Client Service Plan

Introduction

1. The attached Client Service **Executive Summary**

The attached Client Service Plan (CSP) is a compilation of information and requirements agreed to between Sedgwick/CMS and the District of Columbia Government Office of Risk Management for the administration of the Disability Compensation Program. It is designed as a reference for DCORM and representatives of Sedgwick/CMS for claims handling guidelines above and beyond basic claims handling techniques and Sedgwick/CMS Standards and Procedures. The manual is divided into 18 sections with sub-topics in each section.

Sedgwick/CMS has assigned Frank Young as the dedicated Operations' Manager to work with key DCORM contacts in the day to day management of DCORM's Disability Compensation Program. The key contacts at DCORM are as follows: Evelyn Lucas Manager, Disability Compensation; Augustina Ammah, Disability Compensation Specialist; Cara Pearson, Disability Compensation Specialist and Susana Suarez, Program Analyst/Return to Work Coordinator. DC's Office of General Counsel (COTR) is the contact on litigated claims.

Sedgwick/CMS has (2) corporate locations that service this account. There are dedicated adjusters in each of these units responsible for the overall claims handling.

Safety oversight and training is provided by DCORM Safety Specialist.

Plan (CSP) is a completion of information and requirements agreed upon Sedgwick/CMS and the DC Office of Risk Management (DCORM) for the administration of the Disability Compensation Claims Management Program. It is designed as a reference for DCORM and representatives of Sedgwick/CMS for claims handling guidelines above and beyond basic claims handling techniques and Comp Management's Standards and Procedures.

The Client Service Plan documents key elements of basic and value added services. The Client Service Plan is designed as a reference guide to answer questions regarding requirements or procedures that impact overall program results for ORM and Comp Management.

2.1 Client Claims Philosophy

The District of Columbia Office of Risk Management (DCORM) believes in handling all claims promptly and fairly, treating each injured worker with concern, compassion and understanding in accordance with the law of the DC Government jurisdiction. DCORM will use all available resources to administer

legitimate claims as well as to investigate and resist fraudulent and questionable claims.

2.2 Client Background

The District of Columbia Office of Risk Management (DCORM) Claims Bureau is responsible for the oversight, supervision and administration of the Disability Compensation Program (DCP), which covers approximately 33,378 employees. The DCP is a comprehensive, statutorily mandated, self-insured workers compensation program applicable to District government employees. Its purpose is threefold:

To award compensation benefits to injured workers covered by the statu and to eligible survivors of employees whose cause of death was directly attributable to a work injury or occupational illness;

To provide funding for appropriate medical treatment, including emergency medical care, after a District employee sustains an injury or an illness on the job: and;

To facilitate expeditious Return to Work for the injured workers.

3. Account Management

3.1 Client Service Visits

The Client will conduct monthly meetings as needed with DCORM. The purpose of these visits are to:

- Establish program goals and objectives
- Maintain service relationship
- Evaluate and measure program results

3.2 Phone Call Responsiveness

The prompt return of all calls is essential. Calls from an injured worker, OAG, ORM contact or key vendor contact must be returned the same business day or within 24hrs. Under no circumstances, shall a call be returned in excess of twenty-four (24) hours from date of receipt.

3.3 Conversion/Re-classification of Claims

Any claim originally reported as a medical only claim, which requires additional investigation on compensability or denial issues, will be converted immediately to a lost time case.

Medical only claims will be immediately converted to indemnity claims as soon as verification of lost time is received. An explanation of the claim conversion will be documented in the claim notes as soon as the conversion occurs.

Closed files will be immediately re-opened upon notification that a recurrence has taken place. Keep all pertinent information with Claim system.

3.4 File Retention - (To be updated)

3.5 Assigned Examining Staff

The Sedgwick/CMS Manager must immediately notify ORM in the event of any reassignment of an adjuster servicing this program. ORM reserves the right to participate in the interview and selection of candidates considered for the program.

3.6 Claims Closure

Sedgwick/CMS is to conduct regular reviews of all open Workers' Compensation indemnity files and promptly close all files as permitted by DC regulation. All indemnity files without substantive activity will be considered for closure at six-month intervals. At the time of claims closure, the ORM claims contact will receive notification of said closure.

3.7 Current Contract Period

The term of the contract is for three (3) base period years from: December 1, 2008 through December 1, 2011. Included are two (2) one year option periods, with Performance and Incentives and Disincentives.

3.8 States/Jurisdictions Serviced

District of Columbia – Public Sector

3.9 Client Service Plan

The Client Service Plan will be distributed to each Sedgwick/CMS Service Center and the DCP staff.

4. Claims Management

Sedgwick/CMS performs all necessary claims management functions including determination of compensability, eligibility for benefits, payment of medical benefits, identification and referral of cases to rehabilitation, establishing reserves and developing an appropriate payment system. The following identifies the components of our claims management program.

4.1 Claims Reporting

Claims will be reported by employee's supervisors directly to Sedgwick/CMS. Call Center at 888-8DC-Claim (888-832-2524). The operator will conduct a comprehensive interview and produce a claim report. All claims will be assigned a system generated claim number within twenty-four (24) hours of receipt.

4.2 Acknowledgment

Within 24 hours of receipt of a claim, the claims adjuster will send an acknowlegment letter to the injured worker. The acknowledgment letter will contain the system generated claim number assigned to the file, adjusters name and contact information.

4.3 Indexing

Sedgwick/CMS will index all Workers' Compensation indemnity claims utilizing the Sedgwick/CMS Index Bureau number upon receipt of a claim. All open claims will be reviewed by Sedgwick/CMS at six (6) month intervals to determine if there has been any new information updated from the claims bureau.

4.4 Initial Three Point Contact

Sedgwick/CMS shall ensure that three-point 24-hour contact is completed on each new lost claim or that reasonable attempts to complete the three-point 24-hour requirement is evidenced and documented in each file. Reasonable attempts shall mean three or more spaced telephone calls on the day of assignment and the day after. Unsuccessful attempts to contact the parties by phone shall be followed by a letter to that party advising that the adjuster must speak to the party. Efforts of attempt to contact all three parties must be included in the claim file notes. If after 21 calendar days of the initial attempt to complete the three-point contact, contact is not made, the adjuster shall send a notice of determination to the claimant controverting the claim and or notice of abandonment.

Notification to injured worker of adjuster assignment, claim number and contact information in writing. Notification shall be sent whenever there is a change of adjuster.

4.5.1 Medical-Only Claims Contact

When warranted the Sedgwick/CMS adjusters are required to contact the injured worker, and treating physician. Contact will be initiated as deemed necessary in the course of investigating compensability and to screen claims for consideration of Early Intervention.

4.5.2 Indemnity Claims Contact

Within twenty-four hours (24) hours of receipt of an indemnity claim, the Sedgwick/CMS adjuster will initiate contact with the supervisor, injured worker, and treating physician for a determination of return-to-work status and compensability of the claim. All discoveries will be documented.

If the injured worker is unable to be contacted within the first twenty-four hours from the time the claim is reported, a contact letter will be mailed to the injured worker within the first 24 hours after claim receipt.

4.5.3 Internal Investigation

The investigations shall include consideration of severity of injury, potential extent of disability, questions of eligibility for compensation, verification that the accident or injury occurred on the job and opportunities for subrogation.

Sedgwick/CMS shall research past claims information and document all ISO reports, including former claims, if any, and injuries reported from those claims in the case file.

The Sedgwick/CMS adjuster should conduct a telephone investigation whenever possible. To the extent the adjuster determines there is a need for outside investigation, the Claims Manager should be contacted. At all times the name of the person spoken to should be documented in the file notes: name of adjuster at Commission, name of nurse at doctor's office or name of DCP contact, etc.

A twenty-one (21) day investigative summary should be included in all files. It should be succinct and address, compensability and a strategy for claim resolution. (ST and AP)

4.6.1 External Investigations

Sedgwick/CMS will recommend the use of an external investigation as the need arises on a per claim basis. The claims adjuster will select the surveillance company based on the quality of past work, references and pricing. All other external investigations (e.g. AOE/COE, subrogation, etc.) will require notification of and discussion with the Claims Manager, a Disability Specialist or the Disability Compensation Manager prior to completing the referral initiating the service. All fees will be coded as an allocated expense.

The Sedgwick/CMS claims adjuster, in collaboration with the Disability Compensation Branch, will arrange for on-site investigation of catastrophic cases within twenty-four (24) hours of occurrence.

4.7 Recorded Statements

The Sedgwick/CMS adjusters will take recorded statements from the injured worker and all witnesses on:

- All claims involving questions of compensability, injury severity and/ or subrogation.
- Late notice claims
- Stress claims

All recorded statements shall include a description of the accident, witnesses, treating physician and previous injuries, etc.

4.8 Compensability Determination

Each claim should be reviewed to ensure that the claim meets all criteria for compensability. The review must include a determination as to whether the

claimant is eligible to receive benefits under any other coverage (i.e: injured workers who are eligible for PIP benefits). Evaluate potential coordination of concurrent or conflicting laws or benefits such as Federal Disability and DC Retirement, ADA, FMLA, LTD, PTO, Sick Leave, wage continuation, etc.

Should questions of compensability arise, the claims adjuster shall identify a clear plan of action (POA) to investigate compensability of the claim. The investigation should proceed with a final determination being made within twenty-one (21) days of notification. If a determination of compensability cannot be made within twenty-one (21) days, a clear rationale for the inability must be documented in the case history. All proper and timely filings must be completed with the appropriate jurisdiction. Any claims involving suspected fraudulent activities or questionable actions are to be reported to the Claim Manager, Disability Compensation Branch and DCP's Office of Attorney General.

Each claim must be evaluated for the presence of "fraud triggers".

4.9 Benefit Payments

Benefits are to be accurately calculated and documented on all files to include calculation workup and all related changes during the life of the claim. All wage benefits will be processed and payment issued within 5 calendar days of benefits due after Continuation of Pay (COP) period ends. Ongoing payments will be paid on a bi-weekly basis or weekly basis, if a supplemental check is required consistent with the DPM Instruction.

Payments are to be accurately calculated for employee compensation, health and life benefits including but not limited to verification of an employee's average wage from the appropriate District agency contact person and calculation of loss of wage benefits.

Verify the relationship of dependents for assigned payments (via birth certificates, guardianship and or adoptions papers).

Documentation regarding disability should be current in order to validate issuance of disability benefits.
Medical bills are to be appropriately paid on compensable claims within 30 days of receipt.

4.10 Reserves

Initial reserves should be posted within ten (10) days of receipt of the claim. Indemnity, medical and allocated expenses must be included when calculating reserves. Reserves should be documented in the file as soon as supporting medical and/or legal information is received. All cases should be reserved to ultimate exposure as soon as sufficient information has been received to justify the proposed reserve changes.

Reserve amount shall be determined based on current medical diagnosis and other actual information, including disability duration guidelines and shall confirm the reserve accuracy at each diary review.

Sedgwick/CMS shall avoid using "stepladder" or stair step reserving to meet the current expenditures on the claim and reserve to meet the probable or expected total cost of the claim based on current available information

DCORM should be informed in writing of any initial or subsequent reserve change of $50,000 or more. Any reserve greater than $50,000 must be approved by a Compensation Specialist or the Disability Compensation Manager.

4.11 File Documentation

An initial file summary including compensability resolution, medical documentation, reserve justification and plan of action will be completed and documented in the case notes on all Workers' Compensation claims within twenty-one (21) days of receipt of the claim. Updated case analysis summaries will be completed and documented no less than twenty-one (21) days after completion of the initial summary. These summaries will include any and all information that relates to the direction and value of the case, plan of action and target date of completion and closure of the claim.

The adjuster will set forth a factual account of the loss occurrence, steps taken toward verification of factual events and documentation and preservation of related factual data. An outline of further intended actions and necessary investigation with specific time frames for completion must be included.

4.11 Diary/ Plan of Action

Sedgwick/CMS adjusters are required to maintain a thirty (30) day diary on all files unless circumstances of the file development warrant extending the diary. In the event the diary is extended, the basis for the extension must be clearly documented in the file notes. The initial adjuster's review will be a 25 diay diary for file review, NOD filing.

The Contractor shall develop a plan of action in the file with a timeline that provides information on how the claim adjuster intends to move the claim to closure.

4.13 Reporting Requirements

A formal narrative status report will be filed on all claims with an incurred value of $100,000 or more. All other than maintence files.

Claims involving the following are to be reported **regardless of reserves:**

- Fatalities
- Brain injuries resulting in impairment of physical functions
- Spinal injuries resulting in partial or total paralysis of upper or lower extremities
- Amputation or permanent loss of use of upper or lower extremities
- All other injuries resulting in disability of 6 months or more
- Severe burn injuries
- Loss of sight of one or both eyes or sensory loss
- Injuries with significant psychoneurotic involvement

4.14 Supervision

The Sedgwick/CMS Claims Supervisor will be pro-actively involved in the supervision and management of individual claims. Supervisors shall review all files at setup and no later than 30 days after set-up. Supervisors should review medical-only claims if open longer than six (6) months. Supervisors should review cases with material triggers, including physician's PPD ratings, significant reserve changes, legal representation, and consideration of assigned surveillance, subrogation, fraud triggers and referral to Early Assessment.

Supervisory direction should be clearly documented as a value-added contribution to the overall claim file. The claim file will reflect supervisory guidance by direct memorandum or file entries in the case history.

4.15 Settlement Authority (Claims Not in Litigation)

Settlement evaluations will be made promptly, based on information included in the file and other relevant information. Where warranted, settlement will be pursued in a timely and aggressive manner and all negotiations will be handled internally by the claims adjuster. In order to obtain settlement authority, a **Settlement Evaluation Form** must be completed by the claims adjuster and sent to the Disability Compensation Branch for review. Structured settlements should be pro-actively pursued where it is cost effective to do so.

4.16 Reconsiderations

When an injured worker files a request for reconsideration with DCORM on an adverse decision, The DCORM Claim Analyst will render a decision to support, overturn or remand the claim back to the examiner based on an independent review of the claim. As part of a review, the supervisors may be engaged for consultation in the form of a conference call to discuss prior findings, variances or new investigation which may have been developed. The workflow for the reconsideration is as follows:

- The Reconsideration is received at ORM, date stamped and provided to the program analyst who
- A copy is given the claim SCMS CA for imaging

- The case is logged by the Program analyst and folders prepared and provided to the Claim analyst and the SCMS supervisor for review and possible conference call.
- On Friday's the log of the weeks reconsiderations is distributed to both Claim analysts, both Claim supervisors and the SCMS Manager for review as appropriate
- Claims that warrant discussion are reviewed on the following week's conference calls.
- Decision is rendered by the Claim analyst.

5. Subrogation

Sedgwick/CMS will immediately evaluate and monitor all cases for potential subrogation recoveries. The adjuster will discuss all potential subrogation cases with the DCP Branch or General Counsel on litigated claims. Should the Sedgwick/CMS claims adjuster desire not to pursue subrogation, the adjuster will contact the Sedgwick/CMS Account Manager and DCP Manager regarding this decision and document the claim file accordingly. A final decision will be obtained by the Account Manager from DCP's Workers' Compensation Manager and or Workers' Compensation Specialist.

The claims examiners will document subrogation activities in the claim history and send lien letters and updated lien letters. Liens will not be compromised without approval of the Disability Compensation Branch or OAG in litigated claims. The claims examiners will resolve and recover liens and document the file accordingly. If there is a statute of limitations issue approaching, the examiner will engage OAG.

5.1 Recovery Accounting

- All checks must be endorsed for **deposit only** and deposited within 24 hours or one business day.
- Subrogation/Recovery checks are to be included in the Monthly Detail Loss Summary Reports.

All checks are to be made out to DC Treasurer

6. Medical Management

Sedgwick/CMS shall establish and maintain a panel of local preferred physicians, orthopedic, neurology and specialist (neurology) for the Disability Compensation Program (DCP) based on the District's population and type of claims.

Sedgwick/CMS shall maintain and provide a listing of Preferred Provider Organizations (PPO) to employees upon notification of injury or illness. The

listing shall be customized to provide a District-specific PPO including the addition or deletion of specific providers to meet the needs of the District.

7. Independent Medical Examinations

The Sedgwick/CMS claims adjuster is responsible for scheduling/coordinating IMEs. If a nurse case manager is assigned to the claim, a discussion is to be held by all parties to discuss case strategy. The results of the IME will be shared with both parties so that case resolution goals can remain a coordinated effort.

7.1 Medical Case Management

Cases involving the following loss factors are to be reviewed by an Early Intervention Nurse (in-house) for telephonic medical case management:

- Cases with an anticipated lost time of 14 days or more
- Cases involving the back, neck, head, shoulder, knee or multiple body parts
- Stress claims
- Occupational disease claims
- Cases that have reached $2,500 in incurred medical expenses.

The early intervention nurse (in-house) will contact the injured worker and treating physician. The nurse case manager will make three aggressive attempts to make these contacts and will document attempts in the case history notes. Contacts are to be made within 24 hours of receipt of the claim. The nurse case manager's goal is to obtain information regarding the treatment plan and expected return to work date. This information is to be compared with medical and return-to-work criteria to ensure that effective and efficient medical care and return-to-work parameters are followed.

The case manager will address the following issues with the provider: diagnosis, complaints and prognosis. The case manager will develop treatment plan alternatives, if the current treatment plan varies from standard protocols for similar injuries. There must be an explanation of how the proposed plan will maximize the employee's recovery and expedite the date of return to full or modified duty.

The nurse case manager will obtain current physical capabilities and or work restrictions, the worker's medical history and pre-injury job duties as well as light duty opportunities. The identity of any additional medical providers involved will be obtained, along with the date of the next appointment.

All parties are responsible for timely documentation of claims and medical information in the case history notes. The Early Intervention Nurse (in-house) must be notified of all cases re-opened by Sedgwick/CMS that warrant medical

management in order to monitor medical treatment and assist the injured worker as necessary.

Task/Onsite Assignments

Task and Onsite medical management activities must be considered when lost time approaches 3 months and requires permission from DCP for assignment

8. Return to Work Programs

All Sedgwick adjusters and Early Intervention Nurses (in-house) are expected to proactively work with treating physicians to determine what employees **can** do, as well as to obtain objective work restrictions and educate the treating physicians about DCP's return to work programs.

9. Vocational Rehabilitation Services

Sedgwick will actively manage and direct the rehabilitation process, in an effort to assist the injured worker in returning to suitable employment. Quality of services and cost must be taken into consideration when selecting a rehabilitation vendor. All updates will be communicated by phone and activities documented in file notes. There is a 3 month limit for vocational services. Any vocational rehabilitation beyond 3 months or $3500 in cost requires the approval of DCOR. Vocational vendors must be given a budget not to exceed $3500.00.

The claims adjuster must request permission from DCP before assigning vocational rehabilitation to a case. All rehabilitation reports on litigated claims shall be copied to the Office of the Attorney General.

10. Medical Cost Containment

10.1 Fee Bill Audit and PPO Discounts

Sedgwick/CMS will utilize its bill fee review software to review and adjust each medical bill to usual and customary or state-mandated fee schedules. CMS will review all medical bills for availability of PPO discounts where applicable.

10.2 Pharmacy Benefit Program

Scriptnet, a nationwide workers' compensation pharmacy benefit program, is currently available to all injured employees. They will allow injured workers to conveniently fill their prescriptions for treatment of occupational injuries at more than 55,000 pharmacies nationwide, with **NO** out of pocket expenses and **NO** waiting for approvals.

11. Client Audits

The customer's claim files housed in Sedgwick/CMS offices will be available for audit during normal business hours. DCP will identify the files to be reviewed and the list will be sent to Sedgwick/CMS at least two weeks in advance of the audit. Advance notice will provide sufficient time to prepare the necessary claims records for auditing. **The Account Manager will be given prompt notification of the audit schedule.**

11.1 Formal Audit Program

The purpose of the formal audit is to conduct a quality review of randomly selected claim files in order to ensure that employees are receiving the Workers' Compensation benefits due them, the claims handling is cost effective and that the program is managed in a technically competent and proactive manner.

11.2 Formal Audit

A formal audit will be conducted at least quarterly at the selected field location. The audit team will consist of personnel from the DCP Branch..

11.4 Corrective Action Plan

In all instances where the formal audit reveals deficiencies, the account manager must prepare a corrective action plan. The corrective action plan must be submitted to the audit team within 30 days of receipt of the audit report. In the event intolerable situations or conditions persist, the audit team will collaborate with Sedgwick/CMS on an early resolution of problems.

11.5 Scope

The scope of the audit is based on the Performance requirements out lined in the RFP for TPA services. Advance notice of the scope will be given to Sedgwick/CMS prior to the random selection of claims. The results of prior audits, as well as DCP's need to identify and analyze claims handling trends and problems, will determine the scope of each audit.

11.6 File Submission

Original claim files should be submitted for review with all of the activity notes, payment records and reserve calculations. Any information not submitted may have an adverse effect on the final evaluation of the file. The file will be rated on the information contained within the file jacket.

11.7 Rating the Entire File

The entire handling of the file is considered for rating purposes. If the initial handling was done by one adjuster, that portion of the work would be considered along with the current adjuster's work in arriving at the rating. This will hold true for files where two or more adjusters are handling separate aspects of the same accident. If the deficiencies are attributable to someone other than the current adjuster, the comment section should contain a notation of where the deficiencies occurred.

It is the responsibility of the handling adjuster to review all files transferred to him/her and identify all elements of work which may not meet requirements. The ability of the new adjuster to correct prior deficiencies will have a positive effect on the overall file rating.

12. Litigation Management

If a Workers' Compensation file is in litigation, file activities are directed by the claims adjuster in consultation with the Office of Attorney General. All direction on the file will be provided by the adjustor to OAG, except that a file shall continue to be adjusted in the normal course by the adjuster. A file shall be designated in litigation whenever the following triggering events occur:

- Upon the issuance of a notice of informal conference.
- Upon the application for a formal hearing.

A file shall also be designated in litigation whenever benefits, being paid pursuant to an order, are terminated without an agreement by the parties...

Whenever one of the above events occurs, the file shall be forwarded to OAG within **5 business days** of notice of the triggering event and the date that the file is forwarded to OAG shall be documented.

When a file is in litigation, settlement authority lies within ORM. All settlement discussions, including requests for demands, shall emanate from ORM or claim representative unless the claims adjuster has been given explicit authority by ORM to request a demand or make an offer.

If COUN gives instructions to the Claims Examiner concerning the direction of a file in litigation, the adjuster shall document the directions given by COUN in claim system in order to facilitate claim resolution. If COUN's directions are received by e-mail, the adjuster shall paste the e-mail into claim system file. COUN may also document directions if it deems necessary to avoid confusion. All communication from defense attorneys must be coded "LG" in JURIS.

It is established that a litigated claim is directed by COUN; however, the Workers' Compensation Branch expects the claims adjuster to offer suggestions and propose strategies for file resolution when the case is transitioned to COUN as well as during the litigation process.

13. Financial Administration

- The Contractor shall submit invoices on a monthly basis. Invoices shall be prepared in duplicate and submitted to the agency Chief Financial Officer (CFO) with concurrent copies to the Contracting Officer's Technical Representative (COTR). The address of the CFO is:

Office of Finance and
Resource Management

Attention: Accounts Payable
441 4th Street, N.W., Suite 890N
Washington, D.C. 20001

DCOFRM Contact Name:

Kimberly Poole
Financial Specialist
Office of Finance & Resource Management

Phone: 202-727-2719
amber.wilson@dc.gov

Chanelle Hendrix
Manager, Accounts Payable
Office of Finance & Resource
Phone: 202-727-0731
chanelle.hendrix@dc.gov

Sedgwick/CMS Contact:

Michael Wilson (update)
Operations Support Services
Phone: 901 547-4571
Fax: 901 415-3275
Michael.wilson@sedgwickcms.com

Reconciliation:

202-727-0333 DCORM/Accounting Department

14. Sedgwick/CMS Claim Funding

Each Month the Office of Treasurer shall issue a check in the amount pursuant to the contract.

15. DCORM Contacts

15.1 DCORM Office:

District Office of Risk Management
441 4th St. NW.
800 South
Washington, D.C. 20001

15.2 Primary DCORM Contacts:

Evelyn Lucas, Manager Disability Compensation Program
441 4th Street N.W.
800 South
Washington, D.C. 20001
Phone: 202-724-2487
Fax: 202-727-8319
Email: evleyn.lucas@dc.gov

Augustina Ammah, Disability Compensation Specialist
441 4th Street N.W.
800 South
Washington, D.C. 20001
Phone: 202-727-6563
Fax: 202-727-8319
Email: Augustina.ammah@dc.gov

Cara Pearson, Disability Compensation Specialist,
441 4th Street N.W.
800 South
Washington, D.C. 20001
Phone: 202-727-9508
Fax: 202-727-8319
Email: cara.pearson@dc.gov

Susana Suarez, Program Analyst/Return to Work Coordinator
441 4th Street N.W.
800 South
Washington, D.C. 20001
Phone: 202-727-3475
Fax: 202-727-8319
Email: susana.suarez@dc.gov

Office of the Attorney General

Andrea Comentale

Section Chief
Tel. No 202 724-5564
Fax 202 347-8922
Andrea.Comentale@dc.gov

Kevin Turner
Assistant Attorney General
Tel. No. 202 724-5474
Fax 202 347-8922
Kevin.Turner@dc.gov

Pamela Smith
Assistant Attorney General
Tel. No. 202 724-4081
Fax 202 347-8922
Pamela.Smith@dc.gov

Justin Zimmerman
Assistant Attorney General
Tel. No. 202 724-5603
Fax: 202 347-8922
Justin.zemmerman@dc.gov

Charles Tucker
Assistant Attorney General
Tel. No. 202 724-6611
Fax: 202 347-8922
Charles.turcker@dc.gov

Frank McDougald
Assistant Attorney General
Te,. No. 202 724-7309
Fax: 202 347-8922
Frank.mcdougald@dc.gov

LaVana Fitzhugh
Tel.No. 202 724-2029
Fax 202 347-8922
Lavana.Fitzhugh@dc.gov

16. Sedgwick/CMS Company

16.1 Sedgwick/CMS Workers' Compensation Service Centers

Frank Young
Operations Manager
202 585-3711
Fax: 202 727-8319
Jackie.orr@sedgwickcms.com

441 4th Street, NW
Suite 800S
Washington, DC 20001

Laura White
Claims Supervisor
202 216-4705
Fax: 202 727-8319
Laura.white@sedgwickcms.com

1212 NY Avenue NW
Suite 500
Washington, DC 20005

Angela Jones
Claims Supervisor
202 216-4705
Fax: 202 216-4749
Merle.gaithermorgan@sedgwickcms.com

441 Fourth Street, NW
800 South
Washington, DC 20001

Berlina Smith
Claim Assistant Supervisor
202 216- 4715
Fax: 202 216-4749
Berlina.smith@sedgwickcms.com

1212 N.Y. Avenue, NW,
Ste. 501
Washington, DC 20005

Cathy Clanton
Claim Examiner
202 585 3707
Fax: 202 727-8319
Catherine.clanton@sedgwickcms.

441 Fourth Street, NW
800 South
Washington, DC 20001

Selma Taylor
Claim Examiner
202 585 3708
Fax: 202 727-8319
Selma.taylor@sedgwickcms.

441 Fourth Street, NW
800 South
Washington, DC 20001

Anthony Banaszewski
Claims Examiner
202 585-3710
Fax: 202 727-8319
Anthony.Banaszewski@sedgwickcms.cor

441 Fourth Street, NW
800 South
Washington, DC 20001

Debra Bademan
Claims Examiner
202 585-3714
Fax: 202 727-8319
debra.bademan@sedgwickcms.com

441 Fourth Street, NW
800 South
Washington, DC 20001

Shan Rasanayagm
Claims Assistant
202- 585-3703
Fax: 202 727-8319
Shan.rasanavagm@sedgwickcms.com

441 Fourth Street, NW
800 South
Washington, DC 20001

Steve Sweeney
Claim Examiner
202 216-4713
Fax 202 216-4749
Melissa.icban@sedgwickcms.com

1212 N.Y. Avenue, NW,
Ste. 501
Washington, DC 20005

Kateca Malone
Claims Examiner
202 216-4707
Fax: 202 216-4749
Kateca.malone@sedgwickcms.com

1212 N.Y. Avenue, NW,
Ste. 501
Washington, DC 20005

Siobahn Barnett
Claims Examiner
202-216-4706
Fax: 202-216-4749
Sioahn.barnett@sedgwickcms.com

1212 N.Y. Avenue, NW,
Ste. 501
Washington, DC 20005

Seymore Wray
Claims Examiner
202 216-4712
Fax: 202 216-4749
Seymore.wray@sedgwickcms.com

1212 N.Y. Avenue, NW,
Ste. 501
Washington, DC 20005

Lauren Whitaker
Claims Examiner
202 216-4707
Fax: 202 216-4713
Lauren.whitaker@sedgwickcms.com

1212 N.Y. Avenue, NW,
Ste. 501
Washington, DC 20005

Marlise Skinner
Clinical Supervisor
202 216-4716

1212 N.Y. Avenue, NW,
Ste. 501

Fax: 202 216-4749
Marlise.skinner@sedgwickcms.com
Washington, DC 20005

Tiffany Bruce
Customer Serv. Rep.
202 216-4706
Fax: 216-4749
tiffany.bruce@sedgwickcms.com
1212 N.Y. Avenue, NW,
Ste. 501
Washington, DC 20005

Tiffany Johnson
Receptionist/Claim Assistant
202 216-4700
Fax: 202 216-4749
Tiffany.johnson@sedgwickcms.com
1212 N.Y. Avenue, NW,
Ste. 501
Washington, DC 20005

Information Systems

17.1 Via-One/JURIS

DCP has access to Via-One and JURIS for claims reporting, client inquiry access and report generation. Concurrently, DCP has access to Risk Master (Prior TPA) for claim inquiries and report generation.

Questions related to Via-One or JURIS claim systems should be directed to Support Service at (901) 415-7800.

18. Report Distribution

Type of	Frequency	Number of	DCORM

Report		Copies	Recipient
Stewardship Report	Annually	1	DCP Manager
Monthly Claims Summary Report	Monthly	1	DCP Manager
Weekly Pre-Fund and Supplemental Pre-Fund Reports t	Weekly	2	DCP Manager, DCP Claims Specialist
Savings Report	Quarterly Within 5 days after the end of each Quarter	1	DCP Manager