"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.

June 2006 – Criteria for Referral to Case Management

Dear Dr. J:

When should we ask a nurse case manager to get involved in a workers' comp or disability benefits case? Are there specific triggers other than the obvious catastrophic cases? Does the need for a case manager depend on the expertise level of the other parties – the claims adjuster, the doctor, or the employer?

Joe in Jacksonville

Dear Joe:

Well, Joe, your question is timely because the members of the Work Fitness and Disability Roundtable have just been discussing this topic. I've summarized some highlights of our conversation below along with a liberal dose of my own opinions. You're welcome to join the Roundtable yourself. Go to www.webility.md and apply!

Case management is appropriate when it's needed, and an extra expense when it's not. Many of the psychosocial factors that lead to rapid return to work or to needless disability are features of the workplace situation well before an injury occurs. Most employees want to get life back to normal and will return to work quickly regardless of which doctor they see, the skill of the claims person, or the level of sophistication of the employer's RTW program. When the employee and employer are in a goodwill partnership aimed at recovery, that's generally what happens!

No referral may be necessary if the employer's approach is pro-active and positive. The need for referral to case management depends a lot more on the employer's level of sophistication than that of the claims person or the doctor. Especially if the employer sets clear expectations for the process to follow and manages the situation pro-actively, most employees will go along.

The usual "no referral needed" indicators are that:

- neither the employee nor the employer are known to be problems,
- the employee reports the accident quickly,
- the doctor responds to reasonable requests for physical ability guidelines and
- the employer is willing to provide at least short term modified duty if needed.

Employers who have and follow a well-designed standard process have few problems. If the process includes a reasonable request for physical ability information from the treating doctor, most doctors will provide it. If the employer makes it clear that they are willing to provide at least temporary accommodation, most employees will return to work with the employer. In cases where this is not possible, but the employee is immediately referred to a work conditioning program, most employees will follow the recommendations and it will be relatively easy to determine if outside help is needed. No referral would be needed in 95+% of the cases.

Employers who create a negative work environment and have no early intervention program will require significantly more help. The relatively small percentage of employees who are prone to "take a few extra days or months" off will do so if the system allows it. If there is no early intervention program, and the employee delays reporting, and the supervisor declares that the employee is a personnel problem and the doctor prescribes 30 days of bed rest, you would do well to have the number of the case manager stored in your speed-dial. Combinations of the above create situations where close monitoring is required.

The key "make the referral now" indicators are:

- a known problem employee, employer, or doctor
- employer with no immediate response process
- employer refusal to allow alternative duty
- employee who delays reporting the injury
- doctor who prescribes unusual or ineffective effective treatment and fails to plan for return to work
- doctor who fails to respond to "reasonable" requests for physical guidelines

No referral may be necessary if the doctor is managing the process. A referral is also unnecessary if the doctor is the kind who manages the process of return to work along with the medical care. In a good occupational medicine practice, most cases resolve quickly in a few visits and a couple of weeks. To add the involvement of another person would only add to the costs without improving outcomes. Good occupational physicians apply all of their skills, training and experience from the moment they first see a newly injured patient to bringing that case to closure as soon as possible, and to communicating with the employer. If you are lucky enough to have access to occupational physicians or other medical practices where process management is part and parcel of the physician's duties (and there are demonstrably good outcomes), I see no reason to automatically involve a nurse when those doctors are involved. Unfortunately most WC cases are NOT treated by occ docs, but rather by a variety of primary provider's who have little interest in process, even less in WC, and have no experience with return to work issues.

No referral may be necessary if the adjuster is really good. An experienced claims examiner should be able to handle issues that a beginner can't. I hear that there are a LOT of beginner adjusters these days, since the turnover problem in claims shops is big. Examiners pick up a smattering of medical familiarity over time and through on-the-job training that lets them handle run-of-the-mill cases. New ones often simply don't know enough to manage even basic medical issues without an advisor. Claims examiners are often young and in their first jobs, although there are many seasoned veterans in both age and tenure. Insurers generally try to partner the younger and/or less experienced examiners with the older/more experienced ones, but when it comes to making decisions about what and when to pay, often that relationship breaks down because of the milieu the examiner works in.

The claims examiners may have an open caseload of 100-150 claims. On any given day, any of those injured workers, or their spouse, or their employer, or their doctor, or their pharmacist, or their lawyer can call asking for information / action / resolution / decision. In the meantime, each of those cases needs to be managed, information obtained, forms filed, and benefits decided on and paid. In addition, examiners have regularly scheduled case reviews by peers and superiors, training, administrative meetings, and critical actions under time lines dictated by statute and/or rule by the state all of which take time. None of this is ever scheduled or happens in a orderly sequence. The examiners spend the day reacting to the demands coming from every direction while attempting to move each of their assigned cases ahead as best they can. So, do they make mistakes? Yes. Do they stonewall reasonable requests? Yes. Because they are real people who have difficulty managing all the competing issues that vie for a piece of their day. Because the universal rule of human nature is to deal with the squeakiest wheel first. Because when you have more things that need to be done then the time to do them, you have to choose to not do some things. Referrals for case management under these circumstances may make sense, else you risk dropped balls.

DO refer “at risk” cases. Cases that have been identified as "at increased risk" for a FUTURE bad outcome are the ones that should be referred. The risk factors are often called “yellow” or “red” flags. There is no generally-accepted way of evaluating risk at this time, although there is a lot of "common sense" about how to do it. There's also a lot of market experimentation going on with evidence-based vs. common-sense based early assessment tools and methods. For example, four products / services I’ve heard about people using recently are Presley Reed’s Medical Disability Advisor, e-Triage, Absentia, RiskExpert. It is actually kind of silly to wait to refer cases until it is already clear that they are train wrecks, isn't it?

DO refer cases where there’s a chance for a better outcome. Cases should be referred to case management any time it looks like two futures have become possible -- a good one and a bad one -- and there is a clear opportunity for a nurse to make a difference in the situation's outcome. You should only refer the case IF YOU ARE CONFIDENT that the case manager has a decent shot at actually making something good happen. You may want to ask an internal resource (supervisor, medical consultant) whether making the referral makes sense, and what the case manager should be asked to do.

DO refer cases that are still out of work at 28 days without a very good reason why. My personal belief is that all cases should be PRESUMPTIVELY referred for case management if the worker has not returned to work within 28 days unless the claims examiner or employer has a clear reason why case management is not needed -- instead of the other way around. The two things you cannot forget are: (1) 20% of the claims cause 80% of the problems and 80% of the cost. (2) most claims for permanent and total disability began as one that someone predicted would be back to work in two weeks!

I first became aware of case management as a profession after I "reinvented the wheel" while working for a large employer in the mid-1980's and came up with the idea of transforming our acute-care-focused clinic nurses into case managers and directed them to drive situations from the beginning towards a good resolution simply because it was SO obvious that someone needed to do it. The results were also obvious immediately. Workers' comp and disability claims tend to move slowly towards resolution and get off track unless there's someone involved who knows what SHOULD happen and tries to make that a reality.

Since Managed Care came into play, field case management has slowed down and telephonic case management has really picked up —a real sea change. Today, most is done over the phone and field case management is reserved for those cases that the telephonic case manager needs 'eyes' to gain insight into the case. Many cases are handled well by telephonic case managers but the personal touch has been reduced.

Having a CM in place can ensure that the plan of care is appropriate, resources are utilized appropriately and most important, (in Workers Comp) limit the need for attorney involvement since the injured worker and his / her family understand the condition and work together to ensure that the patient is progressing. The case manager (whether field or telephonic) is the one person who many times is the constant player in the case and decreases duplication, fragmentation, cuts through the red tape that exists in the system, as well as ensures that the payer / adjustor are kept up to date and assist the patient / family with issues that may arise with the payer such as late checks in comp or claims payment in managed care.

A very large percentage (easily 25-50%) of employees do not have a regular family doctor; the very gatekeepers to our healthcare system. It is often only with active case management that employees obtain prompt appropriate treatment, optimal outcomes, and successful occupational reintegration, which is the final common pathway to achieving recovery. Recently, I heard about a large employer who had a great RTW program on paper, and pretty good results -- but who got another big increment in improvement by putting in a case manager to facilitate communication and decision-making.

Unfortunately, ineffective yet expensive case management ruins the marketplace for good case managers, just like problem doctors ruin it for good ones. And, the case management business, particularly the field case management business, has been beset with difficulties.

First problem: Game playing with administrative costs. When insurers and TPAs compete on administrative cost rather than delivered outcomes, they start trying to avoid outside expenditures, OR they start trying to foist off work on others, depending on the details of their economic relationships with customers and vendors. In one scenario, the adjusters are discouraged from make referrals for case management; in the other, overworked adjusters have a big incentive to offload work to the case management vendor simply to reduce their own caseload.

Second problem: Time and materials billing. Traditionally, case management companies have been allowed to bill by the hour and not be held accountable for outcomes. Individual case managers have been incented to maximize billable hours, and also not be held accountable for outcomes. This preserves revenues, but breeds flabby results and dissatisfied customers.

Third problem: Late referrals and unrealistic expectations. Case managers often get handed cases very late in the game. The case has already been (nearly hopelessly) bungled by someone who didn't know what they didn't know, but thought they did, and therefore saw no need to ask for help or make a referral. Often, the claims examiner has been trying to hold

down administrative cost -- pennywise and pound-foolish. Case management companies talk about their "early intervention" but they really mean "as soon as we get it" -- which for one of the country's largest case management companies is somewhere between 9 to 18 months after the date of injury. The likelihood of a good outcome is GREATLY reduced; if the case managers bat 50:50 in a group of these cases, they're actually doing great! But each claims manager in the "wrong" side of that 50:50 is disappointed because he / she wanted a miracle. Case management companies need to train their customers when to refer and need to establish realistic expectations. Their interventions will be effective IN THE AGGREGATE, not every time.

Fourth problem: Case managers who don't get the point. Case managers too often act like regular nurses instead of situation managers. They are not comfortable outside the strictly medical arena and are not effective conflict resolvers and disability managers. They document like nurses in the hospital (spending too much time writing down details about everything that happened in order to prove they did the work and justify the bill and spending too little time figuring out how to summarize the highpoints and the key facts in order to answer the busy claims adjuster's likely questions. We've had a group of desk-level claims adjusters tell us they basically don't bother to read the case managers' reports.

Fifth problem: It's now fashionable to be suspicious. Insurers and TPAs have become unsure about the value of case management. The case management companies have been unable to convincingly show that they've made a difference, similar to the problems faced by any of the rest of us who are in the prevention business: "What value did you deliver? Nothing happened!" [Well, duh, isn't that the point?]

There are really only three main "outside" tools available to claims adjusters -- case management, surveillance, and IMEs. Of the three methods, case management is the only "positive" one -- an opportunity to move the claim forward in a win-win manner. Why aren't insurance companies asking these same questions about the other two tools? My suspicion is tradition and time -- evaluating return on investment in each of these three areas is long overdue.

The result of all these problems: today's "short leash" approach to case management, in which the claims adjuster hires the case manager to perform a single task.

This is an area where a little actual research would sure make sense. Why not randomly take half of the cases still out of work at 5 or 10 days post injury and assign them to early "full" case management and let the other half proceed with "usual care" -- and then see which group of cases have the better results at 180 days: quicker resolution, lower total episode cost, higher % RTW, lower litigation rates, etc.

You could have another "treatment arm" to your study: Take all the cases out of work at 90, 120 or 180 days, and randomly assign half of them to case management then and let the others continue with "usual care" -- and again, see what happens.

In the study, it would be fun to pit a couple of case management companies against each other, too, wouldn't it? Now THAT is a real-live quality improvement mechanism likely to drive performance improvement!

By the way, skipping the randomizing part and the "control" group ruins the study. If you simply measure cost per claim for cases referred vs. cases not referred to case management today, the odds will be stacked against the cases with case management -- the fact the adjuster

referred them means the adjuster recognized that the claim was in trouble. They call this "adverse selection" and case management will look like a bad idea.

The insurance companies that scoff at the case managers' "soft savings reports" (reduced days out of work, changes in medical treatment plans) are the same ones who have failed to release data or fund studies to evaluate the effectiveness of case management.

Smiling,
Dr. J

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