Proposal to:

City of Las Vegas

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CCMSI

www.ccmsi.com

CCMSI's Response to City of Las Vegas' Questions

OUTLINE YOUR STANDARDS AND PROCEDURES IN THE FOLLOWING KEY AREAS:

CLAIMS ADMINISTRATION:

- Please explain the process of reporting, assigning, investigating, and making determinations on newly received claims.

  1-800 Capability – We partner with vendors to provide this service. We script questions asked of callers to suit client needs. 24-7 capability can also be utilized if necessary. This service can also include Nurse Case Triage if desired. See section below dealing with medical case management.

  Local Phone, E-mail, & Fax transmissions – Accepted by our local office location.

  On-line Reporting – With our "state of the art" claim system, the City can report claims 24/7/365 via "iCE", our proprietary Internet claims analysis and reporting tool. The Initial Report section of iCE allows the user to create an Initial Report Form in accordance with the State Guidelines. Once submitted, notification is immediate to the claim supervisor, a claim number is automatically assigned, and viewable in iCE. Since the data submitted in real time populates our proprietary claims system, it enables our claim adjusters to begin working your new claims immediately. There is no charge for filing claims via the Internet.

  All FNOL's will be date stamped and reviewed by a qualified claim representative immediately upon receipt. Information contained on the FNOL will be used as the basis for the initial handling instructions, investigation, and reserves assigned to each file. ***An investigation of each claim will be completed no later than ten (10) business days from receipt of FNOL.*** Typically the investigation is completed with 72 hours. All investigation notes are thoroughly documented in the claims file.

Assignments depend upon the below factors:

- Total number of claims
- Type of claims being handled
- Number of new claims received monthly
- Number of claims closed monthly
- Severity/complexity of claims
- Level of experience of the claim representative
- Claim Handling/Reporting Requirements of the City

CCMSI will contact the injured employee, treating physician, and the City within 24-48 hours of the first notice of loss. Our Claims Handling Best Practices dictate 3-point contact be completed within 2 business days of reciept of loss, however, typically this occurs within the first 24 hours.

At that time, the City's designated claims professional will explain their role in the adjudication process together with their points of contact (phone number, fax, e-mail, street address, etc.).

The claims professional is responsible for explaining to the claimant their rights under the appropriate state statutes guidelines, the level of benefits to which they may be legally entitled (if the claim is determined to be compensable) and when they can expect a decision regarding the acceptance of compensability and receipt of their first benefits payment.

CCMSI prides itself on strict adherence to prompt initial contact with the claimant, the employer, as well as, the treating physician or medical professional. Ongoing contact is made on a case specific basis, with proactive case management, and thorough and timely communication being the goal.

The determination of compensability is based on two key factors:

- Confirmation of coverage.
- Investigation of and confirmation of facts using the 3-point contact protocol to validate that the claim occurred within the scope of their employment per state statute.

As a general rule, a complete investigation of each claim will be made within 10 business days from receipt of First Notice of Loss. Each investigation will be thorough enough to justify acceptance or denial of compensability on behalf of the City. If these guidelines cannot be met due to the complexity of the claim, appropriate documentation and a detailed action plan will be established.

Injury claims will be indexed upon initial receipt of FNOL and re-indexed every six months thereafter until the claim is closed. Indexing will also be in compliance with all applicable federal requirements.

The designated claim professional must confirm and document that the reported loss meets the criteria and requirements for a compensable claim in the appropriate State of Jurisdiction.

- Please provide a brief explanation of your Reserving Philosophy.

Our practice is to establish reserves that reflect the expected financial result of the claim. Each claim is based on its own merits, and if, initially minimal information is available, then a minimum reserve is established based on the adjuster's experience.

Reserve analysis includes consideration of past, present and future lost income; past, present, and future medical treatment; permanent disability impairments; permanent total benefits; expenses such as litigation, rehabilitative services, mileage, claimant profile, outside expert needs; and potential settlement costs.

CCMSI works primarily with large self-insured and risk sensitive programs. ***Therefore, we recognize the importance and financial impact of establishing timely and accurate reserves.*** We have proven processes to effectively reserve claims and ***avoid stair stepping.***

One area that makes us unique is that we do not use a cookie cutter approach to reserving. Most TPA's use standard reserve amounts for all claims regardless of claim specific information, which leads to inaccurate reserves. We utilize various guidelines but reserving is performed on a ***case specific basis*** utilizing the knowledge and jurisdictional experience of our adjusters.

CCMSI has built our own Reserving Worksheet incorporated into our proprietary RMIS. Used by all adjusters, the new Reserve Worksheet links into our adjusters' software application toolbar and allows them to save reserve changes as works in progress. This way, adjusters can stop their work, gather additional information or work on another claim, and return to complete the worksheet – with all required information – to capture the reserve in a complete and detailed format.

Moreover, the worksheet is tied to the claim file note, which is updated in CCMSI's claim system and iCE. This way, clients can view the adjuster notes and the entire Reserve Worksheet in iCE to better understand how the adjuster developed the reserve.

- ***Initial reserves are established and posted into the claims system within 10 business days from receipt of the loss.***
- Reserves are evaluated on every file activity and upon each supervisory review.
- Reserves are ***re-evaluated every 30 days*** thereafter depending on the activity and severity of the claim.
- Reserves are re-evaluated and adjusted within 10 days based on any new information made known that significantly changes the exposure on the claim. If additional information is required to fully evaluate the exposure, it is requested in a timely manner.
- CCMSI has pre-defined maximum reserve authority levels for all claims professionals based on their experience level and title. When a reserve exceeds their authority level their supervisor and/or manager must sign off on any change.

Title	Maximum Reserve Authority
Chief Operating Officer	$1,000,000 & greater
Corp. Claim Managers	$1,000,000
Regional V.P.	$500,000
Account Manager/Claim Manager/Branch Manager/State Director/National Account Manager	$250,000
Sr. Claim Supervisor / Claim Supervisor/ Claim Specialist	$200,000
Claim Consultant	$100,000
Claim Representative	$50,000
Claim Associate	$25,000
Medical Only Claim Representative	$5,000
Claim Clerk	$0

- ***The adjuster must document their reserves and the rationale for those reserves in their notes.*** We recognize the importance of establishing timely and appropriate reserves on all cases and the impact they have on our client's effort to manage their total cost of risk. It is equally important that our clients and their carriers are confident in our reserving practice and that they accurately reflect their current exposure on each claim.

The adequacy of reserves will be reviewed every thirty days at each adjuster and supervisor diary. Upon reserve changes, the log notes will be documented with the information and rationale for the change.

- Please explain your strategy for Claim Resolution.

Closure of a claim does not necessarily mean that the exposure presented by the claim has been finally settled and/ or resolved. It merely means that there is no reasonable basis to anticipate further activity and /or financial payment by the client based on events as of the date of closing. It is possible that in the future a claim could be made and an evaluation would need to be made and determination made regarding the statute of limitations.

Workers' Compensation files are closed once all medical expenses and state required indemnity benefits are paid.

Final settlements will be considered only with the full support and consent of the City's designated contact. The settlement value will be analyzed and documented in the file in accordance with the City's rules and regulations. ***CCMSI will not commence settlement negotiations in connection with any claim without obtaining the approval of the City***. A written request for settlement authorization will be sent to the City's designated contact on all proposed settlements. This written request will contain a summary of the accident facts, the nature and extent of injury, the current status of any litigation and settlement recommendation.

- What is the average caseload for your adjusters (Medical Only, Indemnity, other)

  Corporately, our goal is to assign claims representatives a workload that allows them to be both productive and proactive. Therefore, there is some variance on a jurisdiction-by-jurisdiction basis which is further tempered by their experience level and lines of coverage handled.

  Assignments depend upon the below factors:
  - Total number of claims
  - Type of claims being handled
  - Number of new claims received monthly
  - Number of claims closed monthly
  - Severity/complexity of claims
  - Level of experience of the claim representative
  - Claim Handling/Reporting Requirements of the City

  The average caseload for workers' compensation claims representatives is:

Indemnity	125 (MAX 150)
Medical Only	300 (MAX 350)

  On a monthly basis, adjuster caseload reports are run for each Account Manager to review. Monitoring monthly caseloads for our claims adjusters is a key differentiator between CCMSI and its competitors.

  If an adjuster's caseload is too high, we will reassign files and add client service team members as needed. CCMSI acknowledges that a commitment to a manageable caseload is a key component of client service and customer satisfaction.

- Are you willing to provide dedicated staff to this account, with caseload caps?

  CCMSI is willing to work with the City to determine the best possible scenario for servicing your account. It makes sense to consider a dedicated staff model on an account of this size and magnitude. We would be happy to discuss reasonable caseloads that allow the adjusters ample capacity to not only manage the claims but to provide adequate support to the City and their related departments. Setting up a Cost Plus Dedicated claim team allows the City more control of who services their account, and under what parameters.

- For cases involving vocational rehabilitation, whose services do you use?

  CCMSI works closely with each and every client to enlist the services of the most qualified and efficient provider of Vocational Rehabilitation services. If the client already has an agreement with a preferred vendor, we are happy to honor that agreement. If the City is interested in collaborating on a listing of preferred Rehabilitation Counselors, CCMSI has enjoyed a very positive relationship with many providers in the Las Vegas and surrounding areas. This would

include but not be limited to: Genex, Alaris, Capital Vocational Consultants, Coventry, and some individual providers.

- For cases requiring a functional capacity evaluation, whose services do you use?

  CCMSI works closely with each and every client to enlist the services of the most qualified and efficient provider of Functional Capacity Evaluations. In many instances, the treating physician will make a referral to a specific facility for this, and CCMSI will cross check that referral with our preferred network. If the client already has an agreement with a preferred vendor, we are happy to honor that agreement. If the City is interested in collaborating on a listing of preferred FCE providers, CCMSI has had great success with utilizing Matt Smith PT, Kelly Hawkins PT, and some individual providers as well. This specialty is unique, and oftentimes recommendations and referrals are made based on previous success.

- Public Safety employees (police and fire) are eligible for benefits pursuant to NRS 617.455, 617.457, 617.485 and 617.487. Describe an action plan for investigating and administering such claims. Possible defense?

  Once CCMSI is notified of a possible claim under NRS 617.455 or NRS 617.457, an immediate medical investigation is performed. An injured worker is sent to a preferred specialist in the area(s) of Heart or Lung to determine first if a condition exists. A physical examination is performed to determine the extent of the condition, the diagnosis and prognosis, and medical plan of treatment. Once this is completed, it is determined if the injured worker meets the statutory requirements for filing a claim under these statutes. The injured employee's length and status of employment, predisposing conditions, annual physicals, and reporting requirements are all factored into the compensability determination. Discussion with the employer is critical when the final determination is rendered, and ongoing communication throughout the course of the claim is essential.

  These special claims issues will continue to be a challenge for the governmental entities employing firefighters and policemen. Proper application of the statutory requirements and use of appropriate physician specialties is an employer's best defense when dealing with claims of this nature. Reserving these claims is challenging, and continues to be costly; therefore it is the ultimate responsibility of the claims administrator to adjudicate these claims with the highest degree of diligence required on any type of claim. Our philosophy is that these individuals work under the most extreme of circumstances, and should be compensated for any causally related injury or illness. This is where an open line of communication becomes essential with the employer and injured workers, as well as the medical providers in charge of treating these types of illnesses.

- Who handles first level litigation for Workers' Compensation claims?

  CCMSI is unique in that despite the fact that the State of NV does not require adjusters be licensed to handle claims, we have an internal educational growth goal that all adjusters obtain their NV Hearings License. This way, our adjusters have the proper credentials necessary to understand the potential for litigation on a claim, and are equally able to manage that litigation at the first level if need be. CCMSI typically assigns the Hearing Office level of litigation to that assigned adjuster or supervisor, absent any requirement by the client to refer out to Defense Counsel. Some of the more run-of-the-mill issues can easily be handled by the person(s) who

rendered the claims decision…thus alleviating the employer of the added cost of Legal representation. We would work directly with the client, however, on more complicated cases where the early expertise of a licensed Attorney would produce a better outcome.

- Describe the tracking of lost time and restricted duty days on WC claims with particular attention to how this information can be used for OSHA log requirements.

  This information is tracked in our iCE system. CCMSI's iCE OSHA reporting module enables the Client to track incidents, report injuries and generates the OSHA 301 and 301A Forms and 300 and 300A Logs.

  Reporting through iCE is easy and simple. The iCE OSHA module is integrated with CCMSI's claims database so there's no need to input the information twice. CCMSI's system tools will save you time and money.

  The iCE OSHA module integrates directly with the existing CCMSI claims system to leverage the strengths of this system and use them to simplify the task of record keeping mandated by OSHA.

  As "Claims" and "RPOs" are submitted through the Initial Reports tab, a copy is moved into the OSHA module. These OSHA "Incidents" can then be manipulated further by the administrator to refine the data that will be shown on the OSHA logs. The administrator can also record and track time off work or time on restricted duty.

  When needed, the administrator can automatically generate an OSHA 300 and 300A Log and the 301 and 301A Forms for each affected work site. These reports can be re-generated at any time if a correction is required.

- Does your firm conduct internal audits of claims, relative to Best Practices, statutory requirements, Client Special Handling, and Carrier handling requirements? Please explain.

  Annual Corporate Audits - CCMSI annually audits a sample of claims handled by each adjuster. This is done through a standard method understood by all of the claims staff. After each review, discussion and feedback sessions take place with the individual office and claim personnel applicable to the audit. If needed, management of that office implements action plans to address any areas identified as needing improvement. The audit team can also assist with this, if requested.

  If there are any serious issues identified, an earlier repeat-audit may be recommended. This continuous evaluation of the claims staff, as well as the processes and systems, is communicated to senior management. This constant communication fosters growth and development in the claims staff and local management, and encourages continuous improvement in CCMSI's quality handling of claims.

  External Audits and File Reviews - CCMSI coordinates audits and file reviews with the client, broker, or excess insurer, as requested by the client or on an annual basis In fact, we welcome this opportunity to validate our quality procedures, to gauge our performance and to address any

improvements that are needed. The Account Manager facilitates the auditor's review and coordinates the company's written response and procedural action items.

Supervisor Audits – File audits are conducted on a designated number of files for each Adjuster and Client on a monthly basis.

Supervisor Reviews - We perform reviews utilizing a detailed quality checklist to ensure compliance with internal best practices and the client's specific Quality Service Plan. Supervisor reviews are performed upon claim intake and no less than 30 days thereafter.

Any consistent deficiencies in complying with corporate best practices and client service instruction compliance are noted and a corrective action plan is developed. If the adjuster does not immediately take the necessary corrective action they are coached, counseled and trained. If they still are unable to meet our strict standards their employment is swiftly discontinued.

- What is your process for investigating suspected fraudulent activity on claims? Do you currently contract or partner with an SIU firm? Please explain.

CCMSI's claim professionals assign cases to outside vendors for surveillance and/or investigation, and assignments are usually based on an indicator of fraud appearing in relation to a specific case.

Most claims are legitimate, but many are inflated or fraudulent, and all claims should be reviewed for possible fraud. No one indicator by itself is necessarily suspicious. Even the presence of several indicators, while suggestive of possible fraud, does not mean that a fraud has definitely been committed. "Red Flags" are indicators only, not actual evidence. The following criteria are suggested "Red Flags" to initiate field/outside investigation. However, we will work with the City to determine their specific guidelines for utilizing field/outside investigation.

The Claimant:

- Employee is disgruntled, soon-to-retire, seasonal or facing imminent firing or layoff.
- Employee does not get along with supervisors or co-workers.
- Employee took unexplained or excessive time off prior to claimed injury.
- Employee takes more time off than the claimed injury seems to warrant.
- Employee is new on the job and/or has a history of short-term employment.
- Employee is experiencing financial difficulties or other domestic/personal issues.
- Employee waived company sponsored health insurance and has no coverage.
- Employee changes physician when a release for work has been issued.
- Employee has a history of reporting subjective injuries.
- First notification of injury of claim made after employee is terminated or laid off.
- Demands quick settlement decisions and/or payments for medical providers, etc.
- Is unusually familiar with workers' compensation claim handling procedures and laws.
- Receive a "tip" indicating the disabled worker is currently employed elsewhere.
- Employee has submitted substantial material misrepresentation on employment application.
- Employee comes to office for delivery of benefit checks.
- Employee is never home, refuses to allow rehab visits to home without warning prior to visit.
- Employee participates in contact sports or physically demanding hobbies.

- Calls to residence have strange background noises, indicating it may not be a residence.
- Employee is consistently uncooperative, cancels or fails to keep appointment, or refuses a diagnostic procedure to confirm an injury.

The Accident:

- Accident occurs at beginning/end of shift or near the end of a probationary period
- Accident is not witnessed or occurs in area where employee wouldn't normally be.
- Employee has leg/arm injuries at odd time, i.e. at lunch hour.
- Fellow workers hear rumors circulating that the accident was not legitimate.
- Accident not consistent with employee's job description
- Employer's first report of claim contrasts with description of accident in medical history.
- Details of accident are vague or contradictory.
- Incident is not promptly reported by employee to supervisor.

The Treatment:

- Diagnosis is inconsistent with treatment.
- Physician is known for handling suspect claims.
- Treatment for extensive injuries is protracted though the accident was minor.
- "Boilerplate" medical reports are identical to other reports from same doctor.

FIRE, CCMSI's Special Investigation Unit (SIU) program, was designed to assist the CCMSI claims staff with their responsibility to detect, investigate and prevent fraud and abuse within the insurance claims environment, for the benefit of CCMSI's clients and the population at large. In addition, the SIU will be utilized to ensure compliance with state statutes and insurance department regulations that regulate reporting of suspicious claims. This is accomplished through CCMSI's relationship with its contracted SIU, Global Options, which provides nationwide investigative coverage, including a staff of experienced SIU investigators tasked with assisting claims professionals in determining which claims display the elements of fraud, and assisting with the proper investigation and documentation of fraud allegations.

FIRE
Fraud Identification Recovery Edge

Methodology

CCMSI believes that fighting fraud cannot be done piecemeal, but rather must be accomplished through the implementation of, and adherence to, a rigorous methodology focused on identifying instances of potential claims fraud and using all available resources to determine whether the claim is legitimate. This methodology includes:

- Regularly scheduled claim handler training, including but not limited to: fraud red-flags, state fraud reporting requirements, the elements of insurance fraud, etc.
- Sequence of events to occur when a claim handler finds what they believe to be potential fraud.
- Feedback loop with the client to ensure that they are aware of the steps being taken and approve of the approach on each individual claim.

Client Benefits

Through participation in the CCMSI FIRE program, clients realize both the direct and indirect benefits of a comprehensive anti-fraud program, including but not limited to those presented below.

Direct Benefits

- Cost-competitive investigative resources throughout the region and nation.
- Fingertip access to investigative work product including case notes, reports, video and photographs (when applicable) through the FIRE website.
- Fingertip access to Program Management Reports pertaining to your account, all of which allow drilldown from aggregate statistics to detail to individual claims. Reports are available to the CCMSI client in web, chart and Excel format. Report categories currently include:
  - Management Reports, which outline the volume of claimants investigated.
  - Financial Reports, which outline the amount of the clients financial resources utilized on investigation.
  - Fraud Reports, which outline potentially fraudulent cases as identified by the field investigators and managers working on a client's investigations.
  - Feedback Reports, which outline the level of satisfaction that the claims management staff is experiencing with CCMSI's FIRE administrator, Global Options Fraud & SIU Services.
  - Vendor Reports, which outline the performance of Global Options staff and client selected investigative vendors, focusing on video success rates and turnaround time.
- Access to ad-hoc reports available to CCMSI's clients with minimal turnaround time, at no additional cost.

Indirect Benefits

- CCMSI management oversight of investigative work product through the FIRE system that provides reports and access to view investigative work product for collaborative evaluation of claims.
- Adjuster efficiencies through access to the FIRE system and integration between the FIRE system and CCMSI's Toolbar claims management system.

CCMSI will always notify and get approval from the City before referring to any investigative or fraud unit.

- Does your firm complete all reporting to State Agencies, Carriers, Medicare/CMS, and any other required entities on behalf of your clients? Please explain.

Yes.

MMSEA Reporting

CCMSI along with our partner Gould & Lamb have completed our development of a comprehensive solution that addresses both Mandatory Insurer Reporting (MIR) Requirements per MMSEA Section 111 and Medicare Secondary Payer (MSP) Compliance.

Our solution is the only fully-developed and integrated MIR and MSP compliance solution in the industry today. We do not bifurcate the MIR from MSP compliance, nor do we use external third parties to handle our reporting processes. Our approach is to utilize the MIR data to automatically identify claims with MSP exposure (conditional payments and allocations), protecting our customers from potential fines, penalties and litigation post-reporting to CMS.

We work with our client to assist in determining and administering proper RRE registration and maintenance. CCMSI will serve as the Account Manager per MMSEA definition. Our partner Gould & Lamb will serve as the Reporting Agent.

Excess Reporting

In the event that a claim filed by an employee meets the thresholds established by the City and the excess carrier; CCMSI notifies the excess carrier as well as the designated client representative of the claim and assists the excess carrier in administering the remainder of the claim. CCMSI provides any and all necessary documentation to the excess carrier and the City to facilitate a smooth flow of information and payment of claim dollars from the excess carrier to the injured employee, providers and reimbursements to the City.

Our clients' individual excess carrier reporting requirements dictate how and when claims are to be reported. Each client has special handling procedures that include levels of retention, levels of reporting, contacts for reporting, methods of reporting, and reporting criteria. Each file includes a copy of these special handing requirements as a reminder to the handling adjuster of criteria. Our claims automation system also has the ability to flag the adjuster and supervisor at 50% of the retention level through a system automated diary (based on whether claims payments and reserves have reached a threshold). It also has the ability to monitor when the last reporting was completed and when the next is due. Edit screens completed indicate date of first report and follow up reports. CCMSI can generate threshold reports to assist in monitoring excess recovery. iCE can generate reports that assist in excess file identification through Claims Analysis, incurred costs thresholds.

CCMSI Corporate Best Practices include procedures to ensure that reporting on excess claims is compliant with policy, client and CCMSI standards. These standards include but are not limited to:

- Fifty percent of the insured retention level per occurrence
- Permanent total disability as defined by statute
- Fatalities
- Paraplegics and quadriplegics, or spinal cord injury
- Serious burns
- Brain injury
- Amputation of a major extremity
- Any occurrence, which results in serious injury to two or more employees

- Does your firm provide claims administration for multiple lines of Casualty claims?

  Yes, CCMSI handles workers' compensation, liability, and property claims.

COST CONTAINMENT:

- Preferred provider network/physician panels
  - What process is place for modifying, creating, credentialing and updating preferred provider networks?

Network Utilization Guidelines

Utilization criteria or guidelines for network providers are controlled and monitored in a variety of ways with both the Utilization Review process and the credentialing process of the networks. Each network has strict credentialing requirements for the providers, and reviews them on a periodic basis for continuation in their network. In addition, CCMSI monitors providers through the Utilization Review process and throughout the claims management process. It is through this process that they can review outcomes and the treatment process to insure the care provided is appropriate.

Network Contracting and Development Process

By using Comp MC's provider network mosaic, we have found most of our clients have significant provider penetration. We match our clients up with the networks that have an abundance of providers in their region. We are also able to use multiple networks for the best coverage. If however, there are providers that are needed that fall out of all the networks, we would either work with the provider to become part of one of our existing networks, or we would attempt a direct negotiated agreement with that provider.

When a provider wants to be considered for contracting with one of our existing networks, they can go to the network website and complete the on-line nomination request form. Upon receipt from the provider, the nomination form is screened in the provider database to determine whether the provider is currently in the network or is under consideration. If not, the application is moved forward for consideration.

Once the completed application is forwarded, the credentialing process begins. A provider must undergo a comprehensive credentialing process before admission into the network. To be considered, a provider must submit a written application that is screened against pre-determined criteria. An applicant who meets all of the criteria and has provided all of the documentation and information necessary to make that determination will be selected into the network without additional review. As a result, the credentialing process itself takes four to six weeks.

Credentialing

The credentialing process used by The First Health Network, our primary network, is consistent with all leased networks we utilize to demonstrate commitment to continuous quality improvement of the networks and contracted providers through our ongoing monitoring.

Hospitals

Hospitals are re-credentialed annually, including verification of accreditation status. Continuous monitoring includes evaluation of length of stay measures, assessment of outcome measures such as risk-adjusted mortality rates and evaluation of organizational characteristics such as physician staffing and occupancy levels. Client complaints are also monitored and investigated, as well as any media reports regarding quality of care.

Physicians and Other Recommended Outpatient Care Providers

Every two years, it is recommended that the physicians be re-credentialed by re-verifying the status of their medical licenses and DEA registration. On a continual basis, profile all types of network outpatient care providers, monitoring quality of care indicators such as appropriateness and outcomes of care and billing practices.

Also the information collected through clinical management interactions with individual providers and any complaints from clients or members, as well as, federal and state publications and national press clippings help us monitor the status of providers.

For example, to be selected for inclusion in The First Health Network providers must meet the following criteria:

- Accommodate non-life threatening, urgent injury care on a walk-in basis and appointments within 48 hours.
- Have an active return-to-work philosophy and, when appropriate, must coordinate with employers to conduct a light/modified duty assessment.
- Comply with applicable state requirements and provide workers' compensation representatives with information regarding an injured worker's condition and care.
- Be certified to provide treatment to workers' compensation patients in states where certification is required.
- Required, by contract, to refer to other network providers whenever available.

Because First Health is committed to developing networks that provide high quality care for the best market price for our clients, they are able to maintain a very low provider turnover rate in The First Health Network. On an annual basis, 97% of providers remain in the network, with over 99% of hospitals remaining in the network. Physicians generally leave The First Health Network due to relocation, retirement, or death. This retention rate has remained nearly constant over the past decade.

- At what frequency are panels reviewed for possible revisions?

Typically every 6 months.

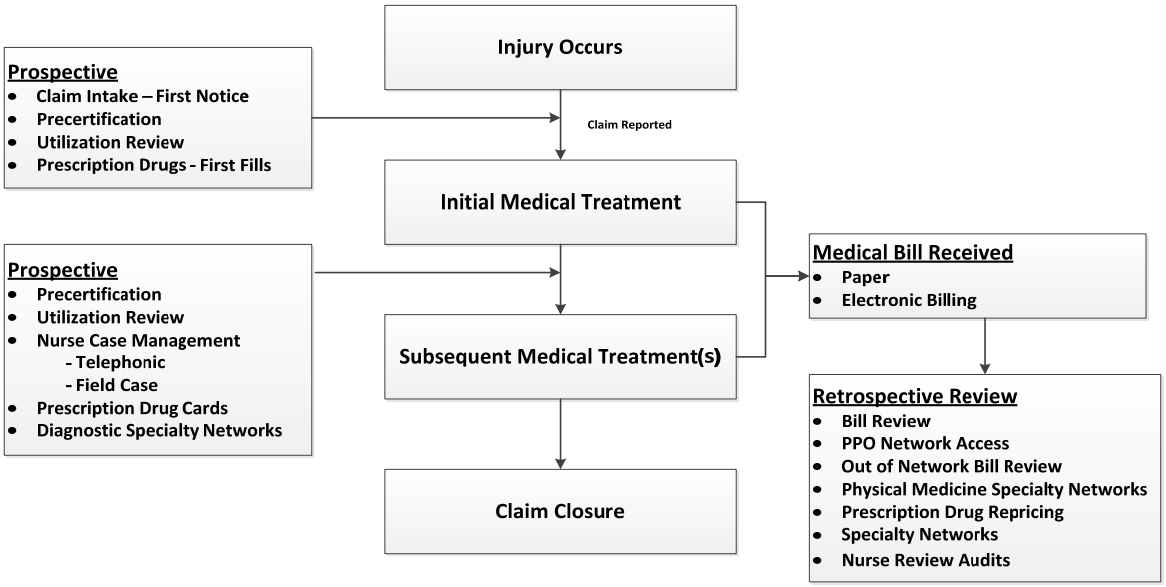
- Managed Care Organizations
  - Do you currently contract with any MCO's for cost containment initiatives?

Managed care programs appear to all look the same. Every program claims to deliver the best results but it is often not clear how those results are obtained.

The success of the Comp MC program is easy to understand. Our superior results come from a strong focus on, and the outstanding execution of, several key areas:

- Prospective services – before the medical treatment is received
- Retrospective services – after the medical treatment is received but prior to provider payment
- System Capabilities – including Advanced Reporting and Analysis, Document Management and Duplicate Bill Detection

The Comp MC program maximizes savings at every possible step during the life cycle of a claim – from the initial report to the final payment.
An overview of the full Comp MC program is as follows:



Comp MC simply delivers the best possible results in an understandable, practical manner and at reasonable costs.

- If so, who, and what services are provided by the MCO in conjunction with TPA claims administration?

  Medical Bill Review/PPO Leasing – Comp MC is contracted with Stratacare for these services.
  Specialty Bill Review – Comp MC is contracted with FairPay for these services.
  Diagnostic Networks – Comp MC is contracted with GENEX MDN for these services.
  PT/OT/Chiro network – Comp MC is contracted with Align/Universal Smart Comp for these services.
  Pharmacy Network – Comp MC is contracted with NPS, PTI, or Corporate Pharmacy for these services.
  Nurse Triage Services - Medcor
  Nurse Case Management – While this can be outsourced to the vendor of the client's choice, CCMSI does have a solid relationship with Genex and has established connectivity with them to streamline the referral process and communication with the adjuster.
  Utilization Review – While this can be outsourced to the vendor of the client's choice, CCMSI does have a solid relationship with Genex and has established connectivity with them to streamline the referral process and communication with the adjuster.

  CCMSI prides itself on being an industry leader in TPA services. Our core focus and competency is in quality claims management services. As a result we partner with various "best in class" partners to provide the highest quality integrated claims and managed care solutions. All of these services are fully integrated electronically into our RMIS and therefore, seamless to our clients.

- Please describe the medical case management function.

  CCMSI works with our clients to determine criteria and timelines in assigning medical case management. We outsource this service to various high quality partners including national companies such as GENEX, as well as, regional and local firms. We will utilize the vendor of the client's choice.

  We will develop the client's desired criteria for the utilization of Nurse Case Management.

  This topic would be developed in detail as one of many steps in the transition process. The criteria and time frames established during this process would then be formalized by including your expectations in your Quality Service Plan.

  CCMSI's general referral criteria for telephonic on field nurse case management are listed below. The referral criteria were established in an effort to provide maximum results and benefits to our clients. These criteria will be adapted to the client's desired protocols.

  Telephonic Nurse Case Management referral criteria:
  - Any lost time file that has potential of four or more provider visits

- Files with chiropractic involvement where chiropractic is the only, or the primary, treating provider and where attempts to achieve MMI/treatment closure have been unsuccessful
- Medical Only claims that have potential for conversion to an indemnity file (e.g. CTS is diagnosis)
- Files where epidural injections have been ordered
- Files with prolonged therapy and/or other treatment (prolonged = > 4 weeks)

Field Case Management referral criteria:

- Catastrophic injuries (head, spinal cord, burns, amputations, crush injuries)
- Unusual diseases or disorders, i.e.: Lyme, RSD, Chronic Pain Syndrome
- Non-union Fractures
- Back surgery/fusion or second back injury, rotator cuff/ACL/meniscus tear
- Pre-existing conditions affecting healing period and treatment
- Inability to secure appropriate treatment/disability plan telephonically
- Multiple medical providers, frequent changes in providers
- Elderly injured/ill worker
- Non-compliant stakeholder—employee, provider or supervisor—inability to resolve telephonically
- Working light duty with no progression to regular duty in near future
- Potential lost time of 60-90 days or more
- Case in TCM for over thirty to sixty (30-60) days
- Aggravation of pre-existing condition
- Re-injury shortly after return to work
- Objective medical findings do not support disability, inability to resolve telephonically
- Other handicaps to employment (communication barriers)
- History of multiple work injuries/illnesses
- Conflict of medical status between physician and injured worker
- Medical diagnosis does not corroborate with cause of injury
- Social and/or behavioral issues
- Return to repetitive work, potential for re-injury/aggravation

- Pharmacy Benefit Management
  - Who is your PBM provider?
  - How many years have you been working with the current provider?
  - What is the AWP discount from your PBM provider?

Comp MC has an integrated pharmacy program linked directly to our proprietary claims software called Comp MC RX. For this program, we partner with Corporate Pharmacy Services (CPS) and National Pharmaceutical Services (NPS) as our PBM. CCMSI has full data integration with CPA and NPS for both claim and payment files.

Adjusters control the activation or deactivation of the drug card through our claims system. Through our data transfer process, this information is sent directly to our PBM partner. Once activated in their system, a drug card is mailed to the injured worker to use at the pharmacy.

Edits can also be set to control such things as the type of medication, specific prescriptions and the prescribing physicians for each claimant. If the claimant is attempting to fill a prescription that is not covered, an email will be sent to the adjuster for them to review and approve if needed. This greatly reduces the possibility of the claimant using the card for non-work related conditions.

The Comp MC Rx program also allows us to capture "First Fills" with a temporary prescription drug card. Studies indicate the first fills account for 80% of all pharmacy costs; therefore, any successful program must capture this event. This temporary drug card allows the employee to avoid out of pocket expense and provides discounts averaging over 35% below fee schedule or AWP nationwide. First fill cards are limited to $150 and 14 day supply of the medication. These cards are terminated automatically 30 days from activation date.

Do you allow the insured to use vendors of their choosing at their own discretion?

Yes. We understand and can meet all requirements necessary to integrate our services with the City's current managed care partners including data interface and the ability for nurses to enter notes in our system.

SYSTEM REQUIREMENTS:

- What type of system does your firm utilize to house, report, and collect data on behalf of your clients? Please describe.

We offer superior technology that allows us to adapt the capture and reporting of data to the client's specific needs. Our technology allows the delivery of key performance metrics and analytics to measure and improve program performance. Just a few examples include our Client Dashboard Report and our new iPhone app that allows our clients to review claims data directly on their iPhone.

A few key features of RMIS, Internet Claims Edge, "iCE" include:

General Features –

- 24-7 internet access to live data
- Flexible user friendly navigation
- Capability to receive data from multitude of data sources
- Password protection with varying levels of security access
- Allows hierarchy of up to 25 levels to track data by state, department, etc.
- Ability to create customized user fields
- Ability to view all claim summary and detail
- Ability to view adjuster notes by category including; summary, medical, litigation, reserves etc.
- Ability to email the assigned supervisor and/or adjuster directly from the claims detail screen
- Ability to generate state specific First Report of Injury and other state forms in PDF
- OSHA reporting (if purchased)
- Medical bill and medical report viewing on-line
- ***iPhone app allowing the viewing of claim and summary data via iPhone***

Reporting Features –

- On-line access to monthly standard reports dating back 24 months
- User specific Executive Portal showing key data upon log-in
- Complete ad-hoc reporting capabilities including financial, claims detail and loss control data
- Summary and detail claim reporting including drill-down capabilities
- Analytical tools including historical and current period comparisons including various graphical presentation
- Cost containment savings and fee reporting
- ***Dashboard providing key performance analytics including, file open duration, reporting lag times etc.***

- Do you have the ability to automatically generate OSHA 300 logs?

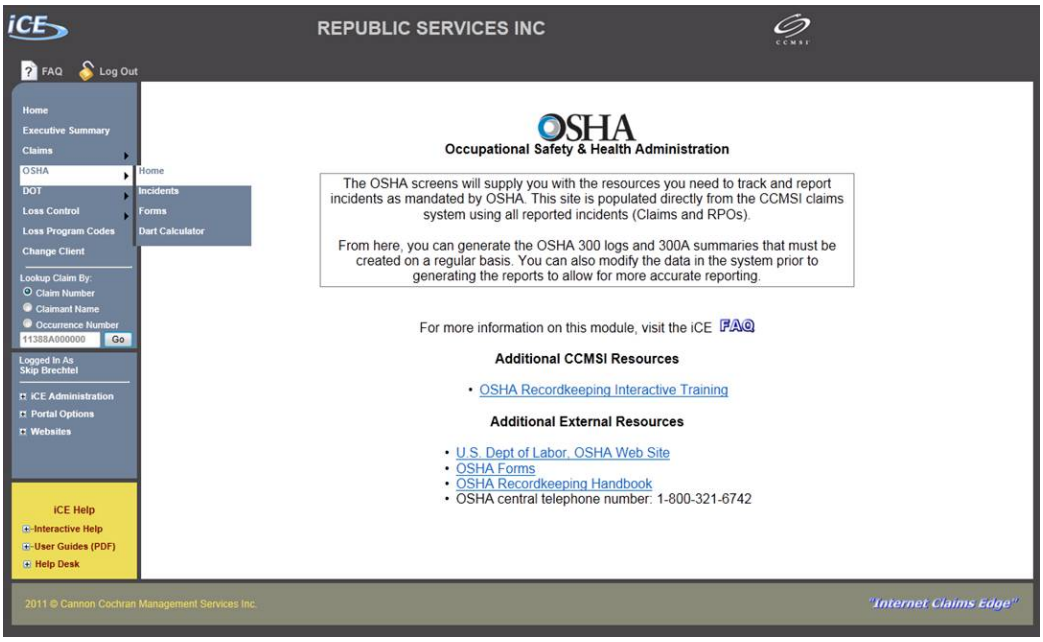
CCMSI's iCE OSHA reporting module enables the Client to track incidents, report injuries and generates the OSHA 301 and 301A Forms and 300 and 300A Logs.

Reporting through iCE is easy and simple. The iCE OSHA module is integrated with CCMSI's claims database so there's no need to input the information twice. CCMSI's system tools will save you time and money.

The iCE OSHA module integrates directly with the existing CCMSI claims system to leverage the strengths of this system and use them to simplify the task of record keeping mandated by OSHA.

As "Claims" and "RPOs" are submitted through the Initial Reports tab, a copy is moved into the OSHA module. These OSHA "Incidents" can then be manipulated further by the administrator to refine the data that will be shown on the OSHA logs. The administrator can also record and track time off work or time on restricted duty.

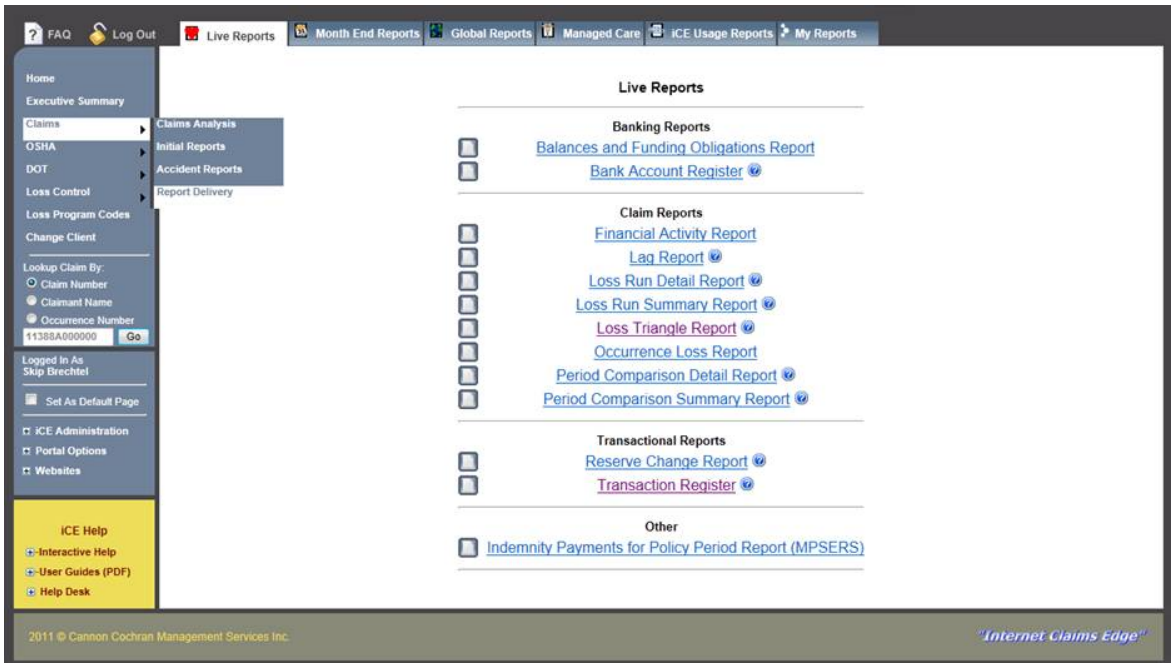
When needed, the administrator can automatically generate an OSHA 300 and 300A Log and the 301 and 301A Forms for each affected work site. These reports can be re-generated at any time if a correction is required. Please see screen shot below of OSHA Module in CCMSI's ICE system.



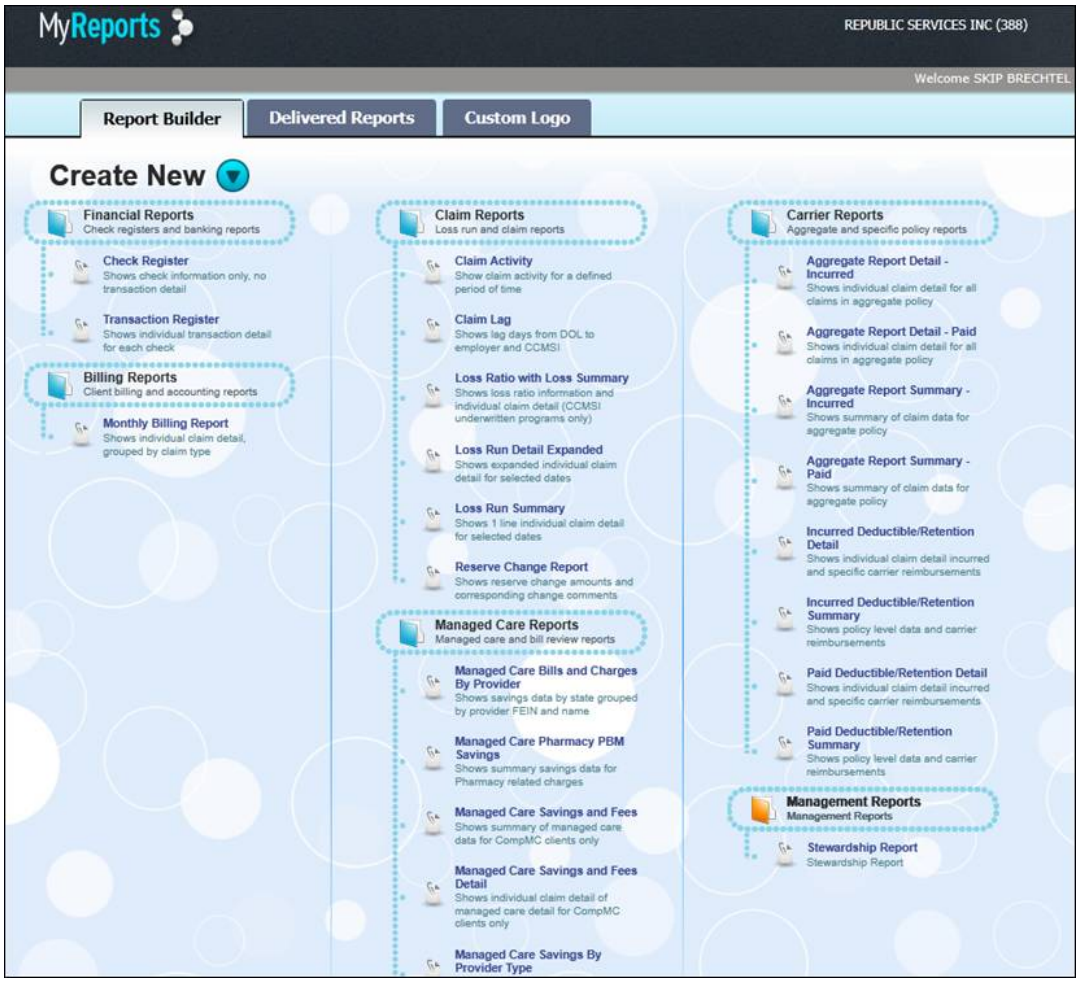
- Is your system capable of providing custom reporting, ad-hoc reporting, real time data reporting, data interfaces with other systems, extracts to carriers/clients/brokers, etc? Please explain.

  Critical to effective Risk Management and loss analysis is the ability to retrieve data quickly and easily. CCMSI's iCE (Internet Claims Edge) risk management system is designed for that purpose. Based upon the desired selection criteria, (see below) ad hoc reports can be generated by the user with a few selective mouse clicks. Reports can range from detailed reports to simple summaries with pie charts.

  Live Reports- This feature provides the 9 most commonly used reports by our clients, including detail and summary loss runs, transaction, comparative period, loss triangles and reserve change reports. These reports can be generated with user-selected periods and as of dates.


FAQ
Log Out
Live Reports
Month End Reports
Global Reports
Managed Care
iCE Usage Reports
My Reports
Home
Executive Summary
Claims
OSHA
DOT
Loss Control
Loss Program Codes
Change Client
Lookup Claim By:
Claim Number
Claimant Name
Occurrence Number
11388A000000
Go
Logged In As
Skip Brechtel
Set As Default Page
iCE Administration
Portal Options
Websites
iCE Help
Interactive Help
User Guides (PDF)
Help Desk
Claims Analysis
Initial Reports
Accident Reports
Report Delivery
Live Reports
Banking Reports
Balances and Funding Obligations Report
Bank Account Register
Claim Reports
Financial Activity Report
Lag Report
Loss Run Detail Report
Loss Run Summary Report
Loss Triangle Report
Occurrence Loss Report
Period Comparison Detail Report
Period Comparison Summary Report
Transactional Reports
Reserve Change Report
Transaction Register
Other
Indemnity Payments for Policy Period Report (MPSERS)
2011 © Cannon Cochran Management Services Inc.
"Internet Claims Edge"

My Reports – CCMSI's newest ICE feature which allows clients to build and schedule reports to their specific requirements



Ad hoc reporting – through iCE our clients can generate a wide array of useful ad-hoc reports with the opportunity to sort and categorize by various fields and data. Robust analytics are provided including useful charts and graphs.

Reports can be obtained and downloaded in several formats:

- Microsoft Excel Spreadsheet. This format will provide the City with information in a sortable format. The selection query, includes:
  - Number of claims
  - Total incurred
  - Outstanding reserve
  - Total paid
  - Total recovered
  - Total paid by class (PPD, TTD, legal, medical, rehabilitation, etc.)
  - Coverage Type
  - Location/Division/Department, etc.
  - Claimant name

- Date of loss
- Claim number
- Entry date
- Date closed
- Status (open, closed, pending)
- Claim type (indemnity, medical, incident)
- Total incurred by claim in the query including the ability to view by class (PPD, TTD, legal, medical, rehabilitation, etc.)
- Outstanding reserve by claim in the query including the ability to view by class (PPD, TTD, legal, medical, rehabilitation, etc.)
- Total paid by claim in the query including the ability to view by class (PPD, TTD, legal, medical, rehabilitation, etc.)
- Number of days the claim is open
- Loss cause
- Loss type
- Body part
- Accident description
- Additional information can be captured based upon client request

- Pie or bar chart. The City will be able to create customized pie or bar charts by selecting one or two of the following:
  - Month of loss
  - Year of loss
  - Coverage code
  - Policy holder
  - Location/Cabinet/Division/Department, etc
  - Body part group
  - Body part detail
  - Claim status
  - Claim type (indemnity, medical, incident)
  - Adjuster
  - Job class
  - Financials
  - Loss type group
  - Loss type detail
  - Cause code group
  - Cause code detail
  - Days open
  - Severity class
  - Occurrence
  - Policy Period
  - Claimant age
  - Length of employment
  - Month closed
  - Year closed
  - Year of input
  - Year of loss
  - And many other options based upon client desire

Custom Reports - In the rare occasion our clients reporting needs cannot be met by our catalogue of standard reports, or ad hoc reporting capabilities, we can custom design and develop the necessary reports to meet your needs. Our standard fee is $125/hour to for development however if the custom report requests are minimal there most likely we will not charge for this service.

Data Migration/Interface

CCMSI has developed a comprehensive and effective data migration process. As a result, we have successfully migrated data for over 40 new clients in the past two years.

We utilize a proven detailed project plan to ensure the accurate and timely migration of all data. We have built numerous data interfaces with client, insurance carrier and cost containment vendor systems.

Therefore, we have the expertise necessary to facilitate all of the City's data and EDI requirements. A few of our key processes for data migration and EDI development are as follows:

1. Securing the following information from the migrating data source
   (a) Type of database, i.e., Microsoft SQL, Oracle, Sybase, FoxPro, FileMaker Pro, etc.
   (b) Data formats available, i.e., tab delimited, space delimited, fixed length, etc.
   (c) Database definition including technical documentation containing specific information about each field, field length, field type, etc.
   (d) Data definition including documentation containing specific information about each field, what the data means and if it uses a control code
   (e) Control code definition including documentation that usually contains a numeric code and the description of the code
   (f) Custom code definitions including customized client-defined data fields and codes
   (g) Projected data for data availability including an extract of all data to date if possible. This will prove us with additional time we can use to work on the more complicated details of the data conversion (data mapping to our tables and control code equivalents)
   (h) Identification of the date that the final data set will be sent to us for conversion. This data will include control totals for post conversion reconciliation of financial data
   (i) Affect the transfer of the raw data. This can be accomplished by email using a compressed and password protected .zip file (if file size permits), or
   (j) Via a compact disc using a recording format that is Microsoft Windows compatible. It should be sent Priority Overnight that same day
2. Validate data received, i.e., check for data format, file corruption, number of tables, record length, etc.
3. Review documentation, i.e., check for completion, identification of key table and data fields
4. Actual transfer of data to Access database (contingent on the number of records in each table
5. Validate transferred data including reconciliation to supplied control totals and a check for data accuracy
6. Data Mapping including extract list of common fields and the distinct data; matching to an equivalent field in our database and adding to the MAP table

7. Control Code Definition and Mapping including an extract list of distinct codes for appropriate fields; matching to an equivalent code in our database and adding to the XREF table
8. Set up Visual Basic programs to include converting mapped data into a Microsoft Access database replica of the claims tables
9. Validation of converted data including reconciliation to supplied control totals and checking for data accuracy. We then check for duplicates and repeat the previous step of the process
10. Transfer data to SQL server
11. Final data validation check to ensure all codes embedded in the converted data conforms to Toolbar (our front end claims adjudication system) standards; to ensure all payment files balance to each other, by payment type and payment code; if available from source data, to ensure all reserve files balance to each other, by reserve type and reserve code
12. Load conversion data in production Toolbar database
13. Create Reserve database (if not received in source data)
14. Update ancillary Toolbar Financial files
15. Identification and elimination of duplicate claims
16. Resolution of unforeseen minor conversion issues as they are identified

- Describe the WC bill processing procedure. Are bills sent to a centralized office or directly to the adjusters? Please explain the system used for this process.

CCMSI is unique in that ALL Medical bills are received and reviewed by the claims representative prior to submitting through the electronic bill review process. This provides an additional level of quality control and also reduces medical costs and bill review fees. All corresponding documentation is requested at that time, if it has not already been provided. Once approved, the bills are forwarded to our medical bill review unit. At that time the bills are entered into our claims system for bill review and processing. Through our proprietary managed care delivery program, Comp MC, CCMSI scans and electronically adjudicates bills based on applicable billing practices, i.e. usual and customary and state fee schedule, and applies applicable PPO discounts. ***Duplicate charges, billing infractions and excess billings are identified and corrected, generating significant savings for CCMSI clients***. Bill images are integrated into our claims application system and readily accessible online by our clients via ICE. Payment data is electronically uploaded to our system on a daily basis. Once this is complete bills are then processed for PPO reductions. 100% of all provider bills are reviewed. Provider bills that do not match one of our PPO networks may qualify for review by our specialty bill review service, an integral part of Comp MC. Our provider bill review process is the most comprehensive and efficient as any in the marketplace.

Line-item bill reviews of invoices are part of CCMSI's service. Screening criteria includes:

- Excessive hourly fees and/or hours billed
- Duplicate billing
- Invoicing for services not provided
- Unnecessary or unsubstantiated professional billing hours

CCMSI adjusters and the Client have the ability to view all medical bills, doctor notes and EOB's online.

Within the Comp MC medical bill review process, hospital bill audits are conducted on all bills for non-participating PPO ambulatory surgery centers and hospitals (inpatient/outpatient).

This review removes:

- Invalid/inappropriate coding
- Unbundled and duplicate charges
- Charges for items/services that were not provided
- Undocumented charges & unrelated charges
- Services and/or length of stay that are outside guidelines for the diagnosis
- Excessive treatments from injuries caused by hospital/physician

Nationally our clients realized a savings of over 37% off of billed charges through our bill review process alone.

Out of Network Specialty Review:

CCMSI's Comp MC program also provides specialty bill review and negotiation cost containment services to provide substantial savings on out of network bills. We partner with an authority in specialty bill review services that provides workers' compensation and liability payers with a first line of defense to identify and dispute inaccurate provider over-billings. With firsthand knowledge of medical billing, coupled with robust industry databases, we are able to be an ally in the fight against egregious provider billing practices. With this partnership, Comp MC is able to offer the largest, most comprehensive service footprint, providing analysis of seven specialty medical bill types across 40+ states, including: Hospital Inpatient, Hospital Outpatient, ASC, Ambulance, DME, Out of State and High Dollar Professional bills. We are also able to significantly impact Implant and Long Term Care bills.

CCMSI workers' compensation clients' net savings in this area averaged 56% after addressing the largest 1-2% of the bills that typically represent 35-40% of our clients' medical spend.

In addition to specialty bill review services, we also offer an up-front negotiation service which secures maximum savings by starting at provider costs instead of billed charges. This service is available in all states for certain workers' compensation bills with total allowance of charges of at least $1,500. These negotiated bills are reviewed and returned within 10 business days of receipt and provider sign-off is obtained through a Negotiation of Charges.

- Please provide electronic link to your demo site.

  www.ccmsi.com

  User Login: **UCTST24**

  Passcode **Hujisam4**

- Do you have an internal or external RMIS support staff? If you have an internal RMIS support staff, would you be willing to assign a specific person to the city's account?

Our Help Desk is located in Danville, Illinois and also in our national CSU (Customer Service Unit) in Metairie, LA. It is open Monday thru Friday, 8AM to 5PM, CST. The claims service and CSU teams are also available at your disposal to assist with any support needs.

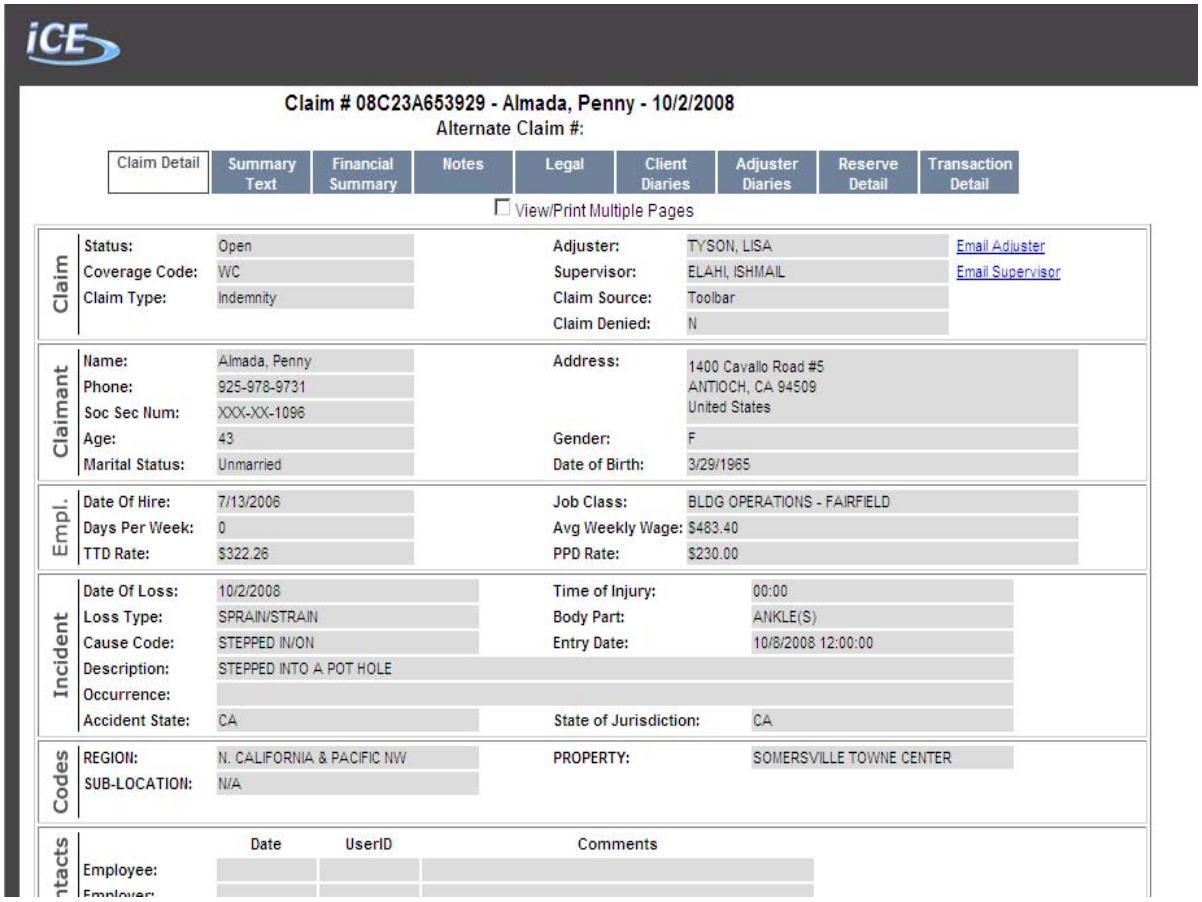
Yes, we will assign an specific person to the City's account at their request.

- Does your system allow client view only access to Adjuster Notes, diaries, transactions, reserves, and financial overviews?

Client employees with appropriate access levels will be able to review all aspects of the claims file through CCMSI's Internet Based Risk Management system, iCE. The Quick Claim Look Up function, allows the user to go directly to an individual claim for review. The information outlined below can be viewed for a particular claim file, a selected group of files, (e.g. department or division,) a particular time period, or for the Client as a whole.

Each electronic claim file is complete with commentary on the items listed below, as well as, the associated financial data. All payments made on a claim are listed on the financial transaction screens. That screen provides information on each individual payment and also contains a link to the scanned images of medical bills and reports. In addition, we offer "as of date" financial information. A simple calendar selection function allows a rollback of information to a previous date.

The following print screen details the categories viewable to the City for a particular claims file.



iCE

Claim # 08C23A653929 - Almada, Penny - 10/2/2008

Alternate Claim #:

Claim Detail | Summary Text | Financial Summary | Notes | Legal | Client Diaries | Adjuster Diaries | Reserve Detail | Transaction Detail

☐ View/Print Multiple Pages

Claim

Status:	Open	Adjuster:	TYSON, LISA	Email Adjuster
Coverage Code:	WC	Supervisor:	ELAHI, ISHMAIL	Email Supervisor
Claim Type:	Indemnity	Claim Source:	Toolbar	
		Claim Denied:	N	

Claimant

Name:	Almada, Penny	Address:	1400 Cavallo Road #5 ANTIOCH, CA 94509 United States
Phone:	925-978-9731		
Soc Sec Num:	XXX-XX-1096		
Age:	43	Gender:	F
Marital Status:	Unmarried	Date of Birth:	3/29/1965

Empl.

Date Of Hire:	7/13/2006	Job Class:	BLDG OPERATIONS - FAIRFIELD
Days Per Week:	0	Avg Weekly Wage:	$483.40
TTD Rate:	$322.26	PPD Rate:	$230.00

Incident

Date Of Loss:	10/2/2008	Time of Injury:	00:00
Loss Type:	SPRAIN/STRAIN	Body Part:	ANKLE(S)
Cause Code:	STEPPED IN/ON	Entry Date:	10/8/2008 12:00:00
Description:	STEPPED INTO A POT HOLE		
Occurrence:			
Accident State:	CA	State of Jurisdiction:	CA

Codes

REGION:	N. CALIFORNIA & PACIFIC NW	PROPERTY:	SOMERSVILLE TOWNE CENTER
SUB-LOCATION:	N/A		

ntacts

	Date	UserID	Comments
Employee:			
Employer:			

The Client will have the ability to filter claims information by any or all of the following:

- Date of loss
- Date of entry
- Date closed
- Policy Holder (if applicable)
- Claimant name
- Claimant social security number
- Claim number
- Total incurred over a specific dollar amount
- Total incurred between specific dollar amounts
- Type of claim (indemnity, medical, and/or incident)
- Claim status (open, closed, pending)
- Location/State/Department, etc
- Description codes (customized by the Client with up to 25 possible fields)
- View claims under investigation
- View denied claims
- View claimants with 1, 2, 3, 4, 5 or more claims

Once the desired claim has been located, the Client will have the ability to view the following information with a simple click of the mouse and download the information to Excel format:

- Claim status (open, closed, pending)
- Claimant information (name, address, etc.)
- Employment information (Average weekly wage, PPD rate, etc.)
- Accident information (loss type, loss cause, accident description, etc.)
- Detailed summary of claim facts and information
- Contact information (claimant, client, and medical provider)
- Ability to e-mail adjuster with any questions
- Legal information (if applicable)
- All adjuster log notes, which can be sorted by date, note activity, or adjuster in ascending or descending order. Adjuster log notes may include the following:
  - Action plan/diary review
  - Claimant contact and summary of conversations
  - Client contact and summary of conversations
  - Excess insurance information and reporting
  - All information obtained during the investigation process
  - A summary of all legal correspondence
  - A summary of all medical treatment
  - A summary of all medical case management activity
  - Reserve rational
  - Settlement evaluation
  - State reporting and correspondence
  - A summary of information regarding subrogation potential, and efforts to recover
  - Supervisor comments and direction to the adjuster
  - A summary of all vocational rehab activity
- Financial and payment transaction analysis which includes the following:
  - Pie and bar charts to provide a comprehensive and visual breakdown of claim reserves and reserve development
  - Financial information valued as of a specific date
  - Payment transactions list all financial transactions. Including check number, input date, payment amount, payee name, payment status, print date, invoice number and comment
  - Medical invoices may also include a scanned image of the invoice, any related attachments such as medical records, as well as the explanation of review.

GENERAL INFORMATION

- Can you provider a cost plus pricing fee structure?

  CCMSI has multiple contracts currently in place that rely upon a Cost Plus method of service fee remuneration. This is a viable and often preferred pricing structure for an account the size of the State. Once loss runs are made available, and finalized staffing models are agreed upon, we are very comfortable with setting this type of pricing up.

- How would you recommend MCO expenses be handled in cost plus contract?

MCO Expenses by law are required to be paid as Allocated Loss Expenses from the claim file. Unless there is specific medical care being provided, these will be coded in our system as such.

- Have you had any fines, penalties or hearings before the Division of Insurance or the Division of Industrial Relations within the past three [3] years? If so, please explain.

CCMSI enjoys a good reputation with both the Division of Insurance as well as the Division of Industrial Relations. Over the past 3 years, we have received minimal fines and administrative penalties, relative to claim audits performed on some of our largest accounts.

- Please provide 3 public entity client references preferably within the State of Nevada.

1) State of Nevada
Ana Andrews, Risk Manager
Phone: (775) 687-3192
Email: amandrews@admin.state.nv

2) Las Vegas Metropolitan Police Department
Jeff Roch, Risk Manager
(702) 828-3406
J5631R@lvmpd.com

3) City of North Las Vegas
Darlene Rosenberg, WC Coordinator
(702) 633-1508
RosenbergD@cityofnorthlasvegas.com

- Please provide Bios of the potential claim account executive contacts. If there are claims adjusters currently employed by the insured, are there options to transition those folks?

CCMSI is certainly willing to discuss potential employment opportunities with any qualified candidates referred to us by the City. These individuals would be subject to the hiring qualifications and background checks of CCMSI and local management.

Brigid Wyszomirski
Nevada State Director - Las Vegas, NV
Biographical Information

Professional Experience
Ms. Wyszomirski began her insurance career in 1993 working for Price Chopper/Golub Corporation, a self-insured grocery chain handling Workers' Compensation and General Liability claims in New York, Massachusetts, Pennsylvania, Vermont and Connecticut. She held a workers' compensation license for the states of Vermont and Massachusetts, and a multi-line adjuster's license from the state of New York. She joined CCMSI (previously known as OHMS) in June 1998 after relocating from New York, and was the lead adjuster responsible for handling Workers' Compensation claims in the diversified business unit. Ms. Wyszomirski was then promoted to State Director of Operations in

January 2000. She currently holds a Workers' Compensation hearing license and a Property/Casualty Independent Adjuster's license.

Professional Training
Brigid earned her Bachelor of Arts degree in History/Political Science from the College of St. Rose in Albany, New York. She has completed several training courses in the areas of workers' compensation, property/casualty, and claims negotiations and settlements at the Insurance Training Alliance in Cranston, Rhode Island. She has earned her AIC designation through the Insurance Institute of America, and is currently working on completion of the ARM designation. Brigid has served on the Board of Directors of the Nevada Self Insurers Association (NSIA), and the Legislative Subcommittee of the NSIA. She is also an active member of the Nevada Chapter of RIMS.

David O. Nettlebeck
Account Manager – Las Vegas, NV
Biographical Information

Professional Experience
David joined CCMSI in February 1999, and was assigned to the Clark County School District dedicated unit, handling medical only and indemnity claims. David was responsible for conducting investigations on all claims, taking numerous recorded statements from injured workers, communicating with nurse/case managers on coordination of medical care, and administering all workers' compensation benefits.

In November 2001, David was promoted to Sales and Marketing as the Senior Account Executive/Manager. David is responsible for client retention, formulation of proposals and pricing, sales cold calls, attendance at marketing functions, assistance with contract implementation, and management of accounts. David is in the process of obtaining his Property & Casualty License with the State of Nevada, Division of Insurance.

Professional Training
Prior to joining CCMSI, David participated in an intensive five-month training program specializing in Nevada workers' compensation, through which David earned his Workers' Compensation Hearing License. David also worked in sales at a local car dealership, and water softener company. He worked for a local transportation company for nine years in the operations department, and prior to that time was in the Air Force for nine years working as a facilities manager.

Lezlie Wooten
Claims Supervisor – Las Vegas, NV
Biographical Information

Professional Experience
Lezlie began her career in workers' compensation in June of 2002 as an Assistant Claims Coordinator in the Corporate Workers' Compensation office at Mandalay Resort Group. She moved over to Nevada Comp First in January of 2003 as they were offering potential for growth. She worked her way up to Claims Supervisor. In March of 2006, Meadowbrook Insurance Group purchased Nevada Comp First, where Lezlie became a Senior Claims Representative. She handled a blended caseload of indemnity and medical only claims for large and small self-insured employers, including but not

limited to, public entities, cement and security companies, casinos, mining, and non-profit organizations. Lezlie handled the State Uninsured Employers account as well as claims filed under the Heart and Lung Act.

Lezlie came to CCMSI in September of 2009 and began working on the Diversified Business team as a Senior Claims Consultant handling indemnity claims. She attends client claim reviews, provider's seminars, DIR orientations and workshops, and assists clients with training whenever requested. Just recently, Lezlie was promoted to Claims Supervisor. She trains and provides direction to the team members as well as reviews claims with them and the clients regularly. Lezlie also coordinates and facilitates monthly team meetings. She is a working supervisor with a reduced caseload, primarily handling Heart/Lung and large loss claims.

Lezlie is a licensed Hearings representative with the State of Nevada Department of Administration, Hearings Division. Lezlie also speaks Spanish as a second language.

WHY SHOULD THE CITY USE YOUR FIRM AS THEIR CLAIMS ADMINISTRATOR?

The following highlights the key areas that we feel differentiate CCMSI from our competitors and provide the basis for delivering a unique claims management approach:

1. Client Intimate Service
2. Superior Loss Cost Savings
3. Technology
4. Unique Culture

Client-Intimate Service:
CCMSI prides itself on collaborating with our clients to deliver a unique brand of client service. We have innovated a new alternative client intimate approach to TPA services by better understanding our clients and together painting the picture of their desired outcomes. A few features of our Client Intimacy model are:

First understand the State and their unique needs - CCMSI's success is built on understanding that each client is unique. Therefore, we must first understand the City, your business objectives and needs to enable us to deliver the services necessary to meet those needs and exceed expectations.

Quality Service Plan - We prepare very detailed, written handling instructions, which design the structure of the program to meet the exact specifications of each client. We then diligently ensure continuous and consistent compliance with these instructions.

Stewardship – We hold an annual performance evaluation and strategy meeting to review the prior year's performance, including service and loss cost results. In addition, we collaborate with the State to develop and innovate strategies for improving the results of the program in the next year.

Superior Loss Cost Savings:

Benchmarking:
In order to benchmark our own performance as a TPA and the performance of our clients, CCMSI conducts industry research and maintains continual focus on the trends in risk management and claims costs. Our company has been published several times in leading risk publications including Risk & Insurance Management for our work related to our cost of risk strategies and benchmarking efforts.

Proven Cost of Risk Savings:
CCMSI has proven results in reducing our client's loss costs. In our past benchmarking efforts utilizing comparable industry data (not broad general data used by other TPA's to quote savings) ***we have established that typically our average cost per claim is between 15-20% less than that of other TPAs and bundled claims services.***

Superior Claims Adjusting:

CCMSI relies on proven methodologies and outstanding adjusters to deliver the maximum loss cost savings available to our clients. We hire the best team members and provide them smaller caseloads and greater resources (such as claims assistants, superior work flow technology, etc.) than our competitors. So rather than managing an overwhelming number of claims and pushing paper, our adjusters can do what they do best which is mitigate loss costs and take care of your injured workers and claimants.

Technology:

We offer superior technology that allows us to adapt the capture and reporting of data to the City's specific needs.

A few key features of RMIS system "iCE" include –

General Features –

- 24-7 internet access to live data
- Flexible user friendly navigation
- Capability to receive data from multitude of data sources
- Password protection with varying levels of security access
- Allows hierarchy of up to 9 levels to track data by location, facility, and department, etc.
- Ability to create customized user fields
- Ability to view all claim summary and detail
- Ability to view adjuster notes by category including; summary, medical, litigation, reserves etc.
- Ability to generate state specific First Report of Injury and other state forms in PDF
- OSHA reporting
- Medical bill and medical report viewing on-line

Reporting Features –

- On-line access to monthly standard reports dating back 24 months

- User specific Dashboard showing key data upon log-in
- Complete ad-hoc reporting capabilities including financial, claims detail and loss control data.
- Summary and detail claim reporting including drill-down capabilities
- Analytical tools including historical and current period comparisons including various graphical presentation
- Cost containment savings and fee reporting

To enhance reporting results and management information for the City, we can design your reporting package to report all key information by location, facility, department, etc.

We also can provide Internet access to managers so they can review reports and specific loss information by location, facility, department, etc.

Unique Culture and Staff:

CCMSI operates a unique culture that provides a home for the highest quality adjusters and Account Managers in the industry.

Unlike our national TPA competitors, we are not owned by insurance carriers, brokers or private equity firms. ***CCMSI is a 100% employee owned ESOP (Employee Stock Ownership Plan) Company.*** This translates to our focus on the TPA industry, our people and our clients. Most of our competitors must answer to parent brokers, insurance carriers or investors whose focus remains on financial performance and return on investment.

This creates a culture that attracts the highest quality team members focused on excellent client service.

The cornerstones of our culture:

Team Member Ownership – Every team member at CCMSI is a vested owner who recognizes the way to drive value in our company is to continue to provide exceptional service to our clients.

Manageable Case Loads and Claims Support – We attract the best adjusters in the industry by offering manageable case loads (150 indemnity files on average) and the administrative support so our adjusters can focus on assisting the injured worker return to health and driving down our clients cost of risk.

Flexibility – We offer our adjusters flexible work schedules and work from home opportunities to allow for overall balance and growth as professionals and individuals.

Our culture allows us to attract and retain the highest quality staff and maintain the lowest turnover percentage in the industry. ***This provides continuity and consistent delivery of exceptional service for our clients.***

- What distinguishing services can your firm provide of which the city should be made aware?

CCMSI recognizes the importance of cost savings, and close monitoring of any and all opportunities to improve the financial exposure of our clients. In response to the growing expectation for fiscal responsibility, CCMSI established an internal Subsequent Injury Recovery department. Due to the complexity of this process in NV, and the need for accuracy in the first submission (to ensure acceptance into the Fund), CCMSI has a dedicated Subsequent Injury Fund Recovery Specialist based in our Reno office. This person's sole responsibility is to review files for eligibility, complete submission packets to send to the State of NV Subsequent Injury Account Board, and pursue 100% recovery on behalf of our clients. In 2008, CCMSI's Recovery Specialist recovered $451,123.00 for CCMSI clients, and in 2007, recovered $667,020.00 for CCMSI clients. This represents a total of $1,118.143.00 since the inception of the program, and the program has rendered a 100% success rate on recoveries for our clients.

- Please comment on your experience with public entity accounts of similar size and scope.

CCMSI has extensive experience and success in delivering claims management solutions to self-insured and governmental entities. Currently over 95% of our clients are self-insured organizations and public entities comprise the largest entity class in our organization.

We recognize governmental entities have sophisticated risk management personnel and thus have high and unique expectations. We recognize in such programs the impact of claims handling, litigation and subrogation to the self-insured organization is magnified, given that all claims are paid directly by the City. Attention to detail and process is also imperative for governmental entities as all expenditures involve strict budgeting and public scrutiny. Our TPA model serves sophisticated governmental entities by delivering a high level of communication, aggressiveness and meticulous, client- specific processes.

Understanding Unique Risks – We have a thorough understanding of the risks facing a state such as the diversity of exposure from law enforcement, firefighting, detention, healthcare, volunteer and administrative positions. Each of these roles from heavy physical trades to administrative functions requires a varying approach to both claims handling and return to work programs.

Unionized employees such as police or fire fighters may also require additional coordination with the City and/or Union Representatives to accommodate benefit payments specific to union contract requirements. CCMSI adjusters work diligently to create an open line of communication with all involved parties in claim resolution efforts.