MINDER
Managing Disability

Dialogue

Workers' Compensation Claims Handling - "Groundhog Day"

The popularity of this 1993 Bill Murray movie rendered the phrase "Groundhog Day" with a common reference to a continually occurring unpleasant situation, according to Wikipedia.

Workers' Compensation claims handling seems to be stuck in a time warp with the same unpleasantries year after year no matter how many attempts have been made to address these issues through various avenues including legislation and technology.

2019 began with the same challenges reverberating; addressing provider fraud, medical disputes arising from applying evidence-based medicine together with a pharmacy formulary, inefficient and ineffective reactive claims management practices through to methods used for outgoing payments.

Why have the legislation and technology paths been littered with failed promises for over the past three decades or so, or indeed almost a generation of workers?

In California, the opportunity for providing high quality, coordinated care as well as controlling medical costs has existed for the past 26 years since the passing of SB1005 (Lockyer, D-Fremont) in 1993 and SB899 (Poochigian, R-Scotts Valley) in 2004, yet there are still ongoing complaints from dragged out medical care and poor recovery through to unacceptably high medical costs and fraud.

Governor Schwarzenegger (Republican) stated after signing SB899, *"We will terminate the fraud and abuse that was going on in the [state workers' compensation] system. Those who were gaming the system, we're saying 'Hasta la vista', because the game is over."* Since the passing of this bill, medical fraud and abuse has been rampant witnessing some of the largest kickbacks in the history of workers' compensation as well as bribes to a California State Senator, Ron Calderon (D-30th Senate District). How can this be possible when an injured worker's access to treaters has been restricted to those chosen by the P&Cs and claims administrators for their Medical Provider Networks, known as MPNs?

The introduction of evidence-based medicine along with a pharmacy formulary promised the delivery of high quality care at the right price. The passing of AB1124 (Perea, D-Fresno) in 2015 established an evidence-based drug formulary for California. Perea stated at the time, *"When workers get addicted to dangerous medications, goals of the program (workers' compensation system) are not met. An evidence-based formulary has proven to be an effective tool in other states and should be considered in California."* At that time, Texas had adopted a formulary from ODG (Official Disability Guidelines, Work-Loss Data Institute) which began in 2011. While Texas reported their savings in pharmaceutical costs and decreased dispensing of opioids with much fanfare, their formulary allowed without prior scrutinization the dispensing of two of the most highly desirable drugs to abuse, a long acting drug called MS Contin with its high dose of morphine, and a highly potent synthetic opioid 80 to 100 times more powerful than morphine called Fentanyl. Texas' motive for introducing their formulary is questionable considering both of these opioids exposed injured workers to developing an opioid use disorder (OUD).

Technology has always been touted as a means to improve claims handling. Today, Insurtech entrepreneurs promising improvements to claims handling promote disrupters to processes ranging from the replacement of paper checks as a payment method through to applying predictive data analytics and Artificial Intelligence.

Computer programming (coding) languages dating back almost 50 years such as COBOL and PL/1 were capable of providing computer programmers with the means to code logic to address payments and disbursement methods. Today that same code (had it been developed) could distribute any payment including an injured worker's temporary disability benefit over multiple payees and with any number of combinations of payment methods. For example, a percentage or a specified amount could be instantly paid into a bank account, another percentage or amount paid into a Paypal account and another percentage or amount applied against any number of debit/credit cards for each payee.

Transforming the decision-making process from reactive to proactive by applying predictive analytics has also been available for over 40 years. The coding language provided by Statistical Analysis System (today know as SAS) has been available since the mid 1970s and the Structured Query Language (SQL) along with the relational database model (RDBMS) it supports is almost 40 years old and remains the clear leader in coding languages for managing data. At the same time as these technologies became available, technology entrepreneurs planted seeds to raise awareness for the next evolution of analytics, Artificial Intelligence. To date, little (if any) of this technology has been harvested in claims handling.

What has caused the legislation and technology paths to be littered with failed promises? The answers are simple - **"mindset"** and **"execution"**. In any business enterprise including P&C insurance, money is always the bottom line in every decision made. The objective of the P&Cs' claims administrators is to close claims quickly with minimum payouts which can incite adversarial claims handling. By law however, with a workers' compensation claim, the injured worker has a right to

receive all the necessary care and medical treatment to return to sustainable employment. It's a Catch-22 however, as to fully undertake the management of an injured worker's recovery process as well as develop a successful reintegration strategy is not in the P&Cs' DNA. Based on 2017 written premiums in California, coverage for physical properties and liabilities totaled $71 billion. Of this amount, 16 percent was for workers' compensation, a comparatively small percentage considering claims handling practices for the remaining coverages encourage an adversarial approach. This percentage excludes the State Compensation Insurance Fund.

Understanding their limitations, P&Cs' claims departments have always found the need to operate through profit making "middlemen" enterprises who prosper by manufacturing crisis and creating chaos, and whose excessive costs for services have resulted in the rationing of medical care by restricting access to both resources and therapies. Both the delaying or outright denial of critical medical care and releasing injured workers from care earlier than appropriate has become the norm. As an example, California IMR Case# CM18-0238095 relates to a 54 year-old woman suffering from impingement syndrome in her right shoulder which she reported in October 2017. Treatments comprised of 16 sessions of physical therapy and a functional restoration program. As of October 2018, she was not working and rated her shoulder pain as 9 out of 10. To assist with controlling her pain and aiding in sleeping, her treating doctor prescribed thirty tramadol hydrochloride 50mg tablets. Because of the low quantity requested and being a short-acting immediate release tablet suggests they were to be taken on an "as needed" basis. The request for the tablets was denied by the claims department's Utilization Review physician and also by the IMR expert reviewer provided by MAXIMUS Federal Services. Shoulder impingement syndrome is a relatively common condition. Reviewing some of the many studies (over 200) describing treatment path options, suggests this woman may not have received high quality, coordinated care nor a timely review of the requested medications. It took a total of 69 days for the UR Review and Independent Medical Review, commencing on October 24th, 2018 when the physician requested the medication to December 31st, 2018 when MAXIMUM Federal Services upheld the denial, stating the medication was medically unnecessary and inappropriate as per the Medical Treatment Utilization Schedule (MTUS). **The cost for these 30 tablets is 92 cents plus a dispensing fee.**

With countless allegations of delays and restricted access to treatments it appears the use of a P&C's MPN combined with their Utilization Review program and the Independent Medical Review has fallen into disrepute. Studies suggest the interpersonal relationship between a patient and their treater is a key factor in achieving the most optimum outcome, yet P&Cs choose to exclude the names of physical therapists and others in their MPN, showing only the network name such as Align Networks or Medrisk for instance. This intentionally restricts the injured worker's ability to compare individuals before choosing their treaters. The consequences of this practice may have been a contributing factor for the poor state of affairs in IMR Case# CM18-0238095. This claim has been active in excess of 446 days. It is unclear whether temporary total disability benefits were paid for this entire period.

The California MTUS is provided by the American College of Occupational and Environmental Medicine (ACOEM). Its Board of Directors predominantly comprises of employers, P&C insurers and organizations providing workers' compensation services to both employers and P&Cs. While the MTUS has been promoted as guidelines based on evidence-based medicine, it has been strongly suggested the MTUS is biased and its implementation into California workers' compensation resembles a Group health insurance plan, i.e. insurers providing group health insurance only contribute to payments

for treatments listed in their plan and provided by their treaters. Similarly, P&Cs providing California workers' compensation coverage only pay for treatments listed in the MTUS and provided through their MPN.

Workers' Compensation claims handling is in dire need of change and to continue with the status quo is not an option. Claims department personnel need to stop thinking like a claims adjuster or claims examiner which connotes someone being adversarial. Regardless of the severity of the injury or illness, an injured worker can experience stress and anxiety caused by a sense of uncertainty and questioning of their self-worth resulting in most part by claims personnel mischaracterizing them as scammers and malingerers which also needs to stop. Claims personnel should also not think of themselves as the injured worker's advocate as they equally have a responsibility to the payer of the injured workers' benefits. Instead, they need to be facilitators - influencers and integrators of the various services required in the recovery process and reintegration strategy as well as the catalysts for a collaborative approach. The key differential then, is the middlemen are removed.

The facilitator takes ownership of every claims handling process that needs to be implemented through a single claims management system which has automated processes. This approach provides a collaborative environment where resources and activities are managed as processes allowing these to be performed in parallel (simultaneously) instead of sequentially (one at a time). All this saves time and reduces costs, both administrative as well as amounts paid for benefits by returning the injured worker to safe, sustainable and gainful employment much sooner.

Had IMR Case# CM18-0238095 been handled with empathy rather than by a "divisional structure", the outcome would have been completely different. Instead of an outright denial, discussion between the three parties through a telephone call, email or text around alternative medications to tramadol HCL, such as a medication combining ibuprofen and acetaminophen, or codeine and acetaminophen could have resolved the matter within minutes. In this case, the woman experiencing a pain rating of 9 out of 10 had to wait 69 days just to be told her 92 cent medication had been denied.

In 2017, 2.8 million employees in private industries experienced a nonfatal injury or illness according to the US Bureau of Labor Statistics, of which 882,000 (or 31 percent) required time off work. Over three decades, this equates to 26,460,000 families (assuming the same figure) whose lives most likely experienced upheaval and disruption caused by the failed promises.

Workers' Compensation claims handling for injured employees has been a major and inexcusable fiasco and in urgent need of a new breed of claims administrator, one who is forward-thinking, using outside-the-box approaches to effect change and break through the Groundhog day time-warp.

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