Attachment A-State of Alaska
Division of Risk Management
Workers' Compensation TPA Policy & Procedures

All Report of Injury or Illness forms (ROI) will be entered into the claims management system as a Notification Only (NO) and then advanced to a Medical Only (MO) or Time Loss (TL) claim, if deemed appropriate.

Risk Management utilizes a claims management system that implements electronic data interchange (EDI) for the submission of all ROI's to the Alaska Department of Labor and Workforce Development's Division of Workers' Compensation (ADOL WC). All new claims must have an initial FROI 00 transmitted for an AWCB number to populate within the claim.

Should the claim be advanced to a MO or TL claim, after the claim is converted to the new status, a FROI 02 must be *immediately* completed to update ADOL WC as to the claim status and current claim number.

All subsequent reporting must be completed through EDI (where applicable) and follow the required ADOL WC procedures, which are regularly updated on their website http://adoledi.info/.

It is the responsibility of the third-party administrator (TPA) to follow-up as to the acceptance of the EDI reporting via Risk Management's claim system. If a report has rejected in error, the TPA is required to refile the report and retransmit it in a timely fashion, keeping with the requirements of ADOL.

New Claims

- All claims must be set up within 24 business hours of the date received to ensure timely contact and proper investigation.
- Claims are assigned to an adjuster when notice of a potential assignment is received, available information is entered online, and the assignment is confirmed from an authorized source within 24 hours of the date received to ensure timely contact and proper investigation for claim determination.
- Mandatory entry items for Claim Set-Up will have a red asterix * next to the field in RK.
    - If one of these mandatory items is not available on the ROI, send an email request to the supervisor, employee, or State of Alaska Employee Call Center (employeecallcenter@alaska.gov).
    - If the employee is new hire/rehire who is missing time from work, and their contact is not in Riskonnect, you can set the claim up and file a FROI 00 which will populate the employee address so the new claim paperwork can be sent out.
    - New hires/rehires are usually available in Riskonnect within 2-3 weeks.

Detailed claim records will be established in the claims management system consisting of all records gathered within the course of claim adjustment, to include report of injury, photos, audio files, and activity recorded as claim notes.

Contacts

- An **initial** contact is made with each injured employee within one (1) business day.
    - Inquire as to the status of other wages and/or jobs during the initial contact and/or recorded statement.
    - Inquire as to the status of any time loss or medical treatment being received due to the injury.
- Employer and treating physician are contacted within two (2) business days.
- All initial contact efforts to employee and providers shall be made telephonically. Telephonic efforts are repeated for two days with an e-mail (if available) also sent on the 2nd day. If no contact has been made, a written letter can be sent on the third day. Contacts are to be pursued until initial contacts are accomplished.
- Employers may be contacted via email, if they have indicated that is their preferred method of contact.
- Initial contact efforts and results are to be clearly and timely documented in the claim file notes. Unsuccessful efforts are also clearly and timely documented in the claim file.
- Every effort should be made to take recorded statements (using professional standards and methods) of witnesses, claimants, and others to establish and maintain a record of the facts regarding the events or damages involved. Provide the appropriate investigation, records gathering, payment and adjustment of all claims. All recorded statements must be uploaded to the claim file in a useable format within one week of completion.

Phone Calls

- A designated person must be assigned to answers incoming phone calls during working hours (8:00AM-4:30PM Alaska Standard Time).
- All voicemails must have a return call made within 1 business day.
- A note must be placed in the claims management system documenting the attempt to return the call or detailing the conversation that took place.

Investigations

- Review, analyze, and evaluate the issues of compensability, scope of employment, controversion, and the employer/employee relationship as each claim relates to the Alaska Workers' Compensation Act, regulations, and remedies.
- The adjuster should use good judgment on a factual basis and shall not rely solely on the Agency or Supervisor's determination of compensability. Any questions on

compensability or scope of employment may be referred to the AGO for review and recommendation. Files must be clearly documented.

- Recognize evidence that may be favorable to the State's legal defense in a claim and take necessary steps to safely preserve the legal "chain of custody" whenever possible.
- Clearly document the initial investigation, the determination of coverage and compensability prior to the first payment of benefits.
- The file should clearly reflect the adjuster's decision in accepting or controverting the claim.
- Controversions for medical reasons must be documented by a medical opinion.
- Recorded Statements or interview are obtained on claims, especially those involving questions of coverage, compensability, category claims, subrogation and any other claims where the adjuster and supervisor deem necessary to substantiate or refute material issues.
- Releases for medical benefits and public records are requested within two (2) business days and obtained timely.
    - Initial releases are to be sent by certified mail.
    - Collect two years of prior health records relevant to the employee's injuries.
    - Calendar the receipt of releases within 14 days to assess the ability to suspend benefits under AS 23.30.18(a).
    - Review newly received health records to determine if a broader release is needed. If so, send expanded release and collect records accordingly.
    - Review prior claim records with injuries to same body parts or PPI rating for other body parts. Copy and include relevant records in the new claim file.
    - Obtain a release for prior and/or subsequent WC cases if they are for same body parts.
    - Collect records from (if applicable):
        - AWCB
        - prior or subsequent employers
        - military (disability awards)
    - Obtain a release from employee and obtain personnel file if:
        - Employee has a prior PPI rating
        - Employee has been off work for 30 days or more
        - SIF potential is indicated in past records
- ISO Indexing is accomplished at setup with re indexing completed at six-month intervals, while claims remain active. Index Systems responses are evaluated and information regarding any prior claim is obtained and used.
- Subrogation / Recovery rights & liens are identified and protected: investigations are initiated, notices are sent timely and recovery pursuit is well documented in the claim file.

- Open issues are identified, documented and an action plan is developed to resolve each issue. The adjuster's notes will reflect the decision process in developing the plan of action. Each open claim file requires an updated plan of action every 60-days.

ISO Indexing

- All indemnity claims must be indexed at opening, at reopening, and then again, at six-month intervals.
- Medical only claims with reserves over $5,000.00 must be indexed at opening, at reopening, and then again, at six-month intervals.

Plans of Actions

- Plans are developed to identify claim status and mitigate exposures effectively and clearly. This includes:
    - A description of the injury and the accepted body part(s) involved.
    - The current medical status, including last office visit, employee's current physical capacities, employee's current restrictions, appropriate care strategies, and next office visit information.
    - The need for or results of an employer's independent medical evaluation (EIME).
    - The employee's current work status and engagement and involvement of the Return-to-Work Coordinator.
    - Authorization and detailed involvement of a nurse case manager (NCM).
    - Vocational rehabilitation status.
    - The details of investigative areas, including, if applicable: red flags, ISO results, surveillance, subrogation, status, and key details from the recorded statement(s).
    - The details of any controversions.
    - A summary of litigation (if applicable).
    - A current review of the reserves.
    - A clear and concise plan of action.
    - Plans are updated at least every 60 days. Follow through or revisions to plans must be evident.
- The adjuster is responsible for keeping the electronic notes within the claims management system current, complete, and accurate to allow Risk Management to electronically audit claim files (NO EXCEPTIONS).
    - Note: An independent audit will be done randomly through the online claims management system.

Wage Information

- Wage request forms must be emailed to doa.dof.workers.comp@alaska.gov.
- During initial contact and/or recorded statement with employee, inquire as to the status of other wages and/or jobs.

- Compensation Reports must be completed via EDI. Compensation Reports should be completed within 24 hours of the issuance or termination of a benefit payment. It is the responsibility of the TPA to ensure proper and timely transmission of the EDI reports, including subsequent and corrective reports.
- A copy of all compensation reports shall be emailed to the Department of Administration Division of Finance doa.dof.workers.comp@alaska.gov, so the State of Alaska (SOA) can make payroll/leave adjustments to the Employee's payroll checks. Reports shall be emailed to Division of Finance within 48 hours of completion.

Reserving

- Electronic Reserve analysis worksheets are required on all claims and included in the claims management system.
- The initial reserves are established within three (3) days and reassessed within the first thirty (30) days.
- Claim reserves reflect the adjuster's best judgment of the probable ultimate payout of the claim at any point in time, based on conscientious evaluation of all key areas of development of a claim.
- Reserves are continually updated and refined, with documented review accompanying every plan of action.
- Reserves that exceed $100,000, the TPA Claims Manager will notify Risk Management and provide the LCE worksheet.
- Reserves that exceed $50,000 will be Tasked to the TPA Claims Manager, or Sr. Adjuster, for review and approval prior to entry.
- Risk Management will reject any pending payment that comes from a claim without adequate reserves.

Light Duty Return to Work Program

- Adjusters will work with Risk Management "Return to Work" Coordinator who will be assessing all time loss claims beyond the 3-day waiting period for potential light duty return to work.
- Adjusters are required to maintain ongoing communication with the Return-to-Work Coordinator throughout the length of the employee time loss.
- Adjusters must evaluate all claims at least every 30 days to determine claimant's ability to return to full or restricted duty.
- Adjusters must keep time loss details regularly and clearly updated in the claim file. Modified duty must be accurately recorded, including continuing periods of disability due to the Employer's inability to accommodate the light duty.
- For employees of the Department of Public Safety (DPS), the adjuster is required to utilize the "DPS Work Status" form when inquiring of the employee's physician as to the current work restrictions.

- When an employee has been released to return to work (light duty or regular duty), has returned to work and/or there is a finding of medical stability, the appropriate documentation needs to be added to the claim file. The appropriate corresponding form(s) should be filed with the ADOL to cease the payment of benefits. This may include a termination compensation report and a controversion of specific benefits, as applicable.
    - These forms should be processed through EDI with the appropriate copies placed in the claim file, sent to the employee, their representative (if applicable), the medical provider(s) (if applicable) and Department of Finance (compensation report copies only).

Reemployment

The TPA is responsible for timely sending out the 45-day (form 07-6170) and 90-day (form 07-6169) Employer's Notice of Time Loss letters.

- In addition: After an employee has been off work for 45 days, the TPA is required to obtain:
    - Release from the employee for 10-year employment history and collect those employment records.
    - The job description for the job the employee held at the time of injury. The TPA may contact Employee Records to request a copy of the employee's job description.
    - The employee's SOA employment application. The application must be specifically requested from the Division of Personnel since it is not kept in the employee's main personnel file. The employment application assists the TPA in identifying and obtaining records from prior employers and will need to be produced to the assigned rehabilitation specialist under 8 AAC 45.510(f).
    - Pursuant to 8 AAC 45.510(f): No later than 10 working days after receipt of the administrator's letter selecting a rehabilitation specialist, the claims adjuster shall forward a copy of the employee's resume, job application, and job description or summary of the employee's job duties, if available, to the rehabilitation specialist, the employee, and Reemployment Benefits Administrator. The TPA shall also forward a copy of the report of injury and all medical reports, compensation reports, and controversions to the rehabilitation specialist, the employee, and the Reemployment Benefits Administrator.

All reemployment plans must be approved by the TPA Claims Manager prior to signature. Do NOT Settle **Recovery / Offsets**

- Cases are effectively managed for optimum recovery.
- Subrogation is appropriately and timely investigated (see below).

- Second Injury Fund qualifications are understood and requests for reimbursement are timely made (see below).
- Social Security and pension offsets are explored on a routine basis and clearly documented in the file.
- Payments subject to COLA are explored on a routine basis and timely calculated and appropriately managed. COLA rates are clearly documented in the claim file.
- Restitution is sought in appropriate cases with the aid of the Attorney General's Office.
- Statute of limitations is understood and protected on offset / recovery avenues.
- Recovery checks should be made payable to the "State of Alaska" and sent to the attention of Risk Management's Accountant with a copy of supporting documentation for the recovery.

Subrogation

- Subrogation opportunities are promptly investigated and maximized. Claims Adjusters shall get approval from TPA Claims Manager as to disposition of a subrogation potential. A note to the file shall be added stating the reason and the TPA Claims Manager's decision.
- Obtain police reports, fire reports, other insured's files, AWCB files or other reports necessary to conduct the proper investigation of a claim and scan the documents as electronic attachments into the claims management system. Clearly document the claim file.
- In cases where a 3rd party is clearly responsible for injury resulting in the SOA paying medicals and/or indemnity benefits, the TPA shall put the 3rd party on notice of the workers' compensation lien and note to the file.
- If there are circumstances regarding the amount of or the ability to recover, the TPA shall consult with Risk Management if the amount exceeds the TPA Claims Manager's settlement authority.
- Any subrogation of $10,000 or over shall be sent to AGO for review and recommendation within six months of the date of injury so an assignment order can be obtained under AS 23.30.015(b), within one year from the date of injury.
- Risk Management prior approval is required for any reduction in the lien amount if that amount exceeds the TPA Claims Manager's settlement authority.
- Recovery checks should be made payable to the "State of Alaska" and sent to the attention of Risk Management's Accountant with a copy of supporting documentation for the recovery.

Second Injury Fund

- Second Injury Fund (SIF) reimbursement (AS 23.30.205) is available for qualifying injuries occurring on or prior to 08/31/18.
- Initial SIF reimbursement requests for injuries occurring prior to 08/31/18 must be submitted prior to 10/01/20.

- SIF reimbursement on established and accepted claims will continue until the Fund's liability for that claim is extinguished. An adjuster shall request reimbursement on an accepted claim on a quarterly basis.
- Any information received indicating that the employee (EE) may have a qualifying condition under AS 23.30.205, will be copied and sent to the designated Human Resource Manager (HRM) with a request to put the documents into the EE's personnel/medical file for Second Injury Fund (SIF) purposes. A copy of the documents must be electronically attached to the claim file in the claims management system and a note shall be entered showing the date that this was completed.
- SOA agencies divide the EE's personnel file into numerous sections. Therefore, when requesting copies of the EE's files from the HRM to determine if the ER has any written knowledge of a qualifying pre-existing condition, the third-party administrator (TPA) must have a signed release from the EE. The TPA must request all personnel files, medical records, family medical leave act (FMLA), Alaska Family leave act (AFLA), SIF, the supervisor's file, and any other file the employer (ER) may keep. These records must be handled in accordance with State of Alaska, Division of Personnel privacy procedures.
- Airport Safety Officers, Correction Officers, Probation and Parole Officers, and Troopers must be certified by the Alaska Police Standards Council (APSC) and they complete a Health Questionnaire and have a Medical Examination Report in a separate APSC file.

Medical Cost Containment

- Treatment is verified as being related to the work injury.
- Medical cost controls include hospital bills, audits, chiropractic utilization review, medical fee schedule and reasonable customary reviews, dental review, pharmacy & durable medical supply management. All medical bills for review beyond the standard review, will be done by the approval of the TPA Claims Manager. If a medical bill exceeds $100,000, the TPA Claims Manager will get additional approval from Risk Management.
- Nurse case manager referral shall be referred to the TPA Claims Manager. The TPA Claims Manager will seek authorization from Risk Management for approval of specific Nurse Case Manager to be assigned to claim.
- Authorization of the nurse must be documented clearly in the file. TPA Claims Manager will formally review nurse case manager files every 60-90 days.
- Any undocumented, unauthorized NCM services will not be paid for by Risk Management and will be the responsibility of the TPA to reconcile.
- Pharmacy and durable medical equipment is to be timely reviewed and managed by each adjuster based upon a documented medical necessity. Authorizations must be clearly documented in each file. No on-going authorization is to exceed 6-months at a time.

- Employer's independent medical evaluations (EIME's) are timely and appropriately utilized. The adjuster should refer to the current "Do Not Use" list when selecting an EIME physician. The results of the EIME and any controversion(s) that arise out of the examination must be clearly documented in the file.

Controversions should be appropriately utilized to curb unnecessary or unrelated expenses.

Process for EIME's

- All relevant medical records, including the pre-injury medical records collected from discovery efforts are to be included in the EIME records.
- Always obtain a copy of the job description prior to EIME. Please contact Employee Records for the job description.
- Review prior work injury files to determine if those medical records should also be included, including injuries to the same body part(s) and any prior PPI ratings for determining an accurate rating under the Combined Values Table of the AMA Guides.
- It is the responsibility of the adjuster to schedule the EIME and ensure that the TPA timely sends out notice letters, makes travel arrangements, and provides them to claimant at least ten days prior to the EIME date.
    - If a case is in litigation, the adjuster must send a copy of the EIME scheduling confirmation within 24 hours of receipt as well as provide the AGO with copies of the notice letters.
    - Please note: A letter of medical necessity is required to approve travel for a companion or any first-class airline ticket for SIME and EIME exams.
- For cases not in litigation, adjuster is responsible for ***all*** aspects of the EIME, including sending out notification letters to all involved parties, preparing the medical records, and writing the EIME letter. If adjuster has questions or concerns regarding the draft EIME letter, the EIME letter and relevant records can be sent to the AGO for review per a review and recommendation referral.
- For cases in litigation, the AGO performs two functions:
    1. Preparing the medical records
    2. Writing the EIME letter
    - All other EIME processes remain the same and are the adjuster's responsibility.

Travel

- Claimant air travel will be arranged through the state's corporate travel account through CTM and travel expenses will be tracked in the claim management system.
- After receiving confirmation from CTM, the TPA must enter a new payment transaction noting financial type as "medical", financial category as "267", noting the amount of the total booking, the payee as "CTM", the seven-digit agency reference as the invoice number, and the date of booking as the invoice date.

- The TPA will reconcile CTM statements on a weekly basis, working directly with Risk Management's accountant on any issues that arise in the billing reconciliation process.
- Ground transportation will be arranged as per the Statute.
- **Car rental is not authorized**.
- All travel must be scheduled, and notification provided to the employee more than 10 days prior to the EIME or SIME.
    - Please note: A letter of medical necessity is required to approve travel for a companion or any first-class airline ticket for SIME and EIME exams.
- Employee's must be informed that any change to travel plans prepared by TPA that is not pre-authorized may be at the employee's expense.

Negotiation/Resolution/Penalty

- Benefits are timely & appropriately paid in accordance with the time frames set out in the Statute.
- If benefits are not timely paid, a penalty must be simultaneously paid as well.
- If penalty is owed due to adjuster failure to timely pay benefits, the TPA will reimburse Risk Management/State of Alaska for the penalty amount and any attorney fees owed due to the failure to pay timely benefits.
    - The penalty report will be provided to TPA during the first week of each month with penalty payment due to the State within five business days of penalty notice receipt.
- If the adjuster reaches a pre-approved settlement with the employee, all case documents shall be sent to the Attorney General's office for drafting of the Compromised and Release Agreement (C&R) as indicated below in the section on "Compromise and Release Agreements".
- The claims adjuster shall immediately calendar the payment deadline for benefits/attorney's fees owed pursuant to a C&R Agreement or attorney's fees stipulation. Payment deadlines are per the Statute and any current applicable case law.

Authority Level

- If the adjuster believes that a claim is appropriate for settlement, the adjuster must provide the TPA Claims Manager with a full and comprehensive review of the file, including the amounts paid to date, which benefits the adjuster in seeking settlement of, details of the total outstanding or anticipated exposure on the file, and the anticipated benefits of settlement.
    - The TPA Claims Manager has authority to completely settle claims, no fragmenting of benefits, up to $25,000 without prior approval from Risk Management.
    - The TPA Claims Manager must be copied on all requests and is expected to participate in the discussions.

- Risk Management will provide authority for settlement of claims beyond the TPA Claims Manager's settlement authority. All authority must be clearly documented by the adjuster within the claim file.

Closure & Reopening Files

- Claims are managed for effective resolution and timely closure.
- If indemnity exposures are resolved, and medical treatment is quarterly or less, the file will be considered for closure 45 days after the issuance of the last billing received, unless there is a significant remaining medical exposure in the life of the claim.
    - If during the 45-day closure period additional billings are received, the 45-day count is restarted.
- Claims settled by C&R Agreement require the adjuster to review the C&R to ensure the State is not paying medical bills for conditions that were waived. All terms of settlement must be updated on the claim's main screen.
- Claim closures must be reviewed and approved by the TPA Claims Manager who will place a note in the claim file confirming claim can be closed.
- If, at the time of closure, there remains an uncollected overpayment to the employee, which was made by an error of the TPA or one of its adjusters, the TPA must provide notice to the Risk Management Claim Administrator via e-mail of the overpayment. The TPA is then responsible for payment of the remaining overpayment balance within seven days of notification.
- If more than three medical bills are paid on a closed claim within a 60-day period or payment greater than $5,000 occurs, the file shall be reopened.
- All files should be reopened within 24 hours of the date of notification, updating the POA regarding the nature & change in circumstances and need for reopening. Follow-up tasks shall be set in accordance with standard claims handling procedures. Reserves should be set.
- If reopening of a claim is not warranted, the assigned adjuster will, upon receipt of a medical bill, review the medical bill and approve or deny it as part of the claim for payment. These bills must still be reviewed and processed within the timeframes delineated within the Statute.

Claim Load Limits

- Per the contract & generally acceptable good professional claims adjusting handling standards, all claims adjusters' caseload maximum is 125 time loss or 200 medical only claims. TPA Claims Manager is allowed 10 claims of any type.
    - **Claim totals cannot be combined. If an adjuster has ANY time loss claims, they cannot have more than 125 claims of any type.**
- If adjusters are assigned more than the maximum amount it is the supervisor's responsibility to reassign files to other adjusters. All reassignments or discussions

regarding complex claims should be documented in the claims management system to show supervisory recommendations & review of the file per auditor's recommendation.
- Any reassignment of claims due to an adjuster's departure will be done prior to the adjuster's departure or no later than two business days after the assigned adjuster's unplanned departure.
- Risk Management will assess and authorize any adjuster to exceed these claim counts on a case-by-case basis after receipt of a written request from the TPA Claims Manager.

Supervision

- Supervision & training are provided to improve investigations, management, and claims resolution.
- File reviews are to be conducted by the TPA Claims Manager every 60-days in accordance with an objective and subjective audit criterion and ensure proper claims handling of all files.
- The Risk Management Claims Administrator shall periodically review all litigated files.
- Claims assignments and internal review thresholds are made in accordance with adjuster experience levels and overseen by the TPA Claims Manager to assure quality.

Document Management

- Date stamp all incoming material, including all mail correspondence, bills, physician reports, request for reimbursement, and faxes; scan into the claims management system upon receipt.
- Date stamp must be the date the document was received at TPA office; not the date staff reviewed it.
- Documents must be attached within one business day of receipt to the claimant's file with the appropriate naming convention.
- All documents to be attached to the claim file must clearly identify what the document is and the date of transaction. The TPA must utilize a universal naming convention.
- Stamp, scan, review all medical billings prior to forwarding to the medical bill review company for processing.
    - Ensure the provider has a current W-9 in the claims management system. If there is not a current W-9, it is the responsibility of the TPA to request one.
    - Ensure the Provider is an Active payee, marked Can Be Payee, address on Contact matches the address listed on HICF, MBRIP is marked Exported to Definiti within the claims management system. If any of these are not marked, reach out to DRM Accountant to assist with updating the Contact.
    - Per statutory requirements, all medical bills must be paid within 30-days of receipt.

Payment Processing -Checks, Stop Pay & Voids

- Check Authority Limits – Checks above $25,000 need to be escalated to the following for approval:
    - Risk Manager - $25,000.01 - $100,000
    - Director – Over $100,000.01
- Risk Management requires an invoice for a manual payment to be issued to a provider/vendor.
- The invoice must be attached to the claimant's file as well as to the check payment itself.
- It is the responsibility of the adjusters to timely review all billings for allocated loss adjustment expense (ALAE) prior to payment to eliminate excessive, improper, or duplicate charges. Ensure a copy of the invoice is attached to the file.
- Overpayment recovery checks should be directed and made payable to the "State of Alaska" and sent to the attention of the Risk Management Accountant.
- Stop Payments and Voids are essentially the same thing- If we void a check in the system, it will flow over to the bank as a "Stop Pay".
- Voids are only made on checks that were not processed.
- Stop Payments are allowed under the following criteria:
    - The check hasn't been cashed.
    - The check must have been "missing/not received" for a minimum of 2 weeks.
    - Proof that the check was "stolen" i.e.: police report.
    - If the payment was erred in some way – due to the bill reviewer, Risk Management or TPA.
    - The claimant changed their address and we failed to change it before issuing a check.
    - All other reasons must be cleared with Risk Management.
    - Checks may be manually reissued after confirmation of stop pay.
- If a check needs to have a Stop Payment issued due to an issue with the payment or check, please contact Risk Management's Accountant via e-mail with the following information:
    - Verification in the claims management system that the check hasn't been cashed.
    - Check number
    - Claimant's name
    - Claim number
    - Amount of check
    - Date check was issued
    - Payee
    - Reason for request (e.g., lost in mail)

W-9 Process for All Payments, Except Through MBR

- Receive invoice.
- Search the Contacts in the claims management system to locate provider/vendor in the system.
    - If the provider/vendor is listed, check to make sure there is a current W-9 attached to provider/vendor file.
    - If provider/vendor is listed but no current W-9 exists -**or-** the provider is not entered into the claims management system, the adjuster shall request a W-9 from the provider/vendor and forward it via e-mail to the Risk Management Accountant for entry.
        - The accountant will advise adjuster once the provider/vendor is entered into the system. Payment can be processed by TPA after the bill has been scanned into the system.
        - Payments are to be managed by TPA to ensure no late penalties.
    - If provider/vendor is listed with a current W-9, the TPA shall process a payment after the bill has been scanned into the system. Payment should be managed by TPA to ensure no late penalties.

Ergonomic Evaluations

In the event of a physician requesting an ergonomic evaluation in a workers' compensation claim, follow this protocol:

- Hire an ergonomic evaluator who has the appropriate training to do the evaluation.
- The ergonomic evaluation must include measurements of the seat pan, distance between back of knee and floor, distance between knee and hip, etc.
- The evaluator must make adjustments to the existing equipment first to determine if the equipment is suitable for the employee. If some of the existing equipment must be changed, the evaluation must give a list of the equipment, measurements, and full details for the equipment in generic terms. They may not recommend equipment by brand name. The description of the appropriate equipment must be clear and complete enough to allow the agency to purchase the correct equipment.
- Send a copy of the ergonomic evaluation to the EE's supervisor and to the EE.
- The responsibility for the purchase of the equipment rests solely with the EE's Department/Division and must be procured through standard state procurement procedures. ***Risk Management does not provide funds for equipment recommended in an ergonomic evaluation.***

Annual Report Filing

- No checks will be written for periods bridging calendar years for payments reported on the annual report. These payments include Temporary Partial, Temporary Total, Permanent Partial, Permanent Total, Death or .041(k).

- For example, if the EE's benefits due cover the period of December 24 through January 6, you will have to write two checks. One for the period December 24 through December 31 and one for January 1 through January 6.

- The TPA is responsible for preparing the AWCB Annual Report to be submitted to AWCB. Risk Management will need to sign the report as the employer and submit prior to March 1st deadline.

Legal Representation

The Attorney General's Office represents the SOA in **all** claim litigation per AS 44.23.020.

SOA Dept. of Law

Torts and Workers' Compensation Section

Civil Division

1031 W. 4th Avenue, #200

Anchorage, AK 99501

Phone: (907) 269-4544

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All representation referrals, WCC's, review and recommendations, controversion reviews, etc., should go to the AGO for proper representation. Please notify the RM Claim Administrator on all referrals to the AGO reserved over the TPA Claims Manager's reserve authority.

Where possible and as applicable all documents will be sent electronically from the TPA to the AGO. Acceptable forms of electronic transmission include: the utilization of the web-based FTP site, the use of CD's, flash drives, or the use of secure e-mail.

Litigation

When a WCC or Petition is received by the TPA, immediately send a copy electronically to AGO. An Initial Representation Referral packet should be sent via electronic submission to the attention of the lead Assistant Attorney General (AAG), cc to the paralegal, the lead legal office assistant (LOA), and the Risk Management Claims Administrator if the claim reserve exceeds the TPA Claims Manager's reserve Authority.

- This referral should contain the referral sheet, listing any important deadlines or information, and a full* copy of the file, including a copy of the initial medical summary (see below).
- The TPA will send the referral and packet to the AGO within 5 working days of the receipt of the WCC or Petition to provide the AGO with adequate time to file an Answer.

- If it is not possible for the TPA to provide a full copy of the file within the 5-day time frame, then the TPA should send the information that is currently available and communicate an expected date of delivery to the AGO.
- If a discovery request accompanies the WCC or Petition, the AGO will be responsible for reviewing, redacting and withholding documents that are subject to privilege before the AGO prints and produces the records to the employee, their representative or other interested party.
- A certification attesting that the submission is a full and complete copy of the file (as of the date of submission) should accompany the referral. This can be completed by either the adjuster or the TPA's paralegal.
- The TPA will forward the initial prehearing conference notice to the AGO within 24 hours of receipt if the prehearing conference notice is not included in the referral packet.
- The TPA shall save an electronic copy of their submission to the AGO, complete with the certification, into Risk Management's claim system.
- The adjuster must mark the file as "open" at the AGO within the claims management system in order to allow the flow of mail from the TPA to the AGO.
- The AGO will close their file upon resolution. Both the AGO file closure email notification and/or the filing of a notice of withdrawal of counsel will trigger the adjuster to mark the referral as "closed" and cease the flow of documentation to the AGO.
- Adjusters may be called upon to attend, provide testimony or be available for legal proceedings, either telephonically or in person.

A <u>single</u> copy of the <u>entire</u> file* is required for all new litigation referrals.

*except for the TPA's internal work product

<u>Medical Summaries</u>

The TPA or its adjuster is responsible for preparing the **<u>initial</u>** medical summary on form 07-6103 (or future electronic format) within <u>5 business days</u> from the date of their receipt of the WCC or Petition as mandated by AS 23.30.095(g). The TPA files the initial medical summary directly with the Board with a copy to all appropriate parties.

- All medical records relevant to the work injury must be filed on a medical summary if the records are in TPA possession or control, including pre-injury records and records for prior work injuries to the same body part(s).
- Medical records are to be organized by date with oldest date first and the newest date last, utilizing the instructions provided on the 07-6103 form.
- Any errors or omissions in the TPA-prepared medical summary will be corrected by the preparer of the summary.
- The AGO is responsible for filing all **<u>subsequent</u>** medical summaries.

Discovery Requests

When a case is in litigation and a discovery request is received, the AGO will use the initial electronic file referral submitted by the TPA to access the majority of the records.

- The AGO will send a request to the TPA for the submission of any additional, updated file materials, which will be delivered electronically from the TPA to the AGO with an additional written confirmation included. The confirmation will certify that the additional documents are a complete supplement to the initial file copy.
    - This submission will be added to the original, so that any subsequent requests for discovery will only require the submission of *updated* records by the TPA to the AGO.
- The AGO is then responsible for reviewing, redacting and withholding documents that are subject to privilege before producing the records to the employee, their representative or other interested party.
- Legacy Claims are maintained electronically within the claim file. The TPA will provide the AGO with the file documentation that is available.
    - If the claim is one that the AGO previously worked on, then every effort should be made at the AGO to locate its file in storage, although this cannot be guaranteed to represent an exact copy of the adjuster's file nor can it be relied on for discovery purposes.

Mediation

If a claim will proceed to mediation, the adjuster is required to do the following:

- Within 10-days of the deadline for submission of confidential mediation briefs to the mediator, the adjuster shall complete a "Mediation Template" on the prescribed form, which contains the following information:
    - An accurate accounting of all-time loss, PPI and .041(k) benefits paid to date.
    - A copy of the most recent compensation report (this report should square with the accounting of indemnity/PPI/stipend benefits paid out).
    - An accurate accounting of the amount of medical costs paid to date.
    - An accurate accounting of any attorney's fees and costs paid to date.
    - An accurate accounting/list of all unpaid medical bills (date of service, provider, and billed amount) with copies of the unpaid medical bills.
    - An accounting of all medical related transportation costs paid to date.
    - An accounting of all unpaid transportation costs including a copy of the written mileage log or lodging/per diem requests.
- A copy of the Mediation Template and corresponding documents shall be e-mailed to the assigned AAG and their paralegal with a cc to the TPA Claims Manager. A copy must be placed in the claim file.

Review and Recommendation Referrals

A Review and Recommendation referral should be sent electronically, preferably via e-mail, to the TWC Section Supervisor with a cc to the appropriate paralegal, lead LOA, and Risk Management Claims Administrator.

- The referral sheets must specify the specific question or issue that the adjuster is requesting assistance with.
- The referral should contain only the following items, unless the TPA believes a full copy of the file is needed for evaluation of their question:
    - Referral form provided by AGO
        - Specify type of referral and action requested (specific question/issue).
        - Note items that are time sensitive and/or require immediate response.
    - A copy of the report of injury
    - A copy of the most recent compensation report
    - A copy of the pertinent medical reports
    - A copy of any written statements or letters
    - A copy of all controversions
    - Any pertinent Board documents or discovery requests
- The adjuster should notate their file accordingly when working with the AGO for a Review and Recommendation referral as opposed to litigation referral.
- The AGO will close their file upon resolution. Both the AGO file closure email notification and/or the filing of a notice of withdrawal of counsel will trigger the adjuster to mark the referral as "closed" and cease the flow of documentation to the AGO.

Controversion Reviews

A Controversion Review referral should be sent electronically, preferably via e-mail, to the lead AAG with a cc to the appropriate paralegal and the lead LOA.

- The referral sheets must specify the specific question or issue that the adjuster is requesting assistance with and a deadline for a response from the AGO.
- The referral should contain only the following items, unless the TPA believes a full copy of the file is needed for evaluation of their question:
    - Referral form provided by AGO
    - A draft of the controversion
    - A copy of the report of injury
    - A copy of the most recent compensation report (if any)
    - A copy of the pertinent medical reports (if any)
    - A copy of any written statements or letters
    - A copy of all prior controversions (if any)
    - Any pertinent Board documents or discovery requests (if any)
- A file is *not* opened at the AGO for a Controversion Review.

Compromise & Release (C&R) Agreements

All C&R agreements shall be drafted and submitted by the AGO on all claims even if the adjuster has reached settlement of the claim themselves. The Attorney General is the legal representative and advisor of the Division of Risk Management. Per AS 44.23.020, the AGO is responsible for drafting legal instruments, including settlement documents, for State agencies. Expected turnaround time of the draft is five (5) business days from the date of all materials being submitted.

- Those claims that do not have a WCC filed, the TPA is required to file all relevant medical records on a medical summary and file that medical summary with the Board. The TPA also shall have all relevant file documentation prepared and electronically referred over to the AGO for drafting of the C&R. This includes the requested payment file audit.
- For those claims already in litigation where a settlement is reached, the AGO will request from the TPA any additional documentation needed to complete drafting of the C&R, including the payment file audit. The adjuster shall provide the AGO with the requested information within five business days.
- Upon approval and payment of the C&R, the adjuster shall update the claim to reflect the terms of the settlement.
- The AGO will close their file upon resolution. Both the AGO file closure email notification and/or the filing of a notice of withdrawal of counsel will trigger the adjuster to mark the referral as "closed" and cease the flow of documentation to the AGO.

Special Handling

The following types of claims or situations require immediate reporting to the Risk Management Claim Administrator and a referral to the AGO:

- Mental injury claims, including stress and PTSD.
- Heart attack, stroke or DVT.
- Environmental exposure, toxic exposure, asthma attacks, or other respiratory conditions.
- Blindness, amputations, seizures, or paralysis.
- Fatalities.
- Accidents involving two or more individuals with serious or life-threatening injuries.
- Unusual treatment or prescriptions (e.g., very new, or controversial medical treatment).
- Surveillance services require pre-approval from Risk Management on non-litigated files and pre-approval of both Risk Management and the assigned AAG on litigated files.

EIME and Litigation

For cases in litigation that require an EIME, the AGO performs two functions:

1. Preparing the medical records
2. Writing the EIME letter

- All other EIME processes remain the same and are the adjuster's responsibility (see section above on EIME's).
- An EIME should not be set on a litigated file without first conferring with the assigned AAG.
- On litigated files, the adjuster must send a copy of the EIME scheduling confirmation within 24 hours of receipt.
- A copy of the appointment letter must be sent to the employee, their representative (if applicable), and the assigned AAG.

Semi-Annual Meetings

TPA is required to meet in-person with Division of Risk Management staff semi-annually at the State Office Building 10th floor in Juneau, AK or in another location designated by the Division.

Risk Management Contacts

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