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2017 Workers' Compensation Claims Audit

Santa Clara County Schools' Insurance Group

August 28, 2018

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Corinne J. Kelsch
Santa Clara County Schools' Insurance Group
645 Wool Creek Drive
San Jose, CA 95112
Via email: CKelsch@sccig.org

RE: Santa Clara County Schools' Insurance Group – 2017 Workers' Compensation Claims Audit

Dear Ms. Kelsch:

Please find enclosed the findings and recommendations of our claims audit on behalf of the Santa Clara County Schools' Insurance Group (SCCSIG). Our audit examines the claims handling practices of Keenan and Associates (Keenan), SCCSIG's third party administrator (TPA).

We present an overview of our findings in Chapter I and discuss our findings in Chapter II. We look forward to discussing this report.

Bickmore appreciates the opportunity to provide claims audit services and the assistance received from the SCCSIG and Keenan. We stand ready to answer any questions. Please feel free to contact Dennis Mitchell at:

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It has been a pleasure to provide services for this important project.

Respectfully submitted,

Dennis Mitchell, CPCU, SCLA, ARM
Senior Claims Consultant

Table of Contents

Exhibits

Tables

Appendices

I. Executive Summary

Santa Clara County Schools' Insurance Group (SCCSIG) is a risk sharing pool formed in 1978 to address the challenges of obtaining insurance at a reasonable cost. Workers' compensation coverage for county schools is provided by pooling resources. Members pool assets to pay their own claims rather than purchase primary insurance from the commercial market. The SCCSIG self-insurance retention (SIR) ranges from $100,000 to $250,000 for the claims reviewed. These claims have excess coverage through the Schools Alliance for Workers' Compensation Excess (SAWCX II) program for occurrence years 1980 through 1995. Keenan and Associates (Keenan) is responsible for claims service as the third party administrator (TPA). Keenan also administers the SAWCX II program.

SCCSIG seeks a workers' compensation claims audit to:

- Be assured its claim services are performed effectively;
- Ensure sound and accurate procedures are in place; and
- Determine recommendations for improvements, as necessary, to better comply with applicable industry best practices, California Labor Code and regulations, and SCCSIG's own policies and procedures.

Eight Keenan adjusting personnel handle day-to-day administration of these older claims, where the latest coverage year is 1995. Oversight is provided by five supervisors who report to an Assistant Manager and Director of Claims. Staff is located primarily in Keenan's San Jose office, although some staff is located in Keenan's Rancho Cordova office. Examiners are provided support by a pool of claims assistants.

Keenan administers claims using a combination of the iVOS claims management information system (CMIS) and physical claim files. iVOS is a web-based program used for recording claim and financial data, as well as attaching electronic images. Keenan adjusters use iVOS to update an electronic notepad in claims and for storage of electronic images. Keenan now operates in a paperless environment. However, because of the age of these claims, most have an accompanying paper which house older documents not converted to documents for electronic storage. During the audit we required very few paper files to supplement review of the electronic claims files.

To assist SCCSIG in evaluating claims administration services Bickmore reviewed:

- Claims data spreadsheets provided by Keenan for claims remaining open in the SAWXC II excess insurance program;
- SCCSIG summary of excess coverage by year;
- Qualifications of Keenan's staff involved in administration of member claims;
- SCCSIG team's approach to claims handling per interview of Keenan's Director of WC Claims and Assistant Manager; and
- Medical Bill Review savings by PRIME for the 2017 calendar year for the entire SCCSIG Program.

In addition, Bickmore:

- Analyzed data, selected and reviewed a sample of 50 open and closed workers' compensation claims onsite at Keenan's San Jose office between July 16, 2018 and July 19, 2018, and remotely through July 23, 2019 for:
  - Conformity with industry best practices, state, and federal laws;
  - Compliance with excess reporting requirements; and
  - Accuracy of the CMIS.
- Interviewed Keenan staff to gain feedback on our understanding of the operation of SCCSIG's workers' compensation claims program and validate audit findings through August 16, 2018.

We find Keenan's overall performance is Superior, with an overall score of 98%. Performance is assessed at superior for 10 of the 12 components reviewed. Two components are assessed as commendable according to the evaluation criteria and scale shown in Tables I-1 and I-2.

Table I-1
Performance Evaluation Criteria

Evaluation	Criteria
Yes	Where performance requirements are met.
No	Where deficiencies may contribute to increased claim costs.
Not Applicable	Where performance requirements are not applicable for claim circumstances presented.

Findings for 'Yes' are divided by possible findings ('yes' plus 'no' findings) to determine the percentage of compliance. Using the scale shown in Table I-2, we assess performance. This approach prevents a criterion involving a few claims from unduly influencing the overall score.

Table I-2
Performance Evaluation Scale

Performance	Average Grade
Superior	95% - 100%
Commendable	90% - 94%
Acceptable	85% - 89%
Requires Improvement	Below 85%

Exhibit I-1, "Claims Audit Scoring Summary with Financials," provides scoring for all claims reviewed by component with a summary of our financial analysis. Exhibit I-2, "Scoring by Component Summary Graph" provides graphic comparison of scoring with the acceptable target.

A list of claims reviewed is included in Appendix A.

Our performance assessment is illustrated in Appendix B "Claims Audit Summary by Component, Subcomponent, and Criteria Scores with Exceptions." Exceptions for components are listed at the end of each section with criteria number(s) and claim number.

We completed a claims audit scoring detail by claim, including analysis of reserves and recommending reserve changes as needed and providing comments supporting the recommendations. Scoring by claim details were reviewed with Keenan and feedback

considered. Due to the sensitive nature of claim details, as some may contain personally identifiable medical information, we do not include them with the report. However, they are available upon request.

To improve performance we recommend implementing the performance enhancements discussed in Table I-3.

Table I-3
Recommendations

Components (Sub-Components)	Recommendations
Claim Settlement Process - 96% (Evaluation Process 93%)	We recommend Keenan **increase supervision** focus on the thoroughness and quality of examiners' evaluation process by requiring documentation of: • Settlement rationale when requesting settlement authority; • Approval of settlement authority with a copy of a document signed by the client, or examiner's notepad entry which include date, time, and identification of individual granting authority; • Resolution plan which outlines steps and target dates to achieve the desired outcome; and • Negotiations by recording amounts of all offers made, date, by whom, and to whom.
Litigation Management - 93% (Strategy Development - 93%)	We recommend Examiners **discuss case strategy** with defense counsel within 30 days of assignment to promote early development of a resolution plan.
Control of Claims - 93% (Use of cost savings alternatives – 98%)	We recommend Keenan **increase supervision** to ensure examiners document consideration of actions to control and mitigate costs, including filing ISO ClaimSearch index every 18 months as required.

We provide narrative discussion of findings related to recommendations in Chapter II.

We recommend our report be read in its entirety.

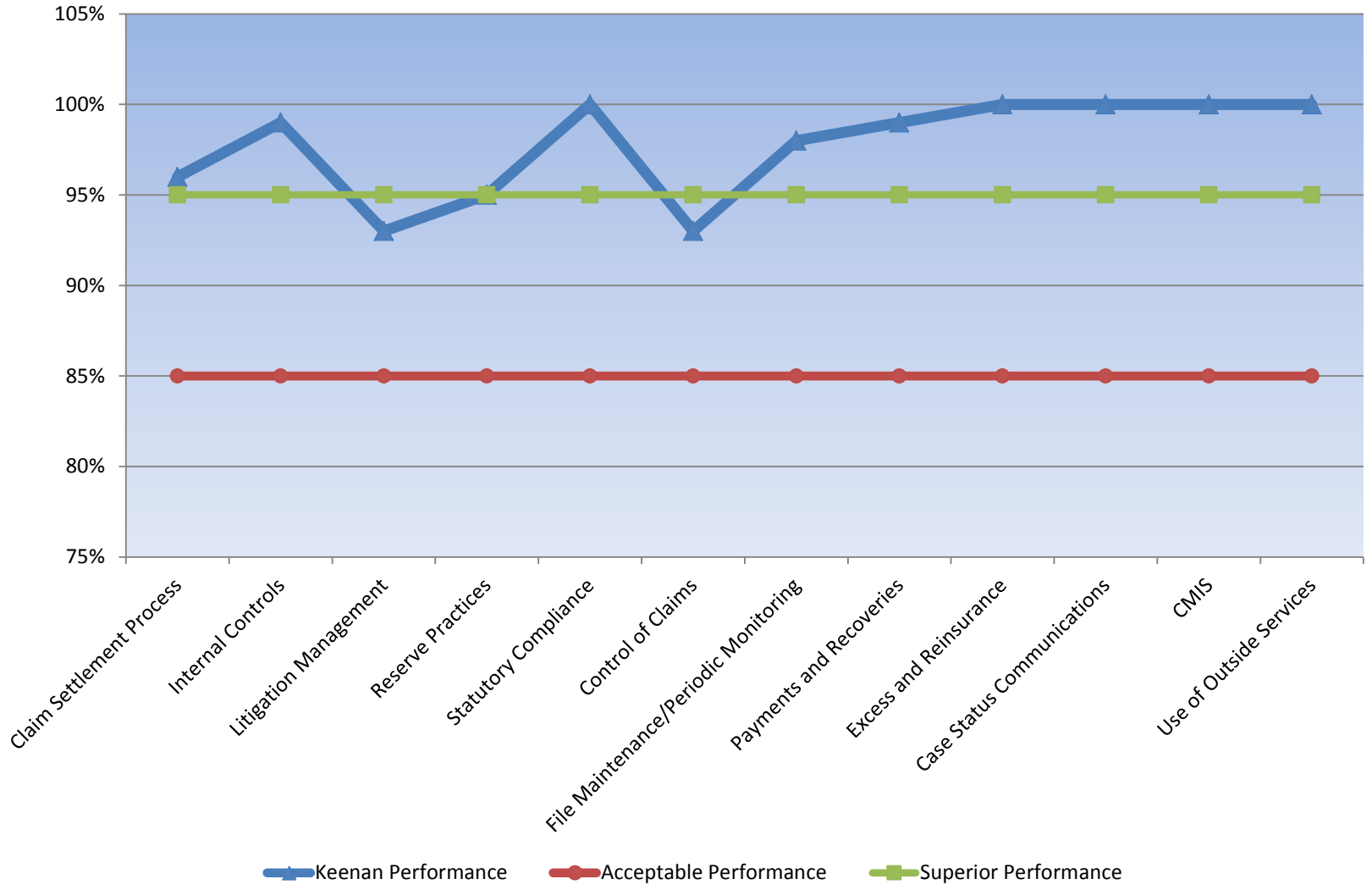
Exhibit I-1
Claims Audit Scoring Summary with Financials

Claims Reviewed:	**50**	**Actual Reserve:**	**$2,225,050**
Incurred:	**$10,389,775**	**Recommended Reserve:**	**$2,208,827**
Paid:	**$8,164,725**	**Net Reserve Change:**	**($16,223)**

Claims Areas of Operation	# Claims Scored	Findings			Actual (Yes)	Possible (Yes + No)	Scoring* (Actual/ Possible)	Target
		Yes	No	N/A				
1. Claim Settlement Process	48	161	6	283	161	167	96%	95%
2. Claims Deductibles	Not Applicable							
3. Internal Controls	50	245	2	53	245	247	99%	95%
4. Litigation Management	17	27	2	221	27	29	93%	95%
5. Reserve Practices	50	134	7	209	134	141	95%	95%
6. Statutory Compliance	45	45	0	105	45	45	100%	95%
7. Control of Claims	49	89	7	504	89	96	93%	95%
8. File Maintenance/Periodic Monitoring	50	193	4	3	193	197	98%	95%
9. Payments and Recoveries	45	128	1	171	128	129	99%	95%
10. Excess and Reinsurance	25	44	0	156	44	44	100%	95%
11. Case Status Communications	46	102	0	98	102	102	100%	95%
12. CMIS	47	188	0	12	188	188	100%	95%
13. Subrogation/Recovery	Not Applicable							
14. Use of Outside Services	4	11	0	239	11	11	100%	95%
Overall Administration:	50	1,367	29	2,054	1,367	1,396	98%	95%

*Scoring for components is a weighted average calculated by dividing the sum of 'yes' responses for criteria by the sum of possible responses.

Exhibit I-2
Scoring by Component Summary Graph



II. Audit Discussion

This chapter provides our findings for each component we measure. Our findings consider how well Keenan's procedures meet industry best practices, state and federal laws, SCCSIG's contractual requirements, and how well Keenan performs per the sample claims review. Below is a narrative discussion of our analysis and findings. Exceptions for all components are found in Appendix B. Upon request, we can provide additional detail including comments related to each claim reviewed. Best practices noted for each component represent our understanding of those practices from experience in managing scores of similar audits.

Our audit discussion is divided into sections addressing each of the twelve components applicable to this sample of mature claims. Two components we usually evaluate in workers' compensation audits are considered not applicable to this audit because of the age of the claims reviewed.

1. Claims Settlement Process

Industry best practices require the claims settlement process to include documentation of:

- Analysis and evaluation of extent of injury within 30 days of receiving information supporting claim resolution;
- Authorization requests and approvals;
- Offers and demands;
- Stipulations to the agreed upon extent of permanent disability approved by the Workers' Compensation Appeals Board (WCAB) which extinguishes that portion of the claim, leaving the claimant's entitlement to lifetime medical benefits; and
- Compromise and Release settlements (also requiring WCAB approval) which may be used to effect a full and final settlement.

SCCSIG procedures appropriately distribute settlement authority as follows:

- Keenan has $50,000 authority for setting reserves and claim resolution, subject to member concurrence and excess carrier approval where the excess layer is involved;

- Settlements exceeding $50,000 and involving the excess coverage layer require the approval of the SCCSIG CEO;

- Settlements with the excess coverage layer require the SAWCX II Reinsurance Manager approval if within the SAWCX II coverage layer; and

- Settlements above the SAWCX II coverage layer require approval of the carrier's excess insurance manager.

Beginning in 2012, section 111 of the Medicare Medicaid SCHIP Extension Act Section of 2007 (MMSEA) established requirements for insurers and self-insurers to report payment obligations involving a Medicare beneficiary (or, in the case of a settlement, a "soon-to-be-beneficiary") to the Centers for Medicare and Medicaid Services (CMS) to promote Medicare's secondary payment status for injuries which would be covered under workers' compensation or liability insurance of self-insurance.

When making a lump sum settlement involving a Medicare beneficiary, the settling party must make a good faith effort to ensure the amount of the settlement is sufficient to fund the claimant's expenses for future treatment. This is usually accomplished using a Medicare Set-Aside Agreement where parties agree on the amount needed for future care and set that amount aside in the settlement.

If the "set-aside" fund proves insufficient, CMS may refuse to pay future medical expenses once the fund is depleted. However, if CMS approves the MSA, CMS will continue to make future payments, regardless of amount. CMS will review any MSA exceeding $25,000 for a current beneficiary ($250,000 for a future beneficiary).

We find:

- Virtually all open claims in this program have future medical exposure;

- Examiners continue to evaluate whether settlement of future medical expense makes financial sense, if so, approach the claimant (or attorney) regarding interest in settlement;

- Most of the claims require a Medicare Set-Aside Agreement (MSA) to document a good faith effort to protect CMS secondary payment interest by the settling parties;

- Many settlements are proposed specifying the MSA will not be submitted to CMS for approval;

- Three exceptions to communicating and adequately documenting the rationale when requesting settlement authority; and

- Two exceptions to thoroughly documenting negotiations, including dates and parties involved when communicating offers and receiving demands.

We agree CMS approval poses issues of approval delays and unreasonably high settlement costs. The approach taken to resolve the claim without CMS approval makes sense as long as there is confidence in the vendor who undertakes preparation of the MSA and provides sufficient guarantees should the set-aside funds prove insufficient. The greater hurdle to overcome in using this approach is convincing the claimant and the attorney that future protection is adequate.

We evaluate the Claim Settlement Process as superior. We recommend Keenan increase supervision focus on the thoroughness and quality of examiners' evaluation process by requiring documentation of:

- ***Settlement rationale when requesting settlement authority;***

- ***Approval of settlement authority with a copy of a document signed by the client, or examiner's notepad entry which include date, time, and identification of individual granting authority;***

- ***Resolution plan which outlines steps and target dates to achieve the desired outcome; and***

- ***Negotiations by recording amounts of all offers made, date made, by whom, and to whom.***

2. Claims Deductibles - Not Applicable

3. Internal Controls

Best practices require:

Payments monitoring and reconciliation with banking and accounting records, including:

- Requirement to perform professional review payments are owed as related to the claim/compensable injury. Best practices require providing training to ensure a thorough understanding of the California Labor Code and Regulations;
- Requirement to approve and requisition payments by separate personnel; and
- Requirement for payee entry to the claims management information system (CMIS) by staff member other than claims handling staff.

Keenan's procedures ensure:

- Compliance with Internal Revenue Service (IRS) 1099 procedures;
- Verification of payee validity by requiring claims staff to obtain the IRS form W-9, "Request for Taxpayer Identification" from the party to be paid, if the payee is not in the iVOS vendor file; and
- Submissions of the IRS form W-9 to the payment processor for entry into iVOS. Where the payee is in the vendor file, a new form W-9 is not required.

Controls on payments are in place and meet or exceed industry best practices.

Workload appropriateness for staff and overall office, including:

- Requiring adjusters with experience appropriately matching claim complexity mix and quantity of claims assigned;
- Requiring supervision of caseload assignment activity; and
- Requiring support for adjusters from clerical staff.

SCCSIG requires Keenan to use reasonable efforts to maintain examiner caseloads with no more than 150 active, open indemnity claims. Caseloads at the time of the audit ranged from 121 through 151 claims, but all caseloads included future medical claims which we would not consider to be open and active indemnity claims. Review of the audit sample reflects current claims activity, with no delays which might indicate excessive caseloads.

Supervision is provided at 180-day intervals or sooner, and is focused on resolving claims and maintaining reserve accuracy.

Seven of the eight examiners' experience exceeds ten years in the industry and more than five years with Keenan. All are capable of handling a wide variety of assignments.

Examiners are provided clerical support where necessary.

Performance for internal controls is superior, scoring 99%.

4. Litigation Management

Best practices require the administrator to avoid unnecessary litigation by:

- Investigating claims promptly;
- Evaluating claims reasonably and making early resolution decisions; and
- Treating claimants and their applicant attorneys (AA) fairly.

Where litigation does occur, to minimize costs, the administrator is expected to:

- Assign defense attorney (DA) timely;
- Make assignment to defense attorney appropriately;
- Develop a legal strategy and budget;
- Collaborate with the defense attorney to facilitate development of alternative resolution strategies where appropriate;
- Consider alternative dispute resolution; and

- Monitor defense counsel's billings to ensure compliance with contractual requirements.

Within the audit sample, we note 33 open, litigated claims. Very few had active litigation, but several were still represented by counsel for medical or settlement issues. Four were referred to counsel because of new issues, and all were timely referred to approved counsel with a summary of the issues.

Counsel's evaluation and strategy are requested timely. We note two exceptions where early discussion of case strategy between the DA and examiner did not occur, although the evaluation and strategy was reviewed and filed. Discussion promotes the examiner becoming an active participant in the case and can accelerate resolution.

We evaluate performance for Litigation Management as commendable. We recommend examiners discuss case strategy with defense counsel within 30 days of assignment to promote early development of a resolution plan.

5. Reserve Practices

Best practices require:

- Establishing initial reserves timely based on the initial report information;
- Documenting the analysis of reserves for indemnity and expense;
- Reevaluating reserve accuracy regularly;
- Recognizing changes in the extent of injury or coverage picture supporting a reserve revision and making adjustments within 30 days of recognition; and
- Prompt investigation, accurate extent of injury or coverage assessments, and realistic litigation budgets to eliminate reserve stair stepping (the practice of increasing reserves incrementally without the benefit of analysis).

We recommend basing reserves on the most probable outcome (MPO) for expected payments. This is a methodology we encourage for other similar entities, as it is fiscally prudent.

Calculation of MPO is recommended as follows:

- Where there is a 75% or greater chance for favorable outcome, reserve for favorable outcome plus 25% of probable adverse outcome;
- Where there is a 51% to 75% chance for favorable outcome, reserve for favorable outcome plus 50% of probable adverse outcome;
- Where there is a 25% to 50% chance for favorable outcome, reserve for favorable outcome plus 75% of probable adverse outcome; and
- Where there is less than a 25% chance for favorable outcome, reserve for 100% of probable adverse outcome.

Expense reserves are equally important and should be established based on estimated medical cost containment and legal expenses.

Our review of the audit sample reflects:

- No initial reserves are established for the sample claims. Examiners review reserves for accuracy at least every 90 to 120 days; and
- Examiners consistently document reserve rationale.

We evaluate performance for Reserve Practices as superior, scoring 95%. In Appendix C, we provide recommendations for three reserve increases and two decreases, for a net decrease of ($16,223), which is less than 1% of the total reserves of $2,225,050 in the audit sample as shown in Appendix A. Our actuaries advise variances of less than 10% have no impact on actuarial projections.

6. Statutory Compliance

State law and administrative rules pursuant to regulations guide performance for:

- Determining eligibility for benefits, and issuing notifications and payments; and
- MMSEA adding mandatory reporting requirements for workers' compensation claims (including self-insurance), no-fault insurance, and liability claims. This act requires claims

administrators to identify a Medicare beneficiary (whose injury or accident might result in a settlement) to enable appropriate determination concerning coordination of benefits, including any Medicare recovery entitlement.

The CMS is responsible for implementing the MMSEA. Claims involving bodily injury should be queried through CMS to determine Medicare eligibility, with eligibility status documented in the claim file.

Medicare liens, or conditional payments, must be satisfied at the time of settlement, and the settlement must preserve the secondary payer position of the CMS. Failure to comply may obligate the member for additional payments post-settlement to satisfy Medicare's rights, in addition to exposing the member to a $1,000 penalty per day per event of non-compliance.

We assess Statutory Compliance as superior, scoring 100%.

7. Control of Claims

Best practices require:

- Coverage determination appropriateness, which would primarily involve claims where a period of employment is covered by a separate insurer or self-insurer;
- Maintaining contacts with the claimant, attorney, and medical providers to identify changes in treatment or opportunities for settlement;
- Investigation, if required to verify the claimed impact of injury if not resolved, and to ensure a claimant receiving life pension benefits is still alive;
- Determination of extent of injury, including verification of required medical treatment; and
- Use of and timely implementation of cost saving alternatives, including:
  - Indexing bodily injury claimants using the Insurance Service Office ISO *ClaimSearch*©; and
  - Appropriate implementation of cost saving alternatives such as bill review, nurse case management (NCM), or utilization review (UR).

Examiners handle claims according to industry best practices. Examiners monitor medical utilization and refer for utilization review when necessary. Bill review is timely and handled by Keenan through PRIME. Bills are reduced to fee schedule with a charge to the client based on 10% of savings between provider charges and fee schedule allowance. Further savings are available through the PRIME preferred provider network which charges 24% of savings between the PPO charge and the fee schedule. Client charges per bill are capped at $10,000 for either fee schedule or PPO reductions.

For calendar year 2017, 15,363 medical and pharmacy bills with billed charges exceeding $8 million were processed by PRIME for the entire SCCSIG JPA. After network and non-network savings were applied the total savings was almost $5.7 million. Program charges of $534,000 produced a net savings of $5.1million or 64%.

We note five exceptions to reporting claims for ISO indexing, which is recommended every one to two years to identify intervening injuries. Keenan requires indexing at 18-month intervals.

We assess performance for Control of Claims as commendable. We recommend Keenan increase supervision to ensure examiners document consideration of actions to control and mitigate costs, including filing ISO ClaimSearch index every 18 months as required.

8. File Maintenance and Periodic Monitoring

Industry best practices require:

- Documentation organized in chronological order;
- Information in the CMIS to match the paper file documentation;
- Periodic claim file review to update disposition plan; and
- Documented supervisory oversight to ensure execution of the disposition plan.

Keenan moved to a totally paperless environment in 2015 and all documentation is currently electronic. Paper claim files are still available and contain documentation going back to the beginning of the claim.

We find:

- Claims reviewed in the sample contained essential documentation such as stipulated awards, findings and awards, and medical examinations used to determine the rating upon which a settlement was based;

- Periodic review of claims by examiners is required 90 to 120-day intervals. We find examiners compliant with two exceptions; and

- Documented supervision is required at 180-day intervals and this is supplemented by the Assistant Manager who also reviews claims at 180-day intervals based on the size of the reserve. We note one exception to the requirement for documented supervision.

In addition to the examiners, supervisors and management reflect a significant presence in the sample claims.

We assess performance as superior.

9. Payments and Recoveries

Best practices require:

- Accuracy and timeliness of payments, including:
  - Documentation in the claim to support reasons for payments;
  - Timely and accurate payment processing; and
  - Timely and appropriate resolution of payment disputes, if any.
- Accuracy and timeliness of recoveries, including:
  - Documentation in the claim to support reason for recovery;
  - Timely and accurate recovery processing; and
  - Documentation of recovery deposit to the appropriate fund.

Other than one payment dispute that could have been handled more effectively with management intercession of both parties, we note no exceptions to handling of payments and recoveries.

We assess performance as superior.

10. Excess and Reinsurance

Industry best practices require qualifying claims be reported to the excess carrier within the timeframe specified, and reporting accurate information. Absent specific excess carrier requirements, reporting claims is required within 30 days of knowledge, where:

- Incurred equals or exceeds 50% of the member's self-insured retention (SIR); and
- Claims involve catastrophic injury or multiple covered claimants.

SCCSIG requires Keenan to notify the SAWCX II Reinsurance Manager of loss costs at 50% of the SIR. Keenan provides adjusters with a list of SIRs by coverage period. Subsequent reporting is through Keenan also.

All claims are reviewed frequently to determine whether excess reporting requirements apply, and for timely reporting where they do apply. The 25 claims in the sample which contain an excess reporting requirement are timely for initial and subsequent reporting. Payments are requested timely where SCCSIG has exceeded its retention.

We assess performance for Excess and Reinsurance as superior, scoring 100%.

11. Case Status Communications

This component measures internal and external communications pertinent to claims handling. Industry best practices require timely:

- Internal communication among TPA personnel regarding investigation and other claims service related issues;
- Communication between TPA staff and members related to claim developments;
- Communication between TPA staff and claimants, or their attorneys, related to claim developments; and
- Communications from between TPA and other parties pertinent to the claim.

We assess performance for Case Status Communications as superior, scoring 100%.

12. Claims Management Information System (CMIS)

Best practices require:

- CMIS support of claims handling efficiency, including:
  - CMIS fields adequate to collect data required to handle claims; and
  - Use of CMIS fields to collect data timely and accurately.
- CMIS support of loss experience reports (LERs), including:
  - Support for provision of LERs to members and loss control personnel; and
  - Support for provision of Electronic Data Interchange (EDI) per regulatory requirements.

The CMIS used by Keenan, iVOS, is a user-friendly, web-based risk management information system supporting essential claim documentation requirements, including:

- Claim information and payment records;
- Reserve history;
- Adjuster notes and diary;
- Document imaging; and
- EDI.

We assess the CMIS and performance for CMIS usage as superior, scoring 100%.

13. Subrogation/Recovery - Not Applicable

14. Use of Outside Contractors

Best practices for use of outside services require:

- Establishing criteria for making assignments to independent service providers;

- Timely assignments; and
- Monitoring outside services, including:
  - Communicating requirements to ensure compliance with service expectations;
  - Reviewing bills to ensure compliance with established billing practices; and
  - Requiring timely and appropriate resolution of billing disputes, if any.

Few outside services are used, with four claims in the sample reviewed for this component. We find assignments are made timely and consistent, with established criteria. Examiners monitor vendors to ensure compliance with billing and service expectations.

We assess performance for Use of Outside Services as superior, scoring 100%.

Appendix A

Claims Audit List

Claim Audit List

Sample #	Claim Number	Member	Incident Date	Claim Type	Adjuster Initials	Total Incurred	Reserve
1.	5001-81-0028	Alum Rock Union Elem School District	10/9/1980	Indemnity	SL	$91,042	$7,940
2.	5001-90-0119	Alum Rock Union Elem School District	2/27/1990	Indemnity (w/ FM)	SL	$151,510	$22,709
3.	5001-94-0001	Alum Rock Union Elem School District	7/2/1993	Indemnity	SL	$314,448	$46,719
4.	5001-94-0005	Alum Rock Union Elem School District	7/15/1993	Indemnity	SL	$146,882	$42,423
5.	5001-94-0099	Alum Rock Union Elem School District	1/3/1994	Indemnity	SL	$210,261	$0
6.	5002-91-0067	Berryessa Union School District	5/9/1991	Indemnity	GiB	$105,887	$17,907
7.	5003-92-0011	Cambrian School District	3/17/1992	Indemnity	PH	$353,503	$97,166
8.	5004-90-0037	Campbell Union School District	5/2/1990	Indemnity	SL	$62,608	$13,668
9.	5005-83-0128	Santa Clara County Office of Education	1/6/1983	Indemnity	SK	$116,311	$92,258
10.	5005-85-0149	Santa Clara County Office of Education	3/11/1985	Indemnity	SK	$49,334	$0
11.	5005-87-0056	Santa Clara County Office of Education	9/30/1986	Indemnity	SL	$73,000	$0
12.	5005-89-0069	Santa Clara County Office of Education	10/4/1988	Indemnity	SL	$103,037	$12,860
13.	5005-89-0077	Santa Clara County Office of Education	10/14/1988	Indemnity	SL	$60,933	$9,056
14.	5005-91-0145	Santa Clara County Office of Education	1/28/1991	Indemnity (w/ FM)	SL	$334,679	$58,082
15.	5005-92-0184	Santa Clara County Office of Education	2/13/1992	Indemnity (w/ FM)	SL	$209,429	$9,016
16.	5005-93-0149	Santa Clara County Office of Education	1/20/1993	Indemnity	SK	$166,504	$0
17.	5005-94-0014	Santa Clara County Office of Education	7/26/1993	Indemnity	SK	$79,194	$10,872
18.	5005-95-0011	Santa Clara County Office of Education	7/19/1994	Indemnity	SL	$58,555	$11,321

Sample #	Claim Number	Member	Incident Date	Claim Type	Adjuster Initials	Total Incurred	Reserve
19.	5005-95-0013	Santa Clara County Office of Education	7/21/1994	Indemnity (w/ FM)	SL	$199,875	$17,486
20.	5005-95-0142	Santa Clara County Office of Education	1/5/1995	Indemnity	SL	$68,727	$0
21.	5005-96-0143	Santa Clara County Office of Education	10/17/1995	Indemnity	SL	$306,419	$58,538
22.	5006-80-0099	East Side Union High School District	2/25/1980	Indemnity	SL	$161,201	$13,482
23.	5006-87-0129	East Side Union High School District	2/26/1987	Indemnity	CH	$162,584	$0
24.	5006-88-0024	East Side Union High School District	9/18/1987	Indemnity	BC	$231,090	$54,000
25.	5006-90-0022	East Side Union High School District	9/12/1989	Indemnity	SL	$168,881	$70,341
26.	5006-92-0093	East Side Union High School District	2/7/1992	Indemnity	CH	$212,265	$142,563
27.	5006-92-0135	East Side Union High School District	5/4/1992	Indemnity	HB	$67,534	$0
28.	5006-96-0023	East Side Union High School District	9/13/1995	Indemnity	CH	$5,602	$0
29.	5007-92-0022	Evergreen School District	11/12/1991	Indemnity	SL	$128,254	$70,347
30.	5007-94-0052	Evergreen School District	2/4/1994	Indemnity	TS	$361,292	$0
31.	5007-96-0009	Evergreen School District	9/1/1995	Indemnity (w/ FM)	SL	$96,516	$9,899
32.	5008-87-0083	Franklin-McKinley School District	5/7/1987	Indemnity	GB	$382,595	$36,859
33.	5008-91-0026	Franklin-McKinley School District	11/20/1990	Indemnity (w/ FM)	SK	$398,885	$5,548
34.	5010-86-0010	Los Gatos Union School District	4/4/1986	Indemnity	SL	$134,424	$37,946
35.	5010-92-0004	Los Gatos Union School District	8/1/1991	Indemnity (w/ FM)	SL	$1,401,892	$430,347
36.	5014-95-0016	Moreland School District	3/21/1995	Indemnity (w/ FM)	CH	$338,499	$27,464
37.	5015-89-0012	Morgan Hill Unified School District	10/7/1988	Indemnity (w/ FM)	SL	$866,635	$315,294
38.	5015-94-0088	Morgan Hill Unified School District	3/1/1994	Indemnity	SL	$57,519	$42,422

Sample #	Claim Number	Member	Incident Date	Claim Type	Adjuster Initials	Total Incurred	Reserve
39.	5017-87-0016	Mountain View School District	12/5/1986	Indemnity	GB	$472,061	$46,840
40.	5018-86-0020	Oak Grove School District	10/14/1985	Indemnity	SK	$372,262	$18,757
41.	5018-93-0104	Oak Grove School District	5/21/1993	Indemnity (w/ FM)	SL	$229,809	$25,515
42.	5018-94-0052	Oak Grove School District	2/11/1994	Indemnity	SL	$67,007	$10,739
43.	5018-95-0069	Oak Grove School District	3/31/1995	Indemnity	SL	$41,434	$4,622
44.	5020-95-0003	Sunnyvale School District	8/30/1994	Indemnity	BC	$86,619	$36,891
45.	5021-81-0005	Union School District	9/16/1980	Indemnity	GiB	$134,096	$41,328
46.	5028-87-0026	Gilroy Unified School District	11/18/1986	Indemnity	SL	$168,886	$26,361
47.	5028-93-0104	Gilroy Unified School District	5/6/1993	Indemnity	SK	$50,642	$0
48.	5028-94-0084	Gilroy Unified School District	2/25/1994	Indemnity	GB	$189,080	$140,705
49.	5028-95-0030	Gilroy Unified School District	11/8/1994	Indemnity	SL	$51,383	$21,500
50.	5028-95-0056	Gilroy Unified School District	2/21/1995	Indemnity	SL	$88,691	$67,259
					Totals:	$10,389,775	$2,225,050

Appendix B

Claims Audit Summary by Component, Subcomponent, and Criteria Scores with Exceptions

Claims Audit

Component, Subcomponent and Criteria Scores with Exceptions

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Components and Subcomponent		Number of Responses			Weighted		Score
01 Claim Settlement Process							
1 Claim evaluation process		*Yes*	*No*	*N/A*	*Actual*	*Possible*	*Pct*
01.01	Does the file reflect recognition of claim issues giving rise to settlement?	45	1	4	45	46	98%
01.02	Does adjuster analyze the elements of compensability and extent of injury?	14	0	36	14	14	100%
01.03	Does adjuster promptly communicate settlement rationale with member and document concurrence?	14	3	33	14	17	82%
01.04	Does adjuster plan negotiations and execute plan documenting demand(s)/offer(s)?	10	2	38	10	12	83%
01.05	Once settlement is negotiated, is appropriate release executed and approved?	3	0	47	3	3	100%
	Subcomponent Total	86	6	158	86	92	93%
2 Appropriateness of authority delegation		*Yes*	*No*	*N/A*	*Actual*	*Possible*	*Pct*
01.06	Is adjuster delegated appropriate authority considering experience?	40	0	10	40	40	100%
01.07	Is case assignment compatible with adjuster's delegated authority with adjuster demonstrating capacity to obtain supervisory insight where complex matters exceed delegated authority?	24	0	26	24	24	100%
	Subcomponent Total	64	0	36	64	64	100%
3 Process to obtain authority in excess of delegated authority		*Yes*	*No*	*N/A*	*Actual*	*Possible*	*Pct*
01.08	Is need for authority request recognized timely and request for authority beyond that delegated requested timely with appropriate explanation and support?	5	0	45	5	5	100%
01.09	Is authority request reviewed appropriately?	6	0	44	6	6	100%
	Subcomponent Total	11	0	89	11	11	100%

Claims Audit

Component, Subcomponent and Criteria Scores with Exceptions

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Components and Subcomponent	Number of Responses			Weighted		Score
	Yes	*No*	*N/A*	*Actual*	*Possible*	*Pct*
01 Claim Settlement Process (95% target)	**161**	**6**	**283**	**161**	**167**	**96%**

Exceptions ('No' Responses)

	CLAIM	QUESTION
1.	5028-94-0084	01.03
2.	5028-93-0104	01.01
3.	5018-95-0069	01.03
4.	5018-93-0104	01.03
5.	5015-94-0088	01.04
6.	5010-86-0010	01.04

02 Claims Deductibles

1 Coverage deductible identification		*Yes*	*No*	*N/A*	*Actual*	*Possible*	*Pct*
02.01	Is coverage deductible timely identified?	0	0	50	0	0	N/A
	Subcomponent Total	0	0	50	0	0	N/A

2 Deductible billing procedure		*Yes*	*No*	*N/A*	*Actual*	*Possible*	*Pct*
02.02	Did examiner timely post a deductible recoverable to the claim?	0	0	50	0	0	N/A
02.03	Did examiner timely communicate the deductible recoverable to the member?	0	0	50	0	0	N/A
02.04	Did examiner follow up with the member to ensure receipt of deductible?	0	0	50	0	0	N/A
02.05	Did examiner credit the deductible to the claim timely?	0	0	50	0	0	N/A
02.06	Was deductible credited to claim prior to claim closure?	0	0	50	0	0	N/A
	Subcomponent Total	0	0	250	0	0	N/A

	Yes	*No*	*N/A*	*Actual*	*Possible*	*Pct*
02 Claims Deductibles (95% target)	**0**	**0**	**300**	**0**	**0**	**N/A**

Exceptions ('No' Responses)

Claims Audit

Component, Subcomponent and Criteria Scores with Exceptions

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Components and Subcomponent		Number of Responses			Weighted		Score
03 Internal Controls							
1 Payments monitoring and reconciliation with banking and accounting records		*Yes*	*No*	*N/A*	*Actual*	*Possible*	*Pct*
03.01	Does adjuster perform a professional review to ensure payments are owed as related to claim/coverage?	39	2	9	39	41	95%
03.02	Does Claims Manager approve payments in excess of delegated authority?	11	0	39	11	11	100%
03.03	Is payee entered to CMIS by staff member other than adjuster to ensure compliance with IRS 1099 procedures and verify payee validity?	47	0	3	47	47	100%
	Subcomponent Total	97	2	51	97	99	98%
2 Workload appropriateness for staff and overall office		*Yes*	*No*	*N/A*	*Actual*	*Possible*	*Pct*
03.04	Adjuster experience is appropriate for mix and quantity of claims assigned?	50	0	0	50	50	100%
03.05	Claims Manager provides appropriate supervision of caseload assignment.	49	0	1	49	49	100%
03.06	Adjuster receives appropriate support from clerical staff.	49	0	1	49	49	100%
	Subcomponent Total	148	0	2	148	148	100%
		Yes	*No*	*N/A*	*Actual*	*Possible*	*Pct*
	03 Internal Controls (95% target)	**245**	**2**	**53**	**245**	**247**	**99%**

Exceptions ('No' Responses)

	CLAIM	QUESTION
1.	5018-95-0069	03.01
2.	5008-87-0083	03.01

Claims Audit

Component, Subcomponent and Criteria Scores with Exceptions

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Components and Subcomponent		Number of Responses			Weighted		Score
04 Litigation Management							
1 Defense counsel assignment appropriateness		*Yes*	*No*	*N/A*	*Actual*	*Possible*	*Pct*
04.01	Adjuster recognized need for defense counsel timely?	4	0	46	4	4	100%
04.02	Adjuster makes assignment to an approved defense counsel appropriately?	4	0	46	4	4	100%
	Subcomponent Total	8	0	92	8	8	100%
2 Legal strategy development and budgeting		*Yes*	*No*	*N/A*	*Actual*	*Possible*	*Pct*
04.03	Legal evaluation and strategy is solicited timely?	4	0	46	4	4	100%
04.04	Does adjuster continue disposition follow up to contain legal costs, develop and monitor legal budget?	14	2	34	14	16	88%
04.05	Is alternative dispute resolution plan developed and implemented prior to trial?	1	0	49	1	1	100%
	Subcomponent Total	19	2	129	19	21	90%

	Yes	*No*	*N/A*	*Actual*	*Possible*	*Pct*
04 Litigation Management (95% target)	**27**	**2**	**221**	**27**	**29**	**93%**

Exceptions ('No' Responses)

	CLAIM	QUESTION
1.	5028-93-0104	04.04
2.	5015-94-0088	04.04

Claims Audit

Component, Subcomponent and Criteria Scores with Exceptions

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Components and Subcomponent		Number of Responses			Weighted		Score
05 Reserve Practices							
1 Reserve practices		*Yes*	*No*	*N/A*	*Actual*	*Possible*	*Pct*
05.01	Is initial reserve set timely and claim reviewed at appropriate intervals to make necessary adjustments?	33	1	16	33	34	97%
05.02	Are reserves balanced to reconcile payments against reserves and adjustments made timely ensuring reserve adequacy?	3	1	46	3	4	75%
	Subcomponent Total	36	2	62	36	38	95%
2 Reserve analysis documentation		*Yes*	*No*	*N/A*	*Actual*	*Possible*	*Pct*
05.03	Is reserve calculation appropriately documented for expected indemnity payments?	3	0	47	3	3	100%
05.04	Is reserve calculation appropriately documented for expected medical payments?	48	1	1	48	49	98%
05.05	Is reserve calculation appropriately documented for expected rehabilitation payments?	1	0	49	1	1	100%
05.06	Is reserve calculation appropriately documented for expected defense counsel payments?	2	0	48	2	2	100%
05.07	Is reserve calculation appropriately documented for expected other expense payments?	44	4	2	44	48	92%
	Subcomponent Total	98	5	147	98	103	95%

	Yes	*No*	*N/A*	*Actual*	*Possible*	*Pct*
05 Reserve Practices (95% target)	**134**	**7**	**209**	**134**	**141**	**95%**

Exceptions ('No' Responses)

	CLAIM	QUESTION
1.	5028-94-0084	05.01
2.	5015-94-0088	05.07
3.	5014-95-0016	05.02
4.	5010-86-0010	05.07
5.	5007-92-0022	05.04
6.	5006-88-0024	05.07
7.	5001-94-0005	05.07

Claims Audit

Component, Subcomponent and Criteria Scores with Exceptions

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Components and Subcomponent		Number of Responses			Weighted		Score
06 Statutory Compliance							
1 Compliance with laws and administrative rules		*Yes*	*No*	*N/A*	*Actual*	*Possible*	*Pct*
06.01	Are necessary notifications timely and appropriately sent?	0	0	50	0	0	N/A
06.02	Is California Governmental Immunities Act and California Government Code requirements properly applied?	0	0	50	0	0	N/A
06.03	Is any Medicare interest identified and protected in a third party settlement in accordance with MMSEA?	45	0	5	45	45	100%
	Subcomponent Total	45	0	105	45	45	100%

	Yes	*No*	*N/A*	*Actual*	*Possible*	*Pct*
06 Statutory Compliance (95% target)	**45**	**0**	**105**	**45**	**45**	**100%**

Exceptions ('No' Responses)

Claims Audit

Component, Subcomponent and Criteria Scores with Exceptions

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Components and Subcomponent		Number of Responses			Weighted		Score
07 Control of Claims							
1 Coverage determination appropriateness		*Yes*	*No*	*N/A*	*Actual*	*Possible*	*Pct*
07.01	Does adjuster make coverage determination appropriately and timely?	6	0	44	6	6	100%
07.02	Where a reservation of rights or coverage denial is necessary, is the Claims Manager involved?	0	0	50	0	0	N/A
07.03	Where a reservation of rights is used, is coverage confirmed or denied upon completion of investigation?	1	0	49	1	1	100%
	Subcomponent Total	7	0	143	7	7	100%
2 Initial contacts		*Yes*	*No*	*N/A*	*Actual*	*Possible*	*Pct*
07.04	Is member initial contact timely and appropriate?	0	0	50	0	0	N/A
07.05	Is claimant or claimant attorney initial contact timely and appropriate?	0	0	50	0	0	N/A
07.06	Are initial contacts with pertinent other parties (i.e., treatment provider, field investigator, witnesses, entities (police/fire) involved in assessing incident facts) appropriate and timely?	2	0	48	2	2	100%
	Subcomponent Total	2	0	148	2	2	100%
3 Investigation		*Yes*	*No*	*N/A*	*Actual*	*Possible*	*Pct*
07.07	Is investigation thoroughness appropriate for determination of compensability / coverage?	1	0	49	1	1	100%
07.08	Is investigation completed timely and where delays occur, follow up activities target a completion date.	0	0	50	0	0	N/A
	Subcomponent Total	1	0	99	1	1	100%
4 Extent of injury		*Yes*	*No*	*N/A*	*Actual*	*Possible*	*Pct*
07.09	Is the nature and extent of injury verified by expert evaluation (job analysis, records review, inspection of photographs by staff, solicitation of PQME/AME, expert witness, sub-rosa, etc.) where needed?	5	0	45	5	5	100%
07.10	Are apportionment / extent of injury determined timely?	1	0	49	1	1	100%
	Subcomponent Total	6	0	94	6	6	100%

Claims Audit

Component, Subcomponent and Criteria Scores with Exceptions

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Components and Subcomponent		Number of Responses			Weighted		Score
5 Use of cost saving alternatives		*Yes*	*No*	*N/A*	*Actual*	*Possible*	*Pct*
07.11	Are cost saving alternatives (utilizing medical utilization review techniques or services, bill review service, NCM service, return to work coordinator, vocational counselor, competing repair estimates, etc.) implemented timely and appropriately?	42	2	6	42	44	95%
07.12	Is claim indexed appropriately?	31	5	14	31	36	86%
	Subcomponent Total	73	7	20	73	80	91%

	Yes	*No*	*N/A*	*Actual*	*Possible*	*Pct*
07 Control of Claims (95% target)	**89**	**7**	**504**	**89**	**96**	**93%**

Exceptions ('No' Responses)

	CLAIM	QUESTION
1.	5028-94-0084	07.12
2.	5028-94-0084	07.11
3.	5028-87-0026	07.12
4.	5015-94-0088	07.11
5.	5005-95-0011	07.12
6.	5005-94-0014	07.12
7.	5005-87-0056	07.12

Claims Audit

Component, Subcomponent and Criteria Scores with Exceptions

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Components and Subcomponent		Number of Responses			Weighted		Score
08 File Maintenance / Periodic Monitoring							
1 File maintenance		*Yes*	*No*	*N/A*	*Actual*	*Possible*	*Pct*
08.01	Is claim documentation organized in chronological order in appropriate sections of claim file?	50	0	0	50	50	100%
08.02	Does information in CMIS match file documentation?	49	1	0	49	50	98%
	Subcomponent Total	99	1	0	99	100	99%
2 Periodic Monitoring		*Yes*	*No*	*N/A*	*Actual*	*Possible*	*Pct*
08.03	Does assigned claim handler periodically review incoming correspondence and update CMIS and disposition plan at appropriate intervals?	46	2	2	46	48	96%
08.04	Is supervisory oversight evident in claim file?	48	1	1	48	49	98%
	Subcomponent Total	94	3	3	94	97	97%

	Yes	*No*	*N/A*	*Actual*	*Possible*	*Pct*
08 File Maintenance / Periodic Monitoring (95% target)	**193**	**4**	**3**	**193**	**197**	**98%**

Exceptions ('No' Responses)

	CLAIM	QUESTION
1.	5028-93-0104	08.03
2.	5018-95-0069	08.03
3.	5006-92-0135	08.04
4.	5005-83-0128	08.02

Claims Audit

Component, Subcomponent and Criteria Scores with Exceptions

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Components and Subcomponent		Number of Responses			Weighted		Score
09 Payments and Recoveries							
1 Accuracy and timeliness of payments		*Yes*	*No*	*N/A*	*Actual*	*Possible*	*Pct*
09.01	Are payment reasons documented in the claim file and entered to system accurately?	45	0	5	45	45	100%
09.02	Are payments processed timely?	45	0	5	45	45	100%
09.03	When payment disputes arise, are disputes resolved appropriately and timely?	0	1	49	0	1	0%
	Subcomponent Total	90	1	59	90	91	99%
2 Accuracy and timeliness of recoveries		*Yes*	*No*	*N/A*	*Actual*	*Possible*	*Pct*
09.04	Are recovery reasons documented in the claim file and entered to system accurately?	13	0	37	13	13	100%
09.05	Are recoveries entered to the system accurately?	13	0	37	13	13	100%
09.06	Is deposit of recovery(ies) to appropriate fund documented?	12	0	38	12	12	100%
	Subcomponent Total	38	0	112	38	38	100%

	Yes	*No*	*N/A*	*Actual*	*Possible*	*Pct*
09 Payments and Recoveries (95% target)	**128**	**1**	**171**	**128**	**129**	**99%**

Exceptions ('No' Responses)

	CLAIM	QUESTION
1.	5028-94-0084	09.03

Claims Audit

Component, Subcomponent and Criteria Scores with Exceptions

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Components and Subcomponent		Number of Responses			Weighted		Score
10 Excess and Reinsurance							
1 Initial reports to excess and reinsurance carrier(s)		*Yes*	*No*	*N/A*	*Actual*	*Possible*	*Pct*
10.01	Is initial report to excess or reinsurance carrier(s) timely and appropriate?	5	0	45	5	5	100%
	Subcomponent Total	5	0	45	5	5	100%
2 Supplemental reports to excess and reinsurance carrier(s)		*Yes*	*No*	*N/A*	*Actual*	*Possible*	*Pct*
10.02	Are supplemental reports submitted timely and appropriately?	23	0	27	23	23	100%
10.03	Do supplemental reports request payment from the excess or reinsurance carrier(s) timely and appropriately?	13	0	37	13	13	100%
10.04	Is the closure notice submitted to excess or reinsurance carrier(s) timely and appropriately?	3	0	47	3	3	100%
	Subcomponent Total	39	0	111	39	39	100%
		Yes	*No*	*N/A*	*Actual*	*Possible*	*Pct*
	10 Excess and Reinsurance (95% target)	**44**	**0**	**156**	**44**	**44**	**100%**

Exceptions ('No' Responses)

Claims Audit

Component, Subcomponent and Criteria Scores with Exceptions

SCCSIG

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Components and Subcomponent		Number of Responses			Weighted		Score
11 Case Status Communications							
1 Internal communications		*Yes*	*No*	*N/A*	*Actual*	*Possible*	*Pct*
11.01	Are communications among administrator staff timely and appropriate?	46	0	4	46	46	100%
	Subcomponent Total	46	0	4	46	46	100%
2 External communications		*Yes*	*No*	*N/A*	*Actual*	*Possible*	*Pct*
11.02	Are communications between administrator staff and members timely and appropriate?	12	0	38	12	12	100%
11.03	Are communications between administrator staff and claimants timely and appropriate?	36	0	14	36	36	100%
11.04	Are communications between administrator staff and parties pertinent to claim timely and appropriate?	8	0	42	8	8	100%
	Subcomponent Total	56	0	94	56	56	100%
		Yes	*No*	*N/A*	*Actual*	*Possible*	*Pct*
	11 Case Status Communications (95% target)	**102**	**0**	**98**	**102**	**102**	**100%**

Exceptions ('No' Responses)

Claims Audit

Component, Subcomponent and Criteria Scores with Exceptions

SCCSIG

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Components and Subcomponent		Number of Responses			Weighted		Score
12 CMIS							
1 CMIS support of claims management efficiency		*Yes*	*No*	*N/A*	*Actual*	*Possible*	*Pct*
12.01	Are CMIS fields adequate to collect data required to handle claim?	47	0	3	47	47	100%
12.02	Are CMIS fields used to collect data timely and accurately?	47	0	3	47	47	100%
	Subcomponent Total	94	0	6	94	94	100%
2 CMIS support of loss experience reports (LERs)		*Yes*	*No*	*N/A*	*Actual*	*Possible*	*Pct*
12.03	CMIS supports provision of LERs to members and loss control personnel?	47	0	3	47	47	100%
12.04	CMIS supports provision of EDI per regulatory requirements?	47	0	3	47	47	100%
	Subcomponent Total	94	0	6	94	94	100%

	Yes	*No*	*N/A*	*Actual*	*Possible*	*Pct*
12 CMIS	**188**	**0**	**12**	**188**	**188**	**100%**
(95% target)						

Exceptions ('No' Responses)

Claims Audit

Component, Subcomponent and Criteria Scores with Exceptions

SCCSIG

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Components and Subcomponent		Number of Responses			Weighted		Score
13 Subrogation / Recovery Practices							
1 Recovery opportunity recognition		*Yes*	*No*	*N/A*	*Actual*	*Possible*	*Pct*
13.01	Is potential for subrogation or risk transfer recovery opportunity timely and appropriately identified?	0	0	50	0	0	N/A
	Subcomponent Total	0	0	50	0	0	N/A
2 Recovery pursuit		*Yes*	*No*	*N/A*	*Actual*	*Possible*	*Pct*
13.02	Are the party(ies) advised of subrogation or risk transfer recovery intentions within 10 days of opportunity identification?	0	0	50	0	0	N/A
13.03	Are party(ies) periodically contacted to provide status of recovery entitlement?	0	0	50	0	0	N/A
13.04	Is recovery appropriately pursued, with legal intervention, as necessary and within an appropriate budget?	0	0	50	0	0	N/A
	Subcomponent Total	0	0	150	0	0	N/A

	Yes	*No*	*N/A*	*Actual*	*Possible*	*Pct*
13 Subrogation / Recovery Practices (95% target)	**0**	**0**	**200**	**0**	**0**	**N/A**

Exceptions ('No' Responses)

Claims Audit

Component, Subcomponent and Criteria Scores with Exceptions

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Components and Subcomponent		Number of Responses			Weighted		Score
14 Use of Outside Services							
1 Use of outside services		*Yes*	*No*	*N/A*	*Actual*	*Possible*	*Pct*
14.01	Is assignment to outside contractor consistent with established criteria?	4	0	46	4	4	100%
14.02	Is assignment to outside contractor timely?	3	0	47	3	3	100%
	Subcomponent Total	7	0	93	7	7	100%
2 Monitoring of outside services		*Yes*	*No*	*N/A*	*Actual*	*Possible*	*Pct*
14.03	Are outside contractor assignments monitored to ensure compliance with service expectations?	3	0	47	3	3	100%
14.04	Are outside contractor bills reviewed to ensure compliance with established billing practices?	1	0	49	1	1	100%
14.05	Where outside contractor billing disputes arise, are they timely and appropriately resolved?	0	0	50	0	0	N/A
	Subcomponent Total	4	0	146	4	4	100%
		Yes	*No*	*N/A*	*Actual*	*Possible*	*Pct*
	14 Use of Outside Services (95% target)	**11**	**0**	**239**	**11**	**11**	**100%**
		Exceptions ('No' Responses)					
	Overall (95% target)	**1,367**	**29**	**2,554**	**1,367**	**1,396**	**98%**

Appendix C

Recommended Reserve Changes

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Member	Claim Number	Injury Date	Reserve	Recommended Reserve
Alum Rock Union Elem School District	5001-94-0005	7/15/1993	$42,423	$30,148
	COMMENTS:	05.04	Examiner recently evaluates reserve and recommends no change despite significant variance between current reserve and 3 year average. We recommend setting reserve at 3 year average.	
		05.07	Recommend setting reserve to accommodate bill review and UR fo claimant's life expectancy.	

Member	Claim Number	Injury Date	Reserve	Recommended Reserve
East Side Union High School District	5006-88-0024	9/18/1987	$54,000	$57,336
	COMMENTS:	05.07	Recommend adjusting ALE reserve commensurate estimation of future medical over claiant's life expectancy.	

Member	Claim Number	Injury Date	Reserve	Recommended Reserve
Evergreen School District	5007-92-0022	11/12/1991	$70,347	$51,608
	COMMENTS:	05.04	Claim is assessed based on a one or three year basis of prior payments, which shows medical trending down C&R valued at $18- $24K. Averaging 3 years' of payments resulted in the highest costs Current reserve is evaluated ($63,8562) and considered appropriate. Recommend reducing reserve to the three year evaluation and continue to monitor medical cost activity	

Member	Claim Number	Injury Date	Reserve	Recommended Reserve
Los Gatos Union School District	5010-86-0010	4/4/1986	$37,946	$44,401
	COMMENTS:	05.07	Recommended reserve to recognize higher than average costs to monitor utilization. For the past 3 years there are over $800 per year cost containment expenses. UR costs alone exceed $500 per year. Recommended reserve is based on $600 per year for life expectancy.	

Member	Claim Number	Injury Date	Reserve	Recommended Reserve
Morgan Hill Unified School District	5015-94-0088	3/1/1994	$42,422	$47,422

COMMENTS:	05.07	Recommend increase as considerable discovery remains to be completed.

Administrator Total:	**$247,138**	**$230,915**
Recommended Change:		**($16,223)**