RESOLUTION - ACTION REQUESTED 2019-556

MEETING: September 24, 2019
TO: The Board of Supervisors
FROM: Kimberly Williams, Human Resources Director
RE: Renewal of AdminSure Agreement for Workers' Compensation Services

RECOMMENDATION AND JUSTIFICATION:
Approve the Renewal of the Agreement with AdminSure, Inc. for Workers' Compensation Services, Which Includes Utilization Review Services, for a Three-Year Period Effective October 1, 2019 through and Including September 30, 2022; and Authorize the Board of Supervisors Chair to Sign the Agreement.

AdminSure is currently the County's Third Party Administrator (TPA) and administers the County's claims filed by injured employees. AdminSure has been providing Workers' Compensation services over the last three years, which includes utilization review services* (the current agreement is for the period of October 1, 2016 to September 30, 2019). The level of expertise and service that AdminSure staff has been providing to the County has been effective. County staff works closely with the TPA on employee claims to ensure that all aspects of each claim are handled efficiently and are in regular communication with AdminSure staff relative to claims, process, and any other related issue that arises.

There has been a reduction in the number of claims since the initial agreement was signed in 2016. Currently, there are 60 open claims and the fees for the initial agreement were negotiated based on an estimated annual claims volume of 72 files. For the renewal, AdminSure had proposed a larger increase in administration fees for the renewal, however, County staff negotiated a lesser dollar amount. The County recognizes that there may be elevated costs for AdminSure to do business since the last three-year agreement and AdminSure recognizes that there is a reduced burden to their staff by the County's reduced claims volume. Currently, the County pays $18,750 in administration fees each quarter. The proposed and recommended quarterly administration fee is $19,125 for the first year of the agreement; a quarterly fee of $19,508 for the second year of the agreement; and a quarterly fee of $19,899 for the third year of the agreement. This results in a 2% increase from the previous three-year agreement and 2% in each year of the agreement.

*Utilization review is the process the TPA uses to review treatment to determine if it's medically necessary.

BACKGROUND AND HISTORY OF BOARD ACTIONS:
Resolution - Action Requested 2019-556

At their meeting of September 27, 2016, the Board of Supervisors approved a three-year agreement with AdminSure with the adoption of Resolution No. 16-517.

ALTERNATIVES AND CONSEQUENCES OF NEGATIVE ACTION:
Do not approve agreement; amend this recommendation as the Board desires and adopt.

FINANCIAL IMPACT:
Workers' Comp administration fees were included in the 2019/2020 fiscal year budget.

ATTACHMENTS:
AdminSure Agreement 2019-2022 (PDF)

RESULT: ADOPTED BY CONSENT VOTE [UNANIMOUS]
MOVER: Rosemarie Smallcombe, District I Supervisor
SECONDER: Merlin Jones, District II Supervisor
AYES: Smallcombe, Jones, Long, Cann, Menetrey
WEEKERS’ COMPENSATION PROGRAM
SERVICE AGREEMENT

THIS AGREEMENT is entered into by and between Mariposa County, hereinafter referred to as the "Client," and AdminSure Inc., hereinafter referred to as the "Administrator."

WHEREAS, the Client has undertaken to self-insure their Workers' Compensation obligation; and

WHEREAS, the Administrator is engaged in the business of administering Workers' Compensation Self-Insurance Programs; and

WHEREAS, the Client desires to retain the services of the Administrator to administer a Workers' Compensation Self-Insurance Program, hereinafter referred to as the "Program," for the Client;

NOW, THEREFORE, the Client hereby retains the services of the Administrator and the Administrator agrees to perform the services for the Client under the terms and conditions of this Agreement.

TERMS AND CONDITIONS

I. TERM: This Agreement shall become effective October 1, 2019 and shall continue for three (3) years until September 30, 2022, unless terminated by the cancellation provision set forth herein.

II. SCOPE OF SERVICES: The Administrator shall provide the services described in Exhibit A attached hereto.

III. CONTRACT PRICE: The Client agrees to pay Administrator fees as set forth in Exhibit B which is attached hereto and made a part hereof. The Client and Administrator must agree, in writing, on any changes to this schedule.

IV. PERIODIC MEETINGS: The Administrator shall meet with the Client and staff either in person or through electronic means, at least quarterly, to:
   A. Assist in developing internal procedures.
   B. Provide orientation and training to personnel involved in the administration of the Program.
   C. Discuss specific claims and general trends in the Program.

V. ADVISORY SERVICES: The Administrator shall provide the Client information regarding the adoption, amendment or repeal of all statutes, rules and regulations, etc., which may directly affect the Program.
VI. REQUIRED FORMS: The Administrator shall provide the Client with all forms required by the State in connection with the Program.

VII. COMPLIANCE WITH LAW: The Administrator shall administer the Program in full compliance with all laws, rules and regulations governing Workers' Compensation and self-insurance.

VIII. CLAIMS ADMINISTRATION: The Administrator shall comply with all performance standards of the Client's excess insurer. The Administrator shall also comply with the Administrator's Workers' Compensation Claims Administration Standards, but under no circumstances are they to be construed as having precedence over the performance standards of the Client's excess insurer. The Administrator shall also have the authority and responsibility to provide claims administration services, which include:

A. Establishing an electronic claim file and computer database record upon receipt of an injury report.
B. Setting and updating reserves.
C. Initiating and maintaining contact with injured workers or their attorneys.
D. Arranging for investigation.
E. Determining compensability.
F. Preparing and issuing benefit notices, if applicable.
G. Arranging for medical treatment and medical services from clinics, facilities, pharmacies, hospitals, specialists, and other vendors as necessary.
H. Performing all utilization review services through MedReview; communicating decisions to approve, modify, delay or deny medical treatment in accordance with State law.
I. Monitoring disability status by reviewing medical reports and contacting doctors for updates.
J. Paying medical bills in a timely and accurate manner.
K. Paying mileage or medical reimbursements to injured workers.
L. Paying temporary disability compensation when appropriate to do so or advising the Client of the need to adjust payroll records when salary continuation is applicable.
M. Arranging medical exams in conformance with State law to determine whether an injured worker's medical condition is permanent and stationary (reached Maximum Medical Improvement/MMI) and what, if any, permanent disability exists.
N. Paying the permanent disability compensation in accordance with the law.
O. Arranging for attorney representation of the Client whenever the need arises.
P. Monitoring attorneys and assisting them in preparing cases.
Q. Auditing and paying legal expenses.
R. Arranging for vocational rehabilitation services when appropriate, monitoring vocational rehabilitation consultants, and assisting them as necessary.
S. Auditing and paying vocational rehabilitation expenses.
T. Preparing and issuing Supplemental Job Displacement Benefits (SJDB) notices and benefits.
U. Preparing and issuing the permanent disability compensation notices.
V. Pursuing subrogation when there is a viable third party.
W. Notifying the Client and excess insurers of all claims which exceed or may exceed the self-insurance retention; maintaining a liaison between the Client and their excess insurers on matters affecting the handling of such claims and arranging for reimbursement to the Client of losses in excess of its self-insurance retention.
X. Obtaining settlement authority and negotiating settlement on appropriate claims.
Y. Attending all hearings that are required by law.
Z. Closing claim files when appropriate to do so.

IX. OBLIGATIONS OF THE CLIENT: The Client shall:
A. Submit all information and reports of work incidents and work injuries to the Administrator in a timely manner of the Client’s knowledge of the incident or injury. Should the information/reports result in a non-claim file, a claim file will not be created or billed for as described herein.
B. Respond to the Administrator’s requests for information and authority within five (5) days of such requests.
C. Provide information that is accurate and is in a form specified by the Administrator.
D. Grant settlement authority to the Administrator in advance of Workers’ Compensation Appeals Board, rehabilitation, and legal hearings, or be available by phone or in person during same.

X. CLAIMS PAYMENT FUND:
A. All claims obligations, including loss, indemnity, and allocated loss adjustment expenses and other claim-related expenses, are the obligations of Client and shall be paid by Client.
B. Client acknowledges and agrees that the depository bank for Client funds provided to Administrator for the payment of claims and allocated loss adjustment expenses is Citizens Business Bank (“CBB”).
C. Client hereby authorizes Administrator to maintain an account with CBB in trust for (“ITF”) Client to be used as the depository/funding account relating to the payment of claims and allocated loss adjustment expenses (“Account”).
D. Duties of Administrator
   1. Any amounts collected by Administrator on behalf of or for Client and any amounts received from Client shall be deposited in the Account. Claims and allocated loss adjustment expenses for the claims will be paid by checks showing the identity of Client that are issued by Administrator against funds in this Account. CBB shall keep records clearly recording
the deposits into and withdrawals from the Account and the balance held on behalf of Client. Administrator shall cause CBB to render an accounting each month and on an annual basis detailing all transactions with respect to the Account, which accounting shall be provided by Administrator to Client.

2. Administrator shall collect, process, and report data in the manner prescribed by the Internal Revenue Service for the purpose of preparing Client’s 1099 Miscellaneous Income filing with respect to the claims and allocated loss adjustment expenses payment. As respects the Account, Administrator shall file required Unclaimed Property reports.

E. Duties of Client

1. Client shall maintain an amount of $65,000 (“Target Amount”) in the Account by sending additional funds to the Administrator for the Account at the interval indicated in paragraph E(2) below so that it equals or exceeds the Target Amount. Client agrees to increase the Target Amount upon request of Administrator, and in an amount to be determined by Administrator, within seven (7) business days after Client is notified by Administrator of the amount of the increase; subject to written justification for the increase of the Target Amount.

2. The Client shall maintain a minimum balance equal to or greater than thirty percent (30%) of the Target Amount (“Minimum Balance”) in the Account at all times. On any day the Account balance is less than the Minimum Balance, Client agrees to send a check to deposit into the Account within seven (7) business days after it is notified by Administrator so that the balance in the Account equals or exceeds the Target Amount. Any request for additional funds that exceeds the Target Amount is subject to written justification.

3. The Client shall submit a check to Administrator for the Account within seven (7) business days of receipt of each request from Administrator to cover each obligation for claims or allocated loss adjustment expenses exceeding $10,000 that have been or are expected to be paid on behalf of Client.

4. The Client shall be liable for and pay any and all overdraft amounts including bank fees and charges and interest thereon that are the responsibility of the Client and subject to verification. In the event Administrator pays any such amounts on Client’s behalf pursuant to Administrator’s agreement with the Bank, Client shall immediately reimburse Administrator upon demand and subject to verification.

5. Except as provided in paragraph E(4) above, the Client shall not be responsible for fees charged by CBB to administer the Client transactions and the Account. However, earnings or credits earned are applied toward such bank fees, with the excess, if any, retained by Administrator.

6. The Client shall provide such documents, written authorizations or resolutions, in a form required or acceptable to the Bank, authorizing Administrator and/or the Bank to effect the agreed to funding and payment arrangement.
F. In the event of any dispute between Administrator and Client regarding the propriety of any request for additional funds as contemplated by E(1) above, or regarding the propriety of Administrator’s actions in paying or determining to pay a claim or claims or an allocated loss adjustment expense, Client shall nonetheless permit or make the payments to the Account under a reservation of rights so that Client may enforce its rights with respect to any such payments or any other matters relating to this section.

XI. ELECTRONIC DATA PROCESSING: The Administrator shall provide the Client with electronic data processing services that will allow for the production of loss experience and transaction reports within ten (10) days following the close of each calendar month.

XII. REGULATORY REPORTING: The Administrator shall prepare all reports required by State and Federal regulatory agencies (if any) in connection with the Program, including the Self-Insurer’s Annual Report required by the Department of Self-Insurance Plans.

XIII. RECORDS: The Administrator shall establish and maintain electronic claim files, claim logs, transaction documents and all other records associated with the Program. These records shall be the property of the Client. Unless this Agreement is cancelled, closed hard files, if any, shall be stored by the Administrator for five (5) years from date of closure and shall thereafter become the responsibility of the Client. Upon cancellation of this Agreement, the Client shall be responsible for maintaining and storing all data, records, etc. The Administrator shall not dispose of or destroy hard files, if any, without the prior, written authorization of the Client.

XIV. ALLOCATED EXPENSES: The Client shall pay for field investigation, defense attorneys, legal costs, remote photocopy, engineering experts, accident reconstruction experts, process servers, messenger service, court reporters, vocational rehabilitation consultants, structured settlement consultants, translators, and any other vendor necessary to administer claim files.

XV. PENALTIES: The Administrator shall be responsible for paying or appealing penalties that are caused by the Administrator. The Administrator shall not be responsible for penalties that are caused by the Client or any third parties.

XVI. INDEMNIFICATION: The Administrator shall indemnify, hold harmless, and defend the Client from all claims, legal actions, losses, expenses, injuries, or damages arising out of the Administrator’s negligence or intentional wrongdoing incident to the performance of this Agreement.

XVII. INSURANCE: Administrator shall procure and maintain for the duration of the contract insurance against claims for injuries to persons or damages to property which may arise from or in connection with the performance of the work hereunder by the Administrator, its agents, representatives, or employees.
A. **Minimum scope and limit of insurance**

Coverage shall be at least as broad as:

1. Commercial General Liability (CGL): Insurance Services Office Form CG 00 01 covering CGL on an “occurrence” basis, including products and completed operations, property damage, bodily injury and personal and advertising injury with limits no less than $1,000,000 per occurrence. If a general aggregate limit applies, either the general aggregate limit shall apply separately to this project/location (ISO CG 25 03 or 25 04) or the general aggregate limit shall be twice the required occurrence limit.

2. Automobile Liability: Insurance Services Office Form Number CA 0001 covering, Code 1 (any auto), or if Administrator has no owned autos, Code 8 (hired) and 9 (non-owned), with limit no less than $1,000,000 per accident for bodily injury and property damage.

3. Workers’ Compensation insurance as required by the State of California, with statutory limits, and Employer’s Liability Insurance with limit of no less than $1,000,000 per accident for bodily injury or disease.

4. Professional Liability (Errors and Omissions) Insurance appropriate to the Administrator’s profession, with limit no less than $1,000,000 per occurrence or claim, $2,000,000 aggregate.

If the Administrator maintains broader coverage and/or higher limits than the minimums shown above, the Client requires and shall be entitled to the broader coverage and/or higher limits maintained by the Administrator. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to the Client.

B. **Other Insurance Provisions**

The insurance policies are to contain, or be endorsed to contain, the following provision:

1. Additional Insured Status: The Client, its officers, officials, employees, and volunteers are to be covered as additional insureds on the CGL policy with respect to liability arising out of work or operations performed by or on behalf of the Administrator including materials, parts, or equipment furnished in connection with such work or operations. General liability coverage can be provided in the form of an endorsement to the Administrator’s insurance (at least as broad as ISO Form CG 20 10 11 85 or both CG 20 10, CG 20 26, CG 20 33, or CG 20 38; and CG 20 37 forms if later revisions used).
(2) Primary Coverage: For any claims related to this contract, the Administrator’s insurance coverage shall be primary insurance coverage at least as broad as ISO CG 20 01 04 13 as respects the Client, its officers, officials, employees, and volunteers. Any insurance or self-insurance maintained by the Client, its officers, officials, employees, or volunteers shall be excess of the Administrator’s insurance and shall not contribute with it.

(3) Notice of Cancellation: Each insurance policy required above shall state that coverage shall not be canceled, except with notice to the Client.

(4) Waiver of Subrogation: Administrator hereby grants to Client a waiver of any right to subrogation which any insurer of said Administrator may acquire against the Client by virtue of the payment of any loss under such insurance. Administrator agrees to obtain any endorsement that may be necessary to affect this waiver of subrogation, but this provision applies regardless of whether or not the Client has received a waiver of subrogation endorsement from the insurer.

(5) Self-Insured Retentions: Self-insured retentions must be declared to and approved by the Client. The Client may require the Administrator to provide proof of ability to pay losses and related investigations, claim administration, and defense expenses within the retention. The policy language shall provide, or be endorsed to provide, that the self-insured retention may be satisfied by either the named insured or Client.

(6) Acceptability of Insurers: Insurance is to be placed with insurers with a current A.M. Best’s rating of no less than A: VII, unless otherwise acceptable to the Client.

(7) Verification of Coverage: Administrator shall furnish the Client with original certificates and amendatory endorsements or copies of the applicable policy language effecting coverage required by this clause. All certificates and endorsements are to be received and approved by the Client before work commences. However, failure to obtain the required documents prior to the work beginning shall not waive the Administrator’s obligation to provide them. The Client reserves the right to require complete, certified copies of all required insurance policies, including endorsements required by these specifications, at any time.

  a. Sub Administrators: Administrator shall require and verify that all sub Administrators maintain insurance meeting all the requirements stated herein, and Administrator shall ensure that the Client is an additional insured on insurance required from sub Administrators.
b. Special Risks or Circumstances: The Client reserves the right to modify these requirements, including limits, based on the nature of the risk, prior experience, insurer, coverage, or other special circumstances.

c. Workers' Compensation insurance as required by the California Labor Code.

XVIII. NOTICES: All notices, demands, requests, or approvals which are required under this Agreement, or which either the Client or the Administrator may desire to serve upon the other, shall be in writing and shall be conclusively deemed served when delivered personally, or forty-eight (48) hours after the deposit thereof in the United States mail with postage pre-paid.

XIX. CANCELLATION: This Agreement may be cancelled by the Client, or the Administrator, giving to the other, in writing, notice of its intention to cancel this Agreement at least ninety (90) days prior to the date of termination. Upon the date of termination of this Agreement, or the date on which records are transferred to another custodian, whichever occurs first, the Administrator shall no longer have the authority or responsibility to administer claims or perform any service on behalf of the Client.

XX. PARTIAL INVALIDITY: If any provision of this Agreement is held by a court of competent jurisdiction to be invalid, void or unenforceable, the remaining provisions shall nevertheless continue in full force and effect.

XXI. GOVERNING LAW: The validity of this Agreement and of any of its terms and provisions shall be interpreted pursuant to the laws of the State of California.

XXII. INTERPRETATION: The terms and conditions of this Agreement shall be construed pursuant to their plain, ordinary meaning and shall not be interpreted against the maker.

XXIII. ASSIGNMENT: The Administrator shall not assign, sublet, transfer by operation of law or otherwise, any or all of its rights, burdens, duties, or obligations of this Agreement without the prior, written consent of the Client.

XXIV. CONFLICT OF INTEREST: The Administrator shall avoid all conflicts of interest or appearance of conflicts of interest in performance of this Agreement.
XXV. ENTIRE CONTRACT: This instrument contains the entire Agreement between the Parties relating to the rights herein granted and obligations herein assumed. Any oral representations or modifications concerning this instrument shall be of no force or effect. Subsequent modifications shall be made in writing with the agreement of the Parties.

COUNTY: 

Miles Menetrey, Chair
Mariposa County Board of Supervisors
9/24/19

ADMINSURE INC.

Alithia Vargas-Flores, President
8/4/19

APPROVED AS TO FORM: 

Steven W. Dahlem
County Counsel
EXHIBIT A
SCOPE OF SERVICES

WORKERS' COMPENSATION PROGRAM OBJECTIVES:

- To ensure that all Workers' Compensation claims filed by the Client's employees are adjudicated on a timely basis by claims examiners licensed by the State of California and administered in accordance with the State of California Workers' Compensation Act.

- To ensure that employees sustaining work-related injuries or illnesses are provided with quality medical care and treatment in a timely manner and that claimants receive appropriate medical and rehabilitative services enabling maximum medical recovery and a safe and expedient return to work as early as possible.

- To develop and implement strategies that reduce the frequency and severity of claims.

- To maximize the usage of technology tools to enhance service delivery, reporting capabilities, and reduce redundant manual processes.

- To refine and enhance previously developed initiatives in managed care to contain program costs.

- To provide on-going review of existing practices and implementation of Best Practices to minimize the Client's Workers' Compensation Program costs and ongoing liabilities.

- Maintain regulatory compliance with applicable State, Federal and local reporting requirements for all facets of the program, including but not limited to the Workers' Compensation Program and OSHA reporting requirements.

The Scope of Work for all Third Party Administration Services will be performed in accordance with the laws, rules, and regulations of the State of California.

I. BASIC REQUIREMENTS:

1. Administrator must possess the required licenses, certifications, and insurance to perform services in every area as specified herein.

2. Administrator must have a minimum of five (5) years of experience providing Workers' Compensation Program administration for self-insured public agencies in the State of California.
3. Administrator shall provide special on-site training services when requested by Client to ensure Client personnel process Workers' Compensation claims effectively, carrying out the procedures required for a successful program.

4. Administrator will adhere to all HIPAA requirements, including the Code of Federal Regulations [45 CFR 164.512(v)] regarding "Disclosures for Workers' Compensation Purposes." Administrator agrees to execute and enter into a HIPAA Business Associate Agreement (BAA) if or when it is deemed necessary at any time by Client.

5. Administrator shall require an examiner to be available and readily respond to a Client designated staff's request for assistance with problem cases, including on-site visits if necessary.

6. Administrator will hold quarterly status meetings and annual stewardship meetings.

II. CLAIMS ADMINISTRATION:
   A. STAFFING REQUIREMENTS

   1. Each examiner shall have an average caseload not to exceed one-hundred sixty-five (165) open indemnity claims. Open indemnity claims may include future medical/medical only claims valued at 1/2.

   2. Administrator shall provide a monthly caseload report to designated Client personnel electronically within five (5) business days of closure of the previous month.

   3. Client will have final approval of any staff replacement or new hire decisions. In addition, Client will have the right to request removal of personnel assigned to this account. Removal will take effect within 30 days of written request.

   4. Administrator will hire a temporary claims examiner at its own expense when an examiner or supervisor's desk has been vacant for more than ten (10) consecutive working days. This will be without regard for the reason of the vacancy.

   5. Administrator shall ensure that any staff (examiners) who is assigned to Client's designated account is available to Client and its staff every business day (excluding holidays) between the hours of 8:00 a.m. and 5:00 p.m. throughout the term of this Agreement. Administrator shall provide direct contact phone numbers to contact supervisor and claims examiners.

   6. Administrator shall annually certify to Client that each claims examiner handling the claims is in compliance with all legal and regulatory licensing and continuing educational requirements as presently or in the future shall be promulgated and required by the State of California. Where required by law or
regulation, copies of all such certifications shall be provided at least annually by Administrator to Client.

B. CLAIMS MANAGEMENT
1. Administrator shall provide all forms necessary for the processing of benefits or claims information including the Employer’s Report of Injury, DWC-1 Form, return to work slips, vouchers, checks, and other related forms. These forms shall be provided electronically if requested. The cost of providing these forms shall be included within the contract price.

2. Upon receipt of the Employer’s Report of Injury, Administrator will prepare an individual claim file within two (2) working days for each claim. Preparation of the claim file shall include entering each new claim into the claims system and establishing appropriate reserves.

3. Future medical claims shall remain open for two (2) years from the last payment of benefit. Reviews shall be documented in the claim notes to include settlement information, future medical care outline, last date and type of treatment, name of excess carrier, excess carrier reporting level, and excess carrier reporting history.

4. Administrator will provide on-site file reviews quarterly, if requested. Other periodic on-site file reviews will include monthly "chart reviews" with select Medical Clinics or physicians along with Client staff. All reviews will be based upon the needs of Client.

5. Reserves shall be established based upon the ultimate probable cost of each claim. All reserve categories shall be reviewed on a regular basis but at least every ninety (90) days. Such review shall be indicated in the claim system’s notes. Any changes to reserves shall include an explanation for the change.

6. Each claim file shall contain the examiner’s plan of action for the future handling of that claim. Such plan of action shall be clearly stated including the reasoning for the plan in examiner’s claim notes. The plan of action will be updated at least every thirty (30) calendar days and clearly identified in the claim system’s notes.

7. Within five (5) days of knowledge of a need for an investigation, Administrator shall conduct a complete and timely investigation to determine claim compensability, nature and extent of injuries, apportionment issues and subrogation potential.

8. The compensability determination (accept claim, deny claim, or delay acceptance pending the results of additional investigation) and the reasons for such determination will be made and clearly documented in the claims
system's notes within five (5) working days of the receipt of the notification of the loss.

9. Delay or denial of benefit letters shall be mailed in compliance with the Division of Industrial Relations' guidelines. Administrator shall simultaneously notify Client of delay or denial of any claim.

10. Client reserves its right to render a final decision on any specific case pertinent to claim compensability.

11. Payment
   i. Administrator shall provide all compensation and medical benefits in a timely manner and in compliance with the statutory requirements of the California Labor Code, Administrator shall compute and pay temporary disability benefits to injured employees based upon earnings information and authorized disability periods, Administrator shall review, compute, and pay all informal ratings, death benefits, Findings and Awards, life pensions, or Compromise and Release settlements.
   ii. The initial indemnity payment will be issued and mailed to the injured employee, together with properly completed notices, within fourteen (14) days of the first day of disability. Late payments must include the 10% self-imposed penalty in accordance with Labor Code Section 4650. Penalties must be reported immediately to Client.
   iii. All indemnity payments subsequent to the first payment will be verified, except for obvious long-term disability, and issued in compliance with Labor Code Section 4651. Late payments must include the 10% self-imposed penalty in accordance with Labor Code Section 4650.
   iv. Transportation reimbursement will be mailed within five (5) days of the receipt of the claim for reimbursement. Advance travel expense payments will be mailed to the injured employee ten (10) days prior to the anticipated date of travel.
   v. Late payment of all benefits must include the self-imposed penalty in accordance with California law. Client will be provided a listing of any administrative penalties paid during the month, which were the responsibility of Administrator, together with a check from Administrator payable to Client for reimbursement.
   vi. Payments on awards, computations or Compromise and Release agreements will be issued within the required time limits. Those settlements that require board approval shall be submitted to Client in a timely manner for Board review.
   vii. Medical bills will be reviewed for correctness, approved for payment, and paid within the time limits established by Labor Code section 4603.2. If all or part of the bill is being disputed, Administrator will notify the medical provider, on the appropriate form letter, within the time limits established by Labor Code 4603.2.
12. Return to Work
   i. Administrator shall provide assistance to Client in returning injured employees to modified duty while recovering and prior to their return to regular duties.
   ii. Administrator shall consult frequently with Client in those cases where the injury might involve permanent work restrictions and/or retirement potential.

13. Permanent Disability
   i. Administrator shall explain and assist injured employees in completing the necessary forms to obtain a permanent disability rating.
   ii. Administrator shall determine the nature and extent of permanent disability and arrange for an informal disability rating whenever possible to avoid Workers’ Compensation Appeals Board litigation.
   iii. All permanent disability benefit notices shall be sent to the employee as required by the Labor Code.

14. Vocational Rehabilitation
   In accordance with all applicable California laws in place at the date of injury, Administrator shall:
   i. Determine the Qualified Injured Worker/Non-Qualified Injured Worker status;
   ii. Advise the injured worker of his/her right to rehabilitation benefits; and
   iii. Determine eligibility for and authorize supplemental job displacement benefits as necessary pursuant to Labor Code Section 4658.5, as well as all Vocational Rehabilitation benefits.

15. All claim files shall be reconciled to ensure all indemnity payments have been made correctly. The reconciliation should verify that payment amounts were correct, paid on the appropriate claim file, and all benefit notices were issued accordingly. The physical file should be verified with the computer information. All open claim files shall be reconciled at the time of a request for settlement authorization and at the time of submission for closure. Proof of the reconciliation should remain in the claim file.

16. Excess Insurance
   i. Administrator is the reporting agency for all excess carrier notification and shall identify and report to the excess-carrier(s), with a copy to the Client, all applicable policy reporting levels and criteria. All penalties, forfeitures or disqualifications imposed as a result of late reporting or non-compliance will be the responsibility of Administrator.
   ii. Any case that has the potential to exceed or have reached 50% of Client’s self-insured retention shall be reported to Client and the excess insurer in accordance with the reporting criteria established by the excess insurer. All cases that meet the established reporting criteria are to be reported to Client. All cases that meet the established reporting criteria are to be
reported within five (5) days of knowledge in which it is known the criterion is met.

17. Administrator shall pay fines and/or penalties imposed by the State of California and/or federal government for violations of law and/or regulations arising from acts or omissions of Administrator, including Medicare set-aside violations. Furthermore, Administrator agrees to indemnify, defend and hold the Client harmless from all claims, lawsuits, demands, costs, fees (including attorney fees), judgments and liability asserted against the Client by a third party which arise out of an act or omission by Administrator in the performance or non-performance of this Agreement.

18. The supervisor must review all medical only claims open beyond ninety (90) days from the date of entry by Administrator, for potential closure or conversion to indemnity claim status. Administrator will monitor stipulated cases with future medical provisions. Reserves for future medical will be reviewed semiannually and adjusted accordingly.

19. Administrator shall maintain all loss information as required by the Workers' Compensation Insurance Rating Bureau. Administrator shall assist in the preparation of all reports that are now, or will be required by the State of California or other government agencies with respect to self-insurance programs.

20. Administrator shall record and maintain a file of all industrial injuries reported. Such files shall be made available to the Client or its designated representative for inspection or audit upon request.

21. All claim files shall be maintained in accordance with statutory time requirements and Client shall be notified prior to any destruction of files.

22. Administrator shall be responsible for the storage of closed files up to the statutory requirement. All claim information and associated data are property of Client.

C. REQUIRED CONTACTS
1. Administrator shall initiate a three (3) point contact with the Client's designated staff, injured employee, and medical provider within three (3) working days from receipt of claim. All claim files shall be reviewed at least every thirty (30) calendar days for active claims and at least every six (6) months for claims that have settled but are open for future medical care. The examiner shall distinguish the regular diary review from routine file documentation in the computer notepad. A plan of action will be included and separately labeled in the file notes during a diary review. The supervisor shall monitor the diary reviews by printing a "No Activity" report each month to identify any files that have fallen off the diary system.
2. Employer Contact
   a. Administrator shall contact the Client’s designated staff within one (1) working day of receipt of notice of a "lost time" claim by any source. Such contact with Client shall be documented in the examiner's claim notes after the claim has been created in the system.

   b. Administrator shall request the Employer's Report of Injury form from the Client when or if notification of an injury or incident by any source is received first (i.e., Application of Adjudication, notice of legal representation, or Doctor's First Report of Injury, etc.).

   c. Administrator will confirm with the Client that the DWC-1 form was given to the employee within forty-eight (48) hours of knowledge of the injury. If there is no evidence the form was provided, Administrator will provide the form with the initial contact letter to the employee within three (3) business days of receiving the claim.

D. MEDICAL ADMINISTRATION
   1. The physician's office will be contacted within five (5) days of notice of all new indemnity claims. Such contact will continue as needed during the continuation of temporary disability to assure that treatment is related to a compensable injury or illness. All contact shall be documented in the claims system's notes.

   2. Administrator shall maintain contact with treating physicians to ensure employees receive proper medical treatment and are returned to full or modified employment at the earliest possible date.

   3. Administrator shall maintain direct contact with medical service providers to ensure their reports are received in a timely manner.

   4. Administrator shall arrange medical evaluations when needed, reasonable, and/or requested in compliance with the current Labor Code.

   5. Administrator shall ensure that medical bills are reduced to the recommended rates established by the Administrative Director of Workers' Compensation. The use of a service contractor must be approved by Client. Client shall pay for the use and benefits of the services provided.
E. LITIGATED CASES

1. Client's designated staff shall be alerted to the need for outside counsel as soon as possible, and the examiner shall appoint an attorney who is on Client's panel or in-house counsel if available.

2. When defense counsel is not necessary, Administrator shall work closely with the applicant's attorney in informal disposition of litigated cases.

3. In all cases where a third party is responsible for the injury to the employee, Administrator shall contact the Client's designated staff indicating they will pursue subrogation unless instructed otherwise by Client. When subrogation is to be pursued, the third party shall be contacted within ten (10) days of identification, with notification of Client's right to subrogation and the recovery of certain claim expenses. If the third party is a governmental entity, a claim shall be filed with the governing board within six (6) months of the injury or notice of injury.
   i. Periodic contact shall be made with the responsible party and/or insurer to provide notification of the amount of the estimated recovery to which the Client will be entitled.
   ii. If the injured worker brings a civil action against the party responsible for the injury, Administrator shall consult with Client about the value of the subrogation claim and other considerations. Upon Client's authorization, subrogation counsel shall be assigned to file a lien or a complaint in intervention in the civil action.
   iii. Whenever practical, Administrator should take advantage of any settlement in a civil action by attempting to settle the Workers' Compensation claim by means of a Third Party Compromise and Release. If such attempt does not succeed, then every effort should be made through the Workers' Compensation Appeals Board to offset claim expenses through a credit against the proceeds from the injured worker's civil action.

4. Self-Insurer's Report
   i. Administrator shall maintain records and information to complete the Public Self-Insurers Annual Report in accordance with all State of California requirements.

   ii. Administrator shall provide the Annual Report to Client no later than thirty (30) days before the date on which the annual report is due to the State.
III. CLAIMS REPORTING/INTAKE INFORMATION SYSTEMS (CRIIS)

Administrator must host a Claims Reporting/Intake Information System, hereinafter also referred to as "System", to manage Client's extensive historical and ongoing Workers' Compensation claims data associated with its worksites. Client is seeking a web-based relational database system with the capability to exchange data in real-time or close to real-time. The Administrator and Client will utilize the CRIIS to manage all claims activity. All claims data will be the property of Client and must be made available immediately upon request by properly authorized Client personnel. The CRIIS must provide comprehensive claims data management.

A. System Security and Accessibility

System must be available during normal Client business hours (8am to 5pm PST, excluding holidays).

B. Functions and Features

1. Run real time or almost real time, on line. ("Real time" means instantaneously and "almost real time" means as soon as possible, usually, within five minutes.)

2. Capture and manipulate all third party and Workers' Compensation data elements.

3. Run reports of similar format and consistent content, for ad hoc, custom and standard reports, loss development, incurred but not reported, forecasts and detailed payment registers, and third party claims based on occurrences or claims (third party claims data are maintained on an occurrence basis) at no additional charge to Client.

4. Incorporate drop down menus for data entry.

5. Feature a "kick out" function that will reject and flag an invalid entry where drop-down menus cannot be used and will flag required fields.

6. Capture information about witnesses, including driver's license number and contact information.

7. Support automatic generation of different types of notifications via email.

8. Provide a claims-related internal calendar on which to record items such as jurisdiction deadlines and court dates.
C. Claims intake

1. System must be web-based and allow Client staff to enter incidents of industrial injury or illness.

2. System will generate and distribute the necessary new incident records (DWC-1 and the 5020)

3. System will generate automated emails, to confirm entry, and notify appropriate staff of new entry.

D. Reports

1. System must be able to generate monthly, quarterly and annual reports. Below is a list of typical reports Client requires. Additional reports may be required; Administrator will generate reports at no additional cost to Client.
   a. Subrogation recovery
   b. TTD report
   c. Open claims
   d. New claims by examiner
   e. Reopened claims by examiner
   f. Closed claims by examiner
   g. Monthly payment variance report
   h. Litigated claims report
   i. Claims in subrogation report

2. System must have ability to run ad hoc queries.

E. Implementation

1. Administrator will perform data conversion on all historical data and financial elements.

2. Administrator must be able to respond to Client's requirements promptly, restructure old data into new formats, if required, without losing data integrity.

3. Administrator will provide its standard implementation services at no additional charge.

IV. MEDICAL MANAGEMENT SERVICES
Client currently employs David Donn Consulting, Inc. (“DDC”) for the enforcement and audit of its managed care program. Administrator shall work with DDC or Client's audit consultant, in the ongoing delivery of Medical Management Services. Administrator will provide Workers’ Compensation “Medical Management Services”
for Client, as further described herein. At its sole discretion, Client may employ or not employ any of the Medical Management Services listed herein.

As directed by Client, Administrator will provide the following Medical Management Services:

1. Definitions
   Administrator will provide Workers' Compensation Medical Management Services as requested by Client, including the following individual service elements:

   a. "Utilization Review" or "UR," which means the review of medical treatment requests; the determination of the appropriateness of such requests under state-mandated guidelines; the rendering, delivery and communication of such determinations in compliance with all applicable jurisdictional regulations and requirements; and any ancillary services, workflows and systems required to deliver such services. UR includes but is not limited to the following individual service components:

      i. "Nurse Review" or "NR," which means the initial review of proposed medical treatment for approval or referral to Physician Review (defined below), with such determinations made based on nationally recognized treatment guidelines such as MTUS (Medical Treatment Utilization Schedule), ODG (Official Disability Guidelines) and ACOEM (American College of Occupational & Environmental Medicine). NR includes the rendering of approval determinations and the communication of such determinations to statutorily-required parties (including but not limited to claims examiners, injured workers, physicians and medical facilities, attorneys and Client), in compliance with jurisdictional statutes and regulations.

      ii. "Physician Review" or "PR," which means the physician-rendered review of proposed medical treatment by a physician licensed and qualified to render decisions to approve, adjust or deny such treatments, in accordance with nationally recognized treatment guidelines. PR includes the rendering and communication of such determinations to statutorily-required parties (including but not limited to claims examiners, injured workers, physicians and medical facilities, attorneys and Client), in compliance with jurisdictional statutes and regulations.

   b. Delivery of documentation and information required by "Independent Medical Review" or "IMR." IMR means the process established and regulated by California Senate Bill 863, under which an injured worker may appeal a UR decision through an independent review performed by
the organization ("Independent Medical Review Organization" or "IMRO") designated by the California Division of Workers' Compensation ("DWC").

2. Services
At Client's sole discretion, Administrator will provide all the Medical Management Services listed in the Definitions above, in compliance with all jurisdictional statutes and regulations. If elected by Client, Administrator will cooperate with Client and make all commercially reasonable efforts to provide Medical Management Services through a subcontractor that is identified by Client as having the capability to optimally deliver all financial and operational service elements detailed in this Agreement.

Administrator agrees to work with DDC to deliver optimal service performance, in areas including but not limited provision of staff meeting DDC requirements for experience and training, customization of Medical Management referral triggers and UR determination letters to maximize cost-efficient use of Medical Management Services and optimize Medical Management outcomes, and program reporting compliant with DDC reporting specifications. Administrator agrees to implement in full DDC's program delivery specifications (the "DDC Model"), as detailed in the DDC Model document and updates provided from time to time by DDC and acknowledged and accepted by Administrator.

Administrator will work in good faith with Client and its agents to implement and adhere to all commercially reasonable practices necessary to achieve Client goals for reduction of Medical Management Services usage such that Medical Management Services provide maximum efficiency as determined by Client.

3. UR Plan
Administrator shall develop, file, and to the best of its ability obtain State of California approval of a Client-specific UR plan compliant with California Workers' Compensation statutes and regulations. Administrator shall use commercially reasonable best efforts to obtain approval within timeframes required by the State of California.

4. Determination Letters
When clinically appropriate, URO determination letters shall cite multiple relevant treatment guidelines when indicated, with the guidelines employed to adhere to best-practice state recommendations or requirements. The content of UR determination letters shall satisfy all Client standards.

5. UR Turnaround Time and Documentation
All Medical Management Services and corresponding documentation will be provided within timeframes that comply with applicable jurisdictional statutes and regulations governing the delivery of UR services. All documentation issued as part of Medical Management Services will contain information that is fully compliant with all jurisdictional statutes and regulations.
6. Referral Criteria
Administrator shall adhere to the referral criteria approved by Client specifying which types of treatment requests will be sent to UR and CM for Client. Administrator shall work with Client and its agents in the development of the referral criteria used to determine whether or not medical treatment requests are subject to UR/CM. Client agrees that it will make reasonable efforts to forward medical requests for authorization for which it wants Administrator to perform UR and CM services, to Administrator within 2 (two) days of Client’s receipt of such requests for authorization.

7. Repricing Interface
As directed by Client, Administrator will upload in a format acceptable to Client all treatment recommendations, limitations, and determinations to repricing systems of Client’s bill review vendor, as applicable, for entry and enforcement through the bill review system employed for the review of Client’s Workers’ Compensation medical bills. All UR information shall be provided no later than three (3) business days subsequent to the development of this information by Administrator UR personnel.

8. Program Reporting
Administrator will provide Client with monthly reports as specified by Client. Administrator shall provide customized program reports as directed by Client or its designees.

9. Personnel
All personnel Administrator assigns to Client’s program will be approved by Client prior to such assignment. All nurse and physician personnel providing Medical Management Services on Client cases will carry all licenses, certifications, and degrees required to provide such Medical Management Services in the applicable jurisdiction. Notwithstanding the fact that Client maintains the right to approve the assignment of all Administrator personnel, Administrator is and remains solely responsible for providing qualified personnel to perform Managed Care Services. Administrator’s liability for such provision of qualified personnel is not in any way limited by Client’s approval.

10. Voluntary Appeals Process
For denied or modified treatment requests, Administrator will provide a voluntary appeals process for Client’s injured employees. UR determination letters sent to Client’s employees and their attorneys will include Client-approved language describing this appeals process. If desired by Client, Administrator will perform outreach to Client’s employees regarding the voluntary appeals process as directed by Client, except that this process will not be performed on litigated cases.

At Client’s sole discretion, this outreach will be performed either by Administrator
administrative staff or clinical nurse staff. Administrative staff outreach will only include notification of injured employees of the option to employ the appeals process in cases where additional medical support can be provided by the requesting physician, and Client and Administrator will work together to develop a script that is acceptable to Client and will be followed by Administrator administrative staff. Clinical outreach will include this notification as well as clinical guidance on the reason(s) for Administrator’s UR determination(s).

11. Drug/Narcotics Review Program
If elected by Client, Administrator will implement a drug/narcotics review program whereby red flag narcotics treatment requests or activity (identified by Client or Administrator) are escalated to a specific narcotics review process. At Client’s discretion, this narcotics review process may involve a heightened level of treatment review.

12. Hearing Representation
As required by Client and in relation to the Medical Management Services rendered, Administrator will provide supporting documentation, physician reviewer and/or expert witness with appropriate qualifications at hearings and lien and other payment dispute meetings and conferences, without additional cost to Client, provided that Client has advised Administrator of said requests within fifteen (15) calendar days, or as soon as reasonably possible if Client has received less notice itself. This representation will be provided by Administrator for the duration of its provision of Managed Care Services and up to six (6) months after termination of Managed Care Services. Administrator will work with Client to ensure a mutually effective strategy for defending issues raised by Client’s employee(s) and/or applicant attorney(s) on issues related to UR and IMR.

13. Data Exchange Formats
Administrator will employ data exchange technology and security protocols that conform fully to Client requirements, and make necessary modifications to this technology and these protocols when required by Client. Administrator will support and employ a data exchange facility using secure file transfer security protocols no later than ninety (90) days following commencement of Managed Care Services, unless otherwise mutually agreed by the parties.

14. State Audits
Administrator will perform Medical Management Services in full compliance with all requirements of California Workers’ Compensation regulations. All Medical Management Services and corresponding documentation will be provided within timeframes and containing information that is fully compliant with California state statutes and regulations. Administrator will reimburse Client in full for any and all California state audit penalties incurred by Client as a result of Administrator omission or error.
15. SB 863
Administrator will perform Medical Management Services in full compliance with all requirements of California Senate Bill 863 and statutes for IMR. Such compliance will include but not be limited to providing Client with all resources as required by Client for the fulfillment of IMR processes, and providing Client with UR decision information and medical necessity information as required by Client. Administrator will reimburse Client in full for all IMR costs and administrative costs related to IMR decisions that find against Client due to 1) errors that IMRO determines to have resulted from Administrator error, and 2) errors determined by IMRO to result from failure to follow UR procedural requirements specified under state regulations. Procedural errors shall include but not be limited to: missing signatures required in any Administrator documents or UR decision letters; Administrator failure to provide documentation or other correspondence (written or verbal) within required timeframes; Administrator failure to include required documentation or reports in its written correspondence; Administrator failure to review relevant medical reports in rendering UR decisions (unless Administrator requested and did not receive such reports, provided Administrator requested such reports at least one time from Client, and one time from medical provider in the event Client did not have all requested reports); and Administrator failure to identify information (e.g., MRI results) included in documentation Administrator received from Client or medical providers (provided such information is deemed by IMRO to be relevant to UR decision). Notwithstanding any language to the contrary contained herein, Administrator shall not be responsible for IMR costs or penalties resulting from IMR decisions that find against Client due to new injury information being submitted to IMRO at the time of the IMR.

16. IMR Results Tracking. Administrator shall track all IMR results that are provided to Administrator by IMRO and/or Client, whether delivered in paper format or electronically. If delivered in paper format, Administrator shall scan and convert such documents into electronic files. Administrator shall store such IMR files electronically, together with other documentation associated with each IMR’s respective case.
EXHIBIT B
FEE SCHEDULE

This Exhibit is attached to and made part of the Workers’ Compensation Program Service Agreement between Administrator and Client dated October 1, 2019.

Claims Administration Fees
For services rendered pursuant to the attached Agreement, Client will pay Administrator an annual Claims Administration Fee payable in four (4) installments each year for the period of October 1, 2019 to September 30, 2022, with the first installment invoiced on September 1, 2019 and every three months thereafter as follows:

October 1, 2019 through September 30, 2020: Four (4) Installments of $19,125.
October 1, 2020 through September 30, 2021: Four (4) Installments of $19,508.
October 1, 2021 through September 30, 2022: Four (4) Installments of $19,899.

These fees are premised on an estimated annual (open) indemnity claims volume of 72 files. Should the actual claims volume be less than or exceed these estimates by 15%, then both parties will agree to negotiate in good faith, a reasonable fee adjustment.

Utilization Review Fees

<table>
<thead>
<tr>
<th>Service</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Review</td>
<td>$85.00 per review (includes all non-Physician Review services detailed in Scope of Services for UR of this Agreement (Exhibit A))</td>
</tr>
<tr>
<td>Physician Review</td>
<td>By specialty, billed in increments of no more than 10 minutes:</td>
</tr>
<tr>
<td></td>
<td>$115.00 per hour – Chiropractic</td>
</tr>
<tr>
<td></td>
<td>$175.00 per hour – Occupational therapy, acupuncture, general medicine</td>
</tr>
<tr>
<td></td>
<td>$200.00 per hour – All other specialties</td>
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<tr>
<td>Program reporting, as specified by County</td>
<td>No fee</td>
</tr>
<tr>
<td>Utilization Review system access</td>
<td>No fee</td>
</tr>
<tr>
<td>Hearing/Dispute Representation (documentation and human representation as required by County)</td>
<td>No fee</td>
</tr>
</tbody>
</table>