Public Agency Risk Sharing Authority of California

Workers' Compensation Program

CLAIMS ADMINISTRATOR PERFORMANCE STANDARDS

PARSAC began with the LAWCX standards as a framework for these requirements and enhanced them to meet member expectations, reflect our current practices, and ensure they include industry best practices.

I. EXPERIENCE

A. The Claims Examiner shall have a minimum of five (5) years experience handling claims for public entities; the Claims Assistant shall have a minimum of two (2) years experience.

B. The Manager/Supervisor shall have a minimum of ten (10) years experience handling claims for public entities.

C. The Claims Examiner shall complete annual continuing education training and possess all appropriate certifications and credentials.

II. CASE LOAD

A. Each Examiner shall have a caseload not to exceed one hundred fifty (140) open indemnity claims.

B. The Claims Assistant may handle up to 100 Future Medical/Medical-Only cases in addition to providing clerical support.

C. The Supervisor shall not have an active caseload.

III. CLAIM SUPERVISION

A. The Claims Administrator shall provide supervisory staff that will regularly review the work product of the examiners. Supervisors shall review 20% of the examiner's caseloads monthly and conduct comprehensive reviews on all claims with reserves in excess of $50,000.

B. Supervisors shall conduct the reviews to ensure each examiner is following the performance standards. Such reviews shall be labeled as "Supervisor Review" and be clearly documented.

IV. COMPLIANCE WITH LABOR CODE

A. The Claims Administrator shall comply with all provisions of the Labor Code and Rules and Regulations in effect at the applicable date of injury.

V. CONTACT

A. Upon receipt of the Employers' Report of Injury, the Administrator will prepare a claim file within one (1) working day for each claim.

B. The Administrator will contact the member agency, the claimant and the medical provider within twenty-four (24) hours of receipt. Such contact will continue as often as necessary, but at least monthly. Such contact shall be clearly documented.

C. Return phone calls within one (1) business day.

D. All correspondence from employees will be responded to within five (5) business days of receipt.

CLAIMS ADMINISTRATOR PERFORMANCE STANDARDS

VI. PHYSICIAN CONTACT

A. Physician's office will be contacted within one business day of notice of all new claims to conduct an initial investigation of the medical aspects of the claim and discuss the member entity's return-to-work goals.

B. Contact with the physician's office shall be maintained to ensure injured workers receive proper medical treatment and are returned to full or modified employment at the earliest possible date. Such contact will continue as needed during the continuation of temporary disability to assure that treatment is related to a compensable injury or illness.

VII. DETERMINATION OF COMPENSABILITY

A. The compensability determination (accept claim, deny claim, or delay acceptance pending the results of additional investigation) and the reasons for such determination will be made and documented in the file within three (3) business days of the receipt of the notification of the loss. Delay of benefit letters shall be mailed in compliance with the Division of Industrial Relation's' guidelines.

B. In no case shall a final compensability decision be extended beyond ninety (90) calendar days from receipt of the Employee Claim Form. The examiner must seek prior authorization to delay or deny any PARSAC claim or to accept a claim from a delayed or denied status.

VIII. RESERVES

A. Reserves shall be established based on the facts of the claim and the ultimate probable cost of each claim. All reserve categories shall be reviewed on a regular basis but not less than at least every ninety (90) calendar days on active claims and every six (6) months on claims that have settled but are open to monitor future medical care. Such reviews shall be clearly documented. Any changes to reserves shall include an explanation for the change.

IX. INITIAL INDEMNITY PAYMENT

A. The initial indemnity payment or voucher will be issued and mailed to the injured employee together with properly completed benefit notices within fourteen (14) calendar days of the first day of disability.

B. Members that employ public safety and participate in PERS retirement shall pay LC4850 benefits directly to the employee. PARSAC reimburses only Temporary Disability (TD) benefits.

C. Late payments must include the self-imposed 10% penalty in accordance with Labor Code Section 4650.******

X. SUBSEQUENT INDEMNITY PAYMENTS

A. All indemnity payments or vouchers subsequent to the first payment will be verified, except for obvious long-term disability, and issued in compliance with Labor Code Section 4651.

B. Late payments must include the self-imposed 10% penalty in accordance with Labor Code Section 4650.******

****PARSAC is to be advised of the assessment of any penalty for delayed payment and the reason thereof and the Administrator's plans for payment of such penalty within five (5) days of assessment.**

XI. MEDICAL PAYMENTS

A. Medical bills will be reviewed for correctness, approved for payment, and paid within the time limits established by Labor Code Section 4603.2.

B. If all or part of the bill is being disputed, the Claims Administrator will notify the medical provider, on the appropriate form letter, within time limits established by Labor Code Section 4603.2.

C. The Administrator shall use a third party bill review service to ensure all medical payments are adjusted for fee schedule and applicable discounts.

XII. TRANSPORTATION EXPENSE

A. Transportation reimbursement will be mailed within five (5) calendar days of the receipt of the claim for reimbursement.

B. Advance travel expense payments will be mailed to the injured employee ten (10) calendar days prior to the anticipated date of travel.

XIII. PERMANENT DISABILITY

A. The Claims Administrator shall determine the nature and extent of permanent disability and secure a Disability Evaluation Unit rating where necessary to avoid litigation and may use private raters where appropriate.

B. The Claims Administrator shall take advantage of any potential apportionment for prior claims and impairments.

C. The Claims Administrator shall advise the member or its designated party of potential credits for apportionment or offers of return to work. The Administrator will report to the member or its designated party any overpayments of permanent disability and the plan to recovery such overpayments.

XIV. VOCATIONAL REHABILITATION/SUPPLEMENTAL JOB DISPLACEMENT BENEFITS (SJDB)

A. The Claims Administrator shall send notices pertaining to potential eligibility for supplemental job displacement benefits in accordance with Labor Code §4658-4658.

B. The Claims Administrator shall send notices regarding return to work full duty or notices of a permanent/modified duty job offer to the member agency within the specified timeframes under DWC Regulation 10133.53.

C. When requirements to establish eligibility have been met, the Claims Administrator shall provide a non-transferable voucher for education-related retraining and/or skill enhancement to the employee within 25 calendar days from the issuance of the permanent disability award by the workers compensation judge. The voucher must indicate the

appropriate level of money available to the employee in compliance with Labor Code §4658.5.

XV. DIARY REVIEW

A. All claim files shall be reviewed at least every thirty (30) calendar days for active claims and at least every six (6) months for claims that have settled but are open to monitor future medical care.

B. A plan of action will be included and separately labeled in the file notes during a diary review. The plan of action shall include, but not be limited to: the employee's current work status, medical status, review of reserves, and any future activity to move the claim towards resolution. The plan of action shall be updated via status report every ninety (90) calendar days.

C. The supervisor shall monitor the diary reviews and indicate review and concurrence with the plan of action. Supervisor will identify any files that have fallen off the diary system.

XVI. LOSS RUNS

A. The loss run shall be issued by the 15th calendar day of the month following the closing date.

B. Corrections to the loss run made by the 20th calendar day of the month shall be reflected in the following month's loss run.

C. Requests for reports generated by the employer shall be provided within thirty (30) days calendar days.

XVII. FILE REVIEW & REPORTING

A. The Claims Administrator shall conduct quarterly claim file reviews with the Member. The Administrator will also report to PARSAC every ninety (90) days on all open files; reports to include updated reserves, progressive action plan, critical medical documentation (narrative) and a recommendation.

B. In the event of any of the following, the Administrator is required to immediately contact PARSAC and LAWCX, or their designated agents. The Administrator will also remind the employer of the OSHA reporting requirements for major injuries.

1. Fatality;
2. Amputation of a major extremity;
3. Any serious head injury (including skull fracture or loss of sight of either or both eyes);
4. Any injury to the spinal cord;
5. Any accident which causes serious injury to two or more employees;
6. Any claim believed to be fraudulent and $20,000 has been paid in allocated expenses; and/or
7. Any disability of more than one year when it appears reasonably likely that there will be a disability of more than one (1) year.

C. Concerns regarding agency direction and cooperation, litigation, or difficulty moving a claim toward resolution should be brought to PARSAC's attention at the earliest opportunity.

D. Claims are reportable to PARSAC once the total incurred reaches 50% of the member's individual SIR. The self-insured retention level for the PARSAC pool is $250,000 prior to July 1, 2007 and $500,000 after that date. Claims are reportable to LAWCX once the total incurred reaches 50% of the pool SIR.

E. Excess reporting will be done every ninety (90) days in accordance with LAWCX's Universal Electronic Loss Data Submission Information Specifications. Excess reports are to include copies of the current correspondence, updated medical records and current payment history. Excess reports are to be transmitted via e-mail to the designated party with a copy of all required information sent via regular mail.

F. The Claims Administrator, either directly or through a third party vendor, will maintain all data fields required by CMS and report payments in accordance with Section 111 of the Medicare Secondary Payer Act.

XVIII. REQUESTS FOR REIMBURSEMENT

A. Requests for reimbursement are to be made every ninety (90) days. Requests are to include a present status report and supporting documentation of the costs incurred. Failure to provide supporting documentation may result in the delay and/or denial of reimbursement.

XIX. LITIGATION

A. It is preferable that the Claims Administrator avoids, if possible, any and all litigation with the injured worker and shall thoroughly investigate all potential issues before a making determination that may drive litigation. It is the PARSAC philosophy that we provide high quality, timely and appropriate medical care to our employees and actively support their return to work. This level of investment and commitment reduces the likelihood of litigation and decreases claim costs.

B. Assignment of counsel for litigation of any matter requires prior approval from PARSAC and its Member. If the total incurred reaches 50% of the member's SIR, written authority must be received from both parties prior to engaging in litigation. The Administrator will be required to outline the issue and provide the reason litigation is required for resolution.

C. The Administrator will monitor litigation to ensure progress toward resolution and audit bills before payment, evaluate and advise PARSAC/Member on settlement proposals and trial developments.

XX. SETTLEMENT AUTHORITY (INCLUSIVE OF LIENS)

A. The Administrator shall obtain the employer's written authorization on all settlement or stipulations. If the settlement value enters into the PARSAC layer of funding, written authority from PARSAC is required.

B. Failure to secure authority may result in the denial of reimbursement. Should the settlement value enter into the LAWCX layer of funding, written authority from LAWCX would be required.

C. Claims Administrator shall consult with and obtain authorization prior to settlement of any claim; this includes Stipulation, Compromise & Release and lien settlements. All requests for settlement authority shall include a written claim summary, estimate of permanent disability, and any comments and recommendations.

D. The Administrator shall verify Medicare's interests prior to negotiating settlement of any claim and shall ensure those interests are appropriately addressed in the settlement agreement.

XXI. FUTURE MEDICAL CLAIMS

A. Claims that remain open to monitor future medical care shall remain open for two (2) years from the last benefit provision as defined in Labor Code 3207.

B. Reviews shall be documented in the claim notes to include settlement information, outline future medical care, last date and type of treatment, name of excess carrier, excess carrier reporting level, and excess carrier reporting history.

C. Reserves for future medical treatment will be reviewed every six (6) months and adjusted for use over a three (3) year average and the injured employee's life expectancy based on the current version of the U.S. Life Table. The reason(s) and calculation(s) for the adjustment(s) shall be clearly documented.

D. Every attempt should be made to compromise and release claims open for more than two (2) years, except when a Medicare Set-Aside would be required.

XXII. SUBROGATION

A. In all cases where a third party is responsible for the injury to the employee, the third party shall be contacted within ten (10) business days with notification of the employer's right to subrogation and the recovery of certain claim expenses; such contact will be documented.

B. If the third party is a governmental entity, a claim shall be filed with the governing board within six (6) months of the injury or notice of injury.

C. Periodic contact shall be made with the responsible party and/or insurer to provide notification of the amount of the estimated recovery to which the employer will be entitled. Such contact will be documented.

D. If the injured worker brings a civil action against the party responsible for the injury, the Claims Administrator shall consult with PARSAC about the value of the subrogation claim and other considerations. Upon PARSAC's authorization, subrogation counsel shall be assigned to file a Lien or a Complaint in Intervention in the civil action. Only legal counsel on a contingency fee arrangement and specializing in subrogation will be retained.

E. Whenever practical, the Claims Administrator should take advantage of any settlement in a civil action by attempting to settle the workers' compensation claim by means of a Third Party Compromise and Release. If such attempt does not succeed, then every effort should be made through the WCAB to offset claim expenses through a credit against the proceeds from the injured worker's civil action.

CLAIMS ADMINISTRATOR PERFORMANCE STANDARDS

XXIII. AWARD PAYMENT

A. Payments on Awards, Computations, or Compromise and Releases will be issued within ten (10) business days following receipt of the approved order.

XXIV. CASE CLOSURE

A. Every attempt should be made to conclude cases as fairly and expeditiously as possible; PARSAC discourages unnecessary litigation.

B. Medical-only claims open beyond sixty (60) calendar days should contain documentation as to why the claim remains Medical-only and address whether conversion is needed.

C. Claims with $3,000 or more paid-to-date on any claim open beyond one hundred eighty (180) calendar days from date of entry shall be converted to indemnity status and a reasonable, precautionary indemnity reserve placed on the claim.

D. All indemnity cases where permanent disability is not an issue will be closed within thirty (30) calendar days of the final financial transaction or final correspondence to the injured worker as required by law.

E. All indemnity claims where permanent disability is an issue will remain open for two (2) years from the last payment of benefits and then closed within thirty (30) calendar days from that date.

F. All indemnity claims where permanent disability has been denied will be closed within thirty (30) days of denial.

XXV. RIGHT TO AUDIT OR REVIEW

A. The member or its designated representative is authorized to visit the Claim Administrator's processing and/or storage premises, for purpose of performing a claims audit or review, and have access to all data, including paper documents, microfilm, microfiche, and magnetically stored data which relate to payments or non-payments made by the employer.

B. Any assistance or service provided in response to a claims audit described above will be rendered at no additional cost to the member or employer.

XXVI. ADDITIONAL ITEMS FOR CONSIDERATION

The following additional services would be considered as "added value" services under any claims administration contract:

Online Claims Access
Client Workforce Training
Coverage for Examiner's Absence
Reserve Oversight
Indexing
Medical Management Services
Return to Work Coordination
ADA Interactive Process
Checking Account Reconciliation
Performance Metric

Request for Detail Information – Universal Electronic Loss Data Submission
Workers' Compensation Claims Information Specifications

The data outlined in this request will be utilized for the member's and excess carrier's underwriting process, loss analysis, benchmarking, and actuarial study. **Please provide an electronic data file in Microsoft Excel format**. If you are submitting data for more than one member, please combine the data into one Excel file. The requested file is a data file only, and should not contain any formatting, macros, formulas, hidden columns or rows, report headers, blank rows, or any other Excel "features". Files will be accepted in Excel 1997-2003, 2007-2009, and 2010 formats.

If you need any help generating the loss data file in the required format, please contact the Bickmore IS team at (916) 244-1100.

When compiling your data, please pay careful attention to the following:

- Data must be evaluated as of the last day of the month being reported.
- If the data is being provided for a Joint Powers Authority (JPA), please use the member/entity's name in the Entity Name Field (described below) and not just the JPA's name.
- Workers' compensation claims data should be provided for the entire claim history – all the years you maintain in your risk management/claims information system.
- Workers' compensation claims data transferred from any prior third party administrators (TPA) shall be incorporated into the data submission.
- Loss amounts should include the full amount of the claim and not be limited to any excess insurance recovery (please do not cap payment, reserve, or recovery amounts).
- Losses should be detailed on a per claim basis.
- The file should include all open and closed workers' compensation claims including "Incident Only" (also known as "Information Only", "Record Only", or "Notice Only") and "First Aid" claims. Incident Only and First Aid claims must be identified using the "Claim Type" field (described below.)
- Medical Management, Bill Review, and/or Cost Containment fees incurred prior to July 1, 2012 should be included in the individual claim paid and reserved medical loss amounts rather than as a separate claim record. Claims coded as "Bill Review", "Cost Containment", "Dummy", or "Ouch" will not be accepted.
- Medical Management, Bill Review, and/or Cost Containment fees incurred after July 1, 2012 should be included in the individual claim paid and reserved ALAE loss amounts rather than as a separate claim record. Claims coded as "Bill Review", "Cost Containment", "Dummy", or "Ouch" will not be accepted.
- For claims involving Labor Code (LC) 4850 and LC 4856 benefits, please be sure to include the claim information and show separately any payments and reserves specifically designated for LC 4850 and LC 4856 ("Paid 4850" and "Reserve 4850"). Do not include

these amounts in the "Paid Indemnity" or "Reserve Indemnity" columns.

- Closed claims cannot have reserve amounts included. By definition, a closed claim cannot have case reserves. Therefore, closed claims with reserve amounts will not be accepted.
- All paid, reserve, and incurred amounts must be "positive" numbers. A negative amount may be listed only if it pertains to a subrogation or excess recovery ("Subro Recovery Amount" and "Excess Recovery Amount").

- Per the group's governing documents, members are required to submit loss data. If the data is not submitted in a timely fashion, the member may be penalized. Please note that if the data is not submitted in the proper format or the record layout does not match the following criteria the submission will not be accepted. Should the submission be rejected, the member may be penalized.

ELECTRONIC DATA FILE LAYOUT

This information will only be accepted via the LAWCX web site (http://www.lawcx.org) or via our Secure Insurance data transfer web site accessible at https://si.brsrisk.com. Please do not send files through the e-mail system. You may use whichever site you prefer.

To upload the files using the LAWCX site, go to "Data Submission" on the main menu (http://www.lawcx.org/DataSubmission.aspx) and click on "Enter". Follow the instructions listed to upload the loss data file(s). To use the LAWCX site you must already have site login credentials which should have been previously provided to you. If you do not have credentials, or have forgotten your user ID or password, please contact the Bickmore Information Services Team at (916) 244-1100 for assistance.

To upload the files using Secure Insurance (https://si.brsrisk.com) (*note that this is an SSL (secure) site and the prefix is https and not http*), login to the site using your e-mail address and password. If you have not previously used the site, you can easily register by clicking on the registration link (https://si.brsrisk.com/secureinsurance/UserRegister.do) on the home page and following the registration instructions. LAWCX files sent using Secure Insurance should be delivered to lawcxdata@bickmore.net. If you need any assistance registering or submitting the data, please contact Bickmore at (916) 244-1100.

If for any reason you are unable to use either of the data transfer sites, please contact us for alternative electronic transfer solutions, or you can send the data via CD or DVD media through overnight shipping or the U.S. mail.

Please utilize the following specifications when submitting your information to us. Each record must consist of the 65 data fields described below. If there is no data for a specific field, please indicate by leaving blank (null); do not use spaces, "NULL", "UNKNOWN", or " / / " as placeholders. Note that only fields 3 (Location Name), 7 (Claimant First Name), 11 (Occupation Code), and 39 (Date Closed) can be left blank, and only under specific circumstances. All numeric (amount) fields must be coded as a dollar amount. If there is no amount, code as "$0.00"; do

not leave blank. If using dollar signs ("$") and/or commas (",") in a loss amount field causes problems with your submission process, they can be omitted. The first row of the file must contain a header identifying the columns ***exactly*** as specified below. If using spaces (" ") in column names causes problems with your submission process, you may substitute underscores ("_") instead.

A template of the file with the correct header and a sample claim row is attached for your use/information. These specifications and the sample template are also available for download at the secure data transfer site.

SPECIFICATIONS:

No.	Field Name	Format	Description
1	**Evaluation Date**	mm/dd/yyyy	The date the loss data was evaluated, which should always be the last day of the month being reported
2	**Entity Name**	text (80)	Name of the member entity, district, or employer. For members of a JPA or group, this field should contain the member/entity name, not the name of the JPA or group. The individual employer/entity name will be used to determine the group
3	**Location Name**	text (80)	Name of the claimant's assigned location, building, facility, school, or division (if the same as Department Name, then leave blank). Do not include location numbers
4	**Department Name**	text (80)	Name of the claimant's department. Do not include department numbers
5	**Claim Number**	text (40)	Claim or file number
6	**Original Claim Number**	text (40)	If the claim has been transferred from another TPA or entity, or is the excess or pool layer loss amount on another claim, include the original claim or file number. Otherwise code the same as 5 (Claim Number) above
7	**Claimant First Name**	text (40)	First name of the claimant. Must be mixed case and only include the claimant's first name
8	**Claimant Last Name**	text (40)	Last name of the claimant. Must be mixed case and not include the claimant's first name

9	**Date of Birth**	mm/dd/yyyy	Claimant's date of birth
10	**Gender**	text (1)	Claimant's gender. Code F for female or M for male
11	**Occupation**	text (40)	Job title of claimant at time of injury/illness
12	**Safety Flag**	text (1)	Code "Y" if the claimant is eligible for full salary benefits under Labor Codes (LC) 4850 and 4856 or "N" if not
13	**Class Code**	text (4)	NCCI standard class code based on claimant's occupation at time of injury/illness. (If the code is not captured, then leave blank.)
14	**Date of Hire**	mm/dd/yyyy	Claimant's hire date
15	**Avg. Weekly Wages**	$#,###.##	Average weekly wages at time of injury/illness. If unknown, code $0.00
16	**Claim Type**	text (2)	Code as IO = Incident (or Record or Notice) Only, FA = First Aide, MO = Medical Only, TD = Temporary Disability, PP = Permanent Partial Disability, PT = Permanent Total Disability (100%), DC = Death Claim, or FM = Future Medical. No other codes will be accepted
17	**PD Rating**	###.##	Percentage of rating established by the TPA, State, or independent rater
18	**PD Amount**	$#,###.##	Amount of PD associated with percentage of rating established by the TPA, State, or independent rater
19	**Settlement Type**	text (2)	Code as CR = Compromise and Release, FA = Findings and Award, ST = Stipulated Award, OS = Other Settlement Type, NS = Not Settled. No other codes will be accepted
20	**Settlement Amount**	$#,###.##	Amount of settlement agreed by all parties and approved by a WCAB judge
21	**Settlement Date**	mm/dd/yyyy	Date judge approved settlement

22	**FM Award Flag**	text (1)	Code "Y" if the claim will remain open to monitor future medical care or "N" if the claimant is not entitled to future medical care
23	**Cause of Loss Code**	text (3)	Alphanumeric Cause of Loss code
24	**Cause Description**	text (80)	Ex.: Fall. Only include description (no codes accepted)
25	**Nature of Injury Code**	text (3)	Alphanumeric Nature of Injury code
26	**Injury Description**	text (80)	Ex.: Sprain. Only include description (no codes accepted)
27	**Body Part Code**	text (3)	Alphanumeric Body Part code
28	**Body Part Description**	text (80)	Ex.: Foot. Only include description (no codes accepted)
29	**Text Description**	text (255)	Free form text description of the claim. This field should list the actual description of the injury or event as listed by the employer. Do not include quotes (‘), double quotes (“), or carriage return or end-of-line characters (CRLF)
30	**Fatality Flag**	text (1)	Code "Y" if the injury or illness caused or allegedly caused the claimant's death or "N" if it did not
31	**Litigated Flag**	text (1)	Code "Y" if the claimant is or was represented by an attorney or the employer retained legal representation at any time or "N" if there are no attorneys involved
32	**Accepted Date**	mm/dd/yyyy	Date the claim or a portion of the claim is accepted
33	**Delayed Date**	mm/dd/yyyy	Date the claim or a portion of the claim was once or is currently delayed
34	**Denied Date**	mm/dd/yyyy	Date the claim or a portion of the claim is denied

35	**Date of Loss**	mm/dd/yyyy	Date the incident, injury, or illness occurred or was alleged. If cumulative trauma is alleged, the date of injury shall be listed as the last date of the injurious exposure
36	**Date Reported**	mm/dd/yyyy	Date claim was reported by the claimant to his or her employer. Also known as date of knowledge
37	**Date Received**	mm/dd/yyyy	Date claim was received/reported to the claims administrator/adjuster
38	**Date Entered**	mm/dd/yyyy	Date claim was entered into the risk management/claims information system. Also known as system date, open date, or registration date
39	**Date Closed**	mm/dd/yyyy	Date this claim was closed (if not closed then leave blank)
40	**Status**	text (2)	Code as follows: OP = Open, CL = Closed, RO = Re-opened, RC = Re-closed. No other codes will be accepted
41	**Paid TD**	$#,###.##	Amount paid to date on the claim for temporary benefits (does not include amount paid per LC 4850 and 4856 or Vocational Rehabilitation (VR)/supplemental job displacement benefits (SJDB)
42	**Paid PD**	$#,###.##	Amount paid to date on the claim for permanent benefits
43	**Paid 4850**	$#,###.##	Amount paid to date for losses/injuries to public safety officers per LC 4850 and 4856. Do not include amount in field 41 (Paid TD)
44	**Paid Other Indemnity**	$#,###.##	Amount paid to date for other indemnity benefits not including TD, PD, or LC 4850 benefits. This includes death benefits and/or penalties
45	**Paid Medical**	$#,###.##	Amount paid to date for medical benefits and medical management fees (bill review, nurse case management, utilization review incurred prior to 07/01/12)

46	**Paid VR/SJDB**	$#,###.##	Amount paid to date for VR/SJDB
47	**Paid ALAE**	$#,###.##	Amount paid to date for all non-legal expenses (fees for copy service, surveillance/sub rosa, interpreters, indexing, witnesses, investigations, and expenses incurred after 06/30/12 for bill review, nurse case management, and utilization review services)
48	**Paid Legal Expenses**	$#,###.##	Amount paid to date for legal expenses (fees for defense attorney and depositions)
49	**Total Paid**	$#,###.##	Total paid on this claim to date. Must total the sum of fields 41+42+43+44+45+46+47+48
50	**Reserved TD**	$#,###.##	Current case reserve for only temporary benefits (does not include amount reserved per LC 4850 and 4856 or VR/SJDB)
51	**Reserved PD**	$#,###.##	Current case reserve for only permanent benefits (does not include amount reserved per LC 4850 and 4856 or VR/SJDB)
52	**Reserved 4850**	$#,###.##	Current case reserves for losses/injuries to public safety officers per LC 4850 and 4856. Do not include this amount in field 50 (Reserved TD)
53	**Reserved Other Indemnity**	$#,###.##	Current case reserves for other indemnity benefits not including TD, PD, or LC 4850 and 4856 benefits. This includes death benefits and/or penalties
54	**Reserved Medical**	$#,###.##	Current case reserve for medical benefits and medical management fees (bill review, nurse case management, utilization review incurred prior to 07/01/12)
55	**Reserved VR/SJDB**	$#,###.##	Current case reserve amount for VR/SJDB
56	**Reserved ALAE**	$#,###.##	Current case reserves for non-legal expenses (fees for copy service, surveillance/sub rosa, interpreters, indexing, witnesses, investigations, and expenses incurred after 06/30/12 for bill review, nurse case management, and utilization review services)

57	**Reserved Legal Expense**	$#,###.##	Current case reserves for legal expenses (fees for depositions and defense attorney)
58	**Total Reserved**	$#,###.##	Total current case reserves on this claim. Must total the sum of fields 50+51+52+53+54+55+56+57
59	**Total Incurred**	$#,###.##	Total Incurred losses for this claim. This amount shall be exclusive of any subro or excess recovery amounts. Must total the sum of fields 49 (Total Paid) and 58 (Total Reserved)
60	**Subrogation Recovery**	$#,###.##	Amount recovered for subrogation recovery on this claim file. This amount shall not be deducted from the paid to date, reserve, or total incurred amounts
61	**Excess Recovery**	$#,###.##	Amount recovered from excess carrier on this claim file. This amount shall not be deducted from the paid to date, reserve, or total incurred amounts
62	**4850 Days Paid**	#,###	Number of LC 4850/4856 days paid. Code as "0" if none has been paid. This field will contain the number of days and not the amount of benefits paid to the claimant per LC 4850 and 4856
63	**Mod. Duty Days Worked**	#,###	Number of modified duty days claimant worked. Code as "0" if none worked. This field will contain the number of days and not the amount of salary paid to the claimant
64	**OSHA Days Paid**	#,###	Number of OSHA days paid. Code as "0" if none paid. This field will contain the number of days and not the amount of temporary disability benefits paid to the claimant
65	**TD Days Paid**	#,###	Number of temporary disability days paid. Code as "0" if none paid. This field will contain the number of days and not the amount of TD benefits paid

Paper loss runs and/or Adobe Acrobat files are not acceptable.