

**Reform Claim Data Review Worksheet**

**Demographic Data**

Claim #: \_\_\_\_\_ Claim Type: \_\_\_\_\_ DOI: \_\_\_\_\_

Change in PTP Date: \_\_\_\_\_ Represented Date: \_\_\_\_\_

Description of Injury/Body Part(s) Injured:

\_\_\_\_\_

Employer Size: \_\_\_\_\_ Employer Industry: \_\_\_\_\_

Summary of medical services provided:

\_\_\_\_\_

**Reserves:**

	<b>Paid Losses</b>	<b>Outstanding</b>	<b>Incurred</b>
Medical Total			
TD			
PD			
VR			
Indemnity Total			
Expense Total			
<b>Total</b>			

Comment:

\_\_\_\_\_

**Utilization Review**

UR referral criteria in existence: (Y/N) \_\_\_\_\_

UR referrals needed: (Y/N) \_\_\_\_\_ UR referrals made: (Y/N) \_\_\_\_\_

Retrospective, Concurrent, Prospective (select one): \_\_\_\_\_

Timely process: (Y/N) \_\_\_\_\_ Did UR Certify: (Y/N) \_\_\_\_\_

If non-certified, was LC4062 used: (Y/N) \_\_\_\_\_

If LC4062 used, was treatment later authorized: (Y/N) \_\_\_\_\_

Did LC4062 evaluation recommend treatment other than requested by PTP: (Y/N) \_\_\_\_\_

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Comment:

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**Voucher**

Initial notice within ten days of end of TD (Y/N): \_\_\_\_\_

Mod-Alt Work offered within 30 days from permanent work restrictions: (Y/N) \_\_\_\_\_

Voucher payment due: (Y/N) \_\_\_\_\_ Voucher payment offered: (Y/N) \_\_\_\_\_

Voucher amount: \_\_\_\_\_ Amount accurate: (Y/N) \_\_\_\_\_ Voucher settled: (Y/N) \_\_\_\_\_

Comment:

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**PTP Repealed – Changed approach to medical evidence**

Employer chose PTP: (Y/N) \_\_\_\_\_ PTP report taken at face value: (Y/N) \_\_\_\_\_

Supp report(s) requested: (Y/N) \_\_\_\_\_ Which issues: \_\_\_\_\_

How PTP responded: \_\_\_\_\_

Dispute with PTP: (Y/N) \_\_\_\_\_

If yes, how resolved: \_\_\_\_\_

Comment:

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**Delay Claims - \$10K Cap**

Decision in 90 days: (Y/N) \_\_\_\_\_ Able to complete discovery in 90 days: (Y/N) \_\_\_\_\_

Did PQME eval occur in 90 days: (Y/N) \_\_\_\_\_ Denials within 90 days (Y/N) \_\_\_\_\_

Was denial later accepted after PQME eval: (Y/N) \_\_\_\_\_

Use ACOEM to manage treatment: (Y/N) \_\_\_\_\_

Amount paid during delay period (1<sup>st</sup> 90 days): \_\_\_\_\_

Denial reason (circle one): factual, legal, medical

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Comment:

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**Medical Legal Process**

Issue to be resolved (circle one): LC4060 (AOE-COE) LC4061 (PD) LC4062 (All others)

Method used to resolve: \_\_\_\_\_

Unrepresented (circle one): PTP, PQME Represented (circle one): AME, QME, PQME

Timely selection by parties: \_\_\_\_\_

If unrepresented, did IW select from panel timely: (Y/N) \_\_\_\_\_

If not, did carrier select QME: (Y/N) \_\_\_\_\_

If represented, comment on AME and QME timeliness:

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Who made the PQME choice (circle one): AA or IW, carrier

Timeliness of dispute resolution (circle one): timely, prolonged

Availability of QME on a timely basis to resolve AOE/COE matters: \_\_\_\_\_

Other comments:

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**Medical Provider Network**

Participating: (Y/N) \_\_\_\_\_ Notice Letter Sent re: participation: (Y/N) \_\_\_\_\_

New claims managed pursuant to MPN requirements: (Y/N) \_\_\_\_\_

Claims identified if pre-designation applies: (Y/N) \_\_\_\_\_

Existing claims with MPN, process used:

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Existing claims outside of MPN, process used:

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Comment:

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If not, did carrier select QME: (Y/N) \_\_\_\_\_

If represented, comment on AME and QME timeliness:

\_\_\_\_\_

Who made the PQME choice (circle one): AA or IW, carrier

Timeliness of dispute resolution (circle one): timely, prolonged

Availability of QME on a timely basis to resolve AOE/COE matters: \_\_\_\_\_

Other comments:

\_\_\_\_\_  
\_\_\_\_\_

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Cost impact on claim (circle one): favorable, neutral, unfavorable

Comment:

\_\_\_\_\_  
\_\_\_\_\_

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Cost impact on claim (circle one): favorable, neutral, unfavorable

Comment:

\_\_\_\_\_  
\_\_\_\_\_

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## Reform Claim Data Review Worksheet

### General Questions

Do you have claim procedures that pre-date AB 749?

Do you have claim procedures since AB 749 that show how claim processes have changed since then? What procedures did you implement as a result of SB899?

What were the 5 key changes of reform on claims processing in your view, and how did you implement them?

Has repeal of the PTP presumption changed your claim procedures? If so, how?

Do you have a UR plan?

Do you have referral criteria for UR?

Do you keep statistics for delayed and denied claims? If so, what was the percentage of delayed claims to TNRs? Indemnity TNRs? What was the percentage of denied claims to delayed claims (denied/delayed ratio)? Did these percentages change after 4.19.04, when the \$10K cap for delayed claims was enacted?

What claim procedures did you implement to put LC4062.1 and LC4062.2 into effect? What has been your experience regarding AOE-COE decisions (LC4060), PD evaluations (LC4061) and all other issues (LC4062)?

How has LC4062.1 and LC4062.2 affected your ability to resolve claims, compared to your ability to resolve claims prior to 4.19.04?

What steps did you take to make sure that apportionment is addressed on claims where no final determination was made before the WCAB?

How are you addressing the rating of claims under the AMA Guides?

How is the two-tiered PD system applied, if at all, for claims with dates of injury before 1/1/05?

How is Voc Rehab currently managed as a result of repeal and re-enactment of the voc rehab statutes?

Describe how you administer the voucher process. Has the voucher process changed how you address the provision of regular or modified-alternative jobs for your clients' employees? If so, how?

If you use MIRA, how has MIRA adapted to the changes in the statute? Do you generally see increases or decreases in undeveloped loss estimates?

Has there been an increase in claims being referred to the Second Injury Fund?

What type of MPN is available for your client's access?

What is the overall degree of participation?

What is process for confirming the insured sent the required notice letters?

How do they develop the roster? Who is it communicated to?

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