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Job Description – ORM-C600

Depending on the line of coverage an Adjuster is assigned to, some of the following duties may not be fully applicable.

Claims Adjuster 1-4

Adjusters 1-4 are in a training series and have the same job description.

This is a highly responsible advanced journeyman position dealing with the investigation and management of claims relative to any of the lines of coverage handled by the Louisiana Self-Insurance Program. This requires advanced knowledge of claims investigation, claims law, insurance coverage, civil and criminal law and procedures, court rulings and procedures, and medical terminology. Advanced training and experience in claims investigation and adjusting are required. It is necessary in the performance of these duties to be ready and able to travel to any part of the State of Louisiana or elsewhere.

The person in this job performs the following:

- Investigates, evaluates, and negotiates the most complex personal, casualty, and property claims.
- Performs field investigation tasks including but not limited to:
 - Inspecting an accident site
 - Developing facts of an accident from any physical evidence available
 - Taking photographs
 - Taking measurements
 - Inspecting vehicles for damages/defects
 - Making field notes
 - Making sketch drawings of accident scenes
 - Performing background checks on claimants
 - Researching agency documents
 - Obtaining recorded statements from claimants, witnesses, law enforcement officers, etc.
- Investigates, evaluates and resolves serious, complicated compensation and jurisdictional issues.
- Evaluates litigated and non-litigated cases involving but not limited to all levels of temporary, permanent, and/or multiple disabilities, future medical care payments, etc.
- Evaluates findings, prepares written report and makes recommendations toward further handling of the claim which would include settlement/defense if the case is in litigation.
- Handles litigated and non-litigated files with reserves in excess of \$1,000,000 which include but are not limited to the following types of cases:

- Catastrophic losses
- Quadriplegia
- Paraplegia
- Double amputation
- Brain damage
- Total blindness

Note: These coverages are mandated to be reported to Excess Carrier

- Resolves unique coverage issues including cumulative trauma cases where coverage may involve multiple carriers or claims.
- Provides notice and updates to Excess Carrier regarding any claim which may exceed the state's primary policy limits.
- Determines litigation, prepares claims with attorneys for legal action, attends mediations and trials and testifies in court concerning the results of investigations conducted.
- Directly supervises cases on appeal, excess carrier cases and second injury fund cases.
- Identifies and refers cases involving salvage and potential subrogation recovery to the subrogation unit for handling.
- Must maintain daily relationships of a complex nature with public and private officials at the highest level requiring a high degree of tact and diplomacy.
- Oversees the rehabilitation of injured workers, working closely with the rehabilitation counselors in an effort to return the claimant to a gainful occupation.
- Evaluates permanent partial and permanent total disability cases upon completion of the rehabilitation program to determine claimants' occupational ability and/or settlement value of the case.
- Contacts treating physicians and/or arranges independent examinations of claimants with a medical specialist.
- Assumes an active role in litigation management.
- Maintains direct and constant contact with the assigned defense counsel.
- Evaluates cases involving litigation, working closely with the assigned attorney in developing strategy, budget, etc.
- Obtains legal opinions and case evaluations from defense attorney especially on cases requiring legal interpretation and/or posing major financial losses to the state.
- Is responsible for analyzing, planning, and managing activities of counsel in determining responses to pleadings, motions, discovery, etc.
- Authorizes the taking of necessary depositions of employees, plaintiffs, or expert witnesses.
- Supervises in the preparation of state employees for trial.

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- Attends trials and offers defense counsel assistance and evaluates performance of counsel.
- Is responsible for requesting issuance of contracts to experts and other contract vendors.
- Is responsible for monitoring contracts for professional services and requesting amendments when necessary.
- Analyzes results of contracted services upon completion of work product.
- Works closely with defense counsel in determining plan of action and a litigation budget based upon complexity and exposure of case.
- Reviews bills received on all vendors providing contracted services for accuracy and appropriateness making adjustments as necessary, then approves for payment.
- Authorizes payment of benefits, damages, and/or judgments, This includes receipt of invoices, verification of services/equipment, etc.
- Consults with claimants and/or their attorneys concerning the possibilities of settlement of claims.
- Receives and reviews all bills associated with the claim, reducing costs as necessary and approving for payment.
- Coordinates claims through an exchange of information and/or by acting as a liaison with other state entities , e.g., social security, unemployment, retirement system, family security, police departments, group benefits, Office of the Attorney General, etc.
- Makes recommendations and participates in the development of policies and procedures for the claims unit. Assumes the duties of State Risk Adjuster 5 in his/her absence, if so authorized.
- Attends meetings and conferences as required for information regarding coverage and/or to obtain or assist in closing a specific file.
- Attends training/educational opportunities in order to gain additional knowledge and improve job performance.
- Performs any and all other duties as assigned.
- Adjusters, Supervisors and Managers are subject to be moved to another unit at the discretion of management.

INTRODUCTION – ORM-C601

Claims Adjusters in the various departments perform some activities the same. The procedures are designed so that the activities that are in common are listed in General Procedures, ORM-C800's. Activities that are specific to Medical Malpractice because of the nature of the work performed are listed in this set of procedures.

Medical Malpractice defends hospitals and doctors, nurses and other medical care providers. Physicians working in private practice treating private patients and who have a contract to work with Louisiana State University are sometimes covered by the state's malpractice insurance, depending upon the terms of the particular contract with the state. Medical Malpractice is governed by a separate statute, R.S.40:1299.39

Medical Review Panel

A medical review panel is standard in medical malpractice cases. The medical review panel is composed of an attorney who acts as chair with no other function except secretary/administrator, a physician named by plaintiff or plaintiff counsel, a physician named by defendant (the state), and a physician jointly named by the two physicians already named. If there is a conflict of interest with a physician, the attorney chair and the appointing attorney jointly choose another physician.

The plaintiff and defense each give evidence to the attorney chair. The panel reviews the evidence and comes to a decision before a suit can be timely filed. If a suit comes in before the panel has decided, the suit is deemed premature and subject to dismissal. Whichever side wins the panel pays for the panel. The attorney chair can charge up to \$2000 and each physician can charge up to \$300. The plaintiff can file an affidavit for paupership; if that occurs, the state must pay the panel cost. Filing fee charged is \$100.00 per named defendant. It must be paid by the claimant to the Medical Review Panel before the claim is considered viable.

The assigned Claim Adjuster maintains close contact with state hospitals.

SET UP NEW CLAIM FILE – ORM-C602

Responsibility

The assigned Claims Adjuster performs the following activities for setting up a new claim file.

Forms or Reference Material Required

Appointment and Contract Approval Form (g:\Claims-General\ORMtemplates)

ORM-C800 Claims Adjuster 1-4 General – Set Up New Claim File section

Procedure

Litigated Claims

A panel request is filed through the Division of Administration, Medical Review Panel office, and a panel number assigned.

NOTE: All suits filed prior to a decision being rendered by the Medical Review Panel are in violation of RS 40:1299.39.1. The defense counsel will be instructed to file an Exception of Prematurity on all suits filed without the claim first being submitted to the Commissioner of Administration for a Medical Review Panel.

1. Review the petition.
2. Enter the case into STARS. Refer to Set Up a New Claim File – ORM-C802.
3. Request 2 sets of medical records from defendant medical care providers. Send 1 complete set to defense counsel upon receipt.
4. Investigate the case to determine coverage and whether the state has primary coverage.
5. Review any depositions associated with the case.
6. After filing fees are received, complete **Appointment and Contract Approval Form** for attorney assignment by the Attorney General's Office; scan copy of the panel request, certification that fees have been paid, and the Appointment and Contract approval Form and e-mail to adjuster's address. The scanned materials are then e-mailed to the Division of Risk Litigation.
7. Review the state attorney panel submission and plaintiff attorney panel submission.
8. If suit is filed, contact plaintiff attorney for an informal extension of time within seven (7) days of receipt of claim. Request a scanned copy of the lawsuit if received through the mail. Forward a copy of the suit to defense attorney. Place hard copy in the file.
9. Confirm extension in writing to plaintiff attorney (**30 Day Extension Form Letter**).
10. Update and track legal information on all suits, requests for medical review panels, and other claims with plaintiff attorney involvement.

11. Upon notification of attorney assignment, forward copy of medical records to assigned attorney and enter the appropriate attorney and defense counsel information in the STARS Litigation screen.
12. Document all work activity in STARS Attachments/Notes.

Medical Record Review

Medical records are reviewed and may be used to shape the defense of a case. The medical record reviews become a part of the case files.

1. Request two certified copies of the records from the hospital/medical facility. Forward one copy of the records to the defense attorney. Give the retained copy to ORM medical director for review.
2. If independent nursing review seems necessary, select a nurse from the approved list of contract medical records reviewers in the file g:\contract\adjusters (fiscal year).doc (or for the current year) to review the case and read medical records. Persons on the list are rotated.
3. Send the adjuster's copy of the medical records to the medical record reviewer. The records may be copied and a copy retained.
4. The medical record reviewer analyzes the records and prepares a report. The medical record reviewer sends the report and the adjuster's copy of the records back to the assigned Claim Adjuster.
5. Forward a copy of the medical record review to the defense attorney in the case.

Investigation

1. Upon receipt of the medical records or request from assigned defense counsel, determine the need for an investigation and who is to be responsible for the investigation.
2. Obtain approval of supervisor for assignment of outside Adjusters/investigators.
3. Take recorded statements of witnesses in person, if possible, or by telephone if supervisor approves.
NOTE: Recorded statements of primary witnesses are transcribed, but those of secondary witnesses may be summarized.
4. Make recorded tapes available for review by defense counsel if necessary.
5. Prior to entering into any settlement negotiations with plaintiff, obtain settlement authority in accordance with approved authority levels and limits as defined by ORM-C800 General procedure – Request for Settlement Authority section
6. Obtain a release on all settlements; if suit has been filed, instruct attorney to obtain a dismissal.

Non-Litigated Claims

If non-litigated case arises, refer to Set Up a New Claim File – ORM-C802.

CASE MANAGEMENT – ORM-C603

Responsibility

The assigned Claims Adjuster performs the following activities involving case management.

Forms or Reference Material Required

ORM-C800 Claims Adjuster 1-4 General – Case Management section

Adjuster Fact Sheet for Claims Council (g:\Claims-General\ORMtemplates)

Medical Closing Checklist (g:\Claims-General\ORMtemplates)

Procedure

Unfavorable Medical Review Panel (MRP) Decision

1. Contact the defense attorney to request a recommendation for settlement or defense of the claim; update the claim file and the Adjuster Activity Sheet.

NOTE: The defense attorney shall provide written reasons for his/her recommendation. A settlement recommendation by the defense attorney must include a full quantum evaluation and specific recommendations for settlement dollars requested.

2. Obtain the possible judgment value from the defense counsel.
3. Adjust reserves in accordance with the information provided.
4. Request that the defense attorney provide the requested information within thirty (30) days from the receipt of the written request.

NOTE: This requirement also applies to a Material Issue of Fact Decision in which the MRP states that there was a breach in the standard of care, but the breach did not cause the damages.

Independent Medical Expert

1. Prior to consideration of settlement or trial, ensure **every** medical malpractice claim is evaluated for the necessity of review by an **independent** expert in the appropriate area of medicine involved in the incident.
2. If necessary, retain more than one independent expert if more than one medical specialty is involved.

NOTE: Physicians at Tulane School of Medicine may be considered independent experts **only if** Tulane staff, residents, interns or medical students are not involved in the care in question.

STARS Litigation Tracking

1. Enter appropriate code for pre-panel lawsuit in STARS MRP and Litigation screens.

2. Prior to file closure check legal tracking for accuracy and completeness (see medical closing checklist).

Reporting Requirements for In-House Claims Investigations

Initial Report

1. Complete the first report within sixty (60) days of receipt of the medical records.
2. Place a copy of the report in the claim file.
3. Provide a copy of the report to unit supervisor.

Final Investigative Report

1. Within six (6) months of receipt of a claim or prior to Claims Council decision regarding settlement or defense, complete a final **Investigative Report** and include the report in the claim file.
2. Ensure the report includes facts of the case and a full evaluation including the opinion of the medical expert(s) for defense.
3. If the report includes the plaintiff's expert opinion (if known), ensure that the opinion is clearly identified as such.
4. Provide the unit supervisor (Adjuster 5) with a copy of the report.

Pre-Trial Status Report

1. Review the file at least six (6) weeks prior to an anticipated trial date.
2. Ensure the claim file contains a status report from the attorney including expert opinions and the attorney's recommendation regarding settlement versus trial. For obtaining settlement authority, refer to ORM-C800 General procedure – Request for Settlement Authority section.
3. If a status report is not in the file, immediately prepare and forward a written request to the defense counsel; provide a copy of request to the unit supervisor.
4. Before going to Claims Council, prepare and give Adjuster Fact Sheet for Claims Council (g:\Claims-General\ORM Templates) to unit supervisor for review and approval to try the case.
5. Present the case to Claims Council for final decision.

Subrogation

Subrogation potential may exist for medical equipment malfunctions. If so, follow procedures outline in ORM-C800 General procedure – Case Management / Subrogation Process section.

Mediation

Authority to mediate is given by appropriate supervisory level depending on the amount of settlement authority sought. Mediation may be conducted after settlement authority has been granted.

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1. Adjuster attends and participates in mediation.
2. Attorneys for both plaintiff and defense, the assigned Claims Adjuster, and as required other ORM personnel meet to mediate a case. Attorneys for each side make an opening statement.
3. The attorneys present their sides of the case.
4. The assigned Claims Adjuster and any other ORM personnel evaluate the case in monetary terms to determine some maximum amount to offer the plaintiff, not to exceed the amount authorized by Claims Council and approved by DRL.
5. During mediation, if authority granted is not sufficient to settle, parties may agree upon a number to recommend to ORM for further authority.
6. Mediation agreement is signed by both attorneys and ORM adjuster.

CLAIMS PAYMENTS – ORM-C604

Responsibility

The assigned Claims Adjuster performs the following for paying claims.

Forms or Reference Material Required

ORM-C800 Claims Adjuster 1-4 General – Claims Payments C804 section
Claims Payment Form

Procedure

Paying Claims Invoices

Refer to Claims Payments – ORM - C804.

Issue Settlement Check

Refer to Claims Payments – ORM - C804.

Future Medical Expenses in Medical Malpractice Claims

The assigned Claim Adjuster additionally handles future medical bills that are for medical care from the date of acceptance into the future.

1. When any settlement involves payment of future medical expenses, create a separate claim containing a copy of the necessary settlement documents.
2. Obtain supervisor approval of settlements for future medical expenses if the amount exceeds his/her authorized limit.
3. Close the primary claim.
4. If there is a yearly maximum on a future medical claim, clearly note that information in STARS Attachments/Notes.
5. Log each payment and document a running balance on these types of future medical claims.
6. Adjuster fills out Claims Payment Form and sends along with invoice to the Med Mal Administrative Coordinator. Make applicable payments within sixty (60) days of receipt, unless additional information is needed.

Request for Purchase

1. If a medically necessary purchase is required (usually for future medical bill), ensure a W-9 is on file for the company selling the item, e.g., a company selling a van funded by the state.
2. Send written confirmation to vendor to purchase the item. Ensure that the required approval authority is obtained for the purchase.
3. When the invoice is received, pay as for a claim invoice. Refer to ORM-C800 General procedure – Claims Payments section

RESERVES – ORM-C605

Responsibility

The assigned Claims Adjuster performs the following activities for Reserves.

Forms or Reference Material Required

ORM-C800 Claims Adjuster 1-4 General – Reserves section

Procedure

1. Compute an initial reserve upon receipt of the file. Up to your authorized amount may be entered. If more is needed, request supervisor/manager to enter the higher reserve. May use Eason's Louisiana Quantum Study to establish an initial reserve for the case.
2. Within ninety (90) days of receipt of the initial case assessment from the attorney, realistically evaluate and reserve the claim.
3. Set 6 month diary to review reserves with attorney.

DIARY AND ACTIVITY REPORT – ORM-C606

Responsibility

The Assigned Claim Adjuster performs the following activities for diary entry and completing the Adjuster Activity Report.

Forms or Reference Material Required

Procedure

Diary

Initial Diary Entries

Refer to Diary and Activity Report– ORM-C805.

Diaries During and at End of Case

Refer to Diary and Activity Report– ORM-C805.

Activity Report

Refer to Diary and Activity Report– ORM-C805.

CONTRACTS – ORM-C607

Refer to ORM-C800 Claims Adjuster 1-4 General – Contracts section

REQUEST FOR SETTLEMENT AUTHORITY (RSA) – ORM-C608

Refer to ORM-C800 Claims Adjuster 1-4 General – Request for Settlement Authority section

CLAIMS COUNCIL – ORM-C609

.Refer to ORM-C800 Claims Adjuster 1-4 General – Claims Council section

MISCELLANEOUS ACTIVITIES – ORM-C610

Responsibility

The assigned Claims Adjuster performs the following miscellaneous activities.

Forms or Reference Material Required

Claims History form (g:\Claims-General\ORMTemplates)

Future Medical Information form (g:\Claims-General\ORMTemplates)

Procedure

Reservation of Rights

If needed, refer to Miscellaneous Activities – ORM-C800.

Meetings

If needed, refer to Miscellaneous Activities – ORM-C800.

Trial

Attend trials when required or when appropriate.

Credentialing

Refer to statute R.S.40:1299.39.1 State Medical Review Panel

1. Adjuster receives request from credential verification personnel.
2. Adjuster checks to see if the doctor has an existing folder and reviews for previous claims.
3. Also check in STARS Rolodex to see if any claims exist. Search for doctor's name in Payee Name: field (format - %name%) and click Search button.
4. Do another search using a comma after the name. This ensures a full search review.

If any claims exist:

5. For LSU facilities, provide them with MRP information and lawsuit. Complete the Claims History Form (g:\Claims-General\ORMtemplates) and send the verification to requestor.
6. For non-LSU, fill out the non-LSU form (g:\Claims-General\ORMtemplates) and send to requestor along with lawsuit only.

FUTURE MEDICAL CARE FUND

Set up New Claim File

The assigned Future Medical Care Fund adjuster reviews the file materials provided by the original handling adjuster from Road Hazards, Transportation of General Liability

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Units. This material includes a copy of the settlement documents or judgment which provides the amount for future medical care payments agreed upon in settlement or awarded by way of judgment.

The adjuster determines the amount to be entered into the Financial Bucket in STARS from file materials provided in #1. If the award is capped, MED/BI reserves are set at that amount.

The adjuster enters the file information into STARS. Refer to Set Up New Claim File ORM-C802.

Coverage code for all Future Medical Fund files shall be 9900.

File activity is to be entered into STARS attachments.

The file is to be diaried appropriately on a case-by-case basis.

FUTURE MEDICAL CARE FUND PAYMENTS

The assigned adjuster shall review the invoices received and determine the relatedness to the injury which arose from the litigation. If the treatment, service or medical equipment is unrelated, the invoice is returned to the vender.

The adjuster must check to determine if the invoice is a duplicate.

Refer to Claims Payments – ORM C804 “Future Medical Expenses”

Utilize Pay Type 1P73 for all future medical care fund payments.

Refer to “Request for Purchase” in claim payments – ORM C804 when a request for durable medical equipment, can, etc. is received.

Close a file – ORM-C611

Refer to ORM-C800 Claims Adjuster 1-4 General – Close a File section