CMS recently announced a change in the reporting thresholds to $750 for liability settlements, and advised that it would keep the $750 threshold for no-fault and workers’ compensation settlements, where the insurer does not otherwise have ongoing responsibility for medicals (ORM). Yesterday, CMS issued an alert regarding these changes which can be found [here](#).

As 2017 approaches, we wanted to clarify CMS’ updates as follows:

**For Liability Insurance Cases:** The mandatory reporting threshold for total payment obligation to the claimant (TPOC) after January 1, 2017, has changed from $1,000 to $750. If the most recent TPOC date is after January 1, 2017 and the TPOC amount is greater than $750, the TPOC must be reported.

**For No fault Insurance Cases:** The mandatory reporting threshold for TPOC amounts dated October 1, 2016 or after, changed from $0 to $750. If the most recent TPOC date is after October 1, 2016 and the TPOC amount is greater than $750, the TPOC must be reported.

**For Workers’ Compensation Cases:** The mandatory reporting threshold for TPOC amounts dated October 1, 2016 or after changed from $300 to $750. If the most recent TPOC date is after October 1, 2016, and the TPOC is greater than $750, the TPOC must be reported.

Another change for 2017 is that reporting for cases below the required reporting threshold will be accepted, but are not required. CMS’ recent alert states that until January 1, 2017, cases with amounts less than the required reporting threshold will be rejected unless reported with ORM. After January 1, 2017, cases will only be rejected if the case is noted as having no ORM, and for which the total TPOC amount is $0.

For more information on mandatory reporting or how the reporting thresholds will affect your case, please contact us at poconnor@1strehab.com.
First Rehabilitation Resources, Inc. (FRR) and IMX Medical Case Management Services, Inc. (IMX) Announce Strategic Alliance

FRR is pleased to announce a strategic alliance with IMX, located in Malvern, PA (suburban Philadelphia), and founded in 1995. IMX, URAC accredited as an Independent Review Organization (IRO), provides a full array of medical evaluation and review services (IMEs, FCEs, Record Reviews, etc.) throughout The Mid-Atlantic, in addition to a boutique case management practice in Pennsylvania. Janet Dayhoff and her Team will operate FRR as a separate, sister Company to IMX, with the day-to-day operations continuing in Maryland. FRR and IMX share similar corporate cultures and a dedication to providing the highest level of service to our Clients and the industry. Our goal with the new affiliation is to have the organizations collaborate closely to aid in the continued expansion of both.

POP QUIZ!

1) What is Telephonic Case Management?
   a) Handling all matters related to a case telephonically.
   b) Claims professional, injured worker, and employer communication and coordination.
   c) Coordination between the injured worker, physician and employer telephonically.

2) Why are prior medical records important in the medical management of the claims?
   a) Insight to the injured worker’s background.
   b) It’s part of the check-off list.
   c) It may be helpful to determine if the injured worker lied on an employment application.
   d) All of the above.
   e) None of the above.

3) When is a nurse case manager indicated in a case?
   a) Multiple doctors and conditions
   b) Resistant and difficult injured worker.
   c) Severity and multiple conditions.
   d) All of the above.
   e) None of the above.

Answers can be found on the last page of the Newsletter!
Questions originally from WC Magazine, August/September 2016 Issue
TheCLM.org
Vocational Rehabilitation cases often present the most challenging of scenarios; these Clients have been unsuccessful in their own efforts to return to work and often come into the Program with barriers which extend beyond their work-related physical limitations.

Such was the case of our mid-fifty year old Site Engineer, out of the workforce for more than three years due to carbon monoxide poisoning. This exposure resulted in his impaired balance and cognition, and an overall decrease in his physical stamina.

In the course of a vocational assessment, the FRR Vocational Case Manager (VCM) identified mental processing deficits (ruling out supervisory and managerial tasks), and balance/dizziness issues (limiting material handling and mechanical tasks). Simply developing job targets for a Vocational Rehabilitation Plan was the first obstacle. The Plaintiff Attorney, and the Claims Manager/Defense Attorney suggested a short duration of job placement efforts. All parties, however, acknowledged the limited potential for a successful outcome.

Upon a records review, the VCM noticed that cognitive rehabilitation had been suggested by the IME and was never addressed by the treating Neurologist. It was noted that development of compensatory strategies would be useful for the Client and could coincide with vocational rehabilitation activities. Improvements were immediately noted with the commencement of cognitive rehabilitation; however, the Client struggled to accomplish even limited tasks during weekly job search meetings. One morning, while attending a Job Club at the offices of FRR, he fell sound asleep at the conference room table, requiring the Facilitator to nudge him awake!

With close and almost daily communication between the Client and VCM, in conjunction with his Cognitive Therapist, a feasible and realistic job search schedule was adopted. The Client’s confidence in his work abilities improved, and his resume and cover letter began to generate responses, including interviews.

With a great deal of support and instruction by the FRR VCM, (role-play of difficult interview scenarios, instruction in effective disability disclosure techniques), the Client presented favorably. Following his third interview with a large retirement community, he was offered a full-time Engineer position, meeting his physical needs and offering a starting wage comparable to pre-injury earnings. The FRR VCM monitored the return-to-work for 30 days, maintaining close communication with both the Client and Employer to ensure success.

Approximately six months following case referral, the case was closed with successful job placement. All parties acknowledged their preliminary thoughts of

Medical Case Management is often more comprehensive than most think … yes, it is coordinating and monitoring treatment in a timely and cost effective manner, as well as intervening to ensure the maintenance of quality of life. The case of our mid-fifty-year-old Office Worker is a prime example. Referral was made at four months status post low back injury. The injury occurred while an Office
move was in play, with, also, a significant history of kidney stones (unrelated). Initially, it was thought that the right sided, low back pain was related to probable kidney stones, and treatment was sought with an already treating nephrologist/urologist. Following examination by multiple physicians and their recommended diagnostics, muscular pain was diagnosed with a referral to a Pain Management Specialist. An MRI scan of the lumbar spine revealed lumbar disc bulge. Three epidural steroid injections did not provide benefit.

Upon Nurse discussion with all parties, an evaluation was coordinated with an Orthopedic Spine Surgeon. Following examination and review of diagnostics, the Physician noted lumbosacral disc degeneration, and lumbar canal stenosis with neurogenic claudication, most likely stemming from the L5-S1 foramen and the rather severe stenosis due to lumbosacral disc disease. A small disc bulge at L4-5 was also noted, with the L5-S1 thought to be the most likely culprit. Treatment recommendations included a chairback lumbosacral orthosis (LSO) to restrict trunk mobility, and lumbar physical therapy two to three times per week for six weeks. Continued discomfort would then result in the surgical recommendation.

The Nurse coordinated a second surgical opinion. Following a diagnostic review and examination, a recommendation was made for an L4-L5, L5-S1 right side decompression and laminectomy. The Nurse facilitated a discussion with the Physician regarding the varying surgical options.

The above recommended surgery occurred in the fall. Although the Medical Disability Guidelines (MDG) indicated a January 2017 return to full duty, the Client recovered ahead of schedule and returned to work in early December. Pain free work and daily living is ensuing!

---

This holiday season we hosted our very first joint Holiday Recipe Contest with our sister company, IMX! We voted on the winning recipes in three categories: Most Festive, Best for Large Groups, and Simple yet Scrumptious! Check out the winners below and on the next pages:

**Most Festive:**
**Lemon Ricotta Cheese Cookies**  
*Chris Atella, IMX*

A cake-like lemony treat, an Italian Tradition!

**Ingredients**
*Cookies:*
- 2 ½ cups flour
- 1 tsp baking powder
- 1 tsp salt
- 2 cups sugar
- 2 eggs
- 1 stick unsweetened butter
- 15 oz ricotta cheese

Continued on Page 4
3 Tbsp lemon juice
Zest of 1 lemon

Glaze:
1 ½ cup powdered sugar
3 Tbsp lemon juice
Zest of 1 lemon

Directions
In a bowl add the flour, baking powder and salt.
In another bowl using an electric mixer, blend together the butter and sugar until light and fluffy (about 2 mins) add 1 egg at a time to mix. Add the lemon juice, lemon zest and ricotta cheese. Beat to combine, add the dry ingredients until all ingredients are incorporated together.
Preheat the oven to 375 °.
Spoon the dough (about 2 tablespoons for each cookie) onto a greased baking sheet about 3 inches apart. Bake about 15 minutes (until the cookies are golden around the edges). Cool cookie for about 20 minutes before adding the glaze.
Glaze: mix together the powdered sugar, lemon juice and lemon zest until smooth. Place glaze (about ½ tsp) on top of each cookie. Use back of the spoon to spread the glaze. Let the glaze harden about 2 hours. Store cookies in a plastic or metal container.

Best for Large Groups:
Crockpot Breakfast Casserole
Dora Morris, FRR

A classic breakfast casserole with eggs, sausage, bacon, hash browns, and cheese. Great for the holidays and a crowd!

Prep Time: 30 mins
Cook Time: 8 hours
Serves: 8-12

Ingredients
1 30 oz package frozen shredded hash brown potatoes
½ lb ground sausage, browned and drained

1 lb bacon, cooked and chopped
2 cups shredded mozzarella cheese
1 onion, diced
1 green pepper, diced
1 red pepper, diced
12 eggs
½ cup milk
½ tsp salt
¼ tsp ground black pepper
1/8 tsp sugar

Directions
Grease a large 6 quart slow cooker with cooking spray or butter.
Layer half the hash brown in the bottom of the slow cooker.
Top with half the sausage, bacon, cheese, onions, green pepper, and red pepper. Repeat layers with remaining ingredients.
Pour egg mixture over hash brown and cheese layers.
Cook on low for 6-8 hours or 4 hours on high.
Simple yet Scrumptious: Hot Maryland Crab Dip
Sam Kieley, FRR

Made with real Maryland Crab, of course!

Ingredients

12 ounces jumbo lump or backfin crabmeat (Maryland crab is best!)
Two 8 oz packages of cream cheese
½ cup mayonnaise
2 tsp Worcestershire sauce
Five dashes Tabasco sauce
1 cup shredded cheddar cheese
Old Bay Seasoning (to taste)

Directions

Pre-heat oven to 350 °. Using an electric mixer, blend cream cheese and mayonnaise until smooth.

Combine remaining ingredients, except cheddar cheese and crab. Gently fold in crabmeat, try not to break the lumps. Spoon into ovenproof casserole dish, sprinkle with old Bay seasoning to taste, and bake for 20 minutes/until browned on the edges and bubbly.

Remove from oven, top with cheddar cheese, and return to bake until melted. Serve hot with crackers, pretzels or crusty bread.

Pop Quiz Answers:

1) A, 2) E, 3) D