AmeriSys Ink

FALL EDITION— 2014

INSIDE THIS ISSUE:

Thoughts and Thanks

From: Ron Warble
Executive Vice President

As I have reviewed the other articles contained in this edition of our newsletter, it is clear that challenges remain abundant and complex in this world of occupational injuries and illnesses.

Diseases in foreign and undeveloped countries about which we have only heard rumors in the past have now landed on our shores. With so many of our nation's workforce in positions that could and would be potentially exposed, it is our obligation to make certain we are providing the best information and claim handling possible to address these situations safely and knowledgably.

We are fortunate to live in a nation where there is continual and ongoing research and advancement in the treatment of medically-related conditions. These advances also present their own challenges. Not every new procedure or every new treatment idea is equal either in efficacy or outcomes. With occasional exceptions, we generally expect treatments to be researched and accepted by the FDA for the condition or purpose prescribed. We believe that not only prevents our customer/payers from paying for ineffective or unnecessary care, but also protects the injured or ill employees from the pain and complications resulting from experimental or unproven treatment modalities.

There is also the law of unintended consequences. We applaud the attempts to assist in the epidemic of abuse of prescription drugs, yet we are now, as Amy will describe in her article, dealing with legitimate patients with legitimate needs for pain medication who are having difficulty obtaining these medications because of governmental regulations designed to assist in controlling abuse.

My thanks to all those who are contributing articles to this newsletter to keep us informed of both the challenges as well as the things that are going right in our service to injured employees and their employers.

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Meanwhile, the weather has turned and each day we are drawing closer and closer to the Holidays most of us await so anxiously. I would feel neglectful if I did not encourage each of you to plan time to just sit and reflect. Spend some time just being thankful. Some of you have had big challenges this year ~ medical conditions, loss of loved ones ~ making it difficult for you to really embrace thanksgiving. If that is the case, my wish for you is that there will be people, family, someone who will come alongside and let you know that ***you*** are one of the things for which they are thankful. So perhaps you can be the subject of thanksgiving even if you are having difficulties participating yourself.

Our team will remain here and on duty. One of the things we will be thankful for is the customers who allow us to partner with them to provide services to their organizations and to their injured employees. We will also be thankful for our own team mates who remain vigilant, prepared and ready to serve our customers and one another.

For me, ***I am thankful to be a part of such a great team.***
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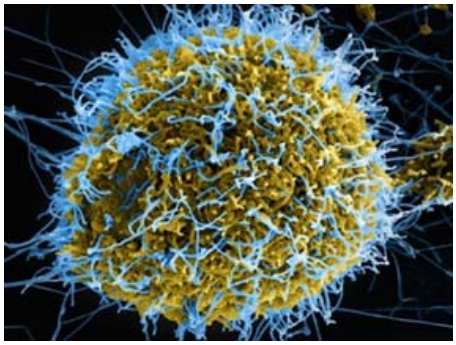
Ebola Exposures In The Workplace

Cheryl Gulasa
Vice President



With the ever present media coverage of Ebola in our country, all First Responders and Health Care Facilities are looking at their processes for addressing potential exposure to Ebola.

(1) Ebola (EVD; also Ebola hemorrhagic fever (EHF)) or simply Ebola is defined as a virus disease of humans and other primates caused by Ebola viruses. Signs and symptoms typically start between two days and three weeks after contracting the virus, with a fever, sore throat, muscle pain and headaches. Then, vomiting, diarrhea and rash usually follow, along with decreased function of the liver and kidneys. At this time, generally, people begin to bleed both internally and externally. Death, if it occurs, is typically six to sixteen days after symptoms appear and is often due to low blood pressure from fluid loss.

At AmeriSys, as the medical management service provider, we feel it is our responsibility to stay current on the issue, the latest in treatment protocols, and to educate our staff, the insurer, and our customers to the best of our ability.

We have taken the initiative to develop policies and procedures related to the potential exposure to Ebola in the workplace.

As we have in the past, when other communicable diseases become a threat to our customers' employees, we have notified the CDC (Centers for Disease Control and Prevention) of our role and looked to them for direction. We have also contacted the Florida Department of Health for any specific recommendations it may have pertaining to our state and our healthcare facilities.

Below is an excerpt from the CDC at it relates to the handling and treatment of Ebola.

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

(2) **Per the CDC as of 10/15/2014:**

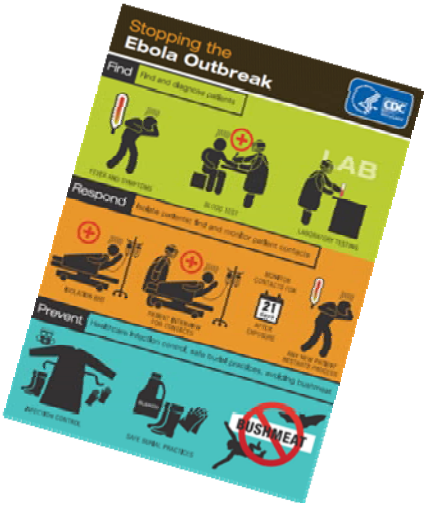
Recommendations for EMS and Medical First Responders (including Firefighters and Law Enforcement Personnel) are as follows:

1. *Address scene safety:*
   - *If PSAP (Public Safety Answering Points) call takers advise that the patient is suspected of having Ebola, EMS personnel should put on the PPE (personal protection equipment) appropriate for suspected cases of Ebola (described below) before entering the scene.*
   - *Keep the patient separated from other persons as much as possible.*
   - *Use caution when approaching a patient with Ebola. Illness can cause delirium, with erratic behavior that can place EMS personnel at risk of infection. (e.g., flailing or staggering)*
2. *During the patient's assessment and management, EMS personnel should consider the symptoms and risk factors of Ebola:*
   - *All patients should be assessed for symptoms of Ebola (fever of greater than 38.0 degrees Celsius or 100.4 degrees Fahrenheit, severe headache, muscle pain, vomiting, diarrhea, abdominal pain, or unexplained hemorrhage). If the patient has symptoms of Ebola, then ask the patient about risk factors within the past 3 weeks before the onset of symptoms, including:*
     - *Contact with blood or body fluids of a patient known to have or suspected to have Ebola;*
     - *Residence in - or travel to - a country where an Ebola outbreak is occurring (a list of impacted coun tries can be accessed at the following link: http://www.cdc.gov/vhf/ebola/outbreaks/guinea/index.html*

(http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/index.html)); or

- *Direct handling of bats or nonhuman primates from disease-endemic areas.*

- *Based on the presence of symptoms and risk factors, put on or continue to wear the appropriate PPE and follow the scene safety guidelines for suspected case of Ebola.*
- *If there are no risk factors, proceed with normal EMS care.*



EMS Transfer of Patient Care to a Healthcare Facility

EMS personnel should notify the receiving healthcare facility when transporting a suspected Ebola patient, so that appropriate infection control precautions may be prepared prior to patient arrival. Any U.S. hospital that is following the CDC's infection control recommendations (http://www.cdc.gov/vhf/ebola/hcp/infection-prevention-and-control-recommendations.html) and can isolate a patient in a private room is capable of safely managing a patient with Ebola.

Use of Personal protective equipment (PPE)

Use of standard, contact, and droplet precautions is sufficient for most situations when treating a patient with a suspected case of Ebola as defined above. EMS personnel should wear:

- *Gloves*
- *Gown (fluid resistant or impermeable)*
- *Eye protection (goggles or face shield that fully covers the front and sides of the face)*
- *Facemask*
- *Additional PPE might be required in certain situations (e.g., large amounts of blood and body fluids present in the environment), including, but not limited to, double gloving, disposable shoe covers, and leg coverings.*

Pre-hospital resuscitation procedures such as endotracheal intubation, open suctioning of airways, and cardiopulmonary resuscitation frequently result in a large amount of body fluids, such as saliva and vomit. Performing these procedures in a less controlled environment (e.g., moving vehicle) increases risk of exposure for EMS personnel. If conducted, perform these procedures under safer circumstances (e.g., stopped vehicle, hospital destination).

- *In addition to recommended PPE, respiratory protection that is at least as protective as a NIOSH-certified fit-tested N95 filtering face-piece respirator or higher should be worn (instead of a facemask).*
- *Additional PPE must be considered for these situations due to the potential increased risk for contact with blood and body fluids including, but not limited to, double gloving, disposable shoe covers, and leg coverings.*

If blood, body fluids, secretions, or excretions from a patient with suspected Ebola come into direct contact with the EMS provider's skin or mucous membranes, then the EMS provider should immediately stop working. He/she should wash the affected skin surfaces with soap and water and report exposure to an occupational health provider or supervisor for follow-up.

Recommended PPE should be used by EMS personnel as follows:

- *PPE should be worn upon entry into the scene and continued to be worn until personnel are no longer in contact with the patient.*
- *PPE should be carefully removed without contaminating one's eyes, mucous membranes, or clothing with potentially infectious materials.*
- *PPE should be placed into a medical waste container at the hospital or double bagged and held in a secure location.*
- *Re-useable PPE should be cleaned and disinfected according to the manufacturer's reprocessing instructions and EMS agency policies.*
- *Instructions for putting on and removing PPE have been published online at http://www.cdc.gov/HAI/prevent/ppe.html and http://www.cdc.gov/vhf/ebola/pdf/ppe-poster.pdf[PDF - 2 pages](http://www.cdc.gov/vhf/ebola/pdf/ppe-poster.pdf).*
- *Hand hygiene should be performed immediately after removal of PPE.*

Currently, AmeriSys' staff is being continually educated in their role, upon receipt of a call that relates to a potential Ebola exposure, to adhere to the following protocol:

Procedure:

- If a call is received regarding an Ebola exposure, as protocol describes for all escalated events, the call is immediately transferred to Nurse Case -Manager.
- The Nurse Case-Manager should inquire as to the nature of the exposure, for example:
  - Have they been in contact with someone who is known to be sick with Ebola?
  - How did this contact occur? Are they a First Responder? Do they work in a hospital or in a laboratory environment?
  - When was the exposure? Per the CDC, "The incubation period for Ebola, from exposure to when signs or symptoms appear, ranges from 2 to 21 days (most commonly 8-10 days)."
- The Nurse Case-Manager should inquire whether they are experiencing any symptoms such as fever, vomiting, diarrhea and/or abdominal pain.
- Prior to directing the injured employee to a medical facility for evaluation, notify the facility of the incoming injured employee to allow them to prepare for the evaluation. Give the facility the initial information obtained from the injured employee.
- Once the injured employee has been directed for treatment, the Nurse Case-Manager should immedi ately notify both his/her supervisor and the Claims Supervisor.
- Per the CDC, the treating facility is responsible for notifying the CDC immediately of the potential exposure.
- The assigned Nurse Case-Manager should be notified immediately in order to follow the claim closely, reporting to all appropriate parties.

The determination of the compensability to an employee for an Ebola exposure is finalized by assessing that the exposure of illness can be, or is considered to be, "occupational", meaning that it rose out of the scope and course of employment.

Our First Responders have an increased risk of being exposed to Ebola as a regular part of their job duties. We stand ready to direct them to initial care per CDC guidelines, along with follow-up care from a network Infectious Disease Physician.

(1) **http://www.wikipedia.org**
(2) **www.cdc.gov**

Heads Up From The Field

Amy Krietemeyer
Supervisor FCM

As Field Nurses we work one-on-one with injured workers as well as many of the medical entities involved in your claims. It is this unique skill set that affords close monitoring and coordination of medical. This results in early intervention and proposed solutions to issues. In the last year we are seeing multiple issues with pharmacies either not stocking the medication or refusing to provide requested medications to those with valid prescriptions. We have seen this across the board but especially around Central Florida. This has resulted in post-operative patients being discharged from the ambulatory surgical centers and not being

able to find a pharmacy that has the narcotic pain reliever in stock. When meeting with pharmacies they have reported that per the government they are only allowed to request a specified number of pills per month (regardless of how many valid scripts they get). As a matter of fact there are several local CVS pharmacies who had their rights to dispense narcotics taken away because they requested more pills to be delivered to their pharmacy in a month's time than was allowed by the government. Many times this is at the expense of acutely injured and post-operative patients who truly need this type of medication.

We are working closely with our vendor partner myMatrixx in search of solutions. In the interim we have started to request that the physicians provide the narcotic script well before the surgery date to permit search of a pharmacy that has the medication in stock prior to surgery. We will continue working with our vendor partner and government entities when appropriate to assist with proposed solutions to this complex issue.

AmeriSys myMatrixx

Workers' Compensation: A Physician Specialty?

Pam Shaw
Provider Relations Coordinator

Is Workers' Compensation a "Specialty" for physicians and providers? Physicians are frequently asked to complete disability certification forms from injured workers. The certification process can be contentious because of the number of stakeholders, the varying definitions of disability and the nature of the administrative systems. Disability systems include workers' compensation, private disability insurance, the Americans with Disabilities Act, and the Family and Medical Leave Act. Strategies that help the physicians complete disability certification forms effectively include the identification of a disability type, ascertainment of the definition of disability being applied, the evaluation of workplace demands and the essential job functions, the assessment of the injured worker's capacity, and the accurate and timely completion of the forms in their entirety. Insufficient training on disability rating requirements during medical school and residency complicates this process.

Although Workers' Compensation eligibility for benefits is a carrier determination, physicians are frequently called on to certify claims for their patients. Familiarity with Workers' Compensation will enhance the physician's ability to complete the forms/evaluations effectively and efficiently. Evaluations should objectively assess a patient's impairment and functional capacity, assess other contributing factors, delineate restrictions and reasonable accommodations, ascertain employability and classify the disability in accordance with prevailing administrative standards.

The physician must truly believe in the concept of early return-to-work as a best practice or they will quickly succumb to pressure exerted by those patients who are adamant about "needing time off to get better." In addition, the physicians must be willing to cultivate a specialist network of providers who practice with the same philosophy and are willing to confront those specialists who take injured workers out of work for indefinite time frames and schedule unending follow-up visits based solely on a patient's subjective complaints. The effective Workers' Compensation physician must understand the difference between a true functional deficit and a subjective complaint of pain. Physicians do a disservice to patients with work-related injuries by not understanding basic return-to-work practices**.**

Since little or no training on this "specialty" is provided by the medical schools or residency programs; it is very important that networks and provider relations departments provide the physicians and offices with the training and education necessary to allow quick efficient delivery of medical benefits to the injured worker in a cost effective manner that allows facilitation of return-to-work.

Validating What Is Going Right!

The Importance of System Data!

Viviane Vasconcelos
Director of Information Systems

The Information Technology team has been focusing on the use of systems' data to Analyze and Identify what is going right and where there may be an opportunity for improvement.

These analyses enable us to be more prepared, to provide better customer service, and to meet the expectations of our clients. One such analysis allows us to ensure that we have the right number of intake lines for claim reporting, and the correct number of team members who are ready to answer the calls from our injured workers as fast as possible.

For months we have been measuring the claims intake lines at our Altamonte office, focusing on the time it takes for the call to be answered. This office receives over 1700 intake calls per month.

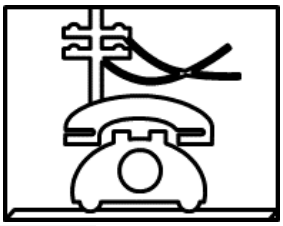
Below is the data for the last three months:

- September: 98.7% of all calls were answered with only a 1.3% abandoned call rate, and with an average wait time of 8.96 seconds.
- August: 98.8% of all calls were answered with only a 1.2% abandoned call rate, and with an average wait time of 8.61 seconds.
- July: 99.2% of all calls were answered with only a 0.8% abandoned call rate, and with an average wait time of 8.17 seconds.

We all take pride in serving our customers and in delivering our services in a high quality manner. **This data validates our hard work!**

TELEPHONE LINES (PM 1.1)

Maintain a sufficient number of telephone lines and staff so that ninety percent (90%) of incoming intake/triage calls are answered.



Summary Results:

Abandoned	25	1.3%
Answered	1887	98.7%

Detail Results:

Call No.	Call Date	Arrival Time	End Time	Caller ID
1	9/2/2014	9:15:19 AM	9:15:23 AM	38627569
2	9/2/2014	2:43:35 PM	2:43:37 PM	35238001
3	9/3/2014	8:48:44 AM	8:48:50 AM	30592458
4	9/4/2014	8:00:33 AM	8:03:29 AM	75477708
5	9/4/2014	1:11:05 PM	1:11:07 PM	95456399
6	9/4/2014	2:18:45 PM	2:18:48 PM	81399506
7	9/4/2014	8:56:40 PM	9:09:08 PM	85074758
8	9/6/2014	1:22:09 PM	1:22:13 PM	94196186
9	9/8/2014	8:21:06 AM	8:37:13 AM	30564071
10	9/9/2014	3:13:44 PM	3:13:51 PM	86349922
11	9/11/2014	7:57:53 AM	8:00:10 AM	95437697
12	9/11/2014	1:19:34 PM	1:19:42 PM	71765353
13	9/11/2014	2:59:21 PM	2:59:21 PM	94144481
14	9/12/2014	11:31:45 AM	11:49:42 AM	35295556

"SERVICE BEYOND THE CONTRACT"

AmnioFix®

Maja Sokmensuer
Utilization Review Specialist

What does a ruptured tendon and amniotic tissue have in common….Read below for information on the latest biologic on the market.

Recently we received an inquiry in the UR Department about **AmnioFix®** for treatment of a ruptured tendon in a foot. The questions were "What is it? What is it used for? How much does it cost? Is it FDA approved or experimental?" These are all good questions, all deserving of research and a response.

AmnioFix® when mixed with saline is an injectable which is composed of micronized amniotic tissue. The amniotic membrane contains a combination of growth factors unique to placental tissue which reduces scar tissue formation, inflammation in the surgical site, enhances soft tissue healing, and acts as a barrier.

AmnioFix® has been used for Rotator Cuff Tears, Torn Tendons or Tendonitis, other inflamed Soft Tissues (Bursitis and Fasciitis), Chronic Muscle Tears or Sprains, and can be added to Plasma Rich Protein (PRP) for a "super charged PRP" in more difficult cases. Over 120,000 human implants have occurred to date with very rare side effects and no known rejections.

There is extensive medical literature on the applications of amniotic membrane dating back over 100 years, with documentation of over 50,000 eye surgeries using a form of the amniotic membrane for ocular burns and conjunctiva injuries, and being used in sheet form for wounds and other surgical applications numbering over 70,000.

AmnioFix® is processed in compliance with FDA regulation 21CFR 1271, known as the current Good Tissue Practices, as well as bank standards established by the American Association of Tissue Banks (AARB) and is considered tissue product under Section 361 of the Public Health Service Act. Since it is regulated as a tissue product, AmnioFix® does not need FDA clearance or approval prior to marketing in the United States.

Currently it is rare for insurance companies, including Medicare, to cover this treatment as it is "deemed experimental." The CPT codes used for an injection would be CPT J3590 (unclassified biologics—i.e. **AmnioFix®**) and CPT 20550 (injection, single tendon sheath), but there is no information regarding cost.

I have no doubt that we will be receiving requests for **AmnioFix®** in increasing numbers in the near future, and this will no doubt evolve in the same fashion as PRP injections.