WORKERS' COMPENSATION CLAIMS ADMINISTRATION SERVICES
PERFORMANCE GUARANTEES AND REVIEWS

The TPA and FCSRMC agree that Performance Reviews will be conducted annually. Each Performance Review will involve Claim File Reviews and an overall Program Management Review. Performance Reviews will be conducted by FCSRMC's Risk Manager, or the designee thereof.

In the Claim File Review process, for each claim file that is reviewed, the reviewer will assign a score from 0 to 100 based upon the criteria outlined in this Attachment. At the conclusion of reviewing all selected claim files, an average score for all claim files reviewed will be calculated. In the Program Management Review process, a separate single score between 0 and 100 will calculated.

The average score for the Claim File Reviews will account for 75% of the overall scoring for the Performance Review. The total score for the Program Management Review will account for 25% of the overall scoring for the Performance Review. As an example, if the average Claim File Review score is 86 points and the Program Management Review score is 70, the total score will be calculated as follows:

Claim File Review average	86 points times 75% weight =	64.5 points
Program Management Review	70 points times 25% weight =	17.5 points
Total Weighted Review Points		82.0 points

The penalties will be based upon the Total Weighted Review Points.

FCSRMC will perform an annual Performance Review in January for the previous calendar year's claims. FCSRMC retains the right, at its sole discretion, to perform such reviews at any time.

Failure to perform at or above expected levels for the Performance Reviews will result in liquidated damages of 1% of the amount that was charged by the TPA for the prior fiscal year. Any liquidated damages will be credited to future amounts invoiced by the TPA to FCSRMC. Only one Performance Review may be applied per fiscal year toward liquidated damages.

The Performance Reviews will measure objective performance standards which are easily identified and measured. After each Performance Review is performed, the TPA will meet with the FCSRMC Risk Manager and/or designee to discuss initial evaluation results. The TPA will be given an opportunity to factually rebut the initial findings. Thereafter, a final tally of the review results will be prepared.

The TPA's expected level for Performance Reviews will be 90 (ninety) total weighted review points for the January 2028 Review, and 95 (ninety-five) total weighted review points thereafter.

CLAIM FILE REVIEWS

For the Claim File Review, FCSRMC reserves the right to audit up to thirty (30) workers' compensation claims opened during the prior fiscal year, selected randomly. The make-up of the files selected for each review will be at least 50% open files. At least 50% of the selected files will have recent (within performance period) dates of injury and the remaining selected files will have dates of injury prior to the beginning of the performance period.

Each claim will generate a score from 1 to 100 points. All timeliness standards of performance are stated in business, not calendar, days. In any instances where a standard is not applicable to a particular claim file, the file will be awarded the full point(s) for that standard. Only transactions that are paid or processed during the performance period will be subject to scoring.

MEDICAL MANAGEMENT/CONTROL – 32 Points

1. **Bill Payment (6 Points)**
   The TPA will review bills, invoices, and other claims for payment submitted by health care providers to identify proper authorization, over utilization, underutilization and billing errors and will adjudicate/pay those bills and mail (postmark) payments within 20 days of receipt. Bills will be properly coded. Rejected bills will be documented in the claim file with the date and reason for rejection.

2. **Plan of Action (10 Points)**
   A written plan of action must be established jointly between the adjuster and, as appropriate, supervisor or case manager within the following intervals:

   a. Within 10 days of the TPA's knowledge of a claim,
   b. Within 30 days of the TPA's knowledge of a claim,
   c. At 90-day intervals thereafter, as long as a claim remains open.

   The plan of action must include, as appropriate, the medical resources required (telephonic or field nurse case manager, specialist referral, transportation, attendant care, etc.), the diagnosis, prognosis, proposed treatment plan, authorized physicians and other providers, description and cost of prescribed medications, the Medicare set aside strategy and anticipated MMI, current work status and stay-at-work or return-to-work plan.

   File documentation will include a clear understanding for adjuster direction, strategy, and "who" is going to do "what" to ensure successful result. The end result desired or expected will be clearly documented.

3. **Timely Care/Treatment (8 Points)**
   Needed medical appointments with specialists, physical therapists, diagnostic tests,

etc., must take place within 7 days of a request for service by an authorized party when appropriate to the diagnosis. If appointment for appropriate service is not available within 7 days of request/referral, file must document reasonable attempts to procure such appointment. The file must document when and how the appointment date was communicated to the claimant.

4. **Stay-at-Work/Return-to-Work Communication (8 Points)**
   The FCSRMC Workers' Compensation Coordinator must be notified in writing, no later than the next business day, of the TPA's knowledge that an employee has been given limitations, restrictions, or other altered duty status or when these limitations, restrictions, or other altered duty status are rescinded or changed. The file must always clearly document work status. A copy of any DWC-25 shall be forwarded to FCSRMC's Workers' Compensation Coordinator no later than the next business day of receipt if it establishes or changes an employee's limitations, restrictions, or other altered duty status.

CLAIMS MANAGEMENT – 43 Points

1. **Claim Receipt, Screening and Assignment (4 Points)**
   Appropriate claim and medical resources are assigned to maximize effectiveness in benefits delivery and claim resolution in accordance with mutually agreed upon (FCSRMC and TPA) criteria.

2. **Timely Reporting, Quality Contact (10 Points)**
   Adjuster will make timely (within 24 hours but not later than the next business day excluding weekends and holidays), appropriate, and meaningful contact with the injured employee, site supervisor, and physician. File will document this contact. If contact is not made, file will document attempts at contact, which shall be attempted in a reasonable and timely manner. After three (3) unsuccessful attempts, adjuster will notify FCSRMC.

   Documentation will include, but not be limited to, documentation of compensability, mechanism of injury, medical necessity of medical care, orientation of the injured worker, duty status, as well as evidence of meaningful medical, educational, vocational and societal background information relevant to the ability of the injured employee to return to his or her usual occupation.

3. **Recovery Activity (4 Points)**
   All possible avenues of subrogation/recovery will be thoroughly explored with appropriate follow-up diaries if authorization given to pursue subrogation/recovery. Employee's prior claim history will be investigated and clearly documented in file.

4. **Communication (10 Points)**
   Evidence/documentation of routine and effective communication between all interested parties involved in the claim: adjuster, nurse case manager, physicians and

other health care providers, employer, employee, legal counsel, etc. Information requested from interested parties should be aggressively pursued. When the information is not provided in a reasonable amount of time, follow-ups for the requested information should be sent at regular intervals until the information is provided or the matter otherwise resolved. The file should be clearly documented with the date and description of each new request or follow-up.

5. **Litigation Management (5 Points)**
   A litigation plan shall be documented and readily evident in the claim file. File will reflect timely response to all legal filings, legal correspondence, and proceedings. Defense counsel reports shall be summarized, and file copies annotated with a meaningful description relative to the contents. FCSRMC shall be included in all emails and correspondence initiated by the adjuster to defense counsel.

6. **Documentation (5 Points)**
   Claim file documentation must be meaningful and self-explanatory. Important decisions must be clearly documented. Actionable events (new information, transactions, correspondence and communication, actions, etc.) must be documented in real-time (i.e., same day). The claim file must include documentation from providers, including physician notes, medical records or medical reports as well as all State of Florida Workers' Compensation Uniform Medical Treatment/Status Report forms (e.g., DWC-1, DWC-25, etc.)

   All claim files shall be sufficiently documented to the point that an individual entirely unfamiliar with the underlying facts of the claim could gain a reasonable understanding of the basic facts and issues involved in the claim without having to consult any outside resources.

7. **Supervisor, Manager Involvement** (**5 Points)**
   Appropriate supervisory/management involvement will be documented in claim file. Supervisory/management directives will include initial assignment and subsequent directives will include involvement in evaluating reserves, involvement in strategic planning, and disposition of claim. Requests by the supervisor/manager for information from interested parties, and follow-ups for that information, should be timely and clearly documented with a date and description of each request and follow-up.

FINANCIAL MANAGEMENT – 25 Points

1. **Reserves (7 Points)**
   A comprehensive reserve analysis must be prepared and be included as part of the claim file within the following intervals:

   a. Within 10 days of the TPA's knowledge of a claim,
   b. Within 90 days of the TPA's knowledge of a claim, and at 90-day intervals thereafter, as long as a claim remains open,

c. At any time where the TPA's professional judgment should have determined a claim event has occurred requiring a reserve increase or decrease.

Increases or decreases of reserves by $50,000 or more requires notice to the Risk Manager, or designee. File should document such notice when appropriate.

2. Medical Payments (6 Points)

Medical reimbursement made on behalf of FCSRMC must be in accordance with contracted rates or the Florida Fee Schedule. Medical reimbursement includes reimbursements for physician office visits, surgeries, pharmaceuticals, physical therapy, and other medical treatments. A random sampling of medical reimbursements paid for each claim file will be reviewed. Duplicated payments must not occur.

3. Indemnity Payments (6 Points)

Determination of the injured employee's proper average weekly wage and compensation rate must be made within 10 days of TPA's receipt of the wage statement as required by Statute/Administrative Code. Indemnity payments must be timely, documented with the coverage period, and accurate. The claim file shall include an explanation/calculation of the indemnity payment and any penalties/fees.

4. Expense Payments (6 Points)

Appropriate use/management of support resources will be reviewed. This will include the use of all vendors/resources enlisted and paid as an allocated loss adjustment expense (ALAE) or a legal expense such as defense counsel, surveillance, translators, Medicare set-aside services, transportation services, etc. To the extent a preferred panel of providers of these services has been established by FCSRMC, use of preferred providers and contracted rates will be reviewed.

PROGRAM MANAGEMENT REVIEW

REPORTING & COMMUNICATIONS – 20 Points

1. Quarterly Meetings (10 Points)

Quarterly claim review meetings will be conducted with the Risk Manager, or designee, to review progress of the claims, the program, review financial indicators of the program, review legislative issues relevant to the program, and to discuss any open issues. Minutes of meetings will be made by the TPA and document any decisions or direction provided. Decisions or direction specific to the claim files will be documented to the applicable file.

2. Reporting and Reimbursement of State of Florida penalties (10 Points)

The TPA will provide quarterly reporting to FCSRMC of all penalties paid by the TPA to the State of Florida. Report will include documentation of the reason for the penalty and describe the responsibility. The TPA will promptly reimburse FCSRMC for penalties for

which the TPA actions are responsible.

STAFFING – 25 Points

1. **Caseloads (10 Points)**
   Average assigned caseloads for adjusters will not exceed 120 open Indemnity claim files for indemnity adjusters, or 225 open Medical Only claim files for medical only adjusters.

2. **Total Staffing (15 Points)**
   Total staffing will meet or exceed contractually agreed figures. FCSRMC reserves the right to interview or speak with new adjusters when changes to staffing are made.

EXCESS INSURANCE – 15 Points

1. **Documentation of appropriate communications with excess insurers (5 Points)**
   All claim files with total incurred experience projections exceeding the self-insured retention for date of injury will document appropriate communication with excess insurance. All required and appropriate information will be provided to excess insurers. The FCSRMC Risk Manager will be copied on all reports to excess insurers.

2. **Prompt reimbursement of excess insurance (10 Points)**
   The TPA will file for reimbursement from excess insurers for each claim file when total payments exceed self-insured retention. Initial filing for reimbursement will occur within 60 days of when total payments exceeded self-insured retention, unless requested otherwise by the carrier. The TPA will follow up with excess insurer every 45 days until all excess insurance reimbursements have been received by FCSRMC.

PRESCRIPTION PROGRAM – 40 Points

1. **Documentation of authorized and unauthorized prescriptions (20 Points)**
   All claim files must reflect the current authorized medications. Claim files must document prescription medications where authorization to fill was denied, documenting the reason(s). All claim files where there have been multiple attempts to fill unauthorized medications will demonstrate appropriate adjuster flags and notes in the claim.

2. **Documentation of expected medication refunds (10 Points)**
   All claim files where medications have been authorized and paid shall be documented within one business day when TPA becomes aware a refund is appropriate.

3. **Provider-dispensed and name brand medications (10 Points)**
   All claim files with provider-dispensed or name brand medications should document a plan to attempt to reduce medication costs.