EXECUTIVES IN WORKERS' COMPENSATION MAGAZINE ISSUE NO. 4 WINTER 2020

EWC MAGAZINE

EDUCATION, STRATEGIES AND RESOURCES

RISING ABOVE

HOW TO BE A BEST PLACE TO WORK

By Sabrina Darsey

A SAFETY STATE OF MIND
MOVING BEYOND AWARENESS
BY GARY L. JARVIS

COMMUNICATING DECISIONS EFFECTIVELY
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From the Editor...

Cheers to five years!

As we collectively celebrated the arrival of the New Year and, more profoundly, of a new decade, we at EWC had added cause for celebration. This year marks the fifth anniversary of The Executives in Workers' Comp Conference. Reaching this milestone has prompted me to reflect on the reasons I started The Executives in Workers' Comp five years ago, and to contemplate what's ahead.

EWC was born out of a twofold vision. I wanted to host a symposium that would provide education for upper and middle management; I also envisioned a platform to expose executives to business partners that could help them with their pain points. Whether industry professionals were looking for cost containment solutions or a quicker turn-around time in their processes, I aspired to design a forum that would facilitate open discussions about their challenges and lead to solutions to their problems.

Along with having an open dialog with service providers, I wanted to offer outstanding education with tips and takeaways so that attendees could apply the information to their jobs immediately. I have been told many times by worker's comp and risk management professionals that they love the fact that in every session, they know they are going to learn useful tips and tools that they can apply to their jobs. It was the inspiration for this magazine also, and I hope that as you read through, you'll find tips and takeaways to help with your job.

EWC's mission has always had service at its core. Going forward, we aim to be your go-to resource, from our annual conferences to our magazine with its informative articles and helpful Legal Experts section and Resource & Panel Guide. This issue in particular is bursting with information useful for your work life.

This anniversary celebration also offers the perfect opportunity for me to express my appreciation to those who have helped make this an unforgettable five years. Specifically, to our amazing sponsors and exhibitors: A profound thank you for your business and continued support throughout the years. I've been enriched personally and professionally by people who serve our industry in various ways; many of you have also become trusted friends and advisors. You have been critical to EWC's growth and success, and I look forward to working with you in the coming years.

And to our board members: The Small Business Administration states that 30 percent of new businesses fail during the first two years of being open, and 50 percent fail during the first five years. For an organization to beat the odds and remain in business for five years requires the support of an extraordinary team, and I am beyond grateful to have you aboard. I am deeply appreciative of the opportunity to partner with such talented, passionate and loyal colleagues who are committed to impacting our industry. Thank you for your unwavering dedication and the outstanding relationship we share. You are the best! Here's to celebrating the next successful chapter together.

While the arrival of this new year and new decade have been a time of reflection, it is also a season of looking ahead. There are unique challenges, fresh opportunities and the need for new skills. EWC was built with those needs in mind and we look forward to meeting those challenges. With our contacts in the industry, we're in position to tap the expertise of your colleagues and draw on insights from our network of business leaders.

And while new challenges and issues will inevitably arise in the coming months, one thing at EWC won't change – our commitment to providing resources and education to equip you for the year ahead. I look forward to meeting the challenges of 2020 with you!

Debra Hinz
Editor in Chief

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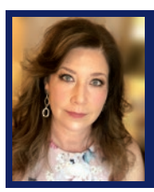

MANAGING EDITOR
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ART DIRECTOR
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A Safety State of Mind

Moving Beyond Awareness

By Gary L. Jarvis, Facilitator and Thought Leader at Qualifying America's Workers

Safety is an awareness, but it is also a state of mind. Safety compliance is mandated – however questionably effective. So how do you develop a safety state of mind?

Traditional risk management, safety training, and hiring processes may be working to an extent and are essential to the safety discipline and reducing losses. But we still have losses! If you continue to experience claims, but your goal is to have zero claims or a substantial and sustainable reduction in claims, your safety program or safety training may be incomplete. But more likely, your hiring processes are deficient.

Safety and hiring processes start in the same place as everything else in the workplace: with the human resources department. Human resources departments are charged with the hiring process. This process includes recruiting, interviewing, hiring, onboarding, and ensuring safe placement by physical abilities-qualifying criteria to reduce the potential of injury. Those are more than mere words – they are safety-oriented words. They have meaning; they reflect the company culture, the company's hiring reputation, whether the company is safe, the company's corporate community responsibility and integrity, and, most importantly, the employees' safety. Human resources departments, along with safety and risk management and operations, forge the direction by incorporating those words. This ensures every employee is qualified to meet the physical demands required to successfully perform the essential functions of the job, allowing safe placement. Otherwise, how do you know the person you are hiring can perform the physical tasks required of the job? Determining this requires a different hiring process: it is a safety process and is perceived as a safety process by applicants.

New hires and incumbent employees have a reasonable expectation of unconditionally safe work practices, safe work conditions, and safe placement in a job they qualified for. By demonstrating that their physical abilities meet the physical demands of the job, employees have a reduced potential for injury. When non-qualified workers are placed randomly in jobs they cannot handle, you are handing them a "gift:" permission to incur an injury in a position with a known history of being hazardous.

Isn't it time to look at other avenues? I believe prudent human resources departments and safety and risk managers will answer yes. Those with foresight will continually consider quality and operational improvements in protecting our most valuable and costly asset, our human capital. It makes sense to

identify upfront the new hire's capacity to perform the physical demands of the job. The bottom line is this: the companies that embrace these concepts have reduced or eliminated incidents in known high-risk jobs and, for the most part, do not have a shortage of workers or recruitment challenges. They maintain a pool of qualified workers to reach out to when needs arise, offering what every employee seeks: an opportunity for a safe hire or qualified advancement.

A useful tool for transforming employees from being safety aware to operating in a safety-driven state of mind is a health care awareness known as Well-Being Awareness. This is an adjutant awareness of potential health issues that are known, not known, or known but not treated. Well-Being Awareness also allows employers to control the impact of health issues on workers' compensation incidence, related costs, and health care benefits-utilization costs. We define policies, procedures, programs, and practices that integrate protection from work-related safety and health hazards in concert with the injury and illness prevention program and the workers' Well-Being Awareness.

The difference between wellness programs and Well-Being Awareness is that one does something *to* you and is associated with exorbitant costs and questionable results. The other does something *for* you by identifying potential or existing health issues, making the employee aware of their options, instilling awareness, and providing the means to intervene on the employee's behalf. During the new hire ability-qualifying process, specific metrics are obtained. This data is shared only with the new hire and is the basis for providing awareness of potential medical conditions. Metabolic (obesity, thyroid) and cardiac (high blood pressure) issues, the most common and most costly conditions, are precursors for stroke and heart attack but would not preclude employers from hiring. Without qualifying criteria, you likely would hire the applicant, but would not know about the potential safety and health issues that could be present, leaving the conditions untreated and the employee's health awaiting a system failure. It is interesting to discover that many individuals have preexisting medical conditions and did not know, or the condition is known to the individual, but it has been untreated. On the positive side, the awareness is turned into the new hire's action plan of continued awareness, education and seeking medical care – usually a lifesaver, particularly when accompanied by early intervention.

The steward of safety management is the employer-employee partnership. This collaboration happens when the employer embraces responsibility for the employee's knowledge of safety practices and proper immediate injury care. The process strengthens the employer-employee relationship, allowing open communication concerning partnering on safety practices and conditions, and injury reduction. Well-Being Awareness promotes a healthier workforce and reduces health benefit-utilization costs.

Additionally, the employee feels the employer cares about them and their safety by investing in safe work placement, and by taking an interest in their total health and well-being. This awareness spills over to the worker's family through early interventions not commonly practiced – a win for all! The process of safe work placement is like going to the gym where a trainer sets you up initially with safe lifts and progresses you over time. The same happens in the workplace. The qualifying lift criteria are the baseline, allowing an employee the opportunity to increasingly qualify for additional job positions that require progressively demanding performance. The data supports the fact that employees can qualify for more physically demanding positions after eight weeks of work performance. The positive effects of employee-employer partnering are evident in an employee's work, safety-mindedness, increased performance, and proper job matching.

Safety management, a job description requirement, is a joint effort for all to identify, report, and become involved in reducing work-related incidents and costs, improve retention, and transfer the legal liability to a third party when possible. The most efficient and practical time to implement safety measures is at the point of hire. The most effective method of reducing injuries is to hire persons who can qualify for high-risk jobs by demonstrating they have the physical ability to meet the physical demands required to perform the essential functions of the job. There are several jobs, particularly those requiring repetitive manual product or patient handling, that have substantial physical requirements to complete the job tasks. Ideally, the employer will reduce these demands through ergonomic job re-designs, where possible. Unfortunately, not all demands can be eliminated. New hire candidates with insufficient physical ability to meet the demands are at increased risk of injury when they are placed on these jobs. They are less likely to be satisfied with the level of physical requirements they must meet to perform the tasks, resulting in a disgruntled, fatigued, and frustrated worker. As a basic business necessity, human resources, safety management, and risk management must meet the employer's need for all new hires to be able to safely perform their job, ensuring the retention of long-term employees.

The components of a multidisciplinary (safety and risk management, operations, and human resources department) and ergonomically designed, qualifying criteria are job analysis, strength demands, and endurance demands. The first step in the job analysis process is to identify those essential functions within the job that appear to be physically demanding. Physical demands arise from the performance of specific tasks (e.g., lifting a heavy box), and from the overall physiological impact of all the tasks performed over an entire shift. It is important to note the emphasis on entire shift. Fatigue is among the leading causations of injury.

Information regarding strength demands is obtained through interviews with workers and their supervisors, and by taking measurements of the loads required by the job. This information also includes the frequency of handling, how an item is handled, and the region of the body in which it is handled (e.g., floor level, knee level, mid-chest, shoulder, and above). Whole-body dynamic strength testing is used in the qualifying criteria. This type of strength testing is more functional and allows the person to perform the qualifying criteria in the same manner as when lifting on the job.

A whole-body strength criteria of ability to lift would allow females and older males to compensate for upper-body weakness by using the legs, so whole-body testing would be

a direct measure of the ability to meet job requirements and safely perform the job. Whole-body testing would also have a less adverse impact on females and older males, at least relative to isolated strength testing.

The endurance demands parameters are obtained through energy expenditure measurements. Working muscles require oxygen to perform the dynamic contractions involved during extended repetitive manual materials, product, and patient handling. The energy expenditure requirement is typically measured by determining the amount of oxygen consumed in the course of performing the work. In the jobs of interest in these studies, it was important to study the energy expenditure over the course of the shift.

Total Worker Health is a system developed by the National Institute for Occupational Safety and Health to control the impact of workers' compensation incidence, related costs, and health care benefits-utilization costs through awareness. Total Worker Health is defined as policies, procedures, programs, and practices that integrate protection from work-related safety and health hazards in concert with an injury and illness prevention program and the workers' Well-Being Awareness.

Recruiting for community workforce shortages is challenging. How does qualifying workers help? First, it enhances the company's community reputation of promoting safety and fostering a safety culture that is dictated by and distributed among the workforce. The concept is equivalent to consumer satisfaction: if the product has a poor performance history, the word gets around. The same is true for the company. Further, when employees experience the company caring for their safety and well-being, and the company introduces measures to reduce the potential exposure of the employee to injury by proper qualifying criteria and safe job placement, this effort becomes noticeable and communicable among workers, peers and community job seekers. Coveted statements by employees such as "A good place to work!"and "The company cares about me" indicate a successful transition from safety awareness to a safety state of mind.

TIPS AND TAKEAWAYS

WHAT TO CONSIDER | RED FLAGS | STEPS TO TAKE | DON'T FORGET

- **Instill safety as a state of mind, as opposed to a passive awareness.**
- **Safety is inclusive, multipurpose, multidisciplinary, multicultural, and a business necessity.**
- **Safety begins with a new hire process that incorporates cognitive ergonomics: how does the worker process safety and functionality, and what are their physical abilities for safe placement paired with the physical demands of the job?**
- **Implement a Well-Being Awareness program for total employee health and safety, substantial and sustainable reductions in claims and total expense, and improved worker retention.**

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301 N. Rampart St.
Suite F
Orange, CA 92868
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CONTACT US:

LFLM Anaheim
Office Managing Partner:
Manuel Garcia
(714) 385-9400
mgarcia@lflm.com

LFLM Sacramento
Office Managing Partner:
Bruce D. Jennett
(916) 441-6045
bjennett@lflm.com

LFLM Concord
Office Managing Partner:
Jeffrey E. Lowe
(925) 499-4999
jlowe@lflm.com

LFLM San Bernardino
Office Managing Partner:
Robert A. Guttman
(909) 890-2265
rguttman@lflm.com

LFLM Fresno
Office Managing Partner:
Larry Solaegui
(559) 431-4900
lsolaegui@lflm.com

LFLM San Diego
Office Managing Partner:
Marijo Kuperman
(619) 233-9898
mkuperman@lflm.com

LFLM Los Angeles
Office Managing Partner:
Demetra G. Johal
(818) 638-8200
djohal@lflm.com

LFLM San Francisco
Office Managing Partner:
Kevin R. Calegari
(415) 781-6676
kcalegari@lflm.com

LFLM Oakland
Office Managing Partner:
Susan N. Hastings
(510) 628-0496
shastings@lflm.com

LFLM San Jose
Office Managing Partner:
Seeta Ambati
(408) 286-8801
sambati@lflm.com

LFLM Redding
Office Managing Partner:
Sidney L. Lamb
(530) 222-0268
slamb@lflm.com

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(714) 543-9090
tkinsey@srtklaw.com

San Jose
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San Diego County
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Fresno/Bakersfield
(559) 436-8136
dchun@srtklaw.com

Inland Empire
(951) 778-2514
jthomas@srtklaw.com

Chico/Redding
(530) 895-8927
jrempel@srtklaw.com

Greater San Francisco
(415) 892-7676
sreubens@srtklaw.com

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(818) 436-0170
ahemmings@srtklaw.com

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ahemmings@srtklaw.com

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Michael W. Sullivan
General Managing Partner

Bartholomew R. Sullivan II
Senior Partner
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CONTACT US:

Bakersfield
Phone: (661) 397-1212
Mg. Partner:
Elizabeth Barravecchia

Fresno
Phone: (559) 435-9823
Mg. Partner:
Ruben Pineda

Los Angeles
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Mg. Partner:
Dave Thomas

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Mg. Partner:
Elizabeth Trimm

San Diego
Phone: (619) 814-1700
Mg. Partner:
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Mg. Partner:
Richard Foley

Santa Rosa
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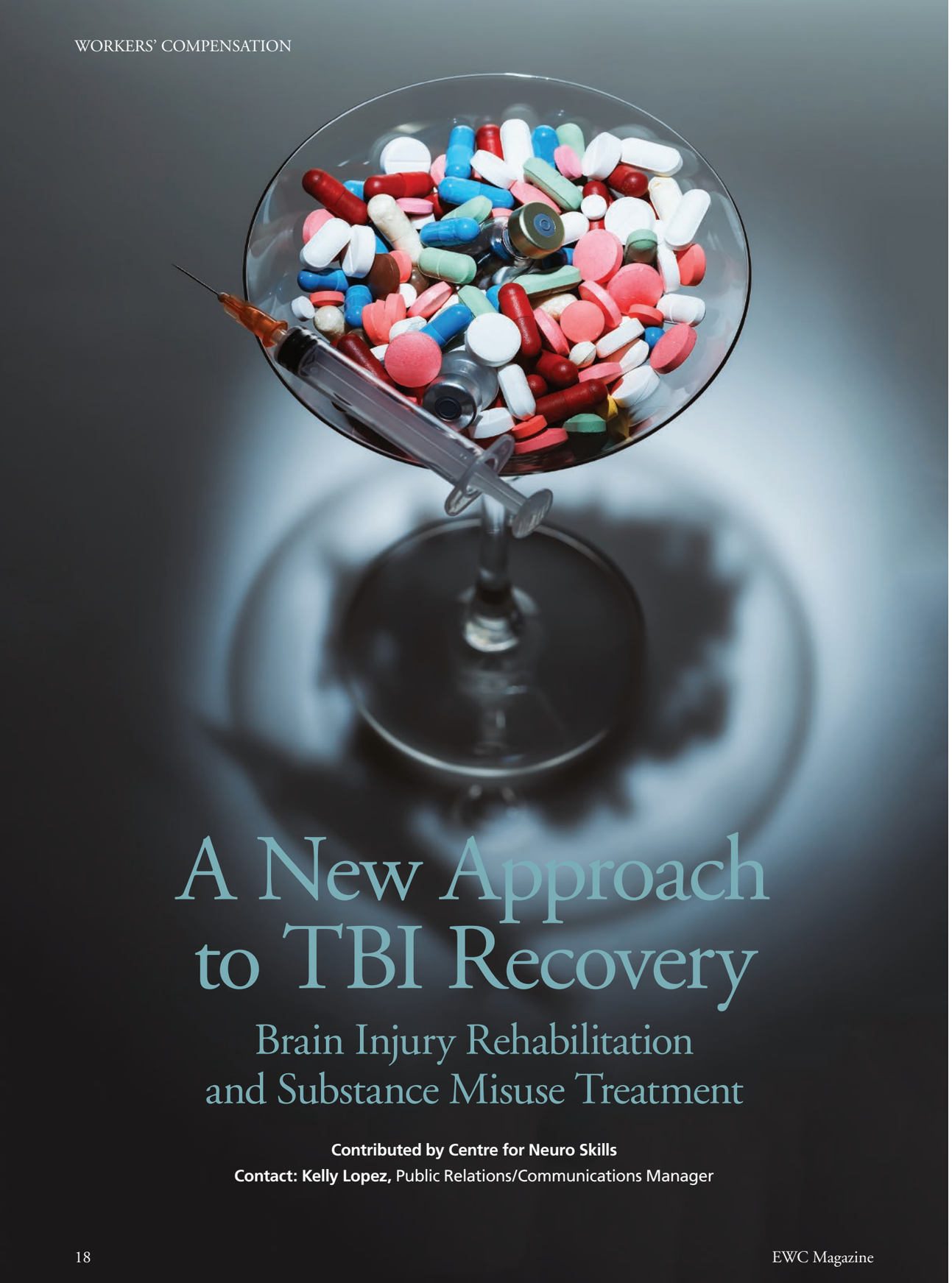


A New Approach to TBI Recovery

Brain Injury Rehabilitation and Substance Misuse Treatment

Contributed by Centre for Neuro Skills
Contact: Kelly Lopez, Public Relations/Communications Manager

Increasingly, when workers experience a traumatic brain injury (TBI) on the job, an underlying malady that exacerbated the accident may be revealed – substance misuse. Too often, drugs and alcohol are involved in that fall from a ladder or jackknife of a tractor-trailer. Insurers and employers face complex challenges in settling such claims, especially with the rise of opioid and benzodiazepine misuse among employees.

Traditionally, treating brain injury and addiction simultaneously involved two rehabilitation efforts, one for TBI and another for substance misuse. TBI care is often the priority, but what about the employee's chemical dependency? If untreated, employers risk repeated accidents caused by impairment. However, a model of rehabilitation is emerging that treats both TBI and addiction, helping patients achieve and maintain sobriety as they recover from work accidents.

The need for dual diagnosis care is evident. Workers under the influence can create legal, physical, and financial harm. Causing injury or death to others is serious enough, but these individuals also face criminal charges, civil suits, unemployment, and damaged personal relationships. Serious consequences also affect worker's compensation insurers and the companies they serve, as two complicated health issues are involved in the claim. Thus, for the worker's compensation adjuster, treating TBI and addiction under one roof is cost effective.

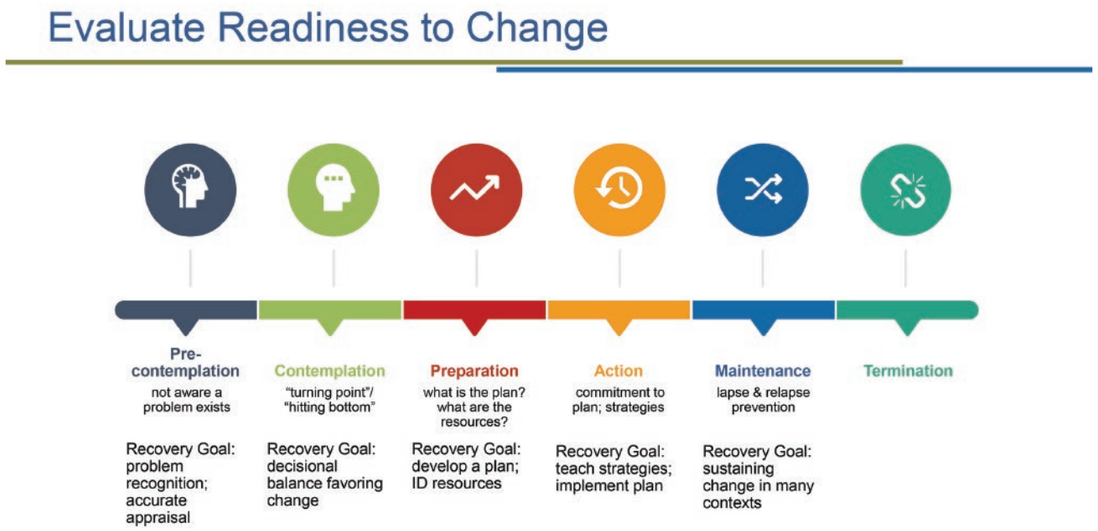
Data on TBI and substance misuse illustrate the magnitude of injury and addiction (Corrigan, 1995; Bombardier, et al., 2003):

- Over 50 percent of persons who sustain a second TBI are under the influence at the time of injury.
- An estimated two-thirds of persons who sustain a TBI are intoxicated (BAC > 0.08) at the time of injury.
- People who misused alcohol or other drugs before a TBI are 10 times more likely to resume substance misuse after the injury (the first six months after injury may be a critical window for intervention).

The traditional approach has been to isolate the two conditions and treat them separately in a linear fashion rather than in a comprehensive holistic way. In the dual treatment model, patients still participate in deficit reduction therapies that address TBI issues. But they're also given counseling, education, and post-treatment tools to support sobriety. A multidisciplinary team thus addresses both conditions simultaneously, focusing on cognitive, physical, and behavioral improvement while introducing new methods of living drug free.

As powerful as this is, people in recovery can still revert to bad habits and drift into old haunts. The good news for insurers and employers is the treatment model's emphasis on relapse prevention. Lifestyle change is a core component, including an introduction to community-based support programs; nutrition, sleep, and physical health education; and establishing healthy daily routines. This departure from the cookie-cutter approach is becoming a path of rebuilding and healing the whole person.

Within the all-encompassing rehabilitation approach, the Transtheoretical, or Stage Change Model (Prochaska & DeClemente, 2005) is an established clinical approach being utilized by rehabilitation professionals who treat substance misuse in TBI patients. For many, the traditional or 12-step approach may not work, as the patient may not realize he or she has "hit bottom" despite a catastrophic work accident. Thus, the model provides a structured methodology that evaluates the readiness to change and helps patients work through that process. Without a foundation that sets up success, many people won't succeed.

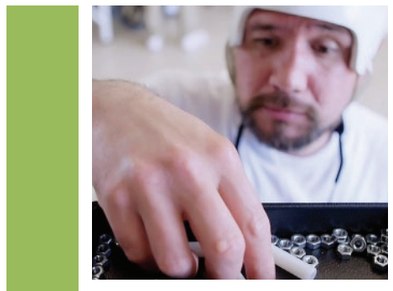


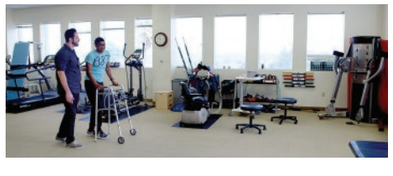
In tandem with intensive TBI therapy focused on independence, the model maximizes patient progress and achieves dual recovery. Adjusters and insurers also benefit, as they interface with the same treatment team and facility, from admission to discharge.

TIPS AND TAKEAWAYS

WHAT TO CONSIDER | RED FLAGS | STEPS TO TAKE | DON'T FORGET

- **When a patient's injury involves drugs or alcohol, consider a provider that can treat TBI and addiction in one facility. Simultaneous treatment of both issues maximizes the time and money spent on rehabilitation.**
- **Ensure that the facility offers community-based treatment, which focuses on reintegration with family and society while connecting patients with resources to maintain sobriety.**
- **The Transtheoretical or Stage Change Model provides a structured approach to substance misuse rehabilitation by assessing the readiness to change while helping patients work through that process.**
- **If untreated, employers risk repeated accidents caused by impaired workers.**





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Settling Claims by Focusing on the Future for Injured Individuals

By Porter Leslie, President of Ametros

"A good claim is a closed claim," is a phrase often overheard in risk manager and claims adjuster circles. Employers, insurance carriers and other workers' compensation payers tend to focus on settling claims, and phrases like this reinforce a one-dimensional view to settlement – as a way for the payer to eliminate financial exposure.

While this is true, to reach a settlement in workers' compensation, both parties are required to agree to a compromise. So, on the other hand, what's in it for the injured person? There need to be perceived or real benefits that outweigh the risk. A greater understanding by all sides of the potential benefits and pitfalls is crucial to informing injured workers and their attorneys how to evaluate that trade-off.

As a professional administrator, I have found that when all parties involved in settlement discussions give thought to what the injured worker's life will be like after settlement, it allows them to address concerns that the individual has that are creating obstacles to settlement. These concerns can often be overcome with proper planning and the help of a professional administrator to set up the injured worker for long-term success. With that in mind, perhaps another phrase to adopt would be "A closed claim leads to a happier and healthier injured worker."

Below are a few common concerns and how an administrator can convert them into potential benefits.

Although the injured worker may not like the workers' compensation system, they have grown used to the assistance and are scared to have no support resources after settlement. A nurse case manager or adjuster has helped them find providers, secured appointments, answered questions, and educated them on their treatment. Also, most injured individuals haven't had to pay (or even touch) any medical bills for their claim. Injured workers lose these resources after settlement and become responsible for managing their care and paying for treatment from their settlement funds.

In my experience, I have found that nearly 32 percent of injured workers have had a significant change in treatment in the first five years since their settlement, such as a change in drug regimen or different type of therapy being introduced.

32%
of injured workers have had a significant change in treatment in the first 5 years since their settlement

Navigating health care alone can be a real concern for an injured worker. A professional administrator is equipped with a care team that can provide hands-on coordination and guidance to the injured worker. Just because the case has settled does not mean their journey to getting well is over. Having resources on hand after settlement can be an enormous benefit for the injured individual and can help them feel comfortable that they can make good choices for their health care after settlement.

Injured workers that are on or expected to be on Medicare will likely have to deal with the reporting requirements of a Medicare Set-Aside (MSA) once they settle the case.

This means that for the rest of their life they need to make sure they are spending funds on Medicare-approved items related to their injury, using appropriate fee schedules, and reporting their expenses per Medicare rules and regulations. This prospect can be overwhelming. If they misuse or misreport their MSA funds and spend down the account, Medicare will refuse to cover future injury-related medical expenses.

It has been my experience that when MSA accounts entirely run out of money, 100 percent of the time, the professional administrator will receive a call from the Benefits Coordination and Recovery Center at Medicare to go over all the reporting to make sure everything lines up before Medicare begins paying for bills.

100%
When MSA accounts run out of money, CMS inquires about these exhaustions just about 100% of the time

Medicare is unquestionably paying attention and is issuing denials when they cannot track what happened. This inquiry could be a daunting call for an injured worker. A professional administrator can give them comfort that they will be prepared and ensures that all this reporting is taken care of for them.

The thought of spending the settlement money too quickly and running out is a common fear that most injured workers have. Medical inflation on certain items can be a scary unknown risk and can eat into the settlement funds. Also, new and more effective treatments may be more costly as well.

Using a professional administrator that can provide medical bill, equipment and pharmacy discounts can help ease an injured worker's mind by ensuring their funds will last as long as possible. Administrators may offer discount networks that provide savings and keep more money in the accounts for future treatment. Using a skilled administrator can significantly reduce the chance that members run out of funds in a given year.

Jim's Story

Each of the concerns above were becoming a reality for Jim, a former laborer and supervisor for a construction company in Indiana who had suffered a serious back injury. He was skeptical of settlement but decided to go for it. After settlement, some of his worst nightmares were coming true; he and his wife were watching his bills closely and were struggling with the cost of his medications, the coordination of his care, and navigating Medicare's guidelines. Fearful of running out of money too soon, Jim even cut back on some treatments so that his money would last. The family turned to their attorney for advice and were directed to a professional administrator. The medical networks and pharmacy discounts available through the administrator produced significant savings on Jim's treatments. Now, Jim can afford to take all the medications he needs. He's back on track with his treatment plan and is feeling better; knowing that his administrative care team is there for him, he is more confident in having settled his case and his prospects for recovery.

How it Works

Professional administrators set up a custodial bank account for individuals who have settled their case, and thereafter they become "members." Members receive a card that they present to their medical providers and pharmacies that enables the electronic direction of bills to the professional administrator. The administrator's health care payment technology automatically verifies the bill's accuracy, applies negotiated discounts to reduce the bill, and electronically pays the appropriate amount to the provider.

While every case is different, members can potentially enjoy savings that range from 5 percent to over 50 percent on their expenses, and the saved money stays in their account. Administrators have tools that can record all transactions and submit required reporting to Medicare for members with MSAs. The administrator may offer members access to an online portal and mobile app to monitor their accounts and view expenses, savings, and transactions, so they always have transparency into their accounts without the hassle of handling the bills themselves. Plus, they don't have to manage their care alone; many administrators have expert member service teams that are available to answer questions, help find providers, and sometimes just to listen.

Professional administration is bringing patient advocacy to injured workers post-settlement, managing their medical issues so members can focus on regaining their health and enjoying their lives. All these benefits stack up and can, in turn, make injured workers more apt to settle their claim, thereby creating more "good claims" in the eyes of risk managers but also promoting more happy and healthy injured workers as well.

TIPS AND TAKEAWAYS

WHAT TO CONSIDER | RED FLAGS | STEPS TO TAKE | DON'T FORGET

- **Find concerns:** Rather than laying out reasons to settle, ask "why would you not settle?" and unearth concerns. This method will help inform you of what areas need focus.
- **Have patience:** Settlement is an educational process. It's hard to reach a compromise on such a complicated agreement in one sitting or one phone call. Have patience, and don't be discouraged if the stars don't align on the first try. Many claims can be open for years before a settlement occurs.
- **Seek help:** Don't believe you need to have all the answers. Whether you are an adviser or adjuster, don't be shy to ask third party experts to help assess unknowns like medical costs, legal issues, structured settlement opportunities, and Medicare rules.

The MSA BLIND SPOT

By John V. Cattie, Jr, Managing Partner at Cattie

For years, the workers' compensation (WC) industry has suffered from Medicare Set-Aside (MSA) blind spots. Current WC industry practices do not align with Centers for Medicare and Medicaid Services (CMS) expectations. CMS clearly discusses its expectations in its WCMSA Reference Guide. Until the danger posed by these MSA blind spots is remedied, parties resolving WC claims will continue to possess an exposure for future medicals, which it fails to account for today. Ideally, the MSA blind spots should be remedied by a lawyer well-versed in MSA obligations under the Medicare Secondary Payer (MSP) Act.

Medicare's WCMSA Workload Review Thresholds

In Section 8.1, CMS shares the situations under which it is willing to review a WCMSA proposal. Those are:

- The claimant is a Medicare beneficiary and the total settlement amount is greater than $25,000.00; or
- The claimant has a reasonable expectation of Medicare enrollment within 30 months of the settlement date, and the anticipated total settlement amount for future medical expenses and disability or lost wages over the life or duration of the settlement agreement is expected to be greater than $250,000.00.[1]

These thresholds are well-known and cited often by WC industry stakeholders. Most WC industry stakeholders, however, interpret these to be the only situations where a WCMSA might be warranted. Taking CMS guidance at face value, the WC industry is dead wrong in its safe harbor interpretation. This incorrect interpretation has created huge MSA blind spots for parties resolving WC claims.

Section 8.1 explains in detail that the workload review thresholds provide no safe harbor.

"These thresholds are created based on CMS' workload, and are not intended to indicate that claimants may settle below the threshold with impunity. Claimants must still consider Medicare's interests in all WC cases and ensure that Medicare pays secondary to WC in such cases."[2]

CMS is unequivocal here and always has been. One can go as far back as at least 2005 to witness CMS' position that these workload review thresholds do not equal safe harbors for parties resolving WC claims.[3]

Note that all WCMSA guidance issued by CMS has been incorporated into its WCMSA Reference Guide as of March 2013.

Workload Review Thresholds Do Not Equal Safe Harbors

As early as 2005, CMS has been saying that its WCMSA workload review thresholds do not equal safe harbors. For at least 12 years, parties resolving WC claims have virtually ignored this MSA blind spot. How has the WC industry's interpretation missed the mark here so widely?

Here's one example to help establish the boundaries of the MSA blind spot. Parties are settling a WC case involving a Medicare beneficiary and closing future medicals. They agree to settle for $24,999. In so doing, they believe they do not have to worry about an MSA issue. Have you seen that? Have you been a party to that? Would it surprise you to hear that ignoring the MSA issue because you settled just under threshold does not mean that CMS grants you safe harbor? How many have mistakenly believed it was OK to ignore the MSA issue under those circumstances?

For too long, parties have ignored the MSP Act when it involves future medicals. The MSP Act says Medicare won't pay where payment has been made under a workers' compensation policy or plan.[4] CMS says, "Claimants must still consider Medicare's interests in all WC cases and ensure that Medicare pays secondary to WC in such cases."[5]

Who's to Blame for the Bad Advice?

There's plenty of blame to go around. Perhaps you as a WC stakeholder have been on autopilot, ignoring the MSA blind spot. Consider this your wake-up call. You have an MSA blind spot that endangers yourself and many others. The size of the blind spot corresponds to the number of WC claims you are resolving annually. Your current protocols fail to meet CMS expectations in 2020.

CMS doubled down on this point in January 2019. In version 2.9 of its WCMSA Reference Guide, CMS added case-specific examples to the workload review thresholds. Those new examples do not advise what to do when a case or claim meets the threshold. Instead, they contemplate situations where the case or claim does not meet the threshold. Those examples are:

"***Example 1:*** *A recent retiree aged 67 and eligible for Medicare benefits under Parts A, B, and D files a WC claim against their former employer for the back injury sustained shortly before retirement that requires future medical care. The claim is offered settlement for a total of $17,000.00. However, this retiree will require the use of an anti-inflammatory drug for the balance of their life. The settling parties must consider CMS' future interests even though the case would not be eligible for review. Failure to do so could leave settling parties subject to future recoveries for payments related to the injury up to the total value of the settlement ($17,000.00).*

"***Example 2:*** *A 47 year old steelworker breaks their ankle in such a manner that leaves the individual permanently disabled. As a result, the worker should become eligible for Medicare benefits in the next 30 months based upon eligibility for Social Security Disability benefits. The steelworker is offered a total settlement of $225,000.00, inclusive of future care. Again, there is a likely need for no less than pain management for this future beneficiary. The case would be ineligible for review under the non-CMS-beneficiary standard requiring a case total settlement to be greater than $250,000.00 for review. Not establishing some plan for future care places settling parties at risk for recovery from care related to the WC injury up to the full value of the settlement."*[6]

In both examples, the WCMSA review process is not available to the settling parties. However, CMS expects steps to be taken to ensure that Medicare is not asked to pay future bills that are someone else's responsibility. Parties resolving WC cases under threshold do not take the steps necessary to protect themselves on this issue. To continue to do so will further jeopardize parties resolving WC claims.

Take Immediate Action to Remedy the MSA Blind Spot

The MSA status quo is broken, and it must change to protect all stakeholders. I highly encourage you to reassess your current MSA protocols. Are they up to present-day standards? Question the MSA vendors you trust about this issue. They should be able to explain why they believe MSAs have been and may continue to be a non-issue for claims under the threshold. What's the justification for the explanation? From a risk perspective, if that risk is acceptable to you, maintain status quo.

If their explanation is not acceptable to you, you should consider a legal review of your current MSA protocols from a lawyer well-versed in MSA legal obligations. Empower your claims examiners to hire a lawyer to review MSA obligations and provide legal advice about your MSA exposure. Add a law firm that provides MSA legal opinions to your panel. Seeking legal advice has become an acceptable means of "considering and protecting" Medicare's interests in 2020.

The MSA issue needs to be examined in every WC case. Anything less than that needlessly exposes stakeholders to potential CMS recovery actions. And we can all agree that no one wants to see that.

[1] Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) Reference Guide. (2019). 3rd ed. [ebook] Available at: https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Workers-Compensation-Medicare-Set-Aside-Arrangements/Downloads/WCMSA-Reference-Guide-Version-3_0.pdf [Accessed 15 Jan. 2020].

[2] Ibid.

[3] Cms.gov. (n.d.). Archive | CMS. [online] Available at: https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Workers-Compensation-Medicare-Set-Aside-Arrangements/Archive [Accessed 15 Jan. 2020].

[4] United States Code, 2006 Edition, Supplement 4, Title 42 - THE PUBLIC HEALTH AND WELFARE.1395y(b)(2)(A)(ii).

[5] https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Workers-Compensation-Medicare-Set-Aside-Arrangements/Downloads/WCMSA-Reference-Guide-Version-3_0.pdf

[6] Ibid, Section 2.9.

Return to Work: Keys for Success

By Beth Burry, VP Clinical Operations, Vocational, Return to Work, & Behavioral Health at Sedgwick, Inc.

In any workplace, regardless of occupation, there is a risk of an employee becoming injured on the job. Given that employees are an organization's most valuable asset and that employees tend to remain more engaged when they are productive, securing a safe return to work as soon as possible benefits both the employer and the employee. In order to provide the best outcomes for both parties, it is vital that employers work collaboratively with claims managers, return to work specialists, and case managers to create a comprehensive return to work solution.

Be Proactive

Although no one wants to think about employees becoming injured on the job, it is crucial that a plan is in place when a workplace injury occurs. Being proactive is a critical component of a return to work initiative, particularly if an employee is out due to a job-related injury. Without a proper return to work plan in place, employees may have unexpected time out of work, a reduction in pay or benefits, and a sense of disconnection from their employer. Similarly, employers may experience a loss in productivity, an increase in claim costs, and longer claim durations when a proactive plan is not followed.

An important part of a proactive return to work plan is having up-to-date functional job descriptions. A job description that is either out of date or does not accurately describe the specific functions of the job can make it challenging to plan an effective return to work strategy. For example, a job description may describe the duties of a warehouse worker, but it may not speciify the number of pounds the employee is lifting and at what frequency; or what type of flexion/extension is needed to perform lifting functions. A basic job description may not address other functions like distance or time spent walking, climbing steps, stairs, or ladders. Without an adequately detailed functional job description of what the employee's essential and non-essential functions are, the return to work plan may not result in an expedited return to work or represent the employee's required job duties.

Furthermore, in developing a proactive return to work plan, employers should also establish a clear return to work timeline as well as outline expectations for temporary duty assignments. When expectations or a targeted timeline is not established, there is an increased risk that the employee may be left in the temporary position much longer than necessary. This can cause frustration on the employer's part as they need someone performing the full duty job, and on the employee's part because it is unclear when the temporary position may end or when they are expected to reassume their full-time duty position. With a clear timeline and outlined expectations, both parties can plan accordingly.

Seek Out Resources

In a comprehensive return to work program, it is important for the employer to identify effective resources to remain current on related policies and procedures. Expert resources help employers to be knowledgeable about physical restriction compliance and how to identify temporary duty opportunities. If employers are not well-versed in temporary modified or light duty opportunities and how to ensure that employees comply with their physical restrictions, employees may be re-injured or have the amount of time they are on restricted duties extended unnecessarily.

Ensuring compliance with state workers' compensation statutes and federal laws is also vital when it comes to return to work programs. Claims examiners or other workers' compensation jurisdictional experts can assist the employer in what documents, forms, or other requirements employers must follow.

One item that may fall to the wayside is having an official document that offers temporary modified or light duty in states where required. Not only is it critical to follow jurisdictional requirements in offering temporary modified and light duty, but having job duties documented helps all parties – employers, employees, and medical providers. An official document allows them to have something to refer to when discussing an employee's ability to perform a job within restrictions. It also serves as a documented agreement outlining what job duties can be tolerated within the employee's restrictions.

Keep Employees Engaged

Communication between the employer and employee is essential even when the employee has sustained a workplace injury resulting in time off. Being out of work, especially for an extended period of time when the employer is not in contact with the employee, can leave the employee feeling disengaged and uninvolved in the return to work process.

Employee engagement and communication as part of a larger return to work program benefit the employer and employee. For employees, work can be a substantial part of how they see themselves, tying into a sense of belonging from a vocational and social perspective. Without that sense of belonging, they can begin to feel isolated and unproductive. Feeling productive is a key motivator, both in recovery and resuming a productive lifestyle.

When employers actively stay in contact with their employees during the recovery process, they are making an effort to retain a valued employee. This engagement ultimately reduces the likelihood of the employee never returning to work and the employer having to train and onboard a brand new employee, thereby incurring additional time and expense. Having an employee who is motivated and engaged in the recovery and return to work process produces better overall outcomes from a medical, cost, and claims perspective. The bottom line is that it is in the best interest of the employer to keep employees productive and working.

Measuring Success

Measuring the success of a return to work program should be done in both a qualitative and quantitative manner. Quantitatively, employers with a strong return to work program should see an overall reduction in total disability and lost time days as well as incurred medical and claims expenses. Additionally, employers may want to examine their out-of-work recidivism rates. For example, they should monitor how many employees have returned to work following an injury, only to go out of work again. If this is happening frequently, then some components of the program need to be changed.

There are also aspects to look at from a qualitative standpoint. For example, was the employer able to expedite a claim resolution that resulted in a successful return to work outcome? Additionally, how was the employee's experience? Was the employee actively engaged in the process? If so, what was the employee's perception? Employers with sound programs will see more employees who successfully return to work and who are satisfied with their recovery and experience.

Key Lessons

The creation of a return to work program is a valuable investment. After all, employees are an organization's most valued asset. It is vital to address the multiple facets of a return to work program when an employee sustains a workplace injury. It is also crucial to remember that this isn't just about a 'work injury' but about a valuable individual who the employer can retain if return to work is approached from a proactive, engaged perspective . With open communication and ongoing use of effective resources, a successful return to work program can reap rewards for everyone.

TIPS AND TAKEAWAYS

WHAT TO CONSIDER | RED FLAGS | STEPS TO TAKE | DON'T FORGET

- **Establish and maintain a proactive return to work plan.**
- **Develop up-to-date functional job descriptions as a part of the plan.**
- **Establish a clear return to work timeline and outline expectations for temporary duty assignments.**
- **Identify effective resources to remain current on related policies and procedures.**
- **Follow jurisdictional requirements in offering temporary modified and light duty.**
- **Communicate and engage employees throughout the recovery and return to work process.**
- **Measure effectiveness of a return to work program in both a qualitative and quantitative manner.**

Communicating Decisions Effectively

By D. Diann Cohen, Vice President Client Relations, MacroPro, Inc.

This scenario has happened to all of us at one time or another: we ask management a question and get back a quick response of yes or no with no explanation. If you are looking for a yes and get it, it rarely raises an issue, but if you get a no response, it can be maddening not knowing why.

Simply providing an answer without an explanation fails to teach our future decision-makers anything. As executives, it is our responsibility to teach our management and employees how to make decisions that are in line with our management ideas and practices. The best way to do that is by example.

The right way to groom future leaders to make decisions that are in line with our business model and philosophy is to provide them with the reasons for our answers. This practice also helps us avoid the unintended consequences that can occur when providing answers with no explanation.

Here is an example. We receive a request to hire another employee for a department and respond to the request with "not approved." Those asking for the help not only feel like they are overworked but also feel undervalued based on the lack of communication – the unintended consequences. Naturally, this is not how we want our employees and management to feel. The best practice in this case is to deliver a response that will help the team understand the decision and in the future, help them communicate when they are issuing a decision. In this case, the following message would help the team understand the decision.

> *At this time, we are unable to approve your request to hire an additional employee. For the last four months, we have been working with our IT department to automate some of the processes in your department, and we will be unveiling those improvements in the next 30 days. We are looking forward to relieving some of the workload from your team soon.*

This response does several things. First, it relays the decision and explains why the decision was made. Second, it provides additional information that the management team can share with the employees in that department. Although the request was denied, there was still good news to share with the staff, which is great for morale.

When it comes to company philosophy and sensibilities, our employees must understand our corporate culture and mission. If your company's mission is to provide the fastest and highest level of services in California at the lowest possible price, then that should be part of your messaging when making decisions. Let's say the marketing department wants permission to go to Chicago to exhibit at a national conference. A response that reinforces the company's vision would be appropriate. The communication back to the requester might look like this:

> *Our company's mission is to serve businesses in the state of California at the best possible price. A national conference does not fit within our business model, as we strive to be the low-cost leader in the industry, and the impact of the expenses associated with this conference is in conflict with our mission. In addition, only a small percentage of the attendees will be from our target market. For these reasons, we must say no to your request.*

After getting a response like this a few times, your employees will know which conferences are appropriate to attend.

The fact of the matter is that we are all busy, our days are long, and time slips away from us. However, we can't let these teaching opportunities go unused. A good leader understands that what and how we communicate with our employees provides valuable education and ultimately strengthens our organizations when done properly.

TIPS AND TAKEAWAYS

WHAT TO CONSIDER | RED FLAGS | STEPS TO TAKE | DON'T FORGET

- **It is imperative that we explain why we made a particular decision when considering an employee's request.**
- **Detailed answers to employees teach the company's sensibilities to future decision-makers.**
- **Detailed communications prevent unintended consequences.**

RISING ABOVE

How to Be a Best Place to Work

By Sabrina Darsey, Division Claims Manager at Athens Administrators

Recently my office received the honor of being ranked in the Top 5 Best Places to Work in San Diego for the fourth year in a row. Many factors go into shaping a company and office into one of the Best Places to Work.

I have worked for 30 years in the workers' compensation industry, both for insurance companies and third party administrators. For five of those years, I worked in marketing for an occupational medical group and physical therapy company. I started my workers' comp career as a claims assistant and worked my way up to a division claims manager. Through this experience, including 15 years in management, I've learned some principles behind what makes a great company and an enjoyable work environment. If building the company of your dreams is your aspiration, I offer my findings on how to create the most productive and rewarding work environment possible.

First, Best Places to Work ensure that the company culture and values come from the top. If the leadership, such as the CEO, CFO, president, executive vice presidents, managers, and supervisors, genuinely believe in their company culture and values, and they live and breathe them, then the staff will also believe in them. Not only does leadership need to "talk the talk," but they need to "walk the walk."

Leaders need to invest in their employees who work hard to make the company successful; they should work alongside their employees and keep the culture and values intact as the company grows. Without their valued employees, the company won't achieve success and certainly won't be able to stay in business. I embrace my company's philosophy on this subject: "Take care of your employees, they will take care of our clients and our clients will take care of us." It seems like such a simple concept, yet why do companies struggle so hard to put it into practice?

Providing a healthy work environment is directly related to building a better place to work. A quality work environment encourages employees to work harder and more efficiently.

I believe the disconnect happens when organizations lose sight of what made them successful in the first place. As employers grow, the employees they once cared about become merely a number, then they become expendable. How many times have we heard that line, everyone is replaceable? Is everyone indeed replaceable? And at what cost? If companies changed their mentality from "everyone is replaceable" to "what can we do to retain our employees and make them succeed?," employee morale would increase, improving the quality of the company.

Building a successful company with a positive work environment starts with hiring the right people. Hire quality team members that are compatible with your company culture and values, and don't be afraid to let the bad ones go. Don't just settle to fill a position; compromising your hiring standards is one of the worst mistakes you can make. Spend time and money to rigorously screen applicants; take your time in interviewing to find the right fit. Speaking from experience, it is well worth the investment.

Creating a pleasant work environment is crucial in keeping your employees happy. It is a key factor impacting a company and its worker productivity. Providing a healthy work environment is directly related to building a better place to work. A quality work environment encourages employees to work harder and more efficiently. Wouldn't you work harder for a company that cares about you and provides you with a supportive work environment? We have probably all known companies that didn't care about their employees, the work environment was toxic, and nobody was motivated to work. No one went above and beyond to work diligently; they did the minimum required to get by. No one wants to be a part of that type of organization. We want our employees to take pride in their performance and our company.

Another key to becoming one of the Best Places to Work is to invest in your employees by providing them with incentives. At our firm, we offer a variety of incentives, such as monthly chair massages, quarterly company meetings, team lunches, flexible work schedules, company-paid summer picnics and holiday parties, a casual dress code, and a work-from-home program. By investing in your employees, you will gain much more in return.

Consider asking your employees for feedback. You can start by asking employees for positive feedback, such as why they like working for the company. You will find out what matters most to them, and it will open the door to deeper communication. You can also ask what they think would make a better work environment. You can keep responses anonymous if needed, but listen to their input and try to implement some ideas to build a more rewarding work environment.

I asked my employees what they thought made our office one of the Best Places to Work, and I repeatedly received the same responses:

- Company culture.
- Work/life balance.
- Team atmosphere.
- Power is not abused.
- Positive environment.
- Shows appreciation to employees.
- Comfortable, respectful, compatible office atmosphere.
- Opportunities and incentives to learn, grow and develop.
- Not just a place to work but a rewarding place to work.
- The company treats us like family; they take care of us.

TIPS AND TAKEAWAYS

WHAT TO CONSIDER | RED FLAGS | STEPS TO TAKE | DON'T FORGET

If you want to improve your company culture, retain employees and become one of the Best Places to Work, I suggest the following:

- **Provide a clear vision and be transparent.**
- **Lead with honesty and integrity.**
- **Provide flexibility and promote growth.**
- **Practice open communication and collaboration.**
- **Promote harmony in the workplace.**
- **Never forget to treat your employees in the way in which you would want to be treated.**
- **Make it your goal to offer employees opportunities for growth and development so they are equipped to succeed. If they succeed, you succeed!**

In the Spotlight

Industry leaders answer our most searching questions.

SARAH JANE JARA, CLP

Senior Risk Analyst at
Red Bull North America, Inc.

Name a person who has had a tremendous impact on you as a leader.
The person that has had a tremendous impact on me as a leader and a mentor is hands down my boss, Simon Keshishian. He is the true definition of a leader by not only mentoring me but also mentoring anyone that crosses his path. He leads by example and is a true team player. Lastly, he never stops learning and is more than happy to pass his knowledge down and lead the way.

What three words would you use to describe your company?
Energy, Creative and Extreme.

Where does your ambition come from – what drives you?
My ambition comes from my desire to live life to the fullest and experience all that life has to offer! In my current professional position, that may be while helping my colleagues execute a great event with risk and safety top of mind or by networking with industry connections to continue learning and growing. I believe in putting my all into my commitments so I can enjoy a work-life balance.

What makes a perfect weekend for you?
All perfect weekends are spent with family and friends, either at a backyard BBQ or traveling to old and new places. I love to spend time at a lake or in the desert, exploring the great outdoors. Otherwise, you're likely to find me at Disneyland.

Do you have a favorite quote or motto?
"All the World's a Stage."

Sarah Jane can be reached at sarahjane.jara@redbull.com.

STACEY TOKUNAGA

Principal Attorney at
The Law Offices of
Stacey L Tokunaga

What are your views on leadership?
Many equate leadership with a position, title or stature in the workplace. I perceive leadership as a process – a series of steps focused on building the best team to achieve our firm's core values, vision and mission. It is the domain of risk-takers committed to a lifetime of excellence in their quest to reach the pinnacle of their field. It is a journey filled with blood, sweat, tears, resiliency, fleeting disappointments, and resolved failures that line the path to successful leadership.

SLT Law is a people-oriented firm that focuses on people development, providing opportunities to hone leadership skills and teamwork in an environment of growth and learning. We value employee development because we believe it is the key to the continued success and growth of the company. A wise man once said, "If you perceive yourself as a leader, and no one is following you, you are merely taking a solitary walk." Therefore, teamwork is a way of life for all potential leaders at SLT Law. Our leaders are successful because they practice the"three Ls" of our organization: Listen, Learn and Lead. If you are only listening to yourself speak, you are not learning and will be a weak leader. Listening to other team members will give you insights that you can incorporate into your thought processes to help broaden your scope of interpretation, enabling you to make more informed decisions and become a more effective leader.

The "Inner Circle" in leadership is a critical aspect and the stabilizing force of a leader. Developing an inner circle is crucial in keeping a leader grounded. The Inner Circle tells me what I need to know, rather than what I want to hear; complements my weaknesses; emulates my strengths; helps bear burdens instead of adding to them; works as a team; adds value to the company; "watches my back;" and is honest and trustworthy.

Members of the Inner Circle must remember that they are the "Eyes, Ears, Heart, and Soul" of the company and must be vigilant to keep the company safe from potential harm. Above all, Inner Circle members must help their leader avoid the pitfalls of believing his or her own press and believing they are "God's gift" to others.

What are your goals with your clients?
Our goal is to deliver successful, cost-effective, timely outcomes for our clients. We are guided by our "Four Cs:" Communication (constant phone calls, e-mails, messaging), Collaboration (conference calls, face-to-face meetings, working lunches), Confidence (successful outcomes through communication and collaboration), and Credibility (positive cost-saving outcomes and timely case closures). Our goal is client satisfaction and a mutually satisfying relationship.

What is the most courageous thing you have done?
After graduating from law school, passing the Bar exam, and receiving licensure, I began working at a defense firm to learn about California's workers' compensation system. Nearly two years later, I mustered the courage to " jump into the fire, body and soul" and start my own defense law firm. Being young, adventurous and immature in the business arena, and driven by a fierce passion, I ventured out on a road rarely traveled by females, let alone an Asian-American female attorney! I left my secure job, took a bold step forward, and vowed to devote my life to reaching my goals.

Fast forward 27 years later, and I remain committed to growing SLT Law and its future leaders through my daily actions: being proactive, being a good listener, setting clear expectations, showing sincerity, promoting teamwork, keeping promises, practicing small acts of kindness, saying "I'm sorry," showing loyalty, taking responsibility for right or wrong decisions, being passionate about what I do, and maintaining a strong commitment to our values, mission, and vision.

What have you learned from the stakeholders in your journey?
I attribute my inspiration in my journey to my parents. From early childhood throughout my formal school years, love, honor, ethics, fairness, perseverance, giving, sharing, and the value of hard work as prerequisites to contributing to society and living a happy, fulfilling life were instilled in me as my parents practiced what they preached. They were my mentors and staunchest supporters, who made me what I am today.

One of the formost lessons I learned from them was to not look at a glass as being half empty but instead to look at the same glass as half full with tremendous opportunities to fill it to the brim. I strive to fulfill these ideals in treating people the way I would like to be treated. To this day, this philosophy has not failed me. As a leader, I am ecstatic to see this philosophy thrive in the workplace. My mirror on the wall does not tell me who the fairest in all the land is; rather, it asks me, "What have you done today to make someone's life better?"

Do you have a favorite quote?
"The greatest gifts my parents gave to me were their unconditional love and a set of values that they lived by and just didn't lecture about – values that included understanding the simple difference between right and wrong, the importance of hard work, education, self-respect, and a belief in America."
Colin Powell – Dedicated citizen of the USA, retired US Army four-star general, and former US Secretary of Defense

Stacey can be reached by phone at (714) 634-7000, by fax at (714) 634-7009, or visit www.sltlaw.com.

Indicators of Excellence

By David B. Dolnick, Dolnick Risk Advisors

One of the most common questions claims professionals ask me has always been, "What is it you are looking for? What do you want from us?"

I'm a risk manager. I started my career in workers' compensation and have accrued considerable experience in the field, but this can be a complex question. That's true when you consider the various levels that question encompasses. It's a perfectly valid query for any service provider to ask stakeholders, and especially their clients. Knowing what employers expect is a good place to start when evaluating and planning for your performance. This article will explore several key areas of excellence and high performance that many risk managers, myself included, will seek from their business partners.

First and foremost, I want stability. I need to be able to know and understand what to expect from my service providers, and that implies that we all minimize needless disruptions or changes in personnel, policy, software, or the practices being employed. I far prefer to deal with one or two adjusters, or a stable and well-running team, not a random field chosen at whim or by the first letter of a claimant's last name (yes, I did encounter a carrier that assigned claims in exactly that manner). Stability matters because workers' compensation is not a commodity. Success and sound results are best built on strong relationships, and that means working for an extended period with a consistent team of professionals. Disruptions to that team cost me time, effort and money.

Second, I want the claim professionals on my team to care. It's such a simple concept, caring. I want you to care about what happens to my employee; I want you to care about the impact on his or her life and to respect that things may never be the same for them if the injury was a serious one with long-term repercussions. You aren't there to be a shoulder for them to cry on, but you should care about what they are going through and do your best to minimize the negative impacts as much as you are able. I want you to care about your profession and your professionalism; to care about the processes and methods you use and rely upon; and most of all, to care about the quality of your work. Care about what the employer or insured wants, care about what your firm and your supervisors want (you won't last long there if you don't, after all). I also want you to care about the various mandated rules, regulations and timetables we all work with, and care about living up to our industry's ethical rules and standards of conduct. Most of all, though, care about your reputation and your good name; at the end of the day, that's all any of us truly own. Fortunately, this isn't a problem for the vast majority of the professionals I've worked with. Still, sometimes it can get lost in the stresses and hassles of tackling a difficult claim or of dealing with difficult people.

Third, please remember why we're all here dealing with workers' compensation matters and issues. There are always going to be difficult, demanding or fraudulent claims. There will always be difficult claimants, physicians with questionable skill or ethics, or vendors who are just plain greedy. We all deal with those situations far too often for comfort, and it becomes temptingly easy to focus on those kinds of negative factors. We run into far too many of them far too often, and we remember them far too long. It's easy to become cynical about what we do, about the people we deal with, but that's a perilous path to travel. It can taint and poison all that we do and can color all our interactions. Try to remember that while any given phone call with a claimant may be your 27th challenging conversation of the day, it's probably the claimant's first – sometimes their first ever. Injured workers can become frightened, nervous, and uneasy dealing with our complex and opaque system of laws, regulations, coverage and rules. The professionals know the ropes, so to speak, but the claimants typically don't. They often fill that gap with their imaginations, with research on the internet, or with advice from friends and family members. They may recall their own claim, whether three or five or 25 years ago, and think that experience was typical of how workers' compensation works (or should work), regardless of whether that's accurate. Remember why we are here: We are administering a vital social insurance program, delivering benefits mandated by law. Let's not move too far away from that in our reaction to the problems and challenges we face.

Fourth on my list is a set of skills that, unfortunately, many in our business place most of their emphasis on: technical competence. I didn't list this as number one because it's a baseline need. It's not unimportant – quite the opposite – but in my four decades of experience, I've known many workers' compensation professionals that rely on their technical knowledge of the field and make no real effort to do anything but meet those minimum standards. There's no passion, no desire to excel, no drive to succeed. Technical competence is important, and vitally so, but it forms only the basis for success; it isn't excellence in itself. You do need to know the law, the regulations, the product or services that you offer. But that skillset is not enough by itself. It serves as the platform for exceptional performance in the field, performance that builds on the technical skills this industry demands.

So, how to measure or know if these four skills are a part of your routine, of the way you conduct yourself every day? Here are some measures of performance that, while commonly used, don't really address the first three skills I've discussed above. It's hard to measure those, because they are not the "what" of claim handling and its allied services; they are the "how." It's hard to measure caring objectively, or to quantify how well you understand the nature of our industry. How you approach these tasks and skills, however, will help your clients know your true value to your organization and to them.

1. Prompt case setup – Clients need to know that claims are being processed efficiently. So do claimants. The claim handlers and the service providers need to be on the same timeline. Delays, especially at the outset of the process, will impact the claim, increase the potential for needless litigation, and often lead to misunderstandings and a loss of trust.
2. Early contact – Establishing a dialogue with claimants, with treating physicians, and with employers helps to reduce uncertainty and fear and lets all the parties to the claim begin the process of moving forward.
3. Timely ISO searches – Understanding a claimant's history is an essential evaluation point for claim handling. Workers who have no prior contact with the workers' compensation system may need a bit more guidance in knowing what to expect, while a significant and repetitive history of claim activity may raise its own questions that need clarification.
4. Timely investigations – Not every claim needs to be assigned to an outside investigator, but every claim does need basic confirmation of the stated facts—some additional information from the parties. Confirming the facts early helps a claim handler make prompt and accurate decisions, especially where AOE/COE questions arise or where there is a potential for subrogation recoveries.
5. Timely reserves – The only thing absolutely true about an initial reserve on a complex claim is that it will most likely change. Nobody expects perfection two weeks into a catastrophic claim, but handling those changes as soon as accurate and additional information becomes available is vital. I know reserves are likely to change, and the more complex a claim is, the more likely that multiple revisions to the reserves will be needed. Do those corrections, but please do them promptly. That helps me focus on those claims where time and attention may have a positive impact. If your timing has an impact and needs to be adjusted, we'll talk about it, but that's rare.
6. Timely special investigations – When red flags are raised in a claim, referring them to an SIU or outside investigation team is vital, and the sooner, the better. This is especially true in cases where either fraud is suspected or where subrogation or risk transfer may come into play.
7. Timely medical management decisions – Claim handlers know who the effective treating physicians are and can help guide employers and employees alike to proper treatment, whether from a primary care provider or from a specialist.
8. Timely communications – Don't wait for a quarterly or semi-annual claim review to tell your client about a potential problem, or the need for them to address return to work. Taking a moment to send an email or make a telephone call in between more formal meetings and reviews can make all the difference. In addition, consider visiting the worksites for major clients; both employer and adjustor will benefit from those interactions and the dialogue they create. Similarly, risk managers should visit their adjusters to see and understand the reality of claim handling. Consider a "chairside" visit to see how the claims process really works.
9. Timely Return to Work help – Injured workers who return to gainful employment rapidly, even if in some limited or transitional manner, tend to fare better, which lowers costs and difficulty for all the participants in a claim.
10. Timely referral to counsel – When claims do litigate, finding the right time to bring in counsel can be critical. Referring too late causes extra work for the attorney, potentially at additional cost, while referring too early has the same effect for the opposite reason. There is for each claim a "right time" to make the referral, and knowing this timing is a vital skill for claim handlers to develop.
11. Prompt closure – Don't let a claim linger for months; it serves no purpose and only skews claim handling statistics and reports.

As you will notice, almost all of these 11 steps are focused on the primary claim handler and their team. There are some additional criteria that I and others apply to the TPA or carrier as a whole. Specifically, I want an accurate idea of the current and planned workloads each claim handler will manage, along with an estimate of the complexity of those claims (e.g., the age of the claim since inception, estimated permanent disability involved, whether the claim was litigated, etc.). Some measure of the stability of that "book" of claims is also helpful, typically measuring the ratio between total new arisings versus total closings. The particulars of the claims themselves help me address the complexity of the claims. There is, after all, a vast difference between handling 250+ med-pay only claims and handling 130 major catastrophic injuries. Those extremes of the workload require different skills. I also want to know what internal programs the company has in place to assure quality handling, and what steps are taken to correct any deficiencies that are observed. An additional question for the companies is whether they offer a risk management information system (RMIS) or whether their system will coordinate with my data processing capabilities.

One newer area that I look for is the data analytics capabilities of the carrier or TPA. There is a wealth of information in both general data and industry-specific information, and (if there is a sufficient volume of claims) in employer-specific data. Those firms that possess in-depth capacity for analyzing that data can gain a significant advance view of trends, probabilities and insights in how to address common problems in handling claims. Data analytics is a newer field, but it's now starting to take off in an exciting and novel fashion.

There is a common thread here, and it's an expectation that applies equally to all the participants in this process we call workers' compensation. Simply put, it's a two-part formula consisting of equal parts competence and communication. If we all strive for those goals, good things will happen in the most unfortunate of circumstances, and the system can work well for all of us.

Workers Compensation Claims and Nurse Triage

By Lester Sacks MD, PhD, Medical Director at Arissa Cost Strategies

If one of your employees is injured, what do you as an employer do? Has your human resources department written protocols, so your employees know exactly what to do? Communicating the proper information and process is important so that the injured employee receives the most immediate and appropriate care. Nurse triage can be a most effective approach to managing an incident! Nurse triage service by trained, telephonic licensed professionals can support the 24/7 needs of the employer and employee.

The nurse triage team will make all the arrangements for your organization, including the desired medical process and protocols to effectively support the individualized protocols, including addressing the utilization of appropriate physicians in your network.

PROCESS FOR CARE

1. In addition to managing the medical aspects of immediate care, triage nurses use not only credible guidelines but also their experience and judgment, so that immediate care is delivered without always referring to a physician.
2. The team will handle the required reporting to the appropriate offices as required by the State's guidelines.
3. If more formal care is required, the nurse will make the necessary referral to the physician within network or company recommendation and discuss medical findings.
4. When necessary, the triage nurse will pre-certify needs and authorizations for care.
5. Most importantly, the triage nurse can give immediate instructions to the injured worker for self-care, making it unnecessary for the worker to lose time and visit the physician's office.

NEXT STEPS PROTOCOL

Once the necessary medical attention is managed, the nurse manages the required "paperwork" with emails to the necessary parties identified initially in the protocols, such as the State, the claims organization and, of course, the employer (maintaining all mandatory HIPAA rules).

WHY A NURSE TRIAGE PROGRAM?

The value of a nurse triage program can be discussed forever because we all have difficulty embracing a change in process. It becomes obvious to those mindful of future projections that a more efficient method of dealing with workplace injuries can be of significant value. Here are a few ways the nurse triage program offers value:

1. It reduces direct and indirect costs of a claim
2. It provides the injured worker appropriate medical service immediately.
3. It ensures timely State reporting.
4. It avoids unnecessary emergency room and physician office care.
5. It removes the supervisor from making a medical decision, which is not their job.
6. It delivers rapid information to claims.
7. All calls can be recorded for accuracy and a permanent record.

The Independent Bill Review System

By Paul C. Herman and Aidan P. McShane, Law Offices Paul C. Herman

Here it is, the most dreaded topic: bills, invoices and liens. In this article, we provide information and timeframes mandated by Senate Bill (SB) 863 to combat and control the cost services provided post January 1, 2013.

With SB 863, the Legislature removed much of the decision-making process on med-legal invoice dispute issues from judges and put it in the hands of independent experts. That legislation is Independent Bill Review (IBR), a process by which a bill review expert examines fee disputes.

The IBR structure controls the submission and response to *all* medical and med-legal billing. However, IBR is only applicable where 1) services were provided on or after January 1, 2013, and 2) the only issue left to be determined is the v alue of services. IBR does not apply to services where there is no fee schedule. IBR does *not* address any *threshold issues* related to lien resolution. These threshold issues include but are not limited to whether services were preauthorized, liens were properly filed, or if there are defenses like Statute of Limitations. Once the WCAB decides upon threshold issues, the disputed balance is processed through IBR.

Two types of services are submitted to IBR: Med-Legal Costs and Treatment Expenses. Each service is processed differently.

Per Labor Code §4620(a): "a medical-legal expense… may include X-rays, laboratory fees, other diagnostic tests, medical reports, medical records, medical testimony, and… interpreter's fees …*for the purpose of proving or disproving a contested claim*." All other charges (medical, surgical, chiropractic, durable medical equipment, interpreter, home health care, etc.) are Medical Treatment Expenses.

IBR PROCESS FOR MED-LEGAL COSTS

If a dispute is only to the proper amount payable per the fee schedule, then the dispute must go through IBR. (LC 9794)

The process begins with a service provider serving a completed bill to an adjuster, with supporting evidence, such as a medical report, photocopy orders, or proof of attendance by an interpreter with the certification number. Thereafter, Defendants must object or pay within 60 days. Objections must be on the Defendant's Explanation of Review (EOR). Any services that are not objected to must be paid in full.

Within 90 days from the Defendant's service of the EOR, the service provider may contest the EOR and request a second review.

The Defendant then has 14 days from the request for a second review to respond with a final written determination. Any services not objected to in the final written determination are payable within 21 days.

At this point, the second review is completed.

After the Defendant has submitted its final written determinations from the second review of the submitted bill, the service provider has 30 days to object or respond. If the service provider's only issue is the amount paid per the applicable fee schedule, the service provider may request IBR. *The service provider must pay the IBR fees up front.*

At this time, the disputed bill is reviewed and analyzed by an independent bill review expert. Upon the completion of the review, the bill review expert issues his or her findings. The following are the options:

1. If it is found that the Defendant owes more money, then the Defendant shall pay the additional amounts and reimburse the IBR fees advanced by the service provider.
2. If the report determines the employer prevails, then the employer owes nothing further.

IMPORTANT! If any of the foregoing deadlines are missed, then the consequences are as follows:

1. If the service provider fails to timely comply with its obligations, the bills submitted are deemed paid and neither Applicant nor Defendant are liable for anything further.
2. If the employer fails to timely comply with a deadline, then the full amount is payable, along with interest and fees.

If the med-legal dispute is *about anything other than the application of the fee schedule*, then that issue must be determined through the Non-IBR system. (LC 9794 and CCR 10451.1(c).)

The Non-IBR system is processed as follows:

1. Service provider submits billing with information validating the invoice.
2. Defendant has 60 days from receipt to pay any uncontested services and to object by way of EOR, with supporting evidence of those services which are disputed.
3. Service provider now has 90 days to object to the EOR.
4. If the provider's objection is timely and *not* based on just the amount per fee schedule, then the Defendant must file a Petition for Determination of Non-IBR Medical-Legal Dispute *and* a DOR, with Proof of Service, within 60 days.

5. Defendant's failure to timely respond is a waiver of all objections to that provider's billing, except as to the issue of the amount.
6. If the employer does not proceed with Step 5 above, then the *service provider may file* the Petition for Determination of Non-IBR Medical-Legal Dispute. The service provider does not need to file a DOR.

At this point, the matter will be submitted to the WCAB for determination of the noncost-related threshold issues. The WCJ has the option to defer until the case-in-chief is ready to be heard in the interest of judicial economy. Once those are decided and only disputes regarding amounts remain, then the parties return to and begin the IBR process as initially described.

CASH IS KING

If it is not already patently clear, the workers' compensation system is driven by two primary factors: the severity of injuries and the cost of determining the extent of those injuries and treating them. Here we focus on the Legislature's attempt to harmonize providing treatment to injured workers, payment to those medical providers, and limiting excessive treatment and costs to the insured – the dual roles of the independent medical review (IMR) and independent bill review (IBR) systems.

Independent bill review appears to have been ignored!

Through 2016, 165,000 IMR applications were filed, while only 2,700 IBR applications were filed. Only 1.6 percent of the disputes the system addressed were through the IBR process. However, of those IBR applications filed, *medical providers were successful in approximately 75 percent of their disputes*. Moreover, with these successful determinations, the medical providers are automatically entitled to penalties, interest, sanctions, attorneys' fees, and reimbursement of the IBR processing fee. As success with liens dwindles, savvy medical providers may learn to navigate the IBR system to recoup funds.

Next, we focus on medical treatment expense charges, including – without limitation – medical, surgical, and chiropractic services; medical equipment; interpreters; and home health care.

In general form and structure, the *Labor Code* and *California Code of Regulations* treat medical-legal expenses and medical treatment expenses relatively similarly. However, there are significant differences in the time frame to object to medical provider billing and issue payments. Being mindful of these differences is the only way to prevent an inadvertent *waiver and automatic penalties and interest*.

IBR PROCESS FOR MEDICAL TREATMENT EXPENSES

IBR is only applicable to *disputes over the amount payable* per the applicable fee schedule. There are some treatment areas where there is no applicable fee schedule implemented. Until a fee schedule is developed, the Workers' Compensation Appeals Board retains jurisdiction over determining the proper amount in dispute. All remaining disputes are submitted to the independent bill review process (*Labor Code* § 9794).

The IBR process begins when a service provider *serves a completed bill to an examiner*, with supporting documentation, such as medical reporting, authorized RFAs, Proof of Attendance by an interpreter with a certification number, etc. This must be done within 12 months of the date of service. Thereafter, *the defendant must object within 30 days of receipt*, via the appropriate Explanation of Review (EOR). If billing is submitted electronically, the time to issue an EOR is reduced to 15 days.

Any services that are not objected to must be paid within 45 days of receipt from the date of receipt of the invoice initially submitted. If the employer is a governmental entity, they have 60 days to pay under *Labor Code* § 4603.2(b)(3). If the billing is submitted electronically, the time to issue payment for both private and governmental employers is reduced to 15 days.

Any services that are not objected to must be paid in full. A failure to pay may include an automatic 15 percent penalty increase on the balance, as well as interest at the prevailing civil rate (currently 10 percent per annum or 7 percent if a governmental entity).

Within 90 days from the defendant's service of the EOR, the service provider may contest the EOR and request secondary bill review. If the provider fails to request a secondary review within 90 days, "the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment" (*Labor Code* § 4603.2(e)(2)).

If a request for secondary review is filed, the defendant has *14 days to respond* with a final written determination on each disputed item or amount. Any balance not in dispute shall be paid within 21 days of receipt of the request for secondary bill review.

At this point, it is the provider's obligation to initiate the independent bill review by making a formal request on the form presented by the administrative director (AD), along with supporting documentation. If the provider fails to request an independent bill review within 30 days from the final written determination, the bill will be deemed satisfied. Neither the employer nor the employee will have liability for further payment.

If the provider requests IBR, the defendant will have *10 days* upon receipt of any Notice of Assignment of IBR to provide all requisite billing, documentation, EORs, requests for secondary review, and final written determinations to the independent reviewer. The provider must initially pay the IBR fee to the AD. If the provider prevails, the fee for IBR is reimbursed by the defendant, along with the other amounts awarded to the provider.

The final determination of IBR is deemed a Final Order of the Administrative Director. As such, the aggrieved party can file an appeal. Unless an appeal is filed within 20 days, this will be considered a final and binding Order. If an appeal is filed, the aggrieved party must dispute the presumptively correct determination of the administrative director at a trial before the Workers' Compensation Appeals Board.

Carl's Corner

By Carl Van, ITP

If You Have to Say No, Be Nice About It

*By **Carl Van,** ITP, President & CEO of International Insurance Institute, Inc. and **Jon Coscia,** President & CMO of Latitude Subrogation Services*

We all have to say no at times.

Some people find it easier than others. Interestingly, almost all of us struggle with the right way to say no.

People who hate to say no find it hard to do so, and sometimes do something much worse than hurt someone's feelings. They either don't say anything, which passively sends an incorrect message of "yes," or they say no in such a way that the other person doesn't know what is being said, sending the message of "maybe."

People who don't mind saying no don't find it hard to do so, but can lack the skills to do it gracefully and often instill hard feelings, even when that is not their intent.

For those of you who have no problem saying no, but need a little guidance on how to say it more effectively, here are some tips.

Tip #1. "I'm Sorry" doesn't have to mean you are really sorry. A little empathy can go a long way.
Tip #2. Repeat back to the other person their point of view. That will allow them to listen to yours. Once you prove to someone you understand their point of view by repeating it back to them, they can stop explaining it over and over again.
Tip #3. You don't have to prove to someone that the situation is their fault. Most people want empathy, not for you to take the blame. If possible, take their side as much as you can, but return to the situation at hand.
Tip #4. Show the other person you wish it could be different. Telling someone, "I wish I could do this for you. However, I just can't…" is much more powerful than "I won't do this for you because I don't have to."
Tip #5. Help solve the problem in another way if possible. Even if alternatives aren't the answer, the fact that you offered them shows you care. Most people when being told "no" can take it a little better if it is coming from someone who seems to genuinely care.
Tip #6. Avoid the word "but" when empathizing. When you say, "I understand, but…" the other person hears, "I don't understand."

Using the tips above, you can say no and avoid conflict. The following examples show how a different approach can save you from an unpleasant situation.

Scenario 1

Pat is a hotel clerk who is trying to help Mr. Donnelly. It's late at night, and he needs a hotel room.

Mr. Donnelly: *Look, I really need a room tonight. You're the sixth hotel I've been to, and I'm getting really tired.*
Pat: *I'm sorry, there are no rooms; we're completely booked.*
Mr. Donnelly: *Please? I'm exhausted.*
Pat: *I understand, but that doesn't change the fact that we have no rooms.*
Mr. Donnelly: *But I'm exhausted.*
Pat: *I understand, but how is that our fault? You should have made a reservation.*
Mr. Donnelly: *Can't you do something for me?*
Pat: (Turning the terminal toward Mr. Donnelly) *Look, we have no rooms!*

Notice how Pat said she was sorry, but she didn't convey that very effectively. She was also concerned with proving Mr. Donnelly was at fault. She offered no real solution and certainly did not sound as if she wished circumstances were different. The next example shows how Pat does when she applies the tips above.

Mr. Donnelly: *Look, I really need a room tonight. You're the sixth hotel I've been to, and I'm getting really tired.*
Pat: *Oh, I'm very sorry, there are no rooms; we have a conference here, and we're completely booked.*
Mr. Donnelly: *Please? I'm exhausted.*
Pat: *Mr. Donnelly, I understand that you are exhausted. I know you don't want to have to keep searching for a room at other hotels. I see how tired you are and understand what you are going through. Believe me, if I had a room, I would definitely give it to you. The truth is, I just don't have a room available. I'd do it if I could but I just can't. Can I help you find a room somewhere else?*
Mr. Donnelly: *Ugh. Okay, yes, please!*

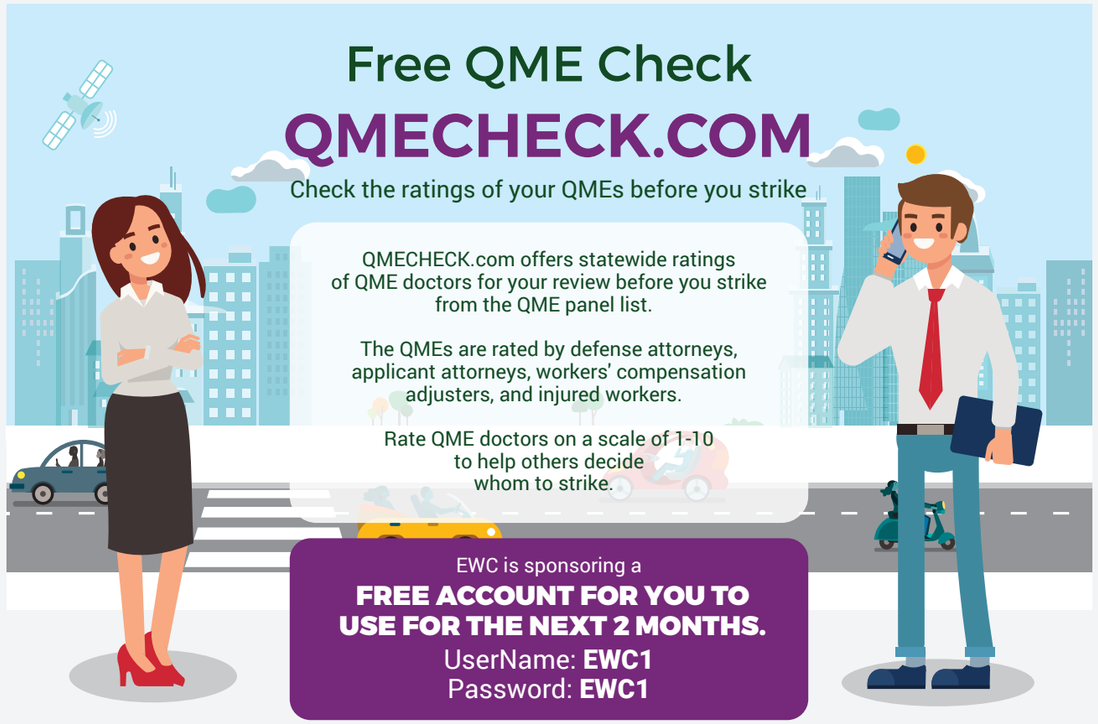
Pat's approach led to a much better result. Mr. Donnelly isn't thrilled, but he is ready to move on.

Scenario 2
Debbie is a salesperson at a department store. The store has a strict policy about not accepting refunds after 30 days.

Mr. Adams: *I want to return this for a refund, please.*
Debbie: *This was purchased over 30 days ago, so I can't do that.*
Mr. Adams: *I didn't know that when I bought it.*
Debbie: *I understand, but you should have read the return policy. It's right there on the sales receipt.*
Mr. Adams: *Who reads sales receipts?*
Debbie: *People who want refunds.*
Mr. Adams: *Come on. It's been 34 days. What's the big deal?*
Debbie: *I understand, but 30 days is the limit. Sorry. You're going to have to be reasonable about this.*
Mr. Adams: (Now angry) *I am being reasonable!*
Notice how Debbie failed to empathize with the customer. She blamed the customer for not understanding the store policy. She even went so far as to imply that the customer is an unreasonable person.

The next example shows what happens when Debbie approaches the situation with the tips to say no in mind.

Mr. Adams: *I want to return this for a refund, please.*
Debbie: *I'm very sorry, Mr. Adams, but since this was purchased over 30 days ago, no refunds are allowed.*
Mr. Adams: *But I didn't know that.*
Debbie: *I understand that. It's on the receipt, and often people don't read their receipts, so I can understand that you didn't know about the policy.*
Mr. Adams: *Well, I have to return it. I can't use it now, and it's expensive.*
Debbie: *Mr. Adams, I really do understand. This is an expensive item, and you now realize you can't use it. I truly wish the store policy were different, and wish there were some way to make an exception. The policy is quite firm, however, and there is just no way to provide a refund. Can I help you find something you can exchange it for that might be acceptable to you?*
Mr. Adams: *Oh…okay. Do you have a catalog or something?*
Again, a change in approach led to a better result. Remember, saying no doesn't have to create bad feelings if you show a little empathy. Follow these simple tips, and you might get a little less resistance from people. ✪



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