

# Workers Compensation Outlook

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## Developing Clinical Best Practices to Target Specific Risks

*Starbucks earned its laurels by ensuring that you could get a consistently great cup of coffee anywhere from Seattle to Manhattan to Miami. That's because the company uses best practices for everything from weighing coffee beans to pulling the perfect shot of espresso, from running the cash register to handling dissatisfied customers. Similarly, training in clinical best practices in workers compensation case management could support consistent quality and have a positive impact, ultimately reducing medical and indemnity costs and improving patient and claim outcomes for high-risk claims. This issue of Workers Compensation Outlook explores ways to identify claims that are potential adverse surprises, i.e., those at risk of becoming high-cost claims or beginning to show signs of doing so. It also addresses what those responsible for claims management need to do to prevent targeted claims from becoming financially catastrophic.*

### The challenges: Chronic pain and increasing costs

Recent Bureau of Labor statistical data show a decrease in reported nonfatal occupational injuries and illnesses that require days off work – a drop of 9 percent from 2008 to 2009. (Some of this drop can be attributed to high unemployment rates.)

Despite the decrease in incidents, workers compensation costs – both medical and indemnity – continue to rise year over year. National Council on Compensation Insurance (NCCI) data show a steady increase in medical and indemnity costs over the last 15 years.

A 2009 NCCI Research Brief reports that 47 percent of workers compensation claims account for 93 percent of workers compensation medical spending. Catastrophic-injury claims account for only 1 percent of claims and 11 percent of medical spending. The bulk of medical spending – 82 percent – is on the 46 percent of claims costing between \$10,000 and \$500,000.

A 2005 Workers Compensation Research Institute (WCRI) study of adverse surprises, where medical costs at 36 months were more than \$50,000, found that most involved chronic conditions with multiple surgeries, with a high proportion of back pain. In addition to surgery, many cases involved physical therapy and chiropractic care, radiology, and mental-health services. Also, in many cases, initial surgery or chiropractic care occurred later, suggesting that the medical treatment during the first six to 18 months post injury did not resolve the medical issue. The study did not address identifying criteria for early intervention.

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The same economic forces depressing employment are driving businesses to tighten their belts in other ways. Businesses need strategies for controlling the medical, indemnity, and administrative expenses of workers compensation.

What are the most effective ways to mitigate severity in medical and indemnity trends without excessive administrative expenses for clinical interventions that might not work anyway?

## **Timely recognition of potentially problematic claims**

The first step in avoiding adverse surprises is to use data-driven risk modeling to identify and target risks throughout the life of the claim. Predictive modeling can use historical data to help identify at-risk claims as well as evidence of increasing risk. Data mining identifies patterns and relationships between outcomes and claim attributes, such as medical and pharmacy data, comorbidity and psychosocial factors, to flag conditions suggesting that a claim is headed in the wrong direction.

Some companies use risk modeling early in the life of the claim to identify claims for management. Doing so makes it possible to allocate claims resources where they can have the most impact. Predictive modeling makes it possible to identify potential high-cost claims and improve the injured worker's chance of recovery and return to work. The problem is, some cases fall through the cracks of predictive modeling. Case management isn't applied early, and the cases don't move to resolution.

In addition to predicting risk, it is important to recognize emerging risk as soon as it becomes evident. That requires mining data throughout the life of the claim in order to make appropriate course corrections if medical treatment starts falling outside accepted guidelines or other issues arise. For example, the system might look for a high number of physical therapy treatments or pain-related prescriptions from multiple providers, which indicate a need to act.

With ongoing review of risk, based on actual claim information, the actual needs of the claim drive the level of clinical intervention. This approach can reduce or eliminate unnecessary expense while delivering maximum impact.

Once you identify the risk, how do you mitigate it?

## **Consider clinical best practices**

Once you have identified risk that requires clinical management, you should apply best practices that target the specific risk.

Best practices are methods or processes that have proven to be most efficient and effective in accomplishing a task or reaching a goal. As these techniques consistently achieve desired results, they are adopted throughout an organization, setting a standard that can continue to evolve as a better way of achieving the desired goal. In other words, whether you're in Bangor or Burbank, whether your barista is brand new or a Starbucks veteran, you'll get the same mocha latte.

Treatment algorithms represent a formalized best practice. For example, in an article in Pain Physician, Laxmaiah Manchikanti, MD, and others describe algorithmic approaches to various chronic pain conditions. Their decision tree shows intervention options based on clinical evaluation and treatment response, giving providers a standardized roadmap for treating chronic low-back, neck, or thoracic pain.

Similarly, clinical best practices can help case managers navigate complex claims with clearly identified barriers to recovery. Standardized best practices help ensure consistent quality regardless of a case manager's prior experience with complex claims or with a specific clinical area. This approach to case management intervention can have a positive impact on the quality of care received and the quality of service perceived, while reducing incurred medical costs. It can also enhance the injured worker's quality of life.

Best practices for case managers should incorporate nationally recognized treatment guidelines, but they must also go further. Ideally, they should include other tools, such as coaching and negotiation, when case managers need to address complex cases.

It takes more than clinical knowledge to address an injured worker who may be unmotivated to change, an uncommunicative physician or one with an ineffective plan for treatment, or any of the challenges that can arise when the injured worker's behavior is driven by psychosocial or economic issues or inappropriate use of narcotics. Case managers who understand the cognitive and behavioral aspects of recovery and premorbidities can help drive better outcomes. That's why Starbucks trains as much on customer service as it does on coffee recipes.

From identifying barriers to validating clinical alerts, development of robust best practice guidelines requires input and buy-in from several disciplines within an organization. Information management, process management, clinical product development, operations, and the medical director all should be involved. Medical directors, available for consultation with the case manager or peer-to-peer discussions with the treating physician, are invaluable resources. Seamless integration between case manager and medical director is critical. Considering possible biopsychosocial issues, access to a psychologist could also prove beneficial.

## **Looking beyond the injury**

Claims may fall outside optimal treatment and recovery guidelines for any number of reasons. The most common are comorbidities, psychosocial issues, perceived disability and catastrophic thinking, a provider who is unwilling to address functional capabilities or return to work, multiple treating physicians, or use/abuse of narcotics.

In some cases, traditional treatment methods have failed, and the injured worker is physically deconditioned. He or she may be at risk for narcotic addiction, alcoholism, depression, and anxiety. Without additional training and resources, many case managers are not equipped to address these biopsychosocial

complications to minimize their impact on the injured worker's outcome.

An article in the March 2006 Practical Pain Management explains that "Biopsychosocial pain disorders are by definition, disorders having three dimensions: biological, psychological and social. Evaluating a chronic pain condition from a one-dimensional biological perspective is limiting, and often fails to fully explain the patient's symptoms. Consequently, assessment requires not only the examination of the biological dimension, but of the psychological and social dimensions as well."

To be most effective, case managers must be able to identify stumbling blocks to recovery and return to work – regardless of their nature – and address them early in the process. Doing so requires an ability to identify biopsychosocial barriers and to apply cognitive behavioral strategies such as active listening, reading nonverbal cues, positive reinforcement, and correcting inaccurate thought processes.

First, case managers must establish rapport and help the injured worker explore how the injury impacts his or her physical and psychosocial functioning.

To educate the injured worker properly, the case manager must identify the injured worker's level of understanding and knowledge of his or her diagnosis, along with any gaps in knowledge. The case manager should help the injured worker understand how his or her thoughts and feelings can impact recovery. The case manager can encourage the injured worker to participate actively in his or her treatment planning and recovery and help the injured worker identify barriers to recovery and assuage associated fears.

For example, an injured worker may find it difficult to remain active. Inactivity can result in deteriorating physical condition, which could increase the risk of reinjury. Inactivity can also lead to negative thinking and depression. To prevent this, the case manager can help the injured worker establish a structure that mimics the work environment. This might include asking the injured worker to wake every day at the same time as he or she would if still on the job. If appropriate, the case manager could also encourage the injured worker to start each day with a walk or some other physical activity.

This approach expands the role of a case manager beyond purely clinical boundaries to address psychosocial issues that could impede recovery. This requires additional training and points to the value of establishing best practices.

Some case managers may have more experience than others in dealing with a specific type of injury. Some case managers will have a greater level of comfort than others when it comes to addressing psychosocial issues. Clinical best practices give all case managers within an organization access to the same baseline of knowledge while holding them accountable to use the processes deemed most effective.

## When pain meds are the problem

Most states have adopted evidence-based treatment guidelines. When physicians follow them, their cases generally do not become problematic. For a variety of reasons, however, some doctors do not treat according to guidelines, and those cases can pose a challenge.

Development of outcome-driven pain management specialty networks could help ensure that injured workers have access to credentialed, experienced pain management specialists. When the guidelines call for 12 physical therapy treatments and a physician prescribes 50, it takes a skilled negotiator to have a productive conversation with the provider. Best practices can help the case manager know when to have the conversation (and why) and understand the goal of the negotiation.

One area of particular concern with chronic pain cases is narcotic pain management. In its Opioid Treatment Guidelines, the American Pain Society/American Academy of Pain Medicine panel notes that "patients with more complex cases, including those with disabling [chronic non-cancer pain (CNCP)], tend to experience better outcomes if they are managed using a comprehensive approach that integrates strategies to improve pain with those that address the functional impairment and psychosocial factors that are often associated with CNCP."

Cases involving narcotics may benefit from careful management. The case manager will need to educate and coach the injured individual and communicate closely with the provider and employer, making sure they have a plan in place to address any medication issues.

The case manager must make sure that the injured worker understands the treatment plan, including any medications, their side effects, and the importance of following doctor's orders. The case manager can provide logs to track dosing regimens. If narcotic pain management threatens to create barriers to recovery, the case manager can help the injured worker learn alternative methods for pain management.

Case management aims to help the individual overcome some of the challenges associated with pain and resume activities he or she previously enjoyed. To that end, increasing physical activity is a key component. Field-based case managers are uniquely positioned to spend time at the individual's home to observe and accurately assess the individual's activities of daily living. Increasing physical activity may include a daily walking program, a more structured physical therapy or work conditioning program, or a return-to-work program with gradual transitional work.

In the event that the injured worker shows a lack of functional improvement while taking opioids, the case manager should review the facts with the individual and the treating provider. In most cases, this should result in therapy tapering and the implementation of non-narcotic alternatives. Here, the case manager should ensure that the physician is aware of the availability of opioid consent forms,

drug testing urinalysis, and similar tools.

It is important that the case manager ensure that the physician is aware of the medical best practices for treatment with narcotics and opioids. For example, if the treatment plan involves narcotics for 30 days or more, the case manager should discuss the necessity of a weaning program.

These discussions are likely to be difficult, but addressing the issue head-on with both the injured worker and the provider is critical if we are to succeed in returning the individual to a preinjury level of functioning and ultimately, return to work. An individual who cannot manage pain without narcotics is probably not a viable candidate to return to work.

## Reaching out to the employer

In order to increase the likelihood of a successful return-to-work strategy, clinical best practices must also engage the employer. The case manager should clarify with the employer what, if any, return-to-work options may be available. If return to work with the preinjury employer is an option, the case manager should see that this goal is incorporated into the injured worker's treatment plan.

An initial step in preparing the injured worker is increasing the individual's confidence in his or her ability to return to work. The case manager can help the employer develop transitional work alternatives that will potentially accelerate the return-to-work process during the medical recovery. Best practices also include managing the transitional duty process. As the injured worker gradually recovers and his or her functional capabilities increase, so should the physical demands of the transitional duty.

Transitional duty allows the injured worker who may have a fear of pain or reinjury to ease back into the workforce. In addition, it often provides on-the-job work hardening, avoiding the unnecessary expense of a formal work-hardening program.

It also demonstrates to the injured worker that the employer cares about the individual's well-being and medical recovery.

## How would it work in the real world?

Consider the case of a 48-year-old deli worker. Following a slicer accident, the medial and distal phalanges of two fingers of her dominant hand were successfully reattached, but she remained out of work 18 months later. She was prescribed medication for pain and depression, but still experienced both. She told her case manager that she spent most of the time at home watching television.

At the initial home visit, the case manager asked probing questions to assess the injured worker's motivations and focused on what the woman loved about her job. The case manager also asked permission to talk to the physician about the fact that the medications were not working and encouraged the injured worker to make a follow-up appointment.

The case manager coached the injured worker, providing practical

suggestions to help her get over her fear that people would stare at her injured hand. The case manager also worked with the employer to find appropriate duties that would not require extensive use of the injured hand, resulting in her successful return to work.

A traditional approach would have been more direct. The resulting confrontation would likely have made the injured worker defensive and resistant to change. Instead, the case manager built a relationship with the injured worker, focused on strengths, and empowered the individual to take control and make positive changes.

## Measuring impact

Building case management clinical best practices for targeted workers compensation conditions is similar to the development of disease management programs commonly promoted by managed care insurance companies – and so it is reasonable to project similar results.

Most disease management programs are designed to identify at-risk patients through claims data analysis; once identified, these patients receive some level of education or intervention depending upon level of risk. Such programs have demonstrated positive impact.

For example, one controlled study involved a large health-management program for individuals who had, or who were at risk for, one or more of 17 chronic conditions or diseases. Analysis of the program included application of rigorous predictive modeling across multiple conditions. For the first year, the program delivered the following results:

- return of least \$2.90 for every dollar invested in the program;
- average savings of \$41 per program member per month;
- 14 percent fewer hospital admissions;
- 18 percent fewer emergency department visits; and
- 7- to 11-percent reduction in absenteeism from work or school.

The United States Department of Defense (DoD) has also examined best practices and found them to produce favorable results. The DoD Medical Case Management Working Group published a white paper in which the department analyzed workers compensation data from 1996 through 2003 for 14 sites that used some form of medical case management.

The authors concluded that the armed services avoided \$46 million in workers compensation costs when compared with the appropriate service average. If all DoD sites had performed like the 14 analyzed sites, the armed services could have avoided \$421 million in workers compensation costs – enough funding for 10,300 GS-07 employees or 98 M-1 tanks.

The DoD best practices addressed an integrated case management team, personnel training, communications, case closure, medical care and coordination, information systems solutions, and return to work.

The DoD white paper also stressed the importance of administrative case management, use of a medical case manager or managed care program, early identification of employees with work-related injuries or illnesses, and proactive preventive measures, such as safety engineering and ergonomic controls.

For each organization, the impact of case management best practices can be assessed at several levels. From a case-impact perspective, individual case management results can be measured in terms of successful outcomes, including percentage of return to work, maximum medical improvement and injured worker satisfaction, and improved claim trends demonstrating reduced medical and indemnity expenses.

## About the author

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