Edging up

Short takes on emerging industry issues – from EDRs to ICD codes and MSAs

It's time to expand use of EDR tech

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After the crash at the Oklahoma State homecoming this past October, one of the key elements in the investigation was the car's event data recorder (EDR).

From electronic navigation systems that talk to you to collision avoidance technology, a growing number of cars are equipped with many of the latest bells and whistles the industry has to offer.[1] There is considerable existing and emerging technology like this that falls under the broad, general term of "telematics."

One of the key components – and something of real interest to adjusters – is EDRs. Think of an EDR as a kind of black box, but one that only records the few seconds before and after impact. While promising in terms of driver and passenger safety, there's an important question we must ask – will this great data consistently get into the hands of adjusters?

It should. Think of what we could do to better resolve claims if we had definitive information about accidents such as the exact speed upon impact, how long the driver decelerated or accelerated before impact, if the driver was trying to brake just prior to impact and more.

We know this technology works because it is already being used by many companies with large commercial truck fleets.[1] When investigating accidents involving trucks, adjusters now have an additional tool to use to determine the factors.

The National Highway Traffic Safety Administration (NHTSA) estimates that some 91% of cars on the road today have EDRs. Despite their widespread use, availability in the claims industry is still very limited.

There are some key factors influencing adoption:

- Who owns all of that data? Is it the owner of the car, the automobile manufacturer, the insurer, law enforcement, attorneys or some government entity like the NHTSA? It's kind of a tricky issue, as each automobile manufacturer has its own proprietary approach to EDRs.

- There is currently a hodgepodge of legislation governing EDR technology. Some states allow it, some don't. In fact, out of privacy and other concerns, some states even have mandates that nullify use of EDR information. As a result, many insurers haven't determined what to do with EDR data, let alone how to work appropriate language into their policies.

Clearly, there is still much we need to do to increase adoption of EDR technology for claim settlements. As an industry, we need to encourage standardization of EDR technology and adoption of uniform state laws governing its use. We need to start more pilot programs and work to train our adjusters on how to maximize the data contained in EDRs. Insurers should include language in their policies granting them immediate access to and use of the technology in the event of an accident. And, we need to encourage car manufacturers to do more to expand utilization of not just EDR technology, but other collision and accident avoidance technology. Beginning in 2014, all new cars sold in the U.S. must include EDR technology.[1] It has been used in more than 100 court cases, so legal precedents have been set. We have a lot more to do to lay the groundwork for use of EDRs, but it is coming.

SOURCE

[1] **National Highway Traffic Safety Administration (NHTSA).** http://www.nhtsa.gov/

A word about ICD codes and leave of absence requests

BY **SHARON ANDRUS**

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The codes established for the International Classification of Diseases (ICD) are used for billing, reporting and other key medical management purposes in workers' compensation and disability claims, but they can create confusion in leave of absence cases.

ICD codes, which provide detailed descriptions of injuries and illnesses, are not required by federal and state leave laws. When a patient requests a leave of absence, their doctor must document that a serious health condition exists, but is not required to include ICD codes.

According to the Family and Medical Leave Act (FMLA) and its regulations, a serious health condition that would entitle an employee to leave under the FMLA includes "an illness, injury, impairment or physical or mental condition that involves inpatient care or continuing treatment by a health care provider."[1] The FMLA also includes descriptions detailing the specific components of inpatient care and continuing treatment.

Employers cannot request an ICD code or use what would be applied in disability or workers' compensation claims in terms of duration management. If a doctor has provided information that satisfies the definition of a serious health condition, an employer cannot request more specific information in order to make their own judgment about whether or not the length of the leave was appropriate or not. It is the treatment provider's responsibility to determine the amount of leave time that is certified.

According to the FMLA regulations, the medical certification should include a statement or description of appropriate medical facts regarding the patient's health condition for which leave is requested. The medical facts "may include information on symptoms, diagnosis, hospitalization, doctor visits, whether medication has been prescribed, any referrals for evaluation or treatment (physical therapy, for example), or any other regimen of continuing treatment."[2]

It is important to point out that the medical facts for the certification "may include...the diagnosis" – not "must include," which further validates that the ICD codes are not required. The equivalent family and medical leave laws in California[3] and Connecticut[4] have taken it one step further and specifically prohibit a healthcare provider from disclosing the underlying diagnosis on leave of absence request forms.

Bottom line – employers should use caution when requesting information related to a diagnosis, including the use of ICD codes, in the management of leave of absence requests.

SOURCES

[1] **29 C.F.R. § 825.113**
[2] **29 C.F.R. § 825.306**
[3] **Cal. Gov. Code § 12945**
[4] **Conn. Gen. Stat. §§ 31-51kk to 31-51qq**

MSAs – Three things employers should know

BY **MICHAEL R. MERLINO II, ESQ.**

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Most risk managers are aware that Medicare set-asides (MSAs) are a significant cost driver of workers' compensation claims. MSAs were developed more than 10 years ago by the Centers for Medicare and Medicaid Services (CMS) and present some well-known challenges, especially when it comes to obtaining CMS' approval of the MSA.

The approval process is managed and run by CMS for the sole benefit of Medicare. When reviewing the medical records to determine the amount of an MSA for the claims Sedgwick has submitted over the years, the CMS reviewer has not made any inferences that resulted in a lower MSA. For example, if it is not clear whether a drug is related to a claim or not, the reviewer will assume it is related and include it in the MSA. Also, CMS does not uniformly apply individual state laws to the MSAs, so in a state like Georgia that has a 400-week limitation on medical benefits, CMS will still calculate the MSA for the claimant's life expectancy instead of limiting it to 400 weeks.

CMS' goal is to protect the Medicare fund and that may result in inflated MSA numbers. To help employers address this challenge, we would like to share three things you can do to obtain a fair result.

1. Understand how much emphasis is placed on the treating physician's medical records

Based on our experience with CMS, the treating physician's records outweigh every other record. If the treating doctor indicates the injured employee needs a specific drug for pain and the employer tries to get an independent medical exam or a peer review explaining that the drug is not needed, CMS accepts the treating doctor's record and dismisses the others. This is not only true of drugs, but of other proposed treatments like surgeries or spinal cord stimulators.

The solution to this problem is either to get clarification from the treating physician or a court order (not a consent order) addressing the treatment in question. In our experience, court orders are difficult to obtain so we focus on the records of the treating physician. It may take some extra time, but it is worth it if the treating physician is even partially cooperative in providing clearer or more detailed medical records about specific recommended treatments or prescription drugs.

2. Submit the MSA early in the lifecycle of the claim

Waiting until the claim is close to settlement creates too much pressure because at this point everyone wants to get the case settled in a few weeks or months. With the added pressure of settlement, employers sometimes don't take a realistic look at what is needed to obtain a fair MSA outcome. Instead of patiently working with the treating physician to obtain the necessary medical information, the employer is inclined to take "short cuts." These short cuts (e.g. submitting an IME that CMS will discount or arbitrarily remove treatment from the MSA because they may deem it isn't reasonable) can lead to imbalanced MSA results.

A better course of action is to start the MSA earlier in the claims cycle (after a major surgery or event) so that there is time to obtain the necessary medical records to appropriately reduce the MSA, if necessary. There is no need to wait until the parties are at the cusp of settlement to get an MSA approved.

Another benefit of this proposed process is that when the parties reach the settlement stage, they will already have an approved MSA in hand. This means there are no outliers when the case is settling and the process can move forward smoothly and efficiently for the benefit of the parties.

3. Submit a favorable MSA promptly

CMS only allows one chance to request approval on an MSA. Once it is approved, the parties are stuck with the result – good or bad. Therefore, if you get a fair MSA number (an MSA that is appropriate to facilitate settlement), it is important to submit it for approval as soon as possible. Once the MSA number is approved, the number is "locked in" and the parties can use that number in the future to eventually settle the case.

In our experience, if an employer waits to get CMS' approval at a later time, it usually results in a higher MSA because either the medical records have changed or CMS has changed its MSA policies. This higher MSA amount usually defeats the settlement. So do not wait, get CMS' approval as soon as possible to preserve an appropriate MSA amount.

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