



JUDICIAL BRANCH WORKERS' COMPENSATION PROGRAM AIMS SERVICE GUIDELINES

(EFFECTIVE JULY 1, 2020)

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

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, and/or terminations.

As stated in the JBWCP Memorandum of Coverage:

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.

The JBWCP shall provide for the defense of, but not the indemnity for, serious and willful misconduct pursuant to Labor Code (LC) 4553, 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.

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 130 claims per Examiner is desired. At no time shall the average caseload exceed 130 claims, unless requested by the Judicial Council and agreed upon by the TPA. The Claims Supervisor shall not carry a caseload.

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



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. 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. Supervisors 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 Supervisor is required to inform the JBWCP Administrator and the Risk Consultant via calendar invite of all claim reviews.
- III. The Claim Status Report will be emailed to the Member, JBWCP Administrator, and the Risk Consultant at least one week prior to the scheduled review.
- IV. 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).
- V. 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.
- VI. 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 AIMS.

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Claim Set Up

It is required that the Member submit a completed Employer's First Report of Occupational Injury or Illness Form (5020) *within five calendar days of injury or notification of injury* and ensure the Injured Worker (IW) has been properly provided an Employee's Claim Form (DWC-1) within 24 hours of the member's notification of a loss. The Member is also encouraged to provide any information pertaining to the accident or incident that caused the injury as timely as possible.

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 Claims System within one working day of receipt.

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

- I. Claims may be submitted via the AIMS' system, email, United States mail, or fax.
- II. The Examiner will complete the three-point contact per company policy and client requirements.
- III. The Supervisor will review all new losses received for an initial assessment of severity, compensability, and subrogation issues.
- IV. The Supervisor 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. 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.
- VI. Management review of the file supporting transition or the determination to remain at Medical only status will be clearly documented in the file notes.

Closures

Supervisors 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 Supervisor shall ensure that the appropriate Reynolds notice has been served upon the

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IW prior to consideration of case closure. All claims not administered by a Senior Examiner shall be reviewed by the Supervisor 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 24 hours of reporting and make the initial contacts with the IW, Treating Doctor, and Member. All claim notes will be entered in the claims system within 24 hours.

Initial Contact

- I. Member Contact - The Examiner shall contact the primary Member contact within 24 hours 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.
- II. Treating Doctor Contact – In addition to obtaining medical status, the Examiner will notify the treating doctor they will be contacted within three business days by a Triage Nurse.
- III. Employee Contact – The Examiner will make initial contact with the IW 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.

Ongoing Contact

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- I. Continued IW contact by the Examiner will be conducted on all non-litigated Indemnity files and documented in the claim notes.
- II. On files receiving total temporary disability, modified duty, and/or any change of status, contact every 14 calendar days.
- III. 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.

Coverage

Each year the JBWCP will provide a Memorandum of Coverage 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 Section 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.

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 Supervisor. 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.

Ergonomic Evaluations

Requests for ergonomic evaluations from the Primary Treating Physician, Panel Qualified

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Medical or Agreed Medical Examiner 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 and Supervisor.

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: 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 AIMS supervisory 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.

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. This requirement shall apply to all standards contained in this section of 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

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electronic claim files.

Fiscal Year

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

Future Medical (FM) Files

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.

Index (ISO) Reporting

Indemnity claims will be indexed at claim inception and annually ongoing through resolution. FM claims shall therein be re-indexed annually. All Index Reports will be reviewed and documented in the file notes.

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. Referral to an investigative vendor will be completed within five business days of receipt of member authorization.

Member authorization shall first be obtained before initiating any investigation. The

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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 (i.e., 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 Supervisor.

Issues/Concerns

Examiners must notify their Supervisor, and other key stakeholders such as the TPA Program

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Manager, JBWCP Administrator, and Risk Consultant if a program issue arises.

Program issues can 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.

Mail/Scanning

Mail is scanned into the AIMS system on a daily basis and indexed directly to the appropriate Examiner for review and action.

Examiners will review their scanned mail daily and identify urgent issues and document any necessary actions within statutory timeframes, adhering to the AIMS Mail Processing Guidelines for timely mail handling requirements.

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 Examiner (AME)/PQME prior to the examination.

If AIMS scheduled the PQME and it is cancelled, or the employee is a no show, the Examiner

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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.

Medicare Set Aside

The Examiner will request authority from the Member for referral of Medicare Set Aside services and provide an estimate of cost for these services.

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.

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 AIMS 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 AIMS 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.

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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 bills will be paid in full, except for laboratory or testing charges, which will be subject to fee schedule through Bill Review. 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 AIMS Supervisor. 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.

Supervisor'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 AIMS Program Manager.

Penalties & Overpayments

Late payments of all benefits must include the self-imposed increase in accordance with LC 4650. If AIMS is responsible for the penalty/increase, they shall issue a check to the JBWCP for the penalties/increases in line with the quarterly report provided. The check shall be paid and submitted to the JBWCP by the 20th of the month following the end of each quarter.

The Examiner shall be responsible for attempting the collection of any overpayment of any benefit. In the event AIMS is unable to collect the overpayment, AIMS 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 AIMS.

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 AIMS for reimbursement to JBWCP.

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The AIMS Program 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.

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.

Program Contacts

JBWCP Administrator

Patrick Farrales, Supervising Analyst
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415-865-8806 | patrick.farrales@jud.ca.gov | www.courts.ca.gov

Trial Court Employees

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Judiciary Employees, Supreme and Appellate Court Justices, & Trial Court Judges

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Risk Consultant

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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.

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.

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

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paid out or advanced against the settlement.

Level I: AIMS 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**. AIMS 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 AIMS within the allotted 10 court day period.

The AIMS Supervisor 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.

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 AIMS Supervisor 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 Level II Settlement Request.

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 AIMS Program Manager will email the SAR to the JBWCP Administrator, the assigned analyst for the trial or judiciary claims, Risk Consultant, and involved Member, with response required within 10 court days of the SAR's Request Date. The subject line will include the claimant name, claim number, and Level III Settlement Request. 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.

Guidelines Applicable to All Authority Levels

Any party who disagrees with a settlement decision made in any level in this process may

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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

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 AIMS Supervisor, the SAR will be forwarded based on the appropriate level of authority, as outlined in the Settlement Authority Levels Guideline section above.

The Examiner and Supervisor 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 AIMS Program 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.

In the event of a disagreement on the proposed settlement, AIMS, 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 AIMS 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.

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AIMS **does** have settlement authority for resolution of EDD & liens.

Staffing Changes

The JBWCP Administrator and Risk Consultant are to be notified by the AIMS Program Manager when Examiner or Supervisor changes occur. Notifications should occur within 72 hours of AIMS notice.

AIMS 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.

Supervisor Review/Diaries

When a Supervisor is reviewing a file, the Supervisor 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 Supervisor diary review:

- I. 10 calendar day supervisory review/Indemnity Initial Review.
- II. Indemnity Initial Subsequent Review within 90 calendar days of initial Supervisor review, allowing for a two-week grace period.

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- 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 Supervisor within 90 calendar days of file set up and at 120-day intervals, allowing for a two-week grace period.

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JUDICIAL BRANCH WORKERS' COMPENSATION PROGRAM

ALLIED MANAGED CARE (AMC) MANAGED CARE GUIDELINES (EFFECTIVE JULY 1, 2020)

AMC 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 24 hours 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.

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. The Triage Nurse completes the AMC Triage template, outlining appropriate treatment and estimated return to work using Official Disability Guidelines (ODG) and American College of Occupational and Environmental Medicine (ACOEM). If there are red flags such as previous injuries or co-morbidities, case management may be recommended with specific goals.

Cases involving judges are not triaged without approval.

The Triage Nurse will do the following:

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



- 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 AlliedConnect management software and the claims system.
- V. Forward the AMC Triage report to the Examiner within three business days for discussion as needed with the Member.

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 AIMS 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.

- 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. Three-point contact includes the provider, employee, and Examiner, and will be completed within 48 hours of assignment.
- 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

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



to facilitate optimum recovery and RTW. The CM will track all lost time, modified and RTW dates within Ventiv. 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 Supervisor 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 24 hours.
- 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

- I. CM will initiate services within 24 hours of referral.
- II. CM will contact the medical provider, injured worker, Examiner within 48 hours of receipt of referral.
- 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.

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- 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 24 hours of appointment.
- VII. 24-hour updates on any significant file changes: 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 Supervisor 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)/Maximum Medical Improvement (MMI).
- IV. Claim is denied.
- V. No impact can be made on file.
- VI. Request from Examiner.
- VII. Task assignment completed.

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



Any Member inquiries regarding tailoring the MPN provider participation should be directed to the AIMS Program Manager.

Members with concerns regarding the service provider by any MPN provider, should be escalated to the TPA Program Manager for follow-up. When appropriate, the TPA Program 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 program is a proprietary network owned by HealtheSystems and customized by AIMS/AMC.

- I. First Fill forms are provided by the Member entity at the time of injury.
- II. The cards are sent out automatically via an electronic interchange between AIMS and the pharmacy program when a file is reported to AIMS. The electronic reporting is sent out at the end of the working day. HealtheSystems processes the file and mails out pharmacy card information within 72 hours.
- III. Cards are automatically closed the following work day when the Examiner closes the file, documents the claim status with a Compromise and Release, or denies the file. The updated claim data is part of the daily eligibility file sent to HealtheSystems.
- IV. The Examiner has the ability to update the pharmacy website to request new cards, turn off cards, or block medications and doctors as needed.
- V. All non-exempt medications that fall outside of the California pharmacy formulary are sent to NCM as part of an early intervention program to review for release and prevent addiction issues.
- VI. If a medication is being held and not released, the NCM will call the IW and Examiner to explain the rationale and what actions may be required before the medication can be released.
- VII. If a medication is determined to require utilization review before being released, the CM will contact the prescribing physician and request a current RFA and medical report documenting the need for the medication be sent to the Examiner. The Examiner will then forward these documents to the Utilization Review (UR) unit for review. The CM will also notify the employee that the medication is being held pending a UR review.

UR REFERRAL CRITERIA

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

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



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
	MRI's and x-rays
	Stress Test/EKG for presumptive cardiac cases
DME Non-Surgical DME Surgical	DME less than \$800 (All)
	Hearing Aides less than \$800
	Exercise Equipment with a value less than \$500
	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
Wheel Chair	
Misc. Request (Weight loss services, biofeedback, drug rehabilitation, non-emergency dental services, computerized muscle testing, uncommon or	NO AUTOMATIC AUTHORIZATIONS.

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



JUDICIAL COUNCIL
OF CALIFORNIA

JUDICIAL BRANCH WORKERS'
COMPENSATION PROGRAM
ADVISORY COMMITTEE

experimental services or devices)	
Physical Medicine - Acupuncture Chiropractic Care Massage Therapy Occupational Therapy, Physical Therapy	Passive or active therapy for no more than 12 visits
	Post Op - Initial physical therapy up to 12 visits.
Specialty Referrals Consultations	Head injury or head trauma - authorization for referral to Neurologist upon recommendation of treating physician at initial consultation.
	Initial Orthopedic referrals
Surgical Procedures	NO AUTOMATIC AUTHORIZATIONS.

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



JUDICIAL BRANCH WORKERS' COMPENSATION PROGRAM LITIGATION MANAGEMENT GUIDELINES

(EFFECTIVE JULY 1, 2020)

LITIGATION MANAGEMENT

- I. The Examiner is to maintain litigation control and direction of the legal aspect of the claim until case resolution.
- II. All direction and communication with defense attorneys will be documented in the file notes.
- III. 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) Supervisor and escalate as necessary.
- IV. 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.
- V. 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.
- VI. 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.
- VII. Consideration for Mediation must be discussed with AIMS Program Manager 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.
- II. The Examiner will discuss case specific issues with the Supervisor to determine the need for a defense attorney prior to referral.
- III. The Examiner will refer to individual Member instructions for the Member's choice of attorney and member-specific communication requirements.

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



- a. If there are no specific instructions, 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.

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



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

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