Workers' Compensation Insurance Glossary

Administrative Services Only (ASO): An agreement employers use when they fund their employee benefit or workers' compensation plan but hire a vendor to administer it.

Actuarial Services: The TASB fund provides an actuarial report estimating the Fund Member's outstanding workers' compensation loss and allocated loss adjustment expense reserves to coincide with the Participation Period or the Fund Member's fiscal year.

Allocated Claim and Cost Containment Services Fees: Regardless of the original submission date of the claim, the Fund will allocate the Allocated Claim and Cost Containment Service fees for any services during this participation period to the appropriate claims.

Adjust: The process of investigation, evaluation, and disposition of liability claims following generally accepted claim handling standards.

Aggregate Deductible: The district agrees to cover losses up to a certain amount (the deductible) during a policy year, and the insurer pays for losses exceeding that amount, with a cap on the total amount the insured (district) will be responsible for, regardless of the number of claims.

Annual Premium: The premium is determined by the estimated payroll expenditures for the fiscal year.

Administrative Services Only (ASO): An arrangement where the district outsources the administrative tasks related to the workers' compensation program, like claims processing and reporting, while retaining the funding and risk for the program.

Case Management: Involves coordinating care and resources for injured workers, aiming for safe and efficient returns to work while managing costs and ensuring compliance with regulations.

Catastrophic Claim: An injury that results in significant long-term damage, disability, or loss.

Electronic Data Interchange (EDI): Refers to the standardized electronic exchange of claim data, like first reports of injury (FROI) and subsequent reports of injury (SROI), between claims administrators and state agencies, using industry standards like those from the International Association of Industrial Accident Boards and Commissions (IAIABC).

Fee Schedule: Fees associated with the claims submitted by type. (See below for claim types)

> **Report Only Claim:** A notification to the insurer about an incident or injury without initiating a formal claim.
>
> **Medical Only Claim:** A claim where an employee seeks medical attention for a work-related injury but doesn't experience any lost time from work, meaning they can return to their regular duties or modified duties immediately after treatment.
>
> **Indemnity (Lost Time) Claim:** A claim where an employee cannot return to work in any capacity; therefore, they are due compensation for lost wages or income.

Independent Medical Examination (IME): An evaluation of an individual's physical and psychological symptoms to assess whether they are eligible for disability benefits or compensation for a physical injury or psychological trauma.

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Interlocal Participation Agreement: A contract between two or more local governmental entities (like cities, counties, or school districts) to cooperate on a specific project or service, allowing them to pool resources and expertise for mutual benefit, often for purchasing goods or services.

Investigative Surveillance Services: Involves monitoring employees suspected of fraud or exaggerating injuries, using methods like video surveillance and social media investigations to gather evidence.

Loss Control / Risk & Safety Services: Services that aim to reduce workplace injuries and related costs by identifying and mitigating hazards, improving safety practices, and implementing effective training programs.

Medical Necessity Review: A process where the workers' compensation carrier determines if a medical service or treatment is necessary and appropriate for a patient's condition, ensuring coverage and payment.

Medicare Reporting: All workers' compensation claims involving Medicare beneficiaries settling on a full and final basis, including those with Medicare-approved WCMSAs, must be reported to the Centers for Medicare and Medicaid Services (CMS).

Peer Review: An evaluation of medical treatment by a physician who wasn't involved in the injured worker's care, verifying the necessity and appropriateness of the treatment.

Pharmacy Network/Ancillary Services: A group of pharmacies that a Third-Party Administrator contracts with, while "ancillary services" encompass a range of medical services beyond those provided by hospitals or doctors, like physical therapy, lab tests, or home health care.

Pre-Authorization/ Utilization Review: The processes used by healthcare providers and insurance companies to ensure medical services, procedures, or medications are necessary and appropriate before they are approved for coverage.

Reserve: The monetary evaluation of an individual claim's total financial exposure as determined by the insurance carrier.

Run-In Claims: Existing claims carried over from a previous claims administrator and transferred to the Fund for claims administration.

Specific Excess Insurance / Stop Loss Coverage: Designed to protect a company from unexpected high-cost claims due to a single, serious, or catastrophic accident. This coverage reimburses the employer when a claim or claims resulting from a single occurrence exceed the self-insured retention.

Self-Insurance: Allows the district to fund its workers' compensation claims instead of paying premiums to an insurance company. The District would assume the financial risk.

Self-Insured Retention (SIR): The SIR acts as a deductible and is usually stated in increments of $100,000. The district would never pay more than that specific, capped amount for claims resulting from a single occurrence.

Specialty Bill Review: A thorough examination of complex medical bills, often exceeding standard fee schedules, to ensure accurate and fair payment, potentially leading to significant cost savings.

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Standard Medical Bill Review: The process where qualified experts review a patient's medical bill to ensure all charges are correct and that the district is not being unnecessarily overcharged.

Subrogation: The right of an insurance carrier to pursue a third party responsible for an employee's injury and recover the costs paid out for the claim.

Texas Department of Insurance (TDI): Division of Workers' Compensation (DWC): State department that oversees and administers workers' compensation regulations.

> **Texas Workers' Compensation Work Status Report – DWC 73:** Form used by treating doctors to document an injured employee's ability to work, including any restrictions.
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> https://www.tdi.texas.gov/forms/dwc/dwc073wkstat.pdf
>
> **Texas Workers' Compensation Report of Medical Evaluation – DWC 69:** Form used by a physician to certify that an injured worker has reached maximum medical improvement and assign an impairment rating. To certify impairment ratings, a doctor must complete a training course and receive permission from the Division to issue these reports.
>
> https://www.tdi.texas.gov/forms/dwc/dwc069medrpt.pdf

Third-Party Administrator (TPA): An organization that handles claims administration, medical management, and other aspects of the workers' compensation programs on behalf of employers or insurers for self-insured companies.