



# Comprehensive Workers Compensation Solutions

**5** petabytes of data

Medicare compliance approach  
that can save you an average of **\$2.5** million  
in aggregate Medicare Secondary Payer (MSP)  
exposure per thousand claims

Industrywide claims database  
that contains approximately **950** million  
claims, including more than 79 million  
workers compensation claims

Improve your  
ability to become **100** percent  
compliant with state and  
federal law

# Why choose us?

**BREADTH OF SOLUTIONS:** We offer a comprehensive set of products and services that address the complex needs of the workers compensation line of insurance.

**ANALYTICS:** We develop leading-edge analytics and embed them in our products to help you maximize productivity and minimize risk. We analyze vast stores of data and give you the answers you need to make optimal decisions.

**DATA:** As an organization committed to providing insights from analytics, we manage more than 5 petabytes of data and have vast data resources to assist your organization.

**SECURITY:** We've obtained third-party evaluations and attestations of our security and privacy controls.

**EXPERTISE:** We have a multidisciplinary team of highly credentialed individuals with advanced academic degrees and backgrounds in actuarial science, data management, statistics, analytics, predictive modeling, claims management, law, and medicine.

**REPUTATION:** We're a leading source of information about risk and have been a trusted intermediary for the property/casualty industry since 1971. We're deeply committed to the workers compensation industry and have been at the forefront of developing groundbreaking solutions and delivering advances for many years.

# Our Spectrum of Workers Compensation Solutions

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**Workers compensation costs are mounting on many fronts. With the combined ratio still well above 100 percent, there's little room for error. How much can your bottom line continue to take?**

**It's time to take control and turn things around. And we can help.**

**With decades of experience that spans every function of the workers compensation line of insurance, no one understands the complexities and intricacies better than we do.**

In the workers compensation arena, the volume of data is massive and continues to grow. Being able to extract meaningful information from that data and find critical insights necessary to manage the line profitably is more important than ever. That's precisely what we do. Our expertise provides us with the ability to manage, mine, and analyze large volumes of data that you can use to improve decision making.

Our comprehensive set of products and services helps you find patterns in complex data sets and navigate the complexities of this dynamic and data-intensive line of business.

By using the data, analytics, expertise, products, and services we offer, you'll be able to:

- make more informed decisions
- improve efficiency
- better manage your expenses
- limit your liability
- curb your losses
- improve your loss ratios

**We can help you take control of rising workers compensation costs.**

## FRAUD DETECTION AND MITIGATION

### Workers compensation insurance fraud

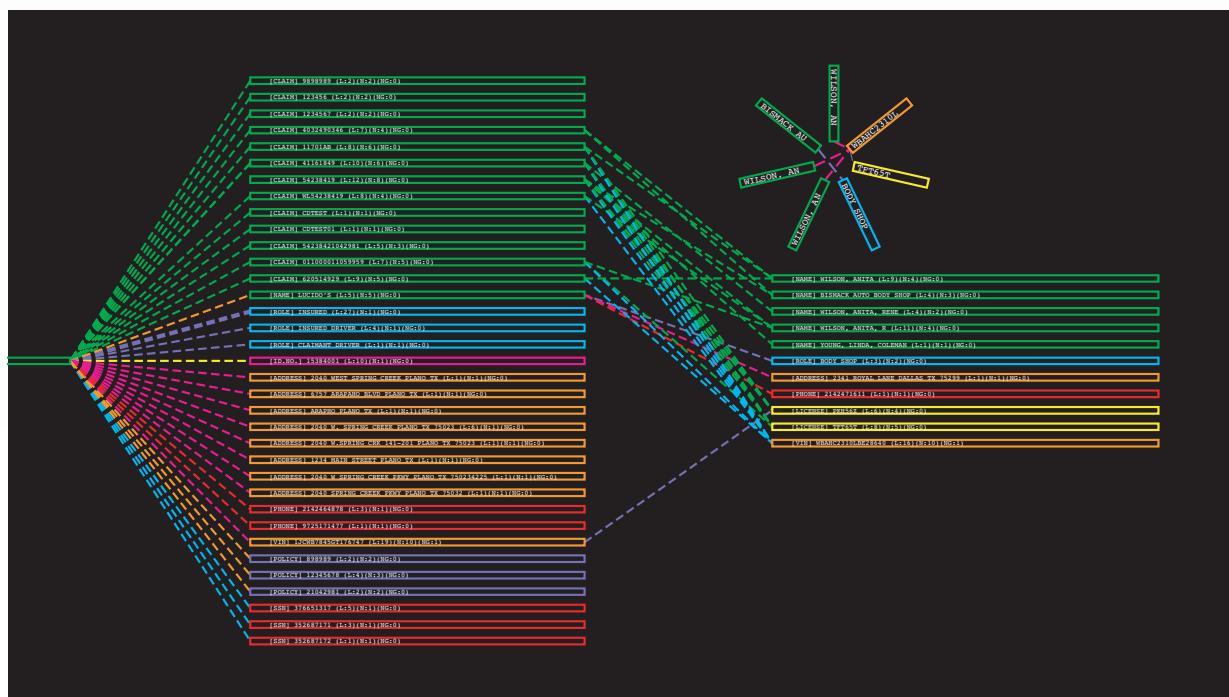
**As new workers compensation fraud schemes continue to pop up and become more complex, the ability to connect the dots to spot suspicious claims or patterns of fraudulent activity is critical.**

To help you combat mounting fraud losses, we have an industrywide claims database that contains approximately 950 million claims, including more than 79 million workers compensation claims. With match reports including data from three major segments (property, casualty, and auto), the system is the insurance industry's most comprehensive resource for claims professionals. When you report a workers compensation claim to our system, you'll get a match report that includes information on other claims with matching data in key fields. The reports average 5.4 matches per claim entered, with an 85 percent hit rate for each claim.

For each claim you enter, you'll also get a report on 15 fraud indicators across all lines of business. The fraud indicators can help you identify questionable claims and increase referrals to your company's special investigation unit (SIU) and the National Insurance Crime Bureau (NICB). When applicable, one or more fraud indicators will appear for each involved party. The indicators include prior SIU involvement, prior salvage, professional discipline and sanctions, prior claims history, and more.

Our claims reporting service also offers a comprehensive array of claims solutions in one platform. The service includes a supervised claims scoring system that improves decision making and helps you process a large number of claims quickly and efficiently, expedite meritorious claims, and detect and route any suspicious claims for further investigation. The service also includes powerful third-party information — such as vehicle location reports and social media findings — that helps you identify trends related to unreported employment, involvement in activities claimants alleged they were unable to perform, and claimant surveillance opportunities.

You can also use our powerful link analysis and data visualization technology to spot suspicious activity and investigate claims. The system analyzes large amounts of data to find internal and external fraud. The software finds hidden connections, such as parties linked to multiple addresses, telephone numbers, vehicles, and claims, and identifies suspicious patterns.



## Premium fraud

An estimated \$9.1 billion\* of the property/casualty industry's losses to insurance fraud is attributed to premium fraud associated with the workers compensation line. That's because even though premium fraud scams are abundant, they are often complex and well hidden and can take much time, effort, and expertise to discover and convict in court.

To prevent and combat premium fraud, we've developed a product that analyzes thousands of data elements from various sources simultaneously to identify the inconsistencies of data relationships with the risk information a business owner submits on the application for coverage. It also analyzes losses, misclassifications, and anomalies of a submitted risk in comparison with similar risks in the same business and location.

With access to a wide range of data sources and the ability to make previously unseen connections between vast amounts of data, the product provides you with a single source to confirm and validate key risk information at the time of risk submission. It also enables you to evaluate risks at the time of renewal to determine if the risk, or any associated terms, is still within the underwriting criteria or terms for a particular line of business. The product can help you take a hard look at your accounts and more easily identify potential trouble spots requiring further investigation.

The product uses data from business statistics, insurance company contributions, and third-party resources. Contributory insurance company data includes specific risk information at the time of submission, final premium audit findings from previous coverage periods, claims data, and bad-debt collection reports. Third-party resources include public data as to ownership of the risk, related companies within the same family of businesses, gross sales and payroll, SIC/NAICS codes, financial information such as liens and bankruptcies, and social media information.

We designed the product to target small to midsize commercial accounts — typically the risks that either fall below the inspection or examination of specialist underwriters or are fast-tracked for underwriting purposes. If your organization has limited capital resources and underwriting capabilities to tackle premium fraud, you'll benefit from incorporating our premium fraud analysis into your underwriting processes.

Additionally, we offer a number of technical information products and training services for underwriters and premium auditors. We're your source for advisory information that can help you properly classify exposures for commercial casualty insurance, including workers compensation, general liability, and commercial auto.

**While bogus injury claims outnumber premium scams, most premium scams cost insurers much more. Experts estimate that, for every \$1 lost through claimant fraud, at least \$4 to \$5 is lost through premium fraud.**

## Medical fraud

Medical fraud has become increasingly problematic for property/casualty insurers. Multiple streams of information sources — such as claimant histories, medical billing data, and provider paperwork — create an environment in which greater and more sophisticated medical billing ploys can flourish.

To fight the evolving fraud schemes, we've created a solution that puts the power back in the hands of individual insurers. We've developed the industry's first medical fraud detection model that integrates the strength and efficiency of highly advanced analytics with a clinically expert Human Touch™ validation process.

We combine our proven expertise in complex data systems with our deep knowledge of property/casualty claims, medical coding, and provider billing by applying clinical conditions and multivariate models to our clients' individual data. The solution quickly reveals patterns of aberrant treatment and billing behaviors that might otherwise go unnoticed.

\*Coalition Against Insurance Fraud



We bring an unparalleled breadth and depth of expertise to our clinical review and validation process. Our highly experienced clinical analysts are able to help you prioritize providers and cases most deserving of SIU attention as well as prevent false positives that other automated detection solutions frequently deliver. The process identifies new and evolving schemes, ensuring the continual improvement of the underlying analytics in the solution to help detect and prevent future suspicious activity.

We provide you with reliable, specific, and actionable cases. As evidenced by its 90 percent referral acceptance rate, the solution helps you avoid the delays and costs associated with false positives, which can be a huge burden on already-strapped SIU resources.

Our approach allows you to identify fraud at the source — and at the earliest stages in the process — for the highest possible returns. Now you can identify potentially fraudulent activity before it reaches significant levels.

Our solution can help you:

- discover pockets of fraud risk in your own medical billing data that might otherwise go undetected
- prioritize exposure associated with specific medical providers to increase productivity
- conduct faster, more effective investigations so you can close a greater number of cases
- improve your ability to analyze claims accurately and process legitimate first-party medical bills quickly
- improve overall customer service and increase customer satisfaction

## COMPLIANCE REPORTING

### State reporting: Workers compensation compliance

**As states continue to change their regulatory requirements to improve the workers compensation system, they're calling on insurers to report increasing amounts of detailed workers compensation data. With internal IT resources shrinking and legacy systems aging, keeping pace with the changing requirements of all the jurisdictions in which you write and ensuring you're in compliance are complicated, resource-intensive tasks.**

When it comes to reporting and compliance, we consistently remain ahead of the pack, creating innovative products that address current issues and are adaptable to accommodate future demands. For instance, we:

- were the first to deliver on the promise of transactional reporting for compliance
- are your “one-stop shop” for automated reporting of all your electronic compliance requirements
- are leading the way in the development of advanced analytics for workers compensation compliance

As a major participant in the workers compensation arena, we maintain active relationships with the top industry organizations, such as the IAIABC and WCIO, working to develop electronic data interchange (EDI) standards and improve the way the industry manages and uses its vast amounts of data. We have a dedicated team of highly experienced and credentialed professionals, many who've been integral members of key EDI committees, task forces, and forums. Through our work with those groups, we've developed a suite of offerings designed specifically for insurers, third-party administrators, and self-insureds and other offerings designed specifically for state accident boards, commissions, and data collection organizations.

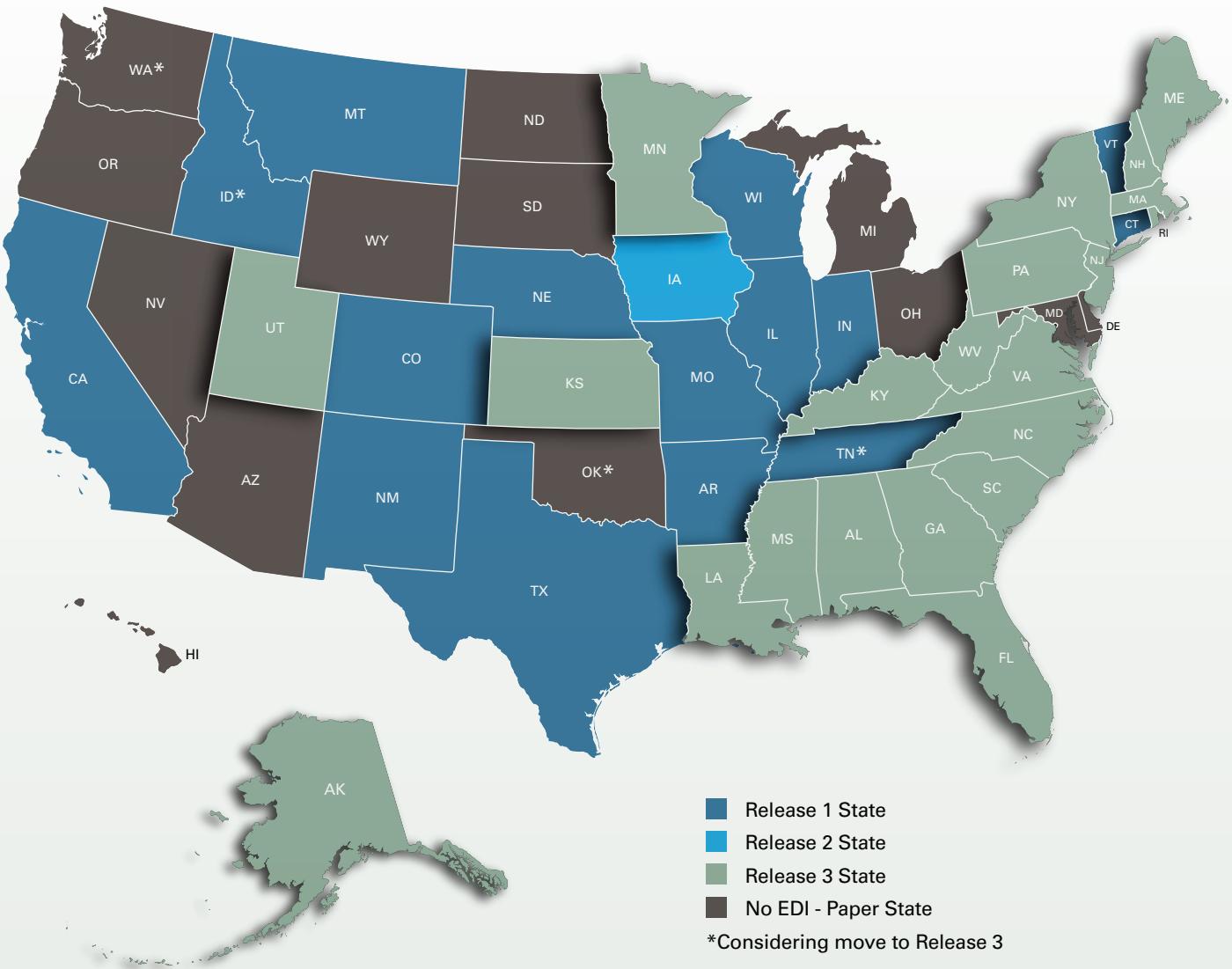
Through our experience handling both sides of the EDI transaction with both insurers and states, we've gained critical insights into the compliance reporting needs of each group. By working with us, you not only get the power of our industry-leading compliance solutions but also our knowledge, connections, foresight, and expertise.

We provide a complete suite of compliance reporting products that offer:

- back-office processing support
- advanced analytics
- injury and policy reporting
- data conversion
- proof of coverage

Those services can help you save money, increase data quality, improve workflow, and ensure timely reporting and compliance when writing your business. In fact, we're the first and only “one-stop shop” for automated reporting of all your electronic compliance requirements.

Our advanced analytics can provide you with a clear picture of your reporting and compliance performance state by state, identify areas of concern, and help avoid potential fines. You can monitor your compliance reporting as a group and by region or office, monitor third-party administrator productivity and accuracy in compliance reporting, and identify where issues lie to create business efficiencies or consolidate processes. You can also uncover discrepancies between the data elements you capture and those required for reporting.



## The move to EDI Release 3 continues to gain momentum

As more and more states move closer to adopting the IAIABC's new Release 3 standard for electronic reporting of first and subsequent reports of injury (FROI and SROI), insurers must deal with a mix of issues. One of the most complex issues for insurers will be redesigning their current reporting systems to capture all the appropriate subsequent reporting maintenance type codes, and, more important, to report them in the appropriate sequence to satisfy the different jurisdictions.

Triggering subsequent reports has always been a labor-intensive process for insurers. With Release 3, they will need to build new triggers and make workflow changes to accommodate the additional required subsequent reports dictated by each state's implementation plan. Insurers will also need to integrate edits for FROI and SROI reports to make sure their systems provide the most effective workflow at the presubmission level.

Insurers who've relied, in the past, on transactional acknowledgments from the states to determine necessary correction activity will need to do extensive correction-management planning for each jurisdiction as states adopt the new expanded requirements.

We have the compliance reporting services and the expertise to help you with your workers compensation reporting needs in all the jurisdictions in which you write, regardless of the regulatory requirements or the EDI Release in place.

## Federal reporting: Medicare and Medicaid compliance

**Compliance with Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) presents many challenges for your organization's systems, processes, and personnel. It also creates significant potential for liability and the need to address all aspects of compliance before settlement.**

### Section 111

Our Section 111 compliance tools address compliance in a way that considers your organization's systems and claims handling procedures. They also minimize intrusion into your adjusters' time and workflow and ensure error-free compliance.

As the most advanced systems in the industry, our solutions not only report data but also offer analytics to provide insight and guidance to manage claims and ensure proactive compliance.

Specifically, our Section 111 compliance tools provide:

- continual monthly queries of every claim
- fully automated checks of claims data for compliance
- notifications about potential reportability issues and missing or incomplete data
- presubmission editing for first-time accuracy
- legal analysis on all Section 111 and Medicare Secondary Payer (MSP) issues from the largest in-house attorney group in the industry
- integration of escalation procedures
- single-entry error correction and data entry into your claims systems or our web-based portal
- seamless integration of Medicare Set-Aside (MSA) and conditional payment compliance
- direct data extraction from your claims systems or manual entry through web interface — with the same quality and error-free results
- out-of-the-box functionality
- a flexible rules-engine architecture for quick response to changing requirements of the Centers for Medicare and Medicaid Services (CMS)

We can also conduct a compliance audit of your Section 111 reporting process to help you avoid penalties, reduce costs, and expedite conditional payment negotiations with the CMS.

Additionally, we can keep you in compliance with the Medicaid reporting and verification requirements in Rhode Island, where insurers that write workers compensation or liability policies are required to participate in a data match program called the Medical Assistance Intercept System (MAIS).

### Medicare Set-Asides

When the Medicare Secondary Payer (MSP) statute was enacted, it charged the Centers for Medicare and Medicaid Services with protecting Medicare's "future interests" in cases involving Medicare beneficiaries or potential beneficiaries. CMS identified Medicare Set-Asides as the preferred method for allocating money to pay for this future treatment. We developed a solution that has saved our clients significant time and money through a combined medical and legal approach to identify issues and make sure they pay only for what is necessary — and nothing more.

Our MSA service provides:

- a convenient online referral process
- easy document upload
- quick turnaround
- monthly management reports
- free nationwide file copy and pickup service
- client newsletters, webinars, and training

### Conditional payments

Our conditional payment services consist of investigation, consultation, and compliance services that can help you challenge and reduce Medicare's "liens" — or demands for reimbursement of conditional payments. If the claimant in a workers compensation or liability case is a Medicare beneficiary, Medicare may make conditional payments to healthcare providers. The program will then have liens on any settlements the claimant may receive from an insurer or other payer.

Section 111 mandatory insurer reporting gives the Medicare program an unprecedented amount of information on such claims. Using that information, the Medicare Secondary Payer Recovery Contractor (MSPRC) can simply demand reimbursement. According to our estimates, Medicare seeks recovery of more than \$3 million per thousand claims. If you don't pay what you owe, Medicare can refer your case to the U.S. Department of the Treasury for collection. And in some situations, you may be liable for double damages.

You need to develop a comprehensive approach to mitigate that liability and reduce costs. We have data that indicates using a comprehensive approach such as ours can save you an average of more than \$2.5 million in aggregate Medicare Secondary Payer exposure per thousand claims.

Many vendors can't or won't aggressively challenge MSPRC demands for reimbursement of conditional payments. But our services provide you a team with the experience to identify issues and advance legal arguments that can reduce Medicare's demands. The result is an average savings of 83 percent per claim.

Our compliance approach:

- improves your ability to become 100 percent compliant with state and federal law
- provides insight into exposure across the entire enterprise and by line of business
- identifies cost mitigation opportunities
- expedites settlements
- moves claims toward faster settlement or resolution
- capitalizes on potential dispute opportunities to decrease conditional payment costs and exposure

## Protocol design for Medicare Secondary Payer compliance

Medicare Secondary Payer compliance continues to present challenges for claims payers. You need a game plan from day one. Recognizing how to navigate the major MSP issues affecting claims should be an integral part of any effective claims handling practice.

With our protocol design services, our consultants can help you meet the challenges by:

- assessing your current MSP compliance practices
- addressing Medicare, Medicaid, and SCHIP Extension Act Section 111 reporting, conditional payments, and Medicare Set-Aside issues
- developing practical compliance protocols based on the MSP statute, your objectives, and your tolerance for risk
- providing education and training for claims handlers and counsel
- assessing potentially medically inappropriate prescription drugs and their effect on settlement costs



## CLAIMS MANAGEMENT

For years, workers compensation writers have struggled with the growing costs of claims. Part of the challenge has been managing claims that have the potential to become complicated and burdensome, both financially and administratively. Cases failing to resolve in a relatively short period of time are a key driver of costs and a significant challenge in resource management and department productivity. Insurers that quickly and correctly identify potentially volatile claims early in the process can intervene and manage those claims proactively for the best possible outcome.

To help you spot difficult workers compensation cases before they spiral out of control, we developed a sophisticated predictive modeling system, which is the first tool in the marketplace that offers ISO-aggregated industry information to supplement your own historical claims data.

Claims costs surge because of many factors, including unnecessary treatment, comorbidities, use of certain medications, secondary gain, fraud, and more. The information you need to detect potentially problematic claims may be difficult to obtain or hidden in the first report of injury, medical records, pharmacy benefit manager (PBM) reports, bill review records, and other documentation.

Because claims handlers have large caseloads and numerous tasks each day, it can be virtually impossible to spot the true loss potential of every claim.

While some organizations analyze their own data to pinpoint problematic claims, our modeling system goes further to assess each claim with proprietary data sets, so you get:

- actionable insights based on sophisticated algorithms to get claims on the right track earlier
- improved results based on comprehensive industry data
- benchmarking capabilities to ensure more reliable predictive scoring outputs
- the ability to triage cases proactively
- a way to match resources to claims based on level of difficulty
- increased efficiency and accuracy in the claims process, improving overall customer satisfaction

20  
80



Roughly 20 percent of workers compensation claims are driving an estimated 80 percent of losses.

Our modeling system offers a vast array of industry information not available elsewhere. By broadening your internal claims data with a comprehensive data set of industry experience, you'll benefit from more predictive and reliable scores than you'd receive with any other solution. In addition, we combine our expertise in complex data systems and our deep knowledge of workers compensation claims management to automate and supplement the data with PBM, bill review, and claim system interfaces. Our system then tests, checks, and validates your data before applying multivariate models and machine learning algorithms to connect obscure, hidden, and disparate relationships among the data.

We offer innovative integration of external and internal data and sophisticated modeling techniques to ensure improved efficiency and effectiveness through a streamlined scoring and assignment process, swift identification of potentially volatile claims, and appropriate handling from inception. The results are fewer unnecessarily severe cases and reassessments, improved claims results, lower loss ratios, and more efficient claim settlement on more routine claims. Our combination of multiple data sources and powerful analytics gives you greater control over workers compensation claims identification and management.

## It's no secret — costs increase as claims age

Data published in a recent journal article highlights the fact that costs dramatically increase the longer workers compensation claims remain open.\*



\*Robert Ceniceros. "Costs Mount Quickly as Workers Comp Claims Age," *Business Insurance*. September 30, 2013, [www.businessinsurance.com](http://www.businessinsurance.com) (accessed July 16, 2014).

## COST CONTAINMENT

**With combined ratios still above 100 percent and market volatility continuing, insurers need to develop new strategies that better assess and manage risk to maximize profitability. The ability to contain claim costs is essential. However, scrutinizing your book of business to spot problem areas isn't straightforward by any means. There's no shortage of data in the workers compensation world. In fact, the amount of data can be overwhelming when you're trying to analyze it to pinpoint problems or look for trends that could drive your business decisions.**

Using the same data you provide us for regulatory reporting purposes, we've developed analytic tools that allow you to make sense of the volumes of your data so you can make more informed decisions when developing your cost containment strategies.

Our tools for analyzing your workers compensation claims data can help you identify where your claims dollars are going and pinpoint loss ratios across classes of business so you can balance your book. For example, you can use our analytics to show you:

- the average cost per claim by industry, occupation, injury type, and body part
- total paid amounts attributed to by category
- average durations of disability by injury type and body part affected
- how long injured employees are out of work

With such analytics, you'll get a better understanding of cost allocation by benefit-type payment and claim dollar allocation by types of industry and occupation. You'll be able to apply this understanding of claim costs to improve management of your overall book of business and your ability to find niche market segments that truly maximize profitability.

We also offer analytic tools to facilitate understanding of medical costs and claim leakage by giving you the ability to view and mine your data in real time. You'll be able to uncover information such as:

- diagnosis, procedure, and prescription trends across the doctors providing treatment
- the places of service where treatment occurs
- other medical-related data sets

You'll be able to see the average cost per claim by procedure type, place of medical service, drug type, and more; total amounts paid versus the amounts charged by provider; and which providers are seeing the majority of your claimants and why.

With such analytics, you'll be able to identify providers that typically charge more than others and increase your awareness of the costs of prescription drugs that are assigned more than others. An understanding of provider trends can help refine your preferred network of providers. Analytics can also illuminate the impact of return-to-work planning and medical payment cost allocation.

You can also use the analytic tools to improve injury prevention efforts. After pinpointing an account or industry in need of injury prevention, our analytics then link that information to detailed claim assets so you can understand the reason injuries are occurring and the types of injuries driving the most losses. You can use that information as a road map to pinpoint employer accounts and business types where your injury prevention efforts will reap the biggest rewards.





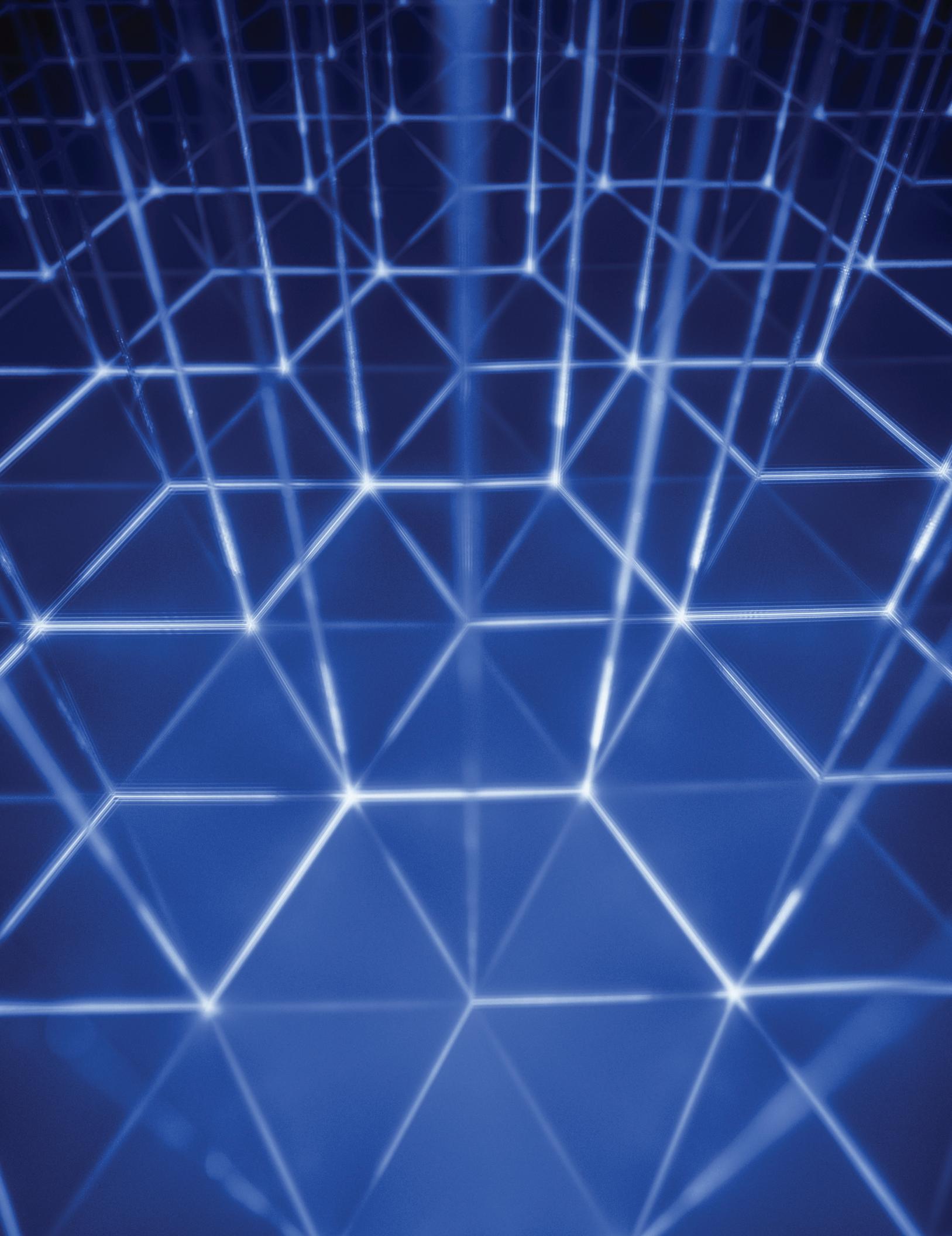
**As workers compensation insurers continue to feel the squeeze of expenses and inefficiencies related to this data-intensive and heavily scrutinized line of insurance, many have turned to outsourcing the management of their claims data.**

If you're seeking help with your entire workers compensation data management process, we have the solution. By outsourcing your data management to us, we can help:

- reduce the significant expenses of upgrading or rebuilding antiquated systems
- establish more efficient and effective data workflows to satisfy ever-changing regulatory reporting demands
- relieve you from the complex, resource-intensive, and time-consuming burden of reporting data in various formats at different times to a host of organizations, including statistical agents, rating organizations, regulators, and industrial accident boards
- boost data quality
- lower the risk of fines or surcharges from the bureaus you report to
- manage runaway data collection and processing costs
- free up limited resources that you can allocate to other critical operations
- take advantage of the Internet for timely, efficient reporting
- analyze your data in new ways so you can identify your cost drivers and make more informed business decisions

Why entrust us with your workers compensation data management processes? As a trusted intermediary for the property/casualty industry since 1971, we:

- have recognized expertise in both data management and systems and in insurance
- follow best practices for data management, ensuring data is accurate, valid, consistent with prior information, complete, and timely
- excel at the compilation and reporting of unit statistical reports; collection of data for specialized claims reports, such as detailed claim information and individual case reports; and creation and reporting of aggregate financial data submissions
- allow data integration directly from front-end policy and claims processing systems — even if you have multiple sources of data from disparate systems — and enable you to transmit data once in a simple format that can be used in a variety of ways
- fully relieve you of the resource-intensive task of reporting premium and loss data to jurisdictions where you do business
- collect, process, and store your workers compensation data, so you can use it for business analysis and other purposes
- manage testing; perform data analysis; provide system setup, training, and technical support; and help set up interfaces with field offices and call centers



## CLAIMS SETTLEMENT CONSULTATION

**Many claims stay open far too long for a variety of reasons.**

**Impediments to settling can include high medical bills, prescription drug costs, and Medicare compliance issues, among others. With the passage of time, your exposure and liability on open claims remain.**

**Medical costs continue to increase, and derivative claims may develop.**

To help you resolve claims expeditiously and cost-effectively, we provide settlement consulting.

With our settlement consulting services, we'll assemble — at no cost to you — a team of attorneys knowledgeable in both workers compensation and liability claims and medical experts, including nurses and pharmacologists, to review your files. The team's goal is always to facilitate settlement.

During the file review phase, we'll provide:

- preparation for mediation
- premediation consultation on Medicare compliance
- preparation of settlement language
- reserve forecasting with a medical cost projection
- an analysis of the potential amount of the Medicare Set-Aside (MSA) for a claim, an assessment of the prescription medications involved, and a cost-mitigation road map
- rated ages of claimants
- coordination of structured settlements
- identification of the correct vehicle(s) for compliance, especially in difficult liability claims
- collaboration with your counsel and claims staff to ensure full Medicare compliance

Taking the file review process to the next level, we work with you and your defense counsel to spearhead a settlement initiative. The starting point is identifying a book of claims you want settled — typically from a particular jurisdiction, geographical location, claimant, or plaintiff attorney. We help to coordinate settlement conferences with opposing counsel, either face-to-face or by telephone.

Once we've identified the claims and set up the conferences, we'll:

- gather the list of claims identifying which claimants or plaintiffs are eligible for Medicare
- make recommendations about which claims require an MSA, a conditional payment investigation or negotiation, and/or Total Payment Obligation to Claimant (TPOC) reporting under Section 111
- expedite preparation of any required MSAs or conditional payment documentation before the conference
- maintain and update the list of claims to include information on the status of MSAs submitted to the Centers for Medicare and Medicaid Services (CMS) for approval, receipt of conditional payment information, and steps needed to satisfy all Medicare compliance requirements

If you're holding the settlement conferences in person, we will, at your request, send an attorney, medical analyst, or both to attend the conference with you and your attorneys. Our experts will answer any MSP questions, help with settlement documents, and coordinate all Medicare issues.

Our settlement consulting services can condense what would otherwise be months of protracted negotiations into a week or less of streamlined discussions. You'll settle your targeted cases quickly and at low cost. And claimants may avoid protracted litigation with the expedited resolution of their case.





## For more information

To learn more about our workers compensation solutions:

Call Verisk Customer Support at **1-855-859-8775**

Send e-mail to **info@verisk.com**

Visit **www.iso.com/workerscomp**



Verisk Insurance Solutions

545 Washington Boulevard • Jersey City, NJ 07310-1686 • [www.iso.com/workerscomp](http://www.iso.com/workerscomp)

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