.

If any SC staff has an unplanned absence, the next level staff is responsible for updating all forms of communication accordingly and contacting the Member and JBWCP Administration if necessary. Every effort should be made to meet deadline commitments. If deadlines are not able to be met, inform the Member and/or any other party expecting the response.

Payments

I. The JBWCP Administrator shall be notified of payments over $25,000 for funding purposes.
II. No payments to vendors will be authorized and/or made without a claimant name and claim number on the invoice.
III. AME/PQME bills will be subject to fee schedule through Bill Review.
IV. Permanent Disability (PD) Advances - All lump sum PD advances will be reviewed and considered by the SC Team Lead. Following potential approval of the advance, the Member will be contacted to discuss the plan to provide the advance as well as the purpose, advantage, or risk of providing the advance.

Team Lead's approval and discussion with the Member will be documented in the claims file. Any concerns expressed by the Member regarding the advance will require immediate notification of the JBWCP Administrator and SC Client Services Manager.

Examiners will establish proactive diaries to manage upcoming disability due to surgeries and scheduled time loss, anticipated PD advances and settlements.

Any deviation from the Service Guidelines must be pre-authorized by the JBWCP and the authorization clearly documented in the claims file.

Penalties & Overpayments

Late payments of all benefits must include the self-imposed increase in accordance with LC 4650. If SC is responsible for the penalty/increase, they are paid with a specific SC code and the file will not be charged, this includes any court ordered penalties.

The Examiner is responsible for identifying overpayment of benefits and notifying their Team Lead to add the overpayment to the Reimbursement Log.

The Examiner shall be responsible for attempting the collection of any overpayment of any benefit. In the event SC is unable to collect the overpayment, SC may be responsible to reimburse the JBWCP for the amount of the overpayment if the basis for the overpayment relates to an error made by SC.

Attempted recovery will be documented in the claims file.

It shall not be assumed or considered a standard practice that all overpayments will be deducted from any outstanding permanent disability or a consideration for New and Further on a future claim. Appropriate benefit notification to the IW seeking credit shall be sent to preserve all rights of recovery. Any overpayment not recovered may not be waived without approval of the JBWCP Administrator. Overpayments which have not been recovered will be evaluated by SC for reimbursement to JBWCP.

The SC Client Services Manager shall maintain a log of all identified overpayments, penalties, etc., and provide a monthly report to the JBWCP Administrator and/or designated staff of overpayments, including a plan of action for reimbursement.

All overpayments or will be documented in the viaOne Overpayment tab. Self-imposed increases (penalties) or Court ordered penalties will be tracked by the Operations Manager. The Examiner and their Team Lead are responsible for notifying the SC Client Services Manager and JBWCP staff of any identified overpayments, self-imposed increases or penalties.

The Examiner is responsible for maintaining the accuracy of the viaOne Overpayment tab, documenting new and resolved/recovered items.

Plan of Action (POA) Documentation

Each claim file shall contain the Examiner's POA outlining the strategic steps to be taken to bring the claim to conclusion. Action plans must be updated at least every 90 calendar days, allowing a two-week grace period for completion on active indemnity claims upon which

indemnity benefits are being paid or are at issue, or whenever a material event has occurred that will significantly affect the outcome of the claim.

Action Plans must be updated at least every 180 calendar days, allowing a two-week grace period for completion on future medical claims

Action Plans must be updated at least every 120 calendar days, allowing a two-week grace period for completion on Medical Only (MO) claims.

Action Plans will be identified as such in the file notes.

Official Disability Guidelines (ODG) will be clearly documented and referenced for ongoing resolution and reserving in indemnity claim files. The primary intent for utilizing disability duration guidelines is to provide a mechanism to Examiners to track an employee's advancement toward either: (1) full duty status; or (2) to a release with permanent restrictions, and to assist Examiners to identify those claims requiring specialized attention and course adjustments. Ultimate responsibility for ensuring identification of, and management against, ODG should reside with Examiners on all indemnity claims (whether or not a Nurse Case Manager is assigned) with the exception of claims with no disability component. If the ODG is not utilized on a claim with a disability component, the file notes must contain supporting documentation. Where disability benchmarks are likely to be exceeded, Examiners should include within their plan of action as to how disabilities will be managed in the future to include the potential for assignment of claims for nurse case management. ODG documentation will be excluded on claims where indemnity exposure has no potential or is no longer possible. ODG documentation is also unnecessary on claims that are only open for future medical, life pension, or permanent total disability benefits.

The Examiner will establish and document in the claims system Return-to-Work target dates for both modified and full duty on all indemnity claims involving lost time, referencing these targets as files are reviewed for ongoing plans. File documentation will indicate review of those claims exceeding target dates with consideration of medical case management services as necessary.

Action Plans must include specific target dates with corresponding proactive diaries to include, but not limited to projected case resolution; anticipated surgeries and/or hospitalizations.

Examiners will establish proactive diaries to support the Plan of Action outlined in each file.

Program Contacts

JBWCP Administrator

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Re-Opened Files

When re-opening files, the Examiner will:

I. Review and establish reserves based on "probable outcome" known at the time of reopening.
II. Review the Occupation Code and Location (at the Date of Injury) and make any necessary corrections.

Reserving

Reserves will be based upon probable outcome and case resolution. Self-insured reserving guidelines are not a requirement of the JBWCP. File documentation must support the reserves established on every file.

Any deviation from the Service Guidelines must be pre-authorized by the JBWCP and the authorization clearly documented in the claims file.

Reserves must include a detailed evaluation documented in the system. Reserves must be evaluated at the following intervals:

I. Initial (preliminary) reserves are to be set within five business days from the date of receipt of claim.
II. Reserves must be reviewed 90 calendar days from date of receipt and every 90 calendar days thereafter (with POA updates).
III. Reserves must be reviewed 14 calendar days from receipt of medical information or a report indicating a change such as extending disability, finding of permanent residuals, receiving notice of any fact which influences the dollar value of the claim, or receiving information that may significantly alter the course or cost of the claim. The reserve review should not be delayed until the next diary date.
IV. FM claims shall maintain reserve evaluations no less frequently than every 180 calendar days (with POA updates).
V. FM claims will be reserved based upon the PROBABLE OUTCOME of the case and medical care relative to the specific file as identified by the examiner's judgement and experience. Life Expectancy can be included as part of the analysis on a case- by-case basis, but it is not a formula calculation.
VI. When combining settlement of previously administratively closed FM files with more current open files, reserves must be established based on the probable outcome of the settlement for each file when settlement exposure is recognized, and no later than at the time of submission of the Settlement Authority Request/Notification (SAR) form.

Return Calls/Respond to Members

Examiners/Team Leads will return phone calls and respond to emails from Members and injured workers within one business day.

Settlement Authority Level Guidelines

All settlement authority amounts shown in Levels I through III are "new money" expected to be paid after the Response Date on the SAR and do **not** reflect money that has already been paid out or advanced against the settlement.

Level I: SC shall have full authority to settle and approve all Compromise &Releases and Stipulations with Request for Award settlements for any Member up to and including **$10,000. SC** shall notify the Member for claims by its covered employees/volunteers at least 10 court days prior to finalizing the settlement offer. If the Member does not agree with the proposed settlement, the Member must contact SC within the allotted 10 court day period.

The SC Team Lead will email the SAR to the court with a copy to the JBWCP Administrator's assigned analyst for the trial courts or directly to the analyst for the judiciary claims. The subject line will include the claimant name, claim number, and Advisory Settlement Notice. File documentation will clarify any time these timelines cannot be met.

Effective May 1, 2023, to streamline and expedite the process, the SC Team Lead will email to the court, Level I SARS with **no PD (no new money) and future medical** only but will not wait the 10 days for a response from the courts and will copy the JBWCP Administrator's assigned analyst for the trial courts or directly to the analyst for the judiciary claims. This change will only apply to Level I SARS with no permanent disability (no new money) and future medical only.

Level II: The **Member** shall have full authority to settle and approve all Compromise & Releases, and Stipulations with Request for Award settlements for claims by its covered employees/volunteers **from $10,001 up to and including $100,000.** The Member must review and respond to the SAR within 10 court days following the SAR's Request Date.

The SC Team Lead will email the SAR to the court with a copy to the JBWCP Administrator's assigned analyst for the trial courts or directly to the analyst for the judiciary claims. The subject line will include the claimant's name, claim number, and Level II Settlement Request. File documentation will clarify any time these timelines cannot be met.

Level III: A **Settlement Authority Panel**, consisting of four voting JBWCP Advisory Committee Members who are not directly involved with the settlement, and the JBWCP Administrator or Designee, in consultation with the JBWCP Member that has received a claim made by its covered employees/volunteers, shall exercise **final decisional authority** over the settlement and approval of Compromise & Releases, and Stipulations with Request for Award for proposed settlements **above $100,000** or when a **dispute** or **impasse** arises.

The SC Team Lead will email the SAR to the JBWCP Administrator, the assigned analyst for the trial or judiciary claims, Risk Consultant, involved Member, and JBWCP general email: jbwcp@jud.ca.gov., with response required within 10 court days of the SAR's Request Date. The subject line will include the claimant's name, claim number, and Level III Settlement Request. File documentation will clarify any time these timelines cannot be met. Once the JBWCP Program Administrator has determined no additional information is needed, the JBWCP Administrator will send the SAR to the panel and involved Member, and the panel meeting will convene within 10 court days following the SAR's Request Date.

Examiners will establish proactive diaries to assure the settlement process timelines are met, specific proactive diaries will be set to assure submission of SARs to Members and 10 Court days prior to any Hearing, MSC or Trial.

Guidelines Applicable to All Authority Levels

Any party who disagrees with a settlement decision made in any level in this process may escalate the decision to the next authority level or the Level III Settlement Authority Panel to make a final decision.

All approved settlements that will exceed the Excess Insurance Coverage Levels will also require authorization of the Excess Insurance Carrier and should be discussed with the JBWCP Administrator.

Settlement Requests

Examiners will not offer settlements prior to receiving complete settlement authority. Examiners will complete the SAR within 30 calendar days of the occurrence of a "triggering" event" (e.g., receipt of MMI/P&S report, clarification/additional information needed is received, request from the DA, etc.). If there is an upcoming Hearing, MSC, or Trial, the Examiner will provide the SAR to SC Team Lead within 20 calendar days, to allow ample time for both Team Lead/Member to review and approve.

Within 10 calendar days within receipt of the SAR from the examiner (total 40 calendar days of the occurrence of a "triggering" event), and 10 Court days prior to any Hearing, MSC, or Trial, the SC Team Lead will submit the SAR to Members for approval, with a copy to the JBWCP Administrator's assigned analyst for the trial courts or directly to the analyst for the judiciary claims. File documentation will clarify any time these timelines cannot be met.

Due to the varying approval processes with each Member, the necessity to provide a settlement outline and authority request as soon as possible is imperative. Settlement requests shall be submitted using the JBWCP standardized SAR form. Each request shall contain a summary of the claim, an explanation/rationale for the recommended settlement amount, claim cost to date, and projected costs. Once reviewed and approved by the SC Team Lead, the SAR will be forwarded based on the appropriate level of authority, as outlined in the Settlement Authority Levels Guideline section above.

SARs will include all outstanding issues, whether or not they are resolved by the proposed settlement (EDD liens, all outstanding liens, any issues remaining in dispute or in litigation). The Examiner and Team Lead are responsible for timely follow-up with the Member to obtain a response to the SAR. Should the Member remain non-responsive, the matter shall be referred to the SC Team Lead and SC Client Services Manager to escalate the issue to the JBWCP Administrator for intervention as appropriate, within the settlement guidelines. If unable to obtain authority within the allotted time, the next settlement authority level (or their designee) may authorize the settlement.

Any deviation from the Service Guidelines must be pre-authorized by the JBWCP and the authorization clearly documented in the claims file.

In the event of a disagreement on the proposed settlement, SC, the Member, or the JBWCP Administrator, may escalate the settlement request to the next level.

All SARs provided to the Members must be reviewed, signed, and returned to SC in a timely fashion. If the requests are not returned within 10 court days, the next settlement authority level (or their designee) may authorize the settlement.

Request for settlement should never be made a day before or the day of a formal appearance at the WCAB. All settlement requests must be coordinated through the Examiner. Defense counsel is not to request settlement authority directly from the Member, without involvement and in coordination with the Examiner. The Member is requested to make every effort to timely address all settlement requests within 10 court days. If discussion with the JBWCP or any other party to the claim settlement is desired, a conference call should be coordinated with all parties in a timely manner. All settlement requests for the Courts will be copied to Maria Kato and the JBWCP general email: JBWCP@jud.ca.gov.

While SC **does** have settlement authority for resolution of EDD and liens, discussions with the Member regarding these outstanding issues and resolution plans will be documented in the claims system and included in Claim Reviews. Settlement of litigated contribution issues will require a SAR and follow the monetary Settlement Authority levels.

Staffing Changes

The JBWCP Administrator and Risk Consultant are to be notified by the SC Client Service Manager when Examiner or Team Lead changes occur. Notifications should occur within 72 hours of SC notice.

SC will coordinate with the JBWCP Administrator any necessary communication or Member distributions necessary as a result of the change in staffing.

Subrogation

Every effort will be made to identify and pursue subrogation recovery at the onset of the claim investigation. Once subrogation potential is identified, the Examiner should discuss the recovery with the respective Member and document the decision and rationale to pursue in the claim file notes. The claim file notes should contain specific information regarding the identification and pursuit of subrogation issues, including documentation of the decision to pursue or not to pursue.

The rationale regarding pursuit of subrogation must be included in the POA documentation until the claim has been resolved.

In some cases, Member subrogation may need to be pursued with the respective county. Should county subrogation be identified, but pursuit of recovery is decided against by the Member, the matter should be brought to the attention of the JBWCP Administrator for direction and assistance. Authority for compromised settlement of the Third-Party Lien must be obtained from the JBWCP Administrator.

Per the MOC, the Member does not have the authority to waive subrogation recovery without approval from the JBWCP.

Use of legal counsel or the SC Subrogation Unit for pursuit of subrogation recovery must be first consulted with the JBWCP and approved by the Member. Documentation of the rationale for assignment of either an attorney or the SC Subrogation Unit will be documented in the file notes.

Examiners will establish proactive diaries to manage subrogation timelines.

Team Lead Review/Diaries

When a Team Lead is reviewing a file, the Team Lead will include an activity note documenting their review, findings, and any action items needed and the expected date of their next review. Below are guidelines for Team Lead diary review:

I. 10 calendar day Team Lead review/Indemnity Initial Review.
II. Indemnity Subsequent Review within 90 calendar days of initial Team Lead review, followed by reviews every 120 calendar days throughout the life of an active indemnity claim, allowing for a two-week grace period. This review will include documentation of the use of NCM services and their continued value to the case.
III. FM Reviews and ongoing Indemnity subsequent review at a frequency no greater than every 180 calendar days thereafter, allowing for a two- week grace period.
IV. MO claims will be reviewed by the Team Lead within 90 calendar days of file set up and at 120-day intervals, allowing for a two-week grace period.

Team Leads will establish proactive diaries to follow up on specific cases or issues as necessary.

Judicial Branch Workers' Compensation Program
Sedgwick Claims Managed Care
Managed Care Guidelines
(January 2025)[2]

SC Medical Case Management Services

I. Nurse Triage: Initial early medical review of injury and treatment needs
II. Nurse Case Management (NCM)
    a. Telephonic Case Management (TCM): Proactive oversight of treatment and return to work activities via phone.
    b. Field Case Management (FCM): On-site nurse intervention with injured worker, providers, and Members. This will generally be short-term task assignments only.

Nurse Triage

The Examiner will review all first reports of injury within one business day of reporting and make the initial contacts with the employee, treating doctor and employer. The employee and treating doctor will be informed they will be contacted within three business days by a Triage Nurse. If the employee is unwilling to communicate with the Triage Nurse, the Examiner will discuss the value and benefit of the communication, document the claims file accordingly and notify the Triage Nurse if contact can continue. Continued Nurse Triage services require examiner referral.

The Triage Nurse will contact the employee and the treating doctor and document the claim file within three business days. The Triage Nurse interviews the employee and/or medically evaluates the first report of injury and any available medical documents. Assessment nurse will confirm diagnosis supports mechanism of injury, compliance with medical treatment, satisfaction with care, assess for red flags/barriers and evaluate need for additional clinical resources. The Triage Nurse will document the following and provide updates directly in the claim file: outlining appropriate treatment and estimated return to work using Official Disability Guidelines (ODG) and American College of Occupational and Environmental Medicine (ACOEM), review work status and availability of accommodations, treating Physician's treatment/disability Plan and their recommendation. If there are red flags such as

[2] Last updated February 2023

previous injuries or co-morbidities, case management may be recommended with specific goals.

Cases involving judges are not triaged without approval from Jade Vu.

All communication with the Injured Worker will be clearly documented in the Claims System and noticed to the Examiner.

The Triage Nurse will do the following:

I. Obtain availability of transitional work and description of injured worker's job duties.
II. Review the ODG and ACOEM for treatment guidelines.
III. Complete assessment of information received and recommend the appropriate level of NCM, if necessary, based on pre-selected TCM and FCM nursing triggers.
IV. Document activities in Via One and the claims system.
V. Follow up with the Examiner with specific recommendations if additional clinical resources are warranted. Examiner to communicate with the member as needed.

The Examiner, in consultation with the Member, will determine if TCM or FCM is necessary and appropriate. If the Member disagrees with the Examiner's recommendation and the SC examiner is strongly recommending NCM, it may be necessary to escalate concerns to the JBWCP Administrator for further dialogue/consideration.

Nurse Case Management

Nurse Case Management (NCM) will be assigned according to case management protocols and by agreement between the Examiner and the Member.

All communication with the Injured Worker will be clearly documented in the Claims System and noticed to the Examiner.

I. Assignment can occur at any point in the life of the claim.
II. The level of assignment (TCM vs FCM) will be analyzed depending on severity of the case, treatment needs, lack of progress in recovery, and other various employee/provider issues.
III. The Examiner's recommendations for case management will be discussed with the Member prior to assignment.
IV. The Examiner will advise the Member that there is an additional cost for NCM services and discuss the benefits and risks of utilizing NCM services. This discussion will be specifically noted in the claims file by the Examiner.

V. Three-point contact will be completed by the assigned nurse case manager (CM) who will assess any barriers, develop an action plan to address the barriers and bring file to resolution
VI. Should the severity of the injury or illness warrant, the Examiner may continue NCM services to aid in their management of the medical aspect of the claim as well as provide physician contact to address concerns and ensure appropriate care is provided.

NCM reports shall include the medical treatment plan, next appointment date, work status, barriers to recovery, and NCM recommendations. NCM will use standard of care guidelines to facilitate optimum recovery and RTW. The CM will track all lost time, modified and RTW dates within the claims system. If the case is assigned for TCM, but the injured worker has lost more than 60 days from work, or if there are other barriers to recovery or Return to Work (RTW) noted, the case should be considered for FCM.

Reporting will be completed after every appointment or significant activity. Staffing with Examiner and Team Lead will be completed at 90-day intervals and will be noted in the claims system.

The Examiner remains in control of the file and provides direction to NCM staff. The Examiner will remain the primary point of contact for communications with the Member. The primary case management goal is to provide the best possible care upfront and help transition employees to return to work.

Case Management Goals include:

I. Work closely with the claims staff and report any significant changes within 1 business day.
II. Facilitate care, motivate, and educate the injured employee on injury and RTW.
III. Obtain restrictions and facilitate transitional return to work.
IV. Address RTW guidelines with provider and discuss treatment options.
V. Coordinate services for IW.
VI. Communicate with Examiner.
VII. Identify barriers and provide solutions.
VIII. Assure safe and timely return to work.
IX. Assist with file resolution.

TCM and FCM Protocols

All communication with the Injured Worker will be clearly documented in the Claims System and noticed to the Examiner.

Any deviation from the Service Guidelines must be pre-authorized by the JBWCP and the authorization clearly documented in the claims file.

I. CM will initiate services within one business day of referral.
II. The CM shall contact the medical provider, and injured worker three times within five business days, and all contacts will be documented in the AMC system.
III. First progress report will include:
    a. Brief description of the accident/injury.
    b. Date of next medical exam, diagnostic testing, surgeries, etc.
    c. MTUS guidelines and ODG guidelines for treatment and RTW.
    d. Current work status substantial off-work status, including any restrictions.
    e. Medical Provider's anticipated RTW date.
    f. Diagnosis, prognosis, and treatment plan.
    g. Specific NCM action plan with target dates.
    h. Identification of unrelated treatments, conditions, and barriers to RTW.
IV. The initial evaluation is completed within seven business days from referral.
V. Progress Reports will be completed every 30 days or significant activity.
VI. Appointment updates to Examiner within one business day of appointment.
VII. Updates on any significant file changes within one business day: RTW modified or full duty, anticipated surgery or anything that may impact the file.
VIII. Closure Report to be completed upon file closure within five days.
IX. CM cases will be staffed with Examiner and Team Lead when case reaches 90 days of service. The staffing must include:
    a. CM goals for resolution.
    b. Action oriented plans with timeframes.
    c. Expected outcomes.
    d. Projected Closure date.
X. File notes will be documented in claim system and AlliedConnect.

Closure Criteria

I. Injured worker has successfully RTW full duty.
II. Injured worker has RTW in a permanent modified position.
III. Injured worker is declared Permanent and Stationary (P&S)/Maximal Medical Improvement (MMI).
IV. Claim is denied.
V. No impact can be made on file.
VI. Request from Examiner.
VII. Task assignment completed.

Any deviation from the Service Guidelines must be pre-authorized by the JBWCP and the authorization clearly documented in the claims file.

Case Management – Re-referral

Cases that were initially closed for NCM may be re-referred. The Examiner will review file to determine need for case management. As with the initial referral, Examiner will discuss and obtain agreement with Member prior to re-assignment.

Medical Provider Network (MPN)

The JBWCP utilizes the SC MPN. This Medical Provider Network is an elective network in which the Member can participate. Participation is strongly encouraged for all Members in order to maintain and minimize medical cost impacts to the JBWCP pooled program fund.

Any Member inquiries regarding tailoring the MPN provider participation should be directed to the SC Client Services Manager.

Members with concerns regarding the service provider by any MPN provider should be escalated to the Client Services Manager for follow-up. When appropriate, the Client Services Manager will address concerns and the potential action or removal of the provider.

Pharmacy Benefit Program

JBWCP Members use a pharmacy network program for all prescription drugs. The Pharmacy Benefits Network is Optum.

All communication with the Injured Worker will be clearly documented in the Claims System and noticed to the Examiner.

I. First Fill forms are provided by the Member entity at the time of injury.
II. Prescription drug cards are sent automatically when an open-accepted claim status is received by the PBM from Juris. Eligibility is transmitted to the BPM every 30 minutes through web services interfaces. Prescription cards are emailed to the claimant within 1-2 business days of receipt of an open-accepted claim.
III. Cards are automatically closed once a claim is received in a status other than Open-Accepted. The closure happens immediately upon receipt of the claim status indicating the claim is closed. Eligibility is transmitted to the PBM every 30 minutes through web services interfaces.
IV. The Examiner, through the PBM portal can request new cards, allow medications, deny medications, and respond to prior authorization requests.
V. Our formularies are structured with our PBM partners for all non-exempt medications to stop for prior authorization required in CA. For a client setup to utilize pharmacy UR,

there is a smart routing list that is referenced. If the medication is on the list to be sent to pharmacy UR it will be routed automatically within the PBM system to go to Pharmacy UR. All other medications will route to the Examiner in the PBM portal. If the client doesn't use PUR, all requests will be routed in the PBM portal to the claims examiner.

VI. Authorization requests are typically sent to us in two manners. We received RFAs directly from the prescribing physician. These are typically addressed by the Pharmacy UR team. Once reviewed the PUR nurse will update the PBM portal system with a decision and that decision is applied when/if the prescription is taken to the pharmacy. If no RFA is requested the process in V. above will be followed. Our Pharmacy UR process may include outreach to the prescriber to obtain medical notes, RFA and any other pertinent supporting documents required to enter a decision. The Examiner can also request that information if they receive the alert as well and then may use that information to enter a decision on the request or forward to a pharmacy UR nurse to review.

UR Referral Criteria

If not specifically listed as "Examiner May Authorize" referral to UR is required.

Authorization Requested	Examiner May Authorize
Ancillary Services (Home health care/aide; nursing care)	NO AUTOMATIC AUTHORIZATIONS. May need CPT codes or pre-negotiated price.
Blood Work	Routine Blood Work to monitor side effects of medications (Rx) on long-term basis; blood work to monitor risk factors (ex. Lipid panel) in presumptive cases.
Diagnostic Testing	Carpal tunnel evaluations (All) - if no pre-existing problems or co-morbidity factors
	MRIs and x-rays
	Stress test/EKG for presumptive cardiac cases
	DME less than $800 (All)

Any deviation from the Service Guidelines must be pre-authorized by the JBWCP and the authorization clearly documented in the claims file.

DME Non-Surgical	Hearing Aids less than $800
	Exercise Equipment with a value less than $500
DME Surgical	Braces (includes back and knee)
	Cane
	Cervical Collar
	Commode 3 and 1, elevated or seat extender
	Crutches
	Hospital Bed
	Knee Scooter
	Reacher (Long handle)/hip kit includes Sock Aid
	Transportation
	Tub Seat, bench or shower chair
	Walker with or without wheels
	Wheelchair
Misc. Request (Weight loss services, biofeedback, drug rehabilitation, non-emergency dental services, computerized muscle testing, uncommon or experimental services or devices)	NO AUTOMATIC AUTHORIZATIONS.
Physical Medicine -	Passive or active therapy for no more than 12 visits
Acupuncture	Post Op - Initial physical therapy up to 12 visits.

Any deviation from the Service Guidelines must be pre-authorized by the JBWCP and the authorization clearly documented in the claims file.

Chiropractic Care Massage Therapy Occupational Therapy, Physical Therapy	
Specialty Referrals	Head injury or head trauma - authorization for referral to Neurologist upon recommendation of treating physician at initial consultation.
Consultations	Initial Orthopedic referrals
Surgical Procedures	NO AUTOMATIC AUTHORIZATIONS.

Judicial Branch Workers' Compensation Program Litigation Management Guidelines (JANUARY 2025)[3]

Litigation Management

I. The Examiner is to maintain litigation control and direction of the legal aspect of the claim until case resolution.
II. The Examiner will contact Applicant Attorney (AA) upon receipt of Application or Notice of Representation, if appropriate. File notes must contain supporting documentation if no initial contact with the AA is made.
III. All direction and communication with defense attorneys will be documented in the file notes.
IV. The Member will discuss concerns regarding the defense attorney's responsiveness and/or ability to work under the direction of the Examiner with the third-party administrator (TPA) Team Lead and escalate as necessary.
V. The Examiner is expected to maintain close contact with both the Member and defense attorney during litigation proceedings.
    a. The Examiner will communicate all court dates, appearances, or depositions to the Member.
    b. The Examiner will involve the Member in preparation for upcoming court dates or appearances.
VI. Defense attorney bills will be reviewed for accuracy prior to payment. Any discrepancy will be documented and discussed with the defense attorney for correction. Discrepancies and resolution will be documented in the file notes.
VII. The Examiner is expected to obtain a litigation budget from the defense attorney. If one cannot be obtained, then the Examiner will escalate, and if there are any changes to the legal strategy, ensure the reserves are changed.
VIII. Consideration for Mediation must be discussed with SC Team Lead and JBWCP staff prior to proceeding.

Attorney Assignment

I. Defense attorney assignment will NOT be automatic upon receipt of notice of litigation from the claimant.

[3] Last updated February 2023

II. The Examiner will discuss case specific issues with the Team Lead to determine the need for a defense attorney prior to referral.

III. The Examiner will obtain the Member's feedback regarding the assignment of an attorney. The Examiner will refer to individual Member instructions for the Member's choice of attorney and member-specific communication requirements. Member disputes or concerns regarding attorney assignment shall be escalated to the JBWCP Administrator, if necessary.

   a. If there are no specific instructions, or the Member is unresponsive despite reasonable follow-up attempts, the Examiner is to use their best judgment on choice of attorney, utilizing the Approved Vendor list.

Litigation Referral

I. The litigation referral will be sent within five days of need of litigation referral, and will include information specific to the case including:

   a. Case status;
   b. Specific defense services requested;
   c. Attorney requirements, including the requirement to follow the direction of the Examiner;
   d. Notification of the JBWCP selected copy service vendor to be utilized; and
   e. Timelines for reporting expectations.

II. Walk-through referral will require Member authority. Examiner will provide cost estimate.

Attorney Requirements

I. All information received by the defense attorney will be timely communicated to the Examiner following the stated timelines:

   a. Awards/Orders – immediate notification;
   b. Medical/Legal Reports – notification within 10 calendar days to allow for timely benefit administration; and
   c. Hearing Notices – Notification within 10 calendar days to allow for preparation and communication with Members.

II. Reporting:

   a. Initial detailed report on compensability is due within 30 days from receipt of the case assignment, to include an opinion as to compensability, financial exposure, and defense strategy as well as a litigation budget.

b. Follow-up 30-day reports will be generated by the defense attorney until the case is resolved.

III. Cases will NOT be transferred from one attorney to another within the same firm without discussion and agreement of the Examiner and Member.

IV. All settlement recommendations will be presented to the Examiner with a detailed explanation supporting the recommendation.

a. The attorney will include the Examiner in settlement discussions prior to submitting settlement recommendations to the Member.

Claim Reviews

I. Defense attorney's participation in a Claim Review is at the Member's discretion and should be on an "as needed" basis.

II. Defense attorneys will NOT bill either the claims file or the JBWCP for their participation in a claim review.

III. Information supplied by the defense attorney during the review will be coordinated with the Examiner.

The defense attorney's participation will be to provide subject matter expertise as requested.