Return-to-work challenges during a recession Page 7

Workers' comp drug tests raise costs Page 8

Doctors filling prescriptions in the office Page 3

Fall 2012

Workers' Compensation and Disability Management News

PYRAMID

An Inside Look at Telephonic, Field, and Vocational Case Management
Page 14

The VA Faces a Backlog of Cases from Returning Troops
Page 12

SSDI Rolls Increase under Obama Administration
Page 4

GENEX®
Solving the Cost/Care Equation

A Message from Peter Madeja, President and CEO, GENEX Services, Inc.

Welcome to the Fall 2012 edition of the GENEX *Pyramid* publication.

In the current economic and business environment, it seems that uncertainty is more often the rule rather than the exception. Companies often cite this uncertainty as one of the reasons behind an inability or unwillingness to make additional investments in their businesses.

Over the course of GENEX's near thirty-five year history, we have found that continuing to invest for both the short- and long-term, and during weak and strong economic periods has paid dividends for our clients and our company.

Consistent with this practice, this year we introduced our Case Manager Scholarship Program. With more than 1,500 case managers, supervisors, and managers employed at GENEX, we have a high degree of certainty that recognizing the importance of supporting students and the schools educating the next generation of nurses and case managers will be beneficial for the future of our industry.

Through programs such as this, which you can read more about in this issue of *Pyramid*, GENEX continues to extend our leadership role in the industry and demonstrate our conviction that investing today will reap benefits for tomorrow.

Best regards,

Peter C. Madeja

Peter C. Madeja

PYRAMID

A news magazine for GENEX clients

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Study Says Doctors Increasingly Fill Prescriptions

By David Sell, Inquirer Staff Writer

JULY 20, 2012—Doctors are increasingly filling—and not just writing—prescriptions for workman's compensation patients in Pennsylvania and New Jersey, sometimes getting paid much more per pill than a pharmacy, according to a study to be released Thursday by a research group funded by insurers and state governments.

The Workers Compensation Research Institute, based in Cambridge, Mass., studied nearly 5.7 million prescriptions paid under workers' compensation for about 758,000 claims from 2007 to 2011 in 23 states, including Pennsylvania and New Jersey.

Not every doctor fills the prescriptions she or he writes. Some federal laws limit the ability of doctors to fill and directly profit from the prescriptions for drugs or tests. New York, Massachusetts and Texas prohibit the practice.

In Pennsylvania, 20 percent of the prescriptions for patients filing workman's compensation claims were filled by a doctor, up from the 17 percent over a three-year period used in the study. The percentage of payments to doctors for prescriptions rose from 15 percent to 27 percent during the same period.

In New Jersey, the prescriptions written by doctors rose from 11 percent to 18 percent, while the payments rose from 10 percent to 12 percent.

The study found that prices paid to doctors for certain drugs—some painkillers, some not—were higher than those paid to pharmacies, both retail and mail order.

"We rarely see a medical cost driver that has grown this rapidly," Dr. Richard Victor, WCRI's executive director said in a statement.

The New York Times recently reported that some distributors help some doctors set up pharmacies within offices, buy drugs in bulk and then repackage them. Repackaging has allowed those distributors and doctors to claim a higher reimbursement price than pharmacies get, though several states, notably California, have closed that loophole.

Greater focus on controlling health-care costs means that various sectors, public and private, are contesting how others make money or pay bills.

The WCRI insists that its research is independent, though the organization gets about 55 percent of its funding from insurance companies and about 20 percent from state governments, including Pennsylvania and New Jersey.

WCRI has been criticized by workers' compensation attorneys. The American Medical Association, which represents doctors, has a general policy that says, "Our AMA supports the physician's right to dispense drugs and devices when it is in the best interest of the patient and consistent with AMA's ethical guidelines."

Disabled America: 5.4 Million Join Social Security Disability Insurance Rolls Under Obama

***By John Merline,* Investor's Business Daily**

APRIL 20, 2012—A record 5.4 million workers and their dependents have signed up to collect federal disability checks since President Obama took office, according to the latest official government data, as discouraged workers increasingly give up looking for jobs and take advantage of the federal program.

This is straining already-stretched government finances while posing a long-term economic threat by creating an ever-growing pool of permanently dependent working-age Americans.

Since the recession ended in June 2009, the number of new enrollees to Social Security's disability insurance program is twice the job growth figure. (See chart on opposite page.) In just the first four months of this year, 539,000 joined the disability rolls and more than 725,000 put in applications.

As a result, by April there were a total of 10.8 million people on disability, according to Social Security Administration data released this week. Even after accounting for all those who've left the program—about 700,000 drop out each year, mainly because they hit retirement age or died—that's up 53% from a decade ago.

To be sure, disability rolls have grown steadily as a share of the workforce since the 1990s (see chart on opposite page).

The main causes of this broader trend, according to a study by economists David Autor and Mark Duggan, are the loosening of eligibility rules by Congress in 1984, the rise in disability benefits relative to wages, and the fact that more women have entered the workforce, making them eligible for disability.

Their research found that the aging of the population has contributed only modestly to the program's growth.

But the big factor in the recent surge is the slow pace of the economic recovery after the severe recession. That has kept the unemployment rate above 8% and created an enormous pool of long-term unemployed and discouraged workers. More than 5 million people have been jobless for 27 weeks or more, nearly twice the previous high set in 1983, according to the Bureau of Labor Statistics.

"We see a lot of people applying for disability once their unemployment insurance expires," said Matthew Rutledge, a research economist at Boston College's Center for Retirement Research.

The number of applications last year was up 24% compared with 2008, Social Security Administration data show.

As the Congressional Budget Office explained: "When opportunities for employment are plentiful, some people who could quality for (disability insurance) benefits find working more attractive...when employment opportunities are scarce, some of these people participate in the DI program instead."

The explosive growth in disability enrollment also "helps explain some of the drop in the labor force participation rate," noted economist Ed Yardeni on his blog.

In fact, the participation rate—the share of working-age people who have or are looking for a job—has fallen to 63.8%

compared with 65.7% at the start of Obama's term.

Ironically, this drives down the unemployment rate, which simply measures how many people are looking for work but haven't been able to find it. When people quit looking or sign up for disability benefits, they no longer count as unemployed.

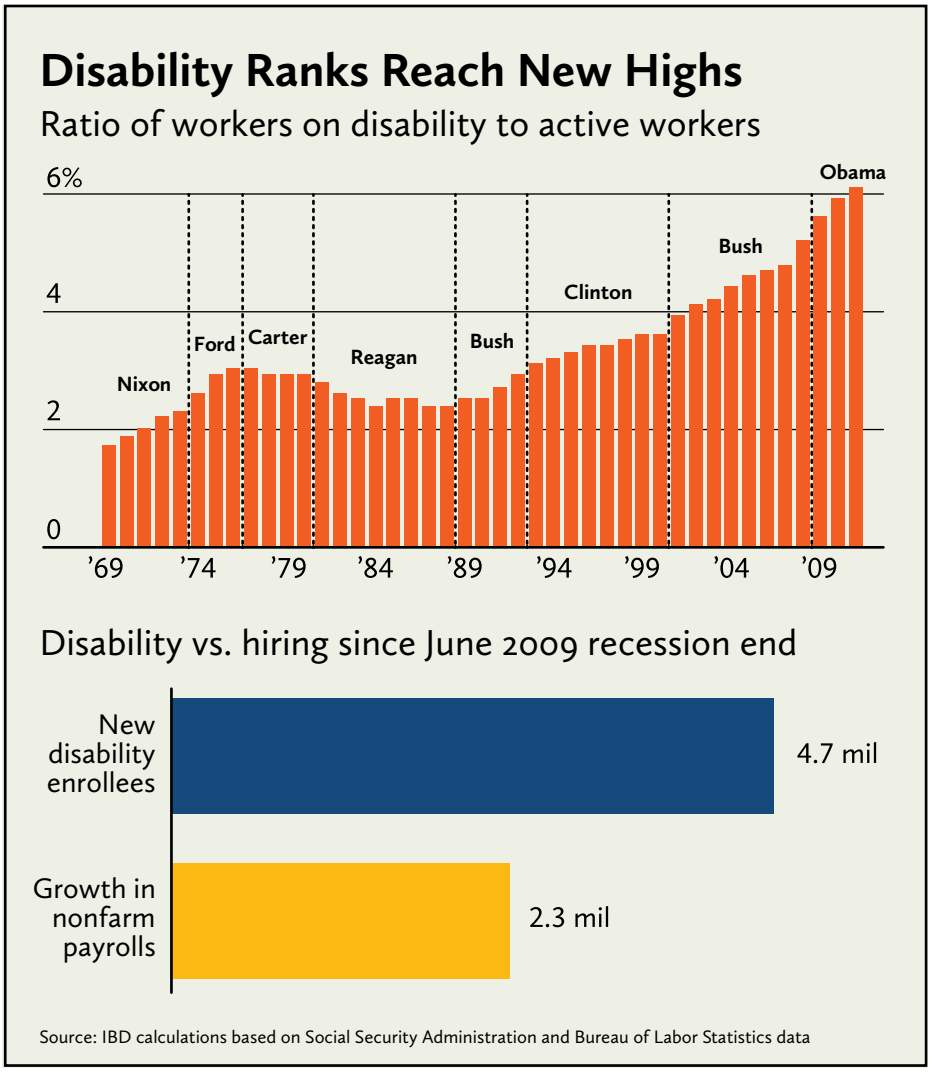
The problem is that few people who get on disability will ever participate in the labor force again. In fact, the vast bulk of those who exit Social Security Disability Insurance do so either because they hit retirement age or died.

As a result, the swelling ranks of the disabled can become a drag on the economy.

A White House report late last year noted that because "workers on SSDI rarely return to the labor force," this can result "in a loss to society of the economic contribution those workers could have made."

What's more, the explosive growth in enrollment is not only increasing the financial strain on the Social Security Disability Insurance trust fund—which is scheduled to go bankrupt in 2018—it's boosting costs for Medicare as well, since SSDI enrollees can qualify for Medicare after two years. SSDI now accounts for more than 16% of Social Security's budget and more than 15% of Medicare's.

Reform ideas that would cut the ranks of those on disability have been bandied about for years. They include tightening eligibility rules, giving workers more options other than full-time disability and offering tax incentives for disabled workers to stay in the workforce.



The reforms so far have spurred little action. But with the program's bankruptcy looming just a few years off, and with the economy showing no signs of producing a surge in jobs, that indifference to reform may soon have to change.

GENEX
Solving the Cost/Care Equation

GENEX Medical Case Management Programs

At GENEX, we want injured workers to have the best chance to achieve maximum recovery goals. And the best chance for optimal results—medical, functional, and financial—occurs when the right people are on the scene, fast. What we do and how we do it makes a difference that can be measured not just in dollars, but also in people's lives.

Telephonic Case Management

Early intervention is critical when it comes to addressing your injured workers. GENEX's Telephonic Case Management nurse reviewers immediately begin managing the claim, accurately identify the appropriate medical intervention, manage cost-effective treatment, and return the injured employee to work at the earliest opportunity.

Field Case Management

Some injured workers require more direct case management to expedite their recovery and return to work. Once referred, each case is immediately assessed and a plan is developed to return the injured worker to optimal functional capacity, saving you money on premiums.

Vocational Case Management

Reduce your wage loss replacement exposure with GENEX Vocational Case Management Services. From vocational assessment to job placement, our goal is to help disabled workers attain sufficient work skills to compete successfully in the labor market and to return to suitable, gainful employment.

Catastrophic Case Management

Our Catastrophic Case Management program gives seriously injured employees the absolute best chance to return to work or achieve maximum functional independence. And, the higher the functional independence achieved, the lower the lifetime costs for the employer or payor.

It's Time to Talk to GENEX!

Contact us at 888.GO.GENEX or genexservices.com

Return-to-Work Challenges

As the economy recovers from recession, employers may still face challenges in their return-to-work programs.

By Mark Noonan

During the recession, inadequate attention has been given to the burdens the economy places on injured workers and the employer work programs that are trying to assist them. Saving money in their workers' compensation programs while finding transitional positions for those returning to work is a challenge for employers. How do you find restricted duty for a returning employee when full-time, full-duty employees are being laid off or having their hours reduced? How do you effectively manage costs while maintaining a return-to-work program?

Economy's Influence

Employment rates tend to rebound much later than the economy itself. Disability benefits seem to have a slow rebound as well. The National Council on Compensation Insurance reports that workers' compensation payers are funding temporary total disability benefits longer than before—likely due to the recession and less return-to-work opportunities.

As injured employees recover at home, they may worry about the end of their recovery period and an end to their disability benefits—a likely incentive not to get well and rush back to work. It may also encourage family members of the injured employee to get medical issues taken care of before they may lose benefits.

The economy is not the only factor influencing the actions of injured employees. With a reduction in the workforce, there is more work to be done by fewer people and those still working may be too concerned that their jobs could be eliminated to report injuries. Others may not report minor injuries because of the fear of being replaced. Employees are likely working beyond full capacity within their work schedules and are unable to pick up the work of a co-worker out on disability.

The economy and unemployment rates had led to a reduction in workers' compensation claims, but it has also contributed to a drop in funding for return-to-work programs—a short-term reaction that will cost employers more money in the long run. In 2010, the frequency of workplace injuries increased 3 percent according to NCCI. That's the first time in almost 20 years.

Failure to return injured workers to work when they become available for restricted duty costs employers in experience, quality product/service, and the costs associated with longer benefit periods. Morale can also be damaged.

Financial Benefits

Employers seeking to cut workers' compensation expenses may cut or delay their return-to-work programs. Instead, employers should note that a strong return-to-work program improves business by saving them money over time. The longer an injured employee is out on disability leave, the higher the cost to the employer. It affects claim reserves, raises claim severity, and can also increase the possibility of litigation. It is important, even when a company's bottom line is being influenced by the economy, for employers to implement and/or continue with their return-to-work programs.

The longer injured workers are away from the workplace, the less likely they are to return. Quick, proactive steps must be taken. Good communication ensures that the employee understands the benefits of returning to work. Early return has mutual benefits: a long-term recovery for the employee and a reduced long-term absence for the employer. A successful return-to-work program will transition an employee back into their job with responsibilities and tasks modified for short periods of time. Insisting on returning to full duty, however, can increase an employer's workers' compensation costs. Long-term injuries and illnesses often result in reduced mental and physical fitness; the worker is not prepared for going back to work. A gradual return to work will build their work stamina and improve the chances of them returning and remaining at full duty.

That doesn't mean sacrificing working employees to allow injured employees to return. Eliminate "make work" positions and focus on work that needs to be done for the facility to work at peak efficiency. Keeping skilled and experienced workers for the next upturn is an investment. Having to replace and re-train employees when business grows is more expensive in time, quality and money. There is no easy answer but employers must measure the impact as they make decisions. Helping to return injured employees to work as quickly and safely as possible is the best outcome for all involved.

Next Step for Employers

A properly implemented and successfully managed return-to-work program is prosperous and proven business strategy, no matter the state of the economy. They get the injured worker back to work while reducing overall costs. A long-term absence debilitates the injured worker as well as a company's bottom line.

Workers' Compensation Drug Tests Raise Costs, Questions

***By Roberto Ceniceros,* Business Insurance**

Amid increasing nationwide demand for drug testing to ensure workers compensation claimants comply with prescribed narcotic regimens and don't misuse their medications, questions are surfacing about the testing industry's business practices and ethics.

The recent questions raised by workers comp experts about the urine and blood testing laboratories are ones that employers seeking their services also should be asking, observers say.

Drug-testing companies provide their services through medical providers, including those treating workers compensation patients who are prescribed narcotics because of the nature of work-related injuries, sources said.

But the Oakland-based California Workers' Compensation Institute is expected to release results as early as this week from a study seeking to answer whether skyrocketing demand for drug testing is a new workers compensation system "cost driver," said Alex Swedlow, CWCI's executive vp-research.

"The level of utilization and costs (of drug testing) have been increasing at a viral-like rate," Mr. Swedlow said. "The preliminary numbers that we are seeing validate that the number of tests and dollars spent on these tests are growing at a very, very significant rate."

Meanwhile, the workers comp system lacks protocols for the testing of narcotics, Mr. Swedlow said. "There is no guideline, no acceptable standard, no rationale for when and how and what to test for," he said.

But drug-testing companies and other testing advocates say prescription-compliance monitoring helps assure that patients in and out of the work compensation system consume addictive pain medications as prescribed for them rather than divert them into the black market.

Testing also helps discourage drug misuse or abuse, such as doctor shopping for multiple prescriptions, and is a "best practice" to ensure patients' well-being, they say.

"Monitoring these medications through urine drug testing is part of the clinical guidelines recommended by the American College of Occupational and Environmental Medicine and Official Disability Guidelines," among other organizations that develop practice guidelines, said Dr. Harry Leider, chief medical officer for Baltimore, Md.-based Ameritox Ltd., a drug-testing company. Ameritox offers a program to help identify workers comp claimants who should be candidates for the testing, Dr. Leider said.

Interest in claimant drug-testing services among insurers, third-party administrators, managed care companies and self-insured employers has grown within the past two years as they seek to determine which claimants might benefit from the testing, said Jennifer Kaburick, director of workers comp product management for St. Louis-based Express Scripts Inc.

"We see (that) discussed more frequently," Ms. Kaburick said. "Our clients discuss it with us as a tactic they are using to help control and manage the use of narcotics. It's an opportunity for them to validate that either the person is taking the medication at dosages that are being prescribed or they are not."

> "WE WANT (PARTNERS WITH) A CLEAN AND DEFENSIBLE AND FULLY TRANSPARENT BUSINESS MODEL."
>
> *Ron Skrocki, GENEX Services*

Payers can then use that information in discussions with claimants' doctors, Ms. Kaburick said.

Interest in testing injured workers for drug-regimen compliance has followed in the wake of U.S. government reports released in the past year about skyrocketing pain-medication use and abuse among the nation's population.

Ironically, while those reports focus on prescription use among the general population, narcotics have been commonly prescribed for injured workers for years because workplace accidents often cause painful injuries, Ms. Kaburick said.

Some payers also have grown interested in prescription-compliance monitoring because narcotics account for a substantial portion of workers comp medical expenses, sources said.

Simultaneously, more companies are entering the drug-testing field, and more drug-testing labs are seeking to service the workers comp industry.

"They have certainly marched into comp and said, "Our services are needed here and underutilized and how can we

grow our business through the comp channel?'" said Ron Skrocki, vp of product management and development for GENEX Services Inc., a Wayne, Pa.-based case-management company.

But some major testing laboratories are themselves raising questions about industry practices in lawsuits against one another. Ameritox Ltd. and San Diego-based Millennium Laboratories Inc., for example, are enmeshed in lawsuits against each other over issues such as their use of science, ethics questions, and business practices used to attract doctors' business.

Some labs have provided doctors with revenue for patient referrals, while others have coached doctors on how to increase their revenue with schemes such as "up-coding" billing practices, sources said.

Such practices have led GENEX to question several lab companies about their business models, ethics, and strategies for attracting new business, said Mr. Skrocki. The vetting has been part of GENEX's search for potential business partners. "We want (partners with) a clean and defensible and fully transparent business model," Mr. Skrocki said.

GENEX also has questioned labs about their workers compensation expertise, their service quality, their technological abilities and their scientific approaches.

"That has been interesting for us, to assess what they say they have against what they (actually) have," Mr. Skrocki said.

Employers seeking the services of drug-testing labs will want to raise similar questions, he said.

"Any of that is something you need to make sure of if you are looking at any of these companies," Mr. Skrocki said.

Calcaneus Fractures

CLINICAL PERSPECTIVE

By Justin M. Weatherall, MD
Foot and Ankle Orthopedic Surgeon
Broward Orthopedic Specialists

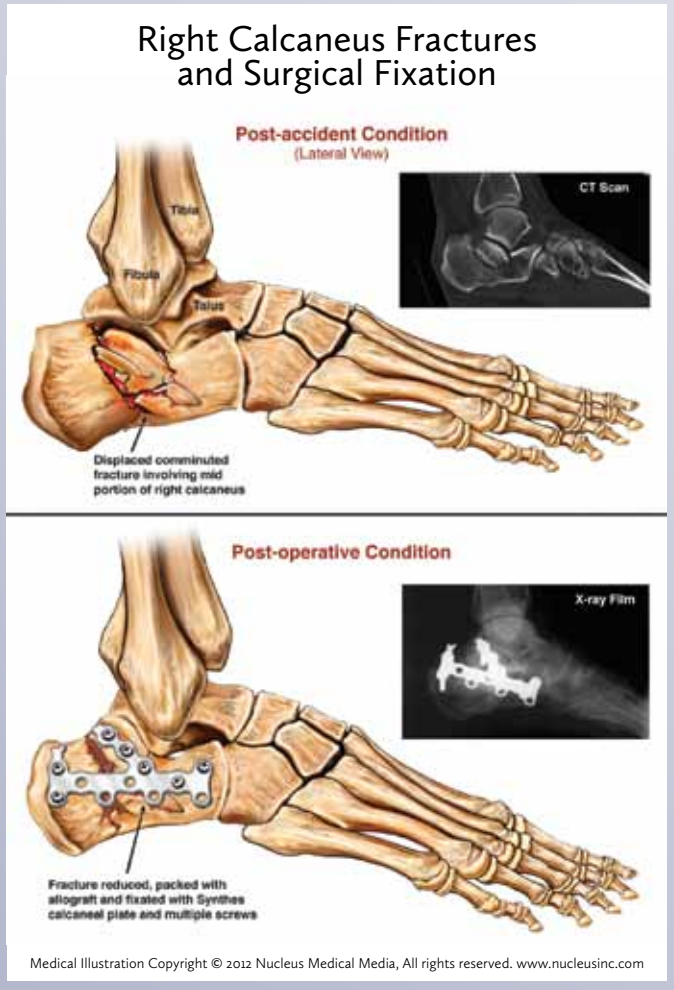
GENEX® CHOICE PROVIDER NETWORK

Fractures of the calcaneus account for approximately two percent of all fractures, and 90% of calcaneal fractures occur in men of working age. Industrial workers make up the majority of calcaneal fractures in workers. A displaced intra-articular calcaneus fracture occurs in 60–75% of fractures, and these fractures may lead to the development of arthritis in the subtalar joint.

The calcaneus is the largest bone in the foot, and it articulates with the talus superiorly and the cuboid distally. The joint between the calcaneus and the talus (aka subtalar joint) is composed of three separate articular facets. They are referred to as the posterior, middle, and anterior facet. The posterior facet is the largest of the three and is the facet most commonly involved in intra-articular calcaneal fractures. The calcaneal tuberosity is on the posterior aspect of the calcaneus, and occasionally fractures of the tuberosity may be a surgical urgency if the displaced bone fragment is pushing on the skin. Fractures of the anterior process of the calcaneus may occur by a twisting injury to the foot and often heal uneventfully. A small percentage of anterior process fractures will require surgery, which typically involves excision of the fracture fragment.

The typical mechanism of calcaneal fractures is a fall from a height with the patient landing on their feet. The denser talus is driven into the calcaneus by the patient's body weight. This pile driver effect causes the calcaneus to occasionally be crushed into multiple fragments and causes widening of the heel due to the bony fragments being pushed apart by the talus occupying their prior location. The posterior facet of the subtalar joint may be fractured in multiple places. In these situations the patient should be told that they have a high risk of developing subtalar arthritis even with surgical treatment. Almost all patients will notice a loss in the range of motion of their subtalar joint after a calcaneus fracture. The subtalar joint helps the foot accommodate to uneven surfaces.

Severe soft tissue injuries may occur with calcaneal fractures and the treating surgeon will have to monitor the patient's skin closely in these situations. The treating surgeon may need to delay surgery until the patient's soft tissues have healed to a point where they can tolerate surgery to minimize post-operative wound healing complications. With high energy mechanisms associated with significant soft tissue injury, a patient may develop a compartment syndrome in the foot, which long term may cause the patient to develop claw toes and sensory deficits in the foot. It is not uncommon for a patient to develop blisters around the heel and foot after sustaining a calcaneus fracture. Multiple treatments have been described for treating the blisters, from leaving them alone, to unroofing them and applying a silver sulfadiazine cream. Open fractures (aka compound fractures) may occur and are treated as a surgical urgency.



Calcaneus fractures may be associated with other injuries such as lumbar spine fractures and other lower extremity fractures. It has been reported that 10% of patients with a calcaneus fracture had a lumbar spine fracture and 25% had an associated lower extremity injury. The peroneal tendons may occasionally be injured due to their location along the lateral wall of the calcaneus. A thorough physical exam of the legs and spine is critical in the initial evaluation of these patients.

The initial radiographic evaluation includes dedicated x-rays of the foot and ankle with a Harris axial view of the heel. A CT scan with sagittal and coronal recon images may be necessary to fully appreciate the severity of the fracture, determine treatment, and for surgical planning.

Historically, calcaneus fractures were treated non-operatively by placing patients in a cast and instructing them to remain non-weight bearing for a period of two to three months. More recently, due to improvements in surgical techniques, combined with the appreciation of the consequences of untreated severe calcaneus fractures, more and more patients have been undergoing surgery to treat calcaneus fractures. The need for surgery is determined by the patient's specific fracture pattern. Patients with non-displaced fractures may be treated non-operatively with a short leg cast or a removable boot and period of non-weight bearing. In cases with a displaced intra-articular fracture, loss of calcaneal height, or significant widening of the heel, surgery may be indicated to restore the bony anatomy. Even with anatomic restoration of the bony anatomy, the patient should be told that they may develop symptomatic arthritis of the subtalar or calcaneocuboid joints. In cases of severe intra-articular fractures, the surgeon may elect to perform a fusion of the subtalar joint knowing that the patient will most likely develop significant arthritis of the joint in the future.

Post-operatively, the patient will be immobilized in a splint, cast, or removable boot and will be non-weight-bearing for six to twelve weeks. In the initial post-operative period, DVT prophylaxis may be required while the patient is immobilized. Patients are followed clinically and radiographically until the fracture has healed. It may take six to nine months until the patient has reached maximal improvement.

Calcaneus fractures can be a severe and disabling injury that can lead to permanent impairment of the patient's foot. Occasionally these injuries will require multiple surgeries including the initial fracture fixation, removing painful hardware, performing fusion of an arthritic subtalar joint, or correcting a painful malunion of the calcaneus. Since these fractures often occur in individuals in the prime of their careers, they can have a large economic impact.

The VA Backlog Keeps Getting Worse

Wounded troops come home from war only to wait years for the help they need

By William Selway, Bloomberg News

Like most politicians trolling for votes, Barack Obama and Mitt Romney rarely miss an opportunity to praise America's veterans, particularly the troops returning home from Iraq and Afghanistan. Here's Romney on May 2: "We are united as one nation in our gratitude to our country's heroes." And Obama on Memorial Day: "As long as I'm president, we will make sure you and your loved ones will receive the benefits you've earned and the respect you deserve. America will be there for you."

That's not the way it's worked for Hector Esparza. A former Army sergeant, Esparza was a gunner escorting convoys to Baghdad during the bloodiest days of the Iraq war. In 2004 he suffered a brain injury when a rocket blew up his Humvee. Now home in Killeen, Tex., he's unable to work due to debilitating headaches and post-traumatic stress disorder. Yet the U.S. Department of Veterans Affairs designated him only 60 percent disabled, which means he and his wife and 6-year-old daughter live on $1,200 a month from the VA. Since 2009, Esparza has been trying to qualify for full disability. In April he received a letter from the agency: With so many claims piling up, it could take another six months before anyone reviews his case. "I was pretty confident that I was going to be taken care of and my family was going to be taken care of," he says. "I feel lied to and disappointed because I don't see that happening."

Esparza is one of hundreds of thousands of former soldiers suffering the effects of a VA overwhelmed by a decade of fighting overseas. With the Iraq war finished and troops returning from Afghanistan, record numbers of wounded former service members are turning to the federal government for disability pay. Over the past four years the number of disability cases filed with the VA jumped 48 percent, to 1.3 million in 2011.

The agency expects the demand from wounded vets to rise as more leave the military. When Obama took office in 2009, Veterans Affairs Secretary Eric Shinseki set a goal of resolving disability claims within 125 days, with 98 percent accuracy. Since then the backlog has only grown, and errors have gone up. Currently about 905,000 claims are awaiting action. According to government figures released in May, 65 percent took longer than four months to resolve—often many months or years longer. "The government is just not fulfilling their promises," says David Autry of Disabled American Veterans, an advocacy group that helps former service members tangle with the VA.

Allison Hickey, the department's under secretary for benefits, says the agency is trying to speed up its work. It's testing computer record keeping at 16 of its 56 regional offices—incredibly, the VA still relies mostly on paper files—and the administration has asked Congress for $128 million more to extend the system to the rest of the country next year. The agency has also hired more workers in the office that reviews claims: There are now 14,320, up some 4,000 from 2008, the VA says.

Despite its rapid growth, the agency still can't keep up. In May the department's inspector general issued a report scolding its poor management. At offices in San Diego, Oakland, and Los Angeles, as many as 60 percent of disability claims were processed incorrectly. One had been awaiting action for more than eight years. On May 17, California's congressional delegation wrote to Shinseki asking him to take "immediate and concrete" steps to cut down on the errors and wait times.

It's not clear exactly what that would mean. The VA has more money and more employees than ever. What's lacking is political pressure to hold it accountable. Romney has criti-

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14,320

workers in the VA office that handles claims.

16 out of 56

VA offices are testing computer record keeping.

cized Obama's military policy but has largely been quiet about the shabby treatment many vets receive when they come home—and hasn't said what, if anything, he'd do to fix it. In his three and a half years in office, Obama has increased the VA's budget but hasn't made improving the agency's dismal performance a priority, except in campaign speeches. "You know, standing up for our veterans, this is not a Democratic responsibility, it's not a Republican responsibility; it's an American responsibility," he told a crowd in Minnesota on June 1. "It's an obligation of every citizen who enjoys the freedom that these heroes defended."

Back in Texas, Hector Esparza and his family wait for Washington to live up to that sentiment. "I feel like they're better off without me, like I'm holding them back," he says. "And even though my wife says she's happy, I know that somebody else could take better care of her financially than I could. I don't want another family going through what I went through."

Congratulations to GENEX's Mariellen Blue

Mariellen Blue, national director of GENEX's case management services and quality assurance programs, was awarded an honorable mention in Dorland Health's Case In Point Platinum Awards in May. The program recognizes the most successful case management and care coordination programs and individuals working to improve the healthcare system.

Mariellen was nominated in the Case Care Manager–Leadership category by one of her team members. She was instrumental in integration efforts when GENEX acquired Intracorp's workers' compensation and disability case management business in 2011. She also manages the GENEX national quality assurance program for case management and utilization management, and was one of the key business designers of the GENEX internet-based case management system.

Congratulations to Mariellen!

LEGISLATIVE UPDATE

ICD-10

The U.S. Department of Health and Human Services has made final a one-year proposed delay — from October 1, 2013, to October 1, 2014 — in the compliance date for use of new codes that classify diseases and health problems. These code sets, known as the International Classification of Diseases, 10th Edition diagnosis and procedure codes, or ICD-10, will include codes for new procedures and diagnoses that improve the quality of information available for quality improvement and payment purposes.

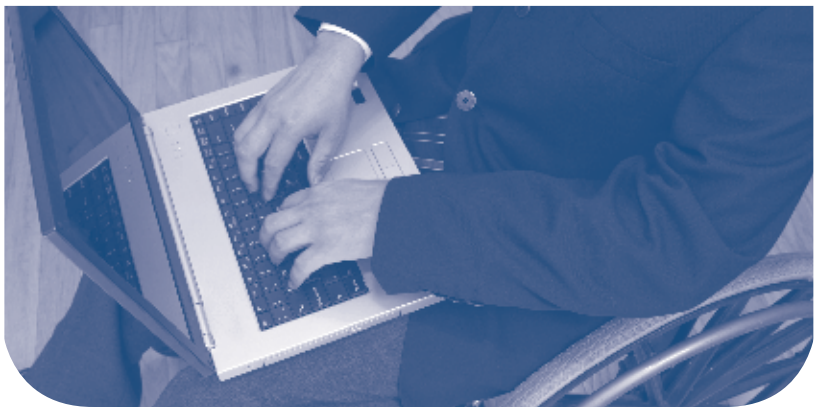
For more information on ICD-10, go to: https://www.cms.gov/Medicare/Coding/ICD10/

CMS Removes Coverage of TENS Units for Chronic Low Back Pain

On June 8, 2012, CMS released a Decision Memo that addressed conditions for coverage of a Transcutaneous Electrical Nerve Stimulation (TENS) unit for chronic low back pain (CLBP) on Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) proposals.

The CMS Decision Memo defined CLBP as "an episode of low back pain that has persisted for three months or longer; and is not a manifestation of a clearly defined and generally recognizable primary disease entity." The Decision Memo also stated that a TENS unit is not reasonable and necessary for the treatment of CLBP, in accordance with the provisions of section 1862(a)(1)(A) of the Social Security Act.

This Decision Memo may be viewed in its entirety at http://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=256.



Telephonic, Field, and Vocational Case Management: *An Inside Look*

In the Spring 2012 edition, we featured an article on GENEX's Catastrophic Case Management, and how our case managers handle severe and tragic injuries. In this issue, we highlight Telephonic, Field, and Vocational Case Management, and learn how these services are crucial to employers who seek to have their injured employees return to work in a safe and expedient manner.

By Michele Ritchie, Marketing Communications Manager, GENEX Services

Early Intervention with Telephonic and Field Case Management

Slipping on a wet floor, falling off scaffolding, and construction accidents are just some of the typical injuries that occur when people are at work. But what happens after an employee suffers a non-life-threatening injury in the workplace? Early intervention comes into play, and there are several factors that determine whether a claimant will be referred to either Telephonic or Field Case Management.

Telephonic Case Management (TCM) and Field Case Management (FCM) are the first interfaces between the claimant, the doctor, and the employer. Part of the case manager's job is to interpret the information for the adjuster. They need to coordinate with the employer, the claimant, and the doctor, and try to resolve the case to get the employee safely back to work and back to his/her pre-injury condition.

A referral often starts with a triage point. Here is an example:

- Claimant slips and falls at work. He reports this to his employer.
- The employer reports the incident to GENEX and the insurance carrier.
- A GENEX case manager follows up with the employer to find out if the employee is still working, or if he needs to be channeled to care.
- Does he need stitches or have a sprain? If so, he will be back at work.

- Is it a back, shoulder, or knee injury? If so, the case manager may direct care to a network provider and will recommend follow-up to coordinate care and return to work.

If it is determined that follow-up is required, then there is a three-point contact:

- **To the injured person**

  The case manager introduces herself and her role, gives the names of the doctor, and explains the process of getting the appropriate care, as well as the follow-up.

- **To the doctor**

  The case manager requests the notes and work slip, and lets the doctor know she will be in contact. She makes the appropriate referrals and may set up the appointment for a specialist, imaging, or therapy.

- **To the employer**

  The case manager follows up with the employer to obtain the job description and discuss the availability of light duty.

Once these steps are complete, the adjuster receives a copy of the notes. For every follow-up appointment, the three-point contact is made and the adjuster is notified.

Telephonic Case Management

"Telephonic Case Management is an early intervention program that is most effective when used at the onset of injury, within the first 90 days," said Helene Glazer, Telephonic Case Management Account Lead at GENEX.

"When a referral comes in, the case manager gathers details about the injury, finds out what the goals are, and contacts the claimant and provider. She coordinates a discussion with everyone to get the employee to the appropriate treatment and back to work as soon as possible," said Glazer.

In TCM, all of the coordinating is done on the phone and via email. The case manager has to type and talk at the same time, often handling 45-50 calls on any given day. A triage case may be open 1-2 weeks, whereas case management cases may be open 90 days to several years.

When a telephonic case manager receives a call, it needs to be handled immediately. Glazer said that her case managers have specific work hours, and that once they are done their day, they are done. They do not take work home with them or use laptops.

"You have to deal with the calls as they come in, and document everything when you are on the phone," she said. Learning how to juggle the calls and deal with interruptions during the day is also one of the challenges of a telephonic case manager.

Examples of cases that may be considered appropriate for TCM include musculoskeletal injuries such as sprains/strains, fractures, and dislocations; burns; lacerations; spinal injuries; repetitive use; and psychological and stress claims.

Out in the Field

FCM is different than TCM in that the case managers work out of their homes. Glazer said that they can make their own schedule, because they need to have the flexibility to go to doctor appointments with claimants, and travel to the claimant's home when necessary. They will often make phone calls and update their case notes in the evening and while on the road.

They are an important resource for the injured worker, who may be intimidated by doctors and not know the right questions to ask. By going to the doctor's appointment with the claimant, the case manager can also keep things moving along, and be an advocate for the claimant.

The field case manager may also meet with the employer to determine if they have light-duty work available until the employee is ready to go back to full-duty work.

There can be a fine line between whether a case is referred to TCM or FCM, and the adjuster usually makes the determination. However, some employers set the criteria for what gets referred to TCM or FCM. Some examples of cases referred to FCM can include:

- Does the claimant need to see multiple providers?
- Is the doctor being non-responsive?
- Is the case considered catastrophic?
- The doctor's treatment plan is contrary to Official Disability Guidelines and the length of disability is beyond the benchmarking.

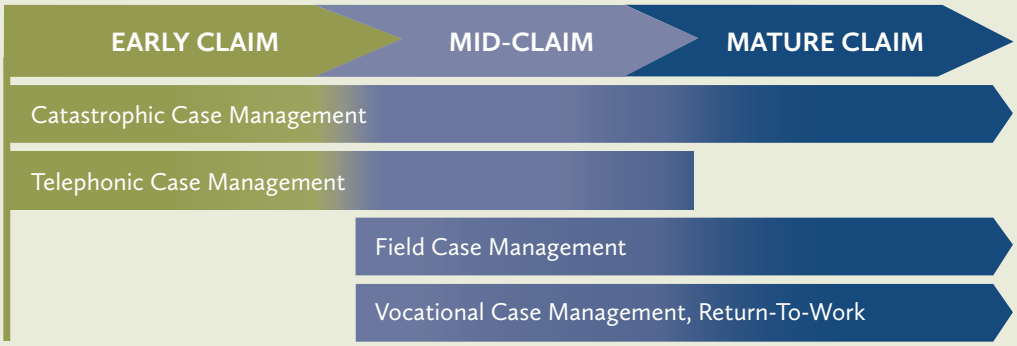
Occasionally, a field case manager will be called upon to visit an injured person, even though the case may be managed telephonically. This is known as an FCM task. Glazer recalled a case where a store manager was on a president's club trip with her company. She slipped and badly fractured her ankle at the resort where they were staying. She had surgery in the emergency room in a Jamaican hospital and was sent home. Once she arrived home, she had to have corrective surgery. After the surgeries and release to home, she kept getting infections, and consequently, more surgery to clear out the infected tissue, along with courses of antibiotics. Because of all the complications, GENEX sent a field case manager to the house, and found that she lived with her parents. They discovered that her father was a diabetic with chronic foot infections and he did not practice the best hygiene. There was potential for contamination in the bathroom/shower, rugs, and ottomans that she used to elevate her foot. The field case manager educated her family on hygiene that better protected her and her father. She was ultimately released back to work after a year of infections and surgeries.

Progression to Wellness, or Not

Most of the time, the injured person progresses to discharge and successfully returns to work. However, sometimes, things can become challenging. Such as when the claimant keeps making excuses to not go to the doctor or to therapy, or will not respond to the case manager.

Claim Life Cycle

Different types of case management can come into play at different stages of the claim. This graph shows the most likely scenarios of claim handling.



"We follow evidence-based guidelines, so we know when a claimant should be hitting certain milestones in their recovery. If we don't get responses from the doctor or the injured person, a field case manager will be sent out to the doctor appointment with the patient to see what is going on, and get clarification from the doctor," Glazer said. "The case manager also makes sure that the doctor understands the job description, so that the doctor can determine if the injured worker can return to work on light duty, or if they need a more aggressive treatment plan."

If the injured person is exceeding expectations of the guidelines, an Independent Medical Exam (IME) is usually requested to get an expert opinion on the situation. The IME assists in determining the compensability of a claim, the necessity of surgery, or if a pre-existing condition is relevant to the claim.

Vocational Case Management

When sick or injured employees are unable to return to work with their original employers, they are usually transferred to Vocational Case Management (VCM). "The goal is to assist injured workers in locating appropriate work so they can return to a productive life," said Gwynn Chambers, branch manager in Glen Allen, VA. "All of our vocational case managers are degreed and specialized with state and national certifications in Rehabilitation Services, which qualifies them to deal successfully with angry and/or depressed and frustrated injured workers. This is often a population which has worked in one field all of their lives and can no longer do that kind of work."

Chambers said that it can be tough placing the injured worker sometimes, because you can't expect them to take a job outside of their restrictions. "And of course, vocational rehabilitation is all about getting people back to work," Chambers said.

Chambers explained that most adjusters do not want to close the claim until the injured worker is proven to be employable, despite not being able to return to the pre-injury job, so they bring in a vocational case manager to help find the claimant another job. She said that in Virginia, the case managers work with the claimants for months, finding a job that meets his/her restrictions. Many times, the claimants have very few transferable skills, so that is what makes it sometimes difficult.

A challenging aspect of VCM is preventing and detecting claimant sabotage. "Our vocational case managers have the experience and resources to further investigate suspicious claims," said Chambers. "This helps to bring cases to resolution even quicker."

One such case involved a claimant who was very marketable. They were trying to understand why the claimant was not receiving call backs from the many job applications he submitted. The case manager discovered that the claimant was intentionally providing the wrong contact number on his job applications. The sabotage was documented and his benefits were terminated.

Success and Rewards

I asked Glazer and Chambers about the rewards of their jobs and what gets them up in the morning. "Getting people better and back to work," said Glazer. "The thrill of making the pieces work together; it's about a lot of little successes. People forget you are there to help them. You need to keep the person thinking that they are a working person with an injury and they will recover…they are NOT a disabled person."

Chambers said that there is nothing more rewarding than seeing a claimant achieve something that they thought they would never do again. "There was a case involving a young claimant who was a large animal veterinarian who became totally disabled from a back injury. His work restrictions prohibited him from returning to working with large animals, and he had many years of pain management and needed help with job placement," she said.

"After the initial assessment, the plan was to find a light duty position. The vocational case manager found a position at a local animal clinic where she volunteered, and the claimant was hired for full-time work treating abandoned dogs and cats," said Chambers.

"The best part of this triumph-over-tragedy story was that this young man, who had spent many years on pain meds for his back pain, was able to get back to a job that he loved and thought he would never do again!"

For more information on Telephonic, Field, or Vocational Case Management, contact your local GENEX representative.

GENEX Announces Inaugural Case Manager Scholarship Award Program

Good Samaritan College

Immaculata University

University of Kansas

University of North Carolina
Chapel Hill

University of Wisconsin
Madison

Pictured from Left to Right

Immaculata University

Harolyn Davis, RN, BSN, GENEX Services

Sister R. Patricia Fadden, IHM, Ed.D.,
President of Immaculata University

Debbi Bromley, GENEX Services

Michele Ritchie, GENEX Services

JB Brigati, GENEX Services

Immaculata University

By Michele Ritchie, Marketing Communications Manager, GENEX Services

On June 4, 2012, GENEX announced its inaugural Case Manager Scholarship Award Program. This program was developed to strengthen the awareness of the case management profession, and to invest in a new generation of future graduates to fill a growing industry need. The program provides $100,000 in scholarship awards to schools nominated by GENEX employees who graduated from those institutions.

The schools that received the scholarship awards for 2012 are:

- Good Samaritan College, Cincinnati, OH
- Immaculata University, Immaculata, PA
- University of Kansas, Lawrence, KS
- University of North Carolina – Chapel Hill, Chapel Hill, NC
- University of Wisconsin – Madison, Madison, WI

Each school received $20,000.

Creating the potential for new students

"As the industry leader and employing 1,500 case managers across North America, we are proud to introduce the scholarship award program," said Peter Madeja, CEO of GENEX. "It is well known that the United States faces a shortage of nurses and that the issue is expected to become more problematic in the coming years. Even in the depth of the recent recession, the demand for nurses has exceeded the available supply of both experienced nurses and new graduates from nursing programs. Through our scholarship program, GENEX will create the potential for new students to enter schools and help address these trends in the future."

The program began earlier this year with the nomination process. GENEX's case managers were asked to nominate their alma mater for a monetary donation to be used in support of the educational endeavors of their student population through scholarships.

Vice President of Human Resources, Debbi Bromley, said, "The nominations were amazing! We really had a hard time narrowing it down to five schools."

What sets these schools apart from the others?

We asked our nominating case managers for their input. Jo Anne Lile, RN, BSN, CDMS, who nominated the University of Kansas School of Nursing, said that the school views

Good Samaritan College

University of Kansas

University of Wisconsin — Madison

The University of North Carolina will be holding their check presentation sometime this fall. Therefore, no photo is available.

case management as a vital role for nurses and case management principles are included in the curricula, particularly in the advanced practice specialty areas.

Harolyn Davis, RN, BSN, nominated Immaculata University, and attended their "ACCEL RN to BSN" program. "The focus on the holistic assessment and implementation of the patient, and the ability to now see the patient as an individual is what sets Immaculata apart from others. This holistic approach to patient care allows the individual to be viewed as flesh and blood; not to be defined as information on a plain, flat report sheet."

One aspect repeatedly mentioned was how prepared the nurses were once they landed in their chosen fields. Emily Veith, MS, CRC, LPC, stated, "My academic pursuits at the University of Wisconsin Rehabilitation Psychology Program trained me exceptionally well to work with the complex array of clients referred to me at GENEX for the last seven years. It also exposed me to areas of rehabilitation that I need to be knowledgeable about in order to best serve my clients."

Angie Herpich, CRC, CCM, echoed those thoughts about her experience at University of North Carolina – Chapel Hill. "The program at UNC is unique in its track options, as all graduate students are extensively trained in the foundational skills. Having expertise in your focus area in addition to all the core knowledge makes their graduate students stand out from students in other programs."

Good Samaritan College of Nursing and Health Science nominator Jeanne Carilli, RN, CCM, said that Good Samaritan is the place to be if you want a taste of real nursing. "Their curriculum was very challenging, but this school turns out the best nurses in the area. The instructors truly care about who they train and refuse to allow anyone to move to the next level until they have demonstrated the necessary competencies to move ahead. This may not always be popular, but when you are talking about the importance of our line of work, it is imperative."

GENEX's case managers work with treating physicians to coordinate appropriate quality care, ensure patient satisfaction, improve medical outcomes, facilitate a patient's timely return to work, and decrease overall health care expenses.

Next year's program will begin with nominations in early Spring.

Pictured from Left to Right

Good Samaritan College

Morey Cohen, President, Good Samaritan College

Sandy Simons, RN, CCM, GENEX Services

Jeanne Carilli, RN, CCM, GENEX Services

Angela Houston, RN, CCM, GENEX Services

Linda Hayes, Dean of Enrollment Management

University of Kansas

Peggy Person, Development Director, KU Endowment Association

Kara Green, RN, BSN, GENEX Services

Jo Anne Lile, RN, BSN, GENEX Services

Rita Clifford, RN, PhD, Associate Dean, Community Engagement, School of Nursing

Cynthia Teel, RN, PHD, FAAN, Professor and Associate Dean, Graduate Programs, School of Nursing

Debra Ford, PhD, Assistant Dean, Student Affairs, School of Nursing

Nell Lucas, Assistant Vice President for Medical Development, KU Endowment Association

University of Wisconsin — Madison

Diane Schneider, MS, CRC, CCM, GENEX Services

Betsy Hovde, GENEX Services

Emily Veith, MS, CRC, LPC, GENEX Services

Kimber Wilkerson, Chair of the Department of Rehabilitation Psychology and Special Education

David Rosenthal, Rehabilitation Psychology and Special Education

Dawn Crim, Associate Dean of the School of Education

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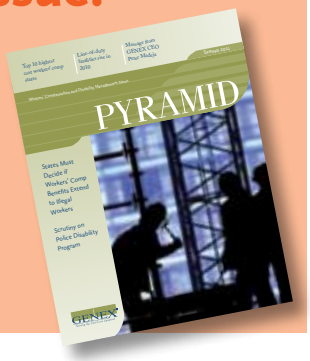

EVENTS CALENDAR

GENEX will be attending these upcoming industry events. We look forward to seeing you!

North Carolina Workers' Compensation Educational Conference
October 10-12, 2012
Raleigh, NC

South Carolina Workers' Compensation Education Conference
October 14-17, 2012
Hilton Head Island, SC

Louisiana Workers' Compensation Conference
October 17-19, 2012
Lake Charles, LA

Michigan Self-Insurers' Association Conference
October 18, 2012
Novi, MI

Alabama Workers' Compensation Organization
October 29-30, 2012
Huntsville, AL

National Workers' Compensation and Disability Conference
November 7-9, 2012
Las Vegas, NV

New Hampshire Adjuster's Association Fall Conference
November 8-9, 2012
Portsmouth, NH

New York Self-Insurers Association Annual Meeting
January 15-18, 2013
New York, NY

PARMA
February 3-6, 2013
Rancho Mirage, CA

It's Time to Talk to GENEX!

Did you know?

GENEX is the #1 outsourced managed care provider for Fortune 500 businesses

GENEX works with over 1,800 entities servicing over 30,000 clients

GENEX has been named the nation's leading case management services provider by *Business Insurance* magazine

GENEX has the broadest array of service offerings in the industry

GENEX has a highly experienced and tenured team

To learn more about our products and services:

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