Claims Review Committee
Standard Operating Procedures

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Composition

The Committee is comprised of 9 members who participate in the Excess Workers' Compensation (EWC) and/or General Liability 1 (GL1) Programs, of which 7 are voting members and 2 are alternates who are eligible to vote at any meeting where a voting member is absent. County members serve two year terms, Public Entity members serve a one year term, and alternate members serve one year terms.

Reference: Committee Composition

Roles

Committee:

The Claims Review Committee is responsible for overseeing all claims administration matters relating to the EWC and GL1 Programs.

Pursuant to the Bylaws, the Committee shall:

- review all claims arising out of the EWC and GL1 Programs, which involve or may involve liability of the Authority
- authorize claim settlements
- advise Executive Committee and Board regarding claims adjusting and legal defense services necessary to protect the funds of the Authority
- review and make recommendations regarding Authority claims handling procedures and requirements

Reference: CSAC EIA Bylaws

Chair:

- Call/authorize meeting to be scheduled
  - Staff will contact Chair to arrange date, time, location (in-person or WebEx)
  - Once authorized, staff will notify the Committee members via e-mail
- Call the meeting to order
- Orchestrate agenda items
- Recognize members to facilitate orderly debate
- Preside over voting
- Enforce rules of the group
- Expedite the business of the group
- Declare meeting adjournment
- Attend the Authority's Annual Strategic Planning Retreat
- Conduct meeting according to Robert's Rules of Order and the Brown Act

Vice Chair:
The Committee Vice Chair's role is to assume the responsibilities of the Chair in their absence.

Legal Counsel/Alternate Legal Counsel:
- Serve in an advisory capacity to the Claims Review Committee
- Confirm the Committee's adherence to the Brown Act

Reference: Brown Act

Staff:
- Michael Pott is the staff liaison for this Committee.
- Assist Chair in facilitating meeting, preparing agendas, taking minutes, and summarizing meetings for those not in attendance
- Advisory to the Committee
- Make recommendations to assist Committee
- Execute Committee's directions

Organizational Responsibilities

Addendum A and B:
Addendum A, the Workers' Compensation Claims Administration Standards, and Addendum B, the Liability Claims Administration Standards, have been developed by staff under the direction of the Claims Review Committee and approved by the Board of Directors as claims handling best practices for members of the EWC and GL1 Programs. It is required that members of these programs advise their Third Party Administrator (TPA) that these standards are utilized in the Authority's claims audits. It is the responsibility of all self-administered entities to ensure their staff is fully trained to ensure compliance with the standards. The claims administration standards are utilized as the basis for quality audits to measure how well an individual TPA or self-administered entity is performing. Workers' Compensation and Liability claims audits are measured against acceptable Authority Standards. At their meeting on January 27, 2012, the Claims Review Committee made the decision to review and update these documents on an as needed basis, with staff to review the guidelines annually, and bring them to the Committee when the need for a change is identified. Updated guidelines are circulated for review and comment to all program members before submitting to the Executive Committee, which will then recommend approval to the Board of Directors.

Reference: Addendum A
Reference: WC Audit Philosophy & Audit Expectations
Reference: Addendum B
Reference: GL Audit Philosophy & Audit Expectations

Reference: EWC & GL1 policy on reviewing Addendum A & B 1/27/12

Delegation of Authority:

Workers' Compensation Settlement Authority

Staff has authority to settle workers' compensation claims when the total paid on the file, including the amount of the settlement, is equal to or less than $300,000 above the member's SIR at the time of settlement.

After an initial grant of authority by the Claims Review Committee up to the reinsurance attachment point, staff has authority to negotiate directly with the reinsurer for settlement authority above that attachment point.

Reference: 11/14/14 CRC Minute Order

Workers' Compensation Reimbursement Authority

Staff has authority to process workers' compensation reimbursements when the total paid on the file is less than or equal to $300,000 above the member's SIR. A request for reimbursement authority up to the total incurred will be submitted to the Claims Review Committee for any potential reimbursement above the member's SIR that exceeds staff authority.

If the reserves are subsequently increased above the initial authorization, staff will prepare an amended reimbursement request to the new total incurred, and the request for reimbursement authority process begins anew.

To avoid delays in processing member reimbursements, staff is authorized to tender reimbursements in advance of Claims Review Committee meetings. Staff will bring a request for ratification of the reimbursement, which will include additional reimbursement authority to the new total incurred, to the next scheduled Claims Review Committee Meeting.

Reference: WC Reporting Reimbursement Procedures
Reference: EWC Reimbursement Authority 11/18/05
Reference: EWC & GL1 Policy on Reimbursement w-out Documentation 9/14/07
Reference: 11/14/14 CRC Minute Order

Liability Settlement and Reimbursement Procedures

Staff has settlement and reimbursement authority up to $250,000 above the member's SIR, exclusive of defense costs incurred (9/10/04 Claims Review Committee meeting, item 3.B.).

After an initial grant of authority by the Claims Review Committee up to the reinsurance attachment point, staff has authority to negotiate directly with the reinsurer for settlement authority above that level.

The Claims Review Committee also approved reimbursement procedures for the GL1 Program (5/31/06 Claims Review Committee meeting, item 3.C.). They state, in part: For most claims, the member is responsible for paying, on an ongoing basis, the legal and other expenses related to a claim, maintaining a loss accounting in their claims system reflecting totals paid for litigation expenses and other expenses. When and if these costs exceed the SIR, the member must obtain written approval of the Authority (as outlined in the Conditions of the GL1 MOCs) and will periodically provide the Authority with a reconciliation of the paid amounts.

Reference: GL1 Staff Settlement Authority 9/10/04
Reference: GL1 Staff Settlement Authority Above Reinsurer's Attachment Points 5/13/05
Reference: GL1 Staff Reimbursement Authority 11/18/05
Reference: GL1 Reporting Procedures
Reference: GL1 Claim Reimbursement Procedures Statement 6/29/06

Audits:

The purpose of a claims audit is to protect the interests of the pool by ensuring that each member is receiving superior claims administration services and following Authority standards. The Claims Administration Standards (Addendums A and B) are used as an auditing tool to measure how well an individual Third Party Administrator (TPA) or self-administered entity is performing.

Reference: Addendum A
Reference: Addendum B

Audit Procedures

The Authority engages the services of auditors to perform claim audits of the members of its EWC and GL1 Programs. The entities to be audited and the corresponding sample size are specifically approved by the Authority in advance of the service being rendered. Entities are audited against the Workers' Compensation and General Liability Claims Handling Standards – Addendums A and B, respectively.

These audits are conducted by one of the Authority's contracted auditors unless an exception is made for members with a SIR of $1 million or greater OR a member's claims are self administered. In those instances, a member may choose to remain in the audit program, using either an Authority contracted auditor or an auditor of their own choosing, and they will be included in the audit cost allocation (partial opt out). Alternatively, members meeting the exception criteria may opt out of the audit program (total opt out), in which case they will be excluded from the audit cost allocation and will not be eligible for reimbursement. In either the partial opt out or total opt out situation, members are still required to obtain audits on a bi-annual or every third year basis (depending on which

program, EWC or GL1) and copies of the audit reports are to be submitted to the Authority for review by the CRC.

In general, audits are conducted on all members at a particular Third Party Administrator/self–administered entity location. During audits of the TPA or self–administered entity, a sampling from all participating members will be included.

Reference: EWC and GL1 Claim Audit Cost Allocation 6/1/05

Frequency of Audits

EWC and GL1 Program members are required to have a claims audit completed once every two years.

New members of either program are audited within the first year of joining the program.

For those members no longer in the EWC Program, the audit schedule is once every three years. Staff has discretion to waive this requirement if the audit is not fiscally feasible.

The Authority shall have claims audits conducted on its EWC and GL1 staff claims monitoring operations on an every other year basis.

Audits may be scheduled more frequently at the direction of the Committee.

Reference: Requirement for Authority to Have Audits and Actuarials 9/28/98
Reference: Policy for Audits on Members no Longer in EWC 11/13/09
Reference: Policy for EWC and GL1 Member Audits 10/01/13

Selection of Auditors

Requests for Proposal (RFP) for audit services are sent at the direction of the Claims Review Committee, which assesses the need to issue an RFP for additional audit services on an annual basis. In addition to sending requests to known vendors, an RFP is posted on the Authority website. Vendors are given equal opportunity to submit proposals. Each proposal is evaluated objectively based on criteria established at the time. The number of auditors contracted by the Authority is determined by the Claims Review Committee based upon the number of claims to be audited in the Programs as a whole, and on the capacity of selected vendors.

Auditors are assigned to audit a Member's TPA, rather than a specific member, except in the case of self administered entities. Audits are assigned with consideration given to geographic location and the number of member's claims being handled at a given TPA. Staff coordinates the scheduling and assignment of auditors.

Post Audit Procedures and Presentation to the CRC

Members and staff receive each audit report from the auditor. Staff reviews each audit report and requests a response from every member audited. Member responses are critical to the review of audits by the Committee. Members are requested to respond to the audit report within 30 days of the receipt of the request. Audit reports are presented to the Claims Review Committee at the next scheduled in-person meeting after the 30 days expire. If a member response has not been received and the Committee determines one is warranted, staff is directed to follow up with the member. If the member has not then responded by the next scheduled Claims Review Committee meeting, the member may be requested to meet with the Committee.

The audit presentation includes a summary of findings, the tracking of priority categories on the audit matrix, and a recommendation for further action if warranted. Staff tracks the results of each audit on an audit matrix which evaluates audit categories deemed to be priority by the Claims Review Committee. An audit matrix comparing audits under discussion shall be presented at each Claims Review Committee meeting. The audit matrix presented will also contain a comparison of prior audits of the same entity in order to track performance from audit to audit. Annually, the entire audit matrix is presented to the Claims Review Committee for review and discussion. Audit reports and member responses will be posted on a secure Authority website for Committee members to access one week prior to the scheduled meeting.

Post Audit Member Entity Performance Review

It is the responsibility of the Claims Review Committee to analyze the impact that audit scores have on the organization overall, and to provide assistance to members to improve claims handling performance where audit results indicate their own, or their TPA's, claim handling practices might adversely impact the pool. Examples of criteria that might lead to this conclusion include:

- Audit category scores 10 – 15% below acceptable accomplishment levels
- Reserve change recommendations that result in a net effect of change +/- 15% or more of the total outstanding reserves on all claims audited

If the Claims Review Committee believes that a member's audit results are deficient and that their audit response does not adequately address specific plans for improvement in deficient audit categories, staff may be directed to work with that member to develop and implement a corrective plan of action. Staff may also be directed to work with a member when their initial audit response does not adequately address specific plans for improvement, but the subsequent audit scores remain the same or lower. Staff's involvement could include:

- Contacting the member to determine if there is a true understanding of the importance of complying with Authority Addendum A or B standards
- Obtaining a detailed plan for improvement from the member

- Meeting with the member and their TPA to discuss goals and timelines for implementing improvement processes
- Conducting interim "mini" audits
- Participating in file reviews and/or
- Scheduling a follow up audit in advance of the normal bi-annual audit

Should the Claims Review Committee believe that the above efforts do not provide the desired result, based on the severity of the audit deficiencies; further action could include a referral to the Underwriting Committee and/or a referral to the Executive Committee. Potential triggers for referral to the Underwriting Committee may include:

- Significant problems in the area of reserving
- Significant problems in one or more audit categories such that claims handling activities could have an adverse financial impact on the pool
- Continued deficient audit scores

Potential triggers for referral to the Executive Committee may include:

- A request by the Underwriting Committee
- Continued deficient audit scores
- Lack of cooperation on the part of the member

Miscellaneous:

Determining Rates for Death Benefits in Workers' Compensation Cases

When death benefit settlements involving minor dependent children will take a claim above a member's SIR, death benefits are to be calculated based on known rates, allowing staff some discretion for negotiation subject to approval by the Claims Review Committee.

Reference: CRC Position on Death Benefits 11/18/05

Reserving Workers' Compensation Future Medical Claims

Workers' Compensation future medical claims are to be reserved in compliance with a "modified" Self Insured Program (SIP) model.

Reference: EWC Policy on Reserving Future Medical Claims 11/14/08

Workers' Compensation Carve Outs

A carve out is intended to make the workers' compensation resolution process more efficient and less adversarial for both employers and employees, while controlling employer costs of benefit delivery. In accordance with Endorsement U-3 to the EWC Memorandum of Coverage, which was approved by the Board 10/1/2010, retroactive to 7/1/2010, the CRC will review proposed carve out agreements prior to implementation.

Reference: EWC Policy in Regard to Workers' Compensation Carve Outs 10/1/10

Reference: EWC Carve Out Guidelines
Reference: EWC MOC, Endorsement U-3

Participation in Amicus Briefs/Writs

There have been several rulings from our legal system that could have negative consequences on public entity cases. The EIA has either identified cases directly, or been contacted by outside interests to participate in an Amicus Brief and/or Writ, to support overturning some of the rulings. With limited time constraints regarding several of these requests, the Committee requested discretionary funds from the Executive Committee. Authority was granted from the Executive Committee, effective 11/18/10, for $15k for the remainder of the 2010/11 year. The Committee will submit an annual budget request for all fiscal years after 2010/11 to address these expenses. Any need for expenses above what has been allocated will be submitted to the Executive Committee for funding approval.

Reference: 11/18/10 Executive Committee Minute Order

Member Attendee Reimbursement Policy

Occasionally, non-committee members have attended committee meetings, either at their request or upon invitation from the committee, to address a business item on the agenda for that meeting. While this is most frequent with the Claims Review Committee, this has also occurred with other committees. A policy statement was approved by the Executive Committee at their meeting on 5/5/11, which applies to all committees.

Reference: Exec Comm Policy Re: Reimb of Expenses for Meetings 5/5/11

Reservation of Rights and Denial Letters

Numerous claims are submitted which include coverage issues. These issues may range from some counts within the complaint being subject to exclusions (such as punitive damages or injunctive relief) to the entire claim not being covered for any of a number of reasons. The Claims Review Committee has adopted a resolution addressing staff's role in dealing with these situations.

Reference: GL1 Policy on Staff Issuance of Reservation of Rights Letter
Or a Denial Letter 7/8/11

Service Provider Contracts

The Executive Committee has adopted a policy outlining the process for determining whether a competitive selection process should be used when a new service offering to members is being created. The policy also provides that the Committee has authority to enter into a service contract as long as the expenditure is included in the budget that is approved by the Board.

Service Provider Contracts that this Committee oversees are as follows:

- WC Claims Auditor
- Liability Claims Auditor
- Deductible Buy-Down TPA
- Coverage Counsel

Reference: Policy Statement Regarding Service Provider Contract Review 12/12/19

Meetings

Code of Conduct/Ethics Policy:

The Board has adopted a Code of Conduct which is applicable to all members, staff, committees, and the Board.

Reference: Code of Conduct

Scheduling:

With a couple of exceptons, the Committee meets in person the second Friday of every other month starting in January at the Authority office. On the alternate months, a WebEx meeting is held on the second Friday of the month, unless the Committee choses a different date and/or location. Additional meetings may be called by the Chair.

Reference: 2020 Schedule of Meetings
Reference: 11/14/14 CRC Minute Order

Quorum:

Pursuant to the Bylaws, a quorum consisting of at least four members of the Committee must be present in order to conduct a meeting.

Voting:

Voting Requirements

Pursuant to the Bylaws, the voting requirement is at least four members of the Committee for all actions of the Claims Review Committee.

Conflicts

Pertinent Authority Code of Conduct Provisions:

2. We are committed to the concepts of democratic, effective and efficient governance by responsible, knowledgeable members of the Board of Directors and Committees with an understanding that official decisions made and actions taken by the Authority are always made in the best interests of the Authority's

membership, as opposed to the interests of the Authority's staff, service providers, or other outside interests.

9. We are committed to the principle that conflicts of interest, (defined as situations in which a person has a financial or other interest or the appearance of a conflicting interest that would call into question the person's ability to act in an impartial manner with respect to a matter affecting the Authority) should be avoided and where present shall be fully disclosed. This includes situations when a member of the Board, a Committee, staff, or vendor has personal interests (including those of his/her family) that are contrary to his/her loyalty to the Authority.

Vote on behalf of the Authority or the Entity I Represent?
Attorney General Opinion No. 00-708 dated 12/8/00 concluded that a member of the governing board (in this case the Claims Review Committee) of a joint powers agency may cast a valid vote on a matter before the agency that is inconsistent with the position by the legislative body which appointed the member.

Should a case under discussion present a potential conflict of interest to a voting member of the Committee, that member must abstain or absent himself/herself from the vote. The Committee will decide if it is necessary to excuse a member from the room if a particular case under discussion is controversial to that member.

Reference: Attorney General Opinion No. 00-708
Reference: EWC & GL1 Policy on CRC Member Conflict of Interest 11/16/07

Voting When Conflict Arises:
According to FPPC:

- Disqualification
  - For financial interest (exception when action required)
- Abstention
  - Conflicting loyalties
  - Perception you can't be fair
  - Ethical dilemmas (exception for necessity to take action)

According to Roberts Rules of Order:

- Duty to vote if you have an opinion
- Right to abstain
- Personal interest - must abstain except
  - Vote for self in an election
  - Vote if other's interests are included in the motion

Closed Session:

Closed sessions may be held in accordance with the provisions of state law and the Brown Act. Information discussed in closed session is confidential. In addition to the Committee and Legal Counsel, only individuals necessary for the discussion will be present. The Executive Committee has appointed the EIA's Chief Legal Counsel, the Claims Review Committee's Legal Counsel, and the Claims Review Committee's Alternate Legal Counsel to serve as legal counsel to the EIA's Board of Directors and all EIA Committees for purposes of obtaining legal advice during closed sessions in accordance with the Brown Act (2/2/12 Executive Committee Meeting, Item 5.B.). All votes in Closed Session will be conducted by roll call.

Reference: 2/2/12 Executive Committee Minute Order
Closed Session Handbook

The Claims Review Committee has adopted a policy detailing when a Committee member and/or another representative of the member's entity is allowed to participate in the closed session discussion regarding a claim from that member's entity. The policy also sets forth whether and to what extent the member can participate in the closed session discussion on the claim, how the member should vote if they are participating in a vote onthe claim, and under what circumstances the member must leave the discussion before a vote takes place.

Reference: Policy Regarding Member's Participation in Closed Session 11/8/19

Glossary of Terms

Please note: The definitions provided in this section convey common, frequent understandings which may be useful to the Claims Review Committee. Many of the words may be defined differently in specific insurance contracts or may have expanded, reduced, or in other ways have different meanings in particular circumstances.

Accepted Claim: A claim in which an injury is accepted as arising from employment and occurring in the course of employment by the TPA or insurer.

ACOEM (American College of Occupational and Environmental Medicine): Until the state Division of Workers' Compensation adopts medical treatment guidelines, the guidelines published by ACOEM are used in most cases to decide the type and extent of treatment received for a work injury or illness.

ADA (Americans with Disabilities Act): A federal law that prohibits discrimination against people with disabilities.

Aggregate: A cumulative amount of all losses for a period of time.

Alternative work: Work offered to an injured worker who cannot return to the job of injury, temporarily, or permanently, that is substantially different from the workers' regular job.

AMA Guides: A national physician's group, the AMA (American Medical Association), publishes a book containing permanent impairment guidelines.

AME (Agreed Medical Evaluator): The evaluator agreed to by two or more litigated parties to conduct a medical-legal evaluation and write a narrative report addressing permanent disability, temporary disability, the injured workers' ability to return to the job of injury, and the nature and scope of medical treatment needed to cure or relieve from the effects of the injury.

Amicus Curiae (friend of the court): An individual or group, not a party to a case, who volunteers to offer information on a point of law or some other aspect of the case to assist the court in deciding a matter before it.

Answer: A responsive pleading following service of a lawsuit.

AOE/COE: Arising out of and occurring in the course of employment.

App. (Application): When filed, the Application for Adjudication document begins the claim litigation process at the Workers' Compensation Appeals Board.

Appeals Board (Workers' Compensation Appeals Board or WCAB): A group of seven commissioners appointed by the governor to review decisions of workers' compensation administrative law judges.

Applicant: An injured worker in a litigated workers' compensation claim.

Applicant's attorney: A lawyer representing the injured worker in workers' compensation litigation.

Apportionment: Allocation of a portion of permanent disability due to causes other than the injury, which thereby reduces the amount of liability for permanent disability.
ARM: Associate in Risk Management.

Attachment Point: The dollar amount of a loss where the next layer of insurance begins to pay for the loss.

AWW or AWE: Average Weekly Wage or Earnings.

Bodily Injury: Physical damage to the body, including death, mental damage, pain, sickness, and disease.

C&R (Compromise & Release): A type of settlement in Workers' Compensation in which a lump sum of money is paid to settle some or all of the future liabilities on a claim.

CIGA: California Insurance Guarantee Association.

Claim Form (DWC-1): The form used by an injured worker to report a work related injury or illness, which must be filled out and turned in at the place of business.

CMS (Center for Medicare and Medicaid Services) Commutation: Reduction of a sum of money due, at a certain rate, for a period of time, to its present value.

Comparative Negligence: The degree of negligence on the part of each of several tortfeasors. California law currently operates on a pure comparative negligence basis, unless Prop 51 applies, with each party able to recover damages and liable for damages in proportion to his/her share in the overall negligence causing an accident.

Complaint: The initial legal pleading filed with the Court by the plaintiff to initiate the legal process against defendants.

CPCU: Chartered Property and Casualty Underwriter.

C.T. (Cumulative Trauma): An injury or condition that was caused by repeated events at work.

Damages: That which has been lost due to an accident or event, generally expressed in dollar terms; may include loss to property, loss of use, bodily injury, personal injury, loss of income, loss of reputation, etc.

Death Benefits: Benefits paid to surviving dependents when injury results in death.

Defendant: (W.C.) The party – usually the employer or insurance company – opposing the injured worker in a dispute. (Liab.) The party named in a lawsuit against whom a claim is being pursued.
Defense Attorney: (W.C.) The attorney hired to represent the employer in workers' compensation litigation. (Liab.) The attorney hired to represent the defendant in a civil lawsuit.

Demur/Demurrer: One of several responsive pleadings to the court following service of a Complaint. The demurrer states that, even if the facts alleged in the Complaint are correct, the legal consequences are not such that liability accrues to the defendant and there is no need to answer them.

Deposition: Testimony by a party having knowledge material to a cause of action taken outside of court but under oath.

DEU: Disability Evaluation Unit.

Discovery: The information gathering process occurring under power of subpoena and with written and oral testimony being provided under oath.

Dismissal: An order or judgement finally disposing of an action or suit by sending it out of court without a trial on the issues. The dismissal may be with prejudice, which bars the right to bring or maintain an action on the same claim or grounds, or without prejudice, in which case there is no bar to bringing or maintaining the action in the future on the same grounds.

DOI (Date of Injury): Either the date a specific injury happened, or, if the illness or injury was caused by repeated events, the date of the last injurious exposure.

DOL (Date of Loss): The first date on which an insured event occurred.

DOR or DR (Declaration of Readiness): The form used to request a hearing before a Workers' Compensation judge.

DWC: Division of Workers' Compensation.

EDD: Employment Development Department pays State Disability or SDI.

Eminent Domain (Public Taking): The power to take private property for public use by a public entity, provided the property is taken for a public purpose and just compensation is given to the owner of the property which is taken.

Employment Practices Liability: Liabilities arising from allegations of discrimination, failure to promote or hire, harassment, Americans with Disabilities Act responsibilities, wrongful termination, etc.

Errors and Omissions Liability: Liability caused by an error or omission in the performance of professional duties.

Essential Functions: Duties considered crucial in the performance of a specific job.

Excess Coverage: Insurance coverage which does not provide for payment to the insured (W.C. reimbursement) or on behalf of the insured (liability – damages) until underlying insurance coverage has paid its limits or the insured has paid its self- insured retention.

Excess Insurance: Insurance purchased to provide higher limits than the primary policy provides.

Exemplary Damages: See Punitive Damages.

FCE (Functional Capacity Evaluation): A systematic process of assessing an individual's physical capacities and functional abilities in order to determine the individual's ability to safely return to work, and to determine if work restrictions, job modifications, or reasonable accommodations are necessary to prevent further injury.

FEC: Future Earnings Capacity.

Findings and Award: The final decision written by a judge regarding settlement of a workers' compensation claim.

FMLA (Family and Medical Leave Act): A federal law that provides up to 12 weeks unpaid, job-protected leave per year for personal or family health problems, which also requires that group health benefits be maintained.

Fraud: Any knowingly false statement or action made for the purpose of obtaining or denying workers' compensation benefits or civil damages.

Future Medical: Post settlement right to continuing medical treatment for a work related injury.

General Damages: Compensation for damages which cannot be quantified by specific documentation. Examples include compensation for pain and suffering, loss of promotion, disadvantage in the labor market, or disfigurement.

General Liability: Liability for property damage, bodily injury, or personal injury to third parties.

Guardian Ad Litem: Guardian appointed only for the case being litigated.

Hold Harmless Agreement: A contractual provision establishing that one party will not be considered liable for particular damages which might arise.

Impairment Rating: A percentage estimate of loss of normal use of injured body parts used to calculate a permanent disability rating.
Incurred: The total dollar amount for which a file is exposed, including paid and outstanding totals, in each reserve category.

Indemnity: The act of making someone "whole" (give equal to what they have lost) or protected from (insured against) any losses which have occurred or will occur.

In Pro Per: An injured worker or plaintiff not represented by an attorney.

Interactive Process: Mandatory process in which an employer and disabled employee must communicate to identify and implement reasonable accommodation(s) to assist the employee in performing the essential functions of the same or an equivalent position with the employer.

Interrogatories: Written questions submitted to a party to a lawsuit, with written responses to be provided under oath within a specified time.

Inverse Condemnation: Action by private property owner against government entity for taking or damage to property caused by public work or project.

JA (Job Analysis): A detailed description of job duties which is signed by both employee and employer.

LeBouef: Case Law which establishes 100% permanent disability based on the determination of non-feasibility for vocational rehabilitation by a vocational expert.

Legal Authorities:

68 (Rule 68) A	Federal Rules of Civil Procedure Statutory settlement offer made in a Federal Court case.
132a	LC 132a Discrimination
998 offer	Ca. Code of Civil Procedure A statutory settlement offer made in a California Court Case.
1877.3	Ins. Code 1877.3 Duty to report fraud
3600	LC3600 Reasons to deny a claim
4600	LC4600 Medical Treatment
4650 (d)	LC 4650(d) Self Imposed 10% penalty
4850	LC 4850 1 year paid leave of absence for specified public employees
5500.5	LC5500.5 Cumulative Trauma
5813	LC5813 Sanctions for bad faith actions
5814	LC 5814 10% penalty, unreasonable delay
10440 & 10445	Title 8, CA Code of Regs Serious and Willful misconduct

Level of Impairment: A percentage estimate of how much normal use of the injured body part(s) is lost due to accident or injury. Impairment ratings are based on guidelines published by the American Medical Association. An impairment rating is used to calculate the permanent disability rating.
Lien: A claim for payment against a workers' compensation or liability Claim.

MDT: Multiple Disabilities Table.

Medical Legal Report: A comprehensive medical exam which addresses permanent & stationary status, permanent disability, and future medical needs, obtained at the request of either party in a workers' compensation claim.

Medicare: Federal program providing medical insurance coverage to seniors and other qualifying persons.

Member: A County or Public Entity participating in the Authority pool.

MMI: Maximum Medical Improvement.

MMSEA: Medicare, Medicaid and SCHIP Extension Act. This Act sets forth the requirements for insurers when dealing with Medicare eligible persons.

MOC: Memorandum of Coverage.

MPN: Medical Provider Network.

MSA: Medicare Set Aside is a portion of money set aside within a settlement to protect Medicare's interests in the future care of an injured worker.

MSC: Mandatory Settlement Conference.

MSP: Medicare as Secondary Payer Act. This Act requires that insurers involved with Medicare-eligible persons shall be considered primary payers of benefits and Medicare shall be secondary.

Negligence: Failure to exercise the care that a reasonably prudent person would exercise in like circumstances.

New & Further: Petition to re-open a claim file for additional disability after settlement by Award.

NOPE: Notice of Potential Eligibility for Vocational Rehabilitation.

Occurrence: An accident or event, which results in personal injury or property damage, neither expected nor intended from the standpoint of the covered party.

P&S (Permanent and Stationary): Medical condition has reached maximum improvement.

Penalty: An amount of money awarded by the WCAB for error in the payment of indemnity or medical benefits.

Permanent Disability (Permanent Partial Disability): Any lasting disability that results in a reduced earning capacity when maximum medical improvement has been achieved.

Permanent Disability Rating: A percentage based on age, date of injury, occupation when injured, and job restrictions at permanent & stationary, which determines the monetary value of the disability caused by the injury.

Permanent Total Disability: Payments made when an injured worker is 100% unable to compete in the open labor market.

Permanent Work Restrictions: The physical restrictions imposed by the doctor when maximum medical improvement is reached, which are in effect for the duration of the injured Workers' working life or as long as the employee remains permanently disabled. These help protect the worker from further injury.

PERS: Public Employees Retirement System.

Petition for Reconsideration: A legal process used to appeal a decision issued by a judge.

Plaintiff: The party who complains or sues in a civil action.

Pooled Loss: The portion of a loss that is allocated to, and paid by the self insured pool.

PQME: A Panel Qualified Medical Evaluator is chosen from a list of three independent qualified medical evaluators provided by the Division of Workers' Compensation Medical Unit to perform a medical legal examination for an in pro per injured worker.

Pre-designated Physician: A personal physician able to treat work related injuries, if the injured worker has advised his employer in writing of the choice prior to injury occurrence.

Property Damage: Physical injury to tangible property or loss of use of property.

Proximate Cause: That which produces the injury, and without which the result would not have occurred.

Punitive Damages: Damages awarded not to compensate the plaintiff, but in order to reform or deter the defendant and similar persons from pursuing a course of action such as that which damaged the plaintiff.

Reserves: Amount of money required to be set aside for the estimated total monetary value of each claim for the eventual payment of claims or losses.

Responsive Pleadings: A written statement filed within a specific period to respond to the accusations contained in the Complaint.

Rogers/ Carter Clause: An addendum to a Compromise and Release agreement which releases defendants from liability for future claims resulting from any subsequent new injury which may arise out of participation in vocational rehabilitation.

RRTW: Release to Return to Work.

S&W (Serious & Willful): Serious & Willful Misconduct is a Petition filed against the employer if the injury was caused by either party's alleged serious misconduct. It is typically filed against the employer.

SAWW: State Average Weekly Wage.

SCHIP: State Children's Health Insurance Program. Section 111 of this Act requires primary payers to report all claims involving Medicare-eligible persons to Medicare at the time of payment(s), settlement, judgment or award, or be subject to fines of $1,000 per day.

SIR (Self Insured Retention): The amount of each loss for which each Member is responsible.

Self Procured: Medical treatment of an injured employee not authorized by the employer.

Sequel: A pathological condition resulting from a disease, injury, or other trauma.

Settlement: A resolution of some or all issues pertaining to a claim.

SJDV: Supplemental Job Displacement Voucher.

SOL: Statute of Limitations.

Specials: Economic damages such as medical costs and wage loss.

Staff: Employees of the Authority.

Stipulations with Request for Award: A type of settlement in which payment takes place over time.

Subpoena: A court summons to appear and/or produce tangible evidence for use at a hearing or trial.
Subrogation: The legal process by which an insurer seeks from a third party, who has caused a loss, recovery of the amount paid to the policy holder.

Sub Rosa: Covert surveillance used to dispute an injured worker's allegation of physical or mental limitations.

Summary Judgment: A judgment granted without formal trial when it appears on the pleadings and other showings to the court that there is no genuine issue of fact and that the moving party is entitled to judgment as a matter of law.

Summons: Notice which accompanies the Complaint which must be served upon a defendant to inform the defendant of pending action.

Temporary Disability: Payments received in place of wages lost due to injury.

Thomas Finding: An addendum to a Compromise and Release agreement which settles issues of vocational rehabilitation based on a good faith threshold issue of liability which, if decided against the applicant, would preclude the recovery of any benefits on the applicant's behalf.

Tort Law (Torts): A wrongful act, other than for violation of contract, and for which a civil action is the appropriate remedy.

TPA: Third Party Administrator.

U&C: Usual & Customary refers to the job at the time of injury.

Utilization Review: The process used to decide whether requested treatment is appropriate for an injured worker.

Verified Claim: The claim form required by the Government Code, for presentation to a public entity. Technically, a claim where the person presenting such is required to certify under oath the truthfulness of the allegations contained therein.

VSC: Voluntary Settlement Conference.

WCAB (Workers' Compensation Appeals Board): Offices throughout California where disagreements over workers' compensation benefits are initially heard by workers' compensation judges.

Work Restrictions: Doctor's description of a level of impairment regarding specific job functions for an injured worker. Work restrictions may be used temporarily, prior to maximum medical improvement, or permanently after maximum medical improvement.

WPI: Whole Person Impairment.