Why Do Claims Get Stuck & What to do about it?

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No conflict of interest
What is a “Stuck” Case?

- “I know it when I see it…”
What is a “Stuck” Case?

- Worker upset and has persistent symptoms
- “Recovery” unusually prolonged (or not at all!)
- Nothing works!
- Poor outcome
- Unfortunate things occurred as case unfolded
- Provider upset and increasingly demanding
What is a “Stuck” Case?

- Claim managers upset and under pressure
- Lawyers often involved
- Reserves have grown larger
- Uncertainty/Desperation drive excessive medical TX
- Injured worker and case goes downhill over time
- Case has no foreseeable end in sight
- Case repeatedly reopened
WHERE DO STUCK CASES FIT IN THE BIG PICTURE?
Where Are We?

• Stuck cases are uncommon but seem ever-present

• Most not truly catastrophic but are simple musculoskeletal injuries (which should resolve quickly)
  - Most are not classic catastrophes such as: Multiple trauma, Head injury, Spinal cord injury, Complex regional pain syndrome
  - Most are creeping catastrophes related to missing delayed recovery cues or are iatrogenic (secondary to poor medical care)
  - Subjective distress > objective pathology

• Percentage of cases that get stuck
  - Approximately 10–20% of cases account for 80–90% of cost
Hints

- It is more important to know about the patient who has the disease than about the disease the patient has. 
  Sir William Osler (1849-1919)

- Treat the patient not the disease

- Pathology important but doesn’t trump behavior

- Early recognition of delayed recovery factors saves lives and is cost-effective for the claim
Case # 1

- Joanne Smith is a 45-year-old female Package Driver
- 4 failed back surgeries
  - “Lives” in hospital bed
  - On multiple meds including opioids
  - Home health aide 4 hours/day
  - Requesting home modifications and modified van
  - Failed SCS, recommended for morphine implanted opioid pump
- Case not settled but assumed 100% disabled
Case # 2

• John Morris is a 35-year-old male Police Officer
• Low back work injury with MRI revealing disc bulge at L5-S1
• Highly symptomatic, distressed over losing job with symptom magnification and developing chronic pain syndrome
• Medications include Vicodin (opioid), Ambien (for insomnia), Flexeril (muscle relaxant) & Celexa (antidepressant)
• Spine surgery recommended by PTP but UR denied
• Functional restoration program recommended by IME
Causes of Stuck Cases

RISK FACTORS AND CAUSES
What Makes Claims Get Stuck?

- Workers’ Compensation system features
- Knowledge, beliefs, decisions, & actions related to:
  - Injured worker-related Issues
  - Medical treatment-related issues
  - WC System-related Issues
  - Insurance-related issues
  - Legal Case-related Issues
If You Could Choose...

• If you could choose between filing a work injury and treating privately, what would you do?
What happens if you’re injured or ill at home?

• See PTP
• Get treated
• Get better
What Happens if you get injured at work?
Problems Related to the Injured Worker

Ill/injured workers thrust into a maze
Cases Slowly Get Stuck in the Complexity

Health status changes

Normal rhythm of Case

= Higher potential for case getting stuck
Road to Recovery for the Injured Worker
Perceptions & Psychosocial Issues Can **Overwhelm IW**

- Problems related to “The Worker”

**Injury**

- Damn, this hurts!

- They're going to fire me.

- They think I'm faking!

- The Worker

- First Week

- First 3 Months
Psychosocial Factors are the “Elephant in the Room”
Psychosocial & Delayed Recovery Factors

- Associated with long term disability when ignored or unaddressed
- Effective prevention/management tools exist to minimize disability and chronicity
Injured Worker related Issues

- Ignorance (WC system information deficit) and false beliefs
- Unrealistic expectations of medical care
- Fear of return to work after injury, future, etc.
- Fear Avoidance behavior – activity = hurt & pain is bad
- Inability to cope & catastrophic thinking
- Low motivation for recovery - Off-work benefits
- Residual effects of childhood abuse (ACE)
- Financial: distressed due to loss of cash income

Often Leads to:

- Mistrust, anger & perceived injustice
- Resistance to RTW / Delayed case resolution
TIP: Injured Worker-related

• Consider, acknowledge & deal with perceived or real IW issues
  o Realize IW may be confused and feel disrespected and marginalized
  o IW needs to perceive claims examiner as patient advocate
  o Early resolution of denied claims and body parts issues
  o Consider the “big picture” – promote authorizations based on:
    • Low cost; Respect for TX MD; Early RTW

• Early recognition and action on problems
  o Manage IWs perceived or real problems
  o Ombudsperson/Claims adjustor needs to TALK to the IW and LISTEN with UNDERSTANDING
  o Early identification of delayed recovery factors
Problems Related to the Doctor

• High volume of patients leave less time for complex problems
  o Medicine as a business with increased productivity demands
  o Medical co-morbidities delay case – not treated by WC doctor

• Extra burdens: perceived and real
  o (Perception of) Medical care interference
    Paperwork, forms, delays awaiting authorization, etc.
    • Evidence based medicine (EBM) – ACOEM Guidelines: not followed

Often Leads to:

• Body part creep
• Worker never gets MMI’d (Maximal Medical Improvement)
Problems Related to the Doctor

- Too focused on symptoms, imaging studies
- Biomedical Model

Often Leads to:

- *Too little focus on function*
- *Too little focus on the IW*
- *Often leads to more procedures and medications*
**Biomedical Model** tries to Narrow Down & Identify the Source of Pain

**DEFINITION:**
Pain is the result of injury or disease that has caused anatomical alteration or pathophysiological harm to body tissues.

![Diagram showing cause and effect relationship with "OW!" symbol.]
The **Biopsychosocial Model**

- The problem is the WHOLE person needs to be treated
- Pain is the result of an interaction among:
  - Emotional / psychological state
  - Bodily anatomy / pathophysiology
  - Thoughts, beliefs, information
  - Residual effects of past history
    - Adverse childhood experiences (ACE)
  - Interactions with the external environment
    - workplace, home, disability system, and health care providers
Problems Related to the Doctor

- Poor communication skills (no training)
- Time pressure / discomfort with underlying issues
- Low respect/understanding for value of other roles / processes
- Chasing the money
- Ignore EBM treatment guidelines
- Refusal to provide documentation, engage with NCM / peers
Problems Related to Medical Care

- Too few doctors are rehabilitation, whole-person oriented
- Too few psychologists will to treat injured workers
- Too few quality functional restoration program
- Payers hesitant to authorize psychological care or FRP despite strong support by ACOEM chronic Pain Guideline
  - Worry re: expanding or prolonging claim
**TIP: Medical-related**

- WC requires unique skill sets, sometimes lacking in PTP
- Consider services of nurse case manager
  - *NCM Role*: work hand in hand with physician
  - *Focus on return to health and function*
  - Coordinates and collaborates with PTP & all other parties
- Insist on a time-limited, goal-oriented treatment plan
  - *If expected plan progress is not made, search for obstacles that can be addressed*
  - *Seek PTP’s assistance in addressing obstacles*
- If the carrot doesn’t work, consider stick (oust PTP from PPL)
Problems Related to the WC System

It Is Difficult to Legislate

Goodwill/Good Behavior
Too Many Players in the System

- Problems related to “The System”
Problems Related to the WC System

• Laws/legal issues complex and burdensome
  o Procedural burden significant - Prescribed steps may create process / service delays
  o Denial of care and Utilization review (UR) may generate disputes / stall cases
  o System may convert medical issues to legal disputes
  o Medical Legal Evaluator (IME) quality variable

• Injured worker often ignored
  o Focus on the claim and process (procedural) frequently takes precedence over communicating with the worker and identifying real issues driving the claim
  o IW may be upset by communication with insurer (written or verbal)

Often Leads to:
  • Stuck claim
**TIP: Issues Related to WC System**

- Earn / deserve workers’ trust – Be an advocate for the IW
- Early resolution of denied claims and body parts
  - May legally be able to wait “X” days, but...
    - Every day you wait leads to potential movement towards a stuck claim
- Identify cases getting stuck early and react appropriately
  - TTD as a risk factor
- Communication with concerned parties
- Fine tune Preferred Provider List (PPL) to include best doctors
Problems Related to Employers

• Ignorance (information & skill deficit) and false beliefs
• Adoption of hostile (defensive) posture
  o Refusal to support modified return-to-work
  o Employer may balk at aspects of claim management
• Desire to solve HR problems with WorkComp
• Refusal to make needed ergonomic modifications

Often Leads to:
  • Stuck claim
TIP: Understand Employer Needs

- Employers often face a tough bottom line, with thin margins
- Help employer understand how
  - Keeping a worker working reduces costs and long-term disability
  - How such reduction can positively affect the bottom line
  - Let Employer know expected course & resolution time for IW’s condition
- Good Employer-Employee Interactions
- Remind employer re: the Golden Rule
Problems Related to the Legal System

• Most claimant attorneys are simply trying to attain what they believe is best for their clients. But…

• Consequences of resorting to legal action
  o Attorney incentives ($$$) problematic
  o Attorney directing medical care problematic
  o Focus shifts to rights & money, not recovery

Often Leads to:
• Return to health often slowed/halted (e.g., med issues resolved legally)
• Stuck case
TIP: Work Collaboratively with Attorneys

• If possible, work collaboratively with Claimant Attorney
• Choose the Defense Attorney carefully!
• Know when to hold ’em . . . Know when to fold ’em.
  o If you are going to fight, fight wisely
Solutions – General Concepts

SOME THEORIES AND OBSERVATIONS
Implications for Action

The Problem:
Stuck cases may look medical

But... Getting these cases unstuck requires identifying & addressing Obstacles to recovery or resolution that can be:

MEDICAL (industrial and nonindustrial)

AND

NON-MEDICAL (psychosocial, educational, cultural, etc.)
## Delayed Recovery Factors

<table>
<thead>
<tr>
<th>Category</th>
<th>Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotions</td>
<td>Depression / Anxiety / Catastrophizing</td>
</tr>
<tr>
<td>Attitudes and Beliefs</td>
<td>Beliefs that pain is a sign of damage and that pain/discomfort is harmful</td>
</tr>
<tr>
<td></td>
<td>Expectations of curative passive treatments</td>
</tr>
<tr>
<td></td>
<td>Belief that all pain must be abolished before return to work or normal activity</td>
</tr>
<tr>
<td>Behavior</td>
<td>Avoidance of activity and social interaction due to fear of pain / reinjury</td>
</tr>
<tr>
<td></td>
<td>Use of extended rest</td>
</tr>
<tr>
<td></td>
<td>Increased use of alcohol and other drugs</td>
</tr>
<tr>
<td>Social Support</td>
<td>Unsupported or overprotective partner / family</td>
</tr>
<tr>
<td>Work</td>
<td>Poor work history</td>
</tr>
<tr>
<td></td>
<td>Job dissatisfaction and low motivation to return to work</td>
</tr>
<tr>
<td></td>
<td>Unsupported work environment</td>
</tr>
<tr>
<td></td>
<td>Prolonged time off work</td>
</tr>
<tr>
<td>Historical</td>
<td>History of family or personal substance abuse / misuse</td>
</tr>
<tr>
<td></td>
<td>History of adverse childhood experiences (ACE)</td>
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<tr>
<td></td>
<td>Psychological disease: ADD, OCD, bipolar, schizophrenia, BPD</td>
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<tr>
<td></td>
<td>Lack of life and coping skills; lack of resiliency</td>
</tr>
<tr>
<td></td>
<td>Health illiteracy</td>
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Injured Worker Negative Thoughts / Beliefs

- It’s not really safe for me to be physically active
- Worrying thoughts have been going through my mind a lot of the time
- I feel that my pain is terrible and never going to get any better
- My pain is over 10/10 and is the worst pain imaginable
- I doubt that I will ever be able to work again
Early Recognition of Delayed Recovery Factors

• Note: Delayed recovery = big risk factor for stuck cases
• Identify risk factors for delayed recovery
  o Simple Screening Questionnaires
    • STarT Back Screening Tool (SBST)
    • Örebro Musculoskeletal Pain Questionnaire
    • The Pain Disability Questionnaire (PDQ)
**TIP:** What should the adjuster look for?

- Are there risk factors for, or evidence of, delayed recovery?
- Does the IW report or exhibit increasing symptoms or continual complaints of pain despite treatment
  - *E.g., poor sleep, inactivity, deconditioning, increased # of prescriptions, added meds?*
- Ongoing medical treatment / cost without benefit
  - No clear treatment plan or path forward
  - Concerns re: medical provider(s)
  - Non EBM (ACOEM) compliant treatments recommended
- Failure of prior RTW effort (no documentation of RTW plan)
- Is diagnosis vague and/or no objective findings
- Prolonged work absence
**TIP**: What should the adjuster do?

- Understand limits of Nevada WC system
  - “Know when to hold then and know when to fold them”
- Nevada WC is a small world – know the players
- Obtain a second medical opinion
- Recommend/Approve a multidisciplinary evaluation
- Keep a positive attitude toward the injured worker
Medical Treatment & Rehabilitation

Biopsychosocial functional restoration approach
Concept: Recovery Takes Time
- Do the Simple Things First

Physical Therapy

Movement/Conditioning

Work Conditioning
Work Simulation

Work Hardening
FCE/CBT/Psychosocial

Functional Restoration
Functional Restoration is an Approach

- Not always an expensive full-time pain program
- A good treatment plan has multiple patient-specific approaches

Functional restoration is an approach with:

- Co-located professionals
- Daily communication
- Functional focus
- Coordinated care

Physician
Psychologist
Physical Therapist
Functional Restoration Components

- Cognitive Behavioral Therapy (CBT)
- Physical Restorative Therapies
- Education and Psychosocial Focus
- Medication/opioid Optimization
- MED Dose/day
- Occupied opiate receptors/dose
Role of Pain Physical Therapist

Importance of Active Therapies (vs. Passive)

- **Increase Active Exercise**
  - Stretching, strengthening, condition, balance, etc.

- **Reduce Passive Therapies**
  - Ultrasound, massage, manual mobilization, etc.

- **Key Role of Physical Therapy**
  - Safe exercise regimen
  - Teach flare-up management
  - Self-directed (home) exercise program
  - Deal with pain avoidance & fear of reinjury
  - Teach self-confidence
Role of Pain Psychologist

- Help patient take responsibility, be self-sufficient and become educated about how to manage pain.
- Teach importance of non-physical aspects of pain and how to deal with them.
- Address fear avoidance, anger, hostility, etc.
- Identify psychological barriers to physical progress.
- Positive interactions with others.
- Re-establishing balanced life.
Why do we care about patient engagement?

- **Empowerment; self-management; internal Locus of control**
  - We can’t help someone who is passive and not actively engaged in his or her own recovery and well being.

- **Intermittent medical and therapy visits inadequate**
  - A patient MUST take charge of their own restoration 24/7
  - Need regular/immediate communication between patient, physician, PT, psychologist
**SOLUTION:** Functional Restoration Approach

- Purpose is to restore function and everyday life activities
- Focus shifts away from treatment of symptoms
- Patient is educated and driving own recovery
- “From patient to person” — (American Chronic Pain Association)
**Functional Restoration Approach**

- **WHO is appropriate?** (Criteria)
  - Establish correct diagnosis
  - Selective screening a **key competency** of FRPs
  - Tailor Program to fit IW’s needs (not just end-stage cases)
  - Frequent communication with all parties

- **Self management important**
  - Patients take responsibility for managing their symptoms & treatment

- **Functionally oriented** (**NOT** pain oriented!)
  - **FOCUS**: to reengage IW in home and work activities
  - **GOAL**: Provide quality cost-effective care within EBM Guidelines

- **FRP After Care and Follow-up**
  - Focus on positive outcomes (3-12 months)
  - Outcome tracking essential!
Outcome Case # 1

- Joanne Smith is a 45-year-old female with 4 failed back surgeries
  - After week 2: Gave up wheelchair and home health aide
  - After week 4: Off opioids and moved back into bedroom with husband
  - After week 5: Seems cheery and when asked why, she said “speak to my husband!”
  - After week 6: Thanked the FRP team for giving her back her life
  - 6 months post-discharge: Still off meds, active in family life, and doing some volunteer work for her church
Outcome Case # 2

- John Morris is a 35 year old male Police Officer with LBP
  - NCM supports and CE authorizes FRP
  - 4-week FRP engagement
  - Weaned from all medications
  - Discharge on a Friday to return to full duty work on Monday
Summary

GET CASES STARTED ON THE RIGHT PATH FROM THE GET-GO!
Summary: Preventing & Unsticking Stuck Cases

- Communication
- Early resolution of disputes
- Treat the injured worker with respect
- Identify risk factors for delayed recovery early and react quickly
- If recovery delayed, identify and address obstacles
Summary: Preventing & Unsticking Stuck Cases

• Identify quality physicians and incentivize them
• Support & encourage functional restoration approaches
• If you do not have one, hire or contract with a medical director
• Utilize services of a nurse case manager
Questions
Don’t Forget . . .

Please fill out the Evaluation Online: http://dir.nv.gov/WCS/Training/

- General Session- Why Do Claims Get Stuck & What To Do About It?

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