NORTHERN CALIFORNIA CITIES SELF INSURANCE FUND
CLAIMS COMMITTEE MEETING
AGENDA - *Revised*

DATE / TIME: **Thursday, March 25, 2021 at 9:00 a.m.**

LOCATION: **Zoom Teleconference**
Call-in Number: 669-900-6833
Meeting ID: 848-230-9629
Passcode: 756497

A - Action
I - Information

1 - Attached
2 - Hand Out
3 - Separate Cover
4 - Verbal

MISSION STATEMENT

The Northern California Cities Self Insurance Fund, or NCCSIF, is an association of municipalities joined to protect member resources by stabilizing risk costs in a reliable, economical and beneficial manner while providing members with broad coverage and quality services in risk management and claims management.

A. CALL TO ORDER

B. ROLL CALL

C. PUBLIC COMMENTS
This time is reserved for members of the public to address the Committee on matters pertaining to NCCSIF that are of interest to them.

pg. 4 **D. CONSENT CALENDAR** **A 1**
All matters listed under the consent calendar are considered routine with no separate discussion necessary. Any member of the public or the Committee may request any item to be considered separately.

pg. 5 1. Claims Committee Meeting Minutes - September 24, 2020
pg. 7 2. Claims Committee Special Meeting Minutes – December 3, 2020
pg. 9 3. Claims Committee Special Meeting Minutes – January 21, 2021

pg. 11 **E. CLOSED SESSION TO DISCUSS PENDING CLAIMS** **A 2**
(Per Governmental Code Section 54956.95)

Liability:
1. Barrett v. City of Yuba City
2. Young v. City of Marysville
3. Googooian v. City of Rocklin

Workers Compensation:
1. NCWA-543918-v. City of Yuba City

F. REPORT FROM CLOSED SESSION **I 4**
The Committee will announce any reportable action taken in closed session

G. FY 20/21WORKERS' COMPENSATION PROGRAM CLAIM AUDITS AND SEDGWICK RESPONSES **A 1**

pg. 12 1. **ALC Angela Mudge – For NorCal Cities SIF**
The Committee will review the most recent Workers' Compensation Program claims audit conducted by ALC in 2020 and the response from Sedgwick to accept and file.

pg. 25 2. **North Bay Associates – For PRISM**
The Committee will review the most recent Workers' Compensation claims audit conducted by North Bay Associates in September 2020 and the response from Sedgwick to accept and file.

H. REVISION TO A-9 ATTACHMENT A: LIABILITY COUNSEL LIST **A 1**

pg. 77 1. **New Addition – Jeffrey Dunn, Best Best and Krieger**
The Committee will be asked to approve revising the NCCSIF Liability Defense Attorney List to include Jeffrey Dunn and legal team.

pg. 81 **I. ROUND TABLE DISCUSSION** **I 4**
This is an opportunity for Committee members to ask questions or raise issue on risk exposures common to the members.

J. ADJOURNMENT

UPCOMING MEETINGS
Risk Management Committee Meeting - April 22, 2021
Board of Directors Meeting - April 22, 2021
Police Risk Management Committee Meeting - May 6, 2021
Claims Committee Meeting - May 27, 2021
Executive Committee Meeting - May 27, 2021

Per Government Code 54954.2, persons requesting disability related modifications or accommodations, including auxiliary aids or services in order to participate in the meeting, are requested to contact Jenna Wirkner at Alliant Insurance Services at (916) 643-2741.

The Agenda packet will be posted on the NCCSIF website at www.nccsif.org. Documents and material relating to an open session agenda item that are provided to the NCCSIF Claims Committee less than 72 hours prior to a regular meeting will be available for public inspection and copying at 2180 Harvard Street, Suite 460, Sacramento, CA 95815.

Access to some buildings and offices may require routine provisions of identification to building security. However, NCCSIF does not require any member of the public to register his or her name or to provide other information, as a condition to attendance at any public meeting and will not inquire of building security concerning information so provided. See Government Code section 54953.3.

Northern California Cities Self Insurance Fund
Claims Committee Meeting
March 25, 2020

Agenda Item D.

CONSENT CALENDAR

ACTION ITEM

ISSUE: The Claims Committee reviews items on the Consent Calendar, and if any item requires clarification or discussion a Member should ask that it be removed for separate action. The Committee should then consider action to approve the Consent Calendar excluding those items removed. Any items removed from the Consent Calendar will be placed later on the agenda in an order determined by the Chair.

RECOMMENDATION: Adoption of the Consent Calendar after review by the Committee.

FISCAL IMPACT: None.

BACKGROUND: Routine items that generally do not require discussion are regularly placed on the Consent Calendar for approval.

ATTACHMENT(S):

1. Claims Committee Meeting Minutes - September 24, 2020
2. Claims Committee Special Meeting Minutes – December 3, 2020
3. Claims Committee Special Meeting Minutes – January 21, 2021

MINUTES OF THE
NCCSIF CLAIMS COMMITTEE MEETING
WEBEX TELECONFERENCE
SEPTEMBER 24, 2020

COMMITTEE MEMBERS PRESENT

Dave Warren, City of Folsom (**Chair**)
Stephanie Van Steyn, City of Galt
Yvonne Kimball, City of Jackson
Jennifer Styczynski, City of Marysville

COMMITTEE MEMBERS ABSENT

Jen Lee, City of Rio Vista

CONSULTANTS & GUESTS

Marcus Beverly, Alliant Insurance Services
Raychelle Maranan, Alliant Insurance Services
Jenna Wirkner, Alliant Insurance Services
Dorienne Zumwalt, Sedgwick
Alex Davis, Sedgwick

A. CALL TO ORDER

Chair Dave Warren called the meeting to order at 10:06 a.m. A roll call was made and the above mentioned members were present constituting a quorum.

B. PUBLIC COMMENTS

C. CONSENT CALENDAR

1. Claims Committee Meeting Minutes - May 28, 2020

A motion was made to approve the Consent Calendar as presented.

Motion: Stephanie Van Steyn **Second:** Jennifer Styczynski **Motion Carried**
Ayes: Stephanie Van Steyn, Jennifer Styczynski, Dave Warren

D. CLOSED SESSION

Pursuant to Government Code Section 54956.95, the Committee recessed to closed session at 10:09 a.m. to discuss the following claims:

Workers Compensation:

1. NCWA-557265, NCWA-557298, NCWA-557302, NCWA-557519 v. City of Folsom
2. NCWA-557556, NCWA-558527 v. City of Marysville
3. NCWA-555964 v. City of Yuba City

Yvonne Kimball joined at 10:24 a.m.

Liability:
1. Rafferty and McDowell v. City of Rio Vista

F. REPORT FROM CLOSED SESSION

The Committee reconvened to open session at 10:37 a.m.

Chair Warren indicated that Committee met and provided direction on the above claims but no reportable action was taken.

E. APPROVAL OF NCCSIF DEFENSE ATTORNEY LIST FOR LIABILITY

Mr. Beverly gave a brief overview of the addition of Roy C. Santos and Michelle Sassano, recommended by the City of Yuba City. Roy C. Santos is qualified and has experience in municipal work, police work and as a City Attorney. The City of Yuba City is also requesting associate Michelle Sassano be added to the Defense Attorney list for liability.

Members discussed adding Roy. C Santos and Michelle Sassano to the Liability Counsel Approved List.

A motion was made to approve the addition of Roy C. Santos and Michelle Sassano to the Liability Counsel Approved List.

Motion: Jennifer Styczynski **Second:** Stephanie Van Steyn **Motion Carried**
Ayes: Stephanie Van Steyn, Dave Warren, Jennifer Styczynski, Yvonne Kimball

F. FY 20/21 WORKERS' COMPENSATION CLAIM AUDIT PROPOSALS

Mr. Beverly gave a brief overview of the four Workers' Compensations RFPs that were sent out to ALC, Farley Consulting Services, ESM and North Bay Associates. North Bay associates didn't submit an RFP because they will be auditing PRISM claims around the same time. Members suggested going with Angela Mudge and auditing only 80 claims. Members also discussed that Tim Farley has done a great job on previous audits. Recommended staying with Farley if we haven't had any issues. This item was tabled for discussion at the Executive Committee Meeting on 9/24/2020 at 11:00 a.m.

G. ROUND TABLE DISCUSSION

None.

H. ADJOURNMENT

The meeting was adjourned at 11:00 a.m.

Respectfully Submitted,

_____ _____
Jennifer Styczynski, Secretary Date

MINUTES OF THE
NCCSIF CLAIMS COMMITTEE SPECIAL MEETING
SPECIAL WEBEX TELECONFERENCE
December 3, 2020

COMMITTEE MEMBERS PRESENT

Jose Jasso, City of Rio Vista (**Chair**)
Stephanie Van Steyn, City of Galt
Yvonne Kimball, City of Jackson
Jen Lee, City of Rio Vista

COMMITTEE MEMBERS ABSENT

Jennifer Styczynski, City of Marysville

CONSULTANTS & GUESTS

Marcus Beverly, Alliant Insurance Services
Jenna Wirkner, Alliant Insurance Services
Steven Scott, Sedgwick
Dorienne Zumwalt, Sedgwick
Alex Davis, Sedgwick

A. CALL TO ORDER

Chair Jose Jasso called the meeting to order at 10:04 a.m. A roll call was made and the above mentioned members were present constituting a quorum.

B. ROLL CALL

C. PUBLIC COMMENTS

D. CLOSED SESSION

Pursuant to Government Code Section 54956.95, the Committee recessed to closed session at 10:07 a.m. to discuss the following claims:

Workers Compensation:

1. NCWA-558197 v. City of Elk Grove

Liability:
1. Desmond v. Trull v. City of Rocklin

Yvonne Kimball joined the call at 10:16 a.m.

E. REPORT FROM CLOSED SESSION

The Committee reconvened to open session at 10:22 a.m.

Chair Jasso announced the Committee met and provided direction on the above claims but no reportable action was taken.

F. ROUND TABLE DISCUSSION

None.

G. ADJOURNMENT

A motion was made to adjourn the meeting at 10:24 a.m.

Motion: Yvonne Kimball **Second:** Jose Jasso **Motion Carried**
Ayes: Van Steyn, Kimball, Lee, Jasso

The meeting was adjourned at 10:24 a.m.

Respectfully Submitted,

_____
Jennifer Styczynski, Secretary

_____
Date

MINUTES OF THE
NCCSIF CLAIMS COMMITTEE SPECIAL MEETING
WEBEX TELECONFERENCE
January 21, 2021

COMMITTEE MEMBERS PRESENT

Jose Jasso, City of Rio Vista, Chair
Stephanie Van Steyn, City of Galt
Yvonne Kimball, City of Jackson
Jen Lee, City of Rio Vista

COMMITTEE MEMBERS ABSENT

Jennifer Styczynski, City of Marysville

CONSULTANTS & GUESTS

Jenna Wirkner, Alliant Insurance Services
Steven Scott, Sedgwick
Dorienne Zumwalt, Sedgwick
Jill Petraca, Sedgwick

A. CALL TO ORDER

Chair Jose Jasso called the meeting to order at 10:08 a.m. A roll call was made and the above members were present constituting a quorum.

B. ROLL CALL

C. PUBLIC COMMENTS - None

D. CLOSED SESSION

Pursuant to Government Code Section 54956.95, the Committee recessed to closed session at 10:10 a.m. to discuss the following claims:

Workers Compensation:

1. NCWA-558122 and NCWA-558656 -v. City of Elk Grove*.
2. NCWA-537202 v. City of Folsom*
3. NCWA-556528 v. City of Yuba City*
4. NCWA-558116 v. City of Galt*

E. REPORT FROM CLOSED SESSION

The Committee reconvened to open session at 10:55 a.m.

Chair Jasso announced the Committee met and provided direction on the above claims but no reportable action was taken.

F. ROUND TABLE DISCUSSION - None

G. ADJOURNMENT

The meeting was adjourned at 10:57 a.m.

Respectfully Submitted,

_____
Jennifer Styczynski, Secretary

_____
Date

Northern California Cities Self Insurance Fund
Claims Committee Meeting
March 25, 2020

Agenda Item E.

CLOSED SESSION TO DISCUSS PENDING CLAIMS

(Per Governmental Code Section 54956.95)

ACTION ITEM

ISSUE: Pursuant to Government Code Section 54956.95, the Committee will hold a Closed Session to discuss the following claims:

Liability:
1. Barrett v. City of Yuba City
2. Young v. City of Marysville
3. Googooian v. City of Rocklin

Workers Compensation:
1. NCWA- 543918 -v. City of Yuba City

FISCAL IMPACT: Unknown.

RECOMMENDATION: The Program Administrator cannot make a recommendation at this time, as the subject matter is confidential.

BACKGROUND: Confidential.

ATTACHMENT(S): None.

Northern California Cities Self Insurance Fund
Claims Committee Meeting
March 25, 2020

Agenda Item G.1.

FY 20/21 WORKERS COMPENSATION PROGRAM CLAIMS AUDIT FOR NORCAL CITIES –ALC

ACTION ITEM

ISSUE: The most recent Workers' Compensation claims management audit for NorCal Cities was conducted by Angela Livingston Collaborations (ALC) and is attached for review, along with a response from Sedgwick regarding the findings and recommendations.

The Executive Summary is found on pages 2-4 of the audit report and includes the following:

Performance Strengths
Outstanding results were achieved in the categories of adjuster caseload, initial contacts and claim investigations, timely award payments, ongoing investigation, subrogation, settlement valuations, timely claim closure, quality of supervisor reviews and initial reserves. All aspects of medical management were strong. The current file reserves on most of the files audited were on point relative to the ultimate claim costs. Proper OSIP reserving was established on the future medical files.

Performance Improvement Recommendations
When the initial TD benefit is triggered an automatic 30-day diary should be set to maintain employee contact while the employee is off work. Likewise, when surgery is approved a diary should be set to secure the surgery date so that contact can be made within three business days of the procedure. Upon receipt of information that would allow the claim to be finalized, we recommend a diary be set to ensure that resolution is pursued within 30 days, with follow up efforts demonstrated every 30-45 days until settlement or closure is achieved.

DISCUSSION: This is the first audit performed by ALC for NorCal Cities, and while the overall score of 84.93% was just under the "good" rating of 85%, on balance the strengths in the most critical areas outweigh the improvement areas. However, maintaining contact with the employee at critical times in the process is important and should be improved with better diary management. The recommendations in this audit and the one conducted by PRISM that is discussed in the next agenda item have maintaining appropriate diary follow up as a theme for improvement in a number of categories. Timely contact with the employee, by all involved, is a key component of a best-case resolution of an injury claim.

The Program Administrators recommend another audit by ALC in November of 2021 as a follow up on the recommendations and particularly diary-driven contact with the employee and/or toward claim resolution. This would also put us back on track to avoid a conflict with the bi-annual PRISM audits.

RECOMMENDATION: Review, accept and file audit and response, with another audit in November.

FISCAL IMPACT: None, already budgeted at $14,625 – 75 files at $195 each.

Agenda Item G.1. (*continued*)

BACKGROUND: Every even year NCCSIF conducts an audit of member Workers' Compensation claims to ensure it is being managed according to NCCSIF standards and best practices. This is the first time ALC has audited the group's claims.

ATTACHMENT(S):

1. NorCal Cities 2020 Workers Compensation Claims Audit by ALC (without Audit Detail)
2. Sedgwick's Response to audit findings and recommendations

January 2021
CLAIMS AUDIT REPORT

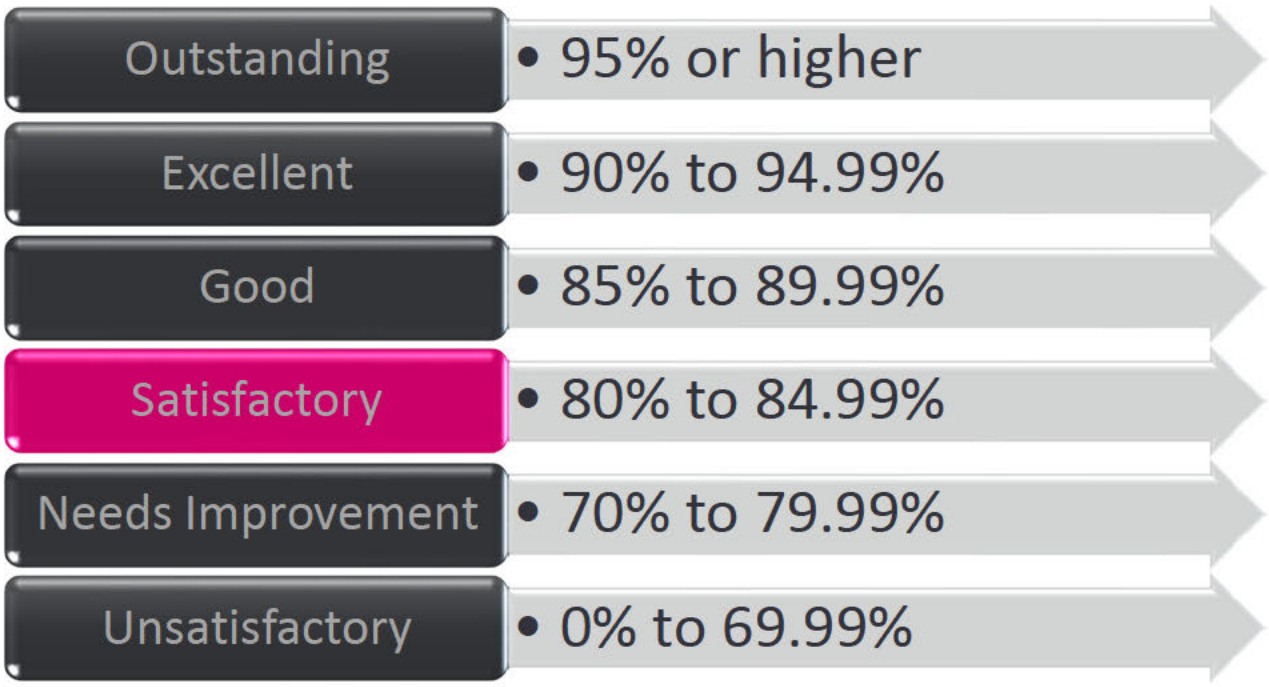
Northern California Cities Self Insurance Fund
TPA Sedgwick

Table of Contents

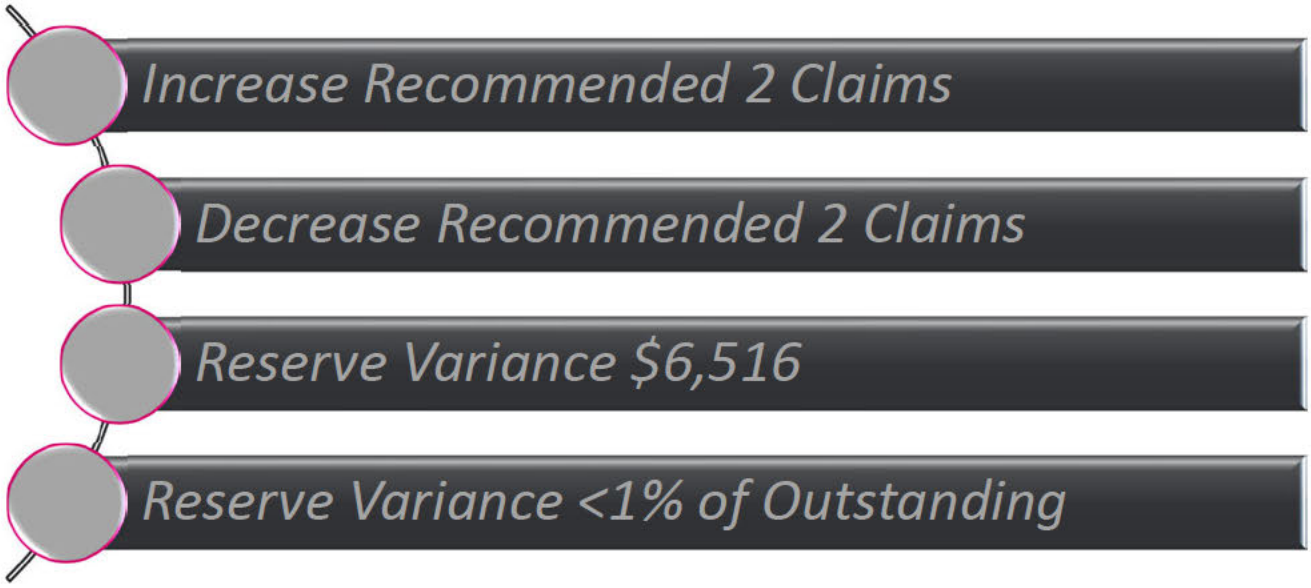
EXECUTIVE SUMMARY

This section will serve as an overview of the audit findings, workload information and recommendations. The ***final score for this audit is 84.93%*** *which falls within the* ***Satisfactory*** *category of the audit scale.*

Category	*Points Available*	*Points*	*Score*
Communication	**51**	**42**	**82.35%**
Compensability	**21**	**20**	**95.24%**
Benefit Payment & Notices	**69**	**53**	**76.81%**
Medical & Disability Management	**136**	**135**	**99.26%**
Litigation Management	**21**	**18**	**85.71%**
Investigation	**1**	**1**	**100.00%**
Recovery	**33**	**31**	**93.94%**
Excess	**18**	**11**	**61.11%**
Resolution of Claim	**44**	**35**	**79.55%**
Plan of Action	**145**	**103**	**71.03%**
Supervision	**140**	**119**	**85.00%**
Reserves	**137**	**125**	**91.24%**
Overall Score	**816**	**693**	**84.93%**



Reserve Detail



Performance Strengths

Outstanding result were achieved in the categories of adjuster caseload, initial employer contact, initial employee contact, initial claim investigations, proper final decisions to accept or deny the claim, award payments timely made, proper use of UR, proper use of NCM, proper use of the MPN, appropriate referrals to approved defense counsel, ongoing investigation, claim indexing, recognition and pursuit of subrogation, initial excess reporting, excess reimbursement requests, settlement valuations, obtaining client settlement authority, timely claim closure, quality of supervisor reviews and initial reserves.

Initial three-point contacts with the employee are routinely completed timely and are of good quality.

Temporary and permanent disability benefits were issued timely in most of the files audited.

All aspects of medical management were strong.

The current file reserves on most of the files audited were on point relative to the ultimate claim costs. Proper OSIP reserving was established on the future medical files.

Performance Improvement Recommendations

When the initial TD benefit is triggered an automatic 30-day diary should be set to maintain employee contact while the employee is off work. Likewise, when surgery is approved a diary should be set to secure the surgery date so that contact can be made within three business days of the procedure. We recommend ongoing contact on claims where no TD is being paid when the claim progression is stalled.

We recommend evaluation of the current workflows to ensure that benefit notices are timely issued upon commencement or ending of temporary disability, 4850 or permanent disability benefits. Further, permanent disability delay decisions were missed in a handful of files. Better use of the diary system could help improve the timeliness of those notifications.

There were two files where apportionment potential existed and was not properly identified and pursued. We recommend additional training on how to spot, document and trigger action to timely pursue apportionment opportunities.

The standards for ongoing excess reporting should be reviewed with the team. We recommend setting the excess reporting diary at least two weeks prior to the report due date to allow for any unplanned absences or distractions.

Upon receipt of information that would allow the claim to be finalized, we recommend a diary be set to ensure that resolution is pursued within 30 days, with follow up efforts demonstrated every 30-45 days until settlement or closure is achieved.

Significant improvement on both the timeliness and quality of the plan of actions needs work. We recommend that POA update diaries be scheduled at least 14 days in advance of the due date to ensure that these are completed timely on an ongoing basis. When the POA is updated each section should be reviewed to ensure that it has current case status information, and that the reserves and action plan align with the case status.

We recommend that supervisor review diaries be scheduled at least 14 days in advance of the due date to ensure that these are completed timely on an ongoing basis.

There were two subcategories where only one downgraded file produced a low score. We consider these to be outliers and not an adverse trend. The categories impacted were delayed timely and appropriately and excess settlement authority sought.

CATEGORY RESULTS

Adjuster Workloads

	NCCSIF			*Other Accounts*				
Adjuster / Supervisor	*Indemnity*	*Med Only*	*Future Med*	*Indemnity*	*Med Only*	*Future Med*	*Total*	*Weighted Value*
Alicia Veloz	46	1	45	57	10	5	164	134
Alyssa Marchuk	44	0	2	79	1	25	151	137
Catherine Clark	124	3	2	0	0	0	129	127
Cristal Rhea	28	0	3	104	6	20	161	147
Kristin Farley	1	30	19	22	6	191	269	146
Rebecca Summers	0	0	189	14	17	74	294	154
Steven Scott/Supervisor	0	0	0	0	0	0	0	0
Total	243	34	260	276	40	315	1168	844

Communication

Initial Employer Contact

Files Meeting the Criteria 14 | Files in Compliance 14

Audit Score 100%

Initial employer contact was appropriately completed and documented within the files meeting the criteria for this category.

Initial Employee Contact

Files Meeting the Criteria 14 | Files in Compliance 12

Audit Score 85.71%

1. [redacted] ***402007160E7-0001***

The claim was received 07/29/20. The initial contacts were due by 08/03/20. There was only one initial contact attempt with the employee 08/03/20. Industry standard is three attempts within three business days of receipt of the claim.

2. [redacted] ***NCWA-558679***

The claim was received on 06/03/20 with initial contacts due by 06/08/20. The employee contact was untimely completed on 06/17/20. There are two documented attempts on 06/04/20 and 06/05/20. A contact letter was issued untimely on 06/09/20.

Initial Physician Contact

Files Meeting the Criteria 12 | Files in Compliance 12

Audit Score 100%

Initial physician contact was appropriately completed and documented within the files that met the criteria for this category.

Appropriate Ongoing Communication with Employer

Files Meeting the Criteria 0 | Files in Compliance N/A

Audit Score N/A

There were no applicable files for this category.

Reserve Deviation

Employee Name	Claim #	Recommendation	Variance
[redacted]	NCWA-558196	Decrease indicated	($32,000)
	NCWA-557269	Decrease indicated	($7,486)
	NCWA-558642	Increase indicated	$5,800
	NCWA-176207	Increase indicated	$27,170
Total			**($6,516)**

Employee Name	Claim #	Recommendation	Employee Name	Claim #	Recommendation
[redacted]	NCWA-556484	No change indicated	[redacted]	NCWA-557200	No change indicated
	NCWA-558664	No change indicated		NCWA-558427	No change indicated
	402007160E7-0001	No change indicated		NCWA-557237	No change indicated
	NCWA-557691	No change indicated		NCWA-558690	No change indicated
	402010290E6-0001	No change indicated		NCWA-558589	No change indicated
	NCWA-558159	No change indicated		NCWA-359740	No change indicated
	NCWA-558498	No change indicated		NCWA-555976	No change indicated
	NCWA-558615	No change indicated		NCWA-558496	No change indicated
	NCWA-558700	No change indicated		NCWA-558367	No change indicated
	NCWA-558178	No change indicated		NCWA-558581	No change indicated
	NCWA-558054	No change indicated		NCWA-55686	No change indicated
	NCWA-556070	No change indicated		NCWA-367736	No change indicated
	NCWA-558395	No change indicated		NCWA-557090	No change indicated
	NCWA-557563	No change indicated		NCWA-558648	No change indicated
	NCWA-47688	No change indicated		NCWA-557627	No change indicated
	NCWA-557983	No change indicated		NCWA-558679	No change indicated
	NCWA-556131	No change indicated		NCWA-558471	No change indicated
	NCWA-558507	No change indicated		NCWA-558503	No change indicated
	NCWA-557732	No change indicated		NCWA-558674	No change indicated
	NCWA-375674	No change indicated		NCWA-557945	No change indicated
	NCWA-558230	No change indicated		NCWA-555988	No change indicated
	NCWA-557807	No change indicated		NCWA-79192	No change indicated
	NCWA-558261	No change indicated		NCWA-558229	No change indicated
	NCWA-558695	No change indicated		NCWA-556829	No change indicated
	NCWA-556083	No change indicated		NCWA-557204	No change indicated
	NCWA-551608	No change indicated		NCWA-558392	No change indicated
	NCWA-57344	No change indicated		NCWA-558706	No change indicated
	NCWA-79871	No change indicated		NCWA-557482	No change indicated
	NCWA-558524	No change indicated		NCWA-557533	No change indicated
	NCWA-558244	No change indicated		NCWA-558336	No change indicated
	NCWA-491687	No change indicated		NCWA-346790	No change indicated
	NCWA-554066	No change indicated		NCWA-557025	No change indicated
	NCWA-544721	No change indicated		NCWA-528981	No change indicated
	NCWA-55103	No change indicated		NCWA-343198	No change indicated
	NCWA-529899	No change indicated		NCWA-556526	No change indicated
	NCWA-555600	No change indicated			

Score Detail

Category	*Points Available*	*Points*	*Score*
Communication			
Initial Employer Contact	14	14	100.00%
Initial Employee Contact	14	12	85.71%
Initial Physician Contact	12	12	100.00%
Appropriate Ongoing Communication With Employer	0	0	N/A
Appropriate Ongoing Communication With Employee	11	4	36.36%
Sub-Total of Category	**51**	**42**	**82.35%**
Compensability			
Delayed Timely & Appropriately	4	3	75.00%
Investigation Timely & Appropriate	3	3	100.00%
Acceptance / Denial Justified	14	14	100.00%
Sub-Total of Category	**21**	**20**	**95.24%**
Benefit Payment & Notices			
TD/PD Benefits Paid Timely	29	26	89.66%
Proper Benefit Letters Sent	30	17	56.67%
Awards Paid Timely	10	10	100.00%
SIP Paid On Late Payments	0	0	N/A
Penalty Reimbursement Plan	0	0	N/A
Sub-Total of Category	**69**	**53**	**76.81%**
Medical & Disability Management			
RTW/MMI Aggressively Pursued	8	7	87.50%
Medical Treatment Managed Appropriately	45	45	100.00%
Proper Use Of UR	35	35	100.00%
Proper Use of MCM	2	2	100.00%
MPN Managed/Disputed Appropriately	46	46	100.00%
Sub-Total of Category	**136**	**135**	**99.26%**
Litigation Management			
Appropriate DA Referral	3	3	100.00%
Assign DA On Panel	3	3	100.00%
Proactive & Timely Management of DA	15	12	80.00%
Sub-Total of Category	**21**	**18**	**85.71%**
Investigation			
Ongoing Investigation Timely & Appropriate	1	1	100.00%
Suspected Fraud Pursued Timely & Appropriately	0	0	N/A
Sub-Total of Category	**1**	**1**	**100.00%**

Category	Points Available	Points	Score
Recovery			
Indexing Completed	28	28	100.00%
Subrogation Recognized & Pursued	3	3	100.00%
Apportionment Recognized & Pursued	2	0	0.00%
Contribution Recognized & Pursued	0	0	N/A
Sub-Total of Category	**33**	**31**	**93.94%**
Excess			
Timely Initial Report To Excess	2	2	100.00%
Timely Excess Updates	13	7	53.85%
Excess Authority Timely Sought	1	0	0.00%
Timely Excess Reimbursement Requests	2	2	100.00%
Sub-Total of Category	**18**	**11**	**61.11%**
Resolution of Claim			
Resolution Pursued 30 Days From Event	14	6	42.86%
Settlement Valued Appropriately	9	9	100.00%
Client Settlement Authority Secured	6	6	100.00%
Timely Continuing Settlement Efforts	3	2	66.67%
Claim Closed Timely	12	12	100.00%
Sub-Total of Category	**44**	**35**	**79.55%**
Plan of Action			
Timely POA Updates	73	44	60.27%
Quality POA Based Upon Current Facts	72	59	81.94%
Sub-Total of Category	**145**	**103**	**71.03%**
Supervision			
Timely Supervisor Reviews	70	49	70.00%
Quality S/R Based Upon Current Facts	70	70	100.00%
Sub-Total of Category	**140**	**119**	**85.00%**
Reserves			
Initial Reserve Posted In 30 Days	14	14	100.00%
Reserves Adjusted 30 Days Of Triggering Event	18	12	66.67%
Current Reserves Appropriate	75	71	94.67%
FM Reserves Consistent With SIP Regs	30	28	93.33%
Sub-Total of Category	**137**	**125**	**91.24%**

AUDIT CRITERIA

The audit criterion was formed by using industry best practices. The file audits specifically focused on claims handling activity from 12/01/19 to the date of the audit. Sedgwick provided a list of the open inventory and a random selection of the files was pulled to gather 65 files from the open and 10 files from the closed inventory. The file selection consisted of a mix of indemnity claims and future medical files. File documents, notes, payments, letters, and reserves are maintained in electronic form. The files were accessed electronically.

AUDIT PROCESS

The audit was completed electronically. Each worksheet was provided to Dorienne Zumwalt and Steven Scott for review and comment.

AUDIT TEAM

Angela Mudge
Owner, President & CEO
Senior Executive with over 28 years of workers' compensation claims leadership, claim technical and operational experience
IEA Certificate, Self-Insured Certificate & WCCP Designation
Prior positions held - adjuster, supervisor, claims manager and vice president

Anne Ruiz
Chief Operating Officer
Over 24 years of workers' compensation claims experience
Associate in Claims Designation, Self-Insured Certificate & WCCA Designation
Prior positions held - adjuster, supervisor, claims services liaison and central services manager

Sherri' Ventimiglia
Senior Collaborator
Over 30 years of workers' compensation claims experience
Self-Insured Certificate & WCCP Designation
Prior positions held – adjuster, claims analyst, supervisor, manager, director of claims and assistant vice president of claims.

Fernando Rodriguez
Collaborator
Over 6 years of workers' compensation claims experience
Bachelor of science in business administration & Self-Insured Certificate
Prior positions held – adjuster and supervisor trainee

March 1, 2021

To: Marcus Beverly, Alliant Insurance Services (via email)

Re: Response to Audit Results for Northern California Cities Self-Insurance Fund– ALC Claims Collaborations

This letter will serve as a response to the ALC Claims Collaborations audit report dated January 2021. The audit generated an overall score of 84.93% as compared to the January 2021 North Bay Associates audit of 86.3%. We want to assure you of our commitment to meet and exceed NCCSIF's performance expectations.

We appreciate that ALC Claims Collaborations noted our performance strengths which include quality initial three-point contacts, timely benefit issuance, strong medical management, accurate reserve calculations, subrogation recovery pursuits, as well as several other strengths. These strengths were also noted in the North Bay audit.

The audit report also provides opportunities for improvement in the categories of timeliness of diary reviews, continued contact when an injured worker is off work, ongoing excess reporting, and claim finalization. As detailed in our audit response to the North Bay audit, we have taken these recommendations to heart and have put into place strategies to improve our overall performance. These strategies include targeted training, diary techniques, additional oversight, and internal audits.

We appreciate our partnership with NCCSIF very much and are dedicated in our commitment of providing excellent claims handling. Please let us know if you have any questions or need additional information.

Sincerely,

Dori Zumwalt
Director, Client Services

Cc (via email):
Heidi Hough, Director Claims
Steven Scott, Team Lead
Devora Brainard-DeLong, VP Client Services
Jenna Wirkner, Alliant Account Representative

Northern California Cities Self Insurance Fund
Claims Committee Meeting
March 25, 2020

Agenda Item G.2.

FY 20/21 WORKERS COMPENSATION PROGRAM CLAIMS AUDIT FOR PRISM – NORTH BAY ASSOCIATES

ACTION ITEM

ISSUE: The attached Workers' Compensation claims audit was conducted on behalf of the group's excess coverage provider, PRISM. Also attached is Sedgwick's response.

The Executive Summary of the report begins on page 3, with the strengths and recommendations for improvement found on pages 4-5 and a graphic of the results in each category on pages 6-7.

Areas showing strong performance are:

- Investigating and deciding on claim compensability.
- Paying the various workers' compensation benefits accurately and timely.
- Reserving sufficient funds to pay each case.
- Documented case planning with timely follow up.
- Moving claims toward resolution in a timely manner.
- Communication with the employer.

Areas needing improvement are:

- Continued contact with the injured employees. Unrepresented employees should be contacted every 30 days when missing time.
- Initial and subsequent excess reporting.
- Timely payment of medical bills. There was 1 claim with numerous medical bills paid late.
- Timely Medical Only conversions.

Most of the areas for improvement are related to timely setting and maintaining diary, particularly for follow up with the injured employee. Sedgwick has provided a response to the audit and recommendations that includes a focus on setting and maintaining examiner and supervisor diaries. Priority should be given to following up with employees on TD at least every 30 days and no more than five days after surgery or doctor visit in which the employee's work status may change or they reach maximum improvement.

RECOMMENDATION: Review, accept and file audit and response.

FISCAL IMPACT: None. Paid for by PRISM.

Agenda Item G.2. *(continued)*

BACKGROUND: NCCSIF's Excess Workers' Compensation Coverage provider, PRISM, conducts a claims audit every other year, focused primarily on current or potential excess claims. The most recent audit was conducted by North Bay Associates and focused on administration of claims from November 15, 2018 to the time of the audit in October 2020. The audit report combines results from both NCCSIF and Napa County, a practice PRISM employs to save time and expense. NCCSIF commissions its own audit every other year that encompasses primary and excess claims.

ATTACHMENT(S):

1. Workers' Compensation Claims Audit by North Bay Associates September 2020 (without Section E., Audit Detail
2. Sedgwick's Response to audit findings and recommendations

NORTH BAY ASSOCIATES

WORKERS' COMPENSATION

AUDITORS • CONSULTANTS

November 2020

Workers' Compensation Claims Audit

PRISM, COUNTY OF NAPA AND NORTHERN CALIFORNIA CITIES SELF INSURANCE FUND/ALLIANT INSURANCE

ADMINISTERED BY

SEDGWICK

PO Box 232 Auburn, CA 95604 · PHONE (530) 269-3473

e-mail alan.fleming@northbayassociates.com

Workers Compensation Claims Audit

November 2020

PRISM, County of Napa and Northern California Cities Self Insurance Fund/Alliant Insurance

Administered by

Sedgwick

CONFIDENTIAL

North Bay Associates

PO Box 232 Auburn, CA 95604 • (530) 269-3473

NORTH BAY ASSOCIATES

WORKERS' COMPENSATION

AUDITORS • CONSULTANTS

December 31, 2020

PRISM
Ms. Karin Wedworth
Workers Compensation Claims Manager

Northern California Cities Self Insurance Fund/Alliant Insurance
Mr. Marcus Beverly
First Vice President

County of Napa
Mr. Kerry John Whitney
Risk Manager

The Workers' Compensation Claims Audit report for November 2020 for these PRISM members: County of Napa and Northern California Cities Self Insurance Fund/Alliant Insurance administered by Sedgwick is presented herewith.

Quick Overview

- *Executive Summary & Audit Profile (page 3)*
- *Summary of Recommendations (page 5)*

We wish to acknowledge the cooperation of the administrator, Sedgwick, for providing us with remote access to the claims data.

This audit was conducted utilizing the PRISM audit standards and scoring system effective 7/1/2019.

This report has been simultaneously provided to the administrator. Although all the data had not yet been tabulated in the form seen here, the general findings and preliminary recommendations of this audit were discussed with TPA management during an exit interview.

Since this report deals with employees' injuries, reserves on the claim files, tactics for further handling, and so on, we suggest it be kept confidential.

We hope that this report is self-explanatory; any comments or questions the reader may have are welcome. It has been a pleasure once again to serve County of Napa and Northern California Cities Self Insurance Fund/Alliant Insurance and PRISM.

Respectfully submitted,

NORTH BAY ASSOCIATES

Alan Fleming
Workers Compensation Claims Auditor

PO Box 232 Auburn, CA 95604 · PHONE (530) 269-3473

e-mail alan.fleming@northbayassociates.com

Table of Contents

Addendum

Table of Contents

A. INTRODUCTION

This is the Workers' Compensation Claims Audit report for November 2020 for these PRISM members: County of Napa and Northern California Cities Self Insurance Fund/Alliant Insurance.

1. Goals of the Claims Audit.

- Gather and present statistical data relating to the administration of the members' workers' compensation claims from 11/15/2018, to date.
- Focus on those claims constituting the bulk of the outstanding reserves, and claims involving key issues and a representative sample of each entity's files.
- Present and explain industry standards, Division of Workers' Compensation Audit Unit standards, and PRISM standards and goals.
- Compare audit findings to the standards, and to prior audits, noting strengths and weaknesses.
- Recommend ways to meet standards and to reach goals.

2. Report Organization.

This report contains twelve audit areas beginning at Section E, page 10. Each has an introduction, point-by-point discussion, and summary and recommendations. Data is presented in as many as four different ways for clarity and for different depths of detail.

First, for an overview, is the Executive Summary on pages 3 and following. The Executive Summary includes summarized strengths and weaknesses, a separate Summary of Recommendations for improvement and the audit scoresheet.

Second, for detailed data and explanation, each numbered paragraph delves into a particular audit item. Each point is explained and audit findings are compared to standards. Comments about any particular claim file are often amplified by "Summary Memos." These can be found in the *Addendum* at Tab Three in order by NBA number.

Third, the Audit Scoresheets numerically restate the same data shown in the text. The audit points are explained in the audit area to which each refers and the Audit

Scoresheets can be found in Tab Four of the *Addendum*.

The *Addendum* contains statistical and other essential data. In brief, the *Addendum* includes the following:

Tab One: Full list of claims audited, sorted by NBA#. These lists may be used to identify claimants; to maintain confidentiality, the body of this report refers only to NBA#'s.

Tab Two: The Reserve Summary reports on the dollar amounts of reserve changes recommended. Reserve Work Sheets provide the detail behind the Reserve Summary report and are located here. The Excess Report shows all excess cases in the sample.

Tab Three: Individual Summary Memos. These are left on certain files for the benefit of the examiner where some issue was pending or where guidance was appropriate. Some explain a definite shortcoming in a file and offer recommendations for further handling. Others offer suggestions on files that are being correctly handled. Not every file audited has a Memo. Since many Memos detail specific recommendations for further file handling, we recommend the client follow up to be certain the administrator acts on these Memos and recommendations. We always encourage the examiners to discuss these Memos with us. In this case, the supervisor chose to discuss some of the Memos and the points raised therein.

Tab Four: The Audit Scoresheets are here. Scoresheets are provided for both the scored audit points and the non-scored audit points. As this is a Group Audit, combined Audit Scoresheets are provided, as well as individual Audit Scoresheets for each Member.

B. EXECUTIVE SUMMARY

The November 2020 workers' compensation audit for these PRISM members: County of Napa and Northern California Cities Self Insurance Fund/Alliant Insurance was begun on 10/23/2020. It covers file activity from 11/15/2018, the date of the last audit.

The sample used to develop the data for this audit was taken from a loss run of open indemnity cases provided to us by Sedgwick. The sample consisted of 103 files, or 15.1% of the total open inventory of indemnity files. The sample is a carefully selected and structured sample rather than a random sample. It is weighted in favor of claims with significant potential and claims containing certain key issues. This is called the "dollar value" sampling technique. But we also spread the sample to include the work of all the entities and examiners, to look at files newly opened since the last audit.

Not all audit queries apply to each case in the sample. Some points apply to the beginning stages of a file, while others pertain only to the end. Claims activity during this audit period is the determining factor. Except for historical comparisons, we read but do not consider for audit purposes activity prior to the last audit.

This audit complies with the audit standards and scoring system as adopted by PRISM effective 7/1/2019. The overall claims handling performance for this TPA is rated as **Meets Expectations.**

On the following page is a summary of audit areas showing strengths and weaknesses.

Areas showing strong performance are:

Investigating and deciding on claim compensability.

Paying the various workers' compensation benefits accurately and timely.

Reserving sufficient funds to pay each case.

Documented case planning with timely follow up.

Moving claims toward resolution in a timely manner.

Communication with the employer.

Areas needing improvement are:

Continued contact with the injured employees. Unrepresented employees should be contacted every 30 days when missing time.

Initial and subsequent excess reporting.

Timely payment of medical bills. There was 1 claim which had numerous medical bills paid late.

Timely Medical Only conversions.

Summarized recommendations for further improvement begin on the next page.

C. SUMMARY OF RECOMMENDATIONS

There was strong performance in the following areas:

- Audit results that exceeded expectations were in the areas of initial employer contact, initial employee contact, payments made on the correct claim, plans of action, litigation management, resolution pursued timely, correct settlement valuation, apportionment recognition and pursuit, protection of Medicare interest, member settlement authority, appropriate and timely initial reserves, reserve revisions, separation of 4850/TD, medical reserves consistent with office of self-insured plans, life pension reserves, allocated reserves, subrogation recognition and follow up, coding of self-imposed penalties, proactive pursuit of return to work, and notification of permanent restrictions.

Performance areas that require improvement:

- It is recommended that the PRISM continued employee-contact standards be followed while unrepresented employees are missing time.

- It is recommended that medical bills be paid timely on all claims.

- It is recommended that the examiners review the PRISM medical only conversion requirements and ensure the claims are converted timely.

- It is recommended that initial excess reporting be completed within 5 business days.

- It is recommended that the diary system be used to ensure subsequent excess reports are sent timely

We suggest that the employer, PRISM and AIMS set priorities and adopt a timetable for implementing these recommendations.

The Audit Scoresheet on the following page shows the combined audit score for each PRISM scored audit point. This scoresheet is also in Tab Four of the *Addendum* with the score calculated at 87.7% for the scored audit points only. A scoresheet is also provided in Tab Four of the *Addendum* for the non-scored PRISM audit points.

Scored Audit Point Score = 87.7%

AP	Description	Total	Yes %	Percent Bar
	Compensability Determination			
1.1	Initial Employer Contact	52	98.1	
	Employee Contact			
2.1	Initial Employee Contact	47	100.0	
2.2	Employee Contact Continued	19	57.9	
	Payments and Fiscal Handling			
3.6	File Balancing	48	89.6	
3.9	Timely Payment of Medical Bills	89	97.8	
3.11	Payments Made On Correct Claim	24	100.0	
	Case Review and Documentation			
4.1	Plan of Action Appropriate	102	97.1	
4.2	Examiner Diaries	909	79.5	
4.3	Supervisor Diaries	415	80.7	
4.4	Medical Only Conversion	4	50.0	
	Medical Treatment			
	Litigation			
6.1	Potential Litigation Issues Investigated	0	0.0	
6.2	Litigation Management	30	100.0	
	Apportionment and Resolution			
7.1	Resolution Pursued Timely	78	97.4	
7.2	Correct Settlement Valuation	27	100.0	
7.3	Apportionment Ruled In or Out	19	100.0	
7.4	Apportionment Pursued	11	100.0	
7.5	Member Settlement Authority Request	23	100.0	
7.6	Excess Settlement Authority Request	0	0.0	
7.8	Medicare Interests Protected	1	100.0	
	Reserve Adequacy			
8.1	Appropriate Initial Reserves	52	98.1	
8.2	Timely Initial Reserves	53	100.0	
8.3	Reserves Timely and Appropriate	91	98.9	
8.4	Separation of TD/4850 Reserves	23	100.0	
8.5	Medical Reserves Per OSIP	102	99.0	
8.6	Life Pension Reserved if Applicable	1	100.0	
8.7	Allocated Reserves Accurate	101	100.0	
	Excess Insurance			
9.1	Initial Excess Reporting	20	75.0	
9.2	Subsequent Excess Reporting	139	88.5	
9.3	Excess Reimbursement Requests	0	0.0	
9.5	Closing Report Sent to Excess	1	100.0	
	Subrogation			
10.1	Recognition of Subrogation	5	100.0	
10.2	Appropriate Subrogation Follow Up	6	100.0	
10.3	ER Updating Regarding Subrogation	6	100.0	

10.4	Approval to Accept, Waive, Settle	1	100.0	
10.5	Complaint or Lien Filed Timely	1	100.0	
10.6	Pursued to Maximum Recovery	0	0.0	
	Penalty Summary			
11.2	Penalties Coded Correctly	3	100.0	
	Disability Management			
12.1	Proactive Pursuit of Return to Work	29	100.0	
12.2	Notification of Permanent Restrictions	3	100.0	
	Administrative Information			
13.1	Examiner Caseloads	4	100.0	

D. ADMINISTRATIVE INFORMATION

The workers' compensation claims of County of Napa and Northern California Cities Self Insurance Fund/Alliant Insurance continue to be handled by Sedgwick. The supervisor in immediate charge of these claims is Mr. Steve Scott. He reports to Mr. Jeff Ponta.

1. Claims Examiner and Supervisor Information.

The PRISM examiner standard is 150 to165 open indemnity files based on "future medical" files counted at a ratio of 2:1 relative to other indemnity files. Supervisors should not handle a caseload except for specific issues or a small number of claims with conflict issues.

The following table shows examiner and supervisor caseloads, experience, and certification as reported by Sedgwick. Self Insurance Plans, a state agency, certifies workers' compensation examiners by a one-time test.

Examiners/Supervisors	Caseloads			Experience	Certifications	
	This Account	All Accounts	# of FM	Years Experience	SIP Certified	CCR 2592.02 Training
Examiners						
Napa County						
Alicia Veloz	63	134	6	7	Y	Y
Alyssa Marchuk	80	146	75	4	Y	Y
NCCSIF						
Alicia Veloz	91	134	46	7	Y	Y
Alyssa Marchuk	50	137	1	4	Y	Y
Catherine Clark	145	145	3	4	Y	Y
Cristal Rhea	28	147	0	21	Y	Y
Kristin Farley	19	146	18	4	Y	Y
Rebecca Summers	190	154	190	5	Y	Y
Supervisors						
Steven Scott	0	0	0	21	Y	Y
Column 3 Total	666		XXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX

1.1 Claims Assistant's Duties.

The most common duties of the examiner's principal assistant, whatever the actual job title, may include: doing a triage to separate MO's from indemnity and urgent indemnity from normal indemnity files; controlling and paying ongoing temporary and permanent indemnity payments; calculating and paying Awards; paying medical bills on both indemnity and MO files; and data input.

Here, there are 3.5 examiners per assistant; the assistants' duties include indemnity payments, award payments, and data input.

1.2 Examiner Caseloads.

Number of Examiners: 6
Number of Examiner Caseloads That Meet Standard: 6 (100.0%).

1.3 Supervisor Caseloads.

Number of Supervisors: 1
Number of Supervisor Caseloads That Meet Standard: 1 (100.0%).

1.4 Findings, Summary and Recommendations.

These programs are adequately staffed with experienced personnel. Recommendations are not necessary.

E. AUDIT DETAIL

This section contains the details of this audit for: County of Napa and Northern California Cities Self Insurance Fund/Alliant Insurance. Each area discusses an important group of related points and the subsections offer specifics of narrow points and, finally, findings, a summary and any needed recommendations are offered for the group.

1. Compensability Determination.

This audit area concerns the initial decision regarding compensability of the claim at the time it is reported. Usually simple, this issue is sometimes complicated at the outset. The initial decision to accept, delay, or deny a particular claim is an important milestone. Inquiries in this area are also made to see whether adequate background investigation is made, if necessary, and if communication with the relevant department of the employer is established.

1.1 Initial Employer Contact.

Initial employer contact is part of the three point contact process. The PRISM standard requires this occur within 3 working days of receipt of the claim and that there be evidence of at least three documented attempts. This initial contact should be substantive and clearly documented in the claim file.

Claims Requiring Initial Employer Contact: 52
Claims With Timely Initial Employer Contact: 51 (98.1%).

1.2 Initial Decision.

The examiner's threshold function is to decide if a workers' compensation claim is to be accepted, delayed, or denied. The PRISM standard requires this determination be made within 14 calendar days of the filing of the claim with the employer. In the event the claim is not received within 14 calendar days the initial decision shall be made within 7 calendar days of receipt of the claim.

Claims Requiring Initial Decision: 52
Claims With Timely Initial Decision: 52 (100.0%).

1.3 Indexing.

All claims shall be reported to the Index Bureau at the time of initial set up and re-indexed on as a needed basis thereafter.

Claims Requiring Indexing: 62
Claims With Indexing: 59 (95.2%).

An Exception Is:

- #24674: Appears claim has not been indexed.

1.4 AOE/COE Investigation Needed.

If a decision is made to delay benefits on a claim an investigation shall be initiated within 3 working days of the decision to delay. The investigation should be fully documented with evidence sufficient to justify the actions taken and should show a clear statement of the examiner's thought processes. If the self-insured, defense attorney, or any other source of information was relied upon, then these facts and sources need to be included in the documentation.

Claims Needing AOE/COE Investigation: 15
Claims Investigated Adequately: 15 (100.0%).

1.5 Final Decision Timely Documented.

If an investigation is necessary on a delayed claim, then a final decision whether to accept or deny must be made within 90 calendar days from the date the employer received the claim form.

Claims Requiring Timely Decision: 15
Claims Documented With Timely Decision: 15 (100.0%).

1.6 Findings, Summary and Recommendations.

Initial employer contact was made timely on all new claims except 1. Initial decisions were made timely on all claims as well. All questionable claims were investigated adequately and decisions made timely. Recommendations are not necessary.

2. Employee Contact.

The purpose of this area of inquiry is to learn if the claims examiner makes early telephone contact with each injured worker according to the PRISM standard and whether this telephone contact continues as appropriate.

2.1 Initial Employee Contact.

Initial employee contact is part of the three point contact process. The PRISM standard requires initial contact within 3 working days of receipt of the claim and that there be evidence of at least three documented attempts. This initial contact should be substantive and clearly documented in the claim file. This standard also applies to medical only claims.

Claims In Need of Initial Contact: 47
Claims Showing Initial Contact: 47 (100.0%).

2.2 Employee Contact Continued.

Maintaining employee contact on non-litigated claims with ongoing temporary disability is a widely accepted industry standard. The PRISM standard is that such contact occurs within 3 working days after a scheduled surgery and at a frequency no greater than every 30 days during ongoing temporary disability on claims involving unrepresented injured employees. While assigned nurse case managers maintain employee contact on many cases their role is not a substitute for periodic contact by the examiner.

Claims Needing Continuing Employee Contact: 19
Claims With Continuing Contact: 11 (57.9%).

Some Exceptions Are:

- #20148: Continued contact with employee was not consistently completed while off work.
- #22034: There was no documented continued contact with employee after 8/14/2020.

2.3 Findings, Summary and Recommendations.

Initial employee contact was made timely on all applicable claims. There were 8 claims in which there was not consistent continued contact made every 30 days while employee was missing time. It is recommended that the PRISM continued employee-contact standards be followed while unrepresented employees are missing time.

3. Payments and Fiscal Handling.

This area concerns itself with the timeliness and accuracy of benefit payments. Initial indemnity payments and the issuance of the first DWC notice are checked against the timeliness standards of the Administrative Director of the Division of Workers' Compensation. Subsequent indemnity payments and permanent disability payments are also reviewed for timeliness. Medical payments and payments/reimbursements to the injured employee are also reviewed for timeliness. Accuracy of payments are checked through the file balancing procedure and we look at payments to be sure all are made on the correct claim.

3.1 Timeliness of Initial TD and PD Payments.

California administrative regulations require that initial indemnity payments (or notice, in the case of salary continuation) be issued within fourteen calendar days of knowledge of the injury and disability. In the event notification of injury or disability does not occur within 14 calendar days payment shall be made within 7 calendar days of notification.

Claims Requiring Timely Initial TD and PD Payments: 49
Claims With Timely Initial TD and PD Payments: 49 (100.0%).

3.2 Subsequent TD and PD Payments.

Subsequent indemnity payments are required to be paid once every two weeks exactly and shall be verified except for established long term disability.

Claims Requiring Subsequent TD and PD Payments: 43
Claims With Timely Subsequent TD and PD Payments: 42 (97.7%).

The Exception Is:

- #20148: TD payment 11/1/2019 - 11/11/2019 was paid late. Self-imposed penalty was paid.

3.3 Undisputed Awards Paid Timely.

Payments on undisputed Awards, Commutations, or Compromise and Release agreements shall be made within 10 working days following receipt of the appropriate document, unless Award indicates payment is due sooner.

Claims With Undisputed Awards: 25
Claims With Undisputed Awards Paid Timely: 25 (100.0%).

3.4 Required Benefit Notices.

California administrative regulations require that a benefit notice be sent within 14 calendar days or concurrently with payment to the injured employee each time an indemnity payment is commenced or terminated. Benefit notices are also required to be sent within 14 days when a claim is delayed for further investigation and upon receipt of a permanent and stationary medical report indicating there is or is not any permanent disability.

Claims Requiring Benefit Notices: 61
Claims With Timely Issued Benefit Notices: 55 (90.2%).

The Exceptions Are:

- #22284: 4850 begin notice was not sent.
- #22893: PD advice letter was not sent within 14 days of receiving PR4.
- #25401: PD advice notice was not sent within 14 days of receiving PR4.
- #26756: TD begin notice was not sent when started on 12/21/2018.
- #28062: There was not a start/stop TD notice sent to EE when taken off work from 8/31/2020 - 9/2/2020.
- #29195: Claim delay letter was not sent within 14 days due to claims system change.

3.5 Overpayments.

Overpayments shall be identified and reimbursed timely where appropriate. If necessary, a credit shall be sought as part of any resolution of the claim.

Number of Claims With Overpayments: 0
Claims In Which Overpayment Was Documented: 0 (0.0%).

3.6 File Balancing.

Fiscal handling for indemnity benefits on active cases shall be balanced with appropriate file documentation on a semi-annual basis to verify that statutory benefits are paid appropriately. Balancing is defined as, “an

accounting of the periods and amounts due in comparison with what was actually paid".

Claims Requiring File Balancing: 48
Claims With Timely File Balancing: 43 (89.6%).

3.7 Timely Employee Reimbursements.

Reimbursements to injured employees shall be made within 15 working days of receipt of the request for reimbursement.

Claims Requiring Employee Reimbursements: 21
Claims With Timely Employee Reimbursements: 21 (100.0%).

3.8 Advance Travel Paid Timely.

Advance travel expense payments shall be issued to the injured worker 10 working days prior to the anticipated date of travel.

Claims Requiring Timely Advanced Travel Payment: 16
Claims With Timely Payment: 14 (87.5%).

The Exceptions Are:

- #24379: Mileage for travel to PQME has not been paid to employee.
- #29157: Mileage for travel to PQME was not paid 10 days prior to the appointment.

3.9 Timely Payment of Medical Bills.

Medical treatment billings shall be reviewed for correctness, approval and paid within 60 days of receipt.

Number of Claims With Medical Bills Paid: 89
Number of Claims With Timely Payment of Medical Bills: 87 (97.8%).

The Exceptions Are:

- #22893: Late payment of medical bill. Self-imposed penalty was paid.
- #25401: There were approximately 12 medical bills which were paid late between 8/8/2019 and 2/3/2020. Self-imposed penalties have been paid.

3.10 Medical Bill Objection Letters.

A medical bill provider shall be notified in writing within 30 days of receipt of an itemized bill if a medical bill is contested, denied, or incomplete.

Claims Requiring Bill Objection Letters: 4
Claims With Bill Objection Letters: 4 (100.0%).

3.11 Payments Made on Correct Claim.

In cases of multiple losses for the same injured employee, payments shall be made on the appropriate claim file.

Claims Involving Correct Claim Payment: 24
Claims In Which Payment Was Made On Correct Claim: 24 (100.0%).

3.12 Findings, Summary and Recommendations.

File balancing was completed consistently on 43 of the 48 applicable claims. Indemnity payments were paid timely on all but 1 claim. Payments were made on the correct claims. While medical bills were paid timely on all but 2 claims, there was 1 claim which had 12 late payments of medical bills. There were 6 late or unsent mandatory notices. It is recommended that medical bills be paid timely on all claims. It is also recommended that mandatory notices be sent timely when due.

4. Case Review and Documentation.

Examining workers' compensation claims, like any other business activity, should include a plan of action to achieve an explicit result. Without a plan, the claims examiner merely reacts to outside stimuli and the claims administration process breaks down, to the detriment of everyone concerned. Ideally, a plan should be written and include contingencies. This is where tactics are evaluated.

4.1 Plan of Action Appropriate.

The purpose of this inquiry is to learn whether initial case planning took place when the claim was reported to Sedgwick from any source and if subsequent planning and tactics are appropriate to the case. Plan of action statements should be updated at the time of examiner diary review.

Claims Requiring a Plan of Action: 102
Claims With a Documented and Appropriate Plan of Action: 99 (97.1%).

The Exceptions Are:

- #20874: There was only one documented plan of action between 6/6/2019 and 5/20/2020.

- #22362: Neck is now a problem for EE according to medical reports in 6/2020 on this claim for injured shoulder. Examiner did not follow up with physician for more information until 10/8/2020. Letter was sent over a month ago. Recommend following up with physician. If there is no response by next diary, recommend discussing with supervisor denial of body part and beginning PQME process. Supervisor has suggested body part should be denied since 6/25/2020.

- #27756: EE has not treated since 10/2019. It does not appear that examiner has attempted to contact EE to determine the status of his treatment. Recommend examiner contact employee to discuss claim and that examiner begin PQME process.

4.2 Examiner Diaries.

Examiner diary reviews should occur at intervals not to exceed 45 calendar days on claims not yet settled and not to exceed 90 calendar days on future medical claims.

Applicable Number of Examiner Diaries: 909
Number of Timely Examiner Diaries: 723 (79.5%).

Some Exceptions Are:

- #13625: One or more examiner diaries were not timely.
- #17115: One or more examiner diaries were not timely.
- #23196: The last plan of action was 8/26/2020. Now that new and further has been filed, claim diaries should be set to every 45 days.
- #25705: One or more examiner diaries were not timely.

4.3 Supervisor Diaries.

Supervisor diary reviews should occur at intervals not to exceed 120 calendar days on claims not yet settled and not to exceed 180 calendar days on future medical claims.

Applicable Number of Supervisor Diaries: 415
Number of Timely Supervisor Diaries: 335 (80.7%).

Some Exceptions Are:

- #13387: One or more supervisor diaries were not timely.
- #17531: One or more supervisor diaries were not timely.
- #25401: One or more supervisor diaries were not timely.
- #23899: Supervisor reviews through 5/18/2020 incorrectly indicated that neither side was represented. EE became represented in 2018.

4.4 Medical Only Conversion.

All medical only claims shall be reviewed for potential closure or transferred to an indemnity examiner within 90 calendar days following claim creation.

Claims Requiring Conversion: 4
Claims With Timely Conversion: 2 (50.0%).

The Exceptions Are:

- #16205: MO claims should be assigned to indemnity examiner within 3 months and converted to indemnity claim by 6 months. Claim was not converted to indemnity claim until approximately 11 months after opening claim.

- #18932: MO claim was not assigned to indemnity examiner within 3 months.

4.5 Timely Response to Written Inquiries.

All correspondence requiring a written response shall have such response completed and transmitted within 5 working days of receipt.

Claims Requiring Timely Written Response: 13
Claims With Timely Written Response: 13 (100.0%).

4.6 Ongoing Employer Contact.

Ongoing employer contact shall be maintained and documented in the claim file with respect to current issues of importance.

Claims Requiring Ongoing Employer Contact: 48
Claims With Ongoing Employer Contact: 48 (100.0%).

4.7 Findings, Summary and Recommendations.

With the exception of 3 claims, plans of action were timely and appropriate. Examiner diary reviews scored 79.5% and supervisor diary reviews scored 80.7%. There were 2 claims that were not assigned to an indemnity examiner timely. One of the claims was not converted to indemnity within 6 months. It is recommended that the examiners review the PRISM medical only conversion requirements and ensure the claims are converted timely.

5. Medical Treatment.

Medical treatment includes the appropriate use (or lack thereof) of additional cost containment measures such as utilization review and nurse case management services.

5.1 Appropriate Use of UR.

Each Member shall have in place a Utilization Review process as set forth in Labor Code Section 4610.5.

Claims Requiring Appropriate Use of UR: 57
Claims With Appropriate Use of UR : 57 (100.0%).

5.2 Appropriate Use of NCM.

Nurse case managers shall be utilized where appropriate.

Claims Requiring Appropriate Use of NCM: 1
Claims With Appropriate Use of NCM: 1 (100.0%).

5.3 Findings, Summary and Recommendations.

Utilization review and nurse case management were used appropriately. No recommendations are necessary.

6. Litigation.

Litigation has a major impact on any self-insured program. Although it affects only a minority of files, it uses a disproportionate amount of time and money. This audit area focuses on litigation issues and management.

6.1 Investigation of Potential Litigation Issues.

Investigation of issues identified as material to potential litigation shall be promptly initiated. The Member shall be alerted to the need for said investigation and consulted with an acceptable outside investigator when such is needed. The Member shall be kept informed on the scope and results of the investigation.

Claims Requiring Investigation of Litigation Issues: 0
Claims With Adequate Investigation of Litigation Issues: 0 (0.0%).

6.2 Litigation Management.

The Member shall be advised when it is deemed appropriate to assign defense counsel. Defense counsel assigned shall be from a list approved by the Member. Initial referral and ongoing litigation management shall be timely and appropriate. The third party administrator or self-administered entity shall maintain control of litigation as related to ongoing claim activities.

Claims Requiring Litigation Management: 30
Claims With Appropriate Litigation Management: 30 (100.0%).

6.3 Communication With Employer on Litigated Claims.

The third party administrator or self-administered entity shall keep the appropriate Member personnel fully advised of ongoing litigation issues. Knowledgeable Member personnel shall be involved in the preparation for medical examinations and trial, when appropriate or deemed necessary, so that all material evidence and witnesses are utilized to obtain a favorable result for the defense.

Number of Claims Requiring Communication: 30
Number of Claims With Adequate Communication: 30 (100.0%).

6.4 Findings, Summary and Recommendations.

Litigated claims were managed effectively. No recommendations are needed.

7. Apportionment, Resolution of Claim and Settlement Authority.

This area is probably the most important to any claims operation. It is essential to conclude every case at the earliest possible moment. This requires not only a high examiner energy level but also a case load appropriate to the claims examiner's experience and expertise to know what to do next and how to do it. It is in the interest of all parties to move cases toward resolution as quickly as possible. No case ever gets better by being aged or ignored.

Workers' compensation files that are not disposed of with all due speed can be ranked as follows: 1) those that are not being handled proactively but with no apparent ill effect by the time of this audit; 2) those in which the delays have resulted in an ill effect; and 3) those where the ill effect is workers' compensation benefits being paid needlessly.

7.1 Resolution Pursued Timely.

Within 10 working days of receiving medical information that a claim can be finalized; the claims examiner shall commence appropriate action to do so.

Claims Requiring Timely Resolution: 78
Claims With Timely Resolution: 76 (97.4%).

The Exceptions Are:

- #22893: Settlement documents were sent to employee in November of 2019. Employee has not returned these. While settlement documents have been resent to employee several times, more action should be taken to help him get these signed. Examiner should try to contact the employee by phone. On 3/6/2020, supervisor asked examiner to consider asking member for help. Recommend examiner contact employee by telephone and ask for some help from the member getting these signed.

- #26551: DA rated claim on 9/15/2020 and asked for settlement authority. Examiner has not yet requested settlement authority.

7.2 Correct Settlement Valuation.

Here we measure the examiner's technical and tactical evaluation of the settlement value of each case that was or is in the finalization stages. Settlement value shall be documented appropriately utilizing all relevant information.

Number of Claims With Settlement Evaluation: 27
Number of Claims Evaluated Correctly: 27 (100.0%).

7.3 Apportionment Ruled In or Out.

Each claim file shall be documented that apportionment has been ruled in or out.

Claims Requiring Apportionment Ruled In or Out: 19
Claims With Documentation of Ruled In or Out: 19 (100.0%).

7.4 Apportionment Pursued.

If potential apportionment is identified, all efforts to reduce exposure shall be pursued.

Number of Claims With Apportionment: 11
Claims In Which Apportionment Adequately Pursued: 11 (100.0%).

7.5 Member Settlement Authority Request.

Settlement authorization shall be obtained from the Member on all settlements or stipulations in excess of the settlement authority provided by the Member.

Claims Requiring Member Settlement Authority Request: 23
Claims With Timely Member Settlement Authority Request: 23 (100.0%).

7.6 Excess Settlement Authority Request.

No agreement shall be authorized involving liability, or potential liability of excess insurance. The Member shall be notified of any settlement request submitted to excess.

Claims Requiring Excess Settlement Authority: 0
Claims with Timely Excess Settlement Authority Request: 0 (0.0%).

7.7 Proof of Settlement Authority.

Proof of settlement authority shall be maintained in the claim file.

Claims Requiring Proof of Settlement Authority: 21
Claims With Proof of Settlement Authority: 21 (100.0%).

7.8 Medicare Interests Protected.

Medicare eligibility shall be documented in the claim file at the time of settlement evaluation.

Claims Requiring Medicare Inquiry: 1
Claims With Documented Medicare Inquiry: 1 (100.0%).

7.9 Findings, Summary and Recommendations.

Resolution was pursued timely on all but 2 claims. Apportionment was pursued when applicable. Settlement authority was documented on all settled claims. No recommendations are necessary.

8. Reserve Adequacy.

Reserve adequacy is a key area. The self-insured entity wants to know and understand what its total liability is at any given time. Reserving may seem subjective but an experienced examiner can, during any given fiscal year, set case-based aggregate reserves that will still be adequate (within a few percentage points) years later. Most individual cases will close with total costs below the reserve, but many cases will need to have their reserves sharply increased from the initial amounts. Done correctly over the years, decreases in reserves and salvage on closing will offset the increases, leaving the original fiscal year aggregate accurate.

8.1 Appropriate Initial Reserves.

Reserves created at the time the case is first opened should be adequate based on the information then available in the file. A properly trained examiner will recognize the gravity of a loss as the file is created and establish initial reserves for the most probable case value.

Claims Requiring Appropriate Initial Reserves: 52
Claims With Appropriate Initial Reserves: 51 (98.1%).

The Exception Is:

- #27001: Indemnity was not reserved until 10/20/2020. Indemnity should have been reserved at outset on litigated claim.

8.2 Timely Initial Reserves.

The initial reserve shall be posted to the claim within 14 calendar days of receipt of the claim.

Claims Requiring Timely Initial Reserves: 53
Claims With Timely Initial Reserves: 53 (100.0%).

8.3 Reserves Revised Timely and Appropriately.

New information is constantly received into the file and it often impacts the reserves. Here we see if the examiner reacted to the new information by addressing reserve adequacy in a timely fashion. Permanent disability exposure shall include life pension if applicable. Future medical claims shall be reserved in compliance with SIP regulation 15300 allowing adjustment for reductions in the approved medical fee schedule, undisputed utilization review, medically documented non-recurring treatment costs and medically documented reductions in life expectancy.

Allocated expense reserves shall include cost containment, legal, investigation, copy service and other related fees.

Claims Requiring Timely and Appropriate Reserve Revisions: 91
Claims With Timely and Appropriate Reserve Revisions: 90 (98.9%).

The Exception Is:

- #26551: Indemnity should have been reserved when claim became litigated in 11/2019. Indemnity was not reserved until 4/17/2020.

8.4 Separation of TD/4850 Reserves.

Indemnity reserves shall reflect actual temporary disability exposure with LC4850 differential listed separately.

Claims Requiring Separation of TD/4850 Reserves: 23
Claims With Separation of TD/4850 Reserves: 23 (100.0%).

8.5 Medical Reserves Consistent With OSIP.

Medical reserves shall be adjusted in accordance with OSIP regulations.

Claims Requiring Medical Reserves Consistent With OSIP: 102
Claims With Medical Reserves Consistent With OSIP: 101 (99.0%).

The Exception Is:

- #19696: Claim should have been analyzed and reserved for indemnity when claim became litigated. Recommend reserve of 6% PD.

8.6 Life Pension Reserved if Applicable.

Permanent disability exposure shall include life pension reserve if appropriate.

Number of Claims Requiring a Life Pension Reserve: 1
Number of Claims With Appropriate Life Pension Reserve: 1 (100.0%).

8.7 Allocated Reserves Accurate.

Allocated expense reserves shall include medical cost containment, legal, investigation, copy service and other related fees.

Number of Claims Requiring Allocated Reserves: 101

Number of Claims With Accurate Allocated Reserves: 101 (100.0%).

8.8 Findings, Summary and Recommendations.

Initial reserves were appropriate and timely on all but 1 claim. Reserve revisions were also appropriate and timely on all but 1 claim. 4850/TD was separated appropriately. No recommendations are needed.

9. Excess Insurance.

This area looks at the timeliness of initial excess reporting, subsequent excess reporting and excess reimbursement requests as required by PRISM.

9.1 Initial Excess Reporting.

The basis for this query is the common reinsurance reporting requirements, usually when aggregate reserves reach 50% of the self-insured retention; the actual excess insurance policies covering these claims were not examined. Claims shall be reported to PRISM within 5 working days of the day on which it is known the reporting criterion is met.

Claims Requiring Initial Reporting: 20
Claims Reported Timely: 15 (75.0%).

The Exceptions Are:

- #10421: Claim was reserved over 50% of the SIR in 2/2019. Claim was not reported to excess until 5/26/2019.
- #13625: Claim was reserved to 50% of the SIR in 2/2018. Claim was not reported to excess carrier until 10/12/2018.
- #14283: Claim became excess reportable on 8/21/2019. Claim was not reported to excess until 12/12/2019.
- #25705: Claim is excess reportable but has not yet been reported..
- #29157: Claim has been excess reportable since 5/24/2019. It was not reported to excess until 6/14/2019.

9.2 Subsequent Excess Reporting.

Subsequent excess reports shall be transmitted on a quarterly basis on all claims not yet settled and on a semi-annual basis on all future medical claims or sooner if claim activity warrants, or at such other intervals as requested by PRISM.

Number of Subsequent Excess Reports Required: 139
Number of Timely Subsequent Excess Reports: 123 (88.5%).

The Exceptions Are:

- #14283: Subsequent excess report due 3/12/2020 was not sent until

5/14/2020.

- #17531: There were no reports sent between 10/12/2018 and 6/10/2019.
- #20538: Reporting sent on 9/22/2020 was not sent timely.
- #22111: Excess report due 1/2020 was not sent until 6/12/2020.
- #26141: Subsequent excess report dated 9/24/2019 was late. There were 2 reports due between 9/24/2019 and 6/9/2020 which were not sent.
- #26428: Subsequent excess reports sent 11/6/2019 and 10/7/2020 were not timely.
- #26989: There was 1 late excess report.
- #29157: Excess reporting was due every 90 days after initial report of 6/14/2019. It appears there was only 1 subsequent excess report, which was sent on 11/19/2020.

9.3 Excess Reimbursement Requests.

Reimbursement requests should be submitted in accordance with PRISM reporting and reimbursement procedures on a quarterly or semi-annual basis depending on claims payment activity. Excess claim reporting and reimbursement procedures available through the PRISM website should be utilized.

Claims Requiring Reimbursement: 0
Claims With Timely Reimbursement Requests: 0 (0.0%).

9.4 Copy of Award Sent to Excess.

A copy of settlement documents not previously sent shall be sent to excess.

Claims Requiring Award to be Sent: 1
Claims In Which Award Was Sent: 1 (100.0%).

9.5 Closing Report Sent to Excess.

Upon the closing of a claim previously reported to excess a final report shall be sent.

Claims Requiring Closing Report to be Sent: 1
Claims In Which Closing Report Was Sent: 1 (100.0%).

9.6 Findings, Summary and Recommendations.

There were 5 initial excess reports that were sent late. There were also a total of 16 late subsequent excess reports. It is recommended that initial excess reporting be completed within 5 business days. It is also recommended that the diary system be used to ensure that subsequent excess reports are sent timely.

A listing of reportable cases in the audit sample entitled “Excess Reporting"—is at Tab Two in the *Addendum.*

10. Subrogation.

Subrogation is an important issue. This area usually involves few files but is unique in that it allows the administrator to recover some of the clients' funds. It is another indicator of the depth of the claims examiner's knowledge and skills.

10.1 Recognition of Subrogation.

In all cases where a third party (other than a Member employee or agent) is responsible for the injury to the employee, attempts to obtain information regarding the identity of the responsible party shall be made within 14 calendar days of recognition of subrogation potential. Once identified, the third party shall be contacted within 14 calendar days with notification of the Member's right to subrogation and the recovery of certain claim expenses.

Number of Claims Recognized for Potential Subrogation: 5
Actual Subrogation Cases With Timely Initial Action: 5 (100.0%).

10.2 Appropriate Subrogation Follow Up.

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 Member shall be entitled. The file shall be monitored to determine the need to file a complaint in civil court to preserve the statute of limitations.

Actual Subrogation Cases: 6
Subrogation Cases With Appropriate Follow Up: 6 (100.0%).

10.3 Employer Communication Regarding Subrogation.

If the injured worker brings a civil action against the party responsible for the injury, the claims administrator shall consult with the Member about the value of the subrogation claim and other considerations.

Number of Claims With Active Subrogation: 6
Number of Claims With Adequate ER Communication: 6 (100.0%).

10.4 Approval to Accept, Waive, Settle Subrogation.

Member (and PRISM if applicable) approval is required to waive pursuit of subrogation or agree to a settlement of a third party recovery.

Claims Requiring Approval to Accept, Waive, Settle: 1
Claims With Approval to Accept, Waive, Settle: 1 (100.0%).

10.5 Complaint or Lien Filed Timely.

Member authorization shall be obtained to assign subrogation counsel in order to file a lien or Complaint in Intervention in the civil action.

Claims Requiring Timely Filing of Complaint or Lien: 1
Claims With Timely Filing of Complaint or Lien: 1 (100.0%).

10.6 Subrogation Pursued to Maximum Recovery.

Maximum recovery of benefits paid should be pursued, along with assertion of credit against the injured worker's net recovery for future benefit payments.

Claims Requiring Pursuit to Maximum Recovery: 0
Claims With Maximum Recovery: 0 (0.0%).

10.7 Findings, Summary and Recommendations.

Subrogation was recognized and pursued consistently on all 6 of the applicable claims. Employer was also kept informed of the subrogation.

11. Penalty Summary.

This audit area is a review of any claims that fall into the penalty provisions of the Labor Code or Division of Workers' Compensation Rules and Regulations.

11.1 Self Imposed Penalty Paid if Required.

This penalty is required by the Rules and Regulations for any late indemnity payment. The penalty to be paid is 10% of the total amount of indemnity that is paid late and clearly identified as a penalty payment.

Claims Requiring Self Imposed Penalty: 3
Claims In Which Self Imposed Penalty Was Paid: 3 (100.0%).

11.2 Self Imposed Penalties Coded Correctly.

Penalties shall be coded so as to be identified as a penalty payment. If the Member utilizes a third party administrator, the Member shall be advised of the assessment of any penalty for the delayed amount and the reason thereof. The Member contract with the administrator shall specify who is responsible for specific penalties.

Claims In Which Self Imposed Penalty Was Paid: 3
Claims In Which Self Imposed Penalty Was Correctly Coded: 3 (100.0%).

11.3 Penalty Reimbursements to Members.

The third party administrator shall have a plan in place to reimburse the member for any penalties that are the fault of the administrator on a monthly basis or any other periodic basis agreed to by the Member.

Claims Requiring Penalty Reimbursements: 3
Claims With Documented Penalty Reimbursements: 3 (100.0%).

11.4 Findings, Summary and Recommendations.

There were 3 claims in which penalties were paid. The penalties were paid timely and coded correctly. Penalties are also being reimbursed to the members. No recommendations are necessary.

12. Disability Management.

This section looks at communications between the third party administrator and Member regarding return to work and permanent restrictions in the event of permanent disability.

12.1 Proactive Pursuit of Return to Work.

The administrator shall work proactively to obtain work restrictions and/or a release to full duty on all cases. The administrator shall notify the designated Member representative immediately upon receipt of temporary work restrictions or a release to full duty, and work with the Member to establish a return to work as soon as possible. Failing any needed response within 20 calendar days the administrator shall follow up with the designated Member representative.

Claims Where Proactive Pursuit of Return to Work Needed: 29
Claims Where Proactive Return To Work Occurred: 29 (100.0%).

12.2 Member Notified of Permanent Restrictions.

The administrator shall notify the designated Member immediately upon receipt of an employee's permanent work restrictions so that the Member can determine the availability of alternative, modified or regular work.

Claims With Permanent Restrictions: 3
Claims With Timely Notification of Permanent Restrictions: 3 (100.0%).

12.3 Findings, Summary, and Recommendations.

Proactive return to work is being sought on claims where the employees are missing time. The employers are also being notified of permanent restrictions. No recommendations are necessary.

Audit Data

11/4/2020

Scored Audit Points 87.7%

103 Claims

Sedgwick Roseville III

All Clients

Audit Point	Question	Yes	No	Unkn	Tot	%Yes	%No	%Unkn
1. Compensability Determination								
1.1	Initial Employer Contact	51	1	0	52	98.1	1.9	0.0
2. Employee Contact								
2.1	Initial Employee Contact	47	0	0	47	100.0	0.0	0.0
2.2	Employee Contact Continued	11	8	0	19	57.9	42.1	0.0
3. Payments and Fiscal Handling								
3.6	File Balancing	43	5	0	48	89.6	10.4	0.0
3.9	Timely Payment of Medical Bills	87	2	0	89	97.8	2.2	0.0
3.11	Payments Made On Correct Claim	24	0	0	24	100.0	0.0	0.0
4. Case Review and Documentation								
4.1	Plan of Action Appropriate	99	3	0	102	97.1	2.9	0.0
4.2	Examiner Diaries	723	186	0	909	79.5	20.5	0.0
4.3	Supervisor Diaries	335	80	0	415	80.7	19.3	0.0
4.4	Medical Only Conversion	2	2	0	4	50.0	50.0	0.0
6. Litigation								
6.1	Investigation of Potential Litigation Issues	0	0	0	0	0.0	0.0	0.0
6.2	Litigation Management	30	0	0	30	100.0	0.0	0.0
7. Apportionment, Resolution of Claim and Settlement Authority								
7.1	Resolution Pursued Timely	76	2	0	78	97.4	2.6	0.0
7.2	Correct Settlement Valuation	27	0	0	27	100.0	0.0	0.0
7.3	Apportionment Ruled In or Out	19	0	0	19	100.0	0.0	0.0
7.4	Apportionment Pursued	11	0	0	11	100.0	0.0	0.0
7.5	Member Settlement Authority Request	23	0	0	23	100.0	0.0	0.0
7.6	Excess Settlement Authority Request	0	0	0	0	0.0	0.0	0.0
7.8	Medicare Interests Protected	1	0	0	1	100.0	0.0	0.0

Audit Data

11/4/2020

Scored Audit Points 87.7%

103 Claims

Sedgwick Roseville III

All Clients

Audit Point	Question	Yes	No	Unkn	Tot	%Yes	%No	%Unkn
8. Reserve Adequacy								
8.1	Appropriate Initial Reserves	51	1	0	52	98.1	1.9	0.0
8.2	Timely Initial Reserves	53	0	0	53	100.0	0.0	0.0
8.3	Reserves Revised Timely and Appropriately	90	1	0	91	98.9	1.1	0.0
8.4	Separation of TD/4850 Reserves	23	0	0	23	100.0	0.0	0.0
8.5	Medical Reserves Consistent With OSIP	101	1	0	102	99.0	1.0	0.0
8.6	Life Pension Reserved if Applicable	1	0	0	1	100.0	0.0	0.0
8.7	Allocated Reserves Accurate	101	0	0	101	100.0	0.0	0.0
9. Excess Insurance								
9.1	Initial Excess Reporting	15	5	0	20	75.0	25.0	0.0
9.2	Subsequent Excess Reporting	123	16	0	139	88.5	11.5	0.0
9.3	Excess Reimbursement Requests	0	0	0	0	0.0	0.0	0.0
9.5	Closing Report Sent to Excess	1	0	0	1	100.0	0.0	0.0
10. Subrogation								
10.1	Recognition of Subrogation	5	0	0	5	100.0	0.0	0.0
10.2	Appropriate Subrogation Follow Up	6	0	0	6	100.0	0.0	0.0
10.3	ER Communication Regarding Subrogation	6	0	0	6	100.0	0.0	0.0
10.4	Approval to Accept, Waive, Settle Subrogation	1	0	0	1	100.0	0.0	0.0
10.5	Complaint or Lien Filed Timely	1	0	0	1	100.0	0.0	0.0
10.6	Subrogation Pursued to Maximum Recovery	0	0	0	0	0.0	0.0	0.0
11. Penalty Summary								
11.2	Self Imposed Penalties Coded Correctly	3	0	0	3	100.0	0.0	0.0
12. Disability Management								
12.1	Proactive Pursuit of Return to Work	29	0	0	29	100.0	0.0	0.0
12.2	Notification of Permanent Restrictions	3	0	0	3	100.0	0.0	0.0
13. Administrative Information								
13.1	Examiner Caseloads	6	0	0	6	100.0	0.0	0.0

Audit Data

11/4/2020

Scored Audit Points 86.3%

79 Claims

Sedgwick Roseville III

Northern California Cities Self Insurance Fund/Alliant Insurance

Audit Point	Question	Yes	No	Unkn	Tot	%Yes	%No	%Unkn
1. Compensability Determination								
1.1	Initial Employer Contact	39	1	0	40	97.5	2.5	0.0
2. Employee Contact								
2.1	Initial Employee Contact	35	0	0	35	100.0	0.0	0.0
2.2	Employee Contact Continued	10	7	0	17	58.8	41.2	0.0
3. Payments and Fiscal Handling								
3.6	File Balancing	31	5	0	36	86.1	13.9	0.0
3.9	Timely Payment of Medical Bills	64	2	0	66	97.0	3.0	0.0
3.11	Payments Made On Correct Claim	19	0	0	19	100.0	0.0	0.0
4. Case Review and Documentation								
4.1	Plan of Action Appropriate	76	3	0	79	96.2	3.8	0.0
4.2	Examiner Diaries	549	166	0	715	76.8	23.2	0.0
4.3	Supervisor Diaries	261	65	0	326	80.1	19.9	0.0
4.4	Medical Only Conversion	2	0	0	2	100.0	0.0	0.0
6. Litigation								
6.1	Investigation of Potential Litigation Issues	0	0	0	0	0.0	0.0	0.0
6.2	Litigation Management	23	0	0	23	100.0	0.0	0.0
7. Apportionment, Resolution of Claim and Settlement Authority								
7.1	Resolution Pursued Timely	55	2	0	57	96.5	3.5	0.0
7.2	Correct Settlement Valuation	18	0	0	18	100.0	0.0	0.0
7.3	Apportionment Ruled In or Out	12	0	0	12	100.0	0.0	0.0
7.4	Apportionment Pursued	9	0	0	9	100.0	0.0	0.0
7.5	Member Settlement Authority Request	15	0	0	15	100.0	0.0	0.0
7.6	Excess Settlement Authority Request	0	0	0	0	0.0	0.0	0.0
7.8	Medicare Interests Protected	1	0	0	1	100.0	0.0	0.0

Audit Data

11/4/2020

Scored Audit Points 86.3%

79 Claims

Sedgwick Roseville III

Northern California Cities Self Insurance Fund/Alliant Insurance

Audit Point	Question	Yes	No	Unkn	Tot	%Yes	%No	%Unkn
8. Reserve Adequacy								
8.1	Appropriate Initial Reserves	39	1	0	40	97.5	2.5	0.0
8.2	Timely Initial Reserves	41	0	0	41	100.0	0.0	0.0
8.3	Reserves Revised Timely and Appropriately	70	1	0	71	98.6	1.4	0.0
8.4	Separation of TD/4850 Reserves	17	0	0	17	100.0	0.0	0.0
8.5	Medical Reserves Consistent With OSIP	78	0	0	78	100.0	0.0	0.0
8.6	Life Pension Reserved if Applicable	1	0	0	1	100.0	0.0	0.0
8.7	Allocated Reserves Accurate	77	0	0	77	100.0	0.0	0.0
9. Excess Insurance								
9.1	Initial Excess Reporting	12	2	0	14	85.7	14.3	0.0
9.2	Subsequent Excess Reporting	82	13	0	95	86.3	13.7	0.0
9.3	Excess Reimbursement Requests	0	0	0	0	0.0	0.0	0.0
9.5	Closing Report Sent to Excess	1	0	0	1	100.0	0.0	0.0
10. Subrogation								
10.1	Recognition of Subrogation	5	0	0	5	100.0	0.0	0.0
10.2	Appropriate Subrogation Follow Up	6	0	0	6	100.0	0.0	0.0
10.3	ER Communication Regarding Subrogation	6	0	0	6	100.0	0.0	0.0
10.4	Approval to Accept, Waive, Settle Subrogation	1	0	0	1	100.0	0.0	0.0
10.5	Complaint or Lien Filed Timely	1	0	0	1	100.0	0.0	0.0
10.6	Subrogation Pursued to Maximum Recovery	0	0	0	0	0.0	0.0	0.0
11. Penalty Summary								
11.2	Self Imposed Penalties Coded Correctly	3	0	0	3	100.0	0.0	0.0
12. Disability Management								
12.1	Proactive Pursuit of Return to Work	23	0	0	23	100.0	0.0	0.0
12.2	Notification of Permanent Restrictions	2	0	0	2	100.0	0.0	0.0
13. Administrative Information								
13.1	Examiner Caseloads	6	0	0	6	100.0	0.0	0.0

Non Scored Audit Points

11/4/2020

103 Claims

Sedgwick Roseville III

All Clients

Audit Point	Question	Yes	No	Unkn	Tot	%Yes	%No	%Unkn
1.2	Initial Decision	52	0	0	52	100.0	0.0	0.0
1.3	Indexing	59	3	0	62	95.2	4.8	0.0
1.4	AOE/COE Investigation Needed	15	0	0	15	100.0	0.0	0.0
1.5	Final Decision Timely Documented	15	0	0	15	100.0	0.0	0.0
3.1	Timeliness of Initial TD and PD Payments	49	0	0	49	100.0	0.0	0.0
3.2	Subsequent TD and PD Payments	42	1	0	43	97.7	2.3	0.0
3.3	Undisputed Awards Paid Timely	25	0	0	25	100.0	0.0	0.0
3.4	Required Benefit Notices	55	6	0	61	90.2	9.8	0.0
3.5	Overpayments	0	0	0	0	0.0	0.0	0.0
3.7	Timely Employee Reimbursements	21	0	0	21	100.0	0.0	0.0
3.8	Advance Travel Paid Timely	14	2	0	16	87.5	12.5	0.0
3.10	Medical Bill Objection Letters	4	0	0	4	100.0	0.0	0.0
4.5	Timely Response to Written Inquiries	13	0	0	13	100.0	0.0	0.0
4.6	Ongoing Employer Contact	48	0	0	48	100.0	0.0	0.0
5.1	Appropriate Use of UR	57	0	0	57	100.0	0.0	0.0
5.2	Appropriate Use of NCM	1	0	0	1	100.0	0.0	0.0
6.3	Communication With ER on Litigation Issues	30	0	0	30	100.0	0.0	0.0
7.7	Proof of Settlement Authority	21	0	0	21	100.0	0.0	0.0
9.4	Copy of Award Sent To Excess	1	0	0	1	100.0	0.0	0.0
11.1	Self Imposed Penalty Paid if Required	3	0	0	3	100.0	0.0	0.0
11.3	Penalty Reimbursements to Member	3	0	0	3	100.0	0.0	0.0
13.2	Supervisor Caseloads	1	0	0	1	100.0	0.0	0.0

Non Scored Audit Points

11/4/2020

79 Claims

Sedgwick Roseville III

Northern California Cities Self Insurance Fund/Alliant Insurance

Audit Point	Question	Yes	No	Unkn	Tot	%Yes	%No	%Unkn
1.2	Initial Decision	40	0	0	40	100.0	0.0	0.0
1.3	Indexing	43	3	0	46	93.5	6.5	0.0
1.4	AOE/COE Investigation Needed	13	0	0	13	100.0	0.0	0.0
1.5	Final Decision Timely Documented	13	0	0	13	100.0	0.0	0.0
3.1	Timeliness of Initial TD and PD Payments	37	0	0	37	100.0	0.0	0.0
3.2	Subsequent TD and PD Payments	33	1	0	34	97.1	2.9	0.0
3.3	Undisputed Awards Paid Timely	21	0	0	21	100.0	0.0	0.0
3.4	Required Benefit Notices	39	6	0	45	86.7	13.3	0.0
3.5	Overpayments	0	0	0	0	0.0	0.0	0.0
3.7	Timely Employee Reimbursements	16	0	0	16	100.0	0.0	0.0
3.8	Advance Travel Paid Timely	11	2	0	13	84.6	15.4	0.0
3.10	Medical Bill Objection Letters	3	0	0	3	100.0	0.0	0.0
4.5	Timely Response to Written Inquiries	9	0	0	9	100.0	0.0	0.0
4.6	Ongoing Employer Contact	38	0	0	38	100.0	0.0	0.0
5.1	Appropriate Use of UR	45	0	0	45	100.0	0.0	0.0
5.2	Appropriate Use of NCM	1	0	0	1	100.0	0.0	0.0
6.3	Communication With ER on Litigation Issues	23	0	0	23	100.0	0.0	0.0
7.7	Proof of Settlement Authority	14	0	0	14	100.0	0.0	0.0
9.4	Copy of Award Sent To Excess	1	0	0	1	100.0	0.0	0.0
11.1	Self Imposed Penalty Paid if Required	3	0	0	3	100.0	0.0	0.0
11.3	Penalty Reimbursements to Member	3	0	0	3	100.0	0.0	0.0
13.2	Supervisor Caseloads	1	0	0	1	100.0	0.0	0.0

January 19, 2021

To: Marcus Beverly, Alliant Insurance Services (via email)
Karin Wedworth, PRISM (formerly CSAC EIA), WC Claims Manager (via email)

Re: Response to Audit Results for Northern California Cities Self-Insurance Fund– North Bay Associates

This letter will serve as a response to the audit report dated January 4, 2021 and performed in line with the PRISM (formerly CSAC-EIA) Audit Guidelines. The below audit response is designed to address areas evaluated and provide response and performance actions as a result of the audit. The audit generated an overall score 86.3% which provided a rating of Meeting Expectations. We want to assure you of our continued commitment to meet and exceed NCCSIF and PRISM's expectations. We continue to look forward to working with both NCCSIF and PRISM to identify and implement processes to achieve improved results.

Performance Strengths

The audit report is comprised of 40 categories for management of claims, as noted in the audit. We did score at or above 95% in 32 of the 40 categories. (4 categories did not have an applicable file to review). Some of the strengths were observed in the following categories:

- Initial Employee Contact: 100%
- Litigation management: 100%
- Correct settlement valuation: 100%
- Timely initial reserves: 100%
- Allocated reserves accurately: 100%
- Proactive pursuit of return to work: 100%
- Initial Employer contact: 97.5%
- Resolution pursued timely: 96.5%
- Plan of action appropriate: 96.2%

Performance Improvement Recommendations

The following represents review of each category that fell below expectations along with identified actions items we will put into place to address these areas.

- Employee Contact Continued:
  There were 17 total files/points available for this category with 10 completed timely per the audit. This equated to a score of 58.8%. To improve upon this score, we will conduct additional training with the team followed up with ongoing internal audits on lost time claims wherein the claimant is not represented. We will also be completing spot checks of claims to ensure compliance and a scheduled diary.

- Examiner Diaries:
  This category produced a 76.8% score with 715 points available and 549 points attained. This area produced the highest number of missed opportunities and therefore had the highest impact on our overall score. We agree that management of our daily diary is an essential function in the management

and resolution of claims, and we are committed to improvement in this area. To that end we should point out that the quality of diary review and plans of actions scored 96.2%. To greater emphasize the importance of timely examiner diary we will continue to set timely completion of diary as a priority and ensure that examiners are setting diary with early due dates to ensure they complete this vital task timely, if not ahead of due dates. We will continue to track our examiners diary on a weekly basis.

- Supervisor Diaries:
  This category produced a score of 80.1% with 326 points available and 261 points attained. This area produced the second highest number of missed opportunities and had the second highest impact on our overall score. Greater emphasis will be placed on completing supervisor diary timely and within audit timeframes. We will complete weekly spot checks on supervisor diary. We will also run weekly reports to track any outstanding diary.

- Initial and Subsequent Excess Reporting.
  For initial excess reporting there were 14 total points available and 12 points credited for a total score of 85.7%. For subsequent excess reporting there were 95 total points available and 82 points credited for a total score of 86.3%. We will conduct additional training with our examiners to emphasize the due dates for both initial and subsequent excess reporting. We will ensure that a special diary is set well within due dates and time frames to allow for timely reporting of both the initial and subsequent excess reports.

Thank you for the opportunity to evaluate our management of the claims and allow us the opportunity to implement plans to enhance our level of service. We appreciate our partnership with both NCCSIF and PRISM (formerly CSAC-EIA) and we look forward to working with you both in providing the best possible service to everyone associated with the account.

Please let us know if you have any questions.

Sincerely,

Dori Zumwalt
Director, Client Services

Cc (via email):
Heidi Hough, Director Claims
Steven Scott, Team Lead
Devora Brainard-DeLong, VP Client Services
Jenna Wirkner, Alliant Account Representative

Northern California Cities Self Insurance Fund
Claims Committee Meeting
March 25, 2020

Agenda Item H.1.

REVISION TO A-9 ATTACHMENT A: LIABILITY COUNSEL LIST NEW ADDITION – JEFFREY V. DUNN

ACTION ITEM

ISSUE: The City of Folsom is recommending the addition of Jeffrey V. Dunn of the Best, Best & Krieger Law Firm, to the Liability Counsel Approved List. The request is based on an immediate need for a specialist to defend a series of water-related claims against the City. Mr. Dunn is a specialist in the area of water and water rights as well as other complex litigation involving local governments.

Hourly rates for the team to be used for this litigation:

Jeffrey Dunn (Partner)	$350 an hour
Wendy Wang (Of Counsel)	$295 an hour
Daniel Richards (Associate)	$255 an hour
Tyler Richards (Associate)	$255 an hour
Paralegal	$170 an hour

These are in line with the top rates for specialists at other firms on the approved list.

RECOMMENDATION: Approve as requested.

FISCAL IMPACT: None.

BACKGROUND: The Claims Committee regularly reviews and recommends changes to the Approved List of attorneys based on feedback from members and the claims administrator.

ATTACHMENT(S): Jeffrey V. Dunn Bio

Jeffrey V. Dunn

Jeffrey V. Dunn
Partner
(949) 263-2616
jeffrey.dunn@bbklaw.com

Services
California Public Records Act
Economic Development, Real Estate & Affordable Housing
Environmental Law & Natural Resources
Environmental Litigation
General & Special Counsel
Government Policy & Public Integrity
Municipal Law
Public Agency Litigation
Special Districts
Water

Education
Brigham Young University, J. Reuben Clark Law School, J.D.
Brigham Young University, B.S.

Admissions
California

At a Glance

- Jeff has extensive experience in water resource litigation.
- He was recognized as one of California's Top 100 Attorneys by the *Daily Journal* in 2013 and 2016.
- Jeff is a leading authority on the municipal regulation of marijuana distribution facilities.

Profile

Jeffrey V. Dunn is a highly sought after legal counsel to public agencies in complex litigation matters. Recognized as one of California's leading local government litigation attorneys, he was selected as one of *California Lawyer* magazine's Attorneys of the Year for 2014, the *Daily Journal*'s Top 20 Municipal Attorneys in 2013 and Top 25 Municipal Attorneys in 2011. He was also recognized as one of California's Top 100 Attorneys by the *Daily Journal* in 2013 and 2016 and for a Top Verdict in 2018.

Water Resource Litigation

Jeff has extensive experience in water resource litigation — an increasingly complex and critical area of law.

- In *City of Santa Maria v. Adams, et al*, Jeff successfully represented the City of Santa Maria in one of the largest and most complex cases in California involving the adjudication of water rights in Santa Barbara and San Luis Obispo counties. This case was chosen by the State of California as a pilot project for innovative case management programs involving the Internet, which led to significant costs savings for the City of Santa Maria, the lead governmental entity in the case.
- Jeff won a trial in Northern California representing the Truckee Meadows Water Authority, a Nevada joint-powers authority consisting of the cities of Reno and Sparks and Washoe County in their effort to obtain rights to Donner Lake water in 2010. The victory preserves a critical water supply during drought years for 330,000 residents in Reno and surrounding areas.
- Jeff represents County of Los Angeles Waterworks District No. 40 in long-standing disputes over groundwater rights in the Antelope Valley Groundwater Adjudication Proceedings. The adjudication is considered to be one of the state's most complex water rights disputes involving competing claims by two large classes of property owners, agricultural interests, public water suppliers and the United States government. In 2011, he successfully led a group of public water suppliers in establishing the safe yield of the Antelope Valley Groundwater Basin, the common water supply for all users. The Daily Journal selected the trial court decision as a Top Verdict By Impact for 2011.

Jeffrey V. Dunn

- Jeff led a team of defense lawyers in successfully convincing a jury that water suppliers had acquired prescriptive groundwater rights to the Paso Robles Groundwater Basin during times of groundwater shortage conditions. The City of Paso Robles, BB&K's client, was one of the agencies sued by about 600 landowners seeking to claim quiet title to groundwater rights. A first-of-its-kind groundwater rights trial, the *Daily Journal* recognized it as a Top Verdict in 2018.

Complex Litigation for Public Agencies

In addition to water disputes, Jeff is frequently retained by local governments on other complex litigation matters.

- Jeff represented the County of Riverside, the Riverside County Transportation Commission and the City of Corona in highly-publicized litigation against the California Department of Transportation over traffic conditions and private toll lanes on the Riverside (91) Freeway in Orange and Riverside counties. The successful decision led to the removal of governmental restrictions on widening the Riverside freeway to alleviate traffic in the major public transportation corridor between Orange and Riverside Counties.
- Jeff successfully represents clients in disputes involving the California Public Records Act and the Ralph M. Brown Act. This includes the County of Los Angeles in accusations of violating open meeting laws. In a related case, he successfully defended the County of Los Angeles Board of Supervisors against a lawsuit by the *Los Angeles Times* seeking court-ordered disclosure of confidential discussions concerning highly publicized issues regarding the King/Drew Medical Center.
- In 2014, Jeff successfully represented the Western Riverside Council of Governments in its lawsuit to recover unpaid traffic mitigation impact fees from the City of Beaumont. After a 4-week trial, the Orange County Superior Court awarded $43 million to Jeff's client and $14 million in prejudgment interest, which makes the trial court judgment more than $57 million. *The Daily Journal* selected the trial court decision as a Top Verdict by Impact for 2014.
- In 2015, Jeff successfully represented the Castaic Lake Water Agency against a legal challenge to the $73 million acquisition of a private water company. The winning trial court decision secures a public water supply for tens of thousands of residents and businesses in Los Angeles County.

Jeffrey V. Dunn

Jeff is often asked to represent local government interests in matters of statewide importance. He successfully argued cases before the California Supreme Court, including Claremont Police Officers Association v. City of Claremont, (2006) 39 Cal.4th 623, which affirmed the city's right to implement a study to determine whether police officers engaged in racial profiling. He also successfully represented the City of Lake Forest in federal court litigation involving the Americans with Disabilities Act in *James v. City of Costa Mesa* (2012) 684 F.3d 825.

Medical Marijuana Dispensary Regulation

Jeff gained national recognition for his successful representation in one of the most controversial issues facing California cities and counties — municipal regulation of marijuana distribution facilities. He was trial and appellate counsel in key published decisions affirming local government's authority to protect public safety and local land use authority, including the unanimous decision by the California Supreme Court in *City of Riverside v. Inland Empire Patients' Health and Wellness Center* (2013) 56 Cal.App.4th 729. He discussed this subject on the NBC Nightly News, in the Washington Post and in other national and local television, radio and print media.

Northern California Cities Self Insurance Fund
Claims Committee Meeting
March 25, 2020

Agenda Item I.

ROUND TABLE DISCUSSION

INFORMATION ITEM

ISSUE: The floor will be open to the Committee for discussion.

RECOMMENDATION: None.

FISCAL IMPACT: None.

BACKGROUND: This is an opportunity for Committee members to ask questions or raise issue on risk exposures common to the members.

ATTACHMENT(S): None.