WORKERS COMPENSATION CLAIMS MANAGEMENT OVERVIEW

Managing workers compensation claims effectively requires more than simply receiving a claim, reviewing its merits, and processing it for payment. At Gallagher Bassett, our formula for success can be described as "hands-on" and "mind-engaged."

Every Gallagher Bassett professional is completely "hands-on" where your account is concerned, assuming personal responsibility for high performance and results.

Our minds are actively engaged when it comes to the analysis of each claim. We scrutinize each claim for its accuracy and truthfulness, its ultimate cost potential, and other factors that could affect its outcome.

We leverage this formula to produce exemplary levels of service, avoid mistakes, and increase efficiencies and cost savings. You'll find our formula is at work during each of the following steps of the workers compensation claims process as we...

- Review and process all industrial injury cases in accordance with the requirements of state administrative agencies for reporting and notification.
- Determine if compensation is due as a result of injuries or illnesses, in accordance with state law.
- Determine the claimant's eligibility for medical benefits and authorize payment.
- Authorize medical examinations to determine the nature and extent of the disability.
- Determine the claimant's eligibility for temporary disability compensation, authorize payment, and coordinate medical and rehabilitation efforts.
- Determine the extent and degree of permanent disability utilizing the necessary and appropriate medical sources or advisory bodies.
- Determine and initiate appropriate managed care processes.
- Authorize permanent disability compensation and death benefits in accordance with advisory ratings, orders of the administrative agency, or settlement agreements.
- Maintain current estimates of the anticipated cost of all benefits on each claim.
- Initiate the investigation upon receipt of the claim file or upon receipt of new information that may impact claim exposure. Develop short and long term strategies and plans to bring the claim to resolution in an efficient manner.

Everything works together to ensure efficient claims processing. Our highly experienced staff monitors claim actions through the local resolution manager, claim supervisor, the branch manager, Quality Assurance Department, and the home office executive staff.

Our branch offices are subject to an internal audit to verify that your requirements are being met and that the unit is adhering to our established professional standards. Audits determine if branches are complying with state regulations and communicating properly and promptly with all involved parties.

Program implementation and administration

The secrets of success for our workers compensation claims—designing a total system

At Gallagher Bassett, we design your workers compensation claims management program as a total system, with all the elements in place that help ensure cost savings and full control of claims activities.

One of our most important jobs is to work with you to review your corporate concept of workers compensation claims management. We're happy to assist in creating that definition and in suggesting procedures and techniques that will serve as an underlying framework for ongoing program management and total system support.

Ensuring program control and coordination

Your program will increase control and reduce costs of work related injuries. It will improve employee relations by providing the required benefits promptly and through the sensitive handling of injured employee problems. These goals

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can only be achieved if those in charge at your organization understand the program, how it operates, and its objectives. This includes individuals like first-line supervisors, who generally report the injury and refer employees for medical treatment. If they are informed and interact efficiently and sensitively with employees, all parties will feel, and will be, well served.

Everyone involved in the process must understand the general system and their important role in it. Here, we can help by developing a program to orient all staff members who are directly or indirectly involved in the processing of incidents and claims. Or, if you prefer, we will provide advice and assistance on how to structure and conduct meetings and training sessions with department heads, supervisors, and other employee groups.

Utilizing forms management

When it comes to forms, Gallagher Bassett exceeds the norm—providing you with every form necessary for documenting and reporting industrial injuries, physicians' findings, claims administration, program coordination, and internal corporate fiscal information. If you need a special form for workers compensation processing, we'll be happy to help design and develop it.

Building flexibility into your program structure

No program is or should be static. Maintaining efficient operations and consistent policies and objectives requires constant monitoring and review. At Gallagher Basset, we build flexibility into your program structure so that we can respond effectively to change or take advantage of opportunities that emerge in your workers compensation claims management program.

Our representatives will meet with your staff periodically to review the status of your program and to identify and resolve any problems that may arise. We are always on call to respond to your needs.

Complying with laws and regulations

The laws, rules and regulations governing workers compensation claims change constantly, as do the decisions of responsible administrative agencies. We will alert you to changes that could affect your program and will provide you with practical information and advice on how to deal with anything new that needs attention.

Medical management programs

A strong claims management program demands strong management of medical treatment and health care resources in order to ensure high-quality care for injured employees.

Building a powerful program that contains costs also requires prompt access to medical records so you can swiftly determine if compensation is necessary and what benefits to provide.

We flex additional cost-saving power by designing programs that allow you to exert maximum control over your workers compensation medical expenses. We make this possible through an extensive array of services, which include:

- Fee Scheduling
- Usual, Customary and Reasonable Bill Review
- PPO Hospital and Outpatient Care Networks
- Utilization Review Programs
- Medical Case Management and Vocational Rehabilitation
- Telephonic Management Programs
- PPO Retail Pharmaceutical Networks
- Wholesale Prescriptions and Medical Equipment Programs
- Hospital Bill Audit Programs
- Return-to-Work/Post-Loss Activities Programs
- 800 Claim Reporting
- Electronic Workers Compensation Claim Reporting Software
- Managed Care Organizations (MCOs)
- Dental Program
- Integrated Disability Management

We use technology to great advantage in the managed care arena and have established a technologically advanced electronic communication link with our managed care joint service providers. This data link creates substantial cost-and-time savings by providing you with more comprehensive reports, including monthly cost savings.

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Workers compensation reserve management

Helping you set aside less, so you can work with more
At Gallagher Bassett, we recognize the critical importance of reserve management and work to help you set aside only the funds you need to resolve a claim. This frees up your funds for better use and a potentially greater return elsewhere.

Effective reserve and money management can't be left to "best guesses." We try to make a science out of it by combining our extensive experience with sophisticated and proprietary Gallagher Bassett tools and methodologies.

We get down to more accurate reserve management legally
We approach the establishment of the reserve by analyzing the specific claim against the backdrop of state workers compensation laws. The customs and practices of the state's board or commission are also considered. We also take into account the characteristics of the claimant, the work record of the employee, the nature and extent of the injury, type of job, age of the employee, wage level, availability of light-duty work, motivation of the employee, and the legal involvement.

Possibly the greatest factor influencing the outcome of a claim is the injury suffered and the surrounding pathology. These characteristics provide the major "scientific" clues to the anticipated length and type of treatment, the amount of time that will be lost from work, and any possible permanent damage suffered by the employee. These factors directly and measurably affect your liability, which is why we make it a clear and well defined practice to evaluate the reserve each time the file is handled.

Ensuring consistency in establishing reserves comes next
At Gallagher Bassett, we've developed a reserve worksheet for use in files with total experience over $5000. This provides an excellent tool for our staff to use in evaluating the status of reserves in each of the four categories: indemnity, medical, rehabilitation and expense.

We further enhance the reserve process with sophisticated tools, including waypoint®
waypoint® is a cutting edge system developed in a partnership between Gallagher Bassett and Milliman, two of the industry's top names in reserving. waypoint® combines GB's "on the ground" insight into multi-jurisdictional reserving with Milliman's actuarial expertise, in a sophisticated predictive modeling system for individual claim and aggregate ultimate.
waypoint® is one solution to reserving problems that have plagued the industry for years and have become only more complex with changing business, regulatory, and legislative environments. The demands faced by the best claims professionals are such that top-tier claims management organizations will provide them with the best tools in the industry to extend their ability to analyze claims and move them to conclusion. This is especially important for difficult and impactful areas such as reserving.

waypoint® thereby brings to bear the combined claims experience of these two respected organizations to give our claims professionals the best that the industry has to offer. Even better, waypoint® evolves and grows continuously as it receives new claim data, industry changes, and other information.

Waypoint® has been developed specifically to produce the most accurate predictions for GB claims and interfaces directly with our own RISX FACS® system.
Each week, RISX FACS® (our risk management information system) transfers information on all new and existing claims that have experienced activity over the course of the previous week to the waypoint® database, which then calculates accurate per-claim dollar estimates for medical, indemnity, vocational rehabilitation, and expense reserves. These models are based on Gallagher Bassett's past total claim experience and the workers compensation laws for each individual state.

The end result of this detailed and sophisticated Gallagher Bassett approach to reserve management is a figure for reserves, which can be completely trusted for its accuracy with one addition—the skill and detailed understanding of individual claims that our resolution

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managers bring to the process.

Suiting Up for Litigation Management

We work to make sure you are well covered legally
With your approval and direction, Gallagher Bassett will recommend legal services whenever a claim results in litigation. Because the expertise and experience of legal counsel is of such great importance, we work hard to make sure you have nothing but the best legal advice available. We achieve this by:

▶ Recommending a choice of counsel for the defense of litigated claims, directing and monitoring counsel during case preparation, and negotiating compromise and release settlements. We can provide you with a selection of recommended counsel from our own tested attorney directory, or work with the counsel of your choice.

▶ Keeping you informed of ongoing developments in litigated cases. We strongly believe that litigation should not be placed solely in the hands of legal counsel. We want and need to be involved to protect your interests and help speed the process. This is why Gallagher Bassett manages every case, directs defense attorney activities toward your desired result, and promotes constant communication between all parties to ensure that information is properly reported in a timely and accurate manner.

▶ Helping you select other legal experts in matters that may require special investigation or services. At your request, we can recommend qualified specialized firms and explain their capabilities.

▶ Monitoring all claims for potential subrogation, salvage, excess carrier, and state second injury fund recoveries. We will also prepare correspondence to spur collection efforts and assist counsel where litigation is required to accomplish recovery.

At every critical juncture, we want to make sure you are armed with legal muscle that is appropriately leveraged on your behalf.

Establishing claim files for accurate recording and reporting

We offer elaborate procedures to keep information in place and speed claims processing
To ensure the greatest possible accuracy, fast access to information, and speed up the pace of the claims process, we establish a claim file for every indemnity or medical only workers compensation claim you encounter. In more serious claims, we also report claims to the carrier for the set of predetermined circumstances listed below.

For example, a controlled loss file report will be sent to the carrier on all workers compensation cases involving:

- Death
- Heart attack
- Serious occupational disease, e.g., silicosis, asbestosis, hepatitis
- Major member amputation
- Second- or third-degree burns of 25% or more of the body
- Potential permanent total
- Functional overlay, psychological, psychiatric problems
- Serious spinal injuries, e.g., paraplegia, quadriplegia, spinal cord or spinal column surgery
- Serious head or brain injuries, e.g., fractures, concussions
- Catastrophe losses involving two or more individuals
- Complete loss of sight in one or both eyes
- Complete loss of hearing in one or both ears
- Potential AIDS claims
- Certain “Primary Carrier” claims on a client-by-client basis
- Claims with WE exposure.

The file report specifically covers each of the following points:
▶ File Identifiers. Lists client name, location of loss, accident date, the aggregate or specific coverage limits, and an explanation of the potential compensation of the claim.

▶Claims Identifiers. Lists claimant’s name, age, co-morbidities, dependency status, education level, job description, temporary total disability rate and permanent disability rate.

▶Cause of Loss. Provides description of the accident and details injury, including present and past medical information.

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▶ Recoveries. Describes potential for third party recovery or subrogation.

▶ Scope of Damage. Lists total experience figures, paid to date information on medical and indemnity claims, and the basis for these figures.

▶Action Plan. States future management plans for the particular file.

If pertinent, enclosures can be added to the file, including medical reports, legal information, first report of injury forms, and any other relevant information. An expected date for the next report is also indicated.

Communicating constantly with carriers

To protect you and control costs, Gallagher Bassett carefully nurtures good working relationships through constant communication with you, your broker, primary carriers, and excess carriers.

We generate excess reports

You and your broker will be notified, when a claim demonstrates the potential to involve excess layers of coverage, or when a claim meets the criteria listed below.

Count on first dollar reporting

Primary carriers are contacted directly whenever a claim meets a specific dollar limit or falls into one of the following categories:

- Temporary disability (at one year)
- Serious occupational disease
- Death
- Heart attack
- Brain damage
- Dismemberment
- Spinal cord injuries
- Severe scarring/burning
- Loss of sight or hearing
- Multiple fractures
- Others on a carrier-by-carrier basis.

Because we are sensitive to your needs and the requirements of your carriers, we follow specific procedures designed to improve the efficiency of our carrier reporting/communication. Our corporate policy, for example, requires coverage verification for each claim occurrence. We've also developed a Coverage Information Request sheet. This convenient form ensures quick communication of information and includes basic file documentation presented in a clear, concise format.

And when claims are unusual or large, there's our Detailed Status report

In order to keep you informed of significant losses, Gallagher Bassett has developed the Detailed Status Report (DSR)—a valuable tool we use to notify you of large or unusual workers compensation claims and any change in their status. This report provides information about the claim under various headings. The report is mostly narrative, prepared by the resolution manager, and is generated when a claim reaches a dollar limit that you define or when it involves a certain type of serious injury.

Detailed Status Reports are sent when:

- The initial total experience is set at or above the agreed amount.
- A total experience increase is made which sets the total experience at or above the agreed amount.
- The loss is of a serious nature.

A few concluding claims management thoughts

At Gallagher Bassett, we apply proven strengths in many areas to create a complete risk management program that stands the test of your immediate risk management needs and the test of time.

With vision focused on results and your constant satisfaction, we offer a value-added approach that never loses sight of our objective—providing a measurable return on your risk management investment.

Visit us at:
www.gallagherbassett.com

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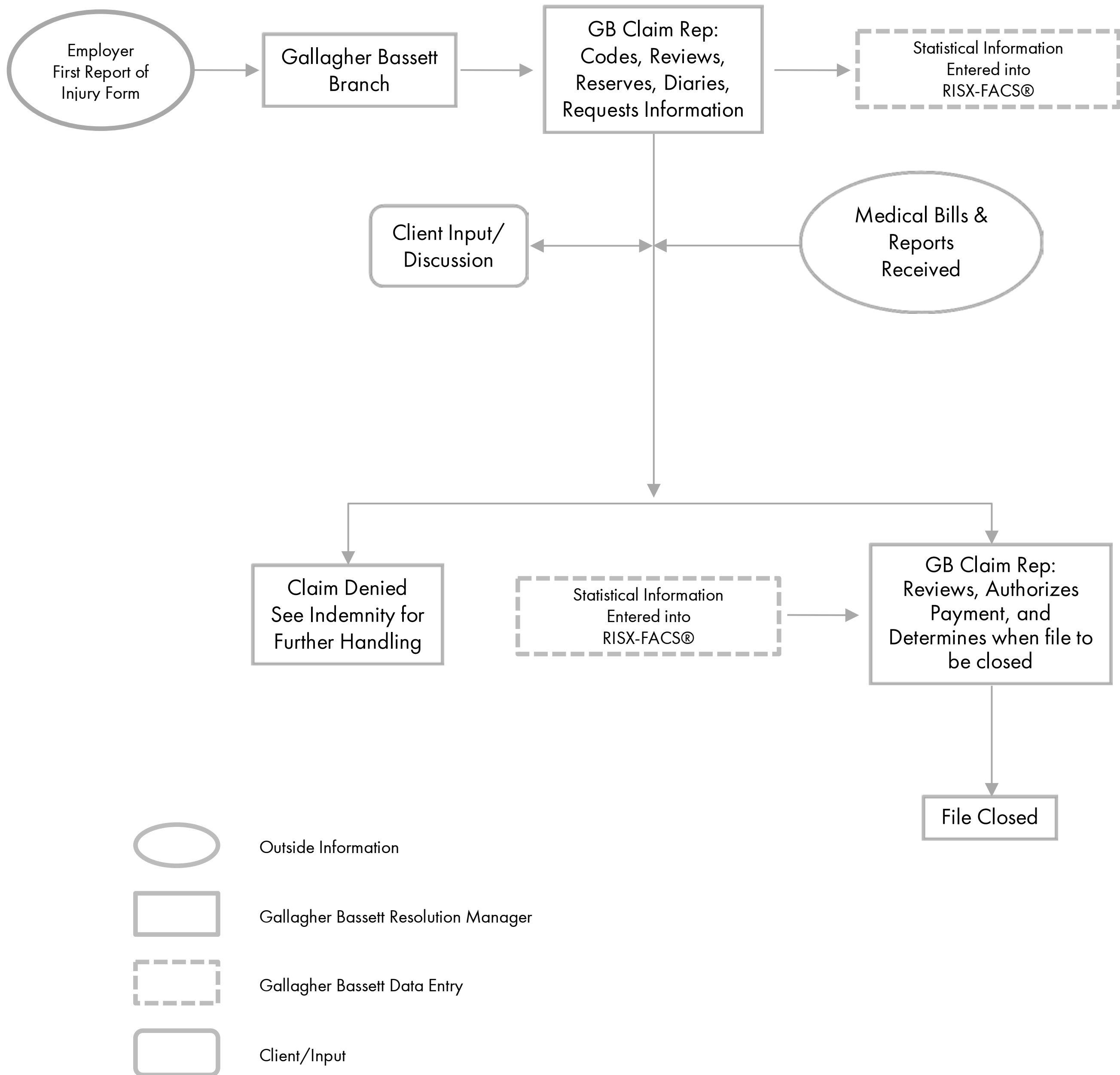
WORKERS COMPENSATION CLAIMS HANDLING PROCESS
MEDICAL ONLY



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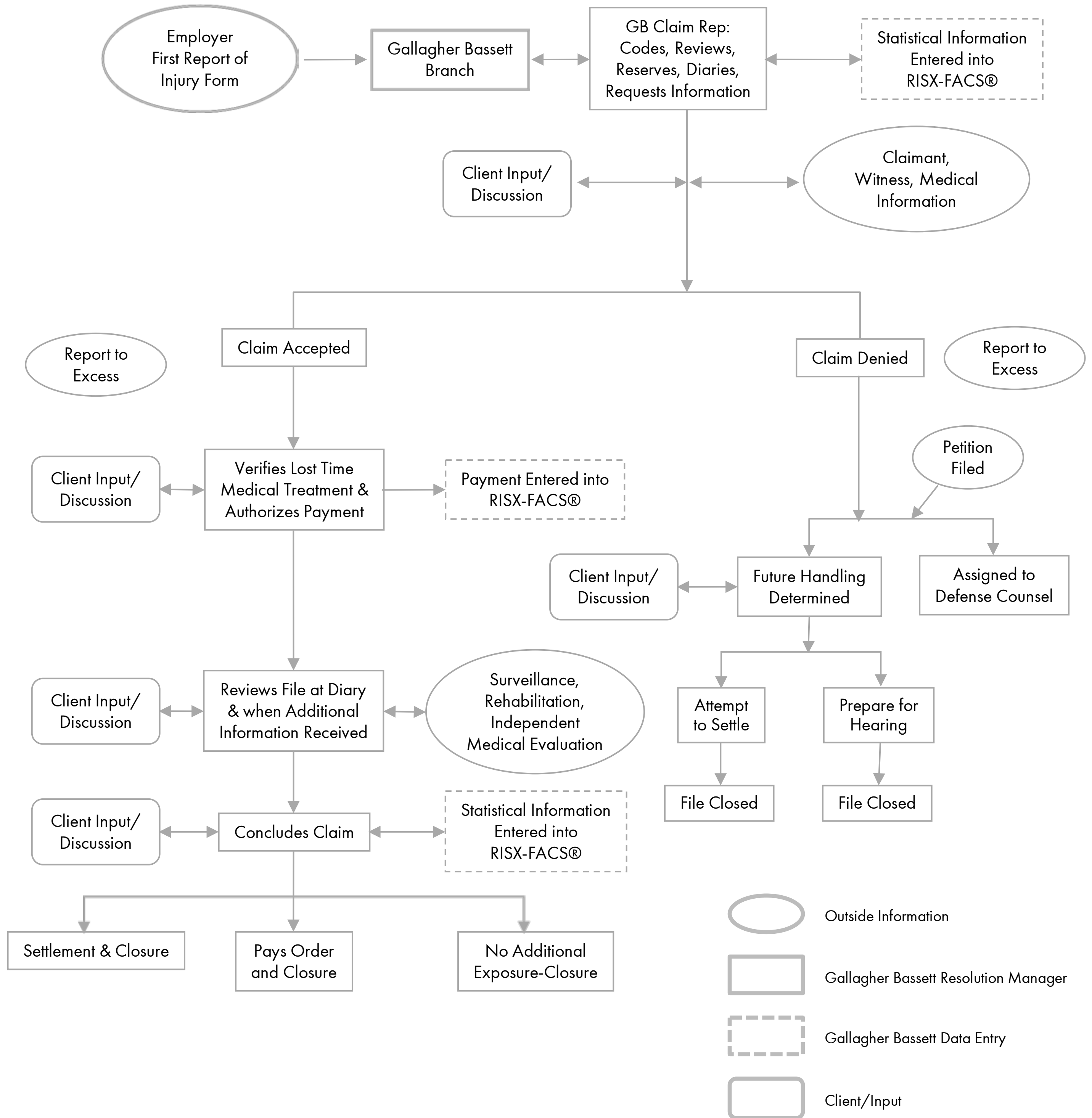
WORKERS COMPENSATION CLAIMS MANAGEMENT OVERVIEW

WORKERS COMPENSATION CLAIMS HANDLING PROCESS INDEMNITY



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WORKERS COMPENSATION BEST PRACTICES

Gallagher Bassett maintains a strong, centrally managed claim network. Our Corporate Best Practices are carried out by our branches. These Corporate Best Practices are based on the foundation by which our services are delivered. Gallagher Bassett's Corporate Best Practices are devised to ensure company-wide compliance and are the benchmark by which we judge the level of an office's performance.

The goal of these Best Practices is to provide you with fast, straightforward facts on how we proceed in the workers compensation arena and how we interact with you as a valued client. You'll find the details on what you need to know to stay informed and what, if anything, is required of you or your organization. If you have any questions or need more information about anything presented here, please contact us, and we'll be pleased to fill in the blanks personally and face to face.

Ground rules of general file control

Handling new claims

All new claims are evaluated, reserved, coded, and entered into RISX-FACS® upon receipt of a state employer's First Report of Injury form or other notice.

Coverage Verification

A formal Coverage Analysis Verification based on the current information available from the Client Service Instructions are documented in the Claim Notebook

Use of diary management

All open files are entered into the RISX-FACS® diary system. Diary is reviewed, and a note is filed in Claim Notebook. Any additional pertinent information is included in the "Plan of Action" section.

Index management

All claims meeting the established criteria are automatically reported to the Index Bureau through RISX-FACS®. Subsequent filings may be necessary on long-term or complicated claims. These filings are documented in Claim Notebook.

Rules for state reporting

All state agency reporting will conform to the applicable workers compensation laws and copies of such are contained within the file or online if filed electronically.

Investigation procedures and rules of contact

Compensability/denial management

Rationale for any decision of compensability is documented in Claim Notebook. Supervisor approval is given prior to issuance of any denial or upon the controversion for either indemnity or medical benefits on new or existing claims.

Initial Analysis Information

Initial contact information is completed, in its entirety, in Claim Notebook, for all cases claiming lost time. The contact's will be documented in claim notebook prior to the issuance of the first Temporary Total Disability (TTD) payment or prior to denial of the claim.

Statements

Statements are taken from the client, claimants, and/or witnesses in the following cases:

1. All controlled loss category cases.
2. All cases with possible subrogation.
3. All cases with a pre-existing condition.
4. All cases where compensability is questionable.
5. Controverted (delayed/denied) claims.

If statements are not taken, the reasons is documented in Claim Notebook.

Three-point contact

Two valid documented attempts to make three-point contact (client, claimant, doctor) is made on all indemnity claims within one business day of knowledge of claim or conversion to indemnity by Gallagher Bassett.

Contacting you

Client contact is generally made by telephone when questions arise or when additional information is required. The client is kept informed of all pertinent ongoing developments.

Establishing claimant contact

On all cases alleging lost time, claimant contact is made prior to the issuance of the first TTD payment. Contact continues throughout the claim at least every

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30 days as TTD continues, or the potential of permanency exists. If contact is not made, an explanation appears in Claim Notebook.

Provider contact

Medical information is requested from doctors and hospitals at the time the file is set up by phone or by mail.

Witness contact

Witnesses are contacted on controlled loss cases or if the case is questionable or where there may be possible subrogation.

Disability and wage verification

All lost time is verified by the physician treating the claimant and confirmed with the client before payment is made. Verification or exceptions are noted in the file. At the time of contact with the client, resolution manager inquires if light duty or modified work is available. Where indemnity payments are required and within three business days of receipt of the claim, any wage information is requested by the claim handler.

Surveillance and activity checks

On cases of extended disability, suspicion of fraud, or where activity belies the injury, checking on the activity of the claimant is prescribed. In fatal/permanent total cases, activity of those receiving benefits will be checked every 6 to 12 months. Professional surveillance is limited to certain types of cases and must have the client's prior approval.

Reserve management

Total Experience (T.E.) – the amount paid to date plus any additional anticipated cost – is based upon the information available at the time of evaluation and is determined by a number of factors. Reserve practices are closely monitored not only by you, the client, but carriers, consultants and state governing bodies.

Creating the initial reserve

We establish an initial reserve that takes into account all current information available at the time of setup. "Block" reserving is prohibited.

Subsequent reserve evaluation

Any change to the reserve will be entered into the claim file and substantiated. "Step Reserving" is unacceptable.

Reserve analysis/Total Experience worksheet & explanation

All files with Total Experience at or above $5,000 contain a fully completed Total Experience Worksheet in Claim Notebook. GB provides a new worksheet for each Total Experience change in RISX-FACS® at or above the $5,000 level.

Reserve Analysis/waypoint®

Resolution managers consider and compare a claim's Total Experience (TE), as suggested by waypoint®—our automated loss reserving system—at each diary. They then place a note is placed in Claim Notebook indicating agreement or disagreement.

Claim coding

All coding fields are accurate and complete based upon information available at the time.

Gallagher Bassett's active claims management

GB checks diligently on medical status, on an as-needed basis, but minimally every 4 to 8 weeks. A final report will be secured from the treating physician stating the degree of any permanent disability. In serious or questionable cases, we will request hospital records.

The claim handler directs the activities of the nurses on Medical Case Management to ensure proper utilization of services until those services are no longer needed.

GB is responsible to initiate, coordinate, and direct the rehabilitation effort. Applicable state laws govern rehabilitation.

Independent medical exams (IMEs)/second opinions

IMEs are conducted to determine the extent of injury, ability to return to work, or need for additional treatment. Most states allow IMEs and/or second opinions. Background information and a reason for the IME request is provided to the physician conducting the IME.

Managing litigation

Gallagher Bassett has the ultimate responsibility for management of all litigated claims. If laws permit, GB will handle the litigated claim portion until such time as outside

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counsel is required.

We also strive for prompt response to counsel inquiries, which is essential. To assist in speeding the legal process, all GB work and responsibilities are completed as quickly as possible. Counsel is required to provide an initial opinion letter within 30 days with complete periodic status reports provided after that on an as-needed basis or at least quarterly.

GB is notified of hearing dates, strategy and settlement demands. No case will be settled without approval of GB, in conjunction with the client and the excess or primary carrier when it is appropriate.

Legal billing

Billing for legal services is handled on a per-case basis. Legal bills will be submitted at least quarterly and at case conclusion. All bills will be itemized with a listing of the activity performed and the appropriate dates and rates.

Recovery management/documentation

Every claim with subrogation potential is investigated. The client and/or the carrier may request pre-approval of subrogation efforts. Lien letters are sent by GB to the appropriate parties. No settlement or lien compromise is made without client approval and the approval of the carrier. The statute of limitations must be recognized.

Seeking recovery from state funds

Any possible recovery from a state fund or offset from Social Security, or need for a Medicare Set-Aside Agreement will be recognized, pursued and documented.

"Non-Excess" recoveries, including subrogation, salvage, contribution, and over-payments will be processed and fully documented within 7 days of receipt, in Claim Notebook. Explanations will be detailed in the file if recovery cannot be processed for any reason.

Medicare SCHIP reporting

In order to maintain the mandatory reporting requirements, all claims contain the following information in RISX-FACS® on each claimant.

1. Legal First Name
2. Legal Last name
3. Social Security Number
4. Date of Birth
5. Gender

Missing information will be actively sought out and the efforts to do so will be documented during each subsequent diary review.

Prior to Settlement, Judgment or Award a vendor assignment will be completed on Medicare Eligible claims for Conditional Payment Research (CPR) and Medicare Set-Aside (MSA) allocation.

Settlement evaluation

Negotiations are controlled by Gallagher Bassett. Where law requires, legal counsel will negotiate under our direction. If applicable, authority to settle and approval of the settlement will be obtained from you and/or the carrier. All releases will be signed by you, not Gallagher Bassett. Mandatory Set-Aside agreements (MSA) will be considered on all qualifying files.

Expert assignments

Branch management approval is required, prior to the assignment of outside vendors, including Surveillance and Activity Checks, and also for any type of referral for investigation, unless otherwise noted by you or a state statute requirement.

File transfer protocol

Externally or internally transferred open claims between GB resolution managers are subject to enhanced 'file transfer protocols'

Benefit payments that fill the bill

Medical bill payment

Medical bills are repriced by the appropriate E-Bill review vendor. They are then scanned and sent electronically to GB. Responsibility for screening the bills for payment or review lies with the claim handler. All bills are paid within 21 days of receipt regardless of whether they are legal, service, or medical. Any exceptions are documented in Claim Notebook.

Documentation and reporting

At Gallagher Bassett, we strive for excellence in a number of ways. We begin with detailed plans of action. We also document everything for legal and management purposes. Some important discussions/decisions are also confirmed in writing with you (and the carrier as applicable). In-depth reports are

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sent to you and other important parties on a frequent basis. Having everyone on the same page, at the same time, ensures efficiency, accuracy, and positive outcomes.

Thorough documentation

All actions taken, and conversations held, will be documented in Claim Notebook.

"Thoughtful" plan of action

Since virtually anything can happen, we try to protect information that's been gathered on a case with detailed record keeping. This is why we request that resolution managers indicate their thought processes, case direction, and other important data in Claim Notebook. This allows the file to literally "speak for itself."

Indication of supervision

Evidence of supervision and claim handler compliance are required on indemnity claims regardless of Total Experience. The initial review must be made within 30 days of file set up, with subsequent reviews at 90-day maximum intervals.

Issuance of client reports

When your contract stipulates, a Detailed Status Report must be completed at the agreed-upon level. Further DSR's are required when conditions change. A separate claim note will be entered upon completion of the DSR that will include the name and company of the addressees.

Supervisors are responsible for ensuring that all completed DSR's are delivered to you in a timely manner.

Controlled Loss Reporting to Carriers

Reporting requirements

A Detailed Status Report will be sent to the carrier on each case with a Total Experience at, or in excess of 50% of the self-insured retention (SIR) level or at other carrier-specified limits. A DSR will also be sent to the "Primary" carrier when the Total Experience meets the level designated by the carrier in the Client Service Instructions

Important report enclosures

Every DSR that is sent electronically to the carrier will include photocopies of medical information deemed relative, including medical and legal information, the employer's first report, and a completed Total Experience Worksheet.

The initial report

Immediate notice by telephone will be made to the carrier when there is any serious injury category claim. Once the Gallagher Bassett branch is notified of a loss that meets certain criteria, a written DSR will be filed within 30 days and the reason for the report will be relayed to the carrier.

Subsequent reports

Status reports provide information on subsequent activity along with copies of file data. Status reports are required quarterly or when the case merits as requested by the carrier. The claim handler indicates a specific date for the next report. It is the responsibility of the GB branch office to provide and initiate both initial and subsequent status reports.

Excess recoveries are requested from the carrier to the branch and information relating to them is entered into the RISX-FACS® system.

Reporting procedures to carrier

Carrier correspondence is conducted directly by the GB branch. Supervisors are responsible for making sure the carrier receives DSR's containing the current claim status. If the Client Service Instructions indicate, all excess recoveries that are obtained are sent to the client contact.

The audit program

The audit program is assurance to you and carriers that GB has a quality control program in place which effectively measures the efforts to achieve the highest quality and adherence to the Workers Compensation Best Practices. Detailed file audits, (as well as Quality Assurance (QA) audits), to confirm the quality of the detailed file audits are performed by GB. The results of the detailed file audits are shared with branch management to monitor the compliance with the Best Practices.

Branch Managers also are required to review a sampling of files each month for compliance to Gallagher Bassett Standards and Client Services Instructions.

The Gallagher Bassett Quality Department, independent of claims operation, also conducts monthly file audits to ensure quality claims

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handling. The role of the Quality Department is to facilitate and validate audit sample selections.

Audits are conducted monthly, with the results reported to claims operation management. There are monthly, quarterly, and year-to-date results with findings shared with claims operation management.

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