ALABAMA SELF-INSURERS
—ASSOCIATION—

VOLUME 4 WINTER 2011

ASIA Objectives

ASIA is committed to a workers' compensation program that:

- Adequately compensates the employee with a work-related injury
- Recognizes fair limitations on employer responsibility
- Provides for an appropriate distribution of the compensation dollar
- Reduces litigation
- Is dedicated to eliminating abuses within the system
- Operates within the bounds of reasonable and necessary regulations

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INSIDE THIS ISSUE:

A Word from the President 2
Calendar of Events 3
Referring of Referrals 3
Update Your Forms 4
Daubert Standard 8
National Council News 10
Membership Update 12

Join ASIA Today: Miss Nothing in 2012!

The Need for an Alabama Self-Insurers Association
Alabama employers and employees are directly affected by a balanced Alabama workers' compensation system. ASIA was formed in 1992 by 10 self-insured companies with the goal of helping employers understand the law and any proposed changes and the need to ensure equitable coverage for the injured employee.

Accordingly, the self-insured employer must be actively involved in review and development of any changes in the program, and ASIA offers the opportunity for positive involvement.

ORGANIZATION

The Association serves a membership composed of large and small businesses and industry, major manufacturers, retailers and others. There are three types of members:

- Active Members - Alabama businesses that self-insure their workers' compensation liability
- Associate Members - Any approved person, firm, corporation or private or public entity representing the interests of self-insured employers (non-voting status)
- Group Fund Members - Eligible to join ASIA under a special discount-pricing program if their Group Fund is an active member

Management of the Association is vested in an elected Board of Directors, which has responsibility for conducting Association business in the interim period between membership meetings. Board members are appointed to three-year terms.

BENEFITS OF MEMBERSHIP

The Association specifically addresses the needs and concerns of Alabama self-insurers through:

- Education
  Educating and informing its members by providing semi-annual seminars which offer the opportunity to learn about new innovations from service providers and allow a forum through which to share experiences and learn from each other
- Legislation
  Advancing legislation of common interest and opposing undesirable legislation or regulations through filing "friend of the court" briefs and lobbying activities and advising members of current administrative, legislative and judicial activities at the state and federal levels
- Preferred Provider Organizations
  Availability of a PPO endorsed by ASIA
- Shared Information
  Cooperating with and providing information to common interest groups, such as the Department of Industrial Relations, and making appearances before the legislature and other governmental committees
- Print Materials
  Distributing relevant information to members through regular newsletters and updates
- Membership Directory
  Availability of a membership directory listing information on all current Active, Group Fund and Associate Members

Alabama Self-Insurers Association

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A Word from the President...

Charles Hough

I hope everyone had an enjoyable Thanksgiving with family and friends. I am sure you are looking forward to the upcoming Holiday Season. I hope it will be enjoyable and safe for everyone.

2012 is fast approaching and it seems like time moves a lot faster as we get older. The Winter Conference is coming up on January 19-20 and we are looking forward to another valuable learning experience. It will once again be at the Cahaba Grand Convention Center in Birmingham, Alabama. The speakers are informative and there of course will be a reception and silent auction on Thursday. Continuing Education Credits are Claims Adjusters 8 hours, Nurses 8.4 hours, Case Managers 7 hours, OT 8.4 hours, CLE 9.2 hours, Insurance 8 hours and PT Credits are applied for.

We are encouraging everyone to register on line. You can go on line at asiaal.org register, pay by credit card, update your membership and get a copy of the program for the Winter Workshop. It is easy, fast and remember updating your membership gets you in the ASIA Directory. The deadline for the directory is March 1, 2012.

The Alabama Legislature will be back in session for the 2012 regular session in February. Among the issues they will address is a possible fine tuning of the immigration act and a number of proposals designed to bring new jobs to Alabama. ASIA will be watching the Legislature and we will alert you to any legislation that impacts workers compensation in Alabama.

Again, we look forward to seeing everyone in January and hope you have a nice Holiday Season.

Charles

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Referring of Referrals...

Carin Pendergraft • Ogletree, Deakins, Nash, Smoak & Stewart, P.C.

Have you ever faced a situation where a doctor has referred one of your employees to another doctor only to have that doctor refer the employee to yet another doctor, and so on and so forth? Getting caught in the referral spider web can feel like you are re-living the same medical issues over and over again (ala *Groundhog Day*). As much as you would like for the treatment nightmare to end, it may seem as though nothing you do works (perhaps you are even reminded of the Eagles' *Hotel California* lyrics, "you can check out any time you want but you can never leave?") While these images may seem a bit dramatic, the referral chain can easily become a never-ending struggle to manage for medical and claims professionals. This is particularly the case where an employee is being treated for the same issue by multiple doctors who rarely communicate, much less agree, with one another in their treatment regimen, issuance of prescription pain medications, or referrals for other treatment. If you have not faced such a claim, consider yourself in the lucky minority. For those of us who have been caught up in the perpetual referral nightmare, the Alabama Court of Civil Appeals recently handed down a decision which will assist employers and claims personnel in appropriately directing and managing medical care: *Ex parte Imerys USA*, ___ So. 3d ___, 2011 Ala. Civ. App. LEXIS 117, 2011 WL 926047 (Ala. Civ. App. May 6, 2011), *cert. denied* Aug. 5, 2011. That case, firmly established what most medical professionals have long known: **there is one authorized treating physician who manages and directs the care to other referring medical providers when necessary.**

Prior to this decision, the issue of who was the "authorized treating physician" was as clear as mud in Alabama. This problem was due, in part, to the interpretation of some language in a prior Civil Court of Appeals decision, which asserted that a "referred specialist becomes an authorized physician" and thereafter, has the implied authority to issue whatever treatment the specialist recommends. *See, e.g., Ex parte Prattville*, 56 So.3d 684, 690 (Ala. Civ. App. 2010)(*explaining Overnite Transportation Co. v. McDuffie*, 933 So.2d 1092 (Ala. Civ. App. 2005)). Before *Ex parte Imerys*, this interpretation had literally created a medical playground for certain savvy claimants' counsel, essentially allowing them to take over the direction and management of medical care for their claimants by getting their clients to request referrals to specific doctors or in other cases to capitalize on situations where doctors differed in their opinions or recommended treatments.

In *Ex parte Imerys*, the claimant sustained a back injury. He originally went to his own doctor, but then decided to select a doctor from a panel of four orthopedists provided by his employer. He chose Dr. Jones and was treated by him for several months until he was placed at maximum medical improvement. Dr. Jones then referred him to a pain-management specialist, Dr. Downey, who then referred the claimant to a different pain-management specialist, Dr. Ryder. Dr. Ryder requested authorization from the employer to refer him to another orthopedist, Dr. Cordover (different from the original orthopedist), to determine whether or not he would benefit from back surgery. The employer denied the authorization.

continued on page 6

ASIA Calendar of Events

JANUARY 19-20, 2012	**ASIA Winter Workshop** Cahaba Grand Conference Center • Birmingham, AL
AUGUST 12-14, 2012	**ASIA Summer Conference** Hilton Sandestin Beach Golf Resort & Spa • Destin, FL
AUGUST 10-12, 2013	**ASIA Summer Conference** Hilton Sandestin Beach Golf Resort & Spa • Destin, FL
AUGUST 9-11, 2014	**ASIA Summer Conference** Hilton Sandestin Beach Golf Resort & Spa • Destin, FL

Homework from a Workers' Compensation Lawyer: UPDATE YOUR FORMS

P. Andrew Laird, Jr. & Jeremiah J. Rogers • Starnes Davis Florie, LLP

Andrew Laird

Jeremiah Rogers

"Misrepresentations as to preexisting physical or mental conditions may void your workers' compensation benefits."

I. INTRODUCTION.

Success is when preparation meets opportunity – Henry Hartman

All too often, it is discovered that an employee's work injury is related to a pre-existing condition that the employee failed to disclose to the employer. Employers cannot do anything to prevent prospective employees from lying on their job applications about pre-existing conditions. But they can take affirmative steps to combat workers' compensation claims that follow an injury or aggravation of an undisclosed pre-existing condition. When an employer prepares properly, the employee's lie presents an opportunity for the employer to mount a successful defense to the employee's workers' compensation claims.

II. PREPARATION: KNOW THE RULES AND PUT THEM IN PLACE.

Under the Alabama Workers' Compensation Act ("the Act"), employers can defend against workers' compensation claims when an employee has been dishonest regarding a pre-existing physical or mental condition. [1] Specifically, the Act provides that an employee is not entitled to compensation if, "at the time of or in the course of entering into employment…the employee knowingly and falsely misrepresents in writing his or her physical or mental condition and the condition is aggravated or reinjured. [2]" To assert this defense, the employer must provide potential employees with the following "magic warning language" in bold print: **"Misrepresentations as to preexisting physical or mental conditions may void your workers' compensation benefits.[3]"**

Thus, under the Act, the employer must be prepared to prove the following elements to successfully assert the willful misrepresentation defense:

(1) The employer provided the employee with the precise statutory warning in bold type;

(2) The employee knowingly and falsely misrepresented a physical or mental condition in writing; and

(3) The employee's pre-existing condition was aggravated or reinjured in an accident arising out of and in the course of the employment.[4]

The statute does not expressly require an employer to establish that it relied on an employee's misrepresentation in hiring the employee.[5] But that did not stop some courts from requiring employers to prove reliance.[6] At last, Alabama's Court of Civil Appeals provided some much-needed guidance on this issue in *Cascaden v. Winn-Dixie Montgomery, LLC.*

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[1] *Cascaden v. Winn-Dixie Montgomery, LLC*, --- So. 3d ---, No. 2100295, 2011 WL 3375652, at *4 (Ala. Civ. App. Aug. 5, 2011) (citing ALA. CODE § 25-5-51 (1975) (as amended)).
[2] ALA. CODE § 25-5-51.
[3] *Id.*

continued on page 5

III. OPPORTUNITY: EMPLOYER RELIANCE ON MISREPRESENTATIONS IS NOT REQUIRED.

In Cascaden, the court created an opportunity for employers to assert the willful misrepresentation defense in a wider range of cases when it held that employer reliance is not an element of the defense.[7] In that case, an employee failed to disclose a pre-existing back injury when he applied for a

IV. PREPARATION, MEET OPPORTUNITY.

As demonstrated by the *Cascaden* decision, employers should not overlook the willful misrepresentation defense. Because employer reliance is not required, the willful misrepresentation defense now applies to a wider range of cases. To turn an employee's misrepresentation into an opportunity, however, employers must complete the following homework. First, employers should include the statutory "magic warning language" in their pre-printed hiring documents. Failure to do so prevents an employer from establishing the defense. Second, in their post-offer medical screening documents, employers should ask specific questions tailored to reveal medical and psychological conditions prevalent in the employer's industry.[9] Doing so will increase the likelihood of the defense becoming available. Making these simple preparations will allow employers to successfully defend against many workers' compensation claims.

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[4] *Hornady Truck Lines, Inc. v. Howard*, 985 So. 2d 469, 478 (Ala. Civ. App. 2007) (citing ALA. CODE § 25-5-51). The third element requires that the employee's misrepresentation be causally connected with the injury. *See BE&K, Inc. v. Weaver*, 802 So. 2d 12, 19 (Ala. Civ. App. 2000) (citing *Logan v. Vernon Milling Co.*, 668 So. 2d 865 (Ala. Civ. App. 1995) (setting out the means by which causation is established)).

[5] ALA. CODE § 25-5-51.

[6] *See e.g., Ex parte So. Energy Homes, Inc.*, 603 So. 2d 1036, 1040 (Ala. 1992) (requiring reliance) (citations omitted), *superseded by statute as stated in, Cascaden*, 2011 WL 3375652, at *4; *Weaver*, 801 So. 2d at 19 (citations omitted) (same). *But see 1 TERRY A. MOORE, ALABAMA WORKERS' COMPENSATION* § 12:31 (West 1998) (Judge Moore discusses the confusion among courts regarding reliance. He notes that the judicial misrepresentation defense, which requires employer reliance, only applies to cases decided before the 1992 amendments to the Act. Because reliance is not included in the Amended Act, no such requirement should be implied to cases decided after 1992.).

continued on page 6

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continued from page 6

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[7] Cascaden, 2011 WL 3375652, at *4
[8] *Id*. (citing 1 Alabama Workers' Compensation § 12:31). The court further concluded that, because the Legislature drafted the statute to include the specific elements of the willful misrepresentation defense, the Legislature intentionally excluded the requirement of reliance from the defense. *Id.*
[9] The Americans With Disabilities Act provides that, before an individual is hired, an employer may inquire only as to whether the individual is capable of performing the required duties of the job. 42 U.S.C. § 12112(d)(2) (1994). However, after a conditional offer of employment has been made, but before the individual begins work (in a post-offer medical screening), an employer may make disability-related inquiries and/or require an individual to submit to a medical examination. The subjects that the individual is questioned upon at this time need not be job-related, as long as all individuals entering the particular job category are asked the same questions. 42 U.S.C. § 12112(d)(3) (1994); 29 C.F.R. §1630.14(b) (1998). But "if an individual is screened out because of a disability, the employer must show that the exclusionary criterion is job-related and consistent with business necessity." *Enforcement Guidance: Disability Related Inquiries & Medical Examinations of Employees Under the Americans With Disabilities Act*, EQUAL OPPORTUNITY EMPLOYMENT COMMISSION, http://www.eeoc.gov/policy/docs/guidance-inquiries.html#N_7_ 42 (last updated Mar. 24, 2005) (citing U.S.C. § 12112(b)(6)(1994); 29 C.F.R. §§ 1630.10, 1630.14(b)(3) (1998)).

Referrals...*continued from page 6*

Both parties moved to compel the Talladega Circuit Court to determine whether: (1) the claimant had to attend an appointment with Dr. Jones (who was the authorized orthopedist); and (2) the company had to honor the referring doctor - Dr. Ryder's – referral to Dr. Cordover (a different orthopedist). After a hearing on these issues, the lower court ordered the employer to authorize the evaluation and treatment by Dr. Cordover.

On appeal, the employer argued that it could not be ordered to authorize the treatment by Dr. Cordover based upon Dr. Ryder's referral because it claimed that only the authorized treating physician had the authority to refer an employee to another medical provider. The Court of Civil Appeals agreed and noted that once the authorized treating physician had made a referral to another doctor, the new doctor had "implicit authority to control the aspect of treatment for which the referral was made." *Id*. at *3.

> **However, the referral does not transfer to the referred physician the right to control all aspects of the employee's treatment. That is, the referred physician does not become the authorized treating physician for all purposes by virtue of the referral. The authorized treating physician continues to have authority over the employee's overall medical treatment.**

Id. (emphasis supplied). The Court of Civil Appeals went on to explain that although Dr. Downey's referral of the claimant to Dr. Ryder fell within the scope of Dr. Downey's authority to direct the claimant's pain-management treatment, it did not provide him the authority to refer the claimant for an orthopedic evaluation or treatment.

In essence, the appellate court found that a doctor whose care was limited to a specific purpose cannot make referrals for treatment that fall outside the scope of their specific purpose. Therefore, the employer was within its power to deny authorization and employee would have to see his original orthopedist, Dr. Jones, in order for any more treatment relating to orthopedics.

In so moving, the Court identified that there can be a limitation on the authorization to a referred specialist. Where claims are appropriately handled by the authorized treating physician, the doctor can effectively eliminate the referral nightmare while at the same time provide better oversight and insight into what is going on with a patient's care.

Ex parte Imerys provides clear guidance to medical and claims professionals with respect to referrals:

(1) The medical specialist has the authority to control the specific treatment for which the referral was made.
(2) A referral for a specific purpose does not transfer to the specialist the right to control all aspects of the employee's medical treatment.

(3) The specialist does not automatically become the authorized treating physician for all purposes of the claimant's medical care due to referral.

(4) The authorized treating physician continues to have the authority over the employee's overall medical treatment.

These principles are not sacrosanct and can be waived where appropriate management of care is not employed by the authorized treating physician. As identified in Alabama's Workers' Compensation Act, the "initial treating physician" dictates the scope of medical treatment. See ALA. CODE §25-5-77(a). The authorized treating physician "is empowered under the Act to treat the employee for so long as is reasonably necessary and to refer the employee to other medical providers for reasonably necessary treatment." Ex parte Alabama Power Co., 863 So.2d 1099, 1102 (Ala. Civ. App. 2003)(emphasis added); See also ALA. ADM. CODE 480-5-5-.12 ("The employer's authorized treating physician…shall be the physician of record for attending or referral purposes.) The authorized treating physician is the appropriate medical professional to make determinations with respect to any referrals. When appropriate, the authorized treating physician may refer the claimant to various specialists for examination, evaluation, or treatment including surgical evaluation, pain management, physical therapy and/or work hardening, specialized tests (MRIs, nerve conduction studies, etc), and even functional capacities evaluations. However, when such parameters are not defined, the management of a claimant's medical care can quickly spiral out of control. As much as we all may love the Eagles, none of us would want any of our employees to be stuck in a medical care situation that never ends, never gets any better, and does not change.

Employers should select a good authorized treating physician who can actively follow and direct the appropriate medical care. Dynamic management of claims by an appropriate medical professional should improve overall treatment assist claimants in getting back to gainful employment, and keep all of us away from the perpetual referral nightmares.

Carin Pendergraft is a Shareholder with Ogletree, Deakins, Nash, Smoak & Stewart, P.C. in Birmingham, Alabama.

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Alabama Senate Bill 187: APPLICATION OF THE DAUBERT STANDARD TO FUNCTIONAL CAPACITY EVALUATIONS

Deborah Lechner, PT, MS • President • ErgoScience, Inc.

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Senate Bill 187 is a piece of legislation, proposed by Alabama Republican Senators Ben Brooks and Cam Ward, which modifies the rules governing expert testimony during civil and criminal trials in Alabama. Bill 187 was signed into law on June 9, 2011 by Governor Robert Bentley. Prior to Bill 187, the Frye Rule was used in the Alabama courts to determine when expert witness testimony is admissable. The Frye Rule is based on a 1923 Federal Court of appeals ruling (Frye v. United States, 293 F. 1013 (DC Cir. 1923)) and required that expert testimony be based only on "principles sufficiently established to have gained general acceptance in the particular field in which it belongs." (M. Roberts, Alabama Tort Law 44.08). Frye essentially meant that expert testimony could be based on any test that was generally accepted regardless of whether that test had any supporting research. Frye allowed tests and measures to be accepted into evidence that had no real supporting research. In contrast, Bill 187 adopts the Daubert Standard as the criteria for admissibility of expert testimony.

The previous lack of a more rigorous standard under Frye has been particularly problematic in Functional Capacity Evaluations (FCEs). FCEs with no supporting validation research are commonplace in Alabama. And many assessment approaches are abused and misused. A classic example of this misuse of testing is the Waddell's Non-Organic Signs used to detect sincerity of effort. These signs were never developed nor validated for purpose of detecting sincerity of effort. Test developer, Gordon Waddell, advises against using his evaluation of non-organic signs for this purpose in published papers and numerous national conference presentations. Despite this advice, Waddell's non-organic signs continue to be widely used to detect sincerity of effort in FCEs.

The Daubert standard is a legal precedent set in 1993 by the US Supreme Court regarding admissibility of expert witness testimony during legal proceedings in federal court. The Daubert standard requires federal judges to be "gatekeepers" of scientific evidence. They must evaluate expert witnesses to determine whether their testimony is both "relevant" and "reliable." (Daubert v. Merrell Dow Pharmaceuticals, 509 U.S. 579 (1993)). As of 2006 the federal Daubert standard had been adopted in 30 states(Table 1.)

According to the 2006 survey, seven other states had neither adopted nor rejected Daubert (Table 2).

Table 1: States Adopting Daubert as of 2006 (30)

States Adopting Daubert as of 2006 (30)	STATES REJECTING DAUBERT AS OF 2006 (14)
ALASKA	ARIZONA
ARKANSAS	CALIFORNIA
CONNECTICUT	COLORADO
DELAWARE	DISTRICT OF COLUMBIA
GEORGIA	FLORIDA
IDAHO	KANSAS
INDIANA	MARYLAND
IOWA	NEVADA
KENTUCKY	NEW YORK
LOUISIANA	NORTH DAKOTA
MAINE	PENNSYLVANIA
MASSACHUSETTS	SOUTH CAROLINA
MONTANA	WASHINGTON
NEBRASKA	

Table 2: Neither Accepting nor Rejecting as of 2006 (7)

ALABAMA
HAWAII
ILLINOIS
MINNESOTA
MISSOURI
NORTH CAROLINA
VIRGINIA

We can now count Alabama as one of the adopting states.

There are two major components of Daubert. The first is relevancy: Does the evidence "fit" the facts of the case? The second is reliability: Has the expert derived his or her conclusions from the "scientific method?" Under Daubert, the "scientific method" includes:

1) Empirical testing: the theory or technique must be falsifiable, refutable, and testable.

2) Testing that has been subjected to peer-review and publication.

3) Testing that has a known or potential error rate

4) Testing with the existence and maintenance of standards concerning its operation.

5) Testing whose theory and technique is generally accepted by a relevant scientific community.

THE FIVE QUESTIONS THAT DAUBERT ASKS ARE:

1) Has the technique been tested in actual field conditions (and not just in a laboratory)?

2) Has the technique been subject to peer review and publication?

3) What is the known or potential rate of error? Is it zero, or low enough to be close to zero?

4) Do standards exist for the control of the technique's operation?

5) Has the technique been generally accepted within the relevant scientific community? [this test was earlier the only relevant criteria under Frye.]

In the Daubert Case, Merrell Dow Pharmaceuticals was sued by a mother who had taken Bendectin (an anti-nausea medication) during pregnancy and whose child was born with birth defects. She sued Merrell Dow for damages but the case was dismissed on summary judgment. The evidence against Merrell Dow was deemed legally insufficient because studies that were cited as evidence for causation between Benedictin and birth defects was based on animal studies instead of human epidemiology studies. The court also ruled that although Daubert's experts recalculated data obtained from previously published human epidemiologic studies, their findings were not considered admissible because they were neither published nor subjected to peer-review.

Two refinements to Daubert have created what has come to be known as the "Daubert Trilogy." In General Electric Co. v. Joiner, 522 U.S. 136 (1997), the US Supreme Court held that appellate courts must defer to the trial court's decision regarding the admissibility of expert testimony unless they are "strikingly wrong." In Kuhmo Tire Co. v. Carmichael, 526 U.S. 137 (1999), the US Supreme Court held that the judge's gate keeping function identified in Daubert applies to all expert testimony, including that which is non-scientific (i.e. technical).

One of the challenges in interpreting Daubert is that there is considerable confusion regarding the term "peer-reviewed." Peer-review is a process of self-regulation by a profession. Peer review methods are employed to maintain standards, improve performance and provide credibility within the profession. In scientific publication, peer-review is used to determine a manuscript's suitability for publication. The peer-review process of evaluating a manuscript for publication involves qualified individuals within the relevant field. The potential authors submit a manuscript to a refereed journal. The scientific or medical journal's editor selects a team of reviewers (usually 3) who are considered experts in the field. Reviewers usually have multiple publications of their own related to the submitted manuscript. Their review is blinded to prevent reviewer bias. After review, the manuscript can be accepted, accepted contingent upon revisions or rejected.

Instead of having true peer-reviewed papers documenting the validity of the FCE, some FCE providers try to claim that their test is peer-reviewed if the article has be read by "peers", published in a non-refereed journal or newsletter, published in the test developer's manual, or is a commissioned "white paper." Based on the above-described Daubert criteria, these methods of validation are obviously inadequate to support a test's admissibility under the Daubert standard.

In the Application of Daubert to FCEs, the five questions become:

1) Has the FCE protocol been tested in actual clinical conditions?

2) Has the FCE protocol been subjected to peer-review and publication?

3) What is the known or potential rate of error? Is it zero, or low enough to be close to zero?

4) Is there a standardized procedure manual? Does it follow professional guidelines for FCEs?

5) How many clinics utilize this FCE protocol?

There are important differences between true validation research and the pseudo –validation research that some FCE providers attempt to use to validate the test. Under Frye, this was not terribly difficult to do. However, under Daubert, this type of pseudo-validation research will not be acceptable. Table 3. below provides a comparison.

TABLE 3.

TRUE VALIDATION RESEARCH	PSEUDO-VALIDATION RESEARCH
• Addresses the reliability and validity of the functional tasks of the test	Cite Studies on small components of the test that were developed for other purposes, i.e.: • Ransford Pain Drawing • Waddell's Non-Organic Signs • Borg Scale of Perceived Exertion • Stover Snook's protocol for determining psychophysical lifting limits for populations norms None of these studies address the repeatability or accuracy of the FCE Merely descriptions of components of the FCE that the protocol has "borrowed" and incorporated into the test

The terms reliability and validity can be confusing. However, a brief look at the definitions can provide clarity. Reliability addresses the question: Is the test repeatable? There are several types of reliability. Two important types of reliability in FCEs are inter-rater reliability and test-retest reliability. Inter-rater reliability means that if two clinicians administer the same test to the same patient, they will obtain same test result. Test-re-test means that if the test is repeated more than once with no significant change in the patient, the test results should be the same.

Validity refers to the accuracy of the test. Does the test really measure what it says it will measure? There are several types of validity relevant to FCEs, some more robust than others. In "face validity," an "expert" reviews the test and renders an opinion that the test "appears valid." The commissioned white paper falls under this category. Obviously this is the weakest form of validity and, on its own, is not adequate validation for FCEs. In "content validity," a list of content the test must cover is compared to the test to determine if all content items are covered by the testing protocol. In job-specific FCEs, content validation would involve comparing the test to the documented job demands. In occupation-specific testing, content validation would involve comparing the test to the occupation description in the Dictionary of Occupational Titles. Again, this is an extremely weak form of validity that cannot stand on its own as the sole validation of the test under Daubert.

In "concurrent validity," the question becomes: Can the FCE determine the physical abilities of the patient/client to perform the physical demands of the job today? So if the FCE states that the employee can perform Medium level work (lifting up to 50 lbs), can the patient perform at the Medium level when released to work? If the FCE says the patient can walk Occasionally (up to 1/3 of the day), can he sustain that level of endurance when released to work? Predictive or prescriptive validity addresses the test's accuracy into the future. If the FCE states that the employee can perform Medium work, can that level be maintained for 6 months without injury after returning to work?

To address these issues of reliability and validity with your FCE provider, several questions should determine whether your provider's test will be admissible under Bill 187/Daubert.

1) Do you have research to support the reliability and validity of your test?

2) Could you provide copies of that research for me?

3) Do you have a procedure manual? Could I see a copy of it?

4) Does your test meet the American Physical Therapy Guidelines for FCEs?

5) How many other clinics use your FCE?

When your FCE provider claims that he/she has research to support the test and you ask them to provide copies, READ the research! Many will claim research but have only the pseudo research described above. If you are not sure what the research says, ask a clinical researcher to evaluate the publications. Getting an objective, third party opinion should not be difficult, especially since Alabama has some of the premier research institutions in the country.

Bill 187 and the Daubert Standard elevate the criteria for the quality of FCE that will be considered admissible in Alabama court cases. Ultimately the effect of the new legislation will play out in future legal cases. As health care providers and self-insured employers, we can take a gamble with FCEs that are not adequately validated in order to test the new ligation. However, the question becomes: Do we really want to take that risk? An alternative, more conservative approach may be to use the knowledge of Bill187/Daubert and the understanding of validation to select an FCE provider whose test will withstand scrutiny under a Daubert challenge.

National Council of Self-Insurers Updates

Larry Holt, Executive Director • National Council of Self-Insurers

United States District Court Eastern District of Arkansas Jonesboro Division
Billy Smith, Plaintiff vs. Marine Terminals of Arkansas, Defendant, and American Home Insurance Company, Intervenor

In the above case, the settling parties attempted to submit a Medicare Set Aside (MSA) to the Centers for Medicaid and Medicare Services (CMS) for approval in a case involving both liability and workers' compensation claims. CMS elected to not review the submission leaving the parties uncertain as to whether they had adequately taken Medicare's interest into account with respect to Mr. Smith's anticipated future medical costs, as required by the settlement agreement they had signed.

The parties sought clarification from the Court which ruled that the MSA prepared was competent and that despite the CMS decision to not review the MSA submission, Medicare's interest had been properly taken into account by the parties in compliance with the Medicare Secondary Payer Act (MSPA).

This case highlights the unfortunate fact that CMS itself causes discomfort and confusion for parties when it comes to settling cases and attempting to comply with the MSPA, where liability claims are involved. However, this case is very instructive in the sense that it informs parties that the use of a competent MSA vendor in the preparation of a MSA is strong evidence (whether judicially ratified or not) that the parties are taking Medicare's interest into account as required by the MSPA.

The National Council of Self-Insurers is grateful to David Korch, Medicare Compliance Analyst, of Providio MediSolutions of Greenwood Village, Colorado, for the above information.

SUBJECT: SENATE LEGISLATION TO IMPROVE MSP PROVISIONS

I have received the following information from Doug Holmes, President of UWC – Strategic Services on Unemployment & Workers' Compensation in Washington, DC.

On October 17, 2011, Senators Ron Wyden (D-OR) and Rob Portman (R-OH) announced the introduction of bi-partisan legislation in the U.S. Senate to address administrative problems that have arisen in the administration of the Medicare Secondary Payer (MSP) provisions of federal law.

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The legislation is entitled, "The Strengthening Medicare and Repaying Taxpayers Act of 2011" (SMART Act). The bill is identified as S 1718

See http://wyden.senate.gov/newsroom/press/release/?id=cc5376dd-567a-4d50-ade9-6dc07ede1669

S 1718 is the Senate companion to legislation previously introduced in the House of Representatives as HR 1063. See http://thomas.loc.gov/cgi-bin/query/z?c112:wH.R.1063:#

The new legislation addresses a number of issues, particularly with respect to Section 111 reporting, conditional payment recovery processes, access to social security numbers and the application of the Medicare Secondary Payer provisions of federal law.

The legislation is supported by the Medicare Advocacy Recovery Coalition (MARC), UWC, National Council of Self-Insurers, the insurance industry and the American Association for Justice.

SUBJECT: STATE JUST SAYS "NO" TO OPIOIDS IN W.C.

Early data show that a controversial Washington State medical guideline has played a part in reducing injured-worker deaths caused by a dramatic rise in the prescribing of opioid pain medications.

The guideline recommends that doctors curb prescribing large doses of the opioid painkillers, which the federal government blames for a nationwide public health epidemic of addiction and deaths, paralleling a rise in the number of prescriptions written along with an increase in dosage amounts prescribed.

Medical experts say Washington State's guideline for chronic noncancerous pain could serve as a model for other states looking to reduce deaths and addiction among workers' compensation claimants and the general population.

They say such guidelines are called for because workers with relatively minor workplace injuries are ending up addicted or dying from overdoses.

"It's one of the most tragic outcomes in workers' comp, said Bob Malooly, former assistant director for Washington's Department of Labor & Industries' Insurance Services Division and current CEO of Claim Maps L.L.C. in Olympia, WA, a NCSI member. "Someone comes in with a back sprain that otherwise would have resolved on its own and they wind up dying of an overdose."

The state of Washington "should be commended for taking action where many other states have done nothing," said Dr. Andrew Kolodny, president of Physicians for Responsible Opiod Prescribing.

Washington's guideline recommends that doctors not increase opioid doses beyond an average daily morphine equivalent of 120 milligrams when a patient does not demonstrate improved functionality and decreased pain at lower doses or without first consulting with a pain management expert.

Dr. Gary Franklin, medical director for Washington's Department of Labor & Industries, said the guideline was introduced in 2007 as an "educational pilot," and updated in June 2010. "There is now very strong evidence in at least three studies, linking specific doses of opioids to increased morbidity and mortality."

According to the White House Office of National Drug Control Policy, the milligram-per-person use of prescription opioids increased 402% from 1997 to 369 milligrams in 2007.

The above was taken from an article written by Roberto Ceniceros, Senior Editor, in the October 3 issue of Business Insurance.

SUBJECT: RISKS OF WORKING AT HOME NEED ATTENTION

As more companies allow their employees to move from cubicles to home offices, outdated risk management plans are likely not keeping up with the exposures related to at-home workers.

"A lot of companies are waiting and seeing," said Richard Lenkov, President of the National Workers' Compensation Coalition in Chicago. "You have all these new risks, but not many specific risk management programs for working from home."

This trend of the workplace is not new. The term, "telework,"

was first used in the 1970's. According to World at Work's "2011 Survey on Workplace Flexibility," today nearly 20% of employees work from home or remotely, with home being the main venue for remote work.

Attention to insurance risk often occurs after an accident has happened. Thus far, there has not been much claim activity related to "telework."

Two recent workers' comp cases, however, may cause greater attention to the risks of work at home.

In June 2011, a New Jersey court granted workers' compensation benefits to the family of Cathleen Renner, an AT&T manager, who died of a blood clot after sitting at her work computer at home for long periods of time.

As more companies allow their employees to move from cubicles to home offices, outdated risk management plans are likely not keeping up with the exposures related to at-home workers.

In the same month, the Oregon Court of Appeals ruled that Mary Sandberg, a J.C. Penney & Co. saleswoman of window treatments and bedding, was entitled to workers' compensation after she tripped on her dog while carrying fabric samples from her home to her car. Ms. Sandberg suffered a broken wrist. Previously, an Oregon Workers' Compensation Board determined that her injury did not arise from her employment and denied her benefits.

Experts say that for companies to reduce their risk of their employees working at home, the companies should clearly identify home office space, requiring that office space be separated from living space. Companies should also clearly define the job duties at home of their employees.

The above was taken from an article written by Louise Esola in Business Insurance of September 12, 2011.

SUBJECT: PRESCRIPTION DRUG COSTS

According to the "Workers' Compensation Prescription Drug Study, 2011 Update," prescription drugs in 2009 accounted for 19% of workers' compensation medical costs. The Study was prepared by the National Council of Compensation Insurance (NCCI), the workers' comp rating and research organization.

The NCCI is a member of the National Council of Self-Insurers.

SUBJECT: MANY PATIENTS DON'T ADHERE TO MEDICATION PROGRAMS

Medication adherence regimens are effective only if they target the individual reasons patients fail to take their prescription drugs and doctors' influence is tapped when necessary.

Brenda Motheral, Executive Director of the Pharmacy Benefit Management Institute in Plano, Texas, said research indicates there are "about 20 different reasons" that patients don't take their medications, from fears of side effects to believing that medication is not a necessity to high cost to simply forgetting.

Dr. Mark Friedlander of Aetna Behavioral Health in Hartford, Conn said an estimated 15% of prescriptions written are never filled. Among patients with ongoing conditions, 50% stop taking prescribed drugs in the first six months. The adherence rate for antidepressants is even lower, with 60% of patients stopping the drug after six months.

A factor that hasn't been sufficiently considered is physicians' communication with their patients about medications, Dr. Friedlander said.

For example, patients are much more likely to stick with medication if they hear about the risks of not taking the meds. Among doctors who allowed themselves to be videotaped meeting with patients, 42% said they discussed the risks with their patients. In reality, only 3% did, said Dr. Friedlander.

Trying to increase medication compliance so employees stay healthy and avoid costlier medical care is one of the toughest challenges for employers.

Innovative Pharmacy Benefit Management (PBM) approaches are necessary because "the way people behave isn't that rational," said Sharon Frazee, VP, Research of St. Louis-based PBM Express Scripts, a National Council of Self-Insurers member. For that reason, educational efforts or financial incentives such as waiving or reducing copays "will only get you so far" in nudging people to comply.

Heather Sundlar, Express Scripts director of clinical services, said, "You have to tailor the intervention to whatever the person's noncompliant habit is."

For example, pilot programs at Express Scripts have shown that the wording of letters to patients and having a physician sign a letter increase compliance. Express Scripts' most effective letter, which used the behavioral science approach of asking people to make a deliberate choice to take the medication, increased compliance 26% compared with a control group, Ms. Sundlar said.

If a person's compliance issues are procrastinating in picking up prescriptions from a pharmacy, then a mail-order drug plan may solve the problem.

The above was taken from an article of September 19, 2011 by RoseAnne White Geisel in Business Insurance.

Notice of Membership Meeting

Please allow this to serve as notice of a special meeting of the ASIA membership on Friday, January 20, 2012, immediately following the Winter Workshop. The meeting will be held at the Cahaba Grand Conference Center in Birmingham.

The purpose of the meeting is to update the ASIA Constitution, which will require amendments to the document. Such amendments must be approved by the membership. The proposed changes to the Constitution are:

ARTICLE III – MEMBERS

5. Voting/Official Privileges: Only Active members shall be eligible to vote. ~~and hold office, other than the office of Executive Secretary.~~ Each Active Member shall be entitled to one vote, whether representing an individual, firm, corporation, pool, or other public or private entity. Voting may be done in accordance with the provisions of the By-Laws of the Association. *(This change will allow an Associate Member to serve as an officer if elected by the Board of Directors.)*

ARTICLE VI – GOVERNMENT

1. Structure: The governing body of this Association shall be its Board of Directors. The Board of Directors shall elect officers of the Association, and shall assume general management of all affairs of the Association. The Board of Directors shall elect an Executive Committee consisting of ~~six (6) Active Members, four of which shall be the Chairpersons of these committees: Government Affairs Committee, Education Committee, Medical Services, and Financial Committee, and the fifth and sixth members shall be~~ the President~~, and~~ Vice President<u>, Treasurer and Secretary</u>. *(This makes the officers the Executive Committee)*

2. Composition: The Board of Directors shall consist of fifteen (15) ~~Active~~ Members, who shall be elected by majority vote of the Active Members of the Association. The allowable number of Directors may be amended upon majority vote of the ~~Active Members~~ <u>Board of Directors</u>. The Directorate shall choose from among its membership four (4) officers. The officers shall be President, Vice President, Secretary, and Treasurer. In addition, the Board of Directors shall elect an Executive Secretary. The Officers shall serve a term of one year, and may serve consecutive terms, or serve at will. *(This will allow an Associate Member to serve on the Board of Directors and empowers the Board of Directors to increase the number of directors, which conforms to the language in the current Bylaws.)*

ARTICLE VII – MEETINGS AND VOTING

1. Frequency: There shall be at least (one) regular annual meeting of the general Association membership each calendar year. The meetings shall be held at times and places specified by the Board of Directors, and upon ~~thirty~~ <u>ten</u> days notice to the membership of the Association. Additional regular meetings of the membership of this Association may be called in accordance with the provisions of the By-Laws of the Association.

2. Voting: At all regular meetings, each Active member shall be entitled to one vote, to be cast by its designated primary or alternate representative. One-third of the Active Members in ~~person or by proxy, or their designees,~~ <u>attendance at a duly called meeting</u> shall constitute a quorum ~~of~~ <u>at</u> any Annual or Regular meeting of the Association. Any matter submitted to a vote of the Membership shall be adopted by the Association upon a simple majority vote of the Active Members present~~, including votes cast by proxy,~~ in accordance with the By-Laws of this Association. *(This strikes reference to proxy, which is prohibited in the bylaws.)*

ARTICLE VIII – AMENDMENTS

Amendments to the Constitution of this Association shall be made by resolution adopted by a majority vote of the <u>Board of Directors</u> ~~Active Members, provided that the resolution shall have been proposed in writing and mailed to the membership at least thirty days prior to the meeting at which the amendments) is (are) to be voted on~~. *(This change would allow the Board of Directors to make future modifications to the ASIA Constitution, instead of requiring a vote of the membership. The membership will continue to elect the Board of Directors, thus giving the membership control over who serves on the Board.)*

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