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Beyond Occupational Medicine: Using a Medical Advisor to Bring Down Claims Costs

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A physician can be one of the most effective tools for reducing workers compensation costs — not in the role most people think, such as the treating physician or independent medical examiner, but as the company medical director or advisor. That a good medical advisor can be so effective in reducing costs is one of the best-kept secrets in workers compensation. There are unexpected opportunities for a medical advisor experienced in workers compensation to assist at all stages of a workers compensation claim. The opportunity to save on claims costs can be optimized by enhancing the role of the current medical director or by using an outside medical advisor.

Companies that use physicians as medical directors generally limit their role to the traditional tasks of occupational medicine, such as overseeing drug testing, medical surveillance, and Department of Transportation testing and, in the case of a company with a centralized workforce, seeing workers in a clinical setting. But a medical director can be used to the fullest potential when he or she also reviews claim files, determines whether an injury is work-related, oversees transitional-duty placement, evaluates requests for independent medical examinations (IMEs) and nurse case management, and assesses requests for large reserve changes.

This article follows the interventions that medical directors and advisors can make over the course of a claim, highlighting the particular places where claims savings may be gained or opportunities may otherwise be missed. Finally, the article covers the logistics of enhancing the present medical director's job description or hiring someone new — and ways to make either arrangement succeed within the present set-up your company has with an insurer or third party administrator (TPA).

Except when the distinction is relevant, this article will use the term "medical advisor" for simplicity, since it is the essence of what both the medical director and the medical advisor can do vis-à-vis workers compensation claims that is relevant for our discussion. However, the terms do have specific meanings. "Medical director" typically refers to an in-house physician and "medical advisor" refers to a contract physician playing the same role. In either capacity, the physician is overseeing files rather than patients and is close to the frontline of workers compensation — reviewing claims, helping develop a claims-handling strategy, and fostering return to work.

Using a proactive strategy early in the life of a claim will save much more money than waiting until the claim has reached a high-dollar threshold and return to work has become delayed with unnecessary time out of work. While this can be difficult to measure precisely, proactively handling claims yields a significant return on investment.

Determine Causality and Work-Relatedness

When a claim is reported, the first thing to be done is to determine whether the claim is work-related. This must be done as soon as the first report of injury is filed, so that the claim can be paid without prejudice within the time frame allowed by state law. If the claim is accepted as a workers compensation claim, and it is later determined not to be work-related, it will be difficult or impossible to move the claim to the group health side of the house where it belongs. Medical review should be a standard part of

a company's compensability investigation.

When a worker has had a documented incident, it is generally assumed that the resulting injury and any subsequent pain are work-related. Frequently, they are not. Naturally, not accepting a non-work-related claim to begin with can lead to enormous savings — especially with expensive back injury or knee-replacement claims. A physician's input in this regard is critical. It is not reasonable to expect nurses or adjusters to be able to identify preexisting conditions, because they do not have the level of training needed to interpret the medical tests or understand the complicated medical language that is found in complete medical reports. An adjuster may jump to the bottom of a medical report to read the conclusion and miss important information in the body of the report. Many adjusters do not know what medical issues are questionable — in essence, they do not know what they do not know — yet, in the quest to reduce claims-handling costs, they are put in the unfortunate situation of having to make judgment calls that they are ill-equipped to make. Most adjusters are not given sufficient access to medical advisors to identify questionable claims.

An important example is back injuries. Claims based on back injuries are almost always deemed to be work-related regardless of whether they are or not. Fifty percent of people with back injuries have a recurrence within two years; therefore, the likelihood of an employee having additional back pain is high, regardless of any new workplace injury. On the other hand, the majority of back strains resolve within a few weeks. Thus, any back pain arising from a specific workplace injury that is followed by a significant pain-free interval should be deemed resolved. Back pain subsequent to this (with no intervening injuries) is more likely from an underlying degenerative back problem and not the result of the earlier workplace injury.

Another example is a degenerative condition known as spinal stenosis, which is a narrowing of areas in the vertebral column where nerves branch off the spinal cord. This condition is not work-related, even though it may appear to be so. This narrowing occurs after chronic degenerative changes, such as spurring and development of osteophytes (boney outgrowths). It is not the result of an acute injury, but someone other than a doctor specifically working on claims to assess work-relatedness might think otherwise.

Knee injuries requiring knee replacement also necessitate expert medical assessment of work-relatedness. A medical advisor would look for whether there is a significant pain-free interval after an injury. If there is, it is important to distinguish a recurrence from a progression of any underlying degenerative disease. An important inquiry is whether there has been a history of problems prior to the injury.

While obtaining a worker's prior medical history seems like it would be standard procedure related to a claim, the fact that an injured worker has an underlying degenerative condition is generally seen as irrelevant from the claims-handling perspective. If the workplace injury exacerbates the underlying problem, the employer is still liable — the employer has "bought" the claim. However, one of the most commonly missed opportunities to cut workers compensation costs is when the on-the-job incident resolves, but pain recurs. This new pain is almost invariably attributed to the workplace injury. Many times this is an incorrect assumption.

One company we know of was about to pay for a total knee replacement. However, after reviewing the file, the medical advisor found that the claimant's acute knee sprain had resolved months before and that the degeneration was the result of progressive arthritis. Prior records were obtained, all of which were sent to the IME physician with an accompanying letter from the medical advisor. The IME physician agreed that the surgery was necessitated by the arthritic condition. The claim was denied, and the knee replacement was paid through the employee's group health plan. The adjuster estimated the workers compensation savings to be $45,000.

In another claim, an overnight shipment driver had driven over a minor bump in the road and then complained of extreme pain. The medical advisor looked for other sources of the pain and found it — Paget's disease of the bone, as evident on a previous MRI. The claim was challenged and payments were discontinued, saving the company more than $50,000. In yet another claim, where an employee was injured in a minor automobile accident and weeks later complained of back and neck pain, the medical advisor found indications in existing x-rays of possible Hill-Sachs deformity, which suggests prior shoulder problems most likely from past dislocations of the shoulder.

While the actions of the medical advisors in these cases seems intuitive, without their presence there would be no one with the same level of expertise making the investigations they are making. Once the medical advisor has given an opinion about causality generally and work-relatedness specifically, the information must be provided to the adjuster so he or she can challenge the claim and close the loop. The employer needs to have an ironclad follow-up system set up to ensure that this information gets to the adjuster and that appropriate action is taken to dispute compensability.

Review Quality of Medical Care and Assure Consistent Treatment

A medical advisor can review workers compensation medical records for purposes of identifying patterns of overtreatment, which wastes money,

or undertreatment, which jeopardizes employees' recovery. The medical advisor should routinely review treatment plans from treating physicians and clinics to make sure treatment is timely and appropriate for the medical condition.

For example, one medical director discovered that employees with carpal tunnel syndrome typically sought treatment only after the injury became severe. Employees' medical outcomes were normally worse due to waiting this long for treatment. The doctor brought this to the attention of the safety director, and the two worked together to develop "pain first-aid" brochures describing the early symptoms of carpal tunnel syndrome. As a result, employees began to seek treatment as soon as they felt any tingling or numbness, thus avoiding progression of the injury. They recovered much quicker, saving lost-time costs, and their injuries oftentimes didn't progress to the point where they required surgery, saving approximately $30,000 for each hospitalization and surgery avoided. Moreover, many employees escaped debilitating pain and loss of productivity, and workplace morale improved, too.

Review Length of Disability and Facilitate Transitional Duty

The medical advisor can also review lost-time cases where the worker has been out longer than medical guidelines suggest is appropriate for the underlying injury. Adjusters can flag the relevant cases and a nurse case manager can validate the adjuster's work. Then the medical advisor should review the files to assure that, in each case, the employee is getting good medical care and is recovering in an appropriate length of time, given both the injury and the particular facts of the case. For example, shoulder injuries often take longer to heal in older employees. Appreciating this, the medical advisor would alert the adjuster to put these types of claims on a different timetable.

When a worker is out longer than a guideline suggests, having a nurse case manager is a good start, but because each case is specific and unique, it is also productive to have the medical advisor review the claim. The additional medical expertise quickly pays off. Saving the cost of two or three back surgeries a year can pay for the medical advisor.

Medical advisors can also facilitate transitional-duty placements. If the company has only a few lost-time claims, the medical advisor should review all of them. If the company has hundreds of lost-time claims, then the number reviewed may need to be narrowed. For example, the medical advisor can review claims with more than 10 days of lost time. He or she can determine whether the length of absence is medically necessary and

whether the company can locate a temporary alternate-duty job for that person.

To review medical restrictions, the medical advisor must obtain the injury treatment form that the treating physician completed. This can be faxed directly from the treating physician (or adjuster) or brought to the medical advisor by the employee returning to the worksite from the office visit. The medical advisor can then review potential transitional tasks to ensure they do not conflict with the medical restrictions. The adjuster and location manager can work together to locate suitable tasks for the employee until he or she is recovered completely.

The medical advisor can also be available as needed to discuss transitional-duty options with adjusters. The medical advisor and the adjuster can visit the worksite to locate potential transitional tasks to be put into a "task bank" and used as needed when employees are injured. This helps both the doctor and the adjuster to see and understand job demands more clearly.

Appreciate Terminology Indicating Symptom Magnification

Doctors sometimes use medical language to indicate that a claimant has complaints disproportionate to the findings. While all adjusters and nurse case managers recognize the term "symptom magnification," the IME or treating physician may use other medical terminology to suggest the same thing. One red flag is when a physician indicates "complaints inconsistent with the mechanism of injury." Another is "positive Waddell signs," which are physical maneuvers that do not increase pressure on an injured body part, yet nonetheless prompt the patient to report greater pain. For example, the motions involved in the axial compression test do not increase pressure on the cervical disks; thus, a "positive" axial compression test suggests that a claimant is magnifying his or her symptoms. Ironically, the vast majority of adjusters understandably believe that a "positive" test is verification of an injury, while in fact the opposite is true.

When medical language suggesting symptom magnification is not understood, important opportunities for surveillance, aggressive case management, and functional capacity evaluations are lost. Giving nurse case managers and adjusters additional medical training to recognize language indicating symptom magnification is vital. A knowledgeable medical advisor can develop medical-training modules and be part of the training team to provide the correct level of medical detail.

Outsourcing claims handling abroad brings up another challenge. It is essential for claims operations that have moved offices to non-English

speaking countries to utilize medical advisors who recognize U.S. medical terminology.

Intervene in Independent Medical Examinations

After the decision regarding compensability and the push toward return to work, the IME is one of the few remaining points in a workers compensation claim where the outcome can be influenced. Having a physician's input regarding IMEs can mean fewer needlessly scheduled examinations and more accurate results from the ones that do occur. In our estimation, up to 30 percent of IMEs are less favorable to employers than they could be due to disorganized or incomplete medical records, no pointed questions to the examiner in the cover letter, and poor timing of the IME given upcoming specialist or radiology appointments. The cost of being unable to dispute the degree of disability and compensability can run into the hundreds of thousands of dollars for many employers, yet most are unaware that a poor result from the IME can mean the loss of this opportunity to save money.

First, the medical advisor can make sure the medical records are complete prior to the adjuster requesting an IME. For example, in 4 out of 30 claims at one claims office, the emergency-room records had not been requested. In fact, adjusters weren't even aware they should request them. These records are critical because immediately after an injury the employee will likely provide more accurate information about how the injury occurred than weeks later.

Also likely to be missing are the claimant's preinjury medical records. Adjusters usually assume that a preexisting injury is irrelevant for purposes of workers compensation. However, it is relevant when the claimant's acute injury resolves but an underlying degenerative process is still progressing.

For instance, one worker had been having a shoulder problem for 18 years. He reinjured his shoulder at work but then recovered. Six months later, he needed shoulder surgery. Because the IME physician was not asked whether the surgery would have been needed regardless of the workplace incident that had cleared up months ago, the IME physician did not address that issue and the workers compensation insurer paid for the surgery even though the answer to the unasked question was "yes." In another example, a pregnant employee reported having back pain. The medical advisor recommended obtaining notes from the woman's obstetric visits; from these, a history of pregnancy-caused back pain was found.

The presence of herniated discs in the preinjury records can also be a very valuable finding for the employer. The value of a back injury claim typically rises when there is a herniated disc. However, studies show that 30 percent to 40 percent of people without a history of back pain have herni-

ated discs. Therefore, records predating the workplace injury are essential in determining whether a herniation is indeed work-related.

Second, the medical advisor can make sure the medical records are properly organized. Because IME physicians are paid a flat rate for their services, many are unlikely to spend time organizing a file chronologically to get a complete picture of the medical situation. This should be done beforehand by the adjuster and then verified by the medical advisor.

Third, the medical advisor can make sure that the cover letter to the IME physician summarizes the pertinent information and asks the requisite questions concerning the work-relatedness of the injury. Typically, the standard cover letter sent by the adjuster is very general. Crucial information is not highlighted for the IME physician, and there are no threshold questions being asked. Two of the most commonly omitted questions are: "Would the required surgery have been necessary regardless of the workplace injury?" and "If this workplace injury had never occurred, would the worker's current medical condition be substantially different?"

Fourth, because the timing of the IME involves a medically sensitive determination, the medical advisor can recommend nixing or rescheduling an adjuster's request for an IME based on the advisor's appreciation of the case. Especially in states where only one IME is allowed every six months, adjusters need to ensure that all useful information is in the file before the IME is done. Without such information, the IME physician must rely on the patient's version of events, which may not be accurate or complete. For example, after one employee waited five months to be seen by a specialist, the adjuster requested an IME before the specialist's report was in the file. Thus, the IME was not as useful as it would have been if the IME physician had the specialist's report on hand to take into consideration. Or, sometimes, an IME is done before the MRI results are in. Because MRI results can suggest causation or degree of injury, the IME should be done after those test results are in the file.

In our experience, a medical advisor eliminates the need for an IME almost 20 percent of the time. When an injured employee is not back on the job in what an adjuster using disability guidelines considers an appropriate time frame, the adjuster routinely orders an IME to "move the claim along." An IME typically costs $1,000 to $1,500 or more (depending on the state). It takes several weeks to get an appointment and at least several more weeks for the report to be transcribed and sent to the adjuster. The insurer or TPA continues to pay indemnity costs during this time unless the employer is able to provide a transitional-duty position. Thus, ordering an IME when it is unnecessary typically costs an employer thousands of

dollars in indemnity and medical payments.

Because the disability guidelines are general and each medical situation is unique, a medical advisor can better determine when an IME is needed than an adjuster. For example, one employee had arthroscopic surgery for an impingement syndrome in the shoulder. The employee was taking longer to return to work than the adjuster expected, so she wanted to order an IME. The medical advisor reviewed the medical file and saw that underlying arthritis was delaying healing and counseled the adjuster to wait another six weeks. The worker was back on the job in four weeks — less time than it would have taken to set up an IME and get the report — and the worker's benefits during that time cost less money than it would have taken to pay for the IME. In one company, the medical advisor saved over $134,000 in one year simply by reducing the need for IMEs.

In another company we know of, the medical advisor reviews every request for an IME and cover letters are often rewritten. This avoids unnecessary IMEs and gets the most out of every one that is ordered.

Improve Uses of Nurse Case Management

Nurse case managers are used frequently by nearly all TPAs and insurers to coordinate medical care. Sometimes they are in-house nurses employed by the TPA, but often they are outside vendors. Nurses can be invaluable in coordinating medical care, checking up on an employee's welfare and circumstances, and making sure an employee can get to an appointment. However, at $95 per hour, nurse case managers are also a significant expense, particularly when the life of a claim is measured in months and years instead of weeks. The costs grow rapidly when there is field case management, where nurses accompany employees to the doctor's office and IMEs to discuss care.

The medical advisor should review all uses of nurse case managers to make sure the service is needed and is brought in at the right time. Certain injuries just take longer to heal, such as shoulder injuries, and using a nurse case manager will not speed the healing process. When to use a nurse case manager should be determined not just by the length of time out of work, but also by the clinical needs of the employee. Ideally, the medical advisor should make sure nurse case managers are being used correctly and give guidance if they have medical questions.

Review Apportionment, Second Injury Funds, and Older Claims

At a later phase in the life of the claim, there are additional opportunities to save costs, either by reducing the degree of permanency or by obtain-

ing reimbursement from a second injury fund. Both of these mechanisms are designed to give employers relief from paying for injuries that are not completely work-related.

Permanency can be based on an impairment (loss of physical function) or disability (loss of earning capacity). Impairment is a reduction in an employee's ability to perform physical activities. This is a medical issue where a medical advisor can offer an opinion. Although doctors hired by the claimant and the employer will both examine the claimant to make the final determination of disability, the company medical advisor can steer the employer in the right direction. In order for the employer and its insurer or TPA to make realistic settlements and estimates of probable permanent partial disability payments, the medical advisor should review the relevant files and provide an internal opinion for the employer.

In some states, an employer can recover money from a second injury fund. These funds were created to pay part of the cost of injuries to employees with preexisting disabilities, thus lessening concerns about hiring these employees. To gain reimbursement from these funds, employers must prove that a prior injury combined with the new workplace injury is greater than the workplace injury alone. When relevant, a medical advisor can use the employee's prior and current medical records to do this.

In addition to reviewing new claims, the medical advisor can add value by reviewing legacy claims — the "old dogs" that have been around for years. The medical advisor can review all medical problems, looking for opportunities for reserve reductions and structured settlements that might be eligible for morbidity-based discounts when an employee has a shortened life expectancy due to cardiac, hypertension, diabetes, or other health problems unrelated to the workplace injury. When selecting files for review, the medical advisor should choose ones with high remaining reserves so that, if the file can be closed earlier than expected, the maximum potential savings can be realized.

Does Your Company Need a Medical Advisor?

A good starting point is to have a qualified medical advisor review a sampling of your claims. He or she should select a cross-section of files from two or three claims offices in different states. A file review of 20 to 30 files in each location is usually sufficient.

The best-qualified medical advisor is a physician experienced in treating occupational injuries and familiar with workers compensation law. Understanding the importance of whether an injury is new or an aggravation of an old injury can be critical to the cost of a claim. Knowl-

edge is more important than personal presentation skills. This can be a back-room job done onsite or offsite depending on the volume of your claims and the location of your workforce. For example, for a company where the workforce is at one location, an onsite medical director has certain advantages. For a decentralized company with widely dispersed locations, a medical advisor located offsite works just as well. Attention to detail is more important than advocacy skills because the medical advisor will be working with files, not treating patients or serving as an expert witness.

The medical director or advisor can be a full- or part-time employee or an independent consultant. The volume of claims will be the most important factor in determining the time required for a medical-review program. Your medical advisor will be reviewing only lost-time claims, not medical-only claims, so if you have only 100 lost-time claims, you would need him or her only four to five hours a week. If you have 1,000 lost-time claims annually, then you may need a medical advisor 20 to 30 hours weekly. A medical advisor will be more useful working on complicated or ambiguous claims such as back injuries than on claims for broken bones or catastrophic injuries, which are generally more straightforward. Companies with manual-labor jobs will benefit more from having a medical advisor than companies with office workers.

Ideally, you'll want your medical advisor to review all lost-time claims where employees are currently out of work, especially those that have no estimated return-to-work date and those where the employee shows no inclination to return to work — always a red flag.

Integrating a Medical Advisor into an Existing Program

A medical advisor can easily be added to an existing injury-management program by hiring a physician in a part-time capacity. The advisor should begin reviewing the most recent lost-time claims and all requests for IMEs. The medical advisor can also review all documentation that is used to justify time out of work. Once the new claims are reviewed, he or she can begin reviewing the older claims, including the IME reports already in claim files.

Specify Parameters in Account Instructions

Since claims are managed initially by claims adjusters, the employer should tailor its specific account-handling instructions so that the medical advisor is able to do his or her job effectively and produce the greatest benefit. (Account-handling instructions are the TPA's or insurer's instruc-

tions to the field adjusters regarding how a client company wants its claims handled.) Here are some model account-handling instructions relevant to a medical advisor's medical-review program.

- All lost-time files where an employee has been out of work for 10 workdays or where return to work is expected to be more than 10 workdays should be forwarded to the medical advisor. When these claims are referred, the medical documentation used to justify disability time, such as the injury status form and office notes, should accompany the referral. This information should be faxed from the treating physician to the adjuster and the adjuster should fax it to the medical advisor. The medical advisor will request additional medical records if needed.

- All claims involving a request for telephonic or field-based nurse case management should be reviewed by the medical advisor prior to assigning these services. For both telephonic and field-based services, the nurse case manager must send a brief update of the claim to the medical advisor on a specific day each week.

- Prior to scheduling an IME for a claimant, the adjuster should send the claim file to the medical advisor for approval. Copies of the drafted cover letter and a checklist of medical records should be included with the referral. All IME reports must be sent to the medical advisor for review when received.

- Any claim where the mechanism of injury doesn't seem consistent with the complaints must be reviewed by the medical advisor. For instance, if a vehicle went over minor bumps and the employee-driver claims excruciating pain, the medical advisor must review the claim file.

- All requests for reserve increases over $25,000 should be approved by the medical advisor.

- All requests for surgery must be reviewed by the medical advisor prior to scheduling.

- All reopened claims must be sent to the medical advisor for review before accepting the claim.

Effective Integration With TPA or Insurer

Setting up a medical-review program with a medical advisor should never take a cookie-cutter approach; the program must be tailored around a TPA's services and the company's injury procedures. If the TPA says it offers physician services, you must find out exactly what this involves. Will physicians be touching any of your claims? Where are the physicians located? How often are they in the claims office? How do they determine which claims will be reviewed? Several TPAs and insurers use physicians in their claims offices, but the mechanisms for determining when these services are used on specific claims vary dramatically. Make sure to get specific details on when doctors will be used on your claims.

The employer should tailor its account instructions according to the insurer's or TPA's best practices. For example, you'll need to know how your claims administrator handles preparation of IME cover letters. Does the insurer or TPA use a checklist-type cover letter or is each IME cover letter customized by the adjuster or by an in-house lawyer? If the person in charge of workers compensation for your company has not visited the insurer's or TPA's office, it is important to do so now.

Furthermore, you must evaluate whether the current procedures in place at your company and at the insurer or TPA catch all problem claims. If not, determine what needs to be changed so that those claims get more aggressive management. For example, at one centralized company with a major facility, the medical department needed to be relocated within the facility so that it was adjacent to the workers compensation and loss control departments. If injured employees stay out of work for extended periods of time, then postinjury procedures need to be developed to bring the duration of time out of work in line with the severity of the injury.

Summary

As part of an overall workers compensation cost-control program, hiring a medical advisor to work proactively on claims is an important but often overlooked step in taking control of your workers compensation costs. With a full, integrated program, you can reduce costs dramatically. While cost-cutting services such as medical bill review have their place, and health-care coordination services such as telephonic case management can be useful if used appropriately, a medical advisor is also critical, because workers compensation is largely about effectively managing medical treatment.

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