edge

SEDGWICK'S QUARTERLY PUBLICATION

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IN THIS ISSUE

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Building telemedicine programs for workers' compensation

BY **TERESA BARTLETT, M.D.**
SVP, Medical Quality, Sedgwick

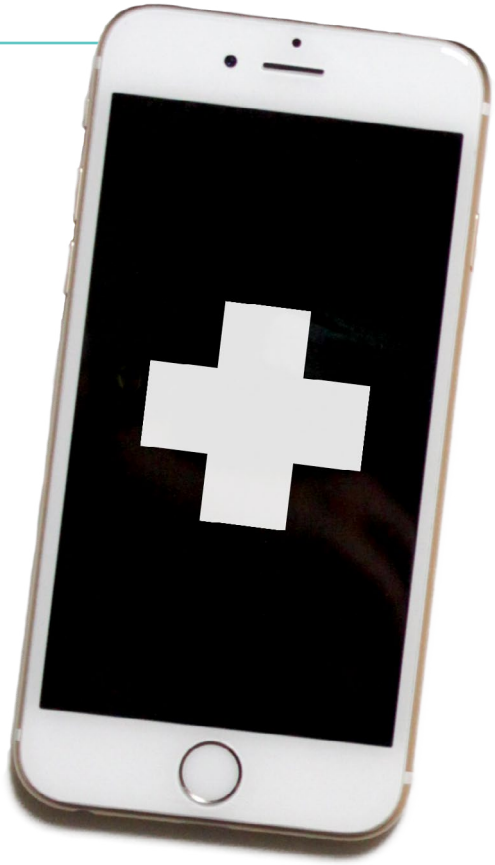
Telemedicine services designed for workers' compensation and group health plans will have similar benefits, but there are many additional components that must be included to provide a quality program for patients with workplace injuries.

Telemedicine services include clinical consultations with nurses via telephone and virtual physician visits using online video technology. Many workers' compensation claims administrators and managed care companies currently provide telehealth services including 24/7 nurse triage and prescription drug reviews. Telemedicine services for workers' compensation engage physicians for medical examinations. These services require physicians who have the knowledge and experience to deliver occupational injury care and meet applicable regulatory requirements. We have seen several failed starts in telemedicine for workers' compensation due to insufficient coordination and connectivity across technology platforms, providers and claims administrators. An important component is flexibility in the network composition and design, which includes all types of ancillary providers to enable opportunities to grow as the needs of the injured employees change.

Telemedicine offers advantages for patients and today's technology ensures doctors can obtain the information they need. For injured employees, the use of telemedicine eliminates the drive time and office wait time for themselves and others who may need to take them to appointments. With the technology and ancillary devices that are currently available, doctors can take blood pressure, complete an electrocardiogram and do various

Telemedicine offers advantages for patients and today's technology ensures doctors can obtain the information they need.

other tests remotely. With the advent of electronic records, physicians often find themselves documenting symptoms and treatment information on their computers during office visits with patients, a task that would be exactly the same with the use of telemedicine.



CONNECTED SERVICES HELP ENSURE QUALITY CARE

A successful telemedicine program for workers' compensation patients can connect everyone involved in the overall process – nurses, physicians, pharmacists, behavioral health specialists, physical therapists and all other clinicians. It is important to thoughtfully connect specific, crucial areas to deliver quality care. When they are all connected across shared systems, with common goals, it improves the employee experience and supports a smooth, efficient process for everyone assisting with the claim.

The industry lacks solutions that can deliver cost benefits to employers or quality care that equals onsite occupational medicine, with real-time support from pharmacists, nurses, behavioral health specialists and other clinicians. A successful program must also put the injured employee first. It is crucial to connect the entire treatment experience from the employee's perspective to ensure they are getting quality care and the best possible outcome.

ESSENTIAL COMPONENTS OF A SUCCESSFUL TELEMEDICINE PROGRAM

There are several critical elements necessary to support good outcomes and quality care – and they apply to both online and office visits. A key part of the process is managing logistics to ensure shorter wait times, provider availability, etc. It is also important to use occupational medicine physicians with proven, quality outcomes, and connect with an experienced workers' compensation network to support billing efficiency and provider management. In addition, to assure patient and data privacy, managed care technology must be protected under the laws established by the Health Insurance Portability and Accountability Act.

A successful telemedicine program for workers' compensation patients should include:

- Technology and logistics – The right platform can ensure easy access, shorter wait times, provider availability and accurate, efficient billing; below is a list of the technology features needed:
  - Rapid virtual access to physicians experienced in occupational healthcare
  - Virtual access to specialists
  - Connectivity to national occupational medicine groups and specialty networks
  - Virtual follow-up care
  - Logistics necessary to prevent long wait times and to connect callers to the right resources
  - Technology existing in the workplace or within the workforce necessary to connect injured employees with telemedicine providers
- Experience and results – One of the keys to improved health and return to work results in workers' compensation is having access to the best-performing occupational medicine providers available around the clock
- Network connectivity – The networks entering into this new approach will need to be organized and trained to meet the needs of providers, employers and injured employees
- Fully transparent pricing – Telemedicine is a form of healthcare enabled by technology, so the cost of services should be fully transparent
- Regulatory compliance – The services must be fully compliant with applicable regulatory requirements, including state reporting, related jurisdictional laws and billing for services

Many of these components are currently missing across the marketplace. Connecting these critical areas will eliminate travel time, and can help reduce lost productivity and lower medical costs associated with occupational injuries, while extending access to high-quality care. The right medical and clinical resources, combined with the necessary technology, can provide significant enhancements for employers and improve the experience for injured employees.

Employers wanting to engage this developing solution for their employees should make sure that the solution will deliver quality care first, followed by convenience.

Changes in Canadian auto accident benefits

BY **LAURIE WALKER**
SVP, Operations, Sedgwick Canada

The structure of Canadian (Ontario-specific) automobile accident benefits underwent various reforms that became effective on June 1, 2016. The primary change impacts accident-related disputes, which will now be settled through a tribunal instead of being handled in court. The responsibility for claims disputes moved from the Financial Services Commission of Ontario (FSCO) to the License Appeal Tribunal (LAT).


THE
OBJECTIVE
IS TO MAKE
PREMIUMS
MORE
AFFORDABLE
&
PROVIDE
MORE
COVERAGE CHOICES
FOR CONSUMERS.

As a part of this change, some other key amendments were made:

- The only dispute resolution process available to parties is a hearing through the LAT
- Mandatory mediation is no longer part of the resolution process
- No court action can be commenced for statutory accident benefits disputes
- There is no right of appeal, other than a reconsideration option with the Executive Chair of the Safety, Licensing Appeals and Standards Tribunals of Ontario for exceptional circumstances and the Divisional Court on a question of law[1]

The FSCO instituted changes to the province's automobile accident benefits that apply to policies issued or renewed on or after June 1, 2016. The objective is to make premiums more affordable and provide more coverage choices for consumers.[2]

Below are some of the coverage changes included in the reforms:

- Medical, rehabilitation and attendant care
  - Catastrophic injuries
    - New policy – Benefits are combined for medical, rehabilitation and attendant care; the total was reduced to $1 million
    - Old policy – Provided two separate limits of $1 million for medical and rehabilitation benefits, and $1 million for attendant care benefits
  - Non-catastrophic injuries
    - New policy – Benefits are combined for medical, rehabilitation and attendant care; the total was reduced to $65,000 for a standard policy
    - Old policy – Provided two separate limits of $50,000 for medical and rehabilitation benefits, and $36,000 for attendant care benefits
    - Time limits for policy coverage for medical/rehabilitation has been reduced from 10 years to 5 years
- Non-earner benefits
  - Durations for receiving benefits
    - New policy – A maximum of two years following a four-week waiting period
    - Old policy – No set duration for qualified applicants who met the six-month waiting period[2]

KEY DIFFERENCES BETWEEN U.S. AND CANADIAN AUTO ACCIDENT BENEFITS

- In some Canadian provinces, like Quebec, the insurance company does not pay the driver's injury claim, the Quebec government does
- Some Canadian provinces require more than liability coverage for any vehicle on the road; liability is the only coverage required in the U.S.
- If a car is registered, it is considered insured; if a driver stops paying insurance, then the vehicle automatically becomes unregistered and the driver is driving illegally

Even though there are several differences between auto insurance in the U.S. and Canada, there are also some similarities. For example, if you cause an accident in the U.S. or Canada, your insurance is required to cover the cost of paying the damages; if the driver does not have comprehensive coverage, their vehicle will not be repaired. Also, all drivers are required to have auto insurance or proof of their ability to pay for damages or it is illegal for them to drive.

MORE ABOUT CANADIAN AUTO ACCIDENT BENEFITS

Third party liability coverage pays for claims as a result of lawsuits against the driver and will pay the costs of settling claims that involve injury, death or property damage. Statutory accident benefits provide injury coverage for the driver regardless of who caused the accident; benefits include supplementary medical, rehabilitation and attendant care, caregiver, non-earner and income replacement benefits. Direct compensation-property damage covers the damage to the vehicle if another person was at fault for the accident; it also covers damage to or loss of use of the vehicle's contents.

Our expert team at Sedgwick Canada can assist your company with questions about commercial auto claims and related benefit reforms in Canada.

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The importance of preserving claim-related evidence

BY **STEVE POWELL**
President, Unified Investigations & Sciences, Inc., a Sedgwick company

Whether a copier catches on fire, water damage forces a business to close or an employee is injured while using machinery on the job, failing to preserve the claim-related evidence can prove to be costly.

When an injury, property damage or product failure happens, a forensic investigation company should be used to secure, collect and preserve the critical evidence. Only then can the claim be properly processed and brought to clarity by determining who or what is at fault.

Consider this example – An office employee sits down to begin the day and his chair breaks causing him to fall and injure his back. The employee has extensive back injuries and the time off he needs to recover causes the business major productivity issues. The reason why the chair malfunctioned may be lost if the evidence is not preserved.

If forensic experts are brought in, they will not only preserve the evidence, but can also do an extensive investigation and ask questions like – how did the chair malfunction and was it the chair that caused the injury? Those questions lead to others, such as – how many of these chairs does the employer own and how many employees are exposed to this hazard? From a risk standpoint, it is important for the employer to know so they can prevent additional employee injuries. From a legal perspective, the outcome of the investigation may result in a subrogation case against the manufacturer of the chair or unveil negligence on behalf of the user.

CROSSING EVERY "t" AND DOTTING EVERY "i"

The forensic investigation process includes identifying, collecting, storing, preserving, examining and testing evidence so the interested parties will know with certainty what caused the loss. A quality investigation will include a rigorous, detailed process with established industry standards that must be followed to ensure accuracy. It requires a skilled, experienced team that is trained in the recommended and accepted protocols that are part of a scientific method of processing physical evidence.

All evidence should be professionally collected, stored and preserved in accordance with applicable standards of care. The environment where the evidence is stored must be safe, secure, clean and organized in order to protect it from loss, contamination and degradation. The security and integrity of the physical evidence must be maintained from the time it is discovered through its collection, examination and testing. Steps including the receipt, transmittal and release of evidence must be fully documented by experts in evidence custody.


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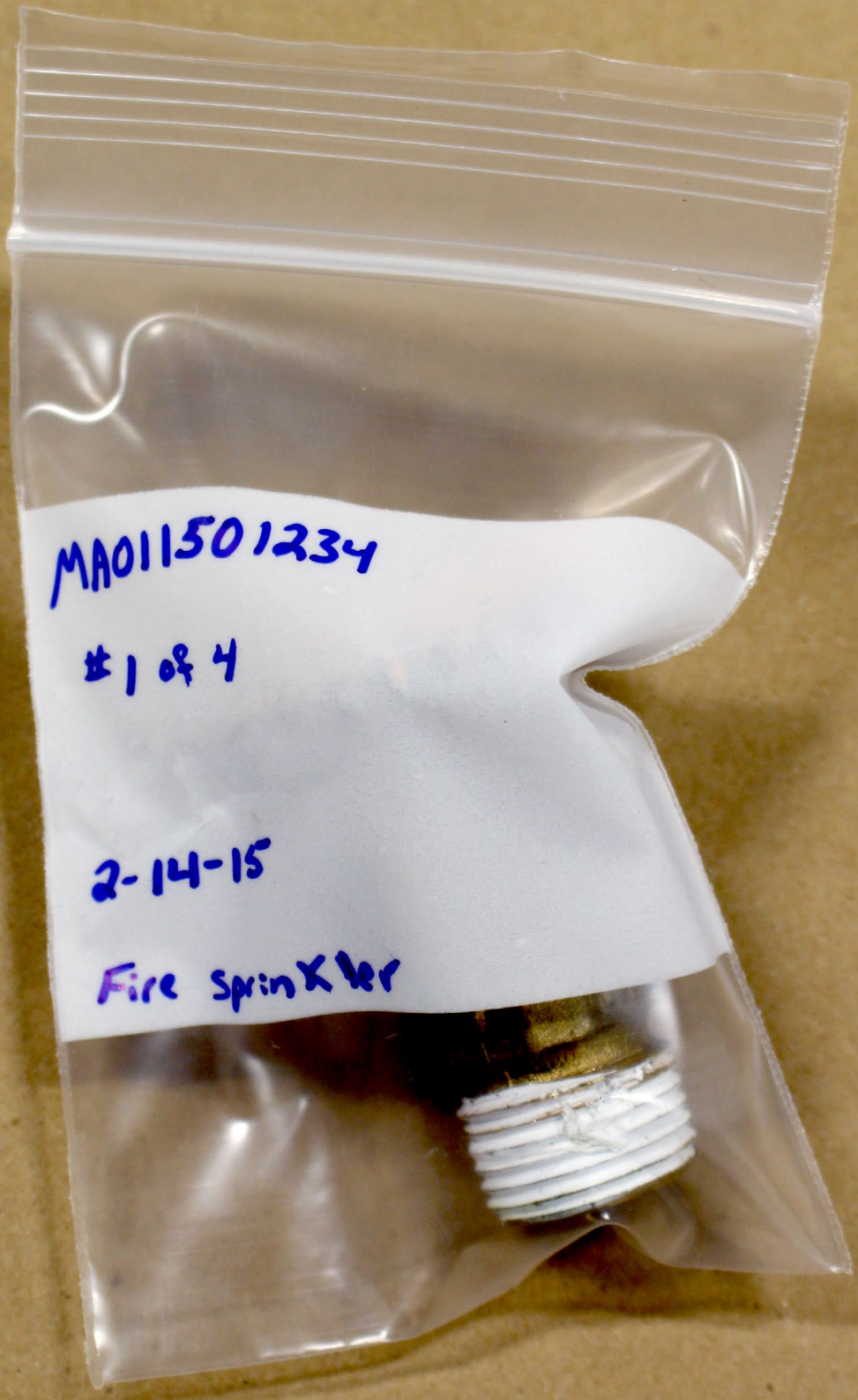
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Fire sprinkler

In addition to workers' compensation claims, forensic investigations are also conducted for property, casualty and liability claims. Here are a couple examples of situations where the expertise of a forensic investigation team can be valuable:

#1 A medical facility has a major water leak coming from the 3rd floor that causes employees and visitors to slip and fall, damages the building's drywall, ceilings, fixtures, mechanical and electrical equipment, and various items on the floors below. In this case, there are possible workers' compensation injuries, property damage and liability claims. There is a need for a thorough investigation into the cause of the water leak. It is prudent that a forensic investigation company is promptly dispatched to go there immediately, secure the evidence and start the process of figuring out what happened and who is liable. In addition to professional investigators, the risk manager will also send workers' compensation, property and liability claims adjusters to determine the scope of the loss and process the claims, and send forensic engineers to determine the cause of the water leak. Once the origin and cause of the loss are identified, the forensic investigator will photograph the evidence, bag it, tag it, label it, transport it, store it and preserve it in a secure storage facility until it can be examined and the cause of all of these claims is properly identified and documented.

#2 A pharmaceutical company that uses refrigerators and freezers to store drugs had a refrigeration unit that stopped working, causing an entire supply of chemotherapy drugs to spoil. There are some important questions to ask – why did the drugs spoil, how did they spoil, were the right protocols in place and whose fault is it? Unless it gets investigated and all the evidence is properly captured promptly on the front end, there's a high potential for spoliation of the evidence. If somebody tampered with the refrigeration units or drugs, or changed them in any way, the evidence is not being preserved properly. A professional forensic investigation company is the right choice for managing the insured's duty to preserve all evidence that can be subject to litigation.


PHOTOGRAPH
LABEL
TRANSPORT
STORE
CATALOG
PRESERVE

PEOPLE + PROCESS = PERFORMANCE AND RESULTS

When something bad happens, you need an expert in the item that failed or caused the loss – a generalist is less likely to provide a thorough, informed investigation.

At Unified Investigations & Sciences (Unified), we have highly-skilled specialists who follow industry standards for methodical collection and preservation of evidence. We photograph it, label it, transport it and store it, and then catalog it and preserve it in one of our secure evidence facilities. We follow guidelines for the safe and systematic investigation and analysis of incidents including evidence handling and storage; the collection and preservation of information and physical items by any technical investigator pertaining to an incident that can be reasonably expected to be the subject of litigation; and for labeling physical evidence collected during field investigations, received in a forensic laboratory, or isolated, generated or prepared from items submitted for examination.

Not everybody in the claims process is up to speed on these standards – but Unified's forensic experts are. It is important to have experts who are trained, experienced, and know how to follow the guidelines to the letter – they must cross every "t" and dot every "i" to meet the requirements. For example, the standards for labeling items properly in the laboratory indicate that the following details must be included – unique file number, date and time collected, name of the person who collected it, a description of what the item is and where it came from. If the labeling is missing any of these details, then it's incomplete. For someone who is not experienced in the collection and preservation of evidence, odds are they are not going to complete the labeling process with those standards, and they are not going to cross every "t" and dot every "i" in the investigation process.

Common mistakes include failure to identify and preserve the evidence, and altering the evidence before all interested parties are able to examine it. These mistakes can cause problems if the case goes into litigation and the evidence is needed.

When a claim occurs, companies and insured parties need forensic investigators who follow the scientific method, and faithfully use a dedicated, disciplined process to ensure they can accurately determine the cause of the loss.

POWER STRIP: CULPRIT OF OFFICE FIRE

An insurance company insured a commercial office, the office building caught on fire, and the fire department came in and put the fire out. The insurance company hired Unified as their forensic investigation company to come to the scene, secure the evidence and figure out what caused the fire. Unified identified the area of origin was a desk in a corner office with a laptop that was plugged into a new power strip with an electrical outlet in the wall. We took the laptop, power strip and wall outlets into evidence. The Unified team did some non-destructive testing with X-rays and our electrical engineers examined all the evidence. We determined that the power strip had a fault in it so the party that manufactured the device was put on notice. The manufacturer's experts took a look at it and determined that our test results were correct. Instead of the insurance company writing a $3,000,000 check to replace the office building that burnt down, the company that manufactured the power strip accepted responsibility for the damages. None of that would have been possible if the evidence was not correctly preserved.

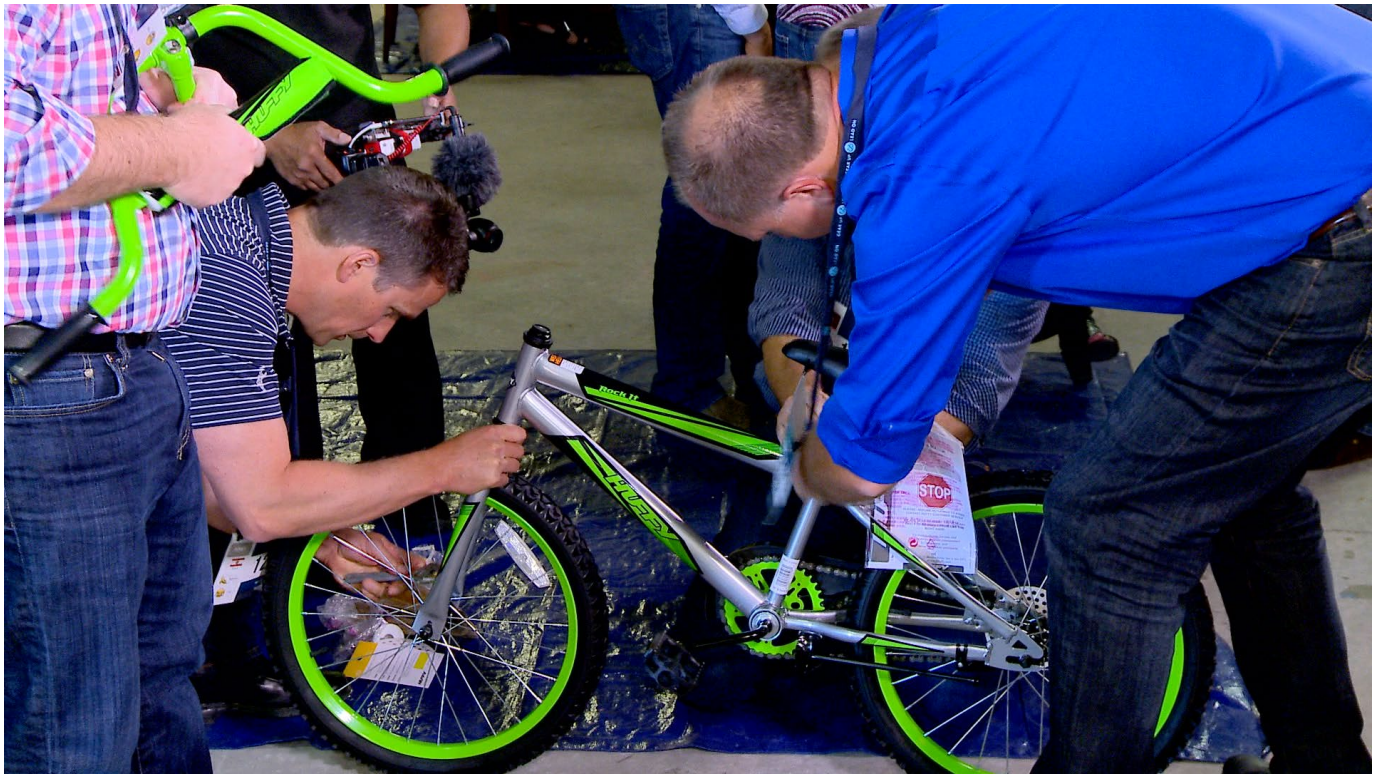
Community spotlight
Putting shoulders to the wheel for community service

BY **KIM KRAUSS**
SVP, Marketing and Communications, Sedgwick

In September, some 250 Sedgwick colleagues teamed up to build bicycles for underserved children in Southern Nevada. Attending the company's 2016 leadership conference near Las Vegas, these colleagues split into 25 teams for a friendly competition that brought them together to do good for the local community. Ultimately, the teams built 25 bikes for girls and 25 for boys, which were presented to the Boys & Girls Club of Southern Nevada.

"The idea came to us when we were planning the conference," Steve Powell, president, Unified Investigations & Sciences, Inc., a Sedgwick company, said. "Sedgwick colleagues were afforded a grand opportunity to put their leadership training to work. We wanted to host a hands-on activity that would tie together all the concepts on the conference agenda into one event that fit our theme, which was 'Gear Up. Lead On.' The bike build was perfect because it allowed colleagues to collaborate, use critical thinking and inclusive behaviors, express positivity, and work together in diverse teams with members from various entities, business lines and skill sets, all with cultural alignment in a **caring counts** approach."

Each time Sedgwick schedules a large meeting, the company includes a community service component. With the help of Team Dynamix, Sedgwick planned the competition as a team-building exercise that would celebrate what is unique about each colleague and drive home the concept that our collection of individual talents and experience is what makes Sedgwick unique as an organization. Colleagues responded to the challenge of the bike build with problem-solving, collaboration and communication within teams and between teams to accomplish the goals of the exercise. They worked together to solve riddles, puzzles and clues, which, when answered correctly, gave them the resources and pieces they needed to build the bikes.



At the end of the project, Mark Jacoby, area director of large clubhouse operations for the Boys & Girls Club of Southern Nevada, personally accepted the 50 bicycles. He spoke about his organization's mission – to enable all young people, especially those in greatest need, to reach their full potential as productive, caring, responsible citizens – and expressed his gratitude for Sedgwick's caring and commitment to helping the boys and girls in their community.

Sedgwick also provided helmets and locks so the recipients could have a safe, fun time riding their new bikes. Colleagues enjoyed naming their teams, earning points for various tasks and meeting quality standards, and they expressed a sense of satisfaction for a job well done.

"This event was intended to grab the heartstrings of our colleagues, motivate them and have that transformative moment," Powell added. "Team members felt good about what they had accomplished. The positive energy focused on who they were working with and who they were doing it for. We really saw the magic in our colleagues."

See our 'Gear Up. Lead On.' video showcasing the event.

Expert view

Q&A with Kathy Tazic, Managing Director, Client Services, National Accounts, Sedgwick

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

edge:
Describe the importance of developing people in the area of client services.

Kathy:
To keep pace in the risk and benefit industry, it is essential for companies to develop leaders who have the capabilities to manage all of the key issues facing employers. We also recognize the complexities of the role and the value of experiential learning as a basis for colleagues to bring excellence to our customers. We are introducing a new program that will start in mid-January called the client services leadership development program. It's designed to create a highly-skilled, diverse and experienced workforce, able to lead into the future for our customers.

edge:
Why is Sedgwick making this investment?

Kathy:
Growing and developing leaders is a critical area for our company. With our ongoing organic growth and the need to provide our customers with the very best leaders, we wanted to create an opportunity where development – meaning giving people both improved skills and experience – is a full-time job. Our business is very dynamic and providing talented colleagues with the opportunity to experience every area of the company is a sound use of resources and will grow a future group of leaders ready for our customers' every need.

edge:
How will the program benefit current and future customers and our colleagues?

Kathy:
We are developing leaders who will be capable of managing relationships with customers that have multiple programs with Sedgwick. This provides the ability to have a single client services colleague who can advise them, and make sure each program is growing and changing to meet the needs of their business. Customers will benefit from an educated, developed team that is well-connected both internally and externally to our industry.

For our colleagues, the program provides them with experience and skills to lead large, multi-faceted programs. It takes each colleague out of their current position and allows them to serve in a different role for a full year. When you bring colleagues from other areas into something new, they can offer a fresh perspective on the way we provide service to our customers and ask some really good questions about the way things are done. This program will also create additional capacity for us to serve new clients and grow with them as they expand their programs with Sedgwick. In addition, it offers colleagues something that we have not done in the past – a formal opportunity to move within areas of the company, supported by education and real-life experiences.

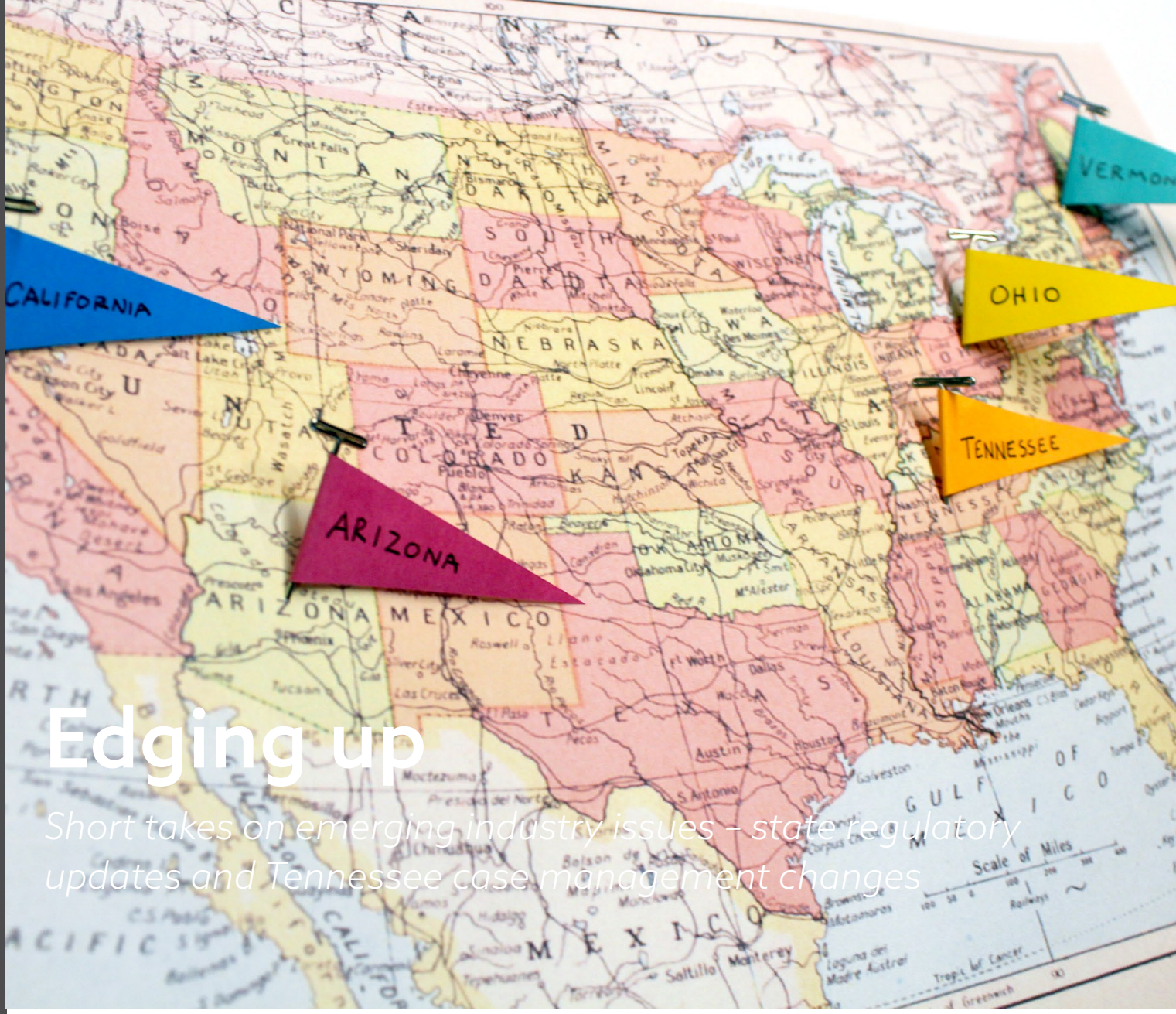
edge:
Is this type of program unique in our industry?

Kathy:
Yes. This is the first time we have done something quite like this. It's a unique program in our industry and focuses on a combination of education and experiential learning with senior leaders. We are also looking to grow a different type of leader than we typically have seen in the industry; one who can flex with our organization and our clients' needs.

edge:
How does Sedgwick's client services leadership development program work?

Kathy:
For the first time in Sedgwick's history, we did a self-nomination process to make sure we were educating colleagues on the program and its requirements. Only colleagues who had previous client-facing experience were considered for the program. The eight colleagues who were selected will go through a one-week immersion process and then they will be assigned to sponsor colleagues who are currently leading some of our top 100 programs. The sponsors will work with the colleagues and they will rotate through four different assignments over that one-year period. It will give them an opportunity to experience different customer environments and lead projects like stewardship, analyzing outcomes and setting goals across programs. Colleagues will also learn specific skills based on their background and needs. This includes public speaking and presentation skills, as well as a strong emphasis on emotional intelligence and how it helps people lead effectively. While completing the client rotations, the colleagues will work as a team on skill development and share what they learn during monthly sessions, and they will have quarterly in-person meetings on larger objectives and training.

Kathy Tazic
Ms. Tazic is a managing director for client services for national accounts at Sedgwick. In her current role, Kathy is responsible for ensuring that our national programs provide excellent outcomes through innovative program designs. This includes both technical execution as well as ensuring ongoing improvement. Kathy joined Sedgwick in 1991 and has held various positions, including client consulting director, national practice oversight, program architect and operations manager. In her latest role, Kathy is overseeing the refinement of client services best practices and an experiential training program for the next generation of client services leaders. Kathy holds a bachelor's degree in communication and technical writing from the University of Illinois-Urbana.



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:

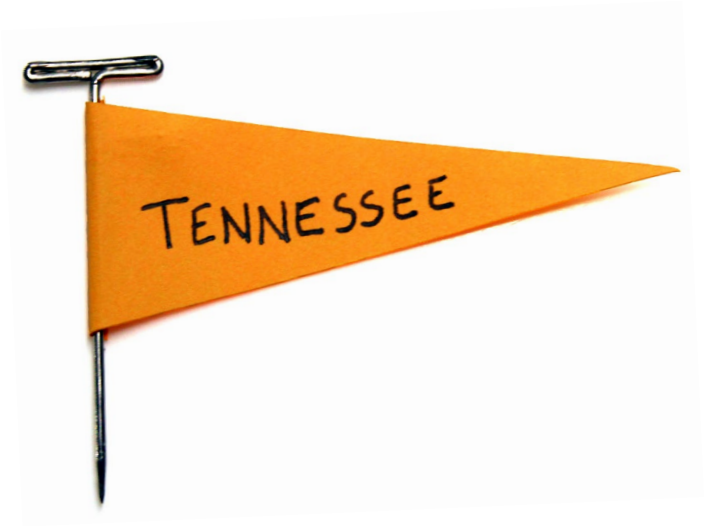
- Encourage prescribers to incorporate best clinical practices when prescribing opioids for treating Ohio's injured employees
- Establish provisions and criteria for treating opioid dependence that arises secondary to treatment with opioid medications
- Provide and strengthen the peer review processes 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.

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