Edging up

Short takes on emerging industry issues – state regulatory updates and Tennessee case management changes

State regulatory updates

BY **ROXANNE BROWN**
Director, Regulatory Compliance, Sedgwick

Recently, several states have made regulatory updates. The following pages highlight the latest changes in Arizona, California, Ohio and Vermont.

Arizona adopted the use of Official Disability Guidelines (ODG) for the treatment of chronic pain and opioids for all pain management. The guidelines are to be used as a tool to support clinical decision making and quality healthcare delivery for injured employees. They are presumed correct if the guidelines provide recommendations related to the requested treatment or service. Preauthorization is not required to ensure payment for reasonably required medical treatment or services, but a provider may seek preauthorization.

Sedgwick's clinical colleagues are well-trained in the use of ODG. We look forward to implementing this useful tool to ensure that Arizona's injured employees are receiving best-in-class care in a safe manner that reduces the potential for abuse and addiction.

California Governor Jerry Brown signed several bills into law in September 2016. Senate bill 482 and Senate bill 1160 will have an impact on utilization review and lien filings. Because many parts of these bills will not be implemented right away, Sedgwick's leadership is evaluating the bills and planning for any changes that might need to occur in workflows and processes. More information will be provided as we near the implementation of these new requirements.

A new opioid rule for prescribers from the Ohio Bureau of Workers' Compensation (BWC) went into effect October 1, 2016. The rule applies to all BWC-certified prescribers and it is designed to help prevent opioid dependence for Ohio's injured employees. For claims with a date of injury on or after September 1, 2016, and for all claims on or after January 1, 2017, reimbursement will be limited to cases in which current best medical practices are followed.

The opioid prescribing guidelines set criteria to be applied by all prescribers when managing opioid analgesics for more than six to eight continuous weeks. Prescribers must register in the Ohio Automated RX Reporting System (OARRS) and use the data to check patient compliance, monitor for a 60 mg morphine equivalent dose (MED) per day trigger to reassess additional risk or mental health concerns, educate patients on potential adverse effects of long-term opioid medication management, perform opioid risk assessment, establish a pain agreement with the patient and meet other requirements.

The goals in implementing this new rule are to:

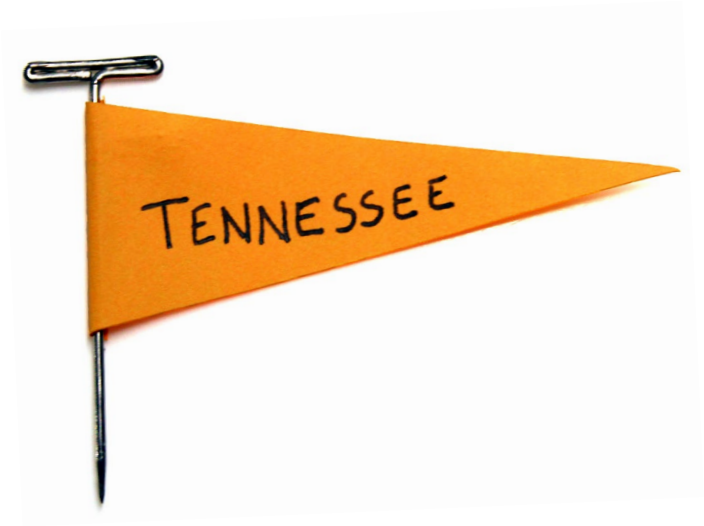
- Encourage prescribers to incorporate best clinical practices when prescribing opioids for treating Ohio's injured employees
- Establish provisions and criteria for treating opioid dependence that arises secondary to treatment with opioid medications
- Provide and strengthen the peer review processes for opioid prescribing that address non-compliance and other quality of care issues in the workers' compensation system

Sedgwick's Ohio managed care organization, CompManagement Health Systems, has implemented processes to ensure compliance with the new rule and guidelines.

Effective November 1, 2016, physicians in Vermont are required to follow treatment guidelines related to prescribing opioid medications or risk denial of payment for services. These guidelines apply to all prescribers in and out of the workers' compensation system.

Workers' compensation rules 11.1400 and 12.1730 allow carriers to deny or discontinue payment if physicians do not comply with all aspects of the Rule Governing the Prescribing of Opioids for Chronic Pain under Department of Health rules for Alcohol and Drug Abuse.

Sedgwick sees this as a very good tool to help impact prescribing patterns and reduce the potential risk for opioid addiction. Our team of complex pharmacy nurses, pharmacists and physicians is prepared to work with prescribing physicians to implement weaning protocols and offer alternative recommendations to assist healthcare providers in safely treating employees in Vermont.



Tennessee case management changes

BY **ROBIN MOLESKI, RN, BSN, CCM**
VP, Clinical Operations, Sedgwick

The Tennessee Department of Labor and Workforce Development announced that new rules for case managers have been adopted by the Bureau of Workers' Compensation. Beginning January 1, 2017, the Bureau will have the authority to assess fees and penalties to enforce the new requirements.

Significant areas impacted by the rule changes include:

- Fees to obtain and renew case manager registration
- Continuing education requirements to maintain registration to be developed by the Bureau
- Fines for not completing forms C-33 Case Management Notification within 30 days of referral and C-34 Case Management Closure within 30 days of closing a case
- Catastrophic cases should have case management services:
  - Case management assignment must occur within seven calendar days of notice of catastrophic injury
  - A face-to-face meeting must occur within 14 calendar days of assignment
  - Documentation about the meeting must be submitted to the Bureau's medical director within 30 calendar days
- Non-catastrophic cases should have one face-to-face meeting within 14 days of assignment to case management, and documentation of the meeting must be submitted to the medical director within 30 calendar days

- In order to meet the requirement for the face-to-face meeting, the telephonic case manager refers the claim to field case management for a task assignment to coincide with an appointment to maximize an optimal impact

Also, the rules now incorporate what was previously known as the Case Management Protocols. A case manager may not:

- Prepare the panel of physicians or influence the employee's choice of physician
- Determine if a case is work-related
- Question a physician or employee regarding issues of compensability
- Conduct or assist in claims negotiation, investigation or any non-rehabilitative activity
- Advise the employee on legal matters, including settlement options, monetary recovery or applicability of workers' comp to the claim
- Accept compensation or award as result of a settlement
- Discuss with the employee or physician what the impairment rating should be
- Reschedule medical appointments without first discussing with the employee
- Refuse to provide case management reports to parties to the claim
- Assist in recording employee's activity for purposes of disproving the claim
- Deny or authorize treatment for purposes of guaranteeing payment or precertification
- Injured worker is required to cooperate with the case manager

Registration requirements include:

- Currently, registered case manager assistants (CMAs) may continue to work under the supervision of a registered case manager for 24 months
- After 24 months, the CMA must obtain one of the following certifications to become a registered case manager: CCM, CRRN, CDMS, COHN; or a master's degree in vocational rehabilitation counseling
- A nurse who is not currently registered as a CMA has 24 months after becoming a CMA to obtain certification

Sedgwick is compliant with all of the existing and updated case management rules in Tennessee.

For questions about the rule changes, please contact Robin Moleski, VP, clinical operations, at managedcarecompliance@sedgwick.com.