Workers' Comp & Safety News

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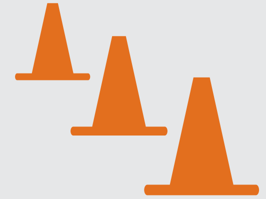

Claims Administration **December 2015/January 2016** **Volume 13 • Number 6**

Physician Choice: Whose Right Is it?

When an employee suffers a work-related injury, workers' compensation law obligates the employer to pay for medical treatment. Who gets to choose the treating physician—and why does it matter?

In some states, the employer gets to choose the physician and all medical providers. This is called a **full control program**. In this type of system, covered employees can seek a second opinion if they are unsatisfied with their care and provide evidence that their care is inadequate, or if the employer fails to notify employees of their rights or neglects to enforce its rights to full control.

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This Just In

"Host employer" is responsible for reporting injuries to temporary workers, says OSHA. In an October 2015 interpretation letter, OSHA clarified that the "host employer" must record injuries and illnesses of temporary workers if it supervises them on a day-to-day basis. The letter states: "OSHA's injury and illness recordkeeping regulation at 29 CFR 1904.31(a) requires employers to record the recordable injuries and illnesses of employees they supervise on a day-to-day basis, even if these workers are not carried on the employer's payroll. Section 1904.31(b)(2)

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In a **partial control program**, the employer selects and posts a list of medical providers. It has the right to require employees to use one of these approved providers for a period of time specified **by workers' compensation** laws. Medical providers must have the skills and qualifications to treat workers' injuries **or refer them to specialists** with the employer's approval. After the initial period of employer control, the employee may continue using those employer-selected providers or choose their own. If the employee feels his/her care is inadequate, he or she will have to submit to an independent medical exam, and the employer may suspend workers' compensation payments until the employee complies.

Some states have **medical panels**. In this type of system, the workers' compensation jurisdiction (the state) maintains a list of approved medical providers. The employer and employee work together to select the providers that offer the best possibility of recovery. This model occurs most frequently in monopolistic states, in which the state's workers' compensation organization pays all claims.

Finally, some states allow **free choice**, where employees can use whatever licensed providers they choose. Some of these states require the employee to designate a "primary treating physician" before they are injured. For example, California requires employees to provide their employer with the name of a licensed medical doctor (M.D.), doctor of osteopathic medicine (D.O.) or a medical group with an M.D. or D.O. as the doctor with overall responsibility for treating their injuries. If employees do not predesignate a doctor, the employee must select a doctor from the employer's medical provider network. If the employer does not have a medical provider network, the employee must go to a doctor selected by the employer during the first 30 days after injury.

Why Does Physician Choice Matter?

While claimants perpetrate some types of workers' compensation fraud, such as passing off non-work injuries as work-related or malingering, physicians can also be guilty of fraud. Dishonest medical clinics, or claims mills, can scam insurers out of millions of dollars by inflating injuries or giving illegal kickbacks to workers. Others might have no licensed doctors and little useful medical equipment. The use of medical provider networks helps employers by ensuring that employees will be treated by prescreened providers. And it can help injured workers by ensuring that they will be treated by a practitioner qualified and experienced in treating workers' compensation injuries. For more information, please contact us.

further clarifies that the host employer must record the injuries and illnesses of temporary workers it supervises on a day-to-day basis."

In this instance, the temporary employment agency handled orientation, training and all personnel matters, including vacation/leave requests, reporting injury/illness, compensation and benefits, corrective action/discipline, and drug screening. It also provided onsite supervision for its employees 24 hours per day, five days per week.

Despite this, the fact that the host employer assigned daily tasks to the temporary workers made it responsible for recording injuries and illnesses. If you are unsure which recordkeeping and reporting responsibilities and other OSHA compliance rules apply to your business, please contact us for assistance.

Depression in the Workplace

Clinical depression affects about one-fifth of women and one sixth of men in the United States at some point in their lifetimes. Why should employers be aware of this problem?

- Depression often strikes between the ages of 25 and 44 — the prime working years. At any one time, one employee in 20 may be suffering from depression, according to the National Institute of Mental Health.
- Depression is costly. Depression causes an estimated 200 million lost workdays each year at a cost to employers of $17 to $44 billion.
- Depression affects productivity. A RAND study found that depression resulted in more days in bed than many other chronic conditions (including diabetes, high blood pressure, ulcers and arthritis).
- Depression adds to your overall group medical costs. Annual healthcare costs for depressed individuals average 80 percent higher ($4,246 vs. $2,371) than for individuals without depression.
- Depression is a safety issue. Depressed workers may be more likely to take risks or fail to heed safety precautions.
- Depression is easily treatable. According to the NIMH, "More than 80% of depressed people can be treated quickly and effectively."

The key to controlling depression and its related costs is early detection and treatment. Left untreated, clinical depression may become a chronic condition. Of course, only a professional can diagnose depression, but if an employee suddenly has problems with productivity, absenteeism or morale, you should suspect depression. Individuals with bipolar disorder, formerly known as manic depression, alternate between extremes of depression and mania.

Train supervisors to look for the following warning signs.

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Warning Signs of Depression

- Depression that lasts more than two weeks or is more intense than "the blues."
- Loss of interest in everyday activities
- Complaints of tiredness or unexplained aches and pains
- Alcohol and drug abuse
- Fatigue
- Weight loss or gain
- Difficulty concentrating, remembering or making decisions
- Talk of death or suicide.

Warning Signs of Mania

- Elation, or mania
- Irritability
- Decreased need for sleep
- Increased energy, activity, talking
- Racing thoughts
- Disturbed ability to make decisions
- Grandiose notions
- Being easily distracted

(adapted from NIMH publication).

When an employee shows five or more of these symptoms for more than two weeks and they interfere with his or her work, depression may be the cause. Supervisors cannot diagnose depression; however, they can help depressed workers get the help they need. To avoid violating an employee's privacy, approach the problem from the standpoint of productivity. A supervisor should first discuss any productivity-related problems with the affected employee — whether it is increased absenteeism, low morale or failure to meet performance goals. Then they should mention to the employee that if health or family concerns are causing these problems, help is available. An employee assistance program (EAP) can provide initial screening services and refer the employee to the appropriate care provider, all on a confidential basis. If your company doesn't have an EAP, refer the employee to a local mental health service provider.

For free brochures on depression and its treatment, call the NIMH at 1-800-421-4211 or visit their Web site at www.nimh.nih.gov. And for more information on how an EAP can help your company deal with mental health and family life issues, please call our office. ■

Second Injury Funds

More than half of all injured workers have a pre-existing condition, according to one expert. When you have an employee with a permanent impairment who suffers a second injury, you are responsible for compensating only the most recent injury. Many employers fail to realize this, leaving thousands of dollars on the table.

More than 20 states have "second injury funds" that pay benefits to workers when an injury aggravates a pre-existing permanent health condition. According to Rupp's Insurance and Risk Management Glossary, Second Edition, second injury funds have the goals of fairly apportioning "liability for compensation benefits and to overcome reluctance to hire handicapped or disabled workers." Insurance carriers and self-insured employers fund second injury funds by paying an assessment, which is usually a percentage of workers' compensation premium written in the state (for insurance carriers) or total benefits paid.

Second injury funds will reimburse an employer or insurer when a worker with a pre-existing condition suffers a second injury that aggravates the pre-existing one. However, reimbursement is not automatic — an insurer or self-insured employer must apply for it.

Generally, if you have a fully insured plan, your insurer will take responsibility for applying to the second injury fund for any eligible claims. The fund will either reimburse the carrier or self-insured employer for lost-time and medical benefits paid to a claimant, or take over payments to the claimant once he or she is deemed eligible for second-

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injury fund payments. The state laws creating the fund will determine which method the second injury fund uses.

To be eligible for reimbursement by a second injury fund, the second injury must be more severe than it would have been if the individual did not have a pre-existing condition. And claims must meet a threshold, such as 104 weeks of indemnity payments, before the fund applies. Second injury funds may cover claims where the pre-existing disability was not work-related. In other words, if you have an employee with a permanent partial disability, such as hearing loss, that was congenital rather than work-related, and a second injury worsened that condition, the state's second injury fund might cover the second injury.

What do second injury funds mean for employers?

Most second injury funds require an employer to certify that it knew that the employee had a pre-existing injury at time of hire, or before the second injury occurred. To protect your organization from the unnecessary cost of second injuries, your human resources and risk management departments should identify every new hire with pre-existing conditions. Although employers might fear that asking employees about pre-existing conditions could violate the Americans with Disabilities Act (ADA), the ADA does not prohibit employers from obtaining information about a pre-existing injury, as long as the employer requires a medical examination or makes medical inquiries only after making a conditional offer of employment. The ADA also does not bar employers from sharing information on an employee's pre-existing condition with a second injury fund or state workers' compensation authorities.

When a worker with a pre-existing injury or condition files a claim, the employer should make the claims adjuster aware of the pre-existing injury or condition. The adjuster will calculate the settlement value of the claim, and/or file the claim with the second injury fund.

Submitting a claim to a second injury fund can help employers with experience-rated workers' compensation policies avoid a big premium increase. It can also make it more appealing to hire former military service persons, many of whom have service-related disabilities.

For more information on second injury funds, or more information on handling permanent partial disabilities in the workplace, please contact us.

Study: Employers Do Not Understand OSHA's Recordkeeping Requirements

A study titled "Exploring the Relationship Between Employer Recordkeeping and Underreporting in the BLS Survey of Occupational Injuries and Illnesses" sought to gauge the accuracy of the Bureau of Labor Statistics' annual Survey of Occupational Injuries and Illnesses.

The study found that employers did indeed underreport injuries, largely because they either did not comply with or did not understand OSHA's recordkeeping requirements.

The study's authors estimated that the BLS survey underestimated injuries by 38 percent due largely to employer error. Specifically:

- 8.4 percent of employers kept no records at all. Of these, half were exempt, but the others should have kept records.
- Most of the employers that maintained OSHA records did not understand what to record. Half included all workers' compensation claims, all workplace injuries and illnesses that resulted in a medical visit, or all reported injuries regardless of severity.

To clarify what employers must report, OSHA states that, as of January 1, 2015, all employers must report:

- All work-related fatalities within 8 hours.
- All work-related inpatient hospitalizations, all amputations and all losses of an eye within 24 hours.

You can report these to OSHA by:

- Calling OSHA's free and confidential number at 1-800-321-OSHA (6742).
- Calling or visiting the nearest OSHA area office during normal business hours.

For more information on your reporting requirements and other OSHA regulations that might apply to your organization, please contact us. ■

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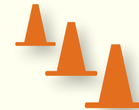

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