"Ask Dr. J"

The "Ask Dr. J" columns are authored monthly by Jennifer Christian, MD, MPH, President of Webility Corporation. See previous columns at www.webility.md.

Dr. J's columns also appear in the monthly Bulletin of the Disability Management Employer Coalition (DMEC). To purchase a book of Dr. J's collected columns, go to www.dmec.org.

The columns often summarize issues discussed by the Work Fitness and Disability Roundtable, a free, multi-disciplinary e-mail discussion group moderated by Dr. Christian. Apply to join the Roundtable at www.webility.md.

July 2005 – Disability Duration Guidelines

Dear Dr. J:

I'm a longtime case manager, but new to supervision. Our vice president decided to buy disability duration guidelines for each of us to use. We didn't use guidelines much in my prior positions. The guidelines he bought have a low, middle, and high number of days for each condition. We don't really know which numbers to use and when. I guess I really don't know what duration guidelines are or what to do with them. Any advice?

Cindy from Cincinnati

Dear Cindy:

You're not the only one who is uncertain how to use disability duration guidelines. It's interesting to me how many companies are using guidelines without a clear understanding of their potential value, as well as, their potential pitfalls. I've been doing some "deep thinking" about duration guidelines recently, and have some ideas to share with you that I hope will be useful. Prepare to "put your thinking cap on". After all, we ARE talking about numbers!

Disability duration guidelines are reference materials that provide an estimate of how long an injured worker should be out of work for a given medical condition. They are typically organized by medical diagnoses (ICD9 and DSM-IV), body parts, or presenting symptoms. Basically, you look up the medical condition, specify the rough nature of the worker's job, and the guideline tells you how long a typical injured worker with that condition is likely to be out of work.

Prior to the development of disability duration guidelines, case, benefits and disability managers all had to rely on their personal experience or anecdotal advice from others in deciding whether disability durations were appropriate or not. Guidelines are intensely attractive because they appear to provide an independent, authoritative source of reliable information.

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Disability duration guidelines can potentially be used for three main purposes:

- To guide return to work efforts
- To estimate future claim costs (assist in reserving)
- To measure disability management performance

There are several sets of disability duration guidelines widely available in the marketplace. Example of freestanding, widely available, and recently updated guidelines include:

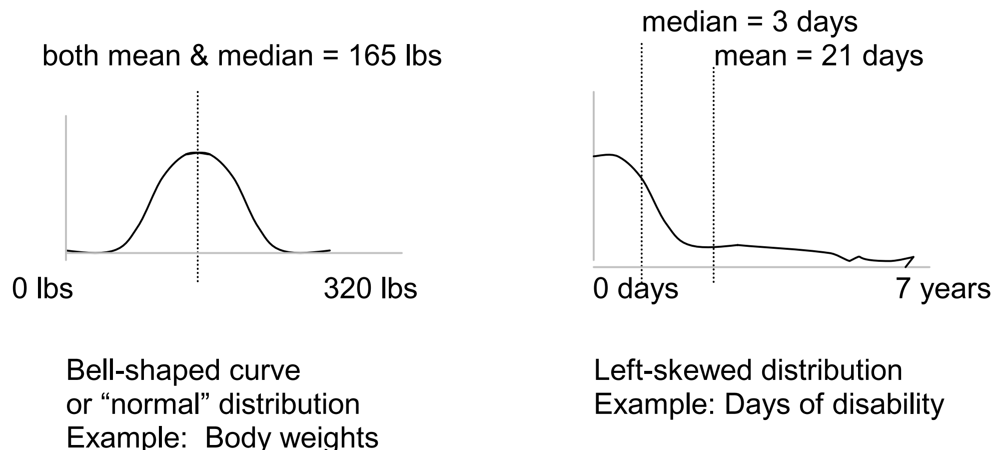
- *Presley Reed's Medical Disability Adviser* published by Reed Group, Ltd.
- *Official Disability Guidelines* (ODG) published by the Work Loss Data Institute
- *Occupational Medicine Practice Guidelines* published by the American College of Occupational and Environmental Medicine (ACOEM)

In addition, some proprietary automated case management or utilization management systems include guidelines as an integral part of their offering, for example, Interqual, Intracorp's ICMS, and CORE's WOMP systems all provide guidance on expected disability durations.

Those who use guidelines often match the guideline numbers with the current length of disability in order to see how they are doing. They feel that there's no need to do anything until the mid-point or optimum date has been reached, and that something really must be done once the claim reaches the maximum or "at risk" date. This strategy is designed to produce poor results.

If you want your company's claims overall to be as well managed as the claims in the disability duration reference book's database, most of your claims must have durations shorter than the optimum or mid-point duration in the disability duration guidelines. In fact, the bulk of your claims have to beat the "average" numbers because claim durations are not evenly distributed around the average. The curve is not actually symmetrical. It is so skewed to the left that it looks like the right half of a bell curve only – because there are waaaaaaaaaay more cases with short durations than long ones.

To illustrate, I have drawn you a couple of graphs on the computer. Not beautiful, but I hope they get the point across. In both examples below, the height of the curve at each point is determined by the number of observations (people in the weight example, and illness episodes for the disability duration example).



Bell-shaped curve
or "normal" distribution
Example: Body weights

Left-skewed distribution
Example: Days of disability

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For disability durations, the lower limit of durations cannot get any shorter that 0 disability days, but the upper limit has a very wide range – up to a lifetime of disability days. And, most cases for many conditions have close to 0 disability days. So, under these circumstances, the difference between the median and the mean becomes important. Remember the difference: To calculate an "average" or arithmetic mean, add up all the disability days for all the cases and then divide by the number of cases. To calculate the median, find the middle case, the one where there are as many cases with shorter durations as there are cases with longer durations. Mean durations will be significantly longer than median durations, because of the large number of disability days being contributed by a small number of cases with really long durations. I urge you to use medians whenever you look at your case distributions. If your company counts the change in total disability days lost or saved, your numbers will be very skewed by outliers. In my opinion, if you want to see evidence of your increasing power to manage disability, track the change in median disability days.

If your organization intends to reduce the total number of disability days for the whole claim population, you must find a way to beat that optimum or mid-range number almost all the time. The way to do that is to always aim for the minimum or best practices duration and take steps to assure that this is what actually happens – and accept that you will hit it most, but not all, of the time.

However, it takes too much time and effort (and money) to try to shorten durations on all cases – you'll spend more money than you save, managing every case one at a time. In order to move your company's overall "average" severity down, the best way is to study what happens in "typical" claims that go too long. Think about how unnecessary days away from work get caused, and set up a method to address those causes. Focus on low cost and systematic changes that will shorten severity in typical cases, which will conserve your resources for the hands-on management of the few, but very complicated claims. The happy side effect of this approach is that as you are getting better at shortening disability on "typical" claims, you will also be strengthening your ability at reducing severity on "difficult" claims as well.

Here is a list of the current and potential uses of disability duration guidelines for your organization.

a. **Duration Guideline as a safe zone.** Disability duration guidelines can create a false sense of security and lull return to work coordinators, case managers and claims handlers into inaction until suddenly the deadline is here and the claim is out of control. Waiting until the duration on claims goes beyond the longest deadline is swinging into action too late.

b. **Duration Guideline as initial prediction.** It is worthwhile to make an initial prediction of disability duration, and to keep that historical prediction, unmodified, in a database in order to compare the eventual actual duration against that first estimate. As a comparison, in the budgeting process, the year-in and year-out comparison of budgeted to actual is a way that skill of the management team gets developed and evaluated.

c. **Duration Guideline as today's best guess about what will really happen.** Your system should allow you to record a predicted disability duration at every update. It is important to allow evolving knowledge of a situation to change the prediction of the outcome – to enable the claims organization to make decisions based on the most realistic assessment of the current situation. (The downside of this is that a weak case manager can simply keep extending disability durations rather than be confronted with the fact that his/her claims keep missing deadlines).

d. **Duration Guideline as tripwire to trigger increased effort / other activities.** Different expectations should be set for the intensity of case management activities depending on where the claim is with respect to the originally predicted duration. For example, a claim that has exceeded the median duration should be investigated to see what the problem is. A claim that has exceeded the 75%ile needs a full court press unless there is a specific reason why it is not needed.

e. **Duration Guideline as "the number to hit" or (better) the "the number to beat".** If the "number to hit" is the same as the conservative figure used for reserving, there is little likelihood that systemwide outcomes will improve. If everyone does their best to hit the reserve number, sometimes they will be successful and sometimes they will not and you're likely to end up at the status quo – or even worse. However, if the "number to hit" is set below (shorter than) the duration predicted for reserving purposes, the chances are better of reducing disability durations for the system as a whole. People perform better when they have a goal.

f. **Duration Guideline as a communications tool.** Duration guidelines developed by third parties can serve as an authoritative reference. The guideline can help patients, doctors, employers and insurance companies establish and share appropriate expectations, given the actual circumstances of the situation. Respected, evidence-based, and explicit guidelines carry much more weight than arbitrary or confidential ones, and thus protect against premature return to work, as well as needlessly prolonged absence.

g. **Duration Guideline as an aid to setting reserves.** Estimating duration for purposes of setting reserves is a conservative business. A clear-eyed and realistic (as opposed to optimistic) assessment of the claim situation and estimate of its most likely outcome is required in order to help set reserves appropriately. (It is not good form to keep revising reserves, especially upwards.)

h. **Duration Guideline as performance standard.** Given all the limitations of guidelines, it is probably not wise to hold case, claims, benefits or RTW managers accountable case by case for getting individual injured workers back to work within the predicted durations. However, a powerful way to evaluate the effectiveness of staff members or teams would be to start comparing actual vs. estimated durations across whole caseloads or other large groups of claims. What is not measured is not managed – and competition to see who is producing the best results would put more zip into performance.

i. **Duration Guideline as aggregate system benchmark.** Imagine how powerful it would be if there were benchmark standards set for median duration of disability for the most common injuries across the whole book of business – and your boss got a report every month tracking the actual performance of each operating unit against those benchmarks. In addition, innovations in claim and case management could be tracked for their effectiveness in reducing median durations.

My Recommendations Regarding Use of Disability Duration Guidelines

Distinguish the multiple uses of disability duration estimates. Use different words to describe the numbers you are using for different purposes.

In order to reduce average disability duration per claim, the tripwire that triggers activities designed to reduce lost time MUST be set earlier than the mid-point or optimum duration. In

other words, you cannot move the whole bell-shaped curve to the left by trying to reduce disability in a few extreme cases. You need to change what happens in the typical cases, too!

Start using minimum or best practice disability durations as the number to “hit”, and optimum or mid-range numbers as the number to “beat” and “at risk” durations as the number to “avoid at all costs”.

Require documented evidence of medical complications and plans to address any red flags for claims that exceed optimum mid-range durations. Discovery of red flags probably requires extension of the predicted disability duration for reserving purposes, but should also trigger a more aggressive or innovative approach to case management. Distinguish between red flags that are biological and thus unavoidable (e.g. age and co-morbidities) vs. those that can be managed (lack of compliance, employee/employer issues). If any of the red flags are non-biological, then your staff should view the new longer duration guideline as the new “number to beat”.

Encourage (and reward) intellectual honesty. Reward case and claims managers who are taking risks, and don’t punish them if they don’t make it. One way to do this is to use one number as the goal, another as the tripwire, and yet another as the reserve projection. As long as the reserve number is beaten, the organization is ahead. On the other hand, case managers whose claims rarely even hit the tripwires, and who consistently achieve their goals deserve extra recognition.

Limitations of Guidelines

There are several important complications that must be dealt with in the practical application of guidelines. These complications are so significant that today’s guidelines are simply unable to deliver their full theoretical value. On the other hand, there is some significant value to be had from using guidelines as a rough guide. To put it bluntly, they are better than nothing.

The first complication is that duration guidelines based on “actual data” reflect the current reality that unnecessarily prolonged disability is very common. The “minimum” or “best practices” duration shown for the sedentary job classification is probably the best available data on the “real” duration of medically-necessary disability. The other (longer) disability durations shown for that same condition for workers in other job classifications are actually caused by a mismatch between the workers’ current functional ability (which has been temporarily altered by the medical condition) and the demands of their usual jobs. In other words, the increased length of disability is NOT medically-required, rather it is caused by the demanding nature of the work itself. Change the work, shorten the duration.

Thus, the effect of a given medical condition on any injured worker's ability to do his or her job is often very dependent upon the specific functional capabilities the job requires. There are tens of thousands of functions the human body can perform and just as many job descriptions. To make guidelines workable, job requirements have had to be grouped into a manageable, small number of categories. To apply a guideline in a given situation, you must first decide what job category to use. It is sometimes very clear what category is appropriate to use, but often it is not. The indicated duration can change significantly based on this choice.

Transitional work is an especially poor fit for duration guidelines, because a transitional work assignment may have little or no relationship to the “usual job”. It is often the case that the transitional work assignment has been designed to put little or no demand on the affected body part.

There are numerous variations in the situations of injured workers with the same or similar diagnoses. For example, diagnoses can vary over time as conditions evolve from one problem to another (for example, angina progressing to heart attack) or as the physician continues the work-up and makes findings (hip pain becomes hip arthritis and then total hip replacement).

Another obvious variation is severity. For example, is the ankle sprain minor, medium, or major? Medical diagnostic databases do not include information about the severity of the injury; it must be inferred from the treatment. This is the paradox: although we are concerned about over-treatment and excessive disability, we are forced to use the extent and nature of the treatment to infer severity and predict disability duration.

Other variability exists as well. Identical injuries happen to individuals who are young and otherwise well, and to ones who are older and infirm. Some already have multiple diagnoses (co-morbidities). The medically-appropriate disability duration can vary greatly as a result. Disability duration guidelines generally try to deal with this issue of biologically-based variability by explicitly recommending that they NOT be used on multiple-diagnosis cases or cases with medical complications. However, organizations that decide to use guidelines frequently say they want them used all the time, so claims and case managers often violate this exclusion, and make inappropriate decisions.

Still another form of variation has to do with the psycho-social context in which the injury is occurring – the workers' relationship with the employer, the employer's ability or willingness to support return to work, the presence of a lawyer, and so forth.

Precise quantification of the effect of each of these variables on disability duration is beyond the scope of any existing guidelines – and yet that is what claims organizations wish they could use guidelines for. It is tempting to use them inappropriately. Their limitations do not make guidelines useless – but they do reduce their value. These limitations must be taken into account so that guidelines are appropriately used and mistakes avoided.

Summary

Reference materials that set disability duration guidelines are an asset to case, claim, benefit and RTW managers because they provide a more plausible basis for expectation setting, reserve setting, and allocation of time and resources than do personal experience and anecdote. However, all the reference guides available today have significant limitations and are not sufficiently strong to be relied on blindly. The impact of using disability guidelines and disability duration estimates in many companies today is blunted because the same words are being used to describe several different purposes and uses of these estimates.

I recommend that more distinctions be made between the different purposes and uses on the individual claim level. Later, when your company has made more progress on its efforts to improve its data warehouse and management reporting capabilities, the ultimate power of disability guidelines to serve as benchmarks for aggregate performance will become apparent.

Smiling,

Dr. J

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