

**CITY CLERK  
ORIGINAL**

C-7737  
07/01/2008



**CITY OF GLENDALE  
MATERIALS MANAGEMENT  
REQUEST FOR PROPOSAL**

**SOLICITATION NUMBER:** RFP 07-88

**DESCRIPTION:** Third Party Administration - Workers' Compensation Claims

**OFFER DUE DATE AND TIME:** February 21, 2008 at 2:00 P.M. LOCAL TIME

**PRE PROPOSAL CONFERENCE:** A pre-proposal conference will be conducted on Wednesday, January 9, 2008 at the City of Glendale Sine Building located at 6829 N 58<sup>th</sup> Drive Suite 202, Conference Rm. A, Glendale, Arizona, 85301 at 10:30 AM, local time.

Offers for the materials or services specified will be received by the City of Glendale, Materials Management at the below specified location until the time and date cited. Offers received by the correct time and date will be opened and the name of each offeror will be publicly read.

**Offer Opening and Submittal Location:** City of Glendale  
Attn: Materials Management  
6829 North 58th Drive, Suite 202  
Glendale, Arizona 85301-2599

Offers must be in the actual possession of Materials Management on or prior to the time and date, and at the location indicated above. Late offers will not be considered. Offers must be submitted in a sealed envelope with the Solicitation Number and the offeror's name and address clearly indicated on the envelope. See Paragraph 2.2 for additional instructions for preparing an offer.

**OFFERORS ARE STRONGLY ENCOURAGED TO CAREFULLY READ THE ENTIRE SOLICITATION.**

For questions regarding  
General Terms and Conditions contact:  
**Brian Guzzi, C.P.M.**  
Materials Management  
(623) 930-2863

For questions regarding  
Scope or Specifications contact:  
**Jim Loeb, ARM**  
Human Resources  
(623) 930-2855  
Jloeb@glendaleaz.com

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Materials Management

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**Third Party Administration - Workers' Compensation Claims**

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SECTION ONE  
**SPECIFICATIONS**

CITY OF GLENDALE  
Materials Management

**Solicitation Number: RFP 07-88**  
**Third Party Administration - Workers' Compensation Claims**

**1.1 SPECIFICATIONS**

INFORMATION ABOUT THE CITY OF GLENDALE

Glendale, Arizona is full service northwest valley city. Currently, the city employees approximately 2,100 full-time employees. The city became self-insured for Workers' Compensation claims on July 1, 1994.

The Proposer staff will be responsible for working on a day-to-day basis with two City of Glendale staff persons:

1. Risk Manager – is responsible for the overall administration of the city's Workers' Compensation self-insurance program. Contact between the Third Party Proposer and the Risk Manager will be on issues outside the regular day-to-day claims administration.
2. Workers' Compensation Claims Analyst - The Claims Analyst reports directly to the Risk Manager and is responsible for handling the daily claims administration duties, supplemental pay and modified duty programs. The Claims Analyst will be the daily contact between the Third Party Administrator and the City of Glendale.

The City of Glendale experiences approximately 250 workers' compensation claims a year. Of the 250 claims, approximately 190 are medical-only and 60 are indemnity. Between 80 and 90 claims are open at any one time. Our fiscal year is July 1 to June 30. Actual claims for the past 3 years are:

Year	Indemnity	Medical-Only	Total
04-05	51	187	238
05-06	21	136	157
06-07	23	190	213

SECTION ONE  
**SPECIFICATIONS**

CITY OF GLENDALE  
Materials Management

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**Third Party Administration - Workers' Compensation Claims**

PROPOSER SCOPE OF SERVICES

The scope of services shall include but not be limited to:

Claim Administration

1. Perform all of the administrative services required and control the disposition of all claims in accordance with applicable statutory and administrative notification requirement of the Arizona Workers' Compensation Act, and all applicable City of Glendale policies and procedures. Copies of all Notices of Claim Status, medical, investigative and legal reports will be sent to the Claims Analyst, City of Glendale upon generation or receipt.
2. Review all claims made by the City of Glendale of personal injury, sickness or disease incurred by an employee in the course of employment during the term of the Agreement, and of death resulting at any time from any of the foregoing.
3. Conduct an investigation of each reported claim to the extent deemed necessary or at the request of the City of Glendale. Request from the Industrial Commission of Arizona information on prior injuries on all new claims and as otherwise requested by the City of Glendale.
4. Subject to prior city approval and vendor selection, arrange for independent investigators, experts or other professionals when such action is necessary to properly process cases, assist in determining the status of disabled claimants, prepare litigated cases, or at the request of the City of Glendale. The Proposer will obtain authorization from the Claims Analyst prior to arranging for any investigators, experts or other professionals.
5. Maintain an electronic and/or paper file for each claim or loss including but not limited to medical reports, legal reports, cost data, and estimates of future liability on an individual claim basis which shall be available for review by the City of Glendale or its authorized agents. (All files whether electronic or paper shall remain the property of the city during subsequent to the expiration of any contract or agreement and shall be returned to the city prior to destruction. Failure to comply shall constitute a breach of contract and be subject to damages and reimbursement for cost for reconstruction of information).
6. Timely pay all benefits as provided by the Arizona Workers' Compensation Act. Assure that medical bill payments comply with medical fee schedules and/or discounted fee arrangements negotiated by or on behalf of the City of Glendale and city approved/selected cost containment vendor, coordinate payment of any temporary disability pay benefits with staff of the City of Glendale.

SECTION ONE  
**SPECIFICATIONS**

CITY OF GLENDALE  
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**Third Party Administration - Workers' Compensation Claims**

7. Assist and support legal counsel selected or retained by the city of Glendale in the preparation and defense of litigated cases and negotiation of settlements, and provide periodic analytical or narrative reports of litigated cases to the City of Glendale. Under no condition will a claim be settled without the express approval of the City of Glendale.
8. Assist the City of Glendale in arranging for rehabilitation or retraining of claimants in appropriate cases.
9. Furnish or make available to the City of Glendale reports containing the following information:
  - a. For each claim or loss, on a monthly basis - the date of injury, a description of the incident, note screens, claim status, total of payments made during the month and to date, and estimate of future cost and total expected cost.
  - b. For each calendar and fiscal year period - the total number of claims or losses; summary of medical and indemnity payments; and estimated future costs and total cost, and any other data deemed necessary by the City of Glendale to comply with Industrial Commission of Arizona reporting requirements.
  - c. For each calendar year period - the total number of claims or losses; summary data as to payments made in the month and to date; and estimated future costs and total cost and any other data deemed necessary by the City of Glendale to comply with Industrial Commission of Arizona requirements.
10. Provide claim forms and other forms believed by the Proposer or the City of Glendale to be appropriate for the efficient operation of the self-insurance program.
11. Maintain an account on behalf of the City of Glendale for payment of workers' compensation claims. Provide the City of Glendale with timely detailed information of transactions related to the account.
12. Timely notify City of Glendale's excess insurers and City of Glendale personnel of all claims or losses meeting the excess carrier reporting criteria with all necessary information about the status of such claims or losses as determined or required by such insurers.
13. In the event any party or entity is potentially responsible for all or part of any claim against the City of Glendale, the Proposer will cooperate with the City of Glendale and its counsel in any attempt at recovery or any action in subrogation against such party or entity.

SECTION ONE  
**SPECIFICATIONS**

CITY OF GLENDALE  
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**Third Party Administration - Workers' Compensation Claims**

14. Submit to the excess insurer on a no less frequently than annual basis, requests for reimbursement of claim payments which exceed the self-insured retention.
15. Notify the Glendale Claims Analyst by fax or electronic mail any supporting documents of the following actions:
  - a. A Request for Hearing, notice of deposition or hearing, or court decision received by the Proposer.
  - b. Prior to sending to claimant, a 20-day letter or a Notice of Claim Status issuing a denial or suspension of benefits.
  - c. Any new claim whose total expected value will be \$25,000 or open more, or claim whose reserves will increase by \$10,000 or more.
16. All claim files created shall be and remains the property of the City of Glendale and shall be made available for review or audit by the City of Glendale or their representatives immediately upon the City of Glendale's request.

Medical Management

1. Monitor the treatment programs recommended by physicians or specialist by reviewing all reports prepared by treating or examining physicians, and by maintaining such contact as may be appropriate or at the request of The City of Glendale to monitor any change of a claimant's condition or circumstances which may affect their ability to work.
2. Recommend any courses of medical management which will expedite recovery and return to work of employees. Implement recommendations as approved by the City of Glendale.
3. Assign city approved/selected nurse case managers on a case by case basis after consultation with City of Glendale staff. If city staff are unavailable, proposer has the authorization to assign a nurse case manager for the initial visit pending contact with city Risk Management representatives.

SECTION ONE  
**SPECIFICATIONS**

CITY OF GLENDALE  
Materials Management

**Solicitation Number: RFP 07-88**  
**Third Party Administration - Workers' Compensation Claims**

Program

1. The Proposer will assist The City of Glendale in following policies and procedures which facilitate a claimant's return to work or reassignment of work in a manner consistent with the claimant's medical condition, the rules and procedures established by the Industrial Commission of Arizona, the Arizona Workers' Compensation Act, and any other state or federal law, including without limitation the "Americans with Disabilities Act" as well as City of Glendale policies and procedures.
2. The Proposer will provide information on changes or proposed changes in legislation, rules and regulations which may affect the City of Glendale.
3. The Proposer will furnish or assist the City of Glendale in the completion, renewal or filing of applications and periodic reports required by the Industrial Commission of Arizona to maintain the City of Glendale's qualification as a self-insured employer pursuant to the Arizona Workers' Compensation Act.
4. Provide access to claims management system to view claims notes, status, payments, and other information deemed necessary for the city to adequately monitor management of claims. Withholding of access to information shall be deemed a breach of contract. (Provide sample screen information in your proposal).
5. Provide savings reports no less frequent than semi-annually, of medical providers charges, breaking out billed, allowed, savings and access fees (including proposer shared revenue with 3<sup>rd</sup> party medical providers and/or preferred provider networks repricing claims).

SECTION TWO  
**TERMS AND CONDITIONS**

CITY OF GLENDALE  
Materials Management

**Solicitation Number: RFP 07-88**  
**Third Party Administration - Workers' Compensation Claims**

**2.1 INCORPORATION BY REFERENCE** All responses shall incorporate by reference the Scope/Specifications, Terms and Conditions, General Instructions and conditions, and any attachments. The "General Instructions and Conditions" (Revision #1) applicable to this solicitation are posted on the Internet. They are available for review and download at the City of Glendale's, Materials Management Internet home page, [www.glendaleaz.com/purchasing](http://www.glendaleaz.com/purchasing). Offerors are advised to review all provisions of the General Instructions and Conditions for this solicitation.

**2.2 RETURN OF OFFER** One CD-ROM containing the entire solicitation, contractor's response to solicitation (Offer) and an originally signed "Offer Sheet" (Section 3.0). With exception to the signed Offer Sheet, no Paper documents will be accepted. Response to the solicitation shall be in MS Word, Excel, Powerpoint and/or PDF format. Offers submitted in a format (paper or electronic) different than specified herein, may be rejected at the discretion of the City. If the offeror does not have this capability, companies such as Kinkos or Alphagraphics can provide this service at a nominal charge.

The offeror shall complete all sections of the solicitation in the format given (ie Offer Sheet, Price Sheet, Questionnaires) in the space provided. If additional space is needed than what is given, enter "See Attachment A for detail".

Submittal of the CD-ROM by the offeror in response to this solicitation shall be construed as the offeror's intent to be bound by any resultant contract.

**2.3 PREPARATION OF OFFER PACKAGE** Only the following items shall be completed and returned. Failure to include all the items may result in an offer being rejected. Offer packages shall be submitted in the following order:

**2.3.1 OFFER SHEET**, Section Three.

**2.3.2 PRICE SHEET/SERVICE FEES**, Section Four.

1. Quote fees on a per claim basis, for contract years one through five.
2. Define "medical only", "lost time" and "allocated expenses" for fee purposes.
3. State fee per claim of takeover claims.

Fees shall be invoiced monthly and annually reconciled to actual files and services. If you are presently working under any performance based agreements, define how your fees are established and evaluated.

**2.3.3 ADDENDUM**, Return all addenda.

SECTION TWO  
**TERMS AND CONDITIONS**

CITY OF GLENDALE  
Materials Management

**Solicitation Number: RFP 07-88**  
**Third Party Administration - Workers' Compensation Claims**

**2.3.4 SAMPLES PER SPECIFICATIONS**, Information requested in Section One and Two

**2.4 ALTERNATE OFFERS/EXCEPTIONS** Offers submitted as alternates, or on the basis of exceptions to specific conditions of purchase and/or required specifications, must be submitted as an attachment referencing the specific paragraph number(s) and adequately defining the alternate or exception submitted. Detailed product brochures and/or technical literature, suitable for evaluation, must be submitted with the bid. If no exceptions are taken, City will expect and require complete compliance with the specifications and all Conditions of Purchase.

**2.5 EVALUATION CRITERIA** The request for proposal shall be evaluated based on the following criteria:

- a) **PROPOSAL QUALITY:** Ability of the Proposer to meet or exceed the specifications and candid responses to the questionnaire.
- b) **SERVICE & PROFESSIONAL EFFORT:** The ability to provide services in an effective and professional manner, the ability to provide claims information in various formats, and the availability and capability of personnel within the Proposer's organization. Favorable consideration will be given to offers that reflect
  - Local staffing adequate to perform the scope of work
  - Experience and knowledge of supervisors and staff
  - Flexibility in use of city designated 3<sup>rd</sup> party vendors/networks/providers
  - Sophistication of customer access and ease of use of proposer claims management information system
- c) **REFERENCES:** Response of references. Name of firm, address, phone number and contact person for three workers' compensation self-insured clients with operations in Arizona.  
  
Governmental or "Municipal" references preferred.
- d) **COST:** The cost of services proposed (including responses to questions in Section Four "Price Sheet.")

The Evaluation Factors will be weighed in the following percentages:

- 30% Cost
- 30% Service and Professional Effort
- 25% Proposal Quality
- 15% References

SECTION TWO  
**TERMS AND CONDITIONS**

CITY OF GLENDALE  
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**Third Party Administration - Workers' Compensation Claims**

**2.6 EVALUATION PANEL** Submittals will be evaluated by an evaluation panel. Award shall be made to the responsive, responsible offeror whose proposal is determined to be the most advantageous to the City.

**2.7 PANEL CONTACT** Proposer shall have no exclusive meetings, conversations or communications with an individual evaluation panel member on any aspect of the RFP, after submittal.

**2.8 PRICE** All prices quoted shall be firm and fixed for the specified contract period.

**2.9 FOB POINT** Prices quoted shall be FOB destination to: City of Glendale, AZ

**2.10 TERM OF AGREEMENT** The term of agreement for this RFP shall be for a one year initial period beginning July 1, 2008.

**2.11 OPTION TO EXTEND** The City may, at it's option and with the approval of the contractor, extend the term of this agreement an additional four (4) year(s), renewable on an annual basis. Contractor shall be notified in writing by the City Materials Manager of the City's intention to extend the contract period at least thirty (30) calendar days prior to the expiration of the original contract period. Price adjustments will only be reviewed during contract renewal.

**2.12 INQUIRIES:**

Any questions related to a Request for Proposal may be directed to Jim Loeb, (623) 930-2855.

Any doubt as to the requirements of this Request for Proposal or any apparent omission or discrepancy should be presented to the city. The city will then determine the appropriate action necessary, if any, and issue a written amendment to the Request for Proposal. Oral statements or instructions will not constitute an amendment to this Request for Proposal.

Questions should be submitted in writing when time permits. The city may require any and all questions to be submitted in writing at its sole discretion. Any correspondence related to a Request for Proposal should refer to the appropriate Request for Proposal subject page and paragraph number. However, the Proposer must not place the Request for Proposal subject on the outside of an envelope containing questions since such an envelope may be identified as a sealed proposal and may not be opened until after the official Request for Proposal due date and time.

SECTION TWO  
**TERMS AND CONDITIONS**

CITY OF GLENDALE  
Materials Management

**Solicitation Number: RFP 07-88**  
**Third Party Administration - Workers' Compensation Claims**

PROPOSERS PRESENTATION:

Finalists will be required to attend an oral review panel to be completed by Mid March. The Proposers will be notified to the date and time of the presentation by Jim Loeb, Risk Manager.

**2.13 AWARD OF AGREEMENT:**

- A. Notwithstanding any other provision of the Request for Proposal, the city expressly reserves the right to:
1. Waive any immaterial defect or informality; or
  2. Reject any or all proposals, or portions thereof;
  3. Reissue a Request for Proposal.
- B. A Service Agreement will be formed when the City of Glendale City Council awards the professional services agreement executed by the selected Proposer.

**2.14 OBLIGATIONS:**

The issuance of this Request for Proposal does not obligate the city to pay any costs incurred in the preparation and submission of proposals. The cancellation of any Agreement made pursuant to this Request for Proposal shall be made to either party upon thirty (30) days written notice.

**2.15 CANCELLATION**

- a. The City of Glendale may terminate upon giving thirty (30) days written notice any Agreement or part thereof made pursuant to this request for proposal for convenience or cause. Any default by the proposer if the proposer fails to comply with any of the terms and conditions of this Agreement, unsatisfactory performance as judged by the Agreement proposer, and failure to provide the City of Glendale, upon request, reasonable assurance of future performance, shall be causes allowing the City of Glendale to terminate this Agreement.

In the event of termination for cause, the City of Glendale shall not be liable to the proposer for any amount, and the proposer shall be liable to the City of Glendale for any and all damages sustained by reason of the default which gave rise to the termination.

SECTION TWO  
**TERMS AND CONDITIONS**

CITY OF GLENDALE  
Materials Management

**Solicitation Number: RFP 07-88**  
**Third Party Administration - Workers' Compensation Claims**

In the event of termination for convenience, the proposer shall observe any instructions from the City of Glendale's Agreement proposer as to work in process. The proposer shall be paid for services accepted by the Agreement proposer.

- b. Any claims remaining open upon termination of any Agreement will be administered and adjusted to completion in accordance with the following provisions:
1. All claim files created shall be and remain the property of the City of Glendale free of any claim or lien and shall be immediately delivered to the City of Glendale upon any termination of Agreement, or
  2. The City of Glendale may pay for the administration of any such outstanding claims for a fee which shall be negotiated at the time of any termination of Agreement based upon the cost of claims administration at that time, or
  3. If requested by the City of Glendale, the Proposer will handle any claims or losses remaining open at the termination of the Agreement, provided the City of Glendale shall continue to make adequate funds available for payment of such claims or losses and any allocated loss expenses, or
  4. The City of Glendale may elect to transfer all open claims to another proposer at the termination of the Agreement.
  5. The Proposer or its agents, employees or attorneys shall be entitled to inspect such files and make copies or extract information there from.
  6. The City of Glendale may cancel any Agreement, without penalty or obligation, if any person significantly involved in initiating, negotiating, securing, drafting or creating the Agreement on behalf of the City of Glendale's departments or agencies, at any time while the Agreement or any extension of the Agreement is in effect, an employee of any other party of the Agreement in any capacity or a consultant to any other part of the contract with respect to the subject matter of the Agreement. The cancellation by all other parties to the Agreement, unless the notice specifies a later time (A.R.S. 38-511).

SECTION TWO  
**TERMS AND CONDITIONS**

CITY OF GLENDALE  
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**Third Party Administration - Workers' Compensation Claims**

**2.16** **INSURANCE** The contractor must furnish proof of the following insurance coverage's to the city at the address shown on the first page of this solicitation within ten (10) days after award:

- Professional Liability (Errors and Omissions) of at least \$1,000,000, in which the aggregate limit available is not less than the stated amount.
- Workers' Compensation with Employers Liability of at least \$500,000.
- Commercial General Liability endorsed or stated to include contractual liability, personal injury, completed operations bodily injury, and property damage with a combined single limit of at least \$1,000,000 per occurrence and \$2,000,000 aggregate.
- Business Automobile coverage for all automobiles for bodily injury and property damage with a combination single limit of at least \$1,000,000.

Proposer shall maintain all of the coverage listed at its own expense at all times that the contract is in effect. Coverage's may be layered as assigned by Proposer but the aggregate limit available shall not be less than the stated amounts. Policies for these coverage's must be issued by an insurance company that is authorized to do business in Arizona and has an AM Best rating of at least A. With the exception of professional liability and workers' compensation, policies for these coverage's must name the City of Glendale as an additional insured, and require the city be provided thirty (30) days notice of cancellation. Coverage shall be primary and non-contributory to all other sources of coverage by the city.

The city reserves the right to terminate any contract or agreement if the contractor fails to maintain such insurance coverage. Certification to be submitted to: Materials Management, 6829 North 58th Drive, Suite 202, Glendale, Arizona 85301-2599.

**2.17** **NOTICE OF INTENT TO AWARD** Information about the recommended award for this solicitation will be posted on the Internet. The information will be available for review on the City of Glendale's, Materials Management Internet home page [www.glendaleaz.com/purchasing](http://www.glendaleaz.com/purchasing) immediately after the City has completed its evaluation process of the offers received. If you have any questions, or would like further information about an intended award, contact the buyer immediately. Any protest must be submitted to the Materials Manager no later than seven (7) calendar days from the date of posting on the Internet.

SECTION TWO  
**TERMS AND CONDITIONS**

CITY OF GLENDALE  
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**Third Party Administration - Workers' Compensation Claims**

**2.18 COOPERATIVE USE OF CONTRACT** This agreement may be extended for use by other governmental agencies and political subdivisions of the State including all members of SAVE (Strategic Alliance for Volume Expenditures). Any such usage by other entities must be in accord with the ordinances, charter, rules and regulations of the respective entity and the approval of the Contractor and City. For a list of SAVE members click on the following link: <http://www.maricopa.gov/materials/SAVE/SAVE-members.PDF>

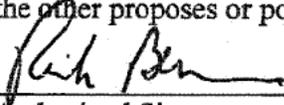
**SECTION THREE  
OFFER SHEET**

CITY OF GLENDALE  
Materials Management

**Solicitation Number: RFP 07-88**  
**Third Party Administration - Workers' Compensation Claims**

**NOTE:** In addition to completing this Section electronically and including it in the CD-ROM submittal, a printed version with original signature shall be submitted with CD-ROM at the time of Offer due date and time.

**3.1 OFFER** Proposer certifies that they have read, understand, and will fully and faithfully comply with this solicitation, its attachments and any referenced documents. Proposer also certifies that the prices offered were independently developed without consultation with any of the other proposes or potential proposers.

 _____ Authorized Signature	Matrix Absence Management, Inc. _____ Company's Legal Name
Rick Bernstein _____ Printed Name	5225 Hellyer Ave #210 _____ Address
VP Business Development _____ Title	San Jose, CA 95138 _____ City, State & Zip Code
(408) 361-7302 _____ Telephone Number	(408) 361-9067 _____ FAX Number
rick.bernstein@matrixcos.com _____ Authorized Signature E-mail Address	www.matrixcos.com _____ Company E-mail Address

**For questions regarding this offer: (If different from above)**

_____ Contact Name	_____ Phone Number	_____ Fax Number
_____ Email Address		

FEDERAL TAXPAYER ID NUMBER: 

Arizona Sales Tax No. \_\_\_\_\_ Tax Rate \_\_\_\_\_

Proposer certifies it is a: Proprietorship \_\_\_\_\_ Partnership \_\_\_\_\_ Corporation X

Minority or woman owned business: Yes \_\_\_\_\_ No X

**SECTION FOUR  
PRICE SHEET**

CITY OF GLENDALE  
Materials Management

**Solicitation Number: RFP 07-88  
Third Party Administration - Workers' Compensation Claims**

**UNALLOCATED SERVICE FEES**

- 1) Quote fees on a per claim basis for contract years one through five. Define "medical only", "lost time" and "allocated expenses" for fee purposes.

For purposes of this Agreement, an "Indemnity Claim" shall mean any qualified Claim:

- For which an indemnity payment is made (i.e. not medical and not expense) on a Qualified Claim or at the time lost from work meets/exceeds the state prescribed waiting period; or
- For which an application for adjudication of a claim or hearing notice is received or otherwise involves litigation, or
- Where paid medical costs exceed \$5,000; or
- Denied or delayed claims requiring investigation beyond the initial 3 point contact and gathering of routine documents normally required to make an initial claim determination, or that otherwise would have been classified as Indemnity Claims; or
- Claims which Client requests to be investigated beyond the initial 3 point contact and gathering of routine documents normally required to make an initial claim determination; or
- Any claim for which subrogation is investigated or pursued beyond identification and initial notice; and as further authorized by the City of Glendale; or

Any medical only claim open longer than twelve months, except those claims closed to active benefits during the first twelve months that remain open thereafter solely for the monitoring of supportive care.

State the period of time claims will be managed for the initial fee.

Life of Contract

2)

NEW CLAIMS

TAKE OVER CLAIMS

<u>PERIOD</u>	<u>INDEMNITY</u>	<u>MEDICAL ONLY</u>	<u>INDEMNITY</u>	<u>MEDICAL ONLY</u>
08-09	\$950	\$150	N/A	N/A
09-10	\$990	\$155	N/A	N/A
10-11	\$1,025	\$160	N/A	N/A

**SECTION FOUR  
PRICE SHEET**

CITY OF GLENDALE  
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Third Party Administration - Workers' Compensation Claims**

11-12	\$1,065	\$166	N/A	N/A
12-13	\$1,105	\$172	N/A	N/A

3) State the services provided for the above flat fee.

Workers' Compensation claims administration services outlined in service agreement.

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4) For claims remaining open past the initial period in 2) above, what is the fee (if any) and for what time period would you continue to manage the claim?  
Claims will continue to be managed until contract termination.

---

5) Identify any internal services provided on a time and expense basis.  
Nurse Case Management at \$98/hr

---

6) Fees shall be invoiced monthly and annually reconciled to actual files and services.  
Agreed.

---

**ALLOCATED FEES AND COSTS TO CLAIM FILES**

8) What types of fees and costs are allocated to individual claim?

Allocated Loss Adjustment Expenses	Matrix Charges
Not included in Administration fees and shall include, but not be limited to:	At Cost

**SECTION FOUR  
PRICE SHEET**

CITY OF GLENDALE  
Materials Management

**Solicitation Number: RFP 07-88  
Third Party Administration - Workers' Compensation Claims**

- |  |  |
|--|--|
| <ul style="list-style-type: none"><li>■ Legal Fees</li><li>■ Professional Photographs</li><li>■ Extraordinary costs for witness statements</li><li>■ Medical Records</li><li>■ Experts' rehabilitation costs</li><li>■ Fees for service of process</li><li>■ Managed Care (described above)</li><li>■ Medical Examinations</li><li>■ Extraordinary Travel made at client's request</li><li>■ Sub rosa investigation</li><li>■ Official documents and transcripts</li><li>■ Pre- and post- judgment interest paid</li><li>■ Court reports</li><li>■ Collection cost payable to third parties on subrogation</li><li>■ Any other similar cost, fee or expense reasonably chargeable to the investigation, negotiation, settlement or defense of a claim or loss which must have the explicit prior approval of the client</li><li>■ Outside Investigation</li><li>■ Index Bureau Reporting</li></ul> |  |
|--|--|

9) Of those fees and costs identified in 8) above, indicate those provided by your firm, and describe the terms and conditions for compensation and/or expenses files (state any specific line items charges including minimum charges)?

None.

10) Of those fees and costs identified in 8 above, provided by a third party, indicate:

a. How the third party is selected

With input from client.

b. Those services provided by a third party

Please see services listed in answer to question number 8.

c. Identify the third party provider(s), how they are compensated, terms of compensation and your firm's compensation for using the third party services. If multiple third parties are used for similar services (i.e. several PPO networks), identify which are most likely to be used for our account and the terms and conditions and costs to the city.

Third party providers are selected with input from the client and they compensated at the vendor cost. For bill review and cost containment programs we work with Coventry/First health.

**SECTION FOUR  
PRICE SHEET**

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- 11) State the fee or estimated total costs, if any, to convert and load our key claims management information data from the current service providers' system to your system?  
Not applicable.
- 12) State the annual fee, if any, to allow the city to have on-line access to your claims management information system. If fees vary by degree of access and/or flexibility of system, provide by attachment the various levels of access and associated costs.  
Included.
- 13) In the event of termination of the contract, note the procedures and costs, if any, for:
  - a. Run-off claims adjusting: Per Open claim per month. Fee to be determined at time of termination.
  - b. Historical loss summaries: No Charge for first summary.
  - c. Transfer of electronic claims history: No charge.
- 14) Will you allow the city to contract directly with a third party preferred provider network and will you process the payments within your proposed fee?  
Matrix's policy is to use the same third party preferred provider network for all of our clients.

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Provide replies to all requested information, comply with the outlined Scope of Services and Requirements, and state clearly any variances. Submit:

- Description of the firm
- A list of local officer(s) and employees
- Identification and resumes of adjusters assigned to the city claims
- At least four client references including contact names and phone numbers
- A complete signed sample of the proposed service contract
- Description of various services and associated fees
- Fee costs to assume open pending claims
- A list of the type, frequency and cost of loss reports (enclose samples)
- Pricing options for a second, third, fourth and fifth year continuation of the contract
- In the event of contract termination, procedures and cost (if any) for run-off claims and historical loss summaries, and
- Details of services to be provided.
- Any online access capability and associated city cost.

Answer all questions only as relates to worker's compensation claim management services.

Name of firm: Matrix Absence Management, Inc.

Address: 5225 Hellyer Avenue, Ste 210 San Jose, CA 95138

Service Contact Name: Rick Bernstein

Phone: (408) 361-7302

**Claims Staffing and Administration:**

- 1) How do you assign claims to adjusters?

New claims are properly set up in the computer system within 1 business day of receipt of employer's first report of injury, with accurate employer, employee, injury, and illness data. All claims must be set up under the appropriate policy. Any coverage issues must be recognized, investigated, and thoroughly documented. Policy and jurisdictional issues must be explained. Employer/employee relationships must be identified.

First reports are reviewed by the claims manager or supervisor and assigned to an examiner with an appropriate initial reserve and coverage code. Supervisors offer specific recommendations based on the skill level of the assigned examiner and the complexity of the

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claim. Activity is recorded in the system and diaries assigned based on the complexity of the claim and per standards.

- 2) What is the turnover rate of local adjusters over the past 5 years?

5.2% over the last 5 years and no turnover from 2005 to date.

- 3) Attach resume and service location for each assigned claims manager, account manager and supervisor (not adjusters) who would be directly involved with the account management. Include:

- a. Background information
- b. Education, and
- c. Related experience

Background statements for Laura Crowe, Anthony Acosta and Carol Coletti are included in our proposal response.

- 4) Attach resume and service location for each adjuster to be assigned claims. Include:

- 5) Background information
- 6) Education
- 7) Related experience
- 8) Type of claims managed
- 9) Case load for open claims by claim type, and

Background statements for Staci Mathias, Samantha Paulsen and Jody Hohman are included in our proposal response.

- 10) Attach names, addresses and telephone numbers of at least three self insured worker's compensation client references generating similar claims volume, including the name of contact person and telephone number. Local references are mandatory.

Paul Piazza, Risk Manager, Honeywell, (973) 455-5981 (self-insured)

Mike Gallet, Hexcel Corporation, (520) 836-8761 extension 4449 (self-insured)

Barbara Biro, RN, Employee Health Program Coordinator, Yuma Regional Medical Center, (928) 336-7220 (large deductible)

- 11) Indicate the number of claims payors/examiners/adjusters available in your Phoenix metropolitan office for Worker's Compensation cases by type of assignment (i.e. medical only; indemnity; etc.).

Currently in our Phoenix office we have four senior level examiners and one medical only examiner.

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- 12) Indicate the number and type of staff you plan to dedicate to the city.

The dedicated team will consist of a supervisor and account manager with one indemnity and one medical only examiner to manage the program for the City of Glendale.

- 13) Identify if the specific claims adjuster to be assigned to this account has previously performed TPA services for a municipality or government agency. If so, please identify the government unit and time period when services were provided.

Staci Mathias will be the claims adjusters assigned to the City of Glendale. Staci is currently managing the workers' compensation claims for the City of Glendale. Prior to joining Matrix Staci managed the workers' compensation program for Mesa Public Schools, City of Yuma and City of Chandler.

- 14) Describe your initial and ongoing training program for staff adjusters. Also describe what type of educational training, if any is provided to your clients.

Indemnity examiners at Matrix are required to have a Self-Insured Administrator's certificate when joining Matrix, or successfully pass the State test within 1 year from date of hire. Claims examiners are required to maintain their respective certifications through attendance at IEA classes, seminars, legal forums, on-line classes, self-study and classes within Matrix. Claims supervisors and managers at Matrix are required to fulfill the experienced claims adjuster training requirements, and may, in addition, receive training in management and leadership of teams, as examples. Medical-Only and/or future medical claims examiners, who are working toward an experienced claims adjuster designation, are expected to obtain their IEA certification, successfully pass the Self-Insured Administrator's Test within 3 years from the start of commencement of training and successfully complete the Matrix training program. This level of examiner is also expected to maintain his or her respective certification by means through continuing education.

A sample agenda is included in our proposal response.

- 15) What is your ratio for the following:

- a. Full-time supervisory staff to claims processors.

1 to 5

- b. Medical only adjuster open case load.

225

- c. Indemnity adjuster open case load.

150

- 16) What factors constitute your system for evaluation and compensating a claims adjuster?

Compensation is based on the industry and the individual examiner's experience and performance meeting Matrix internal standards and the specific goals and objectives of their

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clients. Examiners are eligible to participate in a bonus program in addition to their base salary. Evaluations include supervisory oversight in accordance with our claims standards, monthly supervisory claim file audits, office audits and client audits. The findings of these audits along with our annual performance review system determine the examiners salary increase and participation in the bonus program. To qualify for the bonus, examiners must achieve a score of 90% success in all measured categories. Objective measurements are pulled directly from the system.

- 17) Describe supervisors' role in the claim handling process including claims review and sign off policies. Indicate if they are located in the same office as the adjusters.

The dedicated Matrix claims supervisor will review all new industrial injury or illness claims within one business day of notice and immediately assign them to either a dedicated indemnity or medical only examiner. The claim supervisor is responsible for reviewing office and individual performance against the standards and guidelines of their assigned clients. Supervisory personnel review files and record their findings in the claim system notes with respect to the claim examiner's adherence to published performance standards as well as provide directions for continued handling when applicable.

Claim manager or supervisor approvals are required before any delay or denial decisions. Approvals must be documented in the system. Supervisors review all claims after examiner's initial file workup or, at a minimum, within 30 days from claim setup, recording comments in the system and providing examiner with additional instructions. The supervisor or manager will diary the claim for follow up based on the nature of the claim and the experience of the responsible claims examiner. Afterwards, supervisors review all open, unresolved claims at a minimum every 90 days until all issues are resolved. For stable and mature claims, supervisors or managers review the file at a minimum every 180 days thereafter until the file is closed. All unresolved claims valued in excess of claims examiner's authority will be maintained on active diary by a supervisor. Supervisor or manager signs off on all claim closures.

- 18) Describe your internal quality control efforts and information on how often your claims files are audited internally and by whom. Please supply a copy of an actual audit form and an actual internal claim examiners audit report performed on the specific adjuster to be assigned to this account (client reference may be blackened out).

Upon receipt of the claim, it is reviewed by the claims manager or supervisor for assignment and initial reserve of the file. The claims manager or supervisor will establish a diary to follow up on claim investigations and will review and authorize all first payments, delays or denials recommended by the examiner. Management reviews are performed at 90-day intervals for complex claims. Supervisors set an initial reserve at the time the file is assigned to an examiner. The initial reserve is based on information contained on the employer's first report of injury. When examiners have completed their investigations, they will do a detailed reserve analysis, calculating the probable ultimate cost of the claim in each reserve category (indemnity, medical, and expense).

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The Matrix Quality Assurance Review Program is designed to support the delivery of timely, accurate, efficient, and courteous claim service. Results of the quality assurance reviews are used to evaluate performance, identify training needs, assess workloads, spot trends, recognize client servicing opportunities, and to target areas that would benefit from the development of process improvements.

The Matrix Standards provide the basis for measuring the quality of the claims services that we deliver to our clients. Compliance with these standards is enforced in two ways. On a national level, the Practice Leader for Workers Compensation is charged with overseeing office performance through frequent monitoring of various quality assurance and workload reports, coordinating internal and external audits, and carrying out random claim file and office operations reviews. These reviews may be specific to processes targeted for improvement, conducted to measure compliance with client-specific service requirements (e.g., performance guarantee contracts), or more generally to measure office adherence to claims management standards.

At the corporate level, random audits of office operations are conducted by or under guidance of the Practice Leaders. These reviews evaluate an office's overall performance with respect to standard workflow controls, processes and claim management best practices as defined by Matrix IEB Standards and practice-specific quality assurance guidelines. Results of these reviews are reported to the President.

At the office level, each Claim Manager (or Claims Supervisor or Senior Claims Examiner) is responsible for reviewing office and individual performance against these standards and guidelines – and taking corrective action when needed to improve performance.

In order to monitor office and individual performance – and provide immediate corrective action at the claims level when required, managers and supervisors are required to conduct regular reviews of files managed by subordinate claims examiners. Supervisory personnel review files and record their findings in the claim system notes with respect to the claim examiner's adherence to published performance standards as well as provide directions for continued handling when applicable.

A sample audit form is included in our proposal response.

19) Is your company currently involved in arbitration and/or litigation for any reason? If so, please elaborate.

No.

20) Has your company, or any of your proposed sub-contractors, ever filed for reorganization or bankruptcy? If so, please provide dates and resolution.

No.

21) Describe transition plans to ease the movement of claims management should your firm be awarded this contract (i.e. planning meetings, training of city staff, distribution of policies, procedures or guidelines...).

Not applicable as we are currently managing the program for the City of Glendale.

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22) Provide a copy of your internal claims standards. Outline the established protocol for claims management from first report of injury to claim closure. If not already addressed in your standards identify:

a. Describe your claims handling philosophy.

Matrix has a successful history of working closely with our clients to design and implement workers' compensation claims management programs tailored to their culture and claim philosophy. We put the client's needs first. By maintaining close and open communication with our clients we validate that the program is working well or we work together to make the appropriate adjustments and modifications. Clients that have moved to Matrix tell us they appreciate our commitment and flexibility to meet their expectation for service and responsiveness. In cases where benefits are due, those benefits are paid timely and accurately. Appropriate and cost-effective medical care is provided to insure maximum medical recovery. The employee is returned to work as soon as medically feasible. If the employee first returns to work in a modified capacity the claim is aggressively managed to get the employee released to full duty. The employee and client receive proactive communication throughout the life of the claim and feel their expectations for service and responsiveness were exceeded.

b. Describe your claims reserving philosophy.

It is our policy to establish loss reserves on each claim, regardless of time loss status, based on the probable ultimate outcome of the claim. Using a reserve worksheet to consider each financial component of a claim (indemnity, medical, vocational rehabilitation, legal and other expense categories), these categories are further broken down into their component parts (e.g. indemnity into temporary total and permanent partial disability). Reserves are subsequently re-evaluated whenever significant claim developments will have an impact on the total payout and at regular intervals throughout the life of the claim when the examiner conducts a file status/action plan review.

Initial reserves are established by the claims supervisor or manager when the claim is assigned based on the facts available at that time. The responsible claims examiner will then complete an investigation within ten working days and reevaluate the projected ultimate cost of the claim based on a review of the findings of the investigation, the medical prognosis, employee's work status, state regulations, etc.

Fully adjudicated long-term disability and certain stable future medical claims are reviewed at least every 6 months for continued reserve appropriateness. Matrix's expectations are to reserve a file only five times or less during the handling of the claim.

Reserving limits and client approvals are established based on client and carrier requirements and the experience level of the examiner. Our system-defined limits will not allow reserves to be set in excess of the examiner's limits without review and release from the supervisor.

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- c. The time frame in which injured employee will be contacted after TPA receives notice of claim.

Matrix Claims Management takes a proactive approach to obtaining information once notice of a claim has occurred. Our clients are encouraged to have their employees file claims as quickly as possible.

Investigations are initiated and documented within 1 business day of notice of a new claim from any source. Three-point contact with the employer, employee, and medical provider are required within one business day on all questionable compensability claims, indemnity claims, or when a subrogation investigation is necessary. Medical only contacts will vary based on the nature of claim and individual client service instructions. The employee is advised of acceptance or denial of claim within 3 days of decision or per jurisdiction requirement.

- d. The time frame in which initial contact with the medical provider confirming extent of injury and prognosis will be made

Initial contact is made with the medical provider within 1 business day of receipt of the claim.

- e. How often the employee and medical provider will be contacted

Frequency of contact is based on the individual factors of the claim including: medical complexity, medical treatment, and issues of compensability. Our examiners keep in close contact with the injured employee, medical provider and client to verify benefits are received timely, facilitate return to work and answer any questions they may have throughout the life of their claim.

- f. The frequency for which initial and status report will be provided to city on open cases?

Matrix will continue its current protocol for providing the City of Glendale with initial and status reports. The City of Glendale will have access to all current claim information and the ability to produce reports through our on line claim system, eServices.

- g. What your file diary policy is

All active claims must have an updated plan of action at a minimum of every 30 days. All other claims must have updated plan of action every 90-120 days pending the status of the claim.

Active Indemnity Claims

TTD being paid

Claim on delay

TTD pending

Early intervention or onsite nurse case management

Litigation

Hearing dates

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Outstanding subrogation issues

Stable and Mature Claims

Permanent Disability claims

Permanent Total claims

Medically Stable; routine care or prescription management

Any claims where benefits will be paid for a period of time without the need for active claims or medical case management.

If the claim is open for more than one year, indexing should continue every six months if appropriate.

Claim status changes, such as medical only to lost time or lost time to litigated, should be clearly documented as to why and when. The date of conversion should be considered the date of notice. Each converted claim should then be investigated and handled in accordance with these guidelines.

Any issues or barriers that prevent claim resolution must be identified and a proactive action plan implemented to resolve them. Estimated target dates for follow up or resolution should be evident.

Follow up activities that support case resolution action plans are controlled by establishing and maintaining appropriate diaries throughout the life of the claim. System diaries will reflect active management on all open claims. System diary controls are used appropriately with reminders set at a minimum of every 30 days unless the claim is considered stable and mature as indicated above. Claim activities are documented in electronic claim notes in a timely manner. All relevant claim developments must be documented in the claim. Documentation must meet performance and audit criteria with appropriate security coding.

**23) What your medical bill payment processing timelines are**

Medical bills are processed and paid with 15 business days of receipt of the required information.

- a. What documents and correspondence will be provided to city in regular course of business

State notices, correspondence and other documents requested by the City of Glendale will be provided. The City has access to all claims and reports at any time through eServices.

- b. Comment on your claims handling guidelines for personal interviews, telephone interviews, statements and outside investigations

Three point contact is made with the employee, medical provider and client within one business day of receipt of the claim. Our standards for employee contact and initial employee statement guideline will be appropriate for most claims. If

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statements or outside investigation is necessary, we will contact the City of Glendale for authorization to refer to an independent field investigator.

Telephone calls and electronic mail from employees and clients are returned within one business day and documented in claim system when contact is claim related. Time sensitive correspondence is responded to within 3 business days. Written communications are responded to promptly and in accordance with the urgency of the request, but in all cases within 10 business days. Letters and reports are well written and professional and comply with client and insurer reporting requirements.

All assignments to cost containment vendors, investigators, vocational rehabilitation counselors are clear, limited, approved by client or insurer where required, and managed effectively to maximize results and minimize expense.

The determination may be made that an independent investigation assignment be made. The client/carrier partner will be contacted for approval of the assignment if the client/carrier partner profile requires this level of approval. Matrix then will make the assignment to an approved provider meeting Matrix standards and client/carrier partner approval. The investigator must be qualified to complete in depth assignments including facts of accident/illness, witnesses, prior medical history, prior work history and understand the workers' compensation laws of the jurisdiction. It may also be appropriate for the investigator to interview witnesses, supervisor(s) and co-workers. All other client/carrier partner specific requests must be adhered to. The investigating company must also provide certification of insurance with Matrix Absence Management evidencing at least \$1 million in professional liability coverage and appropriate additional coverage's for workers compensation, general and auto liability.

24) Describe the details of the following services available from your firm:

- a. Office hours  
7 am to 6 pm
- b. Field Loss investigation  
We utilize independent field investigators with client approval.
- c. Special handling for high exposure cases  
We document specific special handling protocols with each client during the program implementation.

The requirements for the initial investigation of the claim and for ongoing claim review include a review of any diagnoses, litigation, reserves or other triggers that

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may indicate the potential for a high exposure. Supervisory oversight requirements include addressing any exposure risks and ensuring special handling instructions are being followed.

When total incurred on any claim reaches \$100,000, our system generates an automatic diary to the examiner and manager. This diary is to be used by the examiner and/or manager to monitor and identify large losses for closer scrutiny and any required reporting.

Legal defense issues are well managed to include clear direction and control. Assignments to attorneys limit the scope of attorney involvement to those activities that would not normally be carried out by the claims examiner. Ongoing communications with the assigned attorney are aimed at affecting a timely and appropriate resolution of the claims with a minimum legal expense and the best possible outcome for the client.

**d. Estimated future economic loss on cases**

Matrix reserves each case based on the facts of the claims. Reserves are continually reviewed to provide the most accurate financial assessment of the claim. Matrix does not provide actuarial services.

**e. Nurse case management on complex cases**

Matrix employs a team of occupational nurses to provide telephonic nurse case management services. Clients can elect to use Matrix occupational nurses or independent nurses of their choice. Matrix generates a monthly report identifying all new claims that fall within established flagging criteria: green, yellow, and red. If claims meet red criteria, the examiner and the nurse will triage the file to determine if nurse case management is appropriate. Referrals are dependent on client approval, on a case-by-case basis. The nurse will then facilitate treatment and early return to work release, to either modified or unrestricted duty, by working with the examiner, employer, employee, and provider. Modified duty is tracked until the employee is released for full duties or is deemed permanent and stationary.

**f. Legal and excess insurance carrier reporting**

Matrix will assume full responsibility for notifying the City of Glenda and the excess insurer of all claims or losses that may exceed the self-insured retention. Matrix will routinely update the City and the excess insurer with all necessary information about the status of such claims as determined and required by the insurers. Claim managers and examiners utilize the automatic diary feature in our claim system to set follow date to manage the notification and recovery with the excess carrier. Matrix will refer cases to counsel with client authorization.

**g. Safety and/or loss control services**

Matrix does provide safety or loss control services.

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h. Prescription drug cost containment

We have prescription drug cost cont available through Tech Health MSC. Both programs provide pres coverage at or below at the AZ fee schedule

i. OSHA 300 tracking

We are able to track recordable cases as determined by the City of Glendale.

25) Describe your willingness to agree to tailored adjustment service standards that would be mutually agreed to that would form part of the contract.

Matrix will work with the City of Glendale to develop mutually agreed upon claims management standards that can form part of the contract.

26) Describe what fraud detection measures you have in place including what vendor(s) you utilize for surveillance.

The Matrix Special Investigation Unit (SIU) Program is a comprehensive strategy designed to assist our claim professionals with preventing, detecting and investigating claims with suspected fraud. The Matrix SIU was created to provide the claims staff and our corporate clients with a national investigative program managed and staffed by experienced professionals. Matrix has contracted with the national insurance investigations firm of MJM Investigations, Inc. to be our managing preferred provider of special investigative services, surveillance, fraud and claim investigation training, SIU compliance and reporting. In addition to our managing preferred provider, Matrix SIU has created a panel of select providers recommended by our clients to provide some of our field surveillance and investigative activity. The Matrix SIU will conduct a complete due diligence background on the selected vendors and ensure their compliance with Matrix' fraud abatement strategy.

27) What % of claims are closed within one (1) year, two (2) years and more than two (2) years? Break out between medical only and indemnity claims.

Average closures by coverage are listed below:

		Within 1 year	Within 2 years	More than 2 years	Grand Total
LT	Number of Claims	1,839	496	76	2,411
	Average	76.28%	20.57%	3.15%	100.00%
MO	Number of Claims	8,993	448	12	9,453
	Average	95.13%	4.74%	0.13%	100.00%
Total Claims Reported		10,832	944	88	11,864
Average		91.30%	7.96%	0.74%	100.00%

28) Describe the processes and forms you have in place to comply with required ICA rules and regulations, for submission, etc.

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All of the necessary state forms are generated as part of the claim file and uploaded to the file. The state notifications are received and logged from the mail daily in order to assure timely filing.

29) Describe your process for:

30) Setting initial reserve levels

It is Matrix Absence Management's policy to establish loss reserves on each workers compensation claim based on the probable outcome of the claim. Initial reserves are established by the claims supervisor or manager when the claim is assigned based on the facts available at that time. The responsible claims examiner will then complete an investigation within ten working days and reevaluate the projected ultimate cost of the claim based on a review of the findings of the investigation, the medical prognosis, employee's work status, state regulations, etc.

31) Frequency of evaluation of reserve levels

Reserves are subsequently reevaluated if needed within 5 business days of any significant claim developments that may have an impact on the total cost of the claim and at least every 90 days throughout the life of active claims. Already adjudicated long-term disability and certain future medical claims are reviewed at least every 6 months for continued reserve appropriateness.

32) Changing reserve levels

Matrix's expectations are to reserve a file only six times or less during the handling of the claim.

33) Describe your type and frequency of communication with the city regarding:

34) Medical status of claimants who are on modified duty with work restrictions.

Contact will be made with the City following medical examinations in which there is any change in the employee's medical condition or work restrictions until the employee is working without restrictions. Type and frequency of communication will be based on the City's preference.

35) Case management of claimants who are off work and being paid total temporary disability benefits.

When a Matrix nurse case manager is assigned to a claim, he or she will contact the District following each medical examination until nurse case management services are terminated or the employee returns to work. Type and frequency of communication will be based on the City's preference.

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36) Will you provide a defense and indemnity agreement in our favor for Acts, Error and/or Omissions arising from your service?

Yes

37) Indicate any other service available from your firm.

In addition to providing all aspects of Workers' Compensation claims management, Matrix can provide clients with customized management of disability and family medical leave programs

38) Indicate any administrative requests your organization would have prior to award of a contract.

As the current claims administrator for the City of Glendale we would not have any administrative requests.

**Medical Management/Cost Containment:**

39) Describe provider networks utilized in Arizona, specifically in the Maricopa County area. If your firm is not currently familiar with the medical community of Maricopa County, describe how the assigned claims adjuster would establish knowledge and awareness of the various providers in this medical community and how the adjuster would develop a good working relationship with key medical providers (e.g. which doctors to recommend for various medical procedures, doctors to utilize for IMEs, legal teams, nurse case managers, and doctors that need to be scrutinized, etc.).

Matrix has established relationships with leading medical providers in Maricopa County. Our claims team uses open communication to try and establish a good working relationship with key medical providers. Matrix also utilizes a search engine provided by our vendor partner to assist us as well.

40) Attach a list of the preferred specialists you utilize in the Maricopa County area.

Please visit the website listed for a complete list of preferred specialists in Maricopa County. [http://intranet/claims/wc/TalisPoint\\_FH\\_Network\\_Referral\\_Sys.doc](http://intranet/claims/wc/TalisPoint_FH_Network_Referral_Sys.doc)

41) Attach a list of the preferred legal firms you utilize in the Maricopa County area.

Jones, Skelton & Hochuli, P.L.C

Contact: Charles Rehling (602) 263-7355

Cross & Lieberman, P.A.

Contact: Larry Lieberman (602) 650-2856

Klein, Lundmark, Barberich & la Mont, P.A.

Contact: Todd Lundmark (602) 279-9777

42) Provide the names of the rehabilitative service providers you use for referrals.

We have established relationships with various vendors based on client choice. Our vendor partners include: Intracorp, and Genex.

43) Provide the names of the nurse case managers and their respective firms.

Joetta Chapman and Sandy McNally, Matrix Absence Management

Julie Lindstrom, Bass and Babb

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44) How do you recognize the need for treatment by a specialist?

All claims management efforts are focused towards achieving timely maximum medical improvement. Referrals to appropriate specialists are part of our claims management process and identified through interaction with the employee, employer, treating doctor and through routine review and diary follow up. Examiners can utilize the team of Matrix occupational nurses to assist in determining the need for a referral to a specialist. Statutory requirements are always part of the equation in directing medical care.

45) Explain your method for managing chiropractic care.

Chiropractic care, as with all medical treatment, is reviewed and approved based on the facts of the claim and the jurisdictional limitations. Chiropractic bills are reviewed by our bill review system and can be supplemented by one time on-site chiropractic consultants looking at frequency of treatment, treatment plans, and charges. All bills are reviewed retrospectively to determine necessity and reasonableness of treatment.

46) What are your guidelines regarding the frequency and duration of physical therapy approved by your staff?

Initial physical therapy approvals are based on the recommendation of the treating provider and the known medical facts regarding the claim. Typically, a two to three week period, with therapy two to three times weekly is approved to give enough time to determine if the condition is improving based on the therapy. Additional approvals are based on the employee's positive response to the treatment plan indicating the prescribed therapy is resulting in returning the employee to pre-injury status. Physical therapy is assigned through our vendor partner, PTPN. We are committed to get each injured worker back to work as quickly as possible. We ensure the employee receives quality service through PTPN. The Matrix examiner will check the progress of a patient mid-treatment to insure they are complying with the treatment plan and receiving maximum medical benefit. If there are any issues or "no shows" by the injured worker, the case manager and adjuster are immediately notified. Physical therapy bills are always reviewed for necessity and reasonableness.

47) How frequently do you request medical status reports from treating physicians?

We request medical status reports following each office visit to effectively manage each claim and the employees return to work. Additionally, the examiner may pose questions to the provider to facilitate return to work or understanding of the treatment plan and the employee's response to treatment as required to direct the claim toward resolution.

48) Describe utilization review practices.

In applicable jurisdictions we are in compliance with and perform claim management in accordance with all laws mandating this practice. In non mandate jurisdictions, we utilize both internal and independent medical resources to quickly resolve complex problems.

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49) Describe your process of ordering, approving and paying for:

- 50) IME's
- 51) Working hardening
- 52) Back school
- 53) Long term rehab
- 54) Vocational retraining
- 55) Nurse case management
- 56) Legal defense
- 57) Surveillance

Clients can elect to pre authorize approvals all services listed above. Once authorized by the client, the examiner will either make the referral directly or make the appropriate referral to the vendor of choice. All bills are customarily paid within 30 days.

Medical and vocational management is appropriately assertive and directed to a successful return to work or other appropriate claim resolution, with timely referrals to assist in managing issues.

58) Describe your case management practices. Identify under what circumstances you assign medical management and within what time frame.

During implementation we provide our clients with our best practices for case management and then determine use of case management based on the client's philosophy. We have programs where cases meeting specific criteria are immediately referred to a nurse case manager. Other programs are case by case requiring client approval before making a referral. Clients may utilize our internal staff of occupational nurses or select independent nurse case managers.

For clients who have elected to participate in the Matrix Early Intervention program, qualified claims are assigned automatically within 24 hours to a nurse case manager based on client protocols. For others, the claims examiner will review serious injury claims with a nurse case manager. If medical case management is deemed appropriate to the claim, the claims examiner will request approval for the referral if required by the client or their insurer.

59) Describe your disability management practices related to disability assessments, coordination of light duty/alternative work, ergonomic workplace assessments and other programs, which facilitate the return to work.

Disability assessments, coordination of light duty/alternative work, ergonomic workplace assessments are part of our routine claims management practices. We will work closely with the client, its medical providers and its individual employers to identify modified duty positions where warranted.

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Permanent disability exposure is evaluated promptly and paid timely and accurately in accordance with the applicable jurisdiction's requirements.

**Claims Processing:**

- 60) Describe your internal claims paying system. Indicate the degree to which it is fully or partially manual and/or automated. (Please include a description of the manual or automated capabilities for adjudicating negotiated rates, including ICA allowable, flat discounts off billed charges, per diems, fixed case arrangements, R & C fee schedules, conversions rates, etc.

Coventry Workers' Comp Services provides a national, rules-based bill review system that has the flexibility and scalability to accommodate the needs of virtually every payer. This system is unique as it runs on a truly Web-centric platform utilizing the latest in Enterprise Java Bean (EJB) and Web application server technology. Coventry has incorporated the latest technology related to state fee schedule rules and proprietary clinical edits, to deliver optimal savings to our customers. The bill review system provides added value to clients by evaluating every savings opportunity on a bill. In addition to automated fee schedules, the system automates provider contracts and code-specific edits to ensure that all potential savings are applied. If, for some reason, a particular item cannot be automatically applied, an edit will appear for the processor with specific instructions regarding how to resolve the edit. Additional automated features include automated claim selection and automated organization selection.

First payments of temporary total or temporary partial disability compensation are issued within 14 days of the first day of disability, within 7 days from receipt of a late first report of injury, or as otherwise specified by jurisdiction and are accurate based on wage information provided by the employer and the jurisdiction's waiting period, and dependent allowance

Subsequent benefit payments are issued every 14 days or as otherwise required by jurisdiction and accurately based on wage statement and include any required adjustments. Waiting periods are paid promptly when retroactive period has expired, if not already included in the first payment

Payments may be set up to automatically generate once the period of time for either a temporary disability or a permanency award is established. Payment diaries are set by the examiner with supervisory oversight to ensure payments are generating and appropriate payment termination dates are set.

- 61) For each of the following processes, label your response as to whether your claim system handles the task in an Automated (A) manner, uses Manual Review (MR), Out Sourced (OS), or Not Checked (NC).

62) Total charges against total allowable payment; OS

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- |   |    |
|---|----|
| 63) Checks for duplicate charges;   | OS |
| 64) Uncashed checks   | OS |
| 65) Compares number of inpatient hospital days on each claim, against admission and discharge dates approved by U.R. firms;   | OS |
| 66) Assures services are provided within scope of a work related injury/illness;  | OS |
| 67) Identifies excess "usual, customary, and reasonable" charges (R & C)) for non ICA fee schedule services;  | OS |
| 68) Identifies inaccurate ICA fees for services billed;   | OS |
| 69) Verifies that a provider is licensed to perform the type of procedure billed;   | OS |
| 70) Identifies that the provider is a participant in a Preferred Provider Organization (PPO) especially one who has multiple locations or tax identification numbers; | OS |
| 71) Reconciles the diagnosis code to the procedure and sex code for consistency;  | OS |
| 72) Overpayment/underpayment;   | OS |
| 73) Pending claims  | A  |

- 74) Describe any significant manual operations required by the claim system, such as acquisition and maintenance of claim files, manual calculations, etc.

The claims system is automated without significant manual operations.

- 75) Describe your diary and follow-up procedures for claims in which additional information is required.

The claims manager or supervisor will establish a diary to follow up on questionable claims investigations and will review and authorize all first payments, delays or denials recommended by the examiner. Time frames for acceptance or denial are governed by state law – and are closely tracked through system diaries and on-line reports. Matrix will notify the injured worker of the decision to delay the claim in accordance with client/carrier partner's instructions and state law. Examiners will complete their initial investigations, complete a reserve worksheet to calculate the ultimate anticipated cost of the claim, and develop a plan of action for managing the claim within 10 working days. On accepted claims, examiners will complete required state forms and authorize first payments in accordance with the jurisdiction. Subsequent payments will be scheduled in accordance with regulations and medical authorizations will be obtained for any additional periods of disability. Final medical reports are sought to establish whether or not the injury has resulted in any permanent disability, which will result in additional benefits or a negotiated settlement in accordance with jurisdictional requirements and client/carrier instructions

- 76) Attach a list of all data elements tracked in your claims management information system.

A list of data elements is included in our proposal response.

- 77) Do you require progress notes to be submitted with all bills prior to payment?

Yes.

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78) If not, what types of bills do not require progress notes?

79) Indicate your payment accuracy percent (percent of claims without dollar error) and date of your most recent audit results.

32 files were reviewed for two examiners for the months of May through July 2007. The audit categories are first pay and subsequent pay which would equal 64 possible answers.

30 were "yes", 1 was "no" which equals a 97% accuracy rate by file (not payment, do not have payment totals), 33 responses were not applicable.

80) How do you determine whether any physician, provider and/or hospital charges submitted were for services actually rendered?

This is a combined responsibility of Matrix and Coventry. Through the clinical edits in the bill review system, Coventry works to detect unbundled, mutually exclusive, and incidental procedures. We routinely receive enhanced savings through the identification of inappropriate treatment intensities for a given diagnosis or treatments that exceed the needs of an injured worker. The claims adjuster also ensures the procedures are related to the reported injury. All doctors within the Coventry networks undergo a stringent credentialing and re-credentialing process that will help ensure that if injured worker treats with a network provider, the provider is likely to provide better quality and behave in an ethical manner

81) How do you identify and address providers who overcharge or perform unnecessary procedures.

The bill review system employs a wide range of cost-containment edits, which can be grouped into two classes; state fee schedule rules and clinical edits. The specific types of clinical edits, such as unbundling of services, are outlined in greater detail below and would include identification of inappropriate diagnostic testing. State fee schedule rules can include several key edit types including:

- Modifier Validation
- Code Attribute Checks (gender, age, validity)
- Modifier Pricing (multiple procedure, assistant surgeon, etc.)
- Utilization (Physical medicine services)
- Procedure to Diagnosis Validation
- Work/Injury Related Diagnosis
- Global Surgical Period

Identification of provider billing anomalies is as much a part of the bill review system as is the pricing of procedures. Various parts of the system work together to assist the process in creating the maximum savings possible on any individual bill.

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As mentioned, a significant portion of the bill review savings includes system edits known as "Enhanced System Savings". These edits are supported by clinical logic that has been developed by clinical experts within Coventry Workers' Comp Services. National Correct Coding Policy Manual (NCCPM), Current Procedural Terminology (CPT), and the American Academy of Orthopedic Surgeons (AAOS) are the primary basis for the clinical edits. A rationale statement has been written for each clinical edit to describe the reasons that the system is recommending a change in payment. These rationale statements are also available to assist the adjuster with explanations as to why a specific bill has been reduced.

The system precisely detects unbundled, mutually exclusive and incidental procedures. Our clients routinely receive enhanced savings through the identification of inappropriate treatment intensities for a given diagnosis or treatments that exceed the needs of an injured worker. With the exception of the CPT, which is maintained by the American Medical Association, the Healthcare Financing Administration (HCFA) defines most coding systems.

Coventry Workers' Comp Services has an on-going clinical edit review process coordinated by a Corporate Steering Committee. Clinical edits and rationales are under constant review, especially when procedure code updates are released. In addition, when state fee schedule updates are released, clinical edits are evaluated against fee schedule rules and regulations and any conflicts are resolved as part of the fee schedule implementation process.

*Unbundled procedure codes* are identified in the bill review system, according to state-specific guidelines and medical policies. Procedure unbundling occurs when two or more procedure codes are used to identify a service when a single, more comprehensive procedure exists to describe the entire service performed. When unbundled services are detected, our bill review system automatically bundles the procedures to the correct procedure code. Occasionally, the correct code is not present on the provider's bill. In this case, our bill review system will automatically add the correct procedure code and price accordingly.

*Incidental procedures* that are commonly performed as a part of a larger procedure are edited in the system. For example, if an injection procedure is billed in conjunction with a tendon repair, the system will identify the injection procedure as an incidental procedure and deny the charge.

*Mutually exclusive procedures* are those procedures that should not be performed during the same visit. The system will automatically identify mutually exclusive procedures and recommend payment only for the most clinically intensive procedure performed.

*Fragmented procedures* are also identified by our bill review system. A fragmented bill is a bill which the provider submits only a portion of the services. The secondary billing includes additional services on the same or different date of service. Our bill review system performs edits and audits on a line-by-line basis and uses other service lines on the bill and in the history database to determine appropriate adjudication.

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*Procedure to diagnosis relationship* edits examines diagnosis codes that are not related to the procedures with which they are billed. A series of edits were created to alert the processor of billing inconsistencies in the areas of radiology and surgeries involving the muscular-skeletal system. These edits can be assigned a severity to disallow services or suspend bills for manual review.

*Outpatient utilization monitoring* is a feature that utilizes a statistical database which contains over 2,000 diagnosis codes and the corresponding number of visits, by percentile, that represent the norm. The client can choose the percentile and the system will identify the number of visits exceeding the parameters. The system can be set to simply print a message on the explanation of review, or can suspend the bill for further review.

Coventry Workers' Comp Services provides an Explanation of Review (EOR) to providers which clearly identifies reductions from applying the fee schedule (UCR if applicable), clinical edits and PPO discounts, as appropriate, and the reasons for the reductions.

Coventry Workers' Comp Services has developed its bill review system to systematically detect for the types of items that may have previously required clinical intervention or review. Our enhanced system savings fully automates all fee schedule rules while also applying clinical edit logic that detects for things such as unbundling, up coding, incidental and mutually exclusive procedures. If the client desires a greater subset of bills or attachments to be reviewed (for example, surgery bills or bills over a specific dollar threshold), we can activate edits within the bill review system to pend specific bills for supplemental review.

- 82) Describe methods utilized to investigate suspicious (possibly fraudulent) Worker's Compensation claims (e.g., surveillance, etc.).

Matrix and its employees are committed to the highest ethical standards to accurately and timely fair evaluation and investigation of each claim utilizing vendor partners that share the same commitment to ethics and the spirit of workers' compensation. At the time of intake claims that potentially require investigation are flagged. The claims examiner evaluates the claim and collects necessary medical information. It is the responsibility of the claims examiner to determine subrogation or fraud potential, and the need for investigation. Matrix generates a weekly report identifying all new claims that fall within established flagging criteria. Matrix will contact the City of Glendale for authorization to arrange for the investigation of appropriate questionable cases. All questionable and litigated claims will be closely managed by the Matrix examiner, who will coordinate the efforts of our attorney and investigator in preparation for litigation and Industries and any subsequent appeals.

**Bill Review**

- 83) When responding to questions in this section, confirm your data:
- a. Does not include duplicate charges and/or savings

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b. Savings reflect the net impact of reconsiderations (i.e. savings adjusted down to reflect impact of reconsiderations)

84) List in detail the pricing you propose to charge for each of the following services:

85) Medical bill review

86) PPO access fees for each available network you propose to use

87) Negotiated discounts

88) Hospital bill Other

The pricing for these services is provided in our service agreement included in our proposal response

89) For each of the above services, will the fee be charged to the city as an allocated or unallocated claims expense?

These fees are charged as an allocated expense.

90) For each arrangement noted above, state the portion in percentage or points that your firm shares with any outside or affiliated firm providing the service.

50 cents per bill.

91) Of the firm noted above, which would you recommend city use and why?

Matrix uses Coventry/FH for all bill review and cost containment services for improved efficiency and overall cost savings.

92) State your best contracted discount for trauma care and per diem non-trauma for the following hospitals

	i. Trauma care	Non-trauma
93) John C. Lincoln 7 <sup>th</sup> Street	No special rates.	Rate based on FS reduction or total charges. Average savings is 38.5%.
94) Thunderbird Banner	No special rates.	Daily per diem rate or reduction based on billed charges. Average savings is 39.2%
95) St. Joseph's	Not a PPO provider.	Not PO Provider.

These providers may be nominated. The client representative or adjuster may obtain a Provider Nomination card to complete and forward to the provider for review and submission if the provider is interested. Upon receipt from the provider, the nomination card is screened in the First Health provider database to determine whether the provider is currently in the network or is under consideration. The non-contracted nominees are logged into the nomination database within five business days.

Their system allows them to electronically log and track all provider nominations. First Health staff has on-line, real time access to track the status of providers throughout the credentialing process. This application helps to ensure that nominations are processed and the credentialing process completed expeditiously. The negotiator produces a report once a week to identify new nominees.

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Provider nominees are sent an information packet within five business days. Within seven days of mailing the packet, each provider is contacted to determine eligibility and interest in the network. First Health places additional follow-up calls to the provider's office, if necessary.

Once First Health receives a completed application, they begin the credentialing process. The assigned account manager will receive a monthly status report to track the progress of the nominee, which he/she then can communicate to the client.

If First Health is unable to obtain a response from the nominated provider, we will communicate with the provider to support their efforts.

- 96) Provide costs savings figures (billed vs. re-priced, % discounts) for hospital, durable medical equipment, radiology, laboratory, .... for your network providers located in the metropolitan Phoenix area during the period January 1, 2007 through December 31, 2007 (excluding duplicate billings). Identify the names of the networks included in the development of the savings report.

The Coventry Workers' Comp Network would be utilized. The average hospital savings in 2007 for the Phoenix, AZ market is 38.7%. The average inpatient hospital savings for John C Lincoln is 38.5%. The average inpatient hospital savings for Thunderbird Banner is 39.2%. In the metropolitan Phoenix, AZ area during the period of January – December 2007, the average savings (excluding duplicates) was \$1,869,318. This is based on professional service type bills only.

- 97) For hospital bill audits/review  
Coventry/First Health

- 98) Do you use your own staff or subcontract?  
We subcontract to Coventry/First Health

- 99) What is the professional experience of the review analyst to be assigned our program?  
Coventry requires Registered Nurses who are trained in conducting hospital bill review audits by their audit supervisor.

- 100) What types of claims are chosen for a bill audit?  
Hospital Bill Audits are usually reserved for bills in excess of \$8,000. The claims type will vary.

- 101) How are sizable and/or key claims flagged?  
Bills are flagged by cost within the bill review system.

- 102) How is the audit conducted?  
The audit is a line item review of all charges associated with a hospital stay and a comparison of the medical documentation to ensure all charges are substantiated in the chart.

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103) How is recovery conducted?

Hospital bill review audits are performed before payment is recommended. Once an audit is completed, Coventry sends the report to Matrix with payment recommendations. We provide the report to the hospital with the payment.

104) What are your or subcontractor fees for this service?

Fees are based on a percentage of savings.

105) What percentage of savings is realized on an average audit?

Averages savings for inpatient bill is 40.4% and the average for outpatient facility bills is 59.5%.

106) Other than reducing bills to the state's fee schedule, what other methods does your firm deploy to provide for further reductions (i.e. upcoding, unbundling, disallowed items, cascading, duplicate bills, unauthorized charges, durable medical items, etc.)?

The Coventry bill review system employs a wide range of cost-containment edits, which can be grouped into two classes: state fee schedule rules and clinical edits. The specific types of clinical edits, such as unbundling of services, are outlined in greater detail below and would include identification of inappropriate diagnostic testing. State fee schedule rules can include several key edit types including:

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Identification of provider billing anomalies is as much a part of the bill review system as is the pricing of procedures. Various parts of the system work together to assist the processor in creating the maximum savings possible on any individual bill.

As mentioned, a significant portion of our bill review savings includes our system edits known as "Enhanced System Savings". There are edits in the bill review systems that are supported by clinical logic that has been developed by clinical experts within Coventry.

The primary resources for the clinical edits are the National Correct Coding Policy Manual (NCCPM), Current Procedural Terminology (CPT), and the American Academy of Orthopedic Surgeons (AAOS). A rationale statement has been written for each clinical edit to describe the reasons that the system is recommending a change in payment. These rationale statements are also available to assist the adjuster with explanations as to why a specific bill has been reduced.

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The system precisely detects unbundled, mutually exclusive and incidental procedures. We routinely receive enhanced savings through the identification of inappropriate treatment intensities for a given diagnosis or for treatments that exceed the needs of an injured worker.

Unbundled procedure codes are identified in the bill review system, according to state-specific guidelines and medical policies. Procedure unbundling occurs when two or more procedure codes are used to identify a service when a single, more comprehensive procedure exists to describe the entire service performed. When unbundled services are detected, our bill review system automatically bundles the procedures to the correct procedure code. Occasionally, the correct code is not present on the provider's bill. In these cases, the bill review system will automatically add the correct procedure code and price accordingly.

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as unbundling, up coding, incidental and mutually exclusive procedures. However, if the client requires a greater subset of bills or attachments to be reviewed (for example, surgery bills or bills over a specific dollar threshold), we can activate edits within the bill review system to pend specific bills for supplemental review.

107) What does your firm use to determine the benchmark for usual and customary fees?

Currently the baseline Coventry will use for establishing the work comp allowable in non-fee schedule states or unvalued codes in fee schedule states is the 80th percentile of Ingenix's MDR product, whenever possible.

108) Describe your savings approach to non-participating network facility bills.

We utilize the Qmedtrix Non-Network program. This program identifies inflation and reprices the charges to a fair and reasonable allowance using historical charged and accepted fee data for both out-of-network and contracted medical services.

Typically, bills sent and received electronically have a turn around time of one business day or less, and paper bills usually take three business days or less, unless further review is necessary. Procedure codes are grouped into logical categories based upon similarity of service and resource utilization. A base allowance is then determined for the assigned code group. BillChek determines a fair and reasonable amount using historical charged and accepted fee data that is continuously updated and includes over 100,000 providers and facilities from national and regional sources across the industry. A geographic adjustment factor is applied to the base allowance using nationally recognized adjustment sources to reflect charges that prevail in the community.

109) What dollar thresholds are employed and what is your average savings on these bills in Phoenix?

Non-network dollar thresholds and bill types:

Inpatient Hospital: Total Charges > \$2500.00

Outpatient Hospital: Total Charges > \$2000.00

Hospital Emergency Room: Total Charges > \$2000.00

ASC: Total Charges > \$1000.00

For the Phoenix, AZ area our average savings for inpatient bills is 40.4% and our average savings for outpatient facility bills is 59.5%.

110) Describe your internal audit process and/or quality assurance program to validate the quality of bill review.

Coventry Workers' Comp Services understands the critical importance of providing accurate and timely repricing results. Their Quality Assessment (QA) Department conducts ongoing, daily internal bill audits as part of our quality improvement program. QA performs the independent, random bill review audits to confirm that bills are priced correctly, in accordance with state fee schedules, the provider contracts and Coventry Workers' Comp Services policies and procedures.

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The QA department determines an appropriate sample size for the random bill audits to ensure the statistical validity of the sample findings. QA regularly reviews the sampling methodology and sample parameters, including the bills processed volume, historical proportion of error, desired confidence level, and +/- error bound. Current sample parameters are set to support monthly accuracy estimates at the bill review office level with a 95% confidence level, an error bound of 2.5% and a 2.5% proportion of error. The audit staff selects the sample daily. Bill review auditors review the bills selected to verify that:

- 1) The correct provider record was selected either manually or by the system.
- 2) The bill was correctly repriced in accordance with the state fee schedule and/or provider's contracted rates.
- 3) Coventry Workers' Comp Services policies and procedures were followed.

Individual processors regularly receive feedback from daily random audits. Bill review management reviews the audit results and implements corrective action at the individual processor level. Retraining and colleague counseling is handled on a per-case basis. In addition, summary internal management reports are produced monthly at the office and department level. QA recommends corrective action plans or develops corrective action plans in collaboration with bill management, based on aggregate trends and error patterns. QA monitors the implementation of corrective actions and measures their effectiveness.

**111) Can your organization accommodate a bill review deliver model employing scanning technology?**

Coventry Workers' Comp Services provides front-end processing to us allowing an electronic process of imaging, data capture, storage of bills, EOB's and billing attachments. The workflow includes scanning, optical character recognition (OCR), formatting, storage, distribution and retrieval. Coventry Workers' Comp Services front-end system scans and indexes all bills for an electronic input into the bill review system. The electronic data file pre-populates the bill review system, eliminating the need for manual bill entry, which increases the level of efficiency and data accuracy. All scanned bills can be sent via EDI to the bill review system daily or multiple times per day. Medical record attachments are scanned and are accessed via web-browser by us.

**112) Describe your electronic data interface capabilities including:**

**113) Mediums employed to transmit payment, fee and vendor information**

The Coventry bill review system supports numerous standard data exchange inputs and outputs. Additionally, they offer more advanced exchange options through the use of their EDI translator services unit.

Coventry Workers' Comp Services currently employs proprietary formats for EDI transmission, but has significant experience in working with standard ANSI formats such as the 837.

The most common EDI connectivity options currently utilized between Coventry Workers' Comp Services and our clients are the following:

FTP

- FTP with PGP encryption.

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- Coventry Workers' Comp Services or client can initiate the connection.
- We support active or passive mode FTP.
- PGP software is required to encrypt and/or decrypt files.

SSH FTP (SFTP)

- Coventry Workers' Comp Services can push files to an SFTP server.

FTP over VPN

- FTP client/server must support RFC959.
- Coventry Workers' Comp Services or client can initiate the connection.
- We support active or passive mode FTP.

Direct Connect

- Extranet - this connection type is available for non-PHI data.
- Dedicated line - preference is FTP over VPN.

All EDI input records received from clients are sent through a scrubbing routine to validate the format and that required data elements are present. If the scrubbers identify a file and/or a record that does not pass the edits, an exception report will be created and sent to the client noting the file and/or record that was in error and the type of error.

114) Steps and procedures for client conversion

Not applicable as Matrix is the current workers' compensation administrator for City of Glendale.

**Claims Management Information System (CMIS):**

115) Describe your firm's CMIS including how long it has been in existence and if it was developed in-house or purchased by a vendor.

We purchased our claims system in 2004. Please review the information regarding eServices for a detailed description of the systems capabilities.

116) Specifically note the time lag between the date of loss notice to the TPA and input of loss information into the CMIS.

Input of loss information is the same day.

117) Identify the date in the month for which city can expect to obtain loss summary reports with valuation dates ending the month prior.

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Reports are available on demand for any period of time. They can manually or automatically generated by the users with access to our online claims system, eServices.

- 118) Identify whether your system allows for entering recoveries as a city line item for a given claim prior to the total incurred amount being netted out. Describe if subrogation recoveries received by and payable to city vs. the TPA can be captured in your CMIS reports.

Subrogation recoveries can be entered as a separate line item for a claim prior to the total incurred amount being netted out. Subrogation recoveries are captured in our RIMS reports.

- 119) Describe the ability to customize reports to city needs and estimate of associated fees.

Customized reports are available through eServices and can be programmed directly by the client at any time. Customized reports can be schedule to run on a regular basis and emailed into the clients in box. If programming is necessary to create the report those fees are billed at \$150 per hour.

- 120) Describe to what extent city would be able to directly access your system including adjuster's activity notes.

Authorized users designated by the City of Glendale will be provided a user name and password to access our online claim system, eServices. Users can have access to all information, including financial, medical and claim notes or limited access.

- 121) Does your information system allow ad hoc or client generated reports?

Yes.

- 122) Does your information system allow the client direct Internet access to claim files including financial data, adjuster notes and activities?

Yes.

- 123) How frequently is the information system data available to the customer updated?

Information is updated nightly.

- 124) What is the lag in the time your claims office receives notice of an injury to the date it is entered into the information system?

Through our intake system, information is electronically entered into our system within two hours of notification of a new claim.

- 125) Attach background information regarding your CMIS including all capabilities available that are included in the proposed pricing.

Information regarding eServices is included in our response.

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**Third Party Administration - Workers' Compensation Claims**

126) Enclose samples of reports that will be available to the city on a monthly, quarterly and annual basis.

Sample reports are included in our proposal response.

127) As a condition to award of this contract, the successful offer or will be required to convert the existing third party administrator's existing electronic claims summary information for closed and open claims to the offertory's system at no cost to the city within 60 days after being supplied with the data. Do you agree to this stipulation?

Not applicable Matrix is the current administrator.

128) Attach proposed and signed service contract.

A proposed and signed service contract is included in our proposal response.