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# VISIONS

## Work Disability Prevention Requires Early Intervention, Focus on Function

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By Karen O'Hara

***“All good doctors are not good injured-worker doctors.”***

—Larry Yuspeh, Louisiana Workers' Compensation Commission

**W**hen treating an injured or ill employee, one of the primary goals is to intervene in a way that prevents the individual from getting sucked into the vortex of avoidable disability.

Work-related disability is rarely medically justified, experts say, yet it is a relatively frequent occurrence. Unnecessary lost work time costs employers millions of dollars each year while simultaneously setting workers back financially, socially, psychologically and physically.

The evidence clearly shows that most injured employees get better faster if they keep working through their recovery period. Early intervention is promoted as a key to effective disability management because data show that injured or ill employees who never lose time from work have better long-term out-

comes than those who do. For those who miss work, the odds for a return to full employment after six months of absence because of a work-related disability are less than 50 percent.

### Preventing Disability

Gideon Letz, M.D., M.P.H., medical officer for the California State Compensation Insurance Fund (State Fund), has long believed that workers' compensation case management needs to shift from away from pre-authorization and utilization review and toward the promotion of disability management as the primary tool for improving injured worker outcomes. Dr. Letz spoke on *Preventing Needless Disability* at a recent conference sponsored by Health Connections Networks (HCN)<sup>1</sup>

“In the past 10 to 15 years, a great deal of attention has been paid to measuring quali-



ty, but little attention has been paid to preventing and managing disability, when up to 80 percent of paid indemnity expense is unnecessary,” he said. “Disability management allows all the major players with a stake in workers' compensation to collaborate on functional recovery.”

Dr. Letz recommends two basic preventive actions in the acute phase of treatment: 1) early intervention to facilitate successful recovery by focusing on the workers' abili-

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## Litigation, Claim Duration Linked to Increased Costs

Dr. Edward Bernacki reports on Louisiana Workers' Compensation Corporation costs by claim category, initial total reserve and claim duration in a recent edition of the *Journal of Occupational and Environmental Medicine* article.

The researchers examined four claim categories: 1) low initial reserve/low cost; 2) migrated catastrophic (low initial reserve/high cost); 3) high initial reserve/low cost, and 4) catastrophic (high initial reserve/high cost). The study is based on five years of data from 36,329 Louisiana workers' compensation claims in these four categories. Among the findings:

- Migrated catastrophic injuries accounted for only 2 percent of all claims but 32.3 percent of costs.
- Accelerated escalation of costs occurred late in the claim cycle (two years).

Among 729 claims initially thought to be low cost (migrated catastrophic), the most significant predictors for cost escalation were attorney involvement and claim duration, followed by low back disorder, marital status, male gender, small company size, high premium, reporting delays and older age.

The researchers concluded that certain contributing factors, particularly attorney involvement and claim duration, are associated with unanticipated cost escalation in a small number of claims that dramatically affect overall losses.

"The results of this study suggest that these cases may be identified and addressed before rapid escalation occurs," they said.

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Determinants of Escalating Costs in Low Risk Workers' Compensation Claims; E Bernacki, et al.; *JOEM*, Vol. 49(7):780-790, July 2007.

ty to perform functional job demands and 2) appropriate triage for those cases that involve "non-routine" care. In California, regulators have attempted to set the stage for this approach through mandatory use of the American College of



Occupational Medicine's (ACOEM) clinical practice guidelines,<sup>2</sup> which include a chapter on *Cornerstones of Disability Prevention and Management*.

Without these actions, if one follows a patient's progress in accordance with the acute-to-chronic pain ladder (Sherri Weiser, 1997), an individual can quickly ascend from the bottom rungs of acute uncertainty and fear to the top rungs of chronic loss of identity and a sick role mentality, Dr. Letz said.

## Physician Involvement

In any given situation, the treating physician's attitude, training and incentives have a significant degree of influence. For example, the majority of physicians who see workers' compensation cases get paid for performing procedures, not for sitting down with patients and reassuring them that they will get better. In addition, many injured workers are seen initially by physicians who have not been trained in occupational medicine, which puts them, their patients and employers at a disadvantage.

Outcomes improve when medical care is provided by knowledgeable and personable physicians whose incentives are aligned with those of the payer. When incentives are not well aligned, practice guidelines, nurse case managers and other mechanisms can be used to achieve the desired results, according to Edward Bernacki, M.D., M.P.H., director of the Occupational Medicine Division at Johns Hopkins University, Baltimore, Md.

"Our physicians are evaluated on their ability to interact with patients," Dr. Bernacki said. "We encourage them to follow their patients, and we pay them for multiple visits. They are affable and they understand the system. They know where to send patients for referrals and what the options are for return to work."

Johns Hopkins is self-insured for workers' compensation and administers its own program. More than 16 years ago, it carved out its own mini-network of physicians with knowledge of the workers' compensation system to deliver care to its hospital and university employees. Dr. Bernacki and his colleagues have been measuring and publishing the results ever since.

The Johns Hopkins system works like this:

Injured workers are directed to an experienced network physician at one of three clinics. Each physician is selected based on their clinical and interpersonal skills.

A nurse case manager facilitates the in-network diagnostic and treatment process. To decrease variability if a case goes out of the network, the case manager takes steps to ensure that established treatment guidelines are followed. Every case is tracked to assess the appropriateness of any medical invention and whether adjustments should be made in the treatment and return-to-work plan through case closure.

An internet-based software system is used to transfer information among all relevant parties. Because Johns Hopkins is self-insured/self-administered for workers' compensation, it has control over this important aspect of the process.

If a workers' compensation claim is rejected, the individual is directed to a designated group health provider.

## Lost Days, Costs Decline

Since implementing this model, Johns Hopkins' employee population has grown from 21,000 to approximately 45,000. In 1992, there were 457 lost-time



claims (21.8 claims per 1,000 employees), 155 medical-only claims and more than 34,000 paid temporary total disability (TTD) days. In 2007, with a much larger working population, there were 237 lost-time claims (5.0/1,000 employees), 2,522 medical-only claims and 13,897 paid TTD days.

Meanwhile, losses per \$100 of payroll fell from \$0.81 to \$0.32 between 1992 and 2007. TTD costs decreased and permanent partial disability (PPD) costs increased slightly. Medical losses increased from \$1.7 million in 1992 to \$2.4 million in 2007.

The data suggest that while claims management is effective in controlling losses and costs, it remains difficult to avoid hazards that exist in an academic medical center environment. In addition, risk in the hospital setting has been shown to be considerably higher than university-based risk. Among the hospital employee population, for example, rotator cuff injuries, meniscal tears and low-back complaints are relatively common.

***“Our losses are roughly half that of other hospitals and universities. We are contributing to the productivity of the institution.”***

“It appears that we can’t completely engineer out the risk,” said Dr. Bernacki, who gave two presentations on workers’ compensation communication and medical practices at the HCN conference. “There is an advantage to managing our cases. Our losses are roughly half that of other hospitals and universities. We are contributing to the productivity of the institution.”

Maryland is an employee-choice state, so Johns Hopkins can only encourage – not require – its employees to see network physicians. However, compliance is about 90 percent, primarily because the physicians have shown they care about their patients.

**Louisiana Experience**

Dr. Bernacki and his colleagues have applied similar principles in a project with the Louisiana Workers’ Compensation Corporation (LWCC), a private, non-profit mutual insurance company that was created to help reviv-

italize the state’s failing workers’ compensation system.

Dr. Bernacki helped the LWCC establish a preferred provider network called OmNet Gold (OG). The network utilizes “managing care physicians” – occupational medicine practitioners who are responsible for providing initial treatment and tracking medical care. The OG physicians refer to selected specialists, including orthopedic surgeons, neurosurgeons and psychiatrists, as well as chiropractors and physical therapists. OG physicians undergo training at seminars conducted by the LWCC and handle cases that emanate from the corporation’s top 200 policy holders with the highest volume of claims. Utilization review is waived for OG providers; physicians outside the network remain subject to pre-authorization requirements.

In a study published in 2006, a team of researchers led by Dr. Bernacki compared the outcomes of 176 cases managed in the OG network to 1,464 cases managed in a more traditional way outside of the network (including utilization review).<sup>3</sup> The claims were analyzed two years after injury, when more than 90 percent of the cases had been resolved and closed. Among claims filed during the study period, August 2003 to July 2004 (valued March 2006), the mean was 53 lost work days for OG-managed claims and 99 days for traditionally managed claims. The data also show that OG-managed claims closed earlier than non-OG-managed claims.

The total cost for OG care was \$12,500, compared to \$20,400 for non-OG cases. The mean OG medical cost was \$5,855, compared to \$9,850 for non-OG medical care. Other costs, such as indemnity, management fees and legal expenses, were also lower for OG-managed cases versus non-OG-managed claims.

“Utilization review seems to have little impact on the behavior of experienced health care providers pre-selected for their ability to appropriately treat and manage workers’ compensation cases,” Dr. Bernacki and his colleagues concluded. “With their experience and expertise in treating injured workers, occupational medicine physicians appear to be able to reduce patient disability, using fewer medical resources, without insurance company oversight.”

Larry Yuspeh, LWCC director of

research and development, said the math is pretty simple:

**Medical treatment + Care management = Good injured worker care**

In other words, the LWCC supports the premise that well-qualified physicians who are unencumbered by pre-certification requirements will take appropriate steps to minimize or eliminate disability in the shortest amount of time possible.

“All good doctors are not good injured worker doctors,” Mr. Yuspeh said during a presentation at the HCN conference. “We partnered with Hopkins because it appeared their model was driven by the provision of appropriate care rather than by discounts. Our focus is on healing the injured worker. It turns out that’s the right thing to do.”

LWCC statistics show that total claim costs grow exponentially as a claim ages (Table 1), but that medical costs as a percentage of total costs decline as a claim ages (Table 2). That’s why the LWCC focuses on early, appropriate return to transitional or restricted duty. In addition, when a case is litigated, the LWCC attempts to settle it as quickly as possible. “We don’t want people going to the pain clinics,” Mr. Yuspeh said.

The moral of both the Johns Hopkins and the OmNet Gold stories is that “you have to connect the payer, the provider and the employer via an integrated claims management system.”

**Table 1: Growth in Claims Costs**

Claims Costs Grow as Claim Ages	
1-30 LTD	3.8 X MO
31-90 LTD	2.1 X 1-30 LTD
91-180 LTD	2.2 X 31-90 LTD
181-365 LTD	1.4 X 91-180 LTD
Over 365 LTD	2.6 X 181-365 LTD
NOTE: 91-180 = 4.6 X 1-30 LTD	
Over 365 LTD = 1.68 X 1-30 LTD	

LTD=Lost time days MO=Medical only

**Table 2: Medical Cost as a Percentage of Total Claims Cost**

Medical Costs Decline as Claim Ages	
1-30 LTD	MED\$ = 2.13 X IND\$
31-90 LTD	MED\$=1.53 X IND\$
91-180 LTD	MED\$=1.25 X IND\$
181-365 LTD	MED\$=1.01 X IND\$
Over 365 LTD	MED\$=.52 X IND\$

LTD=Lost time days MED\$=Medical dollars IND\$=Indemnity dollars

Source: Louisiana Workers’ Compensation Corporation

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## Survey Shows Boomers Not Informed About Common Causes of Disability

Most middle-aged and older workers underestimate their risk of suffering a non-work-related disability that would cause them to miss work for an extended period of time, according to a newly released survey conducted for America's Health Insurance Plans (AHIP) by Harris Interactive.

"Baby boomers' lack of awareness of their risk of disability presents a significant threat to their financial security," said Karen Ignagni, president and CEO of AHIP. "When individuals underestimate their risk of disability, they are less likely to protect their income and are more vulnerable to the financial hardship that suffering a disability can cause."

According to the survey, slightly more than a third of baby boomers believe the chances of becoming disabled because of an illness or injury is 5 percent or less. A slight majority think the chances are 10 percent or less and two-thirds think the chances are 20 percent or less. Social Security Administration statistics show that a worker actually has a 30 percent chance of suffering a disabling injury or illness that results in missing three or more months of work before retirement age.

Among the survey respondents, 26 percent believe the most common causes of disability are back, muscle and joint problems; 18 percent cited work-related injuries as the most common cause and 16 percent cited non-work-related injuries. Research shows that cancer, heart disease and diabetes are actually the leading causes of disability leading to work absence.

"The survey shows that baby boomers need to be better educated about the risks and causes of disability to ensure they take appropriate steps to protect themselves," said Humphrey Taylor, chairman of the Harris Poll.

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Communication really does make a difference in workers' compensation," Dr. Bernacki said. "At Hopkins, we have our own claims payment system, which has helped us a lot in talking to each other."

### Practice Guidelines

In general, well-designed clinical practice guidelines support optimal patient recovery as well as continuous quality improvement. They provide a common language for explaining all aspects of care and help ensure more timely and fairer payment for physicians and other providers who want to be



rewarded for achieving the best possible outcomes, says ACOEM Executive Director Barry Eisenberg.

At the same time, employers benefit from the use of such guidelines because they improve transparency and predictability. Guidelines function as effective cost-management tools, in part because they help explain variations in care.

"Practice patterns matter," Mr. Eisenberg said at the HCN conference. "Disability guidelines are not a just a laundry list of recommendations within the context of the correct way to take care of patients."

The application of disability management principles in workers' compensation is particularly relevant given that a healthy and productive workforce is a "competitive imperative" in today's marketplace, he noted.

### Disability Defined

The ACOEM guidelines define disability management as a "workplace prevention and remediation strategy that seeks to prevent disability from occurring or, lacking that, to intervene early, using coordinated, cost-conscious, quality care management and rehabilitation services."

Mr. Eisenberg said optimally effective disability guidelines feature internationally accepted recommendations using evidence-based medicine and a paradigm of care rather than prescriptive care.

"Guidelines are sometimes criticized for saying, 'Don't do anything' in 100

different ways," Mr. Eisenberg said.

However, the "do-nothing" approach makes sense, given that only a small percentage of medically excused days off work are actually medically required, and about 90 percent of cases are likely to resolve within the first 90 days following an injury.

**"Guidelines are sometimes criticized for saying, 'Don't do anything' in 100 different ways."**

According to the ACOEM practice guidelines, work absence is medically necessary only when:

- Attendance is required at a place of care (hospital, physician's office, physical therapy).
- Recovery (or quarantine) requires confinement to bed or home.
- Being in the workplace or traveling to work is medically contra-indicated (poses a specific hazard to the public, co-workers, or the worker).

By comparison, the guidelines state that a medically unnecessary disability occurs whenever a person stays away from work because of non-medical issues such as:

- The perception that a diagnosis alone (with demonstrable functional impairment) justifies work absence.
- Other problems that masquerade as medical issues, e.g., job dissatisfaction, anger, fear or other psychosocial factors.
- Poor information flow or inadequate communication.
- Administrative or procedural delay.

"This has to be about good care," Mr. Eisenberg said. "That means providing the right care at the right time. When that happens, patients improve faster and at a lower cost to the system."

### California Testing Ground

In California, workers' compensation medical care is presumed to be reasonable (and reimbursable) as long as it is supported by the medical literature. If it is not, the provider must justify the treatment in order to get paid, said Dr. Letz, who contributed to a chapter on "Disability Prevention and Management" in *Current Occupational and Environmental Medicine*.<sup>4</sup> In another major change in California, employers

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may now channel their injured workers to providers who are qualified to be part of state-approved medical provider networks.

Meanwhile, in a pilot project with Industrial Health Strategies, a disability management firm based in Providence, RI, that has developed the Accelerated Case/Claim Evaluation System (ACES), the State Fund has targeted cumulative trauma disorders (CTDs) for study. CTDs were chosen because their etiology is often obscure, treatment challenges frequently arise and costs tend to be disproportionately high in comparison to injury severity, Dr. Letz said.

ACES automatically profiles claims for potential delayed recovery by analyzing more than 100 variables. Claims are ranked in order of potential significance, from one to three, with three representing high-risk claims targeted for ultimate adverse development.

Targeted risk factors include age, date of hire, physical demands of the job, litigation, job satisfaction, availability of transitional work and co-morbidity.

Dr. Letz refers to Industry Claims Information System (ICIS) data from more than 3.5 million claims to illustrate how this model can help address the traditional 80/20 rule as it applies to work-related disability management. In this instance, 13 percent of ICIS-identified claims involve permanent disability and represent 81 percent of total costs. In addition, for every 1,000 patients with low back pain, data show that about half experience some degree of interference with their work and recreational activities, 20 seek medical care, and three develop chronic pain and disability.

"We need to be able to predict the cases that are most likely to go into delayed recovery. That's the Holy Grail for occupational medicine," Dr. Letz said. The bottom line is acting as a coach to encourage people to take better care of themselves. We need to pay doctors to talk to patients about their well-being."

## Staying at Work

Not to be confused with the college's official *Occupational Medicine Practice Guidelines*, ACOEM released a separate guideline on *Preventing Needless Disability by Helping People Stay Employed* in 2006. (It may be accessed under policies and position statements

on ACOEM's website.)<sup>5</sup> This guideline was derived from a 34-page committee report prepared by the college's Stay-at-Work and Return-to-Work Process Improvement Committee under the auspices of the Council on Occupational and Environmental Medicine Practice.

The overriding theme is to "keep little things little by getting the injured worker right back in the saddle," said Jennifer Christian, M.D., M.P.H., chair of the college's Work Fitness and Disability Section and a principal author of the guideline. (Dr. Letz was



also a contributor.) "Many poor outcomes begin as routine conditions."

Dr. Christian, president of Webility Corp., Waylan, Mass. (www.webility.md), is well known as a passionate proponent of work disability prevention efforts. In addition to managing her own company, she facilitates an online Work Fitness and Disability Roundtable and she is responsible for the 60 Summits Project, an effort to propagate SAW/RTW principles contained in the guideline among stakeholders in all 50 states and 10 Canadian provinces. She spoke at the HCN conference on *A New Paradigm for Workers' Compensation and Disability Benefits Systems*.

The SAW/RTW process described in the guideline is a sequence of questions, actions and decisions made by different parties on five separate but parallel tracks: SAW/RTW, personal adjustment, medical care, benefits administration and reasonable accommodation. These decisions collectively determine whether an employee stays at work despite a medical condition or returns to work during or after recovery.

"Human beings have a normal reaction to injury or illness, and how they think about their situation has a lot to do with how things turn out," she said. "The employee has the most power to determine the eventual outcome of a work disability situation because he or she decides how much discretionary

effort to make to get better and get life back to normal. The employer plays the second most powerful role in determining the outcome by deciding whether to manage the employee's situation actively, passively, supportively or hostilely, and whether to provide for on-the-job recovery."

Dr. Christian said the physician's role is to provide facts and advice on the SAW/RTW process. Generally speaking, physicians who are not trained in occupational medicine are uncomfortable with this role, in part because some "guess work" is required, and they are neither trained nor rewarded to do it well.

For Dr. Christian, the crux of the matter is understanding the difference between traditional claims processing (the old way) and work disability prevention (the new way).

"The majority of problematic, high-cost claims begin as innocuous-appearing medical problems and go south because of the way non-medical aspects of the situation have been handled," she said. "In today's complex world, many people need proactive instruction, advice or even one-on-one assistance in how to navigate the health care system, how to select doctors who will provide the most effective treatments and how to cope best with a health-related employment situation."

## References

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