

ATTACHMENT “A”

**THIRD PARTY ADMINISTRATION SERVICES FOR
DISABILITY COMPENSATION PROGRAM**

PRE-PROPOSAL CONFERENCE

SECTION C – PERFORMANCE WORK STATEMENT

C.1 SCOPE

C.1.1 The District of Columbia Government, Office of Contracting and Procurement (OCP), on behalf of the Office of Risk Management (DCORM), (the District) engages the services of a qualified contractor to operate the District’s Self-Insured Worker’s Compensation Program (currently known as Disability Compensation Program (DCP)).

C.1.2 The overall objective of this procurement is to enter into a contract with a Third Party Claims Administrator (TPA) with proven expertise, in order to provide timely and appropriate service and payments to eligible District employees. Necessary payments will be made in accordance with Title XXIII of the District of Columbia Government Comprehensive Merit Personnel Act of 1978 as amended, D.C. Code Sec 1-623.01 *et. seq.*, the District Personnel Manual and all applicable rules and regulations.

C.2 APPLICABLE DOCUMENTS

The Contractor shall provide services in accordance with the most recent versions and future revisions to all federal and District laws, regulations, policies, and subsequent amendments in the operation of its program. The documents relevant to the Contract and their location are identified in Table C-1.

Table C-1

Item No.	Document Type	Title	Location
1	D.C. Law	District of Columbia Government Comprehensive Merit Personnel Act of 1978 as amended, D.C. Official Code Sec.1-623.01 <i>et. seq.</i>	http://dcode.westgroup.com
2	D.C. Law	Police and Firefighters Disability, 5 U.S.C. § 6324, D.C. Official Code 5-707 (2001, 2003 Supp.)	http://dcode.westgroup.com

3		List of Agencies and Number of Employees	Attachment J.6

C.3 **DEFINITIONS**

The terms listed in C.3.1 through C.3.36 are defined as follows when used in the contract:

C.3.1 **Activity Checks and Surveillance** – Investigation and video surveillance of any D.C. government employee enrolled in the DCP to determine their current activities and work status.

C.3.2 **Additional Medical Examination (AME)** – An examination obtained by the Disability Compensation Program, other than a medical examination obtained from the treating physician. It replaces the term “Independent Medical Examination” or “IME” because all health care professionals who provide services to injured employees in connection with the Disability Compensation Program are paid for by the Program. These professionals are required to exercise and display professional, independent medical judgment at all times. An AME includes a brief review of the patient history and treatment to date and a physical examination of the employee. The purpose of the examination is to assist the physician in making a medical determination as to causation of the injury, current physical impairment, and the necessity of current and future treatment.

C.3.3 **Administrative** - Of or relating to the act or process of administering; performance of executive duties; management; to manage or supervise the execution, use, or conduct of.

C.3.4 **Case Management** – The process of proactively monitoring a claim while it remains open. This process includes but is not limited to the initial investigation to determine compensability, ongoing medical case management, i.e., following up with the doctors’ for current medical reports and disability status and an aggressive plan of action to bring the file to conclusion. Other factual evidence leading to a determination of eligibility for benefits and of claim status.

C.3.5 **Claims Adjuster** – A person with insurance training or training in handling workers’ compensation claims, who investigates and processes claims filed by injured workers. Also may be referred to as a claims examiner.

- C.3.6 Claims Division** – The Division within DCORM responsible for the oversight, supervision and administration of the Disability Compensation Program (DCP).
- C.3.7 Composite Audit Score** – (See Attachment J.7 for Contractor’s Performance Evaluation Report to be used in determining performance based incentives or disincentives earned by the Contractor.)
- C.3.8 Continuation of Pay (COP)** – Administrative leave (not charged to the Disability Compensation Program) granted an employee if a traumatic injury results in loss of work: 21 days for employees hired after 1987; 45 days for employees hired before 1987.
- C.3.9 Diary/Plan of Action** - A chronological record or journal of all events, actions, or observations kept daily or at frequent intervals as they occur, together with a detailed formulation of a prospective program of action and goals; an organization tool used to help the Claims Adjuster manage and review all files on their pending. All files should be placed on the adjuster’s diary to be reviewed no less than every 30-60 days.
- C.3.10 Disability Compensation Program (DCP)** – The comprehensive, statutorily-mandated program that defines the coverage, benefits, and requirements of the workers compensation program for District government employees, for which the District is self-insured. The DCP includes awards of compensation benefits and coverage of appropriate medical treatment.
- C.3.11 HIPAA Privacy Compliance** – See H.12
- C.3.12 Incentive Fee Pool** - An additional fund set-aside by the District, with a balance not to exceed X per year or X % of the annual contract amount, whichever is less, from which the contractor may earn, and the District will pay, incentive payments to the contractor, to the extent the Contractor’s performance exceeds the Acceptable Quality Levels specified in Section C.6.
- During the first year of the Base Period of the contract, the amount of the incentive fee pool will not exceed X or X% of the contract value, as the first three (3) months of the contract is the designated transition period and the contractor cannot earn an incentive payment during the transition period.
- C.3.13 Incentive and Disincentive Fee** – The panel of representatives, chaired by the Contracting Officer’s Technical Representative (COTR), and including one or more representatives from the Office of Risk Management (DCORM), and after consideration of the results of the

quarterly Performance Audit along with other information, prepares and delivers its recommendation to the Contracting Officer (CO) as to whether or not the Contractor merits a performance-based incentive or disincentive pursuant to Section B.3, and the resulting level of incentive payment or disincentive payment reduction.

The CO makes the final determination of the level of incentive payment or disincentive payment reduction.

- C.3.14 Information Systems** – It is computer technology to deal more effectively with quantitative data. Its purpose is to reduce the uncertainty associated with the unpredictability of accidental losses. The database consists of loss data, exposure data, legal data, financial data, risk control data and risk financing data.
- C.3.15 Investigations** - To track, examine; to observe or study by close examination and systematic inquiry into all relevant facts; to conduct an official inquiry. Three (3) point 24 hour contact: claimant contacted for all facts of accident, treatment and current status, supervisor or someone in authority at the agency for all facts related to the accident, witnesses and any information material to the claim, and medical provider or medical report within 24 hours or one (1) business day of assignment to determine diagnosis, treatment, prognosis and expected return to work, written compensability decision within 21 days or controverted notice and documented reason for all decisions.
- C.3.16 Leave Buy Back** – The optional repurchasing of leave used by a claimant while a decision on an accepted claim was pending.
- C.3.17 Litigation Support** - Assistance to the Office of the Attorney General for the District of Columbia (OAG) or other designated counsel, and the D.C. Office of Risk Management when a lawsuit is brought against the Disability Compensation Program. This shall include, but not be limited, to providing all records, documents, surveillance videotape, audiotape, review of court filings, in order to substantiate OAG and DCORM's case.
- C.3.18 Lost Time** – The period in which an injured worker is unable to work.
- C.3.19 Medical Management** – The ongoing process of closely monitoring the treating physician's diagnosis, recommendation for treatment, disability status and return to work projection.
- C.3.20 Notice of Determination 1 (NOD 1)** - A written notice to the claimant advising him or her that their benefits are being denied, terminated, reduced or suspended. It sets forth the rationale for the adjuster's determination, that is, a full and complete narrative summarizing the basis

for the eligibility determination. It is accompanied by key documents and materials relied upon in rendering the determination. It also sets forth the request for reconsideration and appeal processes, and allows for the continuation of payments or medical benefits while a timely-filed reconsideration is pending.

- C.3.21 Notice of Determination 2 (NOD 2)** - A written notice to the claimant advising him or her that their benefits are being denied, terminated, reduced or suspended, however, it does not provide for the extension of benefits while a request for reconsideration before the D.C. Office of Risk Management is pending.
- C.3.22 Office of Risk Management (DCORM)** – The Agency within the District of Columbia Government, responsible for the coordination and supervision of the Disability Compensation Program activities and operations for District government employees.
- C.3.23 Payment of Wage Replacement** - Compensation payments to an injured employee or his or her dependents. Depending on whether an injury is temporary, permanent, total or partial, the amount of compensation is determined according to a statutory schedule set forth in D.C. Official Code Section 1-623.01 et seq., and is a percentage of the injured employee’s bi-weekly pay at the time of the injury.
- C.3.24 Performance Audit** – The systematic application of appropriate procedures, to a set or sample of claims processed by the Contractor, to determine if the Contractor applied specified procedures, rules, or other attributes to the claims selected.
- C.3.25 Performance Quarter** – The three (3) month period from which a sample of the claims processed by the Contractor will be drawn for the Performance Audit (See C.3.21).
- C.3.26 Plan of Action (POA)** – A detailed and concise outline in the file indicating a course of action to bring the file to resolution. The POA should be indicated on every diary review as well as being aggressively followed to bring the file to conclusion.
- C.3.27 Preferred Provider Organization** – The group of medical and ancillary service providers in a network with whom the Contractor has established a relationship.
- C.3.28 Reopen or Reestablish Case Files** - To reconsider a claimant’s eligibility based on newly-acquired facts or a recurrence of an injury. The process of reopening and investigating a disability compensation claim that was subsequently closed.

- C.3.29 Reserves** – The amount of money allocated to an individual claim to cover expected future payments for that claim. To include the total exposure for lost wages, permanency, medical treatment and expenses during the life of the claim.
- C.3.30 Return to Work (RTW)** – Return of the employee to the duty or occupation which the employee was performing at the time of injury, or to other suitable gainful employment. This may entail restricted or full duty.
- C.3.31 Settlement** – Agreement of both parties on a set amount which the D.C. Office of Risk Management, and its counsel, approve. The settlement can be either a lump sum or a structured payment to conclusively resolve a claim.
- C.3.32 Subrogation** - A principle of law that enables the Disability Compensation Program, after paying a loss to its employee, to recover the amount of the loss from another party who is legally responsible for it. It is the assumption by the DCP of the employee’s legal right to collect a debt or damages from a third party.
- C.3.33 Three Point Contact** – 24-hour employee, employer/supervisor and healthcare provider contact evidenced and documented in file.
- C.3.34 Transition** – The period of time between the Contract’s execution and (90) calendar days following the contract award in which contractor is to complete the requirements outlined in sections C.5.2.1 through C.5.2.1.4.
- C.3.35 Utilization Review** - Procedures used by medical practitioners and employers in evaluating the necessity, quality and appropriateness of medical care in disability compensation cases. These procedures also evaluate compliance with PPO physicians’ treatment, surgical care provided in inpatient and outpatient settings, and appropriateness of rehabilitation and vocational services. This includes hospital or other bill audits on all bills over \$10,000 and one hundred percent (100%) compliance with pre-surgery certifications on all cases in which surgery is either required or requested.
- C.3.36 Vendor** – An entity or individual that provides specialized medical services and/or equipment to disability compensation claimants of the Government of the District of Columbia.

C.4 BACKGROUND

- C.4.1** The District of Columbia Office of Risk Management (DCORM), Claims Division, is responsible for the oversight, supervision and administration

of the Disability Compensation Program (DCP), which covers approximately 33,378 employees. The DCP is a comprehensive, statutorily mandated, self-insured disability compensation program applicable to District government employees. Its purpose is threefold:

C.4.1.1 To award compensation benefits to injured workers covered by the statute, and to eligible survivors of employees whose cause of death was directly attributable to a work injury or occupational illness;

C.4.1.2 To provide funding for appropriate medical treatment, including emergency medical care, after a District employee sustains an injury or an illness on the job; and

C.4.1.3 To facilitate expeditious Return to Work for the claimants.

C.4.2 The claimant pool consist primarily of employees who live in the District of Columbia, Maryland and Virginia. However, there are Claimants living outside the District of Columbia Metropolitan area as well as out of the United States. There are currently 50 of these individuals. These claimants receive services in the areas or countries in which they reside.

C.4.3 There are currently 1456 open claims. Of these, there are 585 bi-weekly payroll cases. These are claims that have been accepted for compensation and medical benefits. Roughly 70% of theses cases require ongoing management to determine the claimant's current medical condition and the entitlement to compensation and/or medical benefits. Less than 29% of these cases include permanently totally disabled claimants who require management to assure timely periodic payments of compensation, the proper medical benefits or the provision of prostheses. The remaining 1% represents death benefits.

C.4.4 In FY 2006:

- 723 new lost time claims were reported
- 598 medical only claims reported

In FY 2007:

- 758 total open lost time claims
- 593 total open medical only claims

DCORM expects that in FY 2005 2008 the number of cases outlined for each agency will remain approximately the same. Historically, the majority of DCP cases have been traumatic injuries with a need for orthopedic, radiological and neurological evaluation and treatment. The following diagnoses are most common:

- Sprains/Strains
- Carpal tunnel syndrome
- Stress Claims

C.4.5 Employees Covered Under the DCP

The DCP covers District union and nonunion employees and non-uniformed employees of police, fire and EMS agencies. It does not currently cover uniformed Police, Firefighters and Emergency Medical Services personnel. If during the term of this contract, statutory changes are made to include the aforementioned uniformed personnel under the DCP; the Contractor shall be responsible for providing TPA services and related services for this group.

C.5 REQUIREMENTS

C.5.1 The Contractor shall furnish all management, labor, supervision, transportation, equipment and materials necessary for the inclusive operation of the District of Columbia's Self-Insured Disability Compensation Program as a Third Party Claims Administrator for the Disability Compensation Program.

The Contractor shall have responsibility for performing the following three major functions:

- Function 1 – Transition (Section C.5.2)
- Function 2 – Ongoing Operations (Sections C.5.3 through C.6)
- Function 3 – Continuity of Services (Section I.9)

C.5.2 Transition

C.5.2.1 The Contractor shall ensure an orderly and controlled transition of existing claims data from the Sedgwick/CMI Juris system to Contractor's automated claims system without interruption of services. To facilitate the transition, the Contractor shall perform the requirements of C.5.2.1.1 through C.5.2.1.4 listed herein:

C.5.2.1.1 Develop and submit to the District for approval, a detailed transition plan within five (5) business days following contract execution.

C.5.2.1.2 Assume and transfer all existing claims data from the current service provider at the beginning of the contract term. Existing claims data is currently available in an electronic format with corresponding paper files where available.

C.5.2.1.3 Immediately upon receipt of claim file, notify injured workers of the change in administration, and send copies of these notifications to treating physicians, attorneys, rehabilitation vendors, and pharmacies.

C.5.2.1.4 Begin transition activities no later than 5 business days following contract execution (i.e., from the date a final contract document is signed by authorized District and Contractor officials). Transition requirements shall be complete on or before ninety(90) calendar days following contract award.

C.5.3 Ongoing Operations

C.5.3.1 The Contractor shall operate the Disability Compensation Program (DCP) with the dedicated staff at the DCORM Claims Office and at the Contractor's off-site location, in accordance with the requirements listed in Sections C.5.4 through C.5.22.3, and with the Performance Measures and Standards contained in Section C.6. The dedicated staff shall include experienced claims adjusters at all levels as well as experienced supervisors. The Contractor shall not be required to perform the following services on-site.:

1. C.5.9 – Field Nurse Case Management;
2. C.5.10 – Vocational Rehabilitation Services;
3. C.5.11 – Additional Medical Examinations;
4. C.5.12 – Utilization Review

C.5.4 Investigations

C.5.4.1 The Contractor shall conduct all necessary investigations to substantiate initial and continuing eligibility for benefits and shall ensure against overpayments and fraud. The Contractor shall create and assign case file on the same day as received.

C.5.4.2 Contractor investigations shall include consideration of severity of injury, potential extent of disability, questions of eligibility for compensation, verification that the accident or injury occurred on the job and opportunities for subrogation.

C.5.4.3 Contractor investigations shall pertain to new, on-going and reopened claims. The Contractor shall contact interested parties, obtain statements and Document the case file for all reopened claims within two business days of reopening of the claim file.

C.5.4.4 The Contractor shall ensure that three-point 24-hour contact is completed on each new lost time claim or that reasonable attempts to complete the three-point 24-hour requirement is evidenced and documented in each file. Reasonable attempts shall mean three or more spaced telephone calls on

the day of assignment and the day after. Unsuccessful attempts to contact the parties by phone shall be followed by a letter to that party advising that the adjuster must speak to the party. Efforts of attempt to contact all three parties must be included in the claim file notes. If after 14 calendar days of the initial attempt to complete the three-point contact, contact is not made, the Contractor shall send a notice of determination to the claimant controverting the claim. Three-point contact includes, but is not limited to, the requirements of C.5.4.4.1 through C.5.4.4.3 listed herein

- C.5.4.4.1** **Employee** – to verify description of accident, medical/disability status with names of medical providers, job benefits and wage information obtain;
- C.5.4.4.2** **Employer/Supervisor** – to verify description of accident, in the course of and scope of employment, injury, disability status, return to work possibilities and any other pertinent information; and
- C.5.4.4.3** **Healthcare Provider** – to establish history of injury, diagnosis, prognosis, to confirm that work abilities are provided so that employee can return to work as quickly as medically possible.
- C.5.4.5** The Contractor shall document and include in the claim file, any contact and statements from witnesses to the claim.
- C.5.4.6** The Contractor shall investigate and pursue any indication or suspicion of a fraudulent claim.
- C.5.4.7** The Contractor is required to take Recorded Statements from all parties involved in a loss when there are any questions regarding compensability of the claim.
- C.5.4.8** The Contractor shall confer with the COTR on the locations, units, results and recommended actions for all investigations and shall obtain written approval for any allocated loss adjustment expenses.
- C.5.4.9** The Contractor shall provide index information on all cases to the ISO American Services Insurance Group (ISO) within fifteen (15) days of case receipt. Contractor shall re-index each case every six (6) months until the case is closed and document all ISO reports in the case file.
- C.5.4.10** The Contractor investigations shall include but are not limited to copies of protocols that address special investigations.
- C.5.4.11** In the event such research indicates previous claim history, the Contractor shall investigate in accordance with the provisions of this section.
- C.5.5** **Payment of Wage Replacement**

- C.5.5.1** The Contractor shall issue a NOD 1 or NOD 2 compensability decision to each claimant and respective agency contact within twenty-one (21) days after a claim is filed, and shall provide in detail the reasons for such denial or deferrals, and appeal rights, or shall approve compensation pay to the claimant.
- C.5.5.2** The Contractor shall research past claims information and document all ISO reports, including former claims, if any, and injuries reported from those claims in the case file.
- C.5.5.3** The Contractor shall process all wage benefits and issue payments within five (5) calendar days of benefits due after Continuation of Pay (COP) period ends.
- C.5.5.4** The Contractor shall investigate all claims, both medical and wage replacement, to determine compensability prior to any payment being authorized.
- C.5.6 Subrogation**
- C.5.6.1** The Contractor shall investigate and pursue all cases involving possible third party recoveries.
- C.5.6.2** The Contractor shall notify the COTR of any cases involving potential subrogation and shall send letter notification of potential lien to all potential third party tort feasons.
- C.5.6.3** The contractor will document subrogation activities in the claim file and send updated lien letters. Liens will not be compromised without approval from the COTR.
- C.5.6.4** The Contractor shall ensure that preservation of evidence is maintained throughout the life of the claimant file.
- C.5.6.5** The Contractor shall preserve all physical evidence, including electronic evidence, photographs, videos, physical dimensions and conditions that may provide subrogation potential and address compensability issues.
- C.5.6.6** The Contractor shall provide the COTR and OAG with assistance in obtaining additional information, conducting investigations and providing litigation support.
- C.5.6.8** The Contractor shall notify the claimant and all involved parties of the notice of lien.

C.5.6.9 The Contractor shall enter and maintain the injury and subrogation information, including clear and specific injury code data into the data base system.

C.5.6.10 The Contractor shall follow up on the notice of lien with notice to claim file.

C.5.7 Activity Checks and Surveillance

C.5.7.1 The Contractor shall hold annual face-to-face visits with both claimant and beneficiaries in fatal and total permanency cases and in temporary total disability (TTD) cases that are more than two years old.

C.5.7.2 The Contractor shall determine when activity checks and surveillance are required and shall obtain approval for activity checks and surveillance prior to initiation. The Contractor shall notify the COTR of activity checks and surveillance reports initiated and completed; and shall discuss them with the Contractor's designated claim personnel when:

The Contractor shall determine when activity checks and surveillance are required and shall obtain approval for surveillance prior to initiation. The Contractor shall notify the COTR of surveillance reports initiated and completed; and shall discuss them with the Contractor's designated claim personnel when:

C.5.7.2.1 Indications of potential fraud, including any suspicious behavior as reported by the doctor, or when the medical information does not coincide with the claimant's reported activity;

C.5.7.3 The Contractor shall ensure that all surveillance assignments are documented in writing.

C.5.7.3.1 The Contractor shall provide the investigator with a description of the claimant, information related to the claimant, the reason for the request, the number of hours to work on the case and any other pertinent information to increase the potential for significant findings.

C.5.8 Medical Management

C.5.8.1 The Contractor shall establish and maintain a panel of local preferred physicians, specialists, clinic and hospitals (orthopedic, neurology) for the DCORM's Disability Compensation Program (DCP) based on the District's population and type of claims.

C.5.8.2 The Contractor shall maintain and provide a listing of Preferred Provider Organizations (PPO) to employees upon notification of injury or illness. To the maximum extent possible, the Contractor shall include providers

within its PPO to accommodate the District's 100 out-of-area benefits recipients. The Contractor shall customize its PPO Network, i.e. provide a District-specific PPO including the addition or deletion of specific providers to meet the needs of the District, upon request of the COTR.

- C.5.8.3** The Contractor shall expand, as the Contractor deems necessary or at the District's request, during the contract term, its network with providers to meet the District's requirements.
- C. 5.8.4** The Contractor shall maintain its PPO Directory on the Contractor's website with accessible online 365 days a year, 7 days a week, 24 hours per day.
- C.5.8.5** The Contractor shall maintain a 1-800 Help Desk phone number to receive questions and provide panel network information in accordance to the District of Columbia business hours.
- C.5.8.6** The Contractor shall arrange and control in-network, out-of-network and out-of-area medical management services to include but not limited to prospective utilization approval and case management.
- C.5.8.7** The Contractor shall document in the file the evaluation of the quality and appropriateness of the medical treatment.
- C.5.8.8** The Contractor shall verify ongoing disability with supporting medical documentation.
- C.5.9 Onsite Nurse Case Management**
- C.5.9.1** The Contractor shall assign a Telephonic Nurse Case Manager TCM to all cases where lost time will exceed two weeks.”
- C.5.9.2** The Contractor shall ensure that TCM make contact with the claimant within one (1) business day of receipt of the assignment and shall contact the agency contact person within two (2) business days.
- C.5.9.3** The Contractor shall ensure that TCM is involved in medical coordination and determination of medical necessity and denial of medical care based on the appropriateness of medical services with required tracking and follow up. TCM shall be assigned on all cases where the injured worker does not return to work within the estimated length of disability for the injury or illness sustained.
- C.5.9.4** The Contractor shall ensure that TCM reports include action plans and are provided at 30 day intervals or sooner if there is a significant case development.

C.5.9.5 The Contractor shall ensure that all TCM's are licensed nurses and accredited in a clinical setting and possess experience as an NCM in the state where they are performing case management.

C.5.9.6 The Contractor shall ensure that the TCM and the claims adjuster document the case files notes electronically. TCM's shall document file notes for all cases on a monthly basis.

C.5.9.7 Field Nurse Case Management

C.5.9.8 The Contractor shall consider and make a recommendation to the COTR regarding assignment of services on each case where lost time exceeds four (4) months, or sooner if the nature of the injury dictates such consideration and recommendation., Contractor shall obtain written COTR approval for all recommended services prior to scheduling.

C.5.10 Vocational Rehabilitation Services

C.5.10.1 Contractor shall obtain written COTR approval for all recommended rehabilitation services prior to scheduling.

C.5.10.2 The Contractor shall ensure that all vocational rehabilitation counselors utilized for this contract are licensed and accredited in the jurisdiction where they are performing vocational services and that each possesses experience in vocational rehabilitation, or in a clinical setting.

C.5.11 Additional Medical Examinations (AME)

C.5.11.1 The Contractor shall schedule additional medical examinations when one or more of the events listed in C.5.11.1.1 through C.5.11.1.5 occur:

C.5.11.1.1 Diagnosis does not match claim, proposed disability duration is significantly longer than guidelines, and treatment does not match diagnosis;

C.5.11.1.2 Claim management indicators are conflicting (in which case Contractor shall provide input to confirm the basis for continued eligibility under the Comprehensive Merit Personnel Act of 1978, as amended);

C.5.11.1.3 Surgery is recommended.

C.5.11.1.4 There is a question on the underlying opinion of the treating physician;

- C.5.11.1.5** The file indicates a reason to verify the consistency of treatment or that the care provided is appropriate, adequate and solely for the injury incurred in the performance of duty.
- C.5.11.2** The Contractor shall forward all requests for additional medical examination(s) to the physician in writing.
- C.5.11.3** The Contractor shall ensure that each request for additional medical examination(s) explain the reasons for the examination.
- C.5.11.4** The Contractor shall provide the physician providing the additional medical examination(s) with all medical records, including but not limited to, doctors notes, X-rays, diagnostics notes and reports at least seven (7) days prior to the exam (except in emergency situations).
- C.5.11.5** The Contractor shall contact the claimant prior to the additional medical examination and explain the process, confirm claimant's attendance and shall make any necessary travel arrangements.
- C.5.11.6** The Contractor shall document a missed appointment by a claimant, arrange a follow up appointment and contact the claimant by phone within one (1) business day of scheduling.
- C.5.11.7** The Contractor shall provide written follow up to claimant within seventy-two (72) hours of the contact concerning the need to cure the missed appointment and the new appointment date.
- C.5.12 Utilization Review**
- C.5.12.1** The Contractor shall provide cost management services to include but not limited to the items listed in C.5.12.1.1 through C.5.12.1.8 herein:
- C.5.12.1.1** Analysis of diagnosis based on objective findings;
- C.5.12.1.2** A quarterly savings report to be submitted to the COTR showing savings between submitted and re-priced medical charges;
- C.5.12.1.3** Hospital Medical Pre-Certification. The Contractor shall request pre-certification for all surgical intervention and treatment;
- C.5.12.1.4** Fee bill audits. The Contractor shall audit all in-hospital or out-patient bills or surgical procedures in excess of \$5,000.
- C.5.12.1.5** Fee schedule reduction;

- C.5.12.1.6** Adjustment of all medical bills to the fee schedule or “usual and customary” fees, (with a turnaround time of no greater than ten (10) consecutive days);
- C.5.12.1.7** PPO discounting; and
- C.5.12.1.8** Usual and customary review (UCR) to include a fee negotiation agreement with the treating physician, care provider and medical facility.
- C.5.12.2** The Contractor shall ensure all medical bills are reviewed for causality and relation to the injury.
- C.5.12.3** The Contractor shall provide the COTR in an electronic format, weekly pre-fund and supplemental pre-fund reports that include detail and summary information to support all invoices and estimates of amounts needed for wage replacement payments.
- C.5.12.4** The Contractor shall utilize, but not be limited to, the utilization of Presly Reed source, as the standard disability duration guideline.
- C.5.12.5** The Contractor shall document why subsequent treatment is required for the diagnosis listed in C.5.12.5.1 through C.5.12.5.5 herein:
 - C.5.12.5.1** Back pain (all ICD-9 codes);
 - C.5.12.5.2** Wrist pain (all ICD-9 codes);
 - C.5.12.5.3** Knee strain (all ICD-9 codes);
 - C.5.12.5.4** Ankle strains (all ICD-9 codes); and
 - C.5.12.5.5** Fractures (all ICD-9 codes).
- C.5.12.6** The Contractor shall maintain a Utilization Review Program that has at a minimum the American Accreditation HealthCare Commission (URAC) certification.
- C.5.13** **Return to Work (RTW)**
 - C.5.13.1** The Contractor shall ensure that the NCM is familiar with the District of Columbia job functions and that this information is communicated to the treating physician.
 - C.5.13.2** Contractor shall develop a RTW plan with a time line recorded in the file within two (2) business days of receipt of a lost time case. Contractor shall obtain written COTR approval for all RTW plans prior to initiation of the plan.

C.5.13.3 The Contractor shall meet weekly with the COTR to discuss all ongoing lost time cases to encourage RTW.

C.5.13.4 The Contractor is expected to pro-actively work with treating physicians to determine what employees can do, as well as to obtain objective work restrictions.

C.5.14 **Litigation Support**

C.5.14.1 The Contractor shall provide the COTR litigation support and shall cooperate in preparing for litigation involving fraud, false claims, and subrogation or coordination of benefits, including production of documents, making witnesses available and advising the OAG during litigation.

C.5.14.2 The Contractor shall prepare a copy of the file and shall include a detailed summary of the facts surrounding the disputed matter and the applicable code relied on in the denial.

C.5.14.3 The Contractor shall transmit file to COTR within five (5) days of request along with recommendations to the COTR regarding defense or payment.

C.5.14.4 The Contractor shall notify the COTR of dates and location of DCP hearings via e-mail within one (1) business day of receipt of the notice of hearing. This requirement also applies to (but is not limited to) mediations, settlement conferences, and subpoenas.

C.5.14.5 The Contractor shall communicate the outcomes of all hearings, meetings and conferences to the COTR via email within one (1) business day after the event and shall document the claim file with such outcomes.

C.5.15 **Payment of Claims**

C.5.15.1 The Contractor shall process claims paid to employees by the District in accordance with C.5.15.1.1 through C.5.15.1.5 listed herein:

C.5.15.1.1 Accurately calculate payment for employee compensation, including but not limited to verification of an employee's average wage from the appropriate District agency contact person and calculation of loss of wage benefits;

C.5.15.1.2 Verify the relationship of dependents for assigned payments (via birth certificates, guardianship and or adoptions papers);

C.5.15.1.3 Submit for COTR review, weekly pre-fund report that includes both vendor and claimant payments every Wednesday of the preceding pay date;

C.5.15.1.4 Generate a pre-fund report on a weekly basis and transmit that report to the Office of Risk Management for approval. Once approval is obtained, the Office of Risk Management funds the account. Once the account is funded the contractor shall issue the weekly checks. All wage checks should include itemization of benefit deductions; and.

C..5.15.1.5 The contractor shall have the ability to issue daily checks upon DCORM's authorization and provide direct deposit for those DCORM deem appropriate. .

C.5.15.1.6 Approve all medical and vendor bills for services utilizing the appropriate fee reduction methods and ensure that bills are paid within thirty (30) days of receipt.

C.5.15.1.7 Notwithstanding COTR's approval to pay, immediately upon notification by the District the Contractor shall reimburse the District for any incorrect, duplicate or erroneous payments caused by the Contractor's own error, negligence, employee fraud or theft.

C.5.16 Settlements

C.5.16.1 The Contractor shall consult with the COTR to have all proposed settlements approved.

C.5.16.2 The Contractor shall identify claims with possible adverse liability and make recommendations for settlement as soon as the file review indicates within two (2) business days of known information.

C.5.16.3 The Contractor shall send a written request for settlement authority to the COTR on all cases prior to initiation of settlement negotiations. The written request shall include at a minimum, the items listed in C.5.16.3.1 through C.5.16.3.11 herein:

C.5.16.3.1 Claim number, Date of Injury (DOI), name job, years of service;

C.5.16.3.2 Injury description;

C.5.16.3.3 Objective findings;

C.5.16.3.4 Lost-time weeks;

C.5.16.3.5 Final diagnosis and prognosis;

C.5.16.3.6 Current employment status;

C.5.16.3.7 Attorney involvement;

- C.5.16.3.8** PPD exposure amount;
- C.5.16.3.9** Calculation/formula for settlement;
- C.5.16.3.10** Financials for indemnity, medical and allocated loss expense (paid and reserved); and
- C.5.16.3.11** Recovery potential of any subrogation.

C.5.17 Reserves

- C.5.17.1** The Contractor shall establish, on a probable ultimate cost basis, a reserve amount with the initial reserve set within fourteen (14) days of receipt of the claim.
- C.5.17.2** The Contractor shall determine a reserve amount based on current medical diagnosis and other factual information, including disability duration guidelines and shall confirm the reserve accuracy at each diary review.
- C.5.17.3** The Contractor shall avoid using "stepladder" or stair step reserving to meet the current expenditures on the claim and reserve to meet the probable or expected total cost of the claim based on current available information.
- C.5.17.4** The Contractor shall notify the COTR in writing of any initial reserves or reserve adjustment greater than \$50,000.

C.5.18 Diary/Plan of Action/File Management

- C.5.18.1** The contractor shall maintain a thirty (30) day diary on all files unless circumstances of the file development warrant extending the diary. In the event the diary is extended, the basis for the extension must be clearly documented in the file notes. Under no circumstances shall diary reviews exceed ninety (90) days.
- C.5.18.2** The Contractor shall review Temporary and Total Disability (TTD) files on a monthly basis.
- C.5.18.3** The Contractor shall develop a plan of action in the file with a timeline that provides information on how the claim adjuster intends to move the claim to closure.
- C.5.18.4** The Contractor shall ensure that the Claims Supervisor review and document his or her activities to the claim file at the initial time of setup.
- C.5.18.5** Supervisory direction should be clearly documented as a value-added contribution to the overall claim file. The claim file will reflect supervisory

guidance by direct memorandum or file entries in the case history on a continuing basis.

- C.5.18.6** The Contractor shall send written notification to claimant of reassignment of claims adjuster, to include name of new adjuster, claim number, and contact phone number.
- C.5.18.7** The Contractor shall obtain notarized income verification and continuing disability statements annually on all open cases where disability extends beyond one year.
- C.5.18.7** The Contractor shall document in the file all efforts at placing employees in positions in the District Government with reduced capacity or light duty restrictions prior to seeking retraining or vocational rehabilitation.
- C.5.18.8** The Contractor shall document in case file determination of appropriateness of rehabilitation and vocational service.
- C.5.18.9** The Contractor shall include all required executed District claim forms in all files including all applicable attachments on NODs 1 and 2.
- C.5.18.10** The Contractor shall send all AME medical reports to the treating physician within five (5) business days of receipt.
- C.5.18.11** The Contractor shall document on appropriate NOD all continuation of compensation of payment determinations. A copy of the NOD shall be faxed the same day as the date the NOD was issued to DCORM with all reasons for the decision to be included in the NOD. Contractor shall submit evidence that all NODs were sent via certified, first-class mail.
- C.5.18.12** The Contractor shall maintain a 95% upheld rate of determinations through all levels of appeal.
- C.5.18.13** An initial file summary including compensability resolution, medical documentation, reserve justification and plan of action will be completed and documented in the case notes on all case files within thirty (30) days of receipt of the claim.
- C5.18.14** Updated case analysis summaries will be completed and documented no less than thirty (30) days after completion of the initial summary. These summaries will include any and all information that relates to the direction and value of the case, plan of action and target date of completion and closure of the claim.

C.5.19 Reopen or Reestablish Case Files

C.5.19.1 The Contractor shall reopen, reconstruct or reestablish case files including the processing and adjudication of claims involving recurrences of disability.

C.5.19.2 The Contractor shall identify and reconstruct lost files.

C.5.20 Leave Buy-Back Requests

C.5.20.1 The Contractor shall calculate and confirm Leave Buy-Back requests for COTR authorization.

C.5.21 Communication/Reviews

C.5.21.1 The Contractor shall meet with the COTR monthly.

C.5.21.2 The Contractor shall make all files available to the COTR immediately upon request.

C.5.21.3 The Contractor shall respond within within thirty (30) days of receipt of audit evaluations and shall review reports with answers to findings and a plan of action where indicated.

C.5.21.4 The Contractor shall notify the COTR within one (1) business day of any unforeseen problems that arise for which Contractor cannot determine an appropriate course for resolution.

C.5.21.5 The Contractor shall provide the COTR with detailed monthly claims summary reports sorted by agency, Date of Report with specific detail and criteria which includes at a minimum the following:

C.5.21.5.1 All open claims and claims closed during the month for each Agency and claims which had payment during the month; Comp and Medical Claims reported during the month; Claims re-opened during the month; Number of claims closed during the month; Current pending claims (lost time and medical); Claimant Name and Claim Number; Date of report of claim; Event Date; Body Parts; Cause; Injury; Status of Claim (open or close); Type; Days lost for; Comp paid for each claim to date; Medical paid for each claim to date; Current reserves for comp and Medical as of the end of the month; Total incurred (Comp Paid + Med Paid + Comp Reserve + Med Reserve); Total for agency to be given; and Grand total to be given.

C.5.22 Information Systems (IS)

C.5.22.1 The Contractor shall provide the COTR with 24 hour, 7 days a week access to claimants' files electronically via web-based or electronic linkage.

C.5.22.2 The Contractor shall have e-mail and voice mail capabilities for twenty (20) two-minute messages for adjusters and employees. Contractor shall comply with the District-wide Customer Service Voice Mail and Telephone Standards. (Attachment J.8)

C.5.22.3 The prompt return of all calls is essential. Calls from a claimant, OAG, ORM contact or key vendor contact must be returned within twenty-four (24) hours. Under no circumstances, shall a call be returned in excess of twenty-four (24) hours from date of receipt.

C.6 PERFORMANCE MEASURES AND STANDARDS

As noted in Section B.3, if the Contractor’s composite audit score, as defined in Section C.3.7, exceeds X%, the Contractor will earn an incentive fee. If the Contractor earns a composite audit score of less than X%, the District will reduce the contractor’s payment.

The District will use the table below, captioned “Performance Measures and Standards”, to define and measure contractor performance, and accordingly, to determine the amount of the Contractor’s incentive payment or disincentive payment reduction.

The District will use a random sample of case files to conduct the quarterly performance audits. The sample size will be two (2) percent of the open claims during the period being audited. The District will use the evaluation report similar to the one provided in Attachment J.7, which shows the performance measures and associated weights used to determine the Contractor’s composite audit score.

PERFORMANCE MEASURES AND STANDARDS			
Performance Measure	Performance Standard	Acceptable Quality Level	Method of Surveillance
C.5.4- Investigations	1. Case files created and assigned same day as received. (C.5.4.1) 2. 3-Point 24 hour employee, employer and healthcare provider contact evidenced and documented on all lost time cases. Contact witness where applicable. (C.5.4.4) 3. NOD notice issued within 21 days of initial case date. (C.5.5.1)		

	PERFORMANCE MEASURES AND STANDARDS		
Performance Measure	Performance Standard	Acceptable Quality Level	Method of Surveillance
	<ul style="list-style-type: none"> 4. Recorded statements obtained and file documented.(C.5.4.7) 5. Initial Investigation (C.5.4.2) Compensability determination made within 21 days 6. Subrogation (C5.6.1) 		
C.6.2 - Payment of Claims	<ul style="list-style-type: none"> 1. Benefits accurately calculated and documented on all files to include calculation workup and all related changes during the life of the claim. (C.5.15.1) 2. All wage checks will include itemization of deductions, gross and net pay detail in the check stub. (C.5.15.1.4) 		
C.6.4 - Medical Management	<ul style="list-style-type: none"> 1. Ongoing Contact with physician or Nurse Case Manager. Evaluation of the quality and appropriateness of the medical treatment plan is to be documented in the file. (C.5.8.7 & 8) 2. AME/Expert Addressed ME medical reports sent to treating physician within five (5) days of receipt. (C.15.18.11) C.5.11.1) 3. RTW/ Modified Duty Addressed(C.5.13.2) 		
C.5.17 -Reserves	<ul style="list-style-type: none"> 1. Initial Reserves. (C.5.17.1) 2. Current Reserves (C.5.17.3) 		

	PERFORMANCE MEASURES AND STANDARDS		
Performance Measure	Performance Standard	Acceptable Quality Level	Method of Surveillance
C.5.18 - Claims Management	<ol style="list-style-type: none"> 1. Stated Diary Date/Compliance All open files should be on diary and reviewed as the case dictates, but at a minimum every 30 days. (C.5.18.1)) 2. First Status/Plan of Action (C.5.18.13) 3. Ongoing Status/POA(C.5.18.13) 4. Proactive Handling (C.5.18.14) 		
C.5.14 -Litigation Management	<ol style="list-style-type: none"> 1. Referral Document (C.5.14.2) 2. Support Defense Council (C.5.14.2) 		
C.5.18 - Supervision	<ol style="list-style-type: none"> 1. Initial Review (C.5.18.4) 2. 30 Day Review (C.5.18.4) 3. Ongoing Supervision (C5.18.5) 		