Reform Claim Data Review Worksheet

**Demographic Data**

Claim #: ________________  Claim Type: ___________  DOI: ___________

Change in PTP Date: ________________  Represented Date: ________________

Description of Injury/Body Part(s) Injured:

________________________________________________________________________

Employer Size: ________________  Employer Industry: ________________

Summary of medical services provided:

________________________________________________________________________

Reserves:

<table>
<thead>
<tr>
<th></th>
<th>Paid Losses</th>
<th>Outstanding</th>
<th>Incurred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Total</td>
<td></td>
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<tr>
<td>TD</td>
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<td>PD</td>
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<td>VR</td>
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<tr>
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<tr>
<td>Expense Total</td>
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<td></td>
<td></td>
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<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comment:

________________________________________________________________________

**Utilization Review**

UR referral criteria in existence: (Y/N) ___________

UR referrals needed: (Y/N) _______  UR referrals made: (Y/N) _______

Retrospective, Concurrent, Prospective (select one): ________________

Timely process: (Y/N) _______  Did UR Certify: (Y/N) _______

If non-certified, was LC4062 used: (Y/N)_______

If LC4062 used, was treatment later authorized: (Y/N) __________

Did LC4062 evaluation recommend treatment other than requested by PTP: (Y/N) ____

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Reform Claim Data Review Worksheet

Demographic Data

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Comment:
__________________________________________________________

**Voucher**

Initial notice within ten days of end of TD (Y/N): ______

Mod-Alt Work offered within 30 days from permanent work restrictions: (Y/N) ______

Voucher payment due: (Y/N) ______ Voucher payment offered: (Y/N) ______

Voucher amount: ______ Amount accurate: (Y/N) ______ Voucher settled: (Y/N) ______

Comment:
__________________________________________________________

**PTP Repealed – Changed approach to medical evidence**

Employer chose PTP: (Y/N) ______ PTP report taken at face value: (Y/N) ______

Supp report(s) requested: (Y/N) ______ Which issues: _____________________________

How PTP responded: _____________________________

Dispute with PTP: (Y/N) ______

If yes, how resolved: _____________________________

Comment:
__________________________________________________________

**Delay Claims - $10K Cap**

Decision in 90 days: (Y/N) ______ Able to complete discovery in 90 days: (Y/N) ______

Did PQME eval occur in 90 days: (Y/N) ______ Denials within 90 days (Y/N) ______

Was denial later accepted after PQME eval: (Y/N) ______

Use ACOEM to manage treatment: (Y/N) ______

Amount paid during delay period (1st 90 days): __________________

Denial reason (circle one): factual, legal, medical

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Comment:

________________________________________________________

Medical Legal Process

Issue to be resolved (circle one): LC4060 (AOE-COE) LC4061 (PD) LC4062 (All others)

Method used to resolve: ________________________________________

Unrepresented (circle one): PTP, PQME Represented (circle one): AME, QME, PQME

Timely selection by parties: ______________________________________

If unrepresented, did IW select from panel timely: (Y/N) ______

If not, did carrier select QME: (Y/N) ______

If represented, comment on AME and QME timeliness:

_________________________________________________________________

Who made the PQME choice (circle one): AA or IW, carrier

Timeliness of dispute resolution (circle one): timely, prolonged

Availability of QME on a timely basis to resolve AOE/COE matters: __________

Other comments:

_________________________________________________________________

Medical Provider Network

Participating: (Y/N) ______ Notice Letter Sent re: participation: (Y/N) ______

New claims managed pursuant to MPN requirements: (Y/N) ______

Claims identified if pre-designation applies: (Y/N) ______

Existing claims with MPN, process used:

_________________________________________________________________

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Existing claims outside of MPN, process used:


Comment:


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**Medical Legal Process**

Issue to be resolved (circle one): LC4060 (AOE-COE) LC4061 (PD) LC4062 (All others)

Method used to resolve: ________________________________________________________________

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If represented, comment on AME and QME timeliness:

_________________________________________________________________________________

Who made the PQME choice (circle one): AA or IW, carrier

Timeliness of dispute resolution (circle one): timely, prolonged

Availability of QME on a timely basis to resolve AOE/COE matters: _______________________

Other comments:

_________________________________________________________________________________
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Utilization Review

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Cost impact on claim (circle one): favorable, neutral, unfavorable

Comment:

________________________________________________________________________

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UR referrals needed: (Y/N) ________ UR referrals made: (Y/N) ________

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Did LC4062 evaluation recommend treatment other than requested by PTP: (Y/N) ______

Cost impact on claim (circle one): favorable, neutral, unfavorable

Comment:

________________________________________________________________________
Reform Claim Data Review Worksheet

General Questions

Do you have claim procedures that pre-date AB 749?

Do you have claim procedures since AB 749 that show how claim processes have changed since then? What procedures did you implement as a result of SB899?

What were the 5 key changes of reform on claims processing in your view, and how did you implement them?

Has repeal of the PTP presumption changed your claim procedures? If so, how?

Do you have a UR plan?

Do you have referral criteria for UR?

Do you keep statistics for delayed and denied claims? If so, what was the percentage of delayed claims to TNRs? Indemnity TNRs? What was the percentage of denied claims to delayed claims (denied/delayed ratio)? Did these percentages change after 4.19.04, when the $10K cap for delayed claims was enacted?

What claim procedures did you implement to put LC4062.1 and LC4062.2 into effect? What has been your experience regarding AOE-COE decisions (LC4060), PD evaluations (LC4061) and all other issues (LC4062)?

How has LC4062.1 and LC4062.2 affected your ability to resolve claims, compared to your ability to resolve claims prior to 4.19.04?

What steps did you take to make sure that apportionment is addressed on claims where no final determination was made before the WCAB?

How are you addressing the rating of claims under theAMA Guides?

How is the two-tiered PD system applied, if at all, for claims with dates of injury before 1/1/05?

How is Voc Rehab currently managed as a result of repeal and re-enactment of the voc rehab statutes?

Describe how you administer the voucher process. Has the voucher process changed how you address the provision of regular or modified-alternative jobs for your clients’ employees? If so, how?

If you use MIRA, how has MIRA adapted to the changes in the statute? Do you generally see increases or decreases in undeveloped loss estimates?

Has there been an increase in claims being referred to the Second Injury Fund?

What type of MPN is available for your client’s access?

What is the overall degree of participation?

What is process for confirming the insured sent the required notice letters?

How do they develop the roster? Who is it communicated to?

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