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SEDGWICK'S QUARTERLY PUBLICATION

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IN THIS ISSUE

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Complex claims: Mobility breakthroughs and impact on productivity

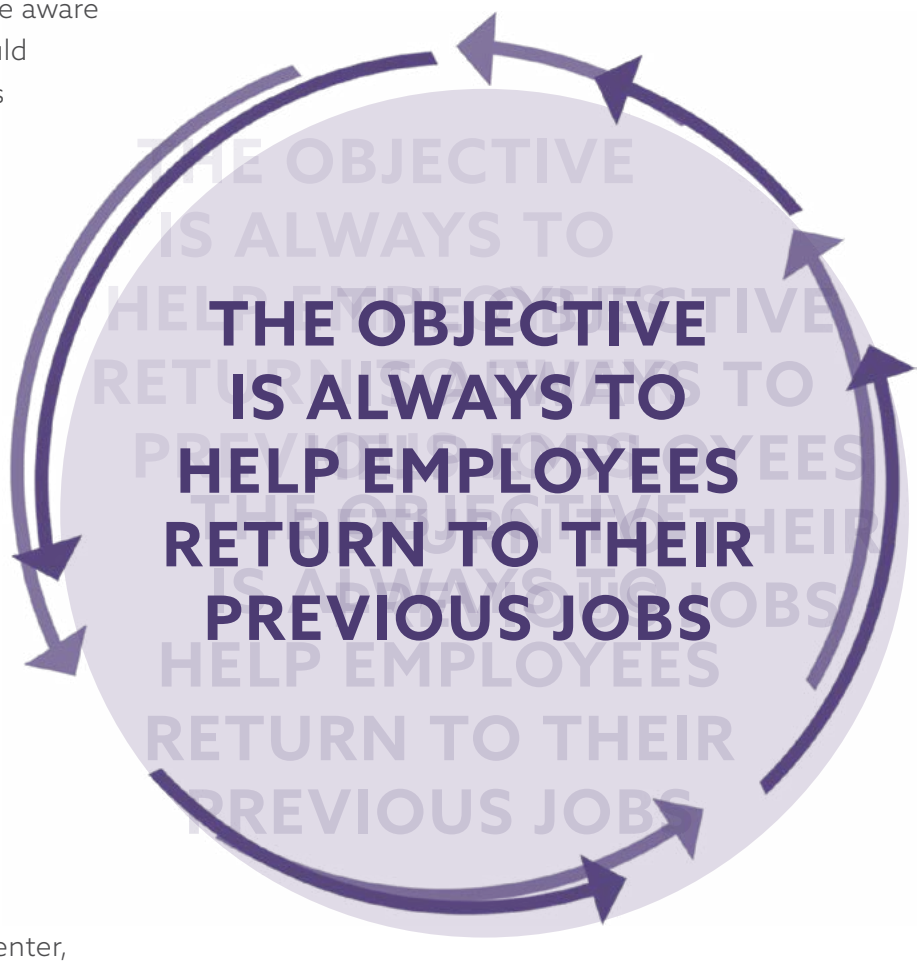
BY **EDWARD CANAVAN, AIC, ARM**

VP, Workers' Compensation Practice and Compliance, Sedgwick

After a traumatic workplace injury, identifying the best physicians to provide medical care for the employee early on is critical to ensuring a good outcome. Another key part of the medical care process is establishing a plan for the physical and occupational therapy needed to help the employee recover. The objective is always to help employees return to their previous jobs or to light duty positions as needed – and to be able to do as much as they did before their injuries. For some patients, this may seem like an unattainable goal, but with the right medical care, they may be able to do more than they imagined.

Finding the employee the appropriate care from providers who understand workers' compensation cases is vital. To help ensure the best results, claims and managed care professionals must work with these doctors and clinical experts to ensure that everything possible is being done to help the employee recover and return to work. Quality providers are aware of the latest treatment options that could impact the employee's recovery such as advancements in physical therapy.

For patients who are unable to walk or those who have severe motor impairments, there is research being done to evaluate medical devices and treatment such as electrical stimulation and training to help improve mobility. One of the medical facilities conducting studies in this area is the Atlanta-based Shepherd Center, a private, not-for-profit hospital specializing in medical treatment, research and rehabilitation for those with spinal cord and brain injuries.



Mitch Fillhaber, Senior Vice President of Corporate Development at Shepherd Center, explained that the technology being studied can have an impact on return to work options, help patients achieve a better quality of life and access more potential jobs than they could have without it. See the adjacent article for more on the valuable research being done at Shepherd Center.

Sedgwick's newly formed complex claims unit specializes in managing workers' compensation claims involving various types of complex and catastrophic injuries such as those affecting the brain and spinal cord. The analysts and advisors in our complex claims unit have 250 years of combined experience and provide expertise and assistance to ensure the cases are progressing. This value-added service is unique to Sedgwick and enhances our efforts to assist the injured employee all while helping to keep the medical management on track.

Mobility devices can help patients get their lives back

BY **ANDREA BUHL, MSN, RN, FNP-BC**

SVP, Clinically Integrated Medical Programs, Sedgwick

For patients with severe injuries, it can take a great deal of therapy and time to be able to recover and return to work. Allowing enough time to assess the patient's potential for recovery is the key. Edelle Field-Fote, PhD, PT, Director of Spinal Cord Injury Research at Shepherd Center, explains that very early after a spinal cord injury, the nervous system goes through a period where it has limited capacity to respond to training, but that changes very quickly. If the nervous system has a few days or weeks to stabilize, the nervous system has greater capacity to respond, and with access to good care and good rehabilitation, the patient can often attain a significant amount of functional improvement.

At Shepherd Center, studies are underway exploring the capabilities of new mobility devices that would allow patients with spinal cord injuries to walk again. This option is life-changing for many people who would normally be confined to a wheelchair. These mobility improvements open up many more options for employers to be able to place their employees back in functional jobs. They also give employees the opportunity to feel like they are not so far removed from the workforce they once knew.

There are several mobility devices being introduced such as the ReWalk, which has been approved by the U.S. Food and Drug Administration (FDA).[1] Some offer the ability to walk over different types of terrain or provide electrical muscle stimulation to assist motorized joints. All of the devices require that the individual be able to use crutches or a walker to maintain their balance.

Dr. Field-Fote notes that in addition to improving mobility, there are also other benefits of walking such as improved respiratory and metabolic function. Being mobile improves pulmonary and urinary function, and decreases the risk of bone fractures. She explains that there are certain areas of the brain associated with memory where new neurons can regenerate. Activities including exercise help stimulate the creation of new neurons, improve the health of existing neurons and facilitate connections between them.

Some of these same concepts apply to motor function; when we do different types of activities as part of physical and occupational therapy, our goal is to help those new connections grow and help compensate for lost functions.

Beyond studies that focus on improving mobility, Shepherd Center experts are also studying approaches that may have the potential to improve hand function. The goal of these studies is to give patients with severe motor impairment in their hands the ability to complete daily activities most of us take for granted like eating, dialing a phone or scratching an itch. Ongoing research and advancements being studied at facilities like Shepherd Center can help patients gain mobility, return to work sooner and improve their overall quality of life.

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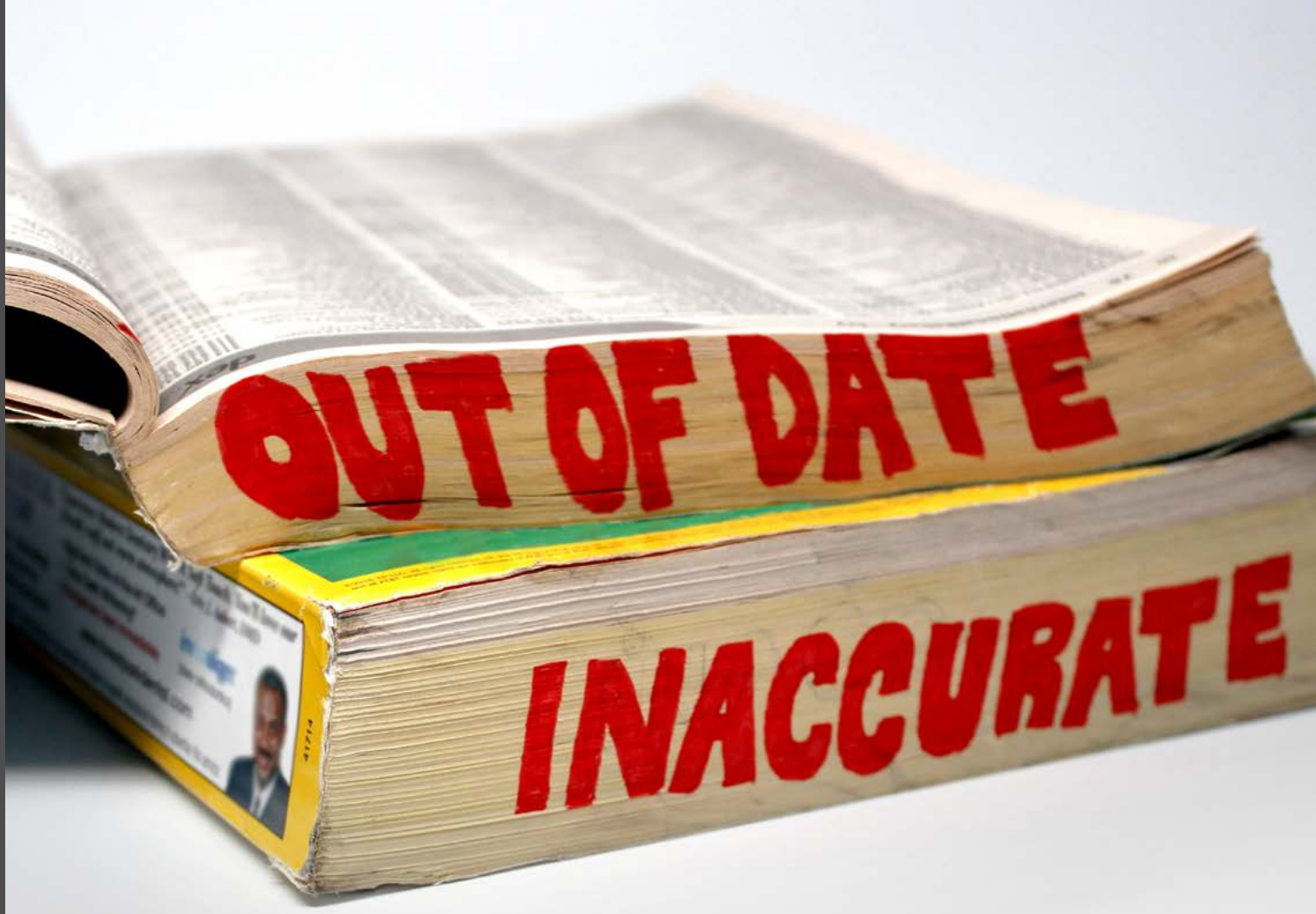

Network improvements: Going the extra mile to help injured employees get to the right doctors

BY **GEORGE FURLONG**

SVP, Managed Care Program Outcomes Analysis, Sedgwick

Whether you need to make dinner reservations at a new restaurant or an appointment for a first-time visit with a doctor, an accurate telephone number and location are essential. If an injured employee is unable to contact or find the physician for their workplace injury, it can be more than an inconvenience.

This is a real issue in the workers' compensation and group health industries where 30% or more of the data in provider networks is incorrect.[1] This includes information such as phone numbers, addresses and whether or not the providers are taking new patients. Every provider database in the industry, whether it is for group health or workers' compensation, builds its list of providers from multiple networks. Part of the problem with the American healthcare system is that the applications used to maintain the information are on several different platforms that do not interface or correspond.

Network information inaccuracy is an industry-wide issue that has received attention from the federal and state governments as it relates to access to care, quality of care and the ability to identify doctors. "States are aware of the tension between accuracy and comprehensiveness when providing information to consumers. They understand that there are constraints on networks and carriers that rely on providers for the information and they are struggling to find a balance to make all stakeholders responsible. The details required for the directories are becoming increasingly complex – languages spoken, whether or not the provider is taking new clients, current office hours – all of that requires responsible and accurate reporting. As the states look for specific policies to further incentivize provider participation in the directories, carriers are looking for ways to streamline the information and make sure they are not duplicating their efforts," explains Robert A. Holden, Senior Vice President at Stateside Associates, a state and local government affairs firm that develops strategies to help industries and associations manage and improve a wide range of issues.

If the doctors do not provide updated information to the many networks they subscribe to or the networks do not take responsibility for updating their data, the employer and the injured employee can suffer. There is nothing worse than for an injured employee to show up at the address they've been given for a doctor's office and find out that the doctor has moved. If an employee is given a telephone number for a specialist who is no longer in business or no longer accepting workers' compensation patients, the employee has to call and ask the claims examiner or case manager to identify a different provider. This can cause treatment delays, unnecessary time away from work, increased claim durations and higher chances for litigation. The more bumps in the road like this, the more contentious – and costly – the claim can become. There has been no effective remedy in group health or workers' compensation until now.

GOING ABOVE AND BEYOND TO TAKE CARE OF INJURED EMPLOYEES

While challenges abound in preferred provider networks, Sedgwick has decided to take a stand and address this systemic problem for its customers and their injured employees by ensuring the provider information we share is accurate. In addition to using our provider benchmarking and search tool to find top-performing doctors for injured employees, we take the extra step to make sure we have the right information for each one of them in our database.

The Sedgwick team has proactively validated the demographic records for 60,000 providers and maintains it on an ongoing basis. We have a group of dedicated colleagues who continuously talk to the best-performing providers for workers' compensation injuries to confirm that we have accurate information to give to injured employees. We have formally addressed the problem with this initiative, which includes continually identifying, updating and managing the data. It is part of providing appropriate care and ensuring injured

employees have the best possible experience.

This process improves efficiencies for our claims examiners and nurse case managers who are trying to take care of the injured employees, relieving them from individually validating and updating the provider information manually. Examiners and case managers still have the capability to update provider information if they find a bad record, but it is a team effort.

In the past, we would also send provider updates back to the networks. The networks frequently would add new records to their databases and not remove the old ones, or call the provider themselves and eventually update their database and three months later the data would be transmitted to the search tool leaving bad records in the system in the meantime. Due to the inconsistencies in their data management processes, we cannot rely on the networks to update the information. If the networks provide inaccurate records, we will continue to update them in our system.

In addition to updating the data, the verification is also tied into our provider benchmarking and search tool. We focus on identifying who the physicians are and assessing their performance and where they stack up in our quality benchmarking system. The process attaches them to their demographic records and validates those records to make sure that we have accurate locations, phone numbers, addresses and hours of operation, and that they are accepting workers' compensation patients. These actions are the most important things we can do to ensure our customers' injured employees get quality, appropriate care as quickly and seamlessly as possible.

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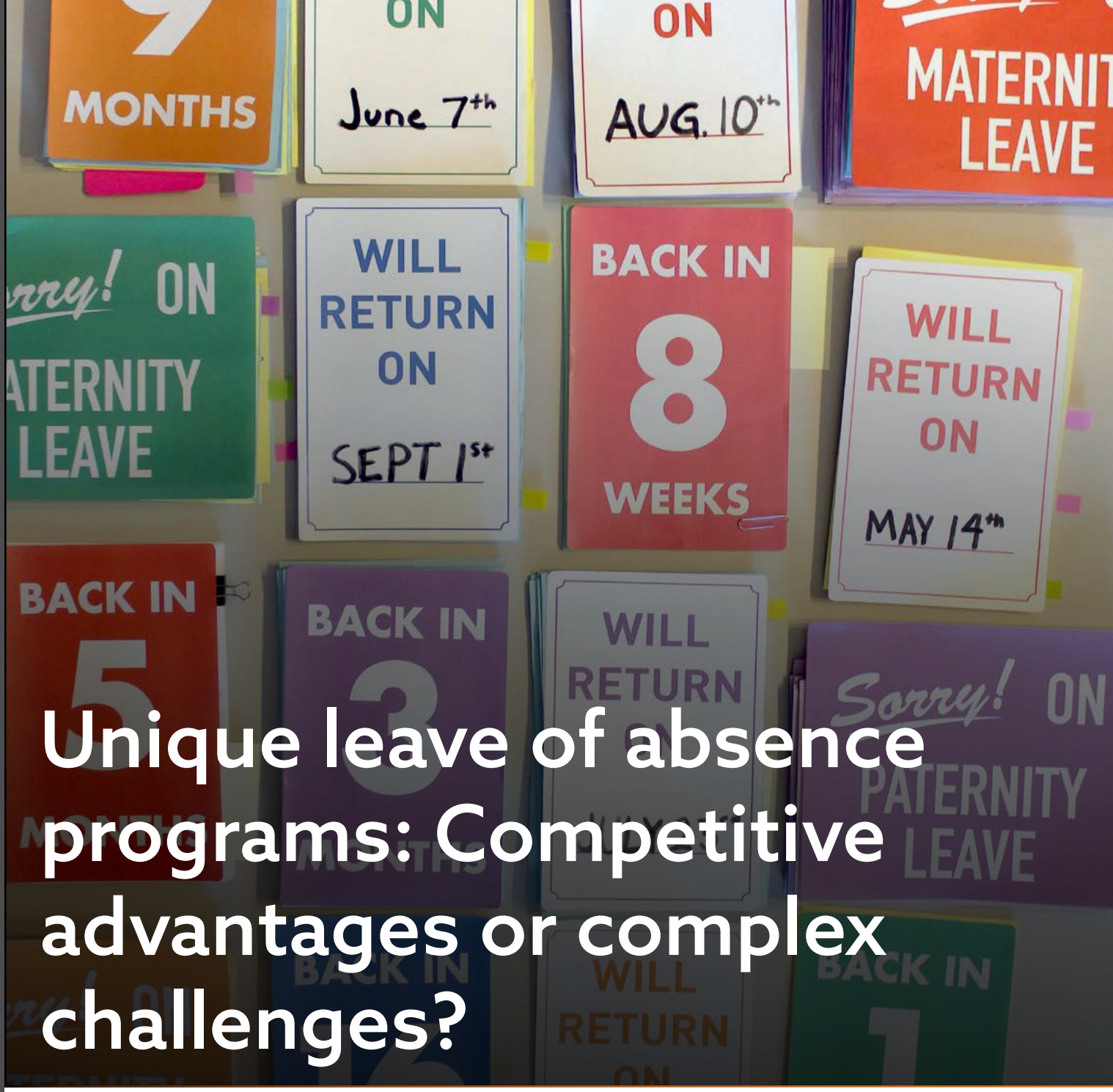

Unique leave of absence programs: Competitive advantages or complex challenges?

BY **STEPHANIE SIMPSON**

SVP, Disability and Absence Management Practice, Sedgwick

As companies enhance their products, services and business processes, some employers also are looking at ways to enhance employee leave of absence benefits to offer more than just legally-required job protection. To meet the ongoing demand for more flexibility and balance between work and life responsibilities, some employers are introducing unique programs such as limited and unlimited paid leave, extended paid maternity and paternity leave, and unlimited paid time off (PTO).

RESPONDING TO A CHANGING WORKFORCE

For many workers, especially millennials, workplace flexibility and family-friendly benefits are no longer just a preference; they are an expectation.[1] When job candidates for key positions are in short supply, offering paid leave helps employers attract and retain experienced, talented employees. Workers in two-earner households find the perk alluring, and today's employees tend to be more concerned with work/life balance than workers in decades past.[2] Paid leave also can have a positive impact on job satisfaction and engagement.

Only 12% of employees working in the private sector currently have access to paid family leave through their employer.[3] According to a survey conducted by the Society for Human Resource Management, 18% of employers offer paid maternity leave and 16% offer paid paternity leave other than what is covered by short-term disability or state programs.[4] The emerging paid leave programs can offer key advantages, but they can be cost-prohibitive for many employers.

California, New Jersey and Rhode Island are the only states that offer paid parental leave. These programs are funded through employee-paid payroll taxes and are administered as part of their respective disability programs.[5] Employers in states without disability programs like these would need to factor the cost of such plans into their annual budget.

KEY CONSIDERATIONS

When evaluating extended paid leave programs, it is imperative for organizations to know their staffing requirements to ensure the business' needs can be met without putting excessive pressure on employees who are working. In service-oriented businesses, if there aren't enough employees to assist customers, the company's reputation and bottom line can be negatively impacted. In some industries, temporary employees can help fill in gaps, while in others this is not possible due to the subject matter expertise required or because of the highly technical nature of some positions. If certain employees with unique skill sets take a leave of absence, it is important for employers to have a plan in place to maintain productivity while employees are off.

In the future, employers may be forced to offer paid leave programs to compete for top talent or comply with parental leave laws.[5]

Here are some key points for employers to consider as they explore unique programs for their specific work environments:

- How will a leave program impact other health and welfare benefits from an eligibility perspective?
- Will the options have a negative impact on company culture and employee morale?
- How will management styles need to change to adapt to this workforce dynamic?
- How do years of service impact a PTO program and will this change if additional leave time is provided?
- Will the options available under parental leave unintentionally create accommodation issues in other areas of disability?
- How will absences be monitored and tracked?
- Are there legal risks if the benefits do not apply to everyone?

While employers rush to adapt to the lifestyles and needs of our changing workforce, it is important to consider how creative adaptations of traditional benefits might impact the operational, financial and legal components of a business. Although unique leave of absence programs might create a strategic advantage in recruiting talented job candidates, employers should be cautious to consider how they might have unintended consequences once their employees elect to take advantage of the benefits.

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Expert view

Q&A with Teresa Cheek, Managing Director, IT Enterprise Initiatives, Sedgwick

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

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

Teresa:
It is an exciting time to be working in the technology field and especially with a company like Sedgwick that is on the cutting edge of innovation. In the not too distant past, the industry was abuzz with talk about predictive analytics – which provides a way to identify

key factors or triggers that historically indicate a claim will take a certain path – giving claims professionals and other experts an opportunity to intervene early if needed to ultimately ensure a better outcome.

We wrapped our advocacy approach into our predictive analytics model and we have seen dramatic results for consumers and customers alike. We believe we will continue to have great success in this area.

Although predictive analytics is still important, and will continue to be refined, we are also seeing a shift (and perhaps pushing for a shift) into prescriptive analytics.

edge:
That's an interesting distinction. Can you define the difference between predictive and prescriptive analytics as they relate to data and customer service solutions?

Teresa:
Predictive analytics is based on data and triggers that provide insight into patterns that can be addressed early in the claims process to achieve a better outcome. Prescriptive analytics is taking that data and then prescribing the next steps to be taken on a claim in a more automated fashion, all while meeting the needs of the individual.

We can no longer take a one-size-fits-all approach to triggers and flags, but really must work to use prescriptive analytics to build a more personalized experience for the employee. This involves going beyond their immediate medical needs, looking at specific characteristics of the claim, and then addressing concerns early to help guide them toward the best possible outcome. To do that effectively, for the millions of people Sedgwick serves, requires smart technology and automation embedded within our advocacy approach.

edge:
Can you give an example of how this could work?

Teresa:
An example of prescriptive analytics in another industry that may bring this to light is the invention and deployment of driverless cars. The technology behind this automation allows cars to predict a set of possible scenarios and be able to make decisions effectively and safely. However, when a car is actually in use, it needs more than a set of predictions and triggers; it will need to appropriately react to each situation it encounters, including unpredictable human drivers in other vehicles. In essence, it is learning and prescribing the right approach to create the right outcome instantaneously. It isn't retrospectively learning and adjusting for future scenarios; it is learning and adjusting in the moment to have a positive outcome right then and there.

Because Sedgwick has the technology to aggregate millions of transactions in seconds and has the depth of millions of claims in our databases, we believe driving towards a prescriptive analytic approach is a near-term innovation and the right thing to do for our customers, consumers and the industry.

edge:
Why is Sedgwick investing in this next level of innovation?

Teresa:
It is all part of thinking differently and using data to help in terms of the customer experience. We are using technology to make the consumer the focus. The more information we have about the injured employee, the better we can serve them. I believe we can use analytics to determine the right path to help the person get well, return to work and have the best possible experience.

With our advocacy approach, our goal is to center the process on the consumer and connect and speak with them in the way they prefer. We are building a different way of using data to drive the interactions; taking the data and really understanding the pattern of the consumer and how they want to engage. For example, people in different generations may have different needs for communication, interaction and information.

edge:
Have you done this already in specific verticals and what has the data shown?

Teresa:
The prescriptive model is on the horizon, but today we deploy predictive analytics very effectively. We have been working with customers to benchmark data on their employee population against industry data to help identify insights about performance. For example, we worked with the airline industry to gain a robust

view of workers' compensation statistics from the pilot's view, the flight attendant's view, the technician's view and more. Customers can compare against the industry by state, cost, injury type, etc., and the tool helps us to easily visualize performance and results. These insights are simplifying the message, giving employers a clear picture of what they want to see and how they want to see it in a timely manner. The analytics are helping set expectations and, most importantly, we can use the data to take action in our processes. If there is a propensity for a certain kind of injury in a specific age group, we can use that data to tailor care for the employees. To be clear, we are mindful of privacy issues and always respect the restrictions on data that our customers request.

edge:
What else is on the horizon for prescriptive analytics and data solutions?

Teresa:
In addition to using our own data integration, we are looking at pre-loss criteria and applying the prescriptive analysis to a claim to avoid complexity and ultimately achieve a better outcome. We want to look specifically at the injured employees to see what we can do to prevent incidents that might impede recovery and enhance our medical programs to meet their individual needs. This includes developing better practices around resource management. We are also applying this approach to guide the claims escalation process. By using analytics to flag specific claims and address potential issues early, we are seeing marked improvements for our customers and consumers.

TERESA CHEEK

Teresa serves as managing director of information technology (IT) enterprise initiatives. Before joining Sedgwick in 2014, she served as vice president of information technology at ServiceMaster Global Holdings. Teresa is based in our Memphis office and has more than 20 years of experience. She is a proven leader in information technology and marketing, and her areas of expertise include business intelligence, cyber-security, customer relationship management, e-commerce, enterprise strategy and data management. She has also had the opportunity to work in various industries during her career including consumer and financial services, automotive, military and retail.

Edging up

Short takes on emerging industry issues – ERISA updates, pregnancy discrimination developments, the Zika virus, and the benefits of integrating claims and managed care services

Proposed changes to ERISA disability claim procedures regulation: Preview and prepare

BY **STEPHANIE SIMPSON**

SVP, Disability and Absence Management Practice, Sedgwick

On November 18, 2015, the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor (DOL) published proposed amendments to the claim procedures regulation for plans providing disability benefits under the Employee Retirement Income Security Act of 1974 (ERISA). The intent of the proposed changes is to align the ERISA regulations with procedural protections that apply to group health plans governed by the Affordable Care Act. The proposed rule is posted online in the Federal Register.

Written comments on the proposed changes were due on January 19, 2016. The DOL published 143 comment letters, which reflect various stakeholder viewpoints. The DOL will review the comments and issue a Final Rule. The new regulations will become effective 60 days after the date of publication of the Final Rule in the Federal Register.

The proposed changes are organized in six categories:

1. Independence and Impartiality – Avoiding Conflicts of Interest
2. Improvements to Basic Disclosure Requirements
3. Right to Review and Respond to New Information Before Final Decision
4. Deemed Exhaustion of Claims and Appeals Processes
5. Coverage Rescissions – Adverse Benefit Determination
6. Culturally & Linguistically Appropriate Notices

If published as written, some of these anticipated changes will have a significant impact on plan sponsors and administrators. A Sedgwick committee thoroughly reviewed the proposed changes and submitted detailed comments that explain concerns with the changes in three of the abovementioned categories. The summary below outlines three of the most significant challenges anticipated with the proposed changes as they are currently written.

IMPROVEMENTS TO BASIC DISCLOSURE REQUIREMENTS

If the plan did not follow views of a treating healthcare provider or other payers of benefits, such as the Social Security Administration, then the adverse benefit communication would need to contain an explanation describing why the plan disagrees with those viewpoints.

Photo credit: CDC

This proposed change is problematic because it would require an administrator to provide an analysis of information that it might not have in its possession and/or may not fully understand. The rationale behind an approval decision is unlikely to be available for a rebuttal (just the conclusion of approval). It is not reasonable to expect one plan administrator to have the expertise, information, interpretations, and other criteria to compare, contrast and analyze benefit approvals. Sedgwick's recommendation is to include an explanation of why the plan did not agree with the opinion of the treating healthcare professional but not reasons for disagreeing with other payers of benefits.

RIGHT TO REVIEW AND RESPOND TO NEW INFORMATION BEFORE FINAL DECISION

The proposed amendment requires a plan to provide a claimant with an opportunity to review any new information obtained during the review of the claim before an adverse benefit determination is made.

At first glance, the proposed new language does not seem problematic, but after reviewing it in detail, one can easily see that the proposed requirements may result in an endless exchange of information with no time limitations. It is unlikely that this back and forth review of commentary would result in the production of new information. There is no advantage to the claimant for the treating provider and the plan to continuously restate their differing opinions instead of the plan deciding if the claimant's condition meets the plan's definition of disability. Furthermore, timely decision-making is part of a reasonable claims process, and the proposed language will potentially require plans to repeatedly extend the decision-making period.

DEEMED EXHAUSTION OF CLAIMS AND APPEALS PROCESSES

Proposed new language is added that indicates a plan's failure to strictly adhere to process requirements will result in a deemed exhaustion of the administrative remedies unless the procedural violation is *de minimis*.

By adding the term "strict" to this section, even minor and inconsequential errors will create an assumption that claim procedures are unreasonable. This language encourages claimants to seek remedies in court for insignificant missteps in case management that have had no impact on claim outcomes. It is likely that these modifications would result in a significant increase in "deemed exhaustion" litigation and would needlessly burden the courts and increase the costs associated with plan administration.

In addition to these challenges, other sections of the proposed amendments should be evaluated for an analysis of the potential requirements resulting from the changes. While plan administrators will have 60 days to prepare after the Final Rule is published, it is not too early to start planning now.

RESOURCES

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In the spotlight: Pregnancy-related discrimination and accommodations

BY **SHARON ANDRUS**

Director, National Technical Compliance, Disability Administration, Sedgwick

Since 1978, the Pregnancy Discrimination Act (PDA) has made discrimination against women for pregnancy, childbirth or related medical conditions a form of unlawful sex discrimination under Title VII of the Civil Rights Act of 1964. Recently, however, this nearly 40-year-old law has been in the spotlight due to the U.S. Supreme Court's decision in *Young v. United Parcel Service*. While issues brought to the nation's highest court always garner significant attention, the issues debated in the *Young* case became somewhat more controversial when the U.S. Equal Employment Opportunity Commission (EEOC) issued interpretive guidance shortly after the Supreme Court agreed to hear the case, but before the Court had rendered any opinions.

The PDA applies to employers with 15 or more employees and requires them to treat pregnant women the same as other employees who are "similar in their ability or inability to work." The PDA also protects pregnant applicants, making it unlawful to refuse to hire a pregnant woman because of her pregnancy (as long as she can perform the main responsibilities of the position). Keep in mind that pregnancy is not considered a disability under the Americans with Disabilities Act (ADA), but complications or impairments related to a pregnancy may result in a disability protected under this law.

The general legal interpretation of the PDA, until recently, was that pregnant employees were to be treated like any other employee who had a non work-related injury or illness. This resulted in many employers taking a "pregnancy blind" approach to accommodations, granting or denying accommodations without regard to a woman's pregnancy. Employers using this approach reasoned that it would be impossible to discriminate against a pregnant woman if her pregnancy never was considered. This approach has now changed significantly.

Prior to the Supreme Court's decision in *Young*, in order to set forth a claim of pregnancy discrimination, a pregnant employee needed to show that: 1) she belonged to a protected class (is pregnant); 2) she sought an accommodation; 3) her employer did not accommodate her; and 4) her employer accommodated others who were "similar in their ability or inability to work." If the pregnant employee showed that these criteria were met, the employer then needed to state a "legitimate, non-discriminatory" rationale for not providing an accommodation. For a pregnant employee to prevail, she then had to show that the employer's justification was a mere pretext designed to mask acts of unlawful discrimination.

On March 25, 2015, the U.S. Supreme Court issued its opinion in *Young v. United Parcel Service*.[1] The Court's ruling impacted the employer's ability to stand behind a "legitimate, non-discriminatory" rationale for not providing an accommodation. In *Young*, United Parcel Service (UPS) argued that it employed a "pregnancy-blind" policy for accommodating employees' light duty requests. UPS argued that, because pregnancy never was considered, its policy could never be a pretext for unlawful discrimination.

The Supreme Court disagreed and ruled that, where an employer's policies impose a "significant burden" on pregnant workers, in the absence of an employer's "sufficiently strong" reason to justify the creation of that burden, an accommodation policy that does not take a woman's pregnancy into account may amount to a form of pregnancy discrimination. Accordingly, policies that provide light duty or similar accommodations to employees, but not to pregnant women, likely will be deemed to create a significant burden on pregnant employees. The *Young* case was remanded to the Fourth Circuit to proceed based on the Supreme Court's opinion and in October 2015, the parties reached a confidential settlement agreement.

Following the *Young* ruling, the EEOC revised the Enforcement Guidance on Pregnancy Discrimination and Related Issues in June 2015 to make them consistent with this opinion. Recently, the PDA has become a focal point of the EEOC's enforcement efforts. This increased focus is likely the result of the EEOC's disagreement with several appellate court decisions, which held that it is not unlawful to deny light duty assignments to pregnant employees if the pregnant employees are treated the same as employees with limitations that did not result from workplace injuries. The EEOC has stated that employers should not focus on the source of an employee's limitations; rather the focus should be on an employee's ability or inability to work. The recent increase in charges against employers and revisions to the EEOC's guidance reflects the EEOC's attempts

to change employers' practices based on this interpretation of the PDA.

In addition to complying with the federal requirements under the PDA, sixteen states, the District of Columbia and four cities also have enacted laws that mandate accommodations similar to those required under the ADA.[2]

A significant challenge for employers is the requirement that pregnancy-related employment laws must be followed by all levels of management. While human resources professionals and legal counsel are usually familiar with the various legal requirements surrounding pregnancy-related leaves of absence and accommodations, not all leaders are aware of their obligations. Front-line supervisors who draw their own conclusions and take unilateral action regarding which duties a pregnant employee can or cannot perform frequently cause significant legal exposure. While liability is almost always measured by the amounts paid to settle a case, this exposure also may negatively impact a company's brand and reputation.

Employers should establish policies and procedures that include regular manager training to assist with proper identification of potential pregnancy-related accommodation issues. These policies and procedures should be regularly reviewed and revised so that they always will reflect recent changes in legal standards. All managers and supervisors should understand that pregnancy-related requests for accommodations should be evaluated on a case-by-case basis, similar to the interactive process for disability claims under the ADA. Leaders need to be trained and equipped to identify pregnancy-related employment issues and to escalate pregnancy accommodation decisions to their legal and human resource professionals before taking action.

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One team with a shared mission: Advocacy for the injured employee

BY **JIM HARVEY**

VP, Client Services, Managed Care,Sedgwick

Having a multi-disciplinary team following a shared mission of advocacy for the injured employee ensures better care management from the first call to report an injury to the moment the examiner closes the claim. Based on a recent study at Sedgwick, connecting services such as provider benchmarking and search tools, panel card production, provider validation, claims management, pharmacy programs, case management and bill review on the same technology platforms improves outcomes and controls costs.

We evaluated the results customers are seeing after placing their claims and managed care services under one roof. Our team reviewed the results achieved by six customers that moved from fully unbundled programs to integrated programs for claims management and managed care. New workers' compensation claims data was pulled for each program 12 months before integration and 12 months after integration. This study focused on indemnity and medical-only claim types. Of the six customers evaluated, four saw improvements while two followed inflation and industry trends. The customers with improvements saw an average reduction of 8.8% with one customer as high as 19.8%. The reductions were mostly from medical and indemnity; occasionally they came from expenses as well. This study showed that there is a significant benefit to combining workers' compensation and managed care services. On average, employers that participate in our integrated services model are seeing a 5% reduction in their medical and indemnity claim costs in the first year.

Some customers use select managed care solutions while others incorporate our full suite of services, which includes clinical consultation; medical bill review; telephonic, strategic and field case management; behavioral health; return to work; complex pharmacy management; utilization review; as well as a range of review and support solutions such as provider benchmarking, and access to medical and specialty networks. The integration of data across these services offers several advantages and can be used to identify trends and create strategies to improve outcomes.

Here is an example of an integrated program in action:

Beginning with a 24/7 nurse line, the injured employee is triaged and the right level of care is determined. Symptoms are reviewed during the initial call, and the nurse can determine if the employee needs treatment by a third party or if the employee can self-treat. If third-party care is needed, the nurse will send the employee to an urgent care facility or occupational medicine clinic within a preferred provider organization network. This step takes treatment decisions, with the related stress and uncertainty, out of the supervisor's hands. The nurse will send medical information to the provider such as where to send the employee for medication, imaging or therapy, if needed. This is pivotal for the continuity of care as the claim progresses. In an effective claims and managed care program operating under one roof, triage nurses, claims examiners and nurse case managers access the same provider search technology and can see provider scores based on treatment and return to work outcomes. Identifying the best doctors and having consistent resources for matching injured employees with those doctors is key to achieving better outcomes. This identification process includes provider benchmarking and search technology, a routine method for provider information validation, and reliable practices for the production, renewal and distribution of panel cards.

Throughout the entire treatment process, the claims examiner has total visibility and can take steps as needed to help move the claim forward such as suggesting peer-to-peer consultations, requesting nurse case management or recommending behavioral health services. Triggers can also be set up in the claims management system for services such as utilization review and field case management. Pharmacy programs with injury-specific and acute to chronic formularies ensure that any drugs inappropriate for the injury type and the age of the claim are identified at the point of sale. The clinical team is notified of any inappropriate prescriptions and will call the provider or pharmacist to discuss alternatives. In addition, meaningful data mining can be readily deployed when bill review, claims management and case management technology are developed and continuously enhanced with a common purpose regarding how, where and when data will be captured in the course of day-to-day business.

The primary elements that make a program successful and help drive positive results include shared missions, accountability, and the managed care and claims teams working together and accessing data through the same systems. By understanding the individual needs of each injured employee and focusing on providing the best medical care, our industry can improve outcomes and help them return to work sooner.

Zika virus: The threat and potential risk

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Employers may be considering the risk posed by the recent spread of the Zika virus and potential claims filed by employees who contract the disease. The Zika virus is transmitted to people primarily through the bite of an infected Aedes aegypti species mosquito. These are the same mosquitos that spread dengue and chikungunya viruses. Mosquitos become infected when they feed on a person already infected with the virus. Infected mosquitos spread the virus to other people through bites. The virus can also be spread through blood transfusion or sexually transmitted.

WHERE IS ZIKA SPREADING?

Prior to 2015, Zika virus outbreaks occurred in areas of Africa, Southeast Asia and the Pacific Islands. In May 2015, the Pan American Health Organization issued an alert regarding the first confirmed Zika virus infections in Brazil. Locally transmitted cases were also reported in the Commonwealth of Puerto Rico. As of March 16, 2016, no mosquito-transmitted Zika cases had been reported in the continental United States, but cases have been reported in returning travelers. Outbreaks are occurring in many countries and the virus will continue to spread, but it is difficult to determine how and where. However, researchers who tracked dengue fever outbreaks in the past predict small local outbreaks of the Zika virus in Florida and Texas.

WHAT ARE THE SYMPTOMS?

About one in five people infected with the Zika virus become ill. Symptoms include fever, rash, joint pain, conjunctivitis (red eyes), muscle pain and headache. The exact incubation period (the time from exposure to symptoms) is not known, but is likely to be a few days to a week. The illness is usually mild with symptoms lasting for several days to a week. The Zika virus usually remains in the blood of an infected person for a few days, but it can be found longer in some people. Severe disease requiring hospitalization is uncommon. Deaths are rare. Cases are identified by the symptoms, confirmation of recent travel to locales with confirmed infections and blood test results.

HOW IS ZIKA TREATED?

No vaccine or medications are available to prevent or treat Zika infections. An infected individual showing symptoms should get plenty of rest, drink fluids to prevent dehydration and take medicine such as acetaminophen to relieve fever and pain. Aspirin and other non-steroidal anti-inflammatory drugs (NSAIDS), like ibuprofen and naproxen, should not be taken until dengue can be ruled out to reduce the risk of hemorrhage (bleeding). An individual taking medicine for another medical condition should consult his or her healthcare provider before taking additional medication.

WHAT SPECIAL PRECAUTIONS SHOULD BE TAKEN BY PREGNANT WOMEN?

A mother already infected with the Zika virus near the time of delivery can pass the virus to her newborn around the time of birth, but it is rare. It is possible that the virus could be passed from mother to fetus during pregnancy. This mode of transmission is being investigated and is not yet understood. To date, there are no reports of infants getting the Zika virus through breastfeeding. The Centers for Disease Control and Prevention (CDC) recommends that women who are pregnant or trying to become pregnant use special precautions including avoiding travel to impacted areas and using protective clothing and insect

repellant. Women who are trying to become pregnant or thinking about becoming pregnant should consult with their healthcare provider before traveling to these areas and strictly follow steps to prevent mosquito bites during the trip.

There have been reports in Brazil of microcephaly and other poor pregnancy outcomes in babies of mothers who were infected with the Zika virus while pregnant. Microcephaly is a medical condition in which the circumference of the head is smaller than normal because the brain has not developed properly or has stopped growing. Additional studies are planned to learn more about the risks of Zika virus infection during pregnancy.

WHAT SHOULD EMPLOYERS DO?

Businesses with employees traveling to areas of infection should follow the precautions outlined by the CDC, including preventative measures to avoid mosquito bites. If a workers' compensation claim is filed for Zika virus exposure, it should be handled the same as any disease or exposure claim would be handled. A thorough investigation of the claim and circumstances involved should be conducted, and medical tests and evaluations should be done to confirm a diagnosis. Compensability determination would follow applicable regulatory standards for determining whether or not exposure occurred within the course and scope of employment.

RESOURCE

Centers for Disease Control and Prevention
http://www.cdc.gov/zika/

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