Alternative Service Concepts
Loyalty • Integrity • Flexibility • Expertise

Claims Administration Best Practices

I RESERVES

A TIMELINESS:

1 The initial reserve must be set within 10 days of the receipt of the claim by ASC and before the end of the month, whichever comes first.

2 The reserves must be adjusted promptly, or - at a minimum - within 30 days of the date the claim handler knew or should have known, of a change in the realistic, practical exposure of the claim.

B ADEQUACY

1 Reserve adjustments must be adequate based on information known and/or available, or reasonably expected, at the time of the evaluation.

2 ASC's reserving philosophy is to reserve for realistic, practical, ultimate exposure. This means neither worse, nor best, case scenario but the realistic value based on injury, damages, liability, jurisdiction, and other influencing factors.

a Any requested variance from this philosophy must be supported by the client Account Profile/Claim Management Guidelines or the carrier's claim-handling requirements.

3 Stairstepping of the reserves must be avoided. Each reserve evaluation must consider the realistic ultimate exposure rather than reserving for the "absolute known" exposure on the date of the evaluation. All parts of the reserve must be considered (loss/expense, indemnity/medical/expense) at each evaluation.

4. All reserve evaluations must be documented in the electronic claim file. This documentation must include the various aspects of exposure such as liability/compensability, injury/damages, permanency, specials/medical/indemnity, legal/other expense.

C EXCEPTIONS

All exceptions to A & B above must be documented in the file notes and/or the client Account Profile/Claim Management Guidelines or applicable carrier claim-handling requirements.

II COVERAGE

A DOCUMENTED

Coverage must be documented as to the carrier name, policy number, SIR/Deductible, limits, a line of business, if a pool - the date the member joined, and carrier's position to the client (i.e. primary, first layer excess, etc.) Further documentation must be included if applicable, for example:

1 Claims Made

If the applicable policy is Claims Made the documentation must include the retro date, date the claim was made against the client, date the claim was reported to ASC, and any applicable extended reporting period

2 Automobile

Description of the vehicle, verification if scheduled, applicable first party coverage, and any first or third party deductible.

3 Property

Description of the covered property, verification if scheduled, ACV/RCV, and any applicable first party deductible.

B CORRECTLY APPLIED

Coverage must be applied correctly to the loss; (i.e. an Automobile Liability policy should not be applied to an E&O claim).

C ISSUES ADDRESSED

Issues of coverage must be recognized and documented in the electronic file notes.

1 Coverage issues must be directed to the carrier in a timely manner.

2 ASC issues Reservations of Rights, Non-Waiver Agreements, Disclaimers, or Excess letters **ONLY WITH** the prior written approval of the applicable carrier.

3 Reservation of Rights letters, Non-Waiver Agreements, Disclaimers, or Excess letters issued by the carrier must be explained to the client in a timely manner.

4 Coverage issues must be followed by the adjuster until resolved

D EXCEPTIONS

All exceptions to A, B, & C above must be documented in the file notes and/or the client Account Profile/Claim Management Guidelines or applicable carrier claim-handling requirements.

III CONTACT

A All client specific requirements, as documented in the client Account Profile/Claim Management Guidelines must be met.

B CONTACT REQUIREMENTS

1 24 Hours
- a Client/Employer
- b Claimant
- c Medical Provider

2 3 Working Days
- a Witnesses

3 Exceptions:
- a Workers' Compensation Medical Only Claims
- b First Party claims with exposure of under $1,000.
- c 24 hour contact is required on a & b above upon knowledge of :
  - (1) potential subrogation
  - (2) questionable compensability
  - (3) potential lost time or permanent impairment

4 Contact efforts must be meaningful with reasonable follow-up on unsuccessful attempts.

C EXCEPTIONS

All exceptions to A & B above must be documented in the file notes and/or the client Account Profile/Claim Management Guidelines or applicable carrier claim-handling requirements.

IV INVESTIGATION

A TIMELINESS

1 Initial Investigation

The amount of time lapsed between receipt of the claim by ASC and completion of the investigation must be appropriate to the peculiarities of the particular claim.

2 Subsequent Investigation

Must be completed within 30 days, or a reasonable time, from the date the need for further investigation was, or should have been, recognized.

B ADEQUACY

1 Recorded or Written/Signed Statements

Statements must be obtained from all key parties to the claim involving:
- a Claims with disputed facts, liability, or compensability.
- b Workers' Compensation claims involving 4 or more weeks of lost time or any permanent impairment/disability.
- c Reportable claims (carrier or client)

(1) Refer to the carrier's Claim Handling Requirements and/or the client Account Profile/Claim Management Guidelines.

2 Index & OFAC

a Index

(1) Unless specifically documented in the client Account Profile/Claim Management Guidelines and not over-ruled by the carrier's Claim Handling Requirements, all bodily injury claims, excluding Medical Only Workers' Compensation must be indexed.

(a) Immediately upon receipt of adequate information and

(b) every 6 months thereafter that the claim remains open.

(2) Requests for additional information must be made on any positive index response.

b OFAC

See the separate section of the manual on OFAC requirements.

(1) All payees must be indexed prior to issuance of the initial payment and, if still receiving payments, each 6 months thereafter.

3 Statutory and jurisdictional requirements concerning investigation must be met.

a MSA - Medicare Set Aside must be considered on all claims that MAY meet Federal requirements.

4 All aspects of liability/compensability must be investigated.

5 Subrogation

a Subrogation potential must be addressed in all files, including

(1) Contractual liability

(2) Vicarious liability

(3) Automobile, Products, Professional and General Liability

b Subrogation may not be waived or discounted, without the express permission of the client and/or carrier.

6 Police/Sherriff department reports must be obtained on all claims in which the police were contacted. If the police did not respond, a copy of the incident report should be obtained.

7 Fire department reports must be obtained on all first-party property losses involving fire.

8 Scene investigations must be conducted based on the needs of the particular claim. Scene investigations should include photographs, diagrams, measurements, etc.

9 If the accident involved a product, the item must be identified, examined, photographed, protected, and it's history determined.

a Potential products claim to include any accident involving machinery or a vehicle with alleged failure of brakes, tires, steering, etc.

b Once potential products liability subrogation is verified, the chain of custody must be established. Use of defense counsel and/or experts should be considered to assist in protecting the product.

10 Damages/Injuries

a Bodily Injury investigations must include

(1) Signed medical authorization if possible.

(2) Medical reports & bills

(a) These should be originals whenever possible. Any photocopies received should be verified.

(3) Medical history

(4) Loss of Wages

(a) On Workers' Compensation, the jurisdictional wage statement

requirement must be met.

(b) Education & work history should be obtained on all serious injuries.

(5) Special damages must be investigated and evaluated.

b Third Party Property Damage investigations must include

(1) Ownership

(2) A full description of the damaged property (auto, real, or other), including its age and condition.

(a) Actual cash value and, if applicable, replacement cost value.

(b) Salvage value

(3) Repair costs

(4) Property damage should be inspected and appraised as warranted by the facts of the accident and the alleged value of the damage.

(5) Loss of use & any diminution of value as applicable.

c First Party Auto Collision & Comprehensive claims should include items listed in b above as required by the coverage provided.

d First Party Property (building or contents) investigations must include

(1) A comparison description from any schedule in the policy against the actual building/contents.

(2) A full description of the covered building (i.e. construction, square footage, date purchased) and the make, model, age, etc. of any scheduled equipment or contents.

(3) Ownership/insurable interest

(4) Actual Cash Value and Replacement Cost Value as required by the coverage.

(5) Statement of Loss

(6) Proof of Loss

C SPECIAL INVESTIGATION - QUESTIONABLE FRAUD CLAIMS

Any information developed by the investigation that indicates the claim may arise from fraud or conspiracy to defraud must be reported within 24 hours to the client, the carrier, and the Field Claim Manager.

The American Heritage Dictionary defines fraud & conspiracy as follows:

fraud (frôd) n. 1. A deception deliberately practiced in order to secure unfair or unlawful gain. 2. A piece of trickery; a trick. 3.a. One that defrauds; a cheat. b. One who assumes a false pose; an impostor.

con·spir·a·cy (k...n-spîr"...-s¶) n., pl. con·spir·a·cies. 1. An agreement to perform together an illegal, wrongful, or subversive act. 2. A group of conspirators. 3. Law. An agreement between two or more persons to commit a crime or accomplish a legal purpose through illegal action. 4. A joining or acting together, as if by sinister design.

1 See separate section of the manual on Fraud/Special Investigation

D EXCEPTIONS

All exceptions to A & B above must be documented in the file notes and/or the client Account Profile/Claim Management Guidelines or applicable carrier claim-handling requirements. **No exceptions are allowed for C - Special Investigation/Fraud**

V DOCUMENTATION

Required "Notes Captions" must be used on all applicable notes on all claims in all accounts. (See separate section on Notes - Glossary.)

A TIMELINESS

Documentation should be entered in the electronic file notes as soon as the activity is completed or as soon as practicable thereafter - preferably within 24 hours.

B ADEQUACY

Documentation must be adequate to provide the reader with what was done, by whom, when, to what result, the thinking or analysis of the results/information by the writer, and the basis for any decision.

1 The electronic file must contain documentation of:

a All activity on file by the adjuster or supervisor.

b Succinct summaries of investigative, medical, and legal reports/correspondence/documents.

c All demands, offers, and negotiations.

d Plans of Action

Plans of action must contain meaningful information on what the adjuster/supervisor will do, by when, to move the claim toward a conclusion. Cursory, redundant ("rubber stamped"), or meaningless comments are unacceptable.

e Where the file contains "suffixed" or "trailer" claims, documentation should be placed in the notes on the lead file (based on suffix number or severity). The remaining claims must contain notations giving the style and claim number of the claim bearing the major documentation.

2 Payments

All payments should include a succinct description of the service, benefit, or settlement being paid in the narrative of the check or check stub.

a The correct applicable dates must be shown in the "From" & "To/Through" fields.

b Generalizations such as "Services Rendered," "Fees to Date," "Full & Final Settlement of All Claims" are unacceptable.

(1) Expense checks for attorneys, experts, appraisers, etc. should show the type of service rendered, and the correct dates of service in the "From" & "To" fields.

(2) Loss payments (P&C Claims) must show the nature of the payment, i.e. "Full & Final Payment Property Damage," "Full for Loss of Use," "Full for ACV Building," etc.

(3) Workers' Compensation indemnity payments must show the type of benefit (permanent partial, death, temporary total, etc.) and the dates covered by the benefits.

(4) Workers' Compensation Medical Benefits - Manually Entered

Medical benefit payments manually entered must contain adequate information describing the benefit being paid, i.e. "Mileage Reimbursement xxx Miles @ $.xxx," etc.

(5) Workers' Compensation Medical Benefits - MBR electronic data feed

Medical Bill Review vendor's data feeds include the EOB/EOR which is printed as a part of the check stub showing the CPT/Procedure code.

C EXCEPTIONS

All exceptions to A & B above must be documented in the file notes and/or the client Account Profile/Claim Management Guidelines or applicable carrier claim-handling requirements.

VI DIARY

A FUTURE DIARY DATE

All Open files must carry an open diary date for the adjuster/supervisor primarily responsible for handling the claim.

B CURRENT DIARY

Diary must be worked on a timely basis. To be considered current diary must be worked within 10 business days of the diary date.

C PLAN OF ACTION

To be considered "worked" each diary must include the status/results of the prior action plan and an action plan for the next diary period.

D ADEQUATE SPAN

Diary on open files must be within 30 calendar days of the prior diary unless the file bears one of the following sub-status codes:

1 SE = 120 day diary span
   a SE on NV Medical Only may carry a span of 365 days due to statutory requirements.
2 LI = 90 day diary span
3 OCC = 90 day diary span

E EXCEPTIONS

All exceptions to A through D above must be documented in the file notes and/or the client Account Profile/Claim Management Guidelines or applicable carrier claim-handling requirements.

VII LITIGATION MANAGEMENT

Any legal action requiring (1) an answer filed with the judicial or jurisdictional body or (2) the appearance of defense counsel is considered to be "litigation."

A REVIEW & ANALYSIS

1 The file must contain the adjuster's thoughts and analysis of the legal action including the soundness of the allegation, any pertinent knowledge of the jurisdiction, and the degree of (and the basis for) the client's exposure.
2 The file must contain the adjuster's thoughts and analysis of what further action must be taken, by whom, to establish further, or diminish, the client's exposure.

B TIMELY REFERRAL TO DEFENSE COUNSEL

1 The legal action must be referred to defense counsel within 24 hours (1 business day) of receipt of the action by ASC unless:
   a A more urgent time frame is required based on the date an answer is due, or
   b The adjuster has obtained written agreement to a waiver of the answer date from the plaintiff attorney.

C PROPER REFERRAL TO DEFENSE COUNSEL

See also Litigation Management Referral To Defense Counsel.

1 Applicable carrier and/or client-attorney selection requirements must be met.
2 Referral to defense counsel must be a formal letter containing the required information or a cover letter with completed format of required information.
3 A copy of Defense Counsel Reporting & Billing Requirements must be sent with each referral. Any modification due to more stringent requirements by the client/carrier should be outlined in the referral or on the Requirements form.
4 All Referrals must contain the following required wording:

> This referral is made on behalf of our captioned client/insured.
> The client and/or their carrier is solely responsible for all fees, charges, and disbursements. ASC has been authorized to review and process the legal expenses and we ask that your bills be forwarded directly to our office.

A copy of the reporting and billing requirements are attached.

Should you not comply with these requirements ASC will be forced to:

1 apply to the client and/or carrier to appoint other counsel, or

2 advise the client and/or carrier that ASC will be unable to continue to handle this claim.

D LITIGATION SCREENS COMPLETED

The Litigation Screens in the claim system must be completed as fully as possible and updated as information is developed.

1 The sub-status code for Litigation ("LI") must be posted in the system on the Sub-Status Screen

E ABANDONMENT TO DEFENSE COUNSEL

Law.Com defines **Abandonment** as: "*n. the act of intentionally and permanently giving up, surrendering, deserting or relinquishing……*"

1 The adjuster must continue to be actively involved in the investigation, direction, and management of both the claim and the legal action.

a The adjuster must direct, consult, and approve the actions of defense counsel.

b The adjuster must not allow or expect defense counsel to fulfill the adjuster's responsibilities in the investigation and/or handling of the claim, communication with the client and/or carrier, evaluation of exposure, or in negotiation.

F CLIENT APPRISED

The adjuster must keep the client apprised of the status of the action, of the evaluation of exposure (loss and expense), further activities projected, and expectations as to results of current activities as well as depositions, settlement conferences, mediations, trial dates, etc.

G PRE-TRIAL REPORT

See also Litigation Management Adjuster's Pre-trial Report for information required in the report - whether from defense counsel or adjuster.

1 The adjuster's pre-trial report must be submitted no later than 60 days prior to trial. If defense counsel submits a pre-trial report, the file must contain the adjuster's review & analysis of the case.

2 Fronted or Carrier Accounts

The adjuster must review the carrier Claim Handling Requirements. Most carriers require that all cases are reportable 60 days before trial whether another reporting criteria applies or not.

a Reporting to the carrier should include the Captioned Report and defense counsel's pre-trial report. The adjuster may attach the adjuster's pre-trial report or include his/her analysis in the body of the captioned report.

b Note that "reportable at 60 days" means the report should be in the carrier's office no later than 60 days before trial.

c This reporting requirement applies even in cases where the adjuster sees no probability of an adverse judgment.

H DEFENSE COUNSEL REPORTING & BILLING

See also Litigation Management - Defense Counsel Reporting/Billing Requirements

1 Defense counsel reporting & billing must meet the requirement outlined in Litigation Management - Defense Counsel Reporting/Billing Requirements and/or the client/carrier requirements if more stringent.

a The adjuster must take action to ensure proper & timely reporting and billing by defense counsel, including notification of their Field Claim Manager and/or client/carrier if counsel fails to cooperate.

b Defense counsel reporting includes submission of a defense budget - and updating that budget as warranted by the development of the case.

(1) All budgets must be approved by the adjuster.

c All legal bills must be reviewed and approved by the adjuster prior to payment.

(1) Fees & expenditures must be supported by documentation received from counsel, i.e. deposition summaries, medical records, etc.

(2) Bills must be in-line with the current defense budget.

2 If defense counsel fails to report or bill within 14 calendar days of the date due, the adjuster must contact the attorney and client (and/or applicable carrier) to advise we are seeking to move the file to another counsel. If the client is unwilling to support ASC in this position, we must advise the client and/or the applicable carrier that we will be unable to continue handling the claim.

I EXCEPTIONS

All exceptions to A through H above must be documented in the file notes and/or the client Account Profile/Claim Management Guidelines or applicable carrier claim-handling requirements.

VIII FOLLOW-UP AND/OR CONTROL

A PROACTIVE

1 The adjuster must take the initiative in pursuing the information and promptly taking action needed to move the claim toward a conclusion.

a Follow-up must be timely and meaningful.

b Follow-up must not be set for the next diary date by rote and without the needed activity by the adjuster.

c Offers should be initiated rather than waiting for demand.

d Alternatives must be considered - return to light work, return to different work, alternative repairs, structured settlements, etc.

B TIMELY PAYMENT

Payments must be made promptly, in general within 5 working days of receipt of all needed information or agreement to pay.

1 Any bill submitted for payment must bear written approval (initials or signature & date) of the adjuster or supervisor.

2 Workers' Compensation benefits (indemnity, medical, and other) payments must be made within the applicable statutory time requirements.

3 P&C loss payments must be made within 5 working days of the agreement.

4 All legal and other expense must be paid within 5 working days of receipt of adequate information.

C MEDICAL MANAGEMENT

1 Workers' Compensation

a All medical bills and reports must be reviewed by the adjuster for relatedness/causation to the alleged injury.

(1) Pre-existing conditions and their impact on the alleged injury must be considered and addressed.

b All medical bills must be subjected to bill review as required by statute and/or client's Account Profile/Claim Management Guidelines.

c The use of a panel of doctors must be considered as allowed by statute.

d Independent medical exams must be considered based on the needs of the claim and any statutory provisions.

e Medical Case Management, Medical Rehabilitation, and Vocation Rehabilitation must be considered based on the needs of the claim and any statutory provisions.

2 P&C

All medical reports, records, and bills must be reviewed for relatedness & appropriateness.

D RESPONSIVENESS

1 All communications from the client, employer, claimant, carrier, attorney, defense counsel, physician, claim supervisor, or another party on a claim must be responded to in a timely, thorough, and professional manner.

(a) Complaints - See the separate section of ASC Manual under Office Administration.

2 All requests for specific, or general, activity on a claim must receive a timely response.

3 All correspondence to parties outside ASC must be on letterhead, company fax template, or e-mail. Handwritten communications are unacceptable.

F TIMELY DENIAL

1 Workers' Compensation

Denials of compensability must comply with the applicable statute.

2 P&C

Denial of liability must be issued within 2 working days of knowledge that the claim should be denied.

3 Coverage

ASC does not issue disclaimers or denials of coverage without the prior written approval of the carrier.

G EXCEPTIONS

All exceptions to A through F above must be documented in the file notes and/or the client Account Profile/Claim Management Guidelines or applicable carrier claim-handling requirements.

IX SUPERVISION

A PROMPT ASSIGNMENT

If the supervisor is involved in assigning new intake claims to the adjuster, the assignment must be made on the date the claim was received by ASC.

B INSTRUCTIONS & GUIDANCE

Initial & follow-up instructions & guidance to the adjuster must be based on the particular claim and the expertise of the assigned adjuster rather than cursory or "rubber stamped."

1 On internal audits, inadequate investigation, handling, or reporting by the adjuster will equate with inadequate supervision.

C RESPONSIVENESS

The supervisor must be responsive to the adjuster and the needs of the claim.

D DIARY

The supervisor's diary must be appropriate to the particular claim and the expertise of the adjuster.

E FOLLOW-UP

The supervisor must follow-up in a timely manner on specific instructions or requests as required by the seriousness of the claim and the propensities of the adjuster.

F EXCEPTIONS

All exceptions to A through E above must be documented in the file notes and/or the client Account Profile/Claim Management Guidelines or applicable carrier claim-handling requirements.

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X SPECIAL AND/OR EXCESS REPORTING

A RECOGNIZED

Reporting criteria based on client and carrier guidelines must be recognized.

1 See the Carrier Requirements and client Account Profile/Claim Management Guidelines contained in separate sections of the ASC Manual.

(a) Not all excess carriers require reporting at 50% of deductible/SIR - some are lower, i.e. Zurich requires reporting at $100,000 or 50% of SIR whichever is less.

Note: The financial trigger for excess reporting is based on the total incurred of the occurrence and/or all related claims.

(b) ASC's requirements on reporting criteria must be followed on all claims on accounts where the contract requires reporting to the carrier. Each excess carrier has a list of non-financial criteria for captioned reports, i.e. fatalities, asbestos, deafness of greater than 50%, etc. ASC's reporting criteria are a combination of the criteria of all carriers and must be followed for all initial reports.

2 Each claim open 120 days or more must be a review for excess reporting.

3 When reported the sub-status codes must be changed to show that the claim was reported and the date reported.

4 The sub-status codes default to "N" for "No" with blank dates on the date fields. Once the file is reviewed for excess reporting or has been reported, the appropriate fields must be changed. The fields are:

(a) Reviewed for excess = ("y" for "yes" or leave "N" for "no")

(b) Date reviewed for excess *(date the claim was reviewed for excess)*

(c) Excess reportable *(does the file meet criteria or incurred amount for reporting = "y" for "yes" or leave "N" for "no")*

(d) Excess reported *(the claim has been reported to the carrier)*

(e) Rein/Exc reported date *(the date the claim was reported)*

B TIMELY

Reports must be prepared and in the hands of the client and/or carrier within the required timeframe.

1 Captioned initial report within 30 days of receipt of the claim by ASC and/or receipt of information of exposure/injury subject to the reporting criteria. Subsequent reports are due each 90 days thereafter unless otherwise stipulated by the client/carrier.

2 All fatality claims must be reported within 24 hours of receipt of notice of the fatality by ASC. This may be in the form of an "initial notice" memo or e-mail giving available information and then followed by a captioned report within 30 days (or as stipulated by the carrier/client).

C PROPER FORMAT

Unless the client/carrier requires a different format the ASC standard Captioned Report format must be used.

1 Captioned reports must offer information of substance and address all known issues.

2 Captioned reports must be professional in content and appearance.

D EXCESS LETTER

A formal letter must be sent to the client advising them to place all carriers with potential coverage for the claim on notice in any claim

1 With an unspecified demand

2 With a demand over the layer handled by ASC

3 In all continuous trigger or repeated exposure claims

E EXCEPTIONS

Claims Administration Best Practices

All exceptions to A through D above must be documented in the file notes and/or the client Account Profile/Claim Management Guidelines or applicable carrier claim-handling requirements.