THE RISK REPORT

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WORKERS COMPENSATION COST CONTAINMENT

Medical costs in America are skyrocketing. According to the government's Agency for Healthcare Research and Quality, "The United States spends a larger share of its gross domestic product (GDP) on health care than any other major industrialized country." In 1960, healthcare consumed about 5 percent of the GDP. This is now estimated at 16 percent with no end in sight.

These are the brutal waters that workers compensation programs must navigate. International Association of Industrial Boards and Commissions Executive Director Gregory Krohm said, "There is virtually no financial incentive for doctors or other providers to deliver high-quality care to injured workers." He went on to say that, "while medical costs continue to escalate ... worker outcomes were not materially changed." Because our injured employees must wade through these waters, it is vital to assist them with outstanding claims management skills throughout the workers compensation process.

A strong workers compensation program begins with the claims administration team. This article discusses the team, their roles, and the importance of communication in settling workers compensation claims—all with an eye toward promoting healing and returning the injured employee to work as quickly and economically as possible.

Working with Third-Party Administrators or Adjusters

The relationship between an organization and its adjusters or third-party administrator (TPA) determines the quality of its claims administration process. To forge that relationship, any employer with a retention or deductible program should develop its own claims handling philosophy and clearly communicate performance standards. Then, the best administrator to meet the needs of the organization should be chosen.

Choosing the Right Administrator. The TPA is the most important choice to be made in setting up a superior risk management program for workers compensation. Before a contract is signed or coverage bound, it is important to determine acceptable caseloads, appropriate communication timelines, costs to access medical provider networks, and the frequency of claim review conferences. Then preselect cost containment vendors, such as nurses and legal counsel.

Review the resumes of adjusters who will work on your files. Accept only adjusters with excellent performance records. Almost any claim auditor will tell you the best adjusters learned their trade from insurers before training programs were gutted during the 1980s and 1990s, so look

for a little gray in your adjusting team's hair when you can.

Lastly, contractually incentivize your TPAs. If they receive a flat fee, they may underwork files. If TPAs are paid for managing a certain number of claims, then what is their incentive to close them? Time-and-expense billings are difficult to manage. Turn to local self-insured association members to review other organizations' TPA contracts before requesting claims management proposals.

Small Caseloads Make the Difference. Assigning the right number of claims per adjuster means the difference between "adjusted" claims and "paid" claims. Among risk managers, there is always lively discussion about the right caseload. Many feel that 125 open lost-time claims is the maximum an adjuster can handle, with about 300 the maximum for a medical-only adjuster. The number of supportive care cases the adjuster handles should be preset as well. Contractually obligate your TPAs to maintain appropriate caseloads, and then ensure that clause is honored.

Working with Adjusters. Partner with your insurer or TPA in managing the claims process. In general, a proactive and savvy adjuster can do more to contain costs than any other single measure. Try to build a cordial relationship with adjusters. Meet them face-to-face when possible to discuss problem files. Do not become known as the client who causes TPA staff to hackle when your name appears on their caller ID. If you have repeated problems with one adjuster, address that issue with managers. Don't beat up the entire staff over one adjuster's failures. Communication is paramount in claims management, but no vendor wants to feel the sting of constant criticism.

In the end, though, there is one guiding principal: *No one spends your money like you do.* Your TPA should be *administering* claims under your close supervision, not *running* your claims program.

Preemployment—Don't Hire Your Next Workers Comp Claim

Is your next workers compensation claim interviewing with your Human Resources (HR) staff right now? Companies often hire employees who have previous medical conditions or who may not be able to perform essential job functions. Don't become responsible for preexisting injuries or for injuries that could have been avoided with proper screening.

There is a major national push to hire workers with disabilities. It is the right thing to do. But there is a fine line between hiring someone who "works the system" and one who has a true disability that can be accommodated. This is where prehire employment practices can ensure only those who can complete job tasks safely are hired. A thorough preemployment physical can help with this determination.

Not All Physical Examinations Are Equal. Use only occupational physicians who specialize in preemployment physicals and who develop detailed health histories. Try to limit the medical history to health information that can impact job performance. File any genetic information separately to comply with the Genetic Information Nondiscrimination Act of 2008.

Testing may include cognitive examinations and mental status assessments. Be sure the physical examination relates to the job the applicant will perform. To protect against discrimination in hiring, require the examination only *after* you make a written conditional offer of employment. Some organizations want only the portion of the exam that indicates whether the potential hire can complete the essential functions. If your state offers a second injury fund, you may need the exam results to prove you were aware of the employee's previous injury to trigger coverage.

To avoid discrimination claims, strive for consistency when conducting preemployment examinations. Examine all final job candidates or none. According to the Equal Employment Opportunity Commission (EEOC), applicants can be rejected only if their medical condition precludes employment because it is "job-related and justified by business necessity."

If an applicant is rejected based on the exam, he or she may pay for another physician's opinion. If the applicant's physician disagrees with your assessment, seek a third opinion, for which the company normally will pay.

Behavioral Components to Injury. Behavior is a key predictor of future injury, according to Jim Palmer of SelectRite. SelectRite specializes in testing that validates an "entitlement mentality," a predictor of future risk behavior that can result in workers compensation injuries and malingering.

A 10-minute, online behavioral test asks questions designed to elicit whether candidates have lied or stolen in previous positions. Via this test, employers can better identify who may report a fraudulent injury or malinger. Why would people answer questions about their character honesty? "Because they have rationalized their behavior," says Mr. Palmer.

An organization such as The National Registry of Workers' Compensation Specialists (NRWCS) can help you find a preemployment screener. Remember, though, that preemployment processes are fertile ground for litigation. If in doubt, seek legal counsel. While employment screening can help eliminate undesirable candidates, it cannot prevent all injuries.

The Importance of Prompt Reporting

Prompt reporting of workers compensation injuries is vital in managing costs. For common workplace injuries, many employers lack a sense of urgency to report claims. But costs escalate dramatically when reporting is delayed.

It is critical to report all claims within 1 day of the injury. Many studies highlight the negative impact of late reporting, so be sure all supervisors and managers are well educated on this necessity. Per data released in 2005 by Fireman's Fund Insurance Company, information from California claims from 1993 to 1999 starkly highlight the importance of prompt reporting. Claims reported on the date of the injury averaged $5,706, while claims reported from 15 to 30 days post-injury cost $7,703. Those reported within 31 to 90 days averaged $10,487.

According to a 2000 National Council on Compensation Insurers (NCCI) study, the most striking cost escalation in late reporting involves back injuries, which are 35 percent more expensive when employers fail to report the injury immediately. Sprains and strains are 13 percent more expensive when reported more than a week post-injury. Late reporting also means increased attorney representation. Twenty-two percent of claims reported within 10 days are litigated compared to 47 percent of those reported more than 31 days post-injury.

Facilitating Prompt Reporting. How can organizations achieve prompt reporting? First, recognize that most managers think financially. Focus your presentations on lowering costs to alter behavior. Next, train frontline supervisors. Cumbersome reporting processes cause delays. Risk control personnel are working to reduce injuries; redeploy them temporarily to streamline reporting procedures when needed.

The Importance of Three-Point Contact

Within 24 hours of receipt of the injury report, adjusters contact the employee, the supervisor, and the medical provider. Normally, contacting the medical provider means obtaining the medical report. For the majority of medical-only claims, this

process works. However, some injuries are deceptive. For example, a minor head strike can become a closed head injury that doesn't manifest until several months after injury. Or a simple back strain may turn into a herniated disc, requiring surgery and months of lost time. In these instances, a more thorough initial medical history taken at first contact may uncover crucial information missed in a routine doctor visit.

Nursing Triage Services Can Significantly Reduce Costs. Reducing the lag time between the injury and first report and aggressively managing medical care early in the process can lower costs significantly. Most insurers assign the injury to an adjuster within 24 hours of receipt, and the adjuster immediately begins medical management. Frequently, the claim reporting breakdown occurs between the date of injury and the date the first report of injury actually reaches the insurer. During that time, most injured employees direct their own care and may seek legal representation because they feel ignored and confused by the claims process.

With nursing triage, injured employees immediately call a nurse case-management helpline. A registered occupational health nurse then determines if the employee can treat with first-aid or should visit a predesignated occupational health clinic or emergency room (ER). The nurse also obtains the employee's medical history and reports the injury to the workers compensation insurer. If the employer has a return-to-work program, the nurse immediately implements temporary modified duty when appropriate.

A Public Entity Risk Institute 5-year study showed that, with nurse triage, average lag time between injury and report dropped to less than 1.5 days; litigation rates dropped 67 percent and remained about 20 percent below the California state average for work comp claims.

Nurse triage works for a number of reasons. First, it is cost effective. Averting doctor's visits or trips to the ER saves both direct and indirect costs. Second, employees appreciate the "high-touch" interaction and feel included in the process when a skilled nurse offers personal advice. The triage process also removes the supervisor from the medical component of the claims. Supervisors may overreact to injuries and direct the employee to the ER, at an average cost of about $850. Finally, the insurer learns of the incident almost immediately and can begin to direct further medical treatment when needed. The triage nurse obtains the necessary information to report the injury to the insurer or the self-insured administrator, which minimizes administrative time that supervisors would otherwise spend.

Nursing triage does not replace the insurer's compensability investigation when warranted. However, due to the depth of information exchanged between the employee and the intake nurse, the claim acceptance process is often expedited.

Don't Ignore "Sleepers." There should be two foremost goals to three-point contact: determine if the claim is compensable or requires an investigation, and identify comorbidities that may inhibit recovery. Many medical-only adjusters simply pay bills. This is an expensive mindset. The medical-only adjuster has a few important roles, including ensuring the initial claims coding is correct to assist the risk manager in determining loss trends and reducing future losses and taking a mini-medical history to assess whether more immediate medical intervention is be required.

Take the head strike, for example. Traumatic brain injuries (TBI) occur 1.5 million times per year in the United States, according to the Centre for Neuro Skills. The lifetime cost to care for a TBI survivor generally runs between $600,000 and $1.9 million. The costs of brain injury continue to escalate—over $48.3 billion annually in

the United States alone, according to the Brain and Spinal Cord Organization.

Failure to lose consciousness does not rule out a brain injury. Employees with prior head injuries are much more likely to suffer more serious injuries in subsequent head strikes. Adjusters should obtain as much medical information as possible to determine if the employee has suffered prior head traumas, perhaps from high school sports or other issues, such as domestic violence. If so, a case manager can assist the employee with appropriate neurological referral and treatment. When a head injury is missed or ignored, the results can be devastating, expensive to treat, and lifelong.

Ongoing Case Management

Multiple-injury claims and conflicting or "wandering diagnoses" often mean that employees are treated for years, with no definitive end in sight. Providers frequently have no "skin in the game." Finding the cheapest providers may work in the short term but fail in the long run. Tracking outcomes and rewarding medical providers for effective treatment improves claims management and helps employees heal faster.

Beware the Wandering Diagnosis. Many experts believe that roughly 20 percent of employee injuries account for 80 percent of an employer's claims costs. One big cost driver is inadequate medical diagnoses and procedures. A company like Best Doctors can help. Founded in 1989 by two Harvard medical professors, Best Doctors began with the premise that if expert physicians consulted with and coached treating doctors, medical care problems would decrease significantly. They believed that medical best practices' oversight would bring big improvements in medical outcomes.

Although Best Doctors began in the healthcare arena, at the request of American Re, a leading provider of excess insurance, it entered workers compensation care in 2001 with CatCare, a catastrophic injury management program. On catastrophic injuries, Best Doctors uses prevetted case managers to assist in the hospital and during employee rehabilitation. In addition to consulting on catastrophic claims, Best Doctors employs world-class physicians who consult with the employee's attending physicians on stalled or difficult claims. These consultations improve medical outcomes. If the attending agrees to work with Best Doctor's physicians, patients are treated in their own community.

On stalled or vague diagnosis claims, the company designs action plans to move claims affected by suspect causation, prescription pain medication overuse, and comorbidities.

Comorbidities Drive Costs. There is no doubt that comorbidities, including diabetes, hypertension, and weight issues, drive costs. A study by the National Council on Compensation Insurance (NCCI), "How Obesity Increases the Risk of Disabling Workplace Injuries," paints a grim view of the U.S. workforce. It is no secret Americans are growing heavier, but according to NCCI, 33 states have obesity prevalence of 25 percent or greater, and 9 of these states' obesity rates are 30 percent or greater. What does this mean to employers? It is no longer a luxury to obtain a full medical history so adjusters can quickly assign nurse case management to support healing. It is a necessity.

Obesity increases workers' risk of diseases and injuries. Some of these diseases negatively impact workplace injuries. Diabetes causes many problems, including delayed healing, increased risk of lower extremity injuries, and vision loss, which can impact a worker's wound care ability and make normal tasks, like walking, more difficult. With the diabetic, lower extremity claims can escalate from a simple blister on the toe to an amputation, for example.

A 2007 Duke University study of 12,000 workers found that non-obese workers filed 5.8 claims per 100 workers on average, while obese workers reported 11.65 compensation claims per 100.

Often, an employee fails to improve. Substance abuse, family problems, or depression may inhibit recovery. While you cannot control these issues, neither can you avoid them. Instituting early psychological treatment can avoid the "He's still not getting better—it must be psych" syndrome which keeps claims lingering, sometimes for years. Adjusters should consider psychological intervention, weight management initiatives, or other treatment early in the claim cycle to avoid stalled recovery.

The Importance of Medication and Pain Management. Managing employees with chronic pain or using opioids is critical to reduce costs. Too often, workers become dependent on narcotics when their pain is neuropathic and may be unresponsive to pain medication.

When the worker's function fails to improve with pain medication and therapy, an integrated pain management program with a solid psychological component and functional goals may help. Monitoring medical providers is critical, according to data released by the California Workers' Compensation Institute. Three percent of prescribing physicians accounted for 65 percent of the Schedule II narcotics' costs. It also pointed to "doctor shopping" trends, where some of the claimants saw up to 3.3 different doctors for pain prescriptions, while other claimants saw an average of 1.9 doctors. Only quality claims management can avert these trends.

The Importance of Return to Work (RTW)

The workers comp cost control tactic with the best return on investment available may be return-to-work (RTW) programs, and they benefit the company as well as its employees. Here are some employer benefits:

- Since some insurers will not quote on accounts that do not have a modified duty program in place, such programs open the door to more insurance markets.
- Managed properly, RTW programs will significantly cut comp costs.
- RTW programs alert employees that the organization will not tolerate malingering.
- RTW programs reduce indirect injury costs, such as overtime, temporary workers, and production decreases.
- Such programs can boost morale because other employees do not have to carry the weight of the injured worker indefinitely.
- Under the Americans with Disabilities Amendments Act of 2008, employers can no longer fail to provide a meaningful return to work to avoid incurring employment liability and potential class action litigation.

Here are benefits to the employee:

- Employees recognize that their employer values them both as employees *and* as people.
- RTW programs help to avoid post-injury depression, a common occurrence as an employee becomes increasingly focused on pain and alienated from the workforce.
- Such programs improve the employee's economic outlook.
- The employee remains a vital part of the workforce and retains valuable employment skills instead of losing skills while on long-term disability.

Achieving Buy-In. Achieving program buy-in by both managers and line employees is critical to a strong return-to-work culture. Risk control personnel know that change cannot be forced on people. For it to work,

senior managers up to the chief executive officer must embrace the RTW philosophy. For example, when there is no modified duty available in one division, an organization should place recovering workers in other divisions. This only happens with senior management support. Support grows when statistics demonstrating the true costs of failing to return injured workers to modified duty are provided to management.

In many organizations with strong safety records, each management meeting begins with an overview of recent accidents and injuries, and a discussion of who is off work and why. This conveys that safety is paramount, and return to work is supported. As insurers withdraw from the excess workers compensation market, remaining insurers will tighten underwriting standards. One broker recently reported his current 2011 excess workers compensation renewal premiums are increasing from 30 to 70 percent. Insurer loss ratios throughout the nation remain troubling, and rates are likely to increase in many states in 2012, if not before. Next to preventing injuries, a solid RTW program is one of the best defenses against rising costs.

Implementing the Program. Implementing an RTW program can begin small. Start with one division or even one unit. Your first goal may be to reduce lost-time claims in the next quarter by some specified percentage. Or try reducing the number of lost workdays per claim. This may be as simple as ensuring the physician's slip is returned to the claim coordinator within one day of the appointment so that RTW can be immediately addressed. Small changes can mean big improvements over time.

The company's position descriptions need to be accurate. Treating physicians must understand that the employer accommodates RTW, and all providers need to have a realistic understanding of the employee's job duties. Physicians sometimes rely solely on the employee's description of his or her duties, which may be overstated.

In today's volatile workplace, an RTW program can help reduce insurance premiums, keep valued employees at work, and keep the organization focused on its mission—operating profitably. While RTW programs help tremendously on difficult claims, resolving these injuries means adjusters must use all the tools at their disposal to close problematic claims.

Resolving Difficult Claims

Every adjuster's ultimate goal is to get the employee to maximum medical improvement (MMI). Adjusters may explain that a case is stalled because "the employee has not reached MMI," as if this ends the discussion. That statement should be the *beginning* of a discussion. Helping an injured employee achieve MMI is the most important goal in treating a work injury.

MMI occurs when treatment options are exhausted and the adjuster terminates temporary total disability payments. MMI may also be referred to a "permanent and stationary," or in some states, a "treatment plateau." At MMI, the employee's medical condition probably will not improve substantially.

Achieving MMI does not necessarily mean the employee functions at his or her pre-injury status; a return to pre-injury status may never occur. It's best described this way: "This person's medical recovery is as good as it gets."

Plan of Action. To achieve MMI, every claim should have a solid plan of action (POA). When an adjuster says, "He isn't MMI," the employer response should be, "What is the next step to achieving MMI?" Cases often languish, sometimes for years, because adjusters do not push the claim to closure. Here are a few tips that can help:

- Always have a POA so that any adjuster or supervisor can pick up the file and

know what to do next. It may be as simple as "Await examination results from Dr. Smith, then schedule the claimant for an independent medical exam (IME) if the employee is not MMI."

- A TPA supervisor should regularly review the file and provide input and advice. If this is not being done, the TPA's management team needs to be contacted and the situated remedied.
- For difficult claims, adjusters need to meet with several senior adjusters. Roundtable meetings work because a fresh set of eyes inevitably either confirms the need for an IME, a referral to a different physician, or other intervention that can help close the claim.
- When a claim is litigated, the attorney needs to keep the file on docket and actively work the claim. If there is a different attorney from the firm on each status report or at each docket setting, it's time to step in. Accept only the best performance from claims counsel. Adjusters should manage counsel, not vice versa.
- Employers should attend docket settings or mediations when possible. This shows not only interest in settlement but also care for the employee.

Going for the Close

The ability to close claims permanently varies widely from state to state. Closing difficult claims also takes some creativity. Consider structured settlements to end claims. Sometimes claimants do not want further treatment but are concerned about future medical bills. Think like the claimant to find ways to settle the claim.

To encourage claim closure, some administrative law judges allow companies with high claim volumes to hold "settlement days." Files move quickly without waiting for a docket date, but both sides must bend to move cases. It is important not to set cases unless the employer is willing to actually pay something to settle the claim. Denied claims or those bound for litigation are not appropriate for settlement days.

Sometimes it is necessary to politely remind judges and those involved that workers compensation was never meant to provide long-term medical treatment except in serious or catastrophic injuries.

Conclusion

Employee talent is a company's greatest asset. Therefore, anything an organization can do to promote healing, provide empathic case management, and return injured employees to the workforce in the best medical and emotional condition is the right thing to do—both for employees and for the organization. Remember:

- Let employees know you care.
- Tackle each claim individually.
- Form a cohesive plan of action.
- Demand only excellent performance from TPAs and legal counsel.
- Push claims to closure. The only good claim is a closed claim.

Finally, workers compensation claims management is a system that begins with the worker understanding the process. Causation and compensability are critical components, as well as effective case management. Only solid communication among all parties will ensure the strongest claims management structure is in place to meet the growing cost of healing injured workers.

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