edge

SEDGWICK'S QUARTERLY PUBLICATION

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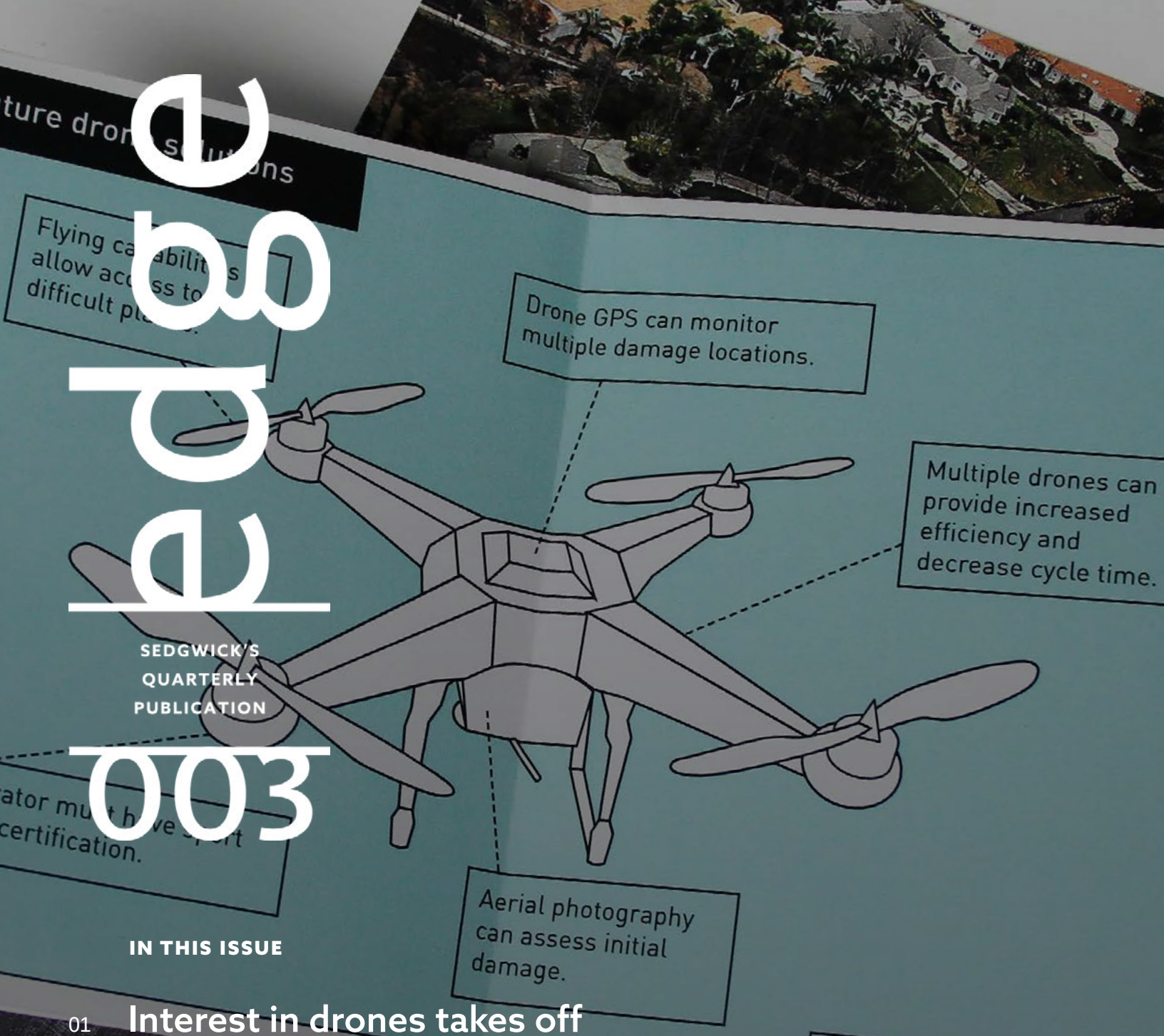

IN THIS ISSUE

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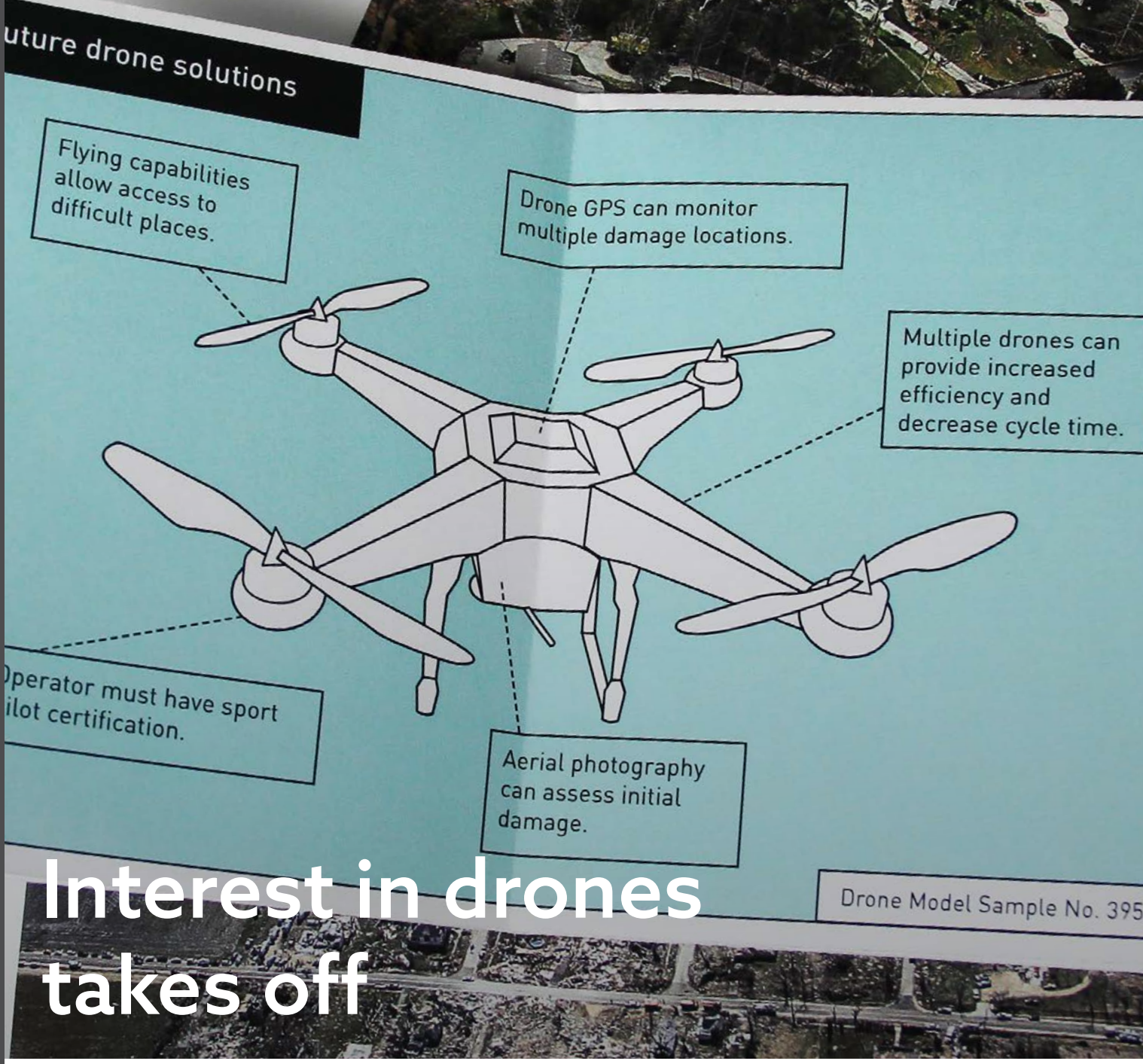


Interest in drones takes off

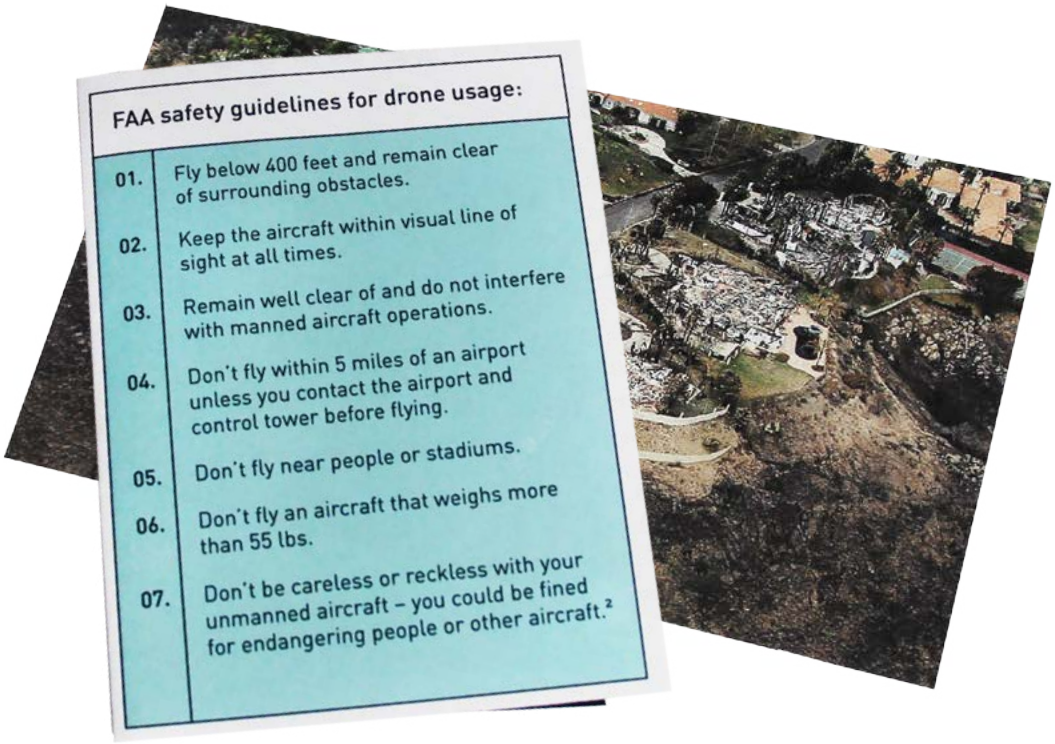
BY **SCOTT RICHARDSON**

SVP, National Property Manager, Vericlaim, a Sedgwick company

As drones gain in popularity, there are a number of ideas and opportunities for them to add value to the insurance industry. They can prove valuable in disaster response efforts, underwriting surveys, claims investigations and in situations where aerial photography is needed. As interest in drones grows throughout the country, there are several challenges for businesses to address. To benefit from this advanced technology, companies will need to define their operational processes, services and usage, while complying with the Federal Aviation Administration (FAA).

FUN FOR HOBBYISTS, VALUABLE FOR BUSINESSES

With the expanded use of drones on the horizon, the FAA has been updating the rules for flying them. Beginning December 21, 2015, individuals who fly small unmanned aircraft for recreational use will be required to register them with the FAA. Existing owners will have to register by February 19, 2016 and new buyers will have to register before their first flight.[1] In addition, the FAA strongly encourages drone operators to follow the safety guidelines below:



Flying an unmanned aerial vehicle for any non-hobby or non-recreational purpose requires FAA authorization. For example, using a drone to take aerial photos of your backyard for personal use is recreational, but using it to take photographs to sell is non-recreational. In addition to obtaining approval to fly a drone for commercial use, the operator must have a minimum of a sport pilot certification as well as a spotter who must be able to keep the drone in their line of sight.[3]

As state legislatures evaluate how the technology should be regulated, the benefits of their use, the economic impact and privacy concerns are among the key areas being considered.[4]

In the underwriting and claims investigation arenas, drones provide several key advantages. They can be used in pre-loss valuations to

gather images of mechanical/industrial equipment on top of large commercial structures or difficult to navigate places, or to survey crops and land for agricultural exposures. After an event such as a hail storm or hurricane, drones can be used to assess the scope and extent of damage to real property and provide a clearer depiction of the magnitude of the loss. They can take in more information and gather it quicker than adjusters can through the standard process; not just for a single loss location, but also when handling multiple loss locations or large property exposures. For example, if an insurance carrier has a client with losses in areas that were subjected to either wind or flooding due to a hurricane, a drone can be utilized to inspect all of the locations that match specific GPS coordinates and gather images for data collection. This data can then be reviewed, processed and analyzed in conjunction with meteorological data. The technology and capabilities of the drone would increase efficiency and decrease cycle time, leading to quicker payments for policyholders.

Sedgwick was recently approved to use drones and our next steps will include defining the service offering and the operational process. If the FAA continues to require commercial users to have a pilot's certification or be on private, approved property, it will restrict the application for drone usage in our industry. We will continue developing services that will be integrated with our property liability solutions while monitoring the evolving FAA requirements.

SOURCES

[1] **Press Release: FAA Announces Small UAS Registration Rule, December 14, 2015.**
http://www.faa.gov/news/press_releases/news_story.cfm?newsId=19856

[2] **Model aircraft operations. FAA. March 2015.**
https://www.faa.gov/uas/model_aircraft/

[3] **FAA Conditions and Limitations. October 2015.**

[4] **Current unmanned aircraft state law landscape. National Conference of State Legislatures. October 8, 2015.**
http://www.ncsl.org/research/transportation/current-unmanned-aircraft-state-lawlandscape.aspx

Advocacy: Secrets to employee re-engagement

BY **SCOTT ROGERS**
EVP, Casualty Operations, Sedgwick

A historical challenge in workers' compensation has been creating the best possible approach to communication that consistently reinforces transparency, puts the injured employees' needs first and reassures them that their claims team is working in their best interests. Employers today, more so than ever before, are engaged in the workers' compensation process and, in partnership with Sedgwick, have developed efficient healthcare and treatment solutions that provide the highest quality of care. They have also developed return to work programs that not only accommodate potential injury-related restrictions and ensure compliance with state and federal employment laws (e.g. Americans with Disabilities Act), but also encourage employees to come back to work as quickly as possible. This approach ultimately results in an improved experience and outcome for all parties. The responsibilities of claims and managed care professionals encompass many activities that already assist with this process, but there is an emerging need to take employee care above and beyond the standard claims management efforts.

This expanded approach involves being an advocate for the employee by listening, communicating, providing information and proper medical care, explaining how this complicated process works – and being there to assist them at every turn. From the time an injury occurs until the moment the claim is closed, the examiners, nurses and all colleagues who assist the employee serve important roles that can impact the outcome of the claim. It's through their experiences that our industry can see the value of employee advocacy and the advantages it can bring for all parties involved.

EXPLORING THE SHIFT IN PHILOSOPHY

There seems to be a change in the philosophy of employers as it relates to workers' compensation injuries. Today, businesses are more interested in making sure their injured employees get everything they need to recover, and they are willing to spend the money and do all the right things as a part of their responsibilities as an employer. Instead of questioning claims, they are more focused on restoring the health of their employees.

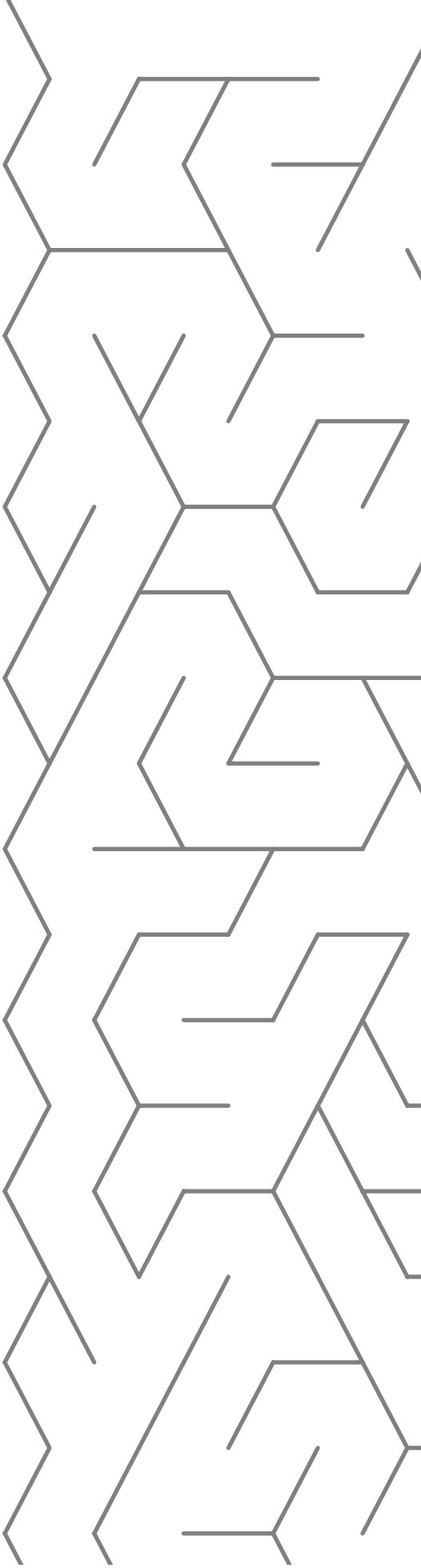
To do this successfully, employers must work closely with claims administrators to develop and implement a process around employee advocacy.

This may include assigning a trained, knowledgeable member of the claims team to guide employees through the process or connecting them with a nurse who can assist with their medical concerns. There are different options based on the individual employer's needs, but each one is designed around the same objective – improving injured employees' health and well-being.

SURROUNDING THE EMPLOYEE WITH SUPPORT

The employee advocate performs an outreach to the employee typically after receipt of the first report of injury. This is someone who asks how they are doing and offers a sympathetic ear. The advocate is also someone who has information on their claim and is connected to all of the resources available to assist the employee. This initial call can offer several advantages including:

- Reassuring the employee that their employer cares and they are not going to lose their job for filing a workers' compensation claim
- Providing guidance to the injured employee that could prevent a minor claim from becoming something major
- Answering initial questions to resolve possible issues that could lead to litigation; if the employee needs additional information, the advocate can get what they need and call them back



- Keeping everyone calm at the outset of the injury and positively impacting the employee's attitude

In this role, the advocate becomes the employee's key contact and will make sure they do not feel alone in this process. The topics for the advocate's outbound calls may include explaining workers' compensation; setting expectations related to claim investigation, medical bills, prescriptions, benefit payments and return to work; or explaining the roles of the adjuster or nurse case manager assigned to their claim.

PROVIDING SPECIALIZED CLINICAL ADVOCACY

Clinical resources may be needed for an employee based on their injury. This type of advocacy includes a phone call from a registered nurse who will ask them how they are doing, answer their medical questions and direct them to the best provider for their injury. At this time, the nurse may also identify any psychosocial issues or other concerns that may impact the employee's ability to recover or return to work, and then direct them to behavioral health or return to work specialists as needed.

BENEFITS AND PROVEN RESULTS

When employees are injured at work, this can be an unsettling time for them – and one that's filled with many questions. Providing upfront communication and a healthcare team focused on their well-being can make the process better for everyone. Employer benefits include reductions in litigation, medical costs and lost time. With the average cost of litigated workers' compensation claims being about 65% more expensive than non-litigated claims[1], reassuring employees and keeping them as happy as possible throughout the claims process can have immeasurable value.

We have experience working with several employers who have implemented successful advocacy programs. One is a retail company that has an advocate who contacts every employee on the first day of an injury to see how they are doing. Their goal was to reduce litigation and they have accomplished it through this process. The company feels that having someone reach out gives each employee a sense of security, as well as the reassurance that they won't lose their job due to filing a claim and they are part of a system that protects them.

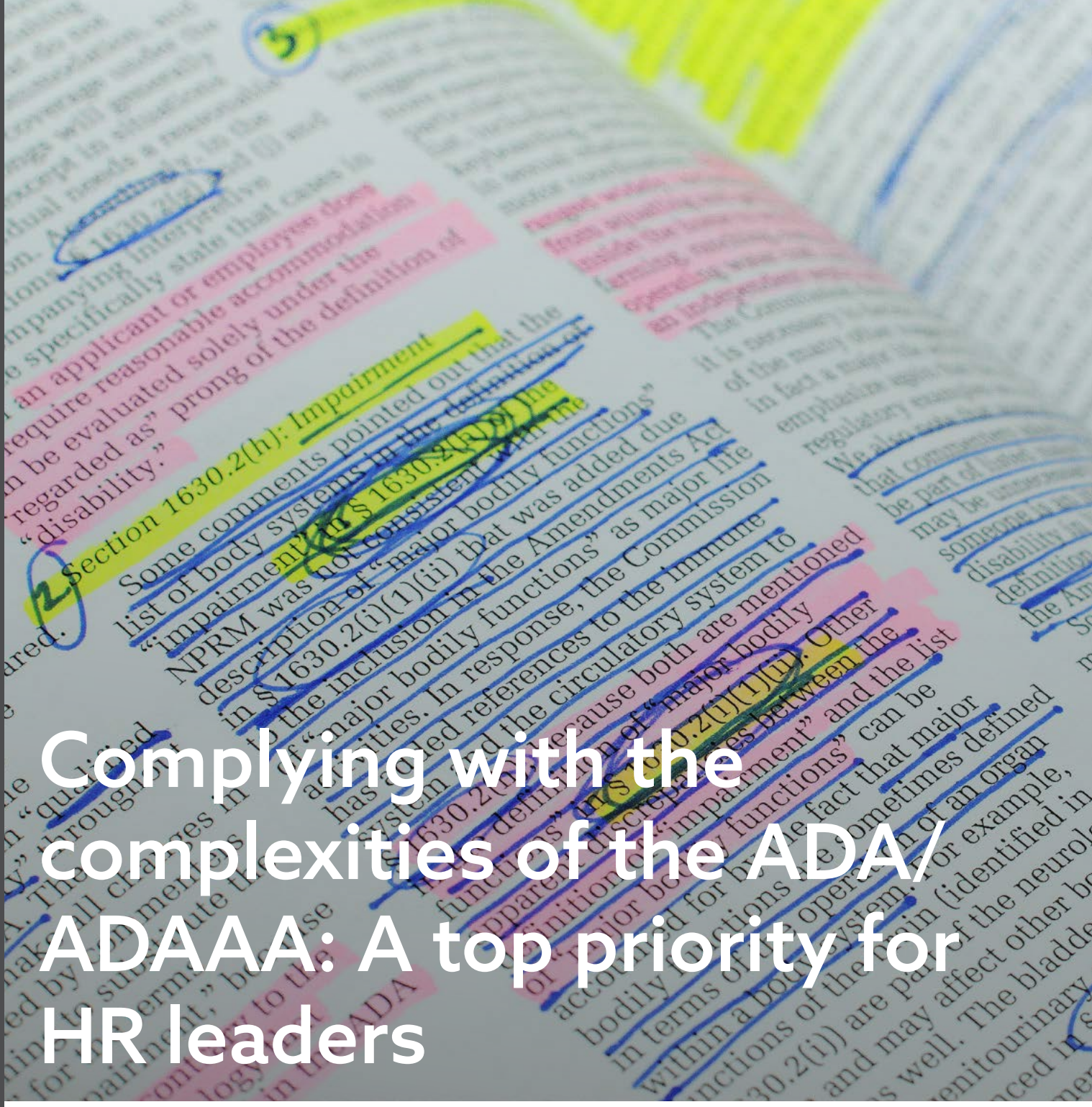
FOCUSING ON THE EMPLOYEE

Examiners, nurses, assigned advocates and other members of the claims and managed care teams all work together to ensure the injured employee has the best possible outcomes. Having a team to surround the employee with care and recovery solutions provides significant dividends related to the continuation of productivity and employee morale – and it can positively influence their overall view of their employer.

[1] **Sedgwick data**

ADDITIONAL RESOURCE

The Relationship Between Attorney Involvement, Claim Duration, and Workers' Compensation Costs. Journal of Occupational and Environmental Medicine, Volume 50, Number 9, September 2008. *https://www.researchgate.net/publication/23250180_The_Relationship_Between_Attorney_Involvement_Claim_Duration_and_Workers_Compensation_Costs*



Complying with the complexities of the ADA/ADAAA: A top priority for HR leaders

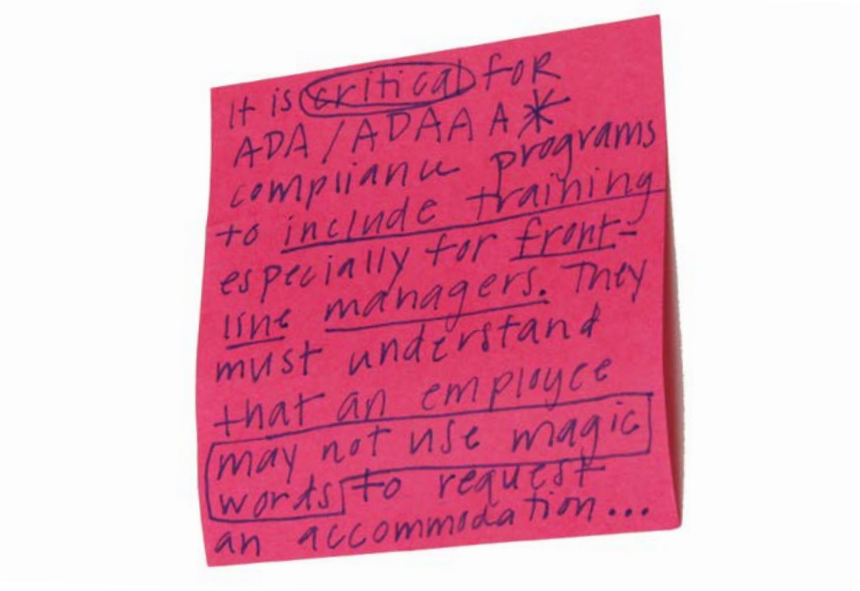
BY **STEPHANIE SIMPSON**

SVP, Disability and Absence Management Practice, Sedgwick

The Americans with Disabilities Act (ADA) celebrated its 25th anniversary on July 26, 2015. One of the goals of this landmark legislation was to improve employment opportunities for individuals with disabilities. The ADA is civil rights legislation, regulated and enforced by the U.S. Equal Opportunity Commission (EEOC). Title I of the ADA prohibits discrimination against qualified individuals with disabilities.

Just over 18 years after the ADA was enacted, the law was amended with the Americans with Disabilities Amendments Act (ADAAA) that was effective on January 1, 2009. The ADAAA retained the ADA definition of disability, but it expanded the interpretation of its terms. The intent of the ADAAA was to encourage broad coverage of individuals with disabilities. Employers were expected to place less emphasis on determining whether a person is disabled and instead focus on the interactive process, so that the employee could perform the essential functions of the position with a reasonable accommodation.

The ADA and ADAAA have made it possible for Americans with disabilities to have meaningful careers; the significant impact of this legislation is remarkable and deserves celebrating. While substantial progress has been made, the laws have not always been easy for employers, acting in good faith, to interpret.



What is challenging for employers currently is the practical application, especially with limited case law and enforcement assistance. Since each situation must be reviewed on its own, no bright-line rules can be applied. Nevertheless, some framework has been developed that provides helpful guidance. Let's take a look at a few hot topics and recommended considerations.

Leave as a reasonable accommodation

One major determination is whether attendance is an essential function for a position. When evaluating a position to determine whether attendance is essential, several factors should be considered such as staffing, overtime costs, enforcement of attendance rules,

job description, training required and other leave policies. If it is determined that attendance is an essential function of a position, then the next question is whether the time requested off is reasonable or if it will be an undue hardship. Unlimited, indeterminate, extended leaves, without regard to attendance guidelines, are not typically considered reasonable, nor are irregular, unpredictable schedules such as an open-ended request to come and go as needed. In contrast, shorter durations of leave such as a couple of days per month – especially when the employee can complete the essential functions before and after the leave and/or with minimal assistance from co-workers – are likely reasonable. Keep in mind the facts of the specific situation will dictate the outcome.

Temporary impairments

Temporary conditions such as the flu, a stomach bug or bronchitis do not usually qualify as a disability under the ADA/ADAAA. However, a temporary condition or injury could develop into a disability if it is "sufficiently severe" and would substantially limit a major life activity – the Fourth Circuit Court of Appeals ruled on this issue last year in *Summers v. Altarum Institute Corp.*, No. 13-1645 (4th Cir. January 23, 2014). This case provides guidance on how to analyze – through an interactive process – whether or not a temporary impairment constitutes a disability and therefore invokes the need for a reasonable accommodation.

Intellectual disabilities: Performance management and accommodations

Employers still struggle with how to handle performance management for employees who disclose having an intellectual disability. The EEOC's guidance, "The Americans With Disabilities Act: Applying Performance And Conduct Standards To Employees With Disabilities," is helpful with examples and practical tips on frequently experienced scenarios that involve performance management and discipline of employees with disabilities. It is important to note that once an individual has indicated that he/she has a disability, then the interactive process must begin. While an employer is not required to remove a progressive counseling and discipline document that was previously presented to the employee, the triggering of the interactive process may impact the timing of future discipline. Keep in mind, the ADA/ADAAA does not require that performance standards be modified. Additionally, qualified individuals with disabilities must be able to perform the essential functions of the position, but assistance may be needed such as additional training and coaching. The amount of time needed to

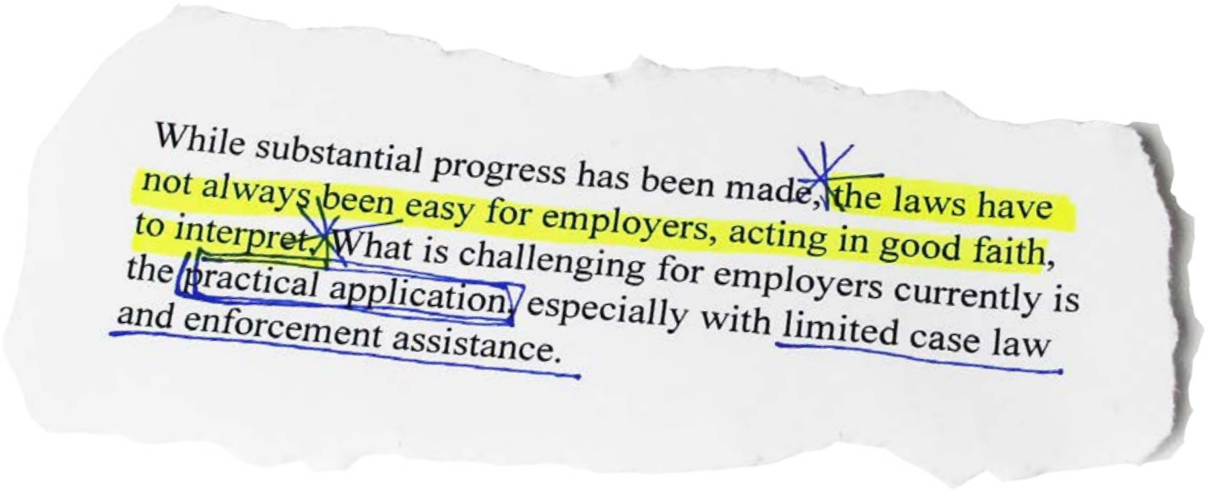
help an employee with a disability is a question that comes up often and no specific time can be set for all situations; the time to meet expectations with the accommodation(s) does need to be a reasonable amount so that the employee has a fair opportunity to improve.

4 Alleged fraud/misuse

Circumstances come up from time to time in which it appears that an employee may not be using a leave accommodation for the purpose it was intended. This may be revealed through social media and cause frustrations among co-workers. It is important to keep emotions in check and handle with an interactive process – through discussions with the employee and the treating physician (if applicable).

ON THE HORIZON

Employers will continue to focus on pregnancy-related accommodations – for both normal pregnancies and those with complications. The Supreme Court remanded *Young v. United Parcel Service* , No. 12-1226 (U.S. S. Ct. March 25, 2015) to the Fourth Circuit, and the parties reached a confidential settlement agreement in early October 2015. In light of this case, the EEOC revised its enforcement guidance on pregnancy in June 2015. Additionally, many states have enacted laws that require employers to provide reasonable accommodations for pregnant employees. Pregnancy-related accommodations will continue to be a hot topic as employers follow these legal developments.



Furthermore, transgender situations may become relevant under the ADA/ADAAA. While assisting transgender employees with transitioning is not new for many employers, the heightened attention the issue has received in the media may lead to further developments. Most of the legal issues so far have been under Title VII, but it is likely for the ADA to come into play with reassignment surgeries.

PRACTICAL POINTERS

It is critical for ADA compliance programs to include training especially for front-line managers. They must understand that an employee may not use magic words to request an accommodation – they need to recognize when an accommodation may be what an employee is requesting without using the word "accommodation." However, these leaders do not need to handle the interactive process without help from internal (or external) resources; they should know when to seek further assistance.

Documentation throughout the interactive process is also very important. Each conversation or interaction must be captured. This information may be needed later when an accommodation needs modifying or is no longer applicable. It is also essential for defending allegations of disability discrimination. A best practice recommendation is to utilize a software program to record the interactive process activity.

Remember to engage your employment counsel – sooner rather than later – as you handle challenging accommodation situations.

This material is for general informational purposes only and is not legal advice. It is not a substitute for advice from legal counsel. Please consult with your attorney before relying on any information contained within this article.

ADDITIONAL RESOURCES

***Summers v. Altarum Institute Corp.*, No. 13-1645 (4th Cir. January 23, 2014).**
http://www.ca4.uscourts.gov/Opinions/Published/131645.P.pdf

The Americans With Disabilities Act: Applying Performance And Conduct Standards To Employees With Disabilities.
http://www.eeoc.gov/facts/performance-conduct.html

***Young v. United Parcel Service*, No. 12-1226 (U.S. S. Ct. March 25, 2015).**
http://www.supremecourt.gov/opinions/14pdf/12-1226_k5fl.pdf

EEOC Enforcement Guidance: Pregnancy Discrimination and Related Issues
http://www.eeoc.gov/laws/guidance/pregnancy_guidance.cfm

Misuse of antipsychotics in workers' compensation patients

BY **REEMA HAMMOUD**

PharmD, BCPS,
Director, Clinical Pharmacy, Sedgwick

Antipsychotics are medications used for the treatment of acute and chronic psychosis and other psychotic conditions. Besides their defined indication by the Food and Drug Administration, antipsychotics are often used and misused for off-label conditions such as depression, post-traumatic stress disorder and insomnia. Like all other medications, they have their fair share of side effects and drug interactions.

According to a 2014 drug trends report, antipsychotics accounted for 2.3% of the total drug cost for workers' compensation claims, with a 2.0% increase in the average cost per prescription in 2014 compared to 2013. Not only are these medications expensive, but their misuse is growing.[1]

In the injury claims we have seen at Sedgwick, these drugs are not always prescribed by a psychiatrist or a behavioral health expert, and patients often do not receive follow-up by a multi-disciplinary team. Antipsychotics are usually prescribed by primary care physicians who are not trained in behavioral management and not familiar with the side effects and drug interactions.[2] A lot of adverse events are often overlooked and drug interactions are not closely monitored.[3] Just recently, Sedgwick's staff pharmacists were referred to a case in which the primary care provider was prescribing his patient anticonvulsants as mood stabilizers, antidepressants for depression and sleep, and antipsychotics for depression and insomnia. The patient was also being followed by a pain specialist who was prescribing opioids, anxiolytics and stimulants. Additionally, the physicians were not exchanging progress notes and the patient was unaware of the dangerous combination he was taking.

This patient was being prescribed medications to help with the side effects of his other medications. Psychosis was not a documented diagnosis for him, yet he was taking two antipsychotic medications to help with sleep and depression. A psychiatric evaluation was never part of the patient's progress notes nor was there a risk assessment in the medical record to determine his risk for drug abuse or overdose. After one of Sedgwick's staff pharmacists spoke with both providers, both of the psychotropic medications were discontinued and the patient was referred to a psychiatrist to help manage his depression and anxiety, which were not related to his workers' compensation injury.

Antipsychotics are generally not recommended for workers' compensation injuries. While there is some data to support use for treatment-resistant depression, there is insufficient data to support their use as standalone therapy. The patient population that we help monitor should rarely be on any psychotropic medications, as studies show that the use of these agents in the treatment of workers' compensation injuries offers little to no benefit in functional improvement or quality of life.[4, 5]

Based on our experience with these types of cases, the use of antipsychotic medications often does more harm than good for the injured employee. Risk managers must evaluate the behavioral health and prescription drug management components of their claims and healthcare programs. A team of physicians, pharmacists and specially trained clinicians must be systematically connected with the claims administration professionals and their systems in order to address life-threatening situations quickly. Behavioral health and pharmacy solutions prompt prevention of these types of dangerous situations and provide key intervention.

Technology interfaces must be equipped to systematically sound the alarm and the first responders must include a multi-disciplinary team of medical experts. Sedgwick's pharmacy clinical review program includes point-of-sale interventions managed by our nurses who review medications prior to dispensing. Drug alerts interface with our proprietary claims management system and when an alert is received, our clinical team will confirm it is the correct treatment for the injury, work with the physician to make any necessary prescription changes – and ultimately ensure the injured employee's safety.

ADDITIONAL RESOURCES

[1] **Workers' Compensation Drug Trend Report 2014.** *www.helioscomp.com*.

[2] **Spielmans GI, Berman MI, Linardatos E, Rosenlicht NZ, Perry A, Tsai AC.** *Adjunctive atypical antipsychotic treatment for major depressive disorder: a meta-analysis of depression, quality of life, and safety outcomes. PLoS Med. 2013 Mar; 10 (3):e1001403. doi: 10.1371/journal.pmed.1001403.*

[3] **Jin H, Shih PA, Golshan S, Mudaliar S, Henry R, Glorioso DK, Arndt S, Kraemer HC, Jeste DV.** *Comparison of longer-term safety and effectiveness of 4 atypical antipsychotics in patients over age 40: a trial using equipoise-stratified randomization. J Clin Psychiatry. 2013 Jan; 74(1):10-8. doi: 10.4088/JCP.12m08001.*

[4] **Hellerstein DJ,** *"Aripiprazole as an Adjunctive Treatment for Refractory Major Depression," Prog Neuropsychopharmacol Biol Psychiatry, 2004, 28(8):1347-8. NCBI website – PubMed 15588762.*

[5] **Ketter TA, Wang PW, Chandler RA, et al,** *"Adjunctive Aripiprazole in Treatment-Resistant Bipolar Depression," Ann Clin Psychiatry, 2006, 18(3):169-72. NCBI website – PubMed 16923655.*

Expert view

Q&A with Darrell Brown
Chief Claims Officer, Sedgwick

The "Expert view" column presents a wide range of claims management topics offering valuable insights and information for clients.

edge:
What are you working on right now that will have an impact on our customers in the near future?

Darrell:
We are focusing on two key areas. The first is continuing to ensure our claims colleagues have the best possible technology and resources to manage claims efficiently while driving positive results for our customers. The second is finding ways to make sure injured employees obtain the best medical care and have an optimal experience throughout the claims process, which will lead to the best outcomes for them, and for our clients and carrier partners. We accomplish this by concentrating on doing the right thing for the employee in everything we do. We always have to stay mindful that something unfortunate has happened to them that can cause real uncertainty relative to their job and how they are going to pay their bills. Therefore, we must approach injured employees in a compassionate way to earn their trust and show them that we are here to help. Doing the right thing in each case includes making sure they have access to quality medical providers for their injury, setting expectations, answering their questions, explaining the roles and responsibilities of the team, being responsive and making key decisions as quickly as possible. It's really about making sure that the examiner, the nurse case manager and everyone who assists with the claim helps the employee through the process. When you take that approach, the rest will fall into place. Focusing on taking care of the injured employee puts the claim on track to better outcomes, reduced litigation and lower costs.

We've been testing a variety of approaches in our claims offices to determine their impact on the claims. In one of our California programs, there is a designated employee advocate on the team whose single responsibility is to help injured employees navigate the system. We have found a strong correlation with this approach and reducing litigation. In another office, we are also looking for opportunities to make claim decisions even faster to improve outcomes. The initial results we are seeing are very encouraging, as we're finding that this approach and philosophy improves durations and decreases litigation.

edge:
What else is on the horizon for claims management solutions?

Darrell:
Even though Sedgwick is the best in the industry at claims management, we are always looking for opportunities to improve the process and the experience for our clients' employees and customers. To this end, we will be rolling out a complex claims team that will assist our claims colleagues by providing oversight and technical assistance with catastrophic and complex claims issues. It is our goal that this team will not only help with the cases they are assigned to, but will also work to elevate our claims process across the organization by establishing new best practices for managing and preventing complex claims. Some workers' compensation and liability claims are catastrophic from the start, but there are others that morph into catastrophic claims. Resolving these claims may sometimes require additional resources. Our claims and case management teams will work on coordinated solutions and strategies to help them reach the best outcomes. These cases encompass a small percentage of the claims, but they are responsible for a greater percentage of the dollars. Having a team that is helping our examiners get those claims resolved in a way that is favorable for our clients' employees and customers, as well as our carrier partners, benefits everyone involved.

In addition, as chief claims officer, I'm excited about what the partnership and collaboration between some of our key departments and our Performance 360 quality initiative can yield in terms of results for our customers and their employees. What we've seen is that when we work together to solve issues, we're very successful.

edge:
How has technology improved the claims process?

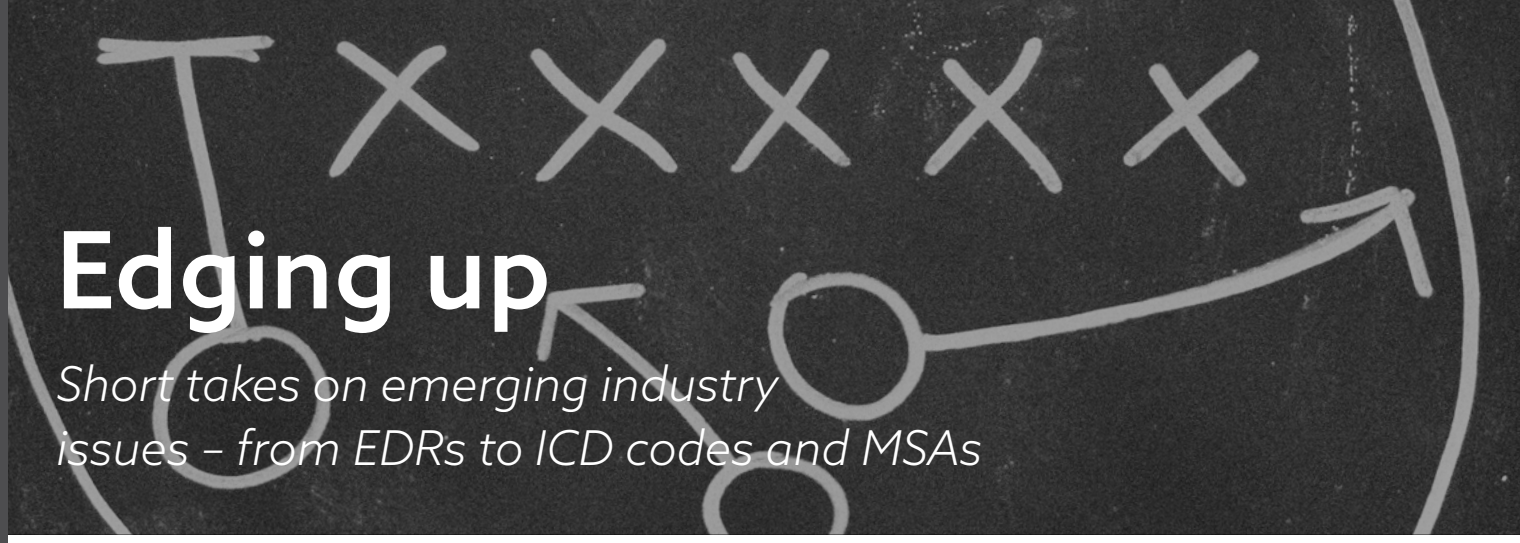
Darrell:
We have made incredible strides in terms of getting employees access to their claims information. With our self-service application, viaOne® express, they can access real-time information using their personal computer, smartphone or other mobile device. We are also sharing payment status and other key claim updates through our push technology option. As we continue to do this and expand the options, I think they will continue to be very well received.

edge:
Looking at the regulatory environment and recent law changes, do you think topics important to our industry will be a part of ongoing debates in light of the changing political landscape?

Darrell:
From an industry perspective, it is a very interesting time for workers' compensation because so much has changed in terms of demographics and preferences. We have to understand the different cultural groups, increased diversity and how societal changes and topics such as recreational and medical marijuana impact what we do in claims administration. We will continue to think about how workers' compensation is impacted with respect to these changes and other regulatory and law changes. There could be continued national attention on workers' compensation between now and the election next year. The related conversations will impact not just claims and workers' compensation, but the broader range of issues for employers. With the changes in the political landscape, our industry and our business need to change with it. We will continue to look at new laws and changes that could impact our clients and the work we do at Sedgwick, so that we will be prepared to respond.

DARRELL BROWN

As Chief Claims Officer, Darrell is responsible for Sedgwick's Total Quality Initiative, Performance 360 and innovation. He is based in our Long Beach, California office and has over 20 years of experience in claims management. Darrell joined Sedgwick in 2001 as an assistant claims manager and later served as an operations manager and area manager for the southern California region. He also spent more than five years as the workers' compensation practice lead. Prior to joining Sedgwick, Darrell worked as a claims manager for a third party administrator specializing in public entities. He has been an instructor for the American Insurance Educational Association teaching advanced workers' compensation, case law and labor code. Darrell holds a self-insurance license in California and earned the Associate in Risk Management designation through the American Institute for Chartered Property Casualty Underwriters.



Edging up

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

It's time to expand use of EDR tech

BY **MARIO RODRIGUEZ**

Director, National Technical Compliance, Sedgwick

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

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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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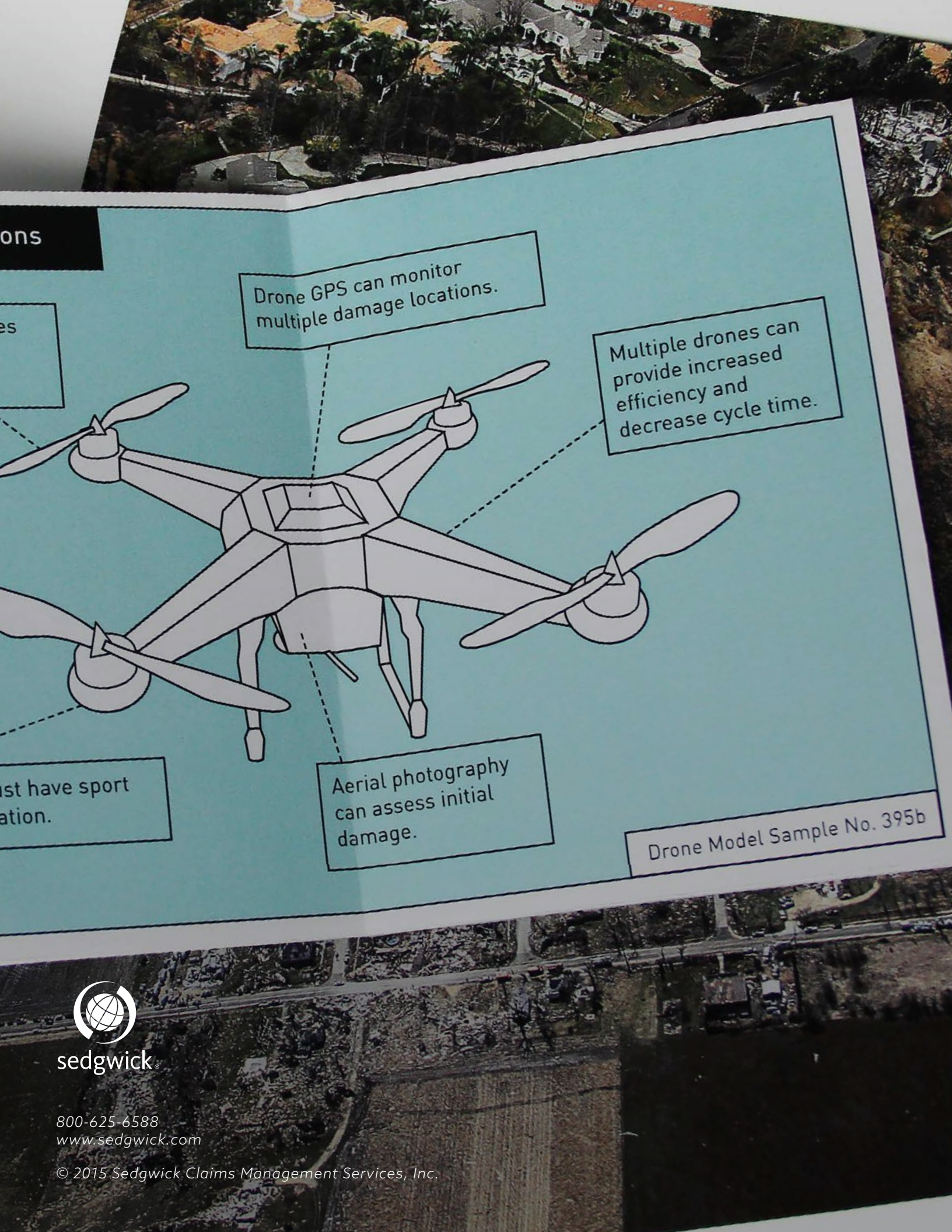

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