MAXIMIZING WC OUTCOMES

Helping Injured Workers
Get Back to Living
With Optimal Care, Timely
Delivery & Empathy

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Healthcare Evolution
All payers

Gaps in Coverage,
poor outcomes, high cost

Subsidies, compulsion

US versus other high income countries

US versus England

$10,000 per patient vs $5000

17% poverty vs 10%

18% Gross Domestic Product vs 12%

RX double, devices triple

Specialists double to triple

REMEDY

- Return to Work (RTW)
- Low utilization of narcotics
- Appropriate referrals for surgery
- Focused, strategic conservative care

Payor World 2018

- Combined ratios of 136%
- Goal 125%
- Workers Comp (WC) weakest performer in insurance underwriting
- Can we reduce costs thru provider/medical world ?
- Seeking assistance in claims adjudication

One Physician Gap – the narrative

- Causation – “more likely than not” vs. “might”
- Clear & reasonable work restrictions
- Medical necessity - for exam & treatment (txmt)
- Maximum Medical Improvement (MMI)
- Rationale for care plan examples – Durable Medical Equip (DME)/Physical Therapy (PT)/Dr of Chiropractic (DC)/ Acupuncture (Acu) for pain relief in lieu of narcotics
- Medical Decision making (with time frames)

History of Injury

- Was there a specific injury or trauma?
- Was there direct trauma?
- Do your clinical findings seem reasonable for the injury described?
- If cumulative trauma - provide start & stop dates of exposure, and hours per day
- Note prior cumulative trauma, sports and hobbies

Past Medical History

- Diabetes, cancer, hypertension, heart disease, gout…
- What really matters--- IMPACT ON RECOVERY FROM INJURY
- Caution re HIPPA sensitive conditions

Causation

- Are the findings on your exam consistent with (c/w) the patient's account of the injury or exposure?
- Are there prior injuries, diseases, activities or exposures that will slow recovery?
- Could the findings be caused by the natural progression of disease or aging?

Sample Causation Phrases

- More likely than not, _____ is causing the current symptoms/findings. (Could be the alleged injury, or a sport/hobby, or aging)
- The reported injury most likely caused a temporary exacerbation/aggravation to the underlying medical condition. That temporary exacerbation should resolve by __/__/__, returning the patient back to the pre injury state

LONG TERM Treatment Plan

- Include Maximum Medical Improvement (MMI) date expected. If MMI changes from prior visit explain why
- If MMI will be delayed, note the steps that are being taken to expedite recovery
- If narcotics were prescribed remember to taper within 2 weeks
- If narcotics will be needed for longer period provide duration & rationale

Pearls for Great Outcomes

- At FIRST visit rule out (r/o) RED FLAGS & set stage for recovery (6-8 weeks – Hamilton & Hall)
- At 2 weeks post Date of Injury (DOI)/first visit – ensure RTW/function/light duty
- Wean off narcotics (60 days for large bone surgery) (opioids increase claim by 119 days)
- Decrease or D/C benzos if prescribing opioids
- And add Delayed Recovery screener such as Orebro (Assessment Tool) if patient has worsened; SOAPP (Screener for Opioid Assessment for Pts w/ pain) or ORT (Opioid Risk Tool) if patient requesting stronger narcotic

Pearls continued

- At 4 wks post DOI/first visit – reconsider DX/txmt if not 50% better – order additional testing or consultation
- At 6 wks post DOI consider delayed recovery
- Start CBT (Cognitive Behavioral Therapy) at any time delayed recovery/opioid risk flag goes up; consider tele pain programs
- Consider Functional Restoration Program (FRP) at approximately 6 wks if no improvement
- Tailor program to patient
- CBT is very affordable, cost-effective

Pearls continued

- Medication Red Flags:
  > 100 Morphine equivs per day
  > 20 mg methadone per day
  > 3200 mg of acetaminophen (2000 with liver dis)
  -- add physician coaching/second opinion
  -- add Urinary Drug Test (UDT) at 90 days of narcotics, and up to 2 to 4 times per year & for cause (ACOEM)
  - Pharmacy Drug Monitoring Program: before prescribing narcotics, the Dr logs in & checks to see what other narcotics the pt is on from other providers; if state has such a program, insist the Dr use it.
  -- drug holiday at 10 weeks instead of 1 year – take them off all narcotics; most will fill a little ill, but not exp withdrawal

Pearls continued

- In rare case that patient (pt) requires long term narcotics, preferred max dose should be 50 mg MED/day (100 MEDs – red flag – death risk)
- To continue on a narcotic pt should demo 30% increase in function
- Measure function specifically. Example – how far and how long one can walk each day
- Consider norepinephrine reuptake inhibitor in lieu of narcotics; NSAIDs (Non-Steroidal anti-inflammatory drugs) always come first and have been shown to be superior i.e.. Fracture (FX) healing

Pearls continued

- Remember delayed recovery risk: Total Temporary Disability (TTD)/lack of work; abuse as child or adult; prior ETOH (ethanol)/drug abuse or family history (hx); depression; personality disorder; NOT DIAGNOSIS
- 37% of adult physician visits are for pain
- 42% of pts have co-morbidities; 20% psych
- Physician Case Mgt (CM) in lieu of Utilization Review (UR)
- Transfer of Care (TOC) to Ortho – consider disability mgt visit 45 days

SPINE – pre publish – Oct 2012

- Primary Care Referrals of Patients with Low Back Pain to PT
- Univ of Utah, Dept of PT; Baylor; and Texas State
- 32,000 patients
- Compare early Physical Therapy (PT) (w/in 14 days) to delayed PT
- Early PT resulted in decreased imaging, additional PT, surgery & opioids
- Total medical costs savings averaged at $2763 per case for pts receiving early PT

Metrics

- Total Temporary Disability (TTD) per case
- Average case duration
- Visits per Hour (should be 3 or less)
- Visit Times – triage
- 48 hr or less report TAT (Turn Around Time)
- Ratios, firsts to follow ups, firsts to PT
- Days to Maximum Medical Improvement (MMI)
- Narrative
- Total claims costs vs. total medical costs; per claim & total
- # of claims with use of narcotics, use more than 2 wks. and use more than 60 days if large bone surgery

Re Cap

- Set stage at first visit and r/o red flags
- Do no harm – do not compound problem
- Keep simple cases simple
- Beware the risks of narcotics, inactivity and unnecessary surgery
- Reconsider diagnosis (dx) & treatment (txmt) at 4 weeks if not improving
- Care about your patient
- Remember that the practice of medicine is a privilege

Future

- Primary Treating Physician (PTP) & specialist relationship
- Patient satisfaction
- Worksite Wellness
- Provider mentoring – model empathy
- Electronic Medial Record (EMR) with additional prompts & ability to provide metrics

Take away

- Find one thing to like about every patient
- If a visit did not go as well as you'd like, call patient that evening to either apologize and/or ask if the patient has any unanswered questions
- Be present in the moment of the visit

QUIZ

1) Which of the following steps improve claims outcomes/total claims costs:
   a) rapid return to function
   b) narcotics limited to 2 weeks
   c) limiting # of follow up visits
   d) a and b
   e) all are true

Quiz continued

2) If a patient is diagnosed with a medial meniscus tear, and he/she alleges that the injury occurred while getting up from a chair at work, what other questions should the clinician ask?

3) The impact on recovery is more important than the actual diagnoses for past medical history (PMH). T or F

Answers

1) D – limiting # of follow up visits does not necessarily improve outcomes – getting pts back to function and off of narcotics is far more important. Payors are glad to pay for office visits that expedite claims closures.
2) Important to query hobbies, recreation, prior injuries and whether the reportedly injured body part has been symptomatic prior to the incident that appears too insignificant for the findings

Answers continued

3) True ---- claims professionals aren't clinicians – they are interested in past medical history (PMH) only as it may affect recovery from the work related injury