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EWC MAGAZINE

EDUCATION, STRATEGIES AND RESOURCES

ACTIVITY CHECKS

A COST-EFFECTIVE INVESTIGATIVE TOOL

By Richard Harer

POST-OFFER EMPLOYMENT TESTING

WHAT WENT WRONG?

PSYCHOLOGICAL IMPACTS

ON THE WORKERS' COMPENSATION CLAIM

REALITY CHECK

DEBUNKING THE MYTHS OF MEDICARE SECONDARY PAYER COMPLIANCE

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CONTENTS

From the Editor...

How We Summer

Summertime is upon us in full vitamin D glory, and I for one am thoroughly enjoying it. I'm soaking up every last drop of this luxuriate-in-the-backyard-under-the-stars, eat-with-your-hands time of the year. This season boasting the longest and warmest days holds some of my fondest memories – remembrances that, with just a taste or a scent, flicker to life across a projector in my mind.

While the sights and sounds of summer vary among us, we all house a cherished reel of these memories stashed in our minds, waiting to be unspooled each June. What's on your reel? What does summer mean to you? For many, it's a chance to break away and catch our breath, bask in longer days of sunlight, up our grill game, and shed our layers – literally and proverbially – before we have to bundle up again. And for the majority of us, present company included, I suspect that if our summer highlight reel had a trailer, the starring role would go to water – fresh, salty, or pool – whether we float, paddle, or plunge into it headfirst. At EWC, it was indeed water – from a crescendoing waterfall to a crystalline lake – that drew us to the perfect sites for our corporate planning sessions. We retreated to these venues to focus on the future and film some videos as a new platform for communicating with you. We hope to save you time by adding videos to our emails, allowing us to relay lots of information quickly, in an easy-to-understand way.

And while summer also means lighter – a break in our schedule, lighter fare, a breezier wardrobe – we're keeping our toes in the waters of conference planning. What should our magazine and our conference look like in 2020? What do you want to see more of? What do you like so far? For these insights and more, we reviewed the results of our post-conference survey. If you took part, thank you for taking the time to give us feedback on what we can do to make EWC Conference the best symposium of the year for you.

I also want to extend a thank you for the kind and encouraging notes and emails I have received since the January debut of *EWC Magazine*. The feedback has been overwhelmingly positive. A claims manager in Oregon called to say she is making it mandatory for her staff to read one article a day because the content was so rich; she found the "Tips and Takeaways" helpful as well. And I spoke to a risk manager in the UK who remarked, "Your magazine is brilliant!" Another gentleman informed me he had considered himself well-informed on all things workers' comp – until discovering vital new information in his first issue. Comments like these let us know we're on the right track.

> Summertime is always the best of what might be.
>
> - Charles Bowden

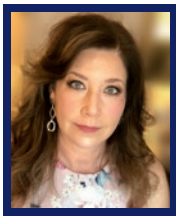
As I write this letter, I am aware that this issue will have hit inboxes at the tail end of summer. And as this season prepares to change once again, one thing at EWC remains constant: Our commitment to bringing you the best. Whether it's through our annual conference or our flagship magazine, we're committed to making EWC your go-to source for education, connection and resources. It is our driving force in making *EWC Magazine* an essential tool in your toolbox for sharpening your knowledge of the latest developments in the industry, from legislation to claims handling to management skills.

Whatever makes your summer flow – whether you staycation or vacation – we hope this issue finds you enjoying it to the fullest. See you in the deep end!

Together we can do great things!

Debra Hinz
Editor in Chief

EWC MAGAZINE
EXECUTIVES IN WORKERS' COMP AND RISK



MANAGING EDITOR
Lacey Atkinson

ART DIRECTOR
Hannah Peacock

Reality Check

Debunking the Myths of Medicare Secondary Payer Compliance

By Brian Cowan, Legal Director, ISO Claims Partners

Medicare Secondary Payer (MSP) is a challenging area of compliance for which federal law, regulations, and policy don't always provide clear answers. This often conflicts with the processes and procedures outlined by applicable contractors. And in certain situations, the Centers for Medicare and Medicaid Services (CMS) requires actions to be taken that aren't fully supported by the MSP. That leaves many gray areas that are up for interpretation. Sometimes this opinion is guided by statutory, regulatory, and codified policy and guidance founded upon sound principles of risk management and good-faith claims handling. Other times, it may be based on mere speculation and a misunderstanding of the foundational law and rules.

If a stakeholder dives deep enough into the world of MSP, sooner or later they'll come across myths. To move past these misconceptions, it's vital to understand what they are and separate fact from fiction.

Here are 10 pervasive myths about Medicare compliance.

WCMSA Myths
Requirements, thresholds, treatments, and more are misunderstood.

Myth #1: Workers' Compensation Medicare Set-Asides (WCMSAs) are required in any workers' compensation claim that's settling future medicals.

Fact: There are no statutory or regulatory requirements regarding WCMSAs in workers' compensation claims settling future medicals. An MSP regulation, found at 42 CFR 411.46, provides the basis for the concept that the parties need to protect Medicare's interests when resolving cases that include future medical expenses, but it does not dictate what steps parties must take. Rather, the WCMSA is the only mechanism that CMS has recognized to date to accomplish this.

Myth #2: If a proposed settlement meets WCMSA review thresholds, it must be submitted to CMS for review.

Fact: "There are no statutory or regulatory provisions requiring that you submit a WCMSA amount proposal to CMS for review. If you choose to use CMS' WCMSA review process, the Agency requires that you comply with CMS' established policies and procedures to obtain approval." See WCMSA Reference Guide, v2.9, Sec. 8.0. CMS will voluntarily review a proposed WCMSA amount in the following circumstances:

- The claimant is a Medicare beneficiary, and the total settlement amount is greater than $25,000; 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.

As part of their compliance protocols, many claims payers, however, have developed their own internal thresholds for when they may submit to CMS. Moreover, a recent trend in the industry explores alternatives to submission.

Don't believe everything you hear about Medicare Secondary Payer. Move past the misconceptions and get the facts.

Myth #3: If the treatment is related to the workers' compensation claim, it should be in the WCMSA.

Fact: MSAs are designed to cover only treatment that is Medicare-covered for the industrial injuries related to the claim. Not all treatment is Medicare-covered for the injuries in any given case. In fact, some treatments are covered for some body parts or injuries and not others. For example, under Medicare Part D, over-the-counter medications are typically not covered. A TENS unit is covered under Medicare for most body parts other than the low back; thus, in cases where the low back is the sole injury, the TENS unit is likely not covered. Any treatment related to the industrial injury not covered by Medicare should be excluded in the WCMSA.

Myth #4: The bigger the WCMSA, the more the claimant can benefit.

Fact: The ideal WCMSA, for both claimant and carrier, is one that's allocated only adequately enough to cover the costs for post-settlement Medicare-covered medical expenses and no more. WCMSA funds may be used to pay only for future Medicare-covered expenses related to the industrial injury, so claimants are restricted in how they can spend those funds.[1] If the WCMSA funds are used for anything else, Medicare could require that the full amount of the settlement (inclusive of attorney fees and other payments) be exhausted before agreeing to pay for any care. For example, a claimant is in a better financial position with an additional $10,000 being included in the settlement outside the WCMSA than they would be if the allocation amount were $15,000 higher than required – because there's no restriction on how the $10,000 can be used, while there is with the $15,000. In that example, if the claimant attempted to spend the extra $15,000 in the WCMSA for anything other than Medicare-covered treatment for the industrial injuries, risk of exposure for the entire settlement exists.

Myth #5: If a WCMSA is too high for the parties to settle a claim, it cannot be lowered without harming the claimant's treatment.

Fact: In many cases, cost mitigation strategies can significantly reduce the cost of a WCMSA without a substantive change to the claimant's treatment. Sometimes it's as simple as asking the treating physician to clarify the claimant's records, so it's clear that certain treatment is unrelated to the industrial injury. In other cases, it may involve switching from brand to generic medication, changing doses of a medication (e.g., going from one 100mg pill of Tizanidine to two 50mg pills of Tizanidine), or switching from a combination drug to the individual drugs (e.g., changing from Percocet 10-325mg to Oxycodone 10mg and 325mg of acetaminophen or from Vimovo to Nexium 20mg and Naproxen 500mg).

Myth #6: All CMS decisions are final, and the approved amount of a WCMSA cannot be changed.

Fact: There are two different processes to request reconsideration of the amount of an approved WCMSA:

- Ask for a re-review. In a re-review, the parties request that CMS reconsider the final approved amount for one of two reasons: (1) because there was an obvious mistake in the decision, or (2) because there are new records that were not previously considered.
- The second is the Amended Review Process (available since July of 2017). This allows parties to ask for a new MSA determination on a case that has not settled in which the pre-vious MSA was approved within the last one to four years and where the amount of the MSA is expected to change by the greater of 10 percent or $10,000. See WCMSA Reference Guide v2.9. Sec. 16 (Re-Review and Amended Review).

Liability MSAs Requirements Confusion

Myth #7: Liability MSAs (LMSAs) are required in all general liability settlements.

Fact: As with WCMSAs, no legal or regulatory mandate requires incorporating an MSA in a workers' compensation or liability settlement. In liability matters, formalized guidance is lacking as to when and how Medicare's interest might be protected following a settlement. The WCMSA program includes a litany of policy memoranda, a formalized voluntary review process, a dedicated contractor (Workers' Compensation Review Contractor), and the WCMSA Reference Guide. Regarding LMSAs, there are none of these formalities. The Office of Information and Regulatory Affairs (OIRA) released a notice in the latter part of 2018 indicating that CMS plans to issue proposed rules regarding options to address future medicals in relation to liability, workers' compensation, and no-fault claims. OIRA's notice further indicated that a Notice of Proposed Rulemaking (NPRM) on this subject is targeted for release by September 2019. While the released notice doesn't provide any specifics, the forthcoming proposed regulation is believed to be focused on LMSAs, and the industry is closely monitoring to determine if CMS will finally take steps to codify policy around future medicals in liability claims.

Recovery Confusion Abounds

Myth #8: Once a delinquent debt is referred to the U.S. Department of the Treasury, the debtor has no further recourse, and the debt must be paid.

Fact: This couldn't be further from the truth. Even if an unpaid and delinquent debt is referred to Treasury, it can still be contested. There are several reasons why a recovery debt may go to Treasury: errant referral by the contractor, unpaid demand, payment improperly applied to the debt, etc. Regardless of the reason the debt was referred, if there's a valid basis to contest the demanded charges under the MSP, the debt can be – and often is – successfully challenged and reduced or eliminated.

Myth #9: Medicare will seek recovery only in the event of a settlement.

Fact: With the institution of the Commercial Repayment Center (CRC) in Non-Group Health Plans (NGHPs) on October 5, 2015, CMS began seeking recovery as soon as a conditional payment is made and assumption for Ongoing Responsibility for Medicals (ORM) is evidenced. This is without regard to a settlement. For workers' compensation and no-fault (medical payments, PIP, etc.), as soon as ORM is reported and if Medicare is paying for related medicals, then recovery can and will occur by way of Conditional Payment Notice (CPN), which will convert to a demand for re-payment. To engage in a dispute or appeal to mitigate costs for unrelated charges (which is prevalent), it's critical that claims payers review the charges for which the CRC contends it is owed.

Section 111 Fines Mistaken As Already Being Levied

Myth #10: Medicare is currently levying fines for Section 111 noncompliance.

Fact: To date, CMS has not levied a civil money penalty (CMP) for failures in Section 111 reporting. In the fall of 2018, the Office of Management and Budget (OMB) issued a notice indicating that CMS is planning to release proposed rules for public comment regarding civil money penalties. At this time, however, there is no regulatory mechanism outlining when CMPs may be imposed. But it's still critical for Responsible Reporting Entities (RREs) to focus on timely and accurate (error-free) Section 111 reporting in anticipation of formalized guidance around penalties.

[i] See WCMSA Reference Guide, v.2.9, Sec. 3.0

Post-Offer Employment Testing

What Went Wrong?

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

Conditional Post-Offer of Employment testing is good for business and the community. A Conditional Post-Offer of Employment test is a physical assessment given to a prospective employee after a formal job offer has been made by the employer. To be hired, the candidate must pass the physical assessment, which tests whether he or she can perform the physical demands of the job safely.

No one desires to see anyone injured on the job. Overexertion along with accompanying fatigue are among the most relevant causations of work-related incidents. It makes sense to hire persons who can perform the quantified physical demands of the job to ensure safe placement and adequate specialization and experience in high-risk manual materials and patient handling. This assessment is not the same as a Functional Capacity Evaluation (FCE) or Functional Capacity Assessment (FCA). Proper employee selection is appropriate for high-risk manual materials handling in fulfillment centers and retail stores, and patient handling in hospitals and nursing facilities.

Understanding the employment laws that pertain to hiring and employment practices includes those set forth by Title VII of the Civil Rights Act of 1964, the Age Discrimination Act of 1967, the Uniform Guidelines on Employee Selection Procedures (1978), the Americans With Disabilities Act of 1992, 2008/2011, and the Office of Federal Contract Compliance Programs (OFCCP), U.S. Department of Labor (DOL).

THE EMPLOYER'S *UNIFORM GUIDELINES ON EMPLOYEE SELECTION PROCEDURES*

Section 60-3.2 (B): Employment decisions include but are not limited to hiring, promotion, demotion, membership, referral, retention, and licensing and certification (does not apply to recruitment).

Focusing on Return on Investment (ROI) calculation and employee selection and safe placement reduces the likelihood of employment litigation, and the frequency and severity of injuries hence reduced claims, reserves, medical treatment, and legal expense.

Section 60-3.3 (A): The use of any selection procedure that has an adverse impact on the hiring, promotion, or other employment opportunities of members of any sex, age, or ethnic group will be discriminatory unless it has been validated or the provisions of section 6 of this part are satisfied.

Section 60-3.6 - The Use of Selection Procedures Which Have Not Been Validated: The use of alternative selection procedures should eliminate adverse impact. Alternative procedures should eliminate the adverse impact in the total process. When validity studies cannot be performed, use selection procedures which are as job-related as possible and which minimize or eliminate adverse impact.

The legal requirements for validation and compliance are job relatedness, essential job functions, reasonable accommodation, objective testing predictive of job performance (validation), and validation studies. The three types of studies cited in section 60-3.5-General Standards for Validity Studies are criterion-related validity studies, content validity studies, and construct validity studies.

WHY DO COMPANIES USE PHYSICAL ABILITY TESTING?

Focusing on Return on Investment (ROI) calculation and employee selection and safe placement reduces the likelihood of employment litigation, and the frequency and severity of injuries hence reduced claims, reserves, medical treatment, and legal expense. The continuation of claims, depending on acuity and claim count, produces an adverse impact on the financials due to the additional sales needed to offset the claim costs in the hundreds of thousands to millions of dollars.

PRECEDENT CASE LAW

2005 *EEOC v. Dial Corporation* – No Business Necessity

Fifty-two women were rejected at Armour meat packing plant jobs due to failing a strength test requiring repetitive lifting of 35 pounds to 65 inches. Approximately 40 percent of female applicants passed the test; virtually all male applicants passed the test. However, women had successfully performed the job in the past.

What Went Wrong?

The test required 6 lifts per minute, whereas the actual job rate averaged 1.25 lifts per minute and the height of the lift was greater during the test than in actual work. The court concluded the test was more difficult than the job; thus, it did not demonstrate "Content Validity" and lacked empirical data to sufficiently demonstrate it was predictive of job performance. The Pass/Fail determinations were subjective without consideration for accommodations or changes to reduce adverse impact. Dial also failed to demonstrate a "Business Necessity." Dial Corporation was ordered to pay $3.4 million for "sex discrimination."

2009 *Sandy v. Kroger* or *EEOC v. Kronos* - Third-Party Subpoena

The case begins in May 2007 when Ms. Sandy applied for the cashier/checking job and was rejected after oral administration of a personality assessment instrument created by Kronos. The EEOC sued Kroger on July 3, 2007, claiming that Sandy was rejected because she is hearing and speech impaired.

As part of its investigation, the EEOC sought the following from Kronos and Kroger: to produce all documents and data constituting or related to validation studies or validation evidence; documents discussing, analyzing or measuring potential adverse impact; all documents related to all job analyses created or drafted by any person or entity relating to all positions; and the user's manual and instructions for the use of the assessment tests used by both companies.

What Went Wrong?

The importance of this case is that it serves notice of potential vulnerability for companies and consultants that develop tests as well as companies that use these tests.

2010 *Indergard v. Georgia-Pacific Corp* - Medical Exam

Indergard's employer, Georgia-Pacific Corp., required all employees returning from medical leave to undergo a physical capacity examination. Indergard's job required an ability to lift 65 pounds. Under the ADA, an employer may not require an employee to submit to a medical examination unless the examination "is shown to be job-related and consistent with business necessity." However, the ADA does allow an employer to "make inquiries into the ability of an employee to perform job-related functions."

The issue before the Ninth Circuit Court was whether Georgia-Pacific required a medical examination, or only inquired into her ability to perform the physical requirements of her job. The Ninth Circuit Court found that the series of tests Georgia-Pacific required Indergard to take constituted a "medical examination" under the ADA.

What Went Wrong?
The court listed the following seven factors in determining whether a test is a medical examination: whether the test is administered by a health care professional; whether the test is interpreted by a health care professional; whether the test is designed to reveal an impairment of physical or mental health; whether the test is invasive; whether the test measures an employee's performance of a task or measures his or her physiological responses to performing the task; whether the test normally is given in a medical setting; and whether medical equipment is used.

2011 *EEOC v. AutoZone* - Job Functions Must Be Essential
The jury returned a verdict that AutoZone failed to reasonably accommodate John Shepherd, an auto parts sales manager.
Shepherd had back and neck injuries. He took several leaves from the company between January 2001 and September 2003. In April 2003, after returning from a month-long leave, he produced a doctor's note indicating that he could not mop or buff the floor. The examination cleared him to return with his previous restrictions, but his personal doctor placed additional lifting, standing and twisting restrictions on his return. He remained on leave and was ultimately terminated under the company's disability policy.

What Went Wrong?
On June 3, 2011, a jury awarded Shepherd $100,000 in compensatory damages and $500,000 in punitive damages on the grounds that mopping and buffing is not an essential job function for a sales manager. This part of the award is likely to be reduced to $300,000 in line with limitations on compensatory and punitive damages awards in the Civil Rights Act of 1991. Additionally, a ruling is pending on the EEOC's request for an additional award of $115,000 in back pay.

2016 *DOL v. Gordon Food Service* – Isokinetic Testing Not Valid for Pre-Employment
Gordon Food Service (GFS) was charged for discriminatory hiring practices at the company's warehouses. There was no Applicant Complaint; however, during a routine audit of the company's "Functional Affirmative Action Plan," investigators noticed the hiring rate for female applicants was significantly lower than male applicants. The investigation findings are that most women failed isokinetic testing, and the strength and agility tests were not administered or interpreted by a health care professional.

What Went Wrong?
The isokinetic test is not valid because the company failed to complete a full validation study, and the requirements are based on the criteria for workers in the coal mining industry. The DOL stated, "We believe the test was more stringent than the actual job requirements." Patricia A. Shiu, director of the OFCCP, said of the GFS situation, "Too often we find 'tests' like the one used in this case exclude workers from jobs that they can in fact perform."

2016 *Ernst v. City of Chicago* - Improper Validation

Ensure you follow all the laws pertaining to employment testing, including the *Uniform Guidelines on Employee Selection Procedures.*

In October 2016, the Human Performance Systems-designed test was found to discriminate against women. Human Performance Systems designed a test for Chicago EMS new hires at the academy training level.

What Went Wrong?
The test was found to have questionable validation that was not job-specific. During the investigation, the work samples were found to be flawed and not representative of job demands, rendering the cutoff scores for Pass/Fail not valid. The *Dial* case was referenced several times.

2016 *Michael Cannon v. Jacobs Field Services* (JFS) – ADA
Cannon was hired by JFS as a Field Engineer. JFS rescinded the job offer after learning of a shoulder injury.

What Went Wrong?
The ADA significantly amended disability protection by the ADA Amendments Act of 2008. Cannon demonstrated he could perform the essential functions of the job.

SUMMARY
Employment testing is serious business. If your company is employing new hire testing, ensure the contractor or vendor and test battery is compliant with employment laws. If you are utilizing any physical ability test, make sure it is appropriate for its intended purpose and is job specific. Ensure you follow all the laws pertaining to employment testing, including the *Uniform Guidelines on Employee Selection Procedures*.

Job descriptions must be up to date and reflect the essential physical demands of the job.

- **Understand the laws that pertain to employment testing.**
- **Identify and select a testing methodology that is compliant with employer selection law, and provides an ROI, indemnification and a defendable test battery.**
- **Understand case law and "What Went Wrong" in employment selection that may lead to legal challenge.**
- **Learn how employee selection leads to reduced physical injuries, reduced claim cost and enhanced workplace safety and health.**

Sources: https://www.lexisnexis.com/en-us/search.page

Activity Checks:
A Cost-Effective Investigative Tool

By Richard Harer, CFE, WCCA, CPI, CFS, Vice President of Specialized Investigations, Inc.

As professionals in our industry, we all know the importance of curtailing workers' compensation fraud. Over the past 20 years, legislation passed in California has helped reduce workers' compensation fraud substantially.

However, a law passed in 1999, SB 262 (Section 1708.8 of the Civil Code, better known as the "Anti-Paparazzi Law"), actually had an adverse impact on the investigation of workers' compensation fraud. In short, this legislation was enacted to protect celebrities from unwanted "invasion of privacy" or "intrusion" into their personal lives. The law also posed limitations on investigators hired by insurance companies to conduct surveillance on claimants. For example, the statute required that an insurance claims handler and an investigator would need "articulable suspicion" of fraud before they could undertake a surveillance investigation. As a result, many insurance companies began requiring that their claims departments refer any questionable claims to their special investigations unit (SIU), who would then, in turn, review the "red flags" and then decide whether surveillance was warranted, based upon "articulable suspicion" of fraud.

The claims staff also recognized that many cases might not meet the "articulable suspicion" requirement— even though the law never explicitly defined what "articulable suspicion" was necessary before surveillance could be initiated. For example, before the law was enacted, a claims handler could refer a case for surveillance if they did not like the claimant attorney's attitude or based upon their own "intuition." After the law was enacted, these were no longer acceptable reasons to conduct surveillance on a claimant.

ENTER ACTIVITY CHECKS!

The activity check has been an investigative tool for many years and was mainly utilized in the past as a cost-savings measure, often in lieu of surveillance. For example, rather than assign a full day or multiple-day surveillance, the claims handler wanted to find out whether the claimant was active and would be a

fitting candidate for future surveillance and if so, the best time to do so. In other words, if the activity check revealed that the claimant was usually at home attending to minor children during the week, but would go shopping on weekends, then the investigator could focus their efforts on weekends in order to maximize the results and minimize the costs.

Activity checks became a more popular investigative tool after the passage of the "anti-paparazzi law." If the claims handler did not have "articulable suspicion" of fraud concerning a claimant, they could outsource the case to an investigator to conduct a "non-filming" activity check to determine whether "articulable suspicion" of fraud could be established. For example, after receiving the case from the claims handler, the investigator would then conduct an activity check and report back that the claimant reportedly leaves for "work" at 7 a.m. each morning. Bingo! There is the "articulable suspicion" of fraud the claims handler and investigator would need in order to proceed with surveillance.

The added benefit of the activity check is that the claims handler and investigator can now conduct and maximize the surveillance on a day and time based upon the "intelligence" gathered during the activity check, thus minimizing the cost of unsuccessful surveillance efforts, in some cases.

Like surveillance, activity checks must also be done professionally and discreetly. The investigator must be well-versed in conducting discreet activity checks and must incorporate proven techniques in also obtaining useful information during the investigation. If the investigator identifies "articulable suspicion of fraud," the evidence is reported immediately to the SIU investigator or claims handler.

Before an investigator goes out to the subject's residence to conduct an activity check, a DMV records search should be performed on the claimant to identify any vehicles that may be registered to them at the provided address or other addresses. The investigator can then conduct a vehicle sighting (license plate reader) report on the claimant's known vehicle license plate number in order to develop additional investigative leads of where the vehicle may be parked and places the vehicle has visited frequently, as well as the make, model, color and other distinguishing features of the vehicle.

The investigator should also conduct preliminary social media and internet searches to develop additional leads and photos of the claimant before proceeding with the activity check.

An "address history" database search should also be run so that the investigator may have other addresses to check if it is determined that the claimant is no longer residing at the provided address. In addition, the investigator can make discreet inquiries to gather further "intelligence" before heading out to the claimant's provided residence.

With this information in hand, the investigator now proceeds to the claimant's address and begins the activity check. The activity check includes, but is not limited to, verifying whether the claimant resides at the reported address, what vehicles they may drive, whether they are currently working, and what level of outside activity they are involved in and when. If not restricted by the client, neighbors are also discreetly interviewed to learn more about the claimant and their extracurricular activities. Many times, information that is developed during an activity check becomes beneficial to the investigation. For example, the investigator may learn that the claimant works nights, plays soccer on the weekends, or restores classic cars in their garage as a hobby. With this information, the investigator immediately reports to the SIU investigator or claims handler, who now has the "articulable suspicion" to proceed with the surveillance.

Of course, the activity check may not result in an "articulable suspicion" of fraud. In this case, there is no limit to the number of activity checks that can be conducted thereafter. For example, the initial activity check may have been done on a weekday morning, with no "activity" observed or identified through discreet investigation. Therefore, another activity check may be more productive on a weekend day or evening. Or, it may be that the claimant's circumstances could change in the future and an activity check may be more productive at a later date. Eventually, the "articulable suspicion" may be established and surveillance warranted.

Also, it may be learned that the claimant is legitimately injured, inactive, or a poor candidate for surveillance. In this circumstance, it may be time to move on and concentrate on another case. In fact, the activity check may have a "silver lining" in that videotape of an obviously injured claimant was not obtained, and the activity check investigation may not have to be disclosed to the claimant attorney through discovery, as no surveillance was conducted.

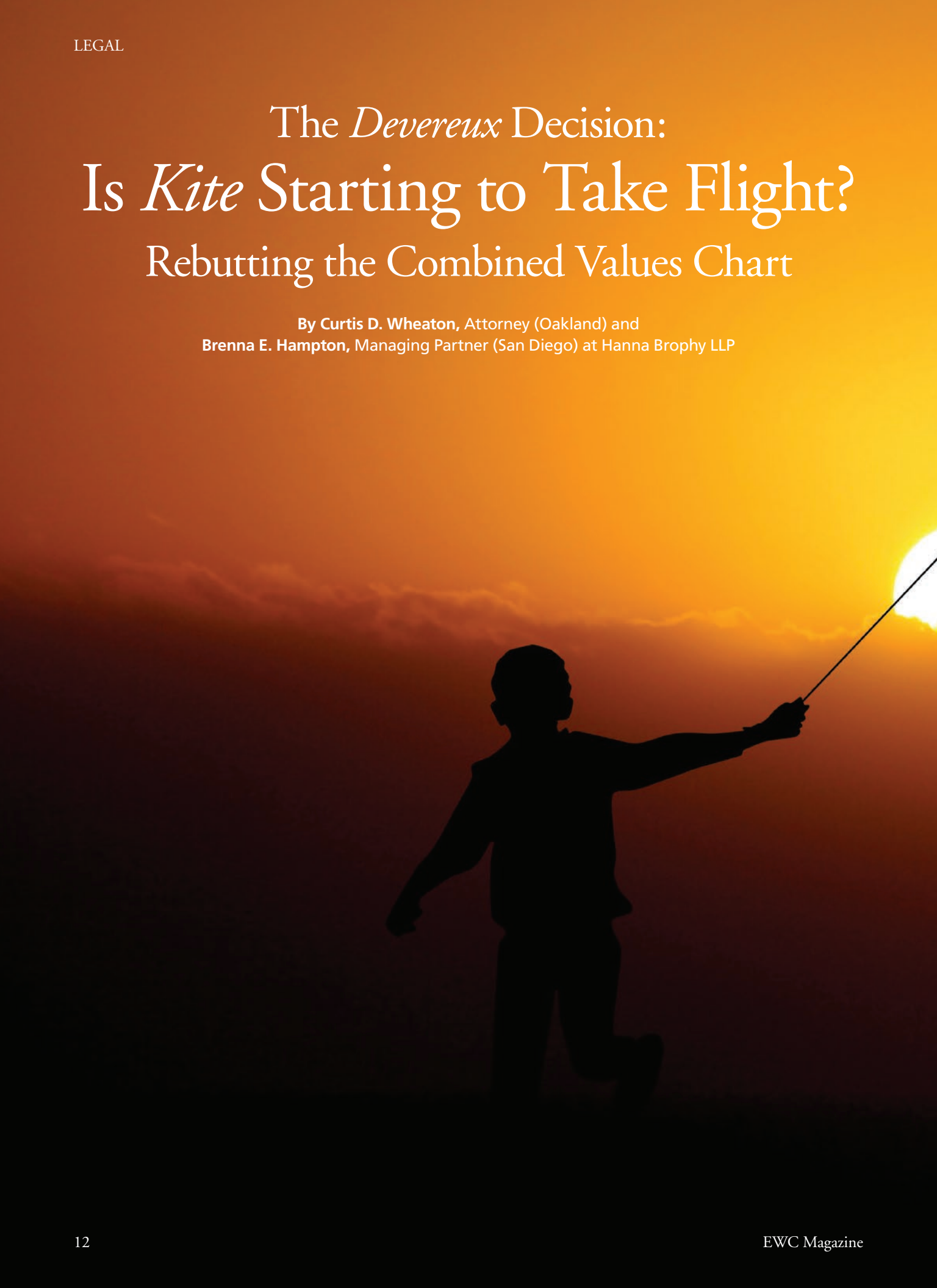
Unfortunately, fraud is not going to disappear and will only find other avenues to rear its greedy head. As Mahatma Gandhi once said, "There is a sufficiency in the world for man's need but not for man's greed." The effective utilization of the activity check can be a cost-effective fraud-fighting tool in the investigative "toolbox."

- **The added benefit of the activity check is that the claims handler and investigator can conduct the surveillance on a day and time that may be more successful, based upon the intelligence gathered during the activity check. This pinpointing could minimize the cost of unsuccessful surveillance efforts in some cases.**
- **The investigator can then conduct a vehicle sighting or license plate reader report on the claimant's known vehicle license plate number in order to develop additional investigative leads of where the vehicle may be parked, places the vehicle has visited frequently, and make, model, color, and distinguishing features of the vehicle.**
- **It may be that the claimant is legitimately injured, inactive, or a poor candidate for surveillance. In fact, the activity check may have a "silver lining" in that videotape of an obviously injured claimant was not obtained, and the activity check investigation may not have to be disclosed to the claimant attorney through discovery, as no surveillance was conducted.**
- **The effective utilization of the activity check can be a cost-effective fraud-fighting tool in the investigative "toolbox" for the claims handler.**

The *Devereux* Decision: Is *Kite* Starting to Take Flight?

Rebutting the Combined Values Chart

By Curtis D. Wheaton, Attorney (Oakland) and
Brenna E. Hampton, Managing Partner (San Diego) at Hanna Brophy LLP



Facts

Applicant Christopher Devereux was employed by the State Compensation Insurance Fund as a workers' compensation defense attorney. He sustained a cumulative injury through 8/15/2015 in the form of hypertension, diabetes, heart, circulatory, and cognitive impairment.

Two medical-legal physicians evaluated Mr. Devereux: Dr. Claude Munday, a neuropsychologist, and Dr. Raye Bellinger, a cardiologist.[1] Dr. Bellinger assessed 30% whole person impairment on the basis of left ventricular hypertrophy, pursuant to a "strict AMA"[2] impairment assessment. That 30% whole person impairment rated to 55% permanent disability under the 2005 Permanent Disability Rating Schedule. Dr. Munday diagnosed Mr. Devereux with "substance/medication induced mild neurocognitive disorder," caused by the four anti-hypertensive medications being used to treat the hypertension. The permanent impairment for cognitive dysfunction found by Dr. Munday ultimately rated to 35% permanent disability.

Under the combined values chart, 55% permanent disability combined with 35% permanent disability results in 71% total permanent disability. Applicant contended the combined values chart did not apply and that the cognitive and cardiac disabilities were subject to addition, for a net 90% permanent disability.

In support of his position, Applicant relied on the medical opinions of both medical-legal physicians, Dr. Munday and Dr. Bellinger. Dr. Munday commented:

> *"It is my perspective that these two impairments that are discrete and in very different areas are best combined through a strict adding procedure than anything else. I do not have a basis to argue that they are synergistic to any significant degree. That is, I would not argue that the actual disability is greater than the simple additive combining of the impairments."*

Dr. Bellinger's respective comment aligned with Dr. Munday, stating "I feel both of these impairments are separate and distinct" and "I find it completely appropriate to simply add my rating … for hypertension followed to Dr. Munday's…."

Decision

At the trial level, the Workers' Compensation Judge determined the additive ratings should be adopted in lieu of the combined values chart, since the medical evaluators each opined additive combination was the most accurate way to determine net disability given the absence of overlap between the cardiac and cognitive impairments. Accordingly, a 90% permanent disability award was issued in favor of Applicant.

On reconsideration, all three reviewing commissioners concurred with the findings of the trial judge.[3] The commissioners reasoned that utilization of the combined values chart is neither strictly mandated nor necessarily preferred. They characterized the combined values chart as a tool "generally" used in conjunction with the ratings schedule, absent contrary opinions from medical experts as to the most accurate means of combining disability.

The decision cites language from *LeBoeuf v. Workers' Comp. Appeals Bd.*,[4] that a disability rating "should reflect as accurately as possible an injured employee's diminished ability to compete in an open labor market."[5]

Therefore, because the medical evaluators concluded (based on substantial medical evidence) that addition of the hypertension and cognitive impairment most accurately reflected overall permanent disability, the WCAB adopted the additive approach and disclaimed application of the combined values chart.

Analysis

The *Devereux* panel did not specifically cite the *Almaraz/Guzman* line of cases within their opinion, but their decision closely mirrors its underlying rationale. In *Almaraz/Guzman*, medical evaluators may depart from a "strict AMA" analysis if analogizing to another section of the AMA Guides provides the most accurate assessment of permanent impairment based

on the functional deficits attributable to an industrial injury. As always, departure from the "strict" impairment rating must be supported by substantial medical evidence setting forth the facts and rationale for the analogical rating.

Devereux conveys the same underlying justification for a departure from the combined values chart. If the addition of permanent disabilities yields the most accurate reflection of net permanent disability, the combined values table can be discarded for that alternate methodology. It is a "substance over form" approach, focusing on the ultimate accuracy of combined disability rating and not whether a physician has spouted sufficient semantics regarding "synergism, synergistic effect, synergisticity, etc."

It is important to recognize the AMA Guides also contain a distinct section on the "Philosophy and Use of the Combined Values Chart."[6] That section directs physicians to make their own independent determination regarding the most accurate means of combining multiple disabilities, even expressly referencing that multiplication of disabilities may be the most accurate method in some (unspecified) cases.[7]

The *Devereux* case is consistent with that approach, where the lack of overlap between the hypertension and cognitive impairment indicated to the evaluating physicians that simple addition provided the most accurate accounting of total permanent impairment. The medical opinion was adopted and incorporated by the WCJ into their award of benefits.

The court in *Kite* relied on the medical determination that there was a synergistic effect in order to find permanent disability outside of the combined values chart. This was a big deal because the combined values chart is an addendum to the permanent disability rating schedule that is required to be used by statute in California to rate a workers' compensation case with multiple permanent disabilities. What distinguishes this case from Kite is that, in *Devereaux*, **neither physician provided an opinion that the cardiac and cognitive impairments acted "synergistically" with one another. In fact, Dr. Munday expressly disclaimed the presence of a synergistic effect**. Thus, *Devereaux* is a pivotal development in case law that opens the door for the Applicants' lobby to rebut a key part of the permanent disability rating schedule.

What Is the Current Standard for Adding Disabilities?

Put simply, there isn't one. At least not a legally binding one. The administrative nature of workers' compensation cases means that only en banc panel, Court of Appeal, and Supreme Court decisions achieve precedential value. **Those bodies have yet to issue a substantive opinion regarding the combination of multiple disabilities**. However, there is a growing slate of panel decisions which have directly addressed the issue.[8] Those decisions are instructive to case participants and persuasive to judges.

The issue of overlap is the most important factor, given that the combined values chart itself is premised on accounting for overlapping factors of disability stemming from multiple permanently disabled body parts/systems.

For example, where an auto mechanic sustains injury to the right wrist and right shoulder, the functional impact of those injuries will overlap significantly. Activities such as lifting, above the shoulder work, forceful pushing, etc., would likely be impeded by both injured body parts. The individual disability ratings for the wrist and shoulder are intended to provide compensation for those distinct functional losses, so the same elements of decreased function would be encompassed within each rating. Therefore, the combined values chart would apply to account for that overlap, ensuring the loss of the same function is not compensated twice.

Devereux v. SCIF (2018): WCAB Panel Endorses Addition of Permanent Dabilities, Declining to Apply Combined Values Chart, Despite No Evidence of "Synergistic Effect" Between Disabilities

Kite, Devereux, and associated cases do not contradict that rationale. Those cases simply recognize that the combined values chart is a rebuttable, one-size-fits-all approach that may not apply in cases where a substantial medical record supports the use of an alternate method of combining disability if it results in a more accurate overall rating that is consistent with the medical record.

Kite is infamous for the term "synergistic effect," intended to describe the interplay of Ms. Kite's bilateral hip impairment that left her unable to compensate for disability to one side of the body with the other. The medical evaluator determined that because the injury to each hip precluded any restoration of function by increased reliance on the other hip, the effects of the disabilities acted in "synergy" such that they should be added rather than combined. The court indicated a preference for rating based on the overall loss of function caused by the bilateral injury outweighed the overlapping factors of disability.

The *Devereux* case is likewise based on the concept of overlapping factors of disability (or more specifically, the lack thereof). The cardiologist and neuropsychologist both opined the impairments to each body system did not overlap and should be added (rather than combined) since they represent two impairments with entirely independent disabling effects.

In both cases, the applicant constructed a substantial medical record indicating that use of the combined values chart was not the most accurate measure of combined permanent disability in comparison to an alternate method proposed by the evaluating physician(s).

In both cases, defendants failed to adequately develop their own factual and medical record, instead relying on legal arguments that the combined values chart was un-rebuttable or that specific semantics were not used by physicians to justify the departure from the chart. There was no direct competing medical evidence which purported to show an overlap between the factors of disability.

Did the Disabilities in *Devereux* Overlap?

The *Devereux* case will likely be cited by the applicant's bar for the proposition that an injury to separate body systems (psyche v. ortho; internal v. cognitive; etc.) is an automatic indicator the disabilities do not overlap, and an additive approach should be taken to combining those disabilities. That position is also inconsistent with *Devereux* because it merely substitutes one presumed approach to combining disabilities with another. *Devereux* promotes a case-by-case inquiry dependent on specific medical findings to each specific injured worker. Trying to substitute a different default standard (albeit more applicant-friendly one) is equally offensive to the WCAB panel's underlying analysis.

Was that necessarily the case? Or did the *Devereux* decision result from a poorly developed evidentiary record?

Mr. Devereux suffered from hypertension and cognitive impairment. From a biological perspective, they are separate impairments to the heart and central nervous system. Is there really no *functional* overlap, especially given the context of Mr. Devereux's role as an attorney?

Even the small portions of the medical record excerpted in the panel decision note Mr. Devereux had a harsh and stressful workplace handling high profile cases. Wouldn't his hypertension *and* cognitive dysfunction impede the ability to perform the work activities expected from an attorney?

Cognitive impairment is almost certain to adversely impact the work of an attorney [insert your favorite lawyer joke here]. Given the added high-stress nature of Mr. Devereux's employment, would hypertension (and/or its resultant restrictions) also impact his capability to practice law in an unmodified capacity, given the stresses and work intensity referenced in the record?

Despite pertaining to separate body systems, it seems plausible that both the hypertension and cognitive impairment would have an impact on many of the same aspects of Mr. Devereux's job, especially as an attorney whose practice includes a high volume of litigation. Despite separate body systems being injured, the resulting functional limitations would preclude the same activities or require the same work restrictions. That would seem to establish the overlapping effects of disability the combined values chart is designed to account for.

Conclusion

The takeaway from *Devereux* is that defendants should not rely entirely on vague legal semantics like "synergistic effect" as the sole determinative factor of whether a medical opinion constitutes substantial evidence to support the addition of permanent disabilities. The WCAB has continually granted deference to medical opinions which purport to establish the most accurate measure of permanent impairment, whether through an *Almaraz/Guzman* impairment assessment or alternate methodologies of combining multiple disabilities.

The *Devereux* decision does not endorse any bright-line rules for combining multiple disabilities. It does the opposite, empowering the medical evaluators in each claim to provide individualized analyses on which method of combination provides the most accurate representation of disability. Ultimately, the parties to each case will be tasked with developing their medical and factual records accordingly. What is clear, however, is that defendants who fail to develop medical evidence to support application of the combined values chart in multiple disability cases will likely contribute to the growing number of cases supporting addition versus combining of disabilities. ✪

The *Devereux* decision does not endorse any bright-line rules for combining multiple disabilities. It does the opposite, empowering the medical evaluators in each claim to provide individualized analyses on which method of combination provides the most accurate representation of disability.

[1] The Devereux decision is unclear regarding whether Dr. Bellinger and Dr. Munday were serving as Qualified Medical Evaluators or Agreed Medical Evaluators. The panel decision itself labels them both as QMEs. However, the trial judge's Report and Rec-ommendation on Petition for Reconsideration states both physicians were AMEs.

[2] References to the "AMA" and "AMA Guides" throughout this article are referring to the American Medical Association, ***Guides to the Evaluation of Permanent Impairment*** *(5th Ed. 2000)(1971).*

[3] Both Defendant and Applicant actually petitioned for reconsideration. Defendant petitioned on the basis it was an error for the trial judge to add the disabilities absent a finding of "synergistic effect." Applicant appealed to correct two factual errors in the Award concerning annual SAW increases and the scope of future medical treatment. Defendant's petition was denied and Applicant's granted, though virtually the entire opinion from the WCAB panel was dedicated to issues raised in Defendant's denied petition.

[4] (1983) 34 Cal.3d 234, 245-246.

[5] Since 1983 (when LeBoeuf was decided), the legislature amended Labor Code 4660, enacted Labor Code 4660.1, and two evolutions of the ratings schedule have been issued by the Department of Industrial Relations. The Devereux panel does not address or reconcile these developments with its reliance on language from the 1983 LeBoeuf decision.

[6] American Medical Association, Guides to the Evaluation of Permanent Impairment (5th Ed. 2000)(1971).

[7] If anyone has encountered a situation (whether in California or another jurisdiction) where disabilities were multiplied, feel free to contact me. I have been trying to think of an example where multiplication would make sense. Phalange-impairment came to mind, but the AMA Guides already adjust impairment values relative to the specific finger/toe position.

[8] See ***Athens Admin. v. Workers' Comp. Appeals Bd.*** *(Kite) (2013) 78 Cal. Comp.Cases 213;* ***Los Angeles County Metropolitan Transportation Authority v. Workers' Comp. Appeals Bd. (La Count)*** *(2015) 80 Cal.Comp.Cases 470;* ***Diaz v. State****, 2015 Cal.Wrk.Comp. P.D. LEXIS 683;* ***Sanchez v. California Dept. of Corrections****, 2015 Cal.Wrk.Comp. P.D. LEXIS 482.*

The Independent Bill Review System

Cash is King

Part 2 of a 2-part series

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

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. This series of articles focuses 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% of the disputes the system addressed were through the IBR process. However, of those IBR applications filed, medical providers were successful in approximately 75% 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.

The IBR apparatus addresses both medical-legal costs and medical treatment expenses. In our previous article ("The Independent Bill Review System," Spring 2019, we focused on medical-legal costs–the costs incurred to prove or disprove a contested claim. Today, 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/invoice 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% penalty increase on the balance, as well as interest at the prevailing civil rate (currently 10% per annum or 7% 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.

TIPS AND TAKEAWAYS

- **Send every bill to your bill review department as quickly as possible and timely respond with the appropriate payment, EOR or deferral.**
- **Be very mindful of timeframes to respond; specifically, for electronically submitted billing.**
- **The EOR form is the only valid objection to a medical provider's billing where there is an implemented fee schedule.**
- **Untimely or inappropriate responses create the risk of waiver, penalties, interest, and costs.**
- **Differentiate between medical-legal costs and medical treatment expenses to determine the appropriate timeframes to pay or object, and which party must initiate the IBR process.**

In the Spotlight

Industry leaders answer our most searching questions.

DAVE NORTH

President and CEO
Sedgwick

Which is most important to your organization – mission, core values or vision?
I share the same core values as those displayed at Sedgwick, which remains at the heart of everything I do and implement within the company. From the start, we have always been a purpose and values-driven business that leads by example for those in the insurance industry. Our growth is rooted in our consistent, diligent and caring approach to the claims process, which drives our work forward for clients daily. Our purpose has always been, and will always be, to take care of people.

What advice would you give to first-time CEOs?
I think every CEO should be adaptable and quick on their feet. The industry is fast-paced and often changing daily, so I find it important to be able to enforce quick, but also thoughtful, responses and action plans. I find some of my most gratifying work to be exemplified when it's not pre-planned or on my calendar because of the new challenge it represents. Facing the unexpected can be challenging for some, but I feel invigorated by it. If you're not able to think, act and respond in the most constructive way, then you're doing a huge disservice to the people you lead.

As an organization gets larger, there can be a tendency for the "institution" to dampen the "inspiration." How do you keep this from happening?
You always need to keep a customer-focused approach in mind and foster a creative environment as your business grows to ensure its core values remain the same. Sedgwick started as a California-based workers' compensation TPA for self-insured employers and is now a global company with over 21,000 employees spread across 65 countries. Sedgwick developed an integrated disability management program for a Fortune 100 company 26 years ago, and that client is still working with us today. We continue to have success stories like these, and it is a great example of our hard work and dedication to our clients.

Who has been your greatest influence in business?
A few years ago, I heard Gloria Steinem speak at "Women to Watch," and her message was about how you see the world through your own lived experiences. That moment forever changed my point of view about diversity and inclusion. At Sedgwick, we are proud of not only how we are advancing those issues within the company, but also how we are helping lead the conversation in our industry about how incredibly important inclusion is.

Where does your ambition come from – what drives you?
I was born in a suburb just outside of Detroit as the eldest of five brothers. During my earlier years, I served as a volunteer firefighter in the local community and later became a professional firefighter with the U.S. Air Force. These experiences coupled with my background in safety led me to the claims industry as a way to serve others during a time of loss and recovery.

What is the most important lesson life has taught you?
You need to learn to make choices that will define you throughout your career. If you are an examiner, your tone affects the lives of those you talk to each day. Those claimants will tell others about you, so be thoughtful in your interaction. As a leader, your choices affect those you lead. The choices you make are yours. The way you are perceived is based on the choices you make. So, I leave you with this – make good choices.

PSYCHOLOGICAL IMPACTS

on the Workers' Compensation Claim

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

How many times have you heard an injured worker say, "I wish you could see what this injury has done to my life! Nothing will ever make up for what I have gone through." Statements like these are a common retort in conversations with injured workers. We need to look beyond this type of assertion by the injured worker and "peel the onion skin" to determine what motivations or considerations drive their attitudes.

We need to consider the dynamics behind the attitudes. Psychosocial behaviors have a significant impact on the management of the injured worker. Clinical research has addressed much of the role of psychosocial factors in recovery and rehabilitation outcomes. However, it is essential to identify and classify the behaviors to better understand how to respond to them.

I recently had the opportunity to attend a seminar by an organization specializing in biopsychosocial rehabilitation. This seminar reviewed some familiar psychosocial factors and the effects on workers' compensation claim management techniques that are worth discussing.

Having been a clinician of occupational medicine for over 50 years, I'm aware that many different circumstances drive a claim response to an injury, but it is helpful to logically organize the grouping of post-injury behaviors.

Four basic post-injury behaviors emerge:

1. **Catastrophic thinking**, an excessively negative orientation toward one's symptoms and health status, causing symptom magnification and the feeling of being powerless to control these thoughts.
2. **Fear**, which leads to escape and avoidance tactics, both linked to disability.
3. **Disability beliefs**, which lead to perceptions concerning the magnitude of the limitations that the injured worker experiences in relation to the debilitating health condition. In essence, beliefs are central determinants of behavior! If the worker believes they are disabled, they become disabled.
4. **Perceived injustice**, the feeling of experiencing unnecessary suffering as a result of another's actions: "Why me when it is your (boss, coworker, wife, husband, children, the world's) fault?"

All psychosocial behaviors have these characteristics in common:

· Treatment resistance
· Severity and duration of disability
· Symptom severity
· Susceptibility to other mental health issues

· Lack of participation in rehab
· Delayed return to work
· *Litigation!*

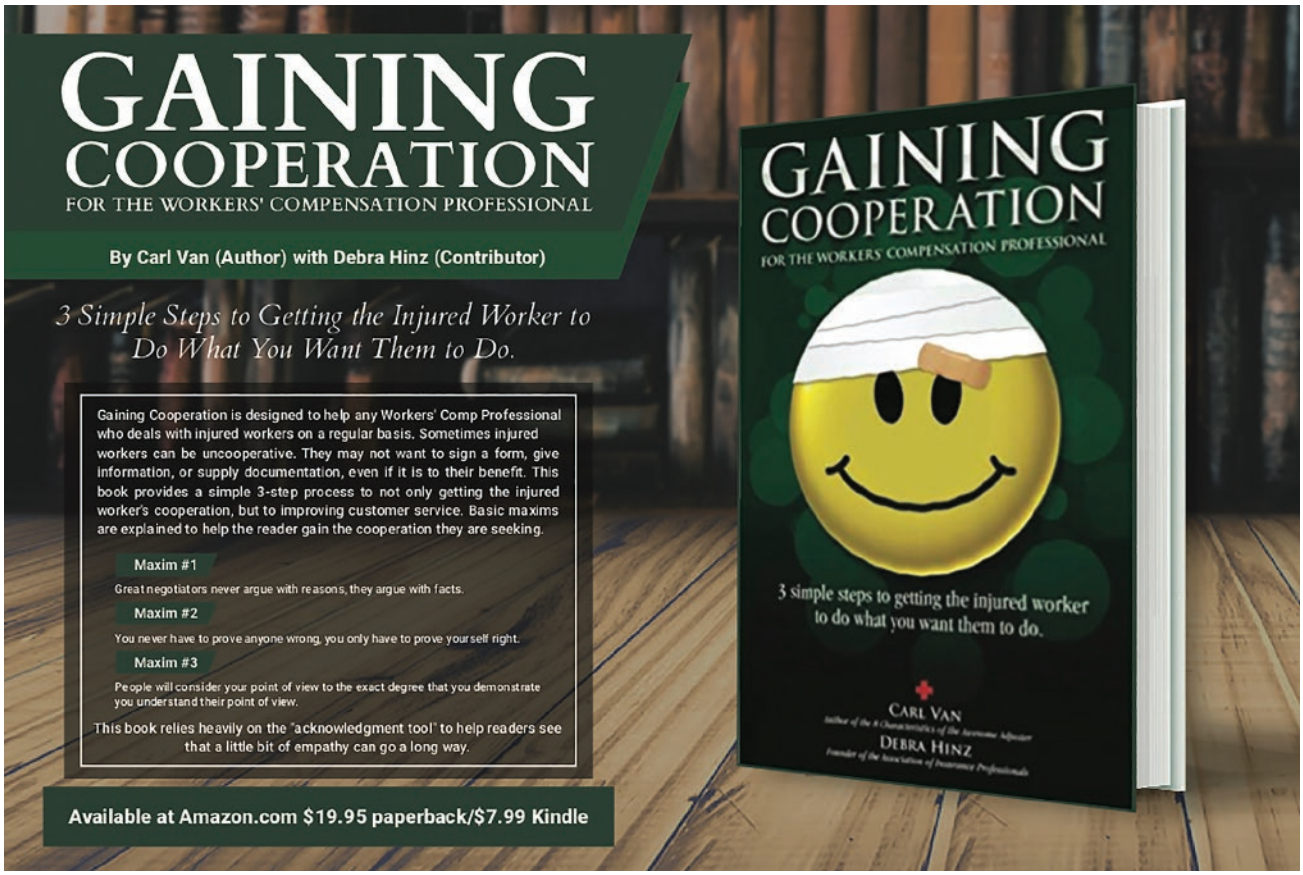
In the past, we in the industry have always followed the rule of "rest to recovery" as the rationale for recommending reduction of an injured worker's involvement in life functions. However, recent studies have shown that inactivity promotes the slowing of recovery, resulting in worsened health status. Moving away from an excessive focus on symptom management and moving toward maximizing participation is essential to the recovery from any disability. This shift in focus is key to the interaction between the injured worker and the administrative team of claims handlers and medical providers to reduce the treatment resistance and delayed return to work.

The big question is, how do we do this? It starts with the first contact between the injured worker and the claims adjuster or triage person. The approach to first contact must be to project a sense of caring and a sense of "How can I help you," rather than project a sense of being in an adversarial posture. Secondly, as stated above, it is imperative to have the injured worker participate in their recovery. The payor, clinician and managed care provider must move the injured worker toward maximizing participation in their medical care. Managing the injured worker back to full activity as soon as possible can be achieved by utilizing a nurse case manager or trained counselor for the facilitation of a collaborative communication process. Finally, those involved in the management of the claim and medical care must strive to understand the factors of the injured worker's disability and related issues to help in both the injured worker's recovery and the avoidance of prolonged litigated claims.

Whenever the opportunity arises to employ the techniques of negotiating the minefield of psychosocial impacts, care providers must address these issues with understanding and empathy for the injured worker. The present focus on psychosocial risk factors for pronounced and prolonged disability should not be interpreted as a neglect of the medical, physical, social and organizational influences on disability. Psychosocial influences represent only one of the dimensions to recovery.

TIPS AND TAKEAWAYS

- **The approach to first contact with the injured worker must be to project a sense of caring.**
- **Payor, clinician and managed care provider must move the injured worker toward maximizing participation in their medical care.**
- **Those involved in the management of the claim and medical care must strive to understand the factors of the injured worker's disability and related issues.**



Carl's Corner

By Carl Van, ITP

Frequently Asked Questions for workers' compensation professionals

In this final installment of a three-part series, Carl addresses common questions.

Q: Are there any words that we use routinely as part of our terminology, but are best not used when discussing settlement with an injured worker?
A: Yes. Consider using some of the following alternatives as part of your everyday negotiations. Most of these routine terms are fine to use with attorneys, but with unrepresented customers, you may want to avoid them.

Offer: We use the word "offer" so much that it is hard to imagine not using it when we discuss the value of a claim. But think about what the word "offer" means. It implies, "This is not what I think the claim is worth, this is just my 'offer.'" When you use the word "offer," you have just planted a seed in the person's mind that there is more to come.

> ***Don't say:*** "We want to offer you $5,000 for your claim."
> ***Do say:*** "Your claim has been evaluated at $5,000, and we want to pay you that full amount."

About: When you use the word "about" when describing something, you sound as if you are not sure. Use exact terms.

> ***Don't say:*** "Your bills are about $2,000.00."
> ***Do say:*** "Your bills come to $2,023.19."

Willing to: When you use the words "willing to," you sound as if you are only doing what is right because you have to, but you would rather not. It gives the impression you are admitting you would get out of paying the claim if you could.

> ***Don't say:*** "We are willing to pay you $10,000."
> ***Do say:*** "We want to pay you what you are entitled to, which is $10,000."

Only: When you use the word "only," you are making the injured worker think that you devalue their case, and whatever figure you use will not be enough.

> ***Don't say:*** "We can only pay you $8,000."
> ***Do say:*** "Your claim is worth up to $8,000."

Most people want to be understood. It is very hard to understand where people are coming from if you don't at least ask. The key is asking with a positive tone.

Throw in: When you use the words "throw in," "bump up," or similar phrases when increasing your offer, it gives the injured worker the impression that more money is easy to get.

> ***Don't say:*** "Let me throw in another $500."
> ***Do say:*** "I am going to alter the valuation by $500."

Don't owe: When you use the words "don't owe," you make it sound like "we won/they lost."

> ***Don't say:*** "We don't owe you anything for that. It's not payable under workers' comp."
> ***Do say:*** "I want to make sure you get everything you are entitled to. Let me explain what is payable," or "If there were any way we could pay you for that, I would love to do it. The workers' compensation code restricts what we can and cannot pay for. Can we review it together?"

Q: Should I ask the injured worker how much they want?
A: Generally, it is not a good idea to ask the injured worker how much they want. If you do, you're giving the impression that what they want changes the value of the claim. It also implies that you and the other person are on the same level. Remember, you are the expert – you have the experience and knowledge.

Imagine you are going in for a surgical procedure. How would you react if the doctor said to you, "Well, we need to remove this from your body. Do you think we should go through your chest or do you think we should go through your back?" How would that make you feel? You probably

would respond, "You're the expert, Doctor, why don't you know?" It is the same as asking the injured worker what they think their claim is worth or how much they want.

If the injured worker tells you what they want, which happens frequently, that is fine. You don't need to prove them wrong. You want to get back to your figure and explain why it's right, staying in your conversation (see "Carl's Corner," Winter 2019/Issue No. 1).

Q: Should we insist on getting a demand package from an attorney before we make an offer?

A. Not really. Remember, you want to stay in your conversation. If you insist on getting a demand before you make the offer, you're giving the attorney first chance of staying in their conversation. In fact, you are anchoring the beginning of the conversation in their demand.

Some attorneys are going to send you a demand package and there's nothing you can do about it. If they do, you might want to ignore their figure since you have your information and you know why you're right. You don't need a number from an attorney to get started.

What you should insist on is getting the information, the medical records, and all the documentation. You are better off without a demand amount from an attorney.

Q: Is it a good idea to tell the injured worker we have full authority to settle the case?

A. This is a great question that relates to making an "opening statement." We think it is a positive move to tell the injured worker or other party you have full authority to settle the case. You aren't telling them you have policy limits authority, and you aren't mentioning your range–you don't want to do that.

To tell them you have full authority to settle the case means they don't have to go over your head to your supervisor; they can deal with you. It means if you decide that something they say leads you to believe you shouldn't even make them an offer, you can make that decision. It means if you decide after you make an offer that you want to rescind it, you have the authority to do that. This autonomy is all positive.

Q: Do you think people might get annoyed if I ask them "why" if they don't accept my offer?

A. Most people want to be understood. It is very hard to understand where people are coming from if you don't at least ask them why. The key is asking with a positive tone. Most customers will appreciate the fact that you asked them "why." That's your trigger to demonstrate you understand their point of view.

Q: Is it a good idea to tell people I have 20 years' experience?

A. The point of telling them this information is to reassure them. You might say, "I've been doing this for over 20 years and I'm going to do what I can to make sure you are fairly compensated." You would not use your years of experience to "pull rank," as in, "I've been doing this for over 20 years so what do you know?" Use your experience to build trust, not to attack or demean people.

Q: Should I tell people my main goal is to pay only what we owe?

A. Perhaps, but not in those words. So many injured workers start off thinking our main goal is to cheat them. We should let them know, "My main goal is to make sure you are fairly compensated." Why? Because if you have done a thorough job of showing them you've done the leg work and you've done your homework in the case, they may just believe the statement that your goal is to make sure they are fairly compensated. This builds trust, and they may just trust your figures.

Q: If I get an outrageously high demand from an attorney, do I respond with a real lowball offer?

A. That's easy – the answer is no. You're the claims professional and you have a fiduciary duty to treat people right. Even if the injured worker is represented, they are still a customer and you have to do the right thing. The best thing to do is treat it as if it's not a real demand and just begin your offer like you were going to do anyway.

Carl is President and CEO of International Insurance Institute, an international training company. Mr. Van is an instructor, author, and conference speaker. He is the dean of the School of Performance, produces an educational magazine and conference, and owns an Executive Management Academy. For fun, he writes songs that he performs with the Awesome Adjuster Band. He can be reached at carlvan@insuranceinstitute.com.

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ORANGE COUNTY
714.543.9090
tkinsey@srtklaw.com

SAN JOSE
408.224.2689
kroberts@srtklaw.com

SAN DIEGO
858.678.9448
kdyess@srtklaw.com

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

SAN FERNANDO VALLEY
818.436.0170
ahemmings@srtklaw.com

CENTRAL COAST
805.654.0256
ahemmings@srtklaw.com