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Medical view of Claims Management: 15 Points to Ponder

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# Agenda

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1. Background
2. Claims Management Principles
3. Rehabilitation and Return to work
4. Managing Subjective Claims



# 1. Background

## Current problems

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- Effects of the economic crunch
- Decreased success rates in rehab protocols/RTW programs due to increased unemployment
- Increase in subjective claim causes

## Effect of Unemployment (KPMG)

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- TPD +5% to +15% increase per 1% increase in unemployment.
- Up to 3 year time lag
  
- DI +7,5% to +15% increase per 1% increase in unemployment.
- Quicker emergence, reduced termination rates



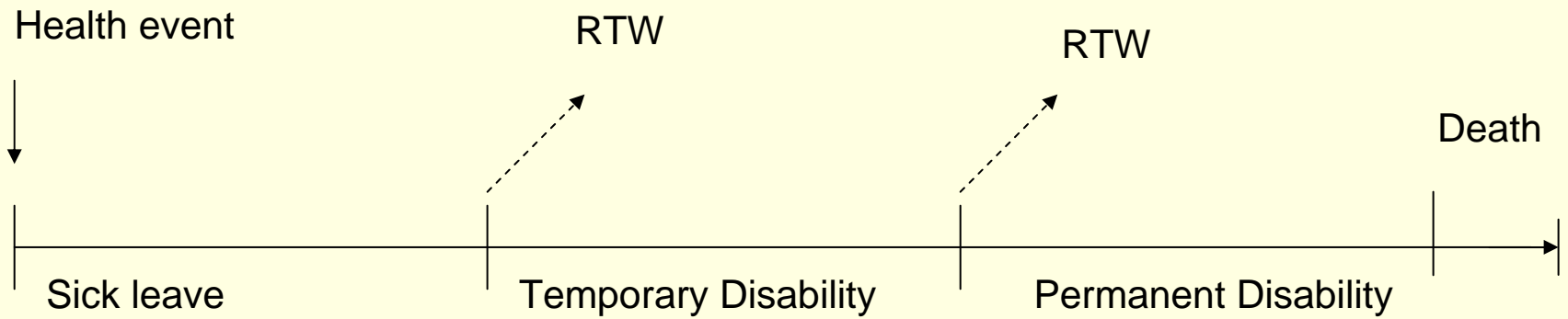
## 2. Claims management Principles

# Why do we want to manage claims?

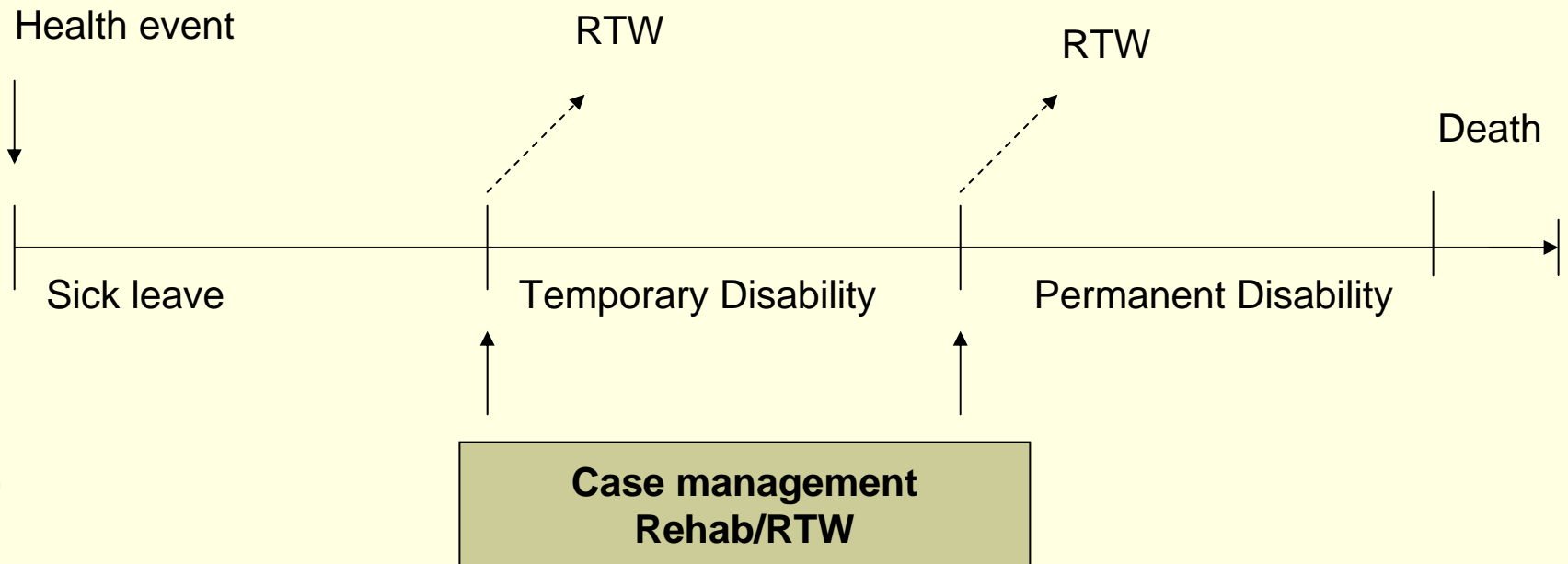
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- To pay all claims with merit
- To keep people employed is in their own best interest
- Science has proven the hazards of being jobless:
  - Increased mortality
  - Increased morbidity (esp mental health)
  - Decreased self-esteem, lack of purpose in life
  - Financial difficulties

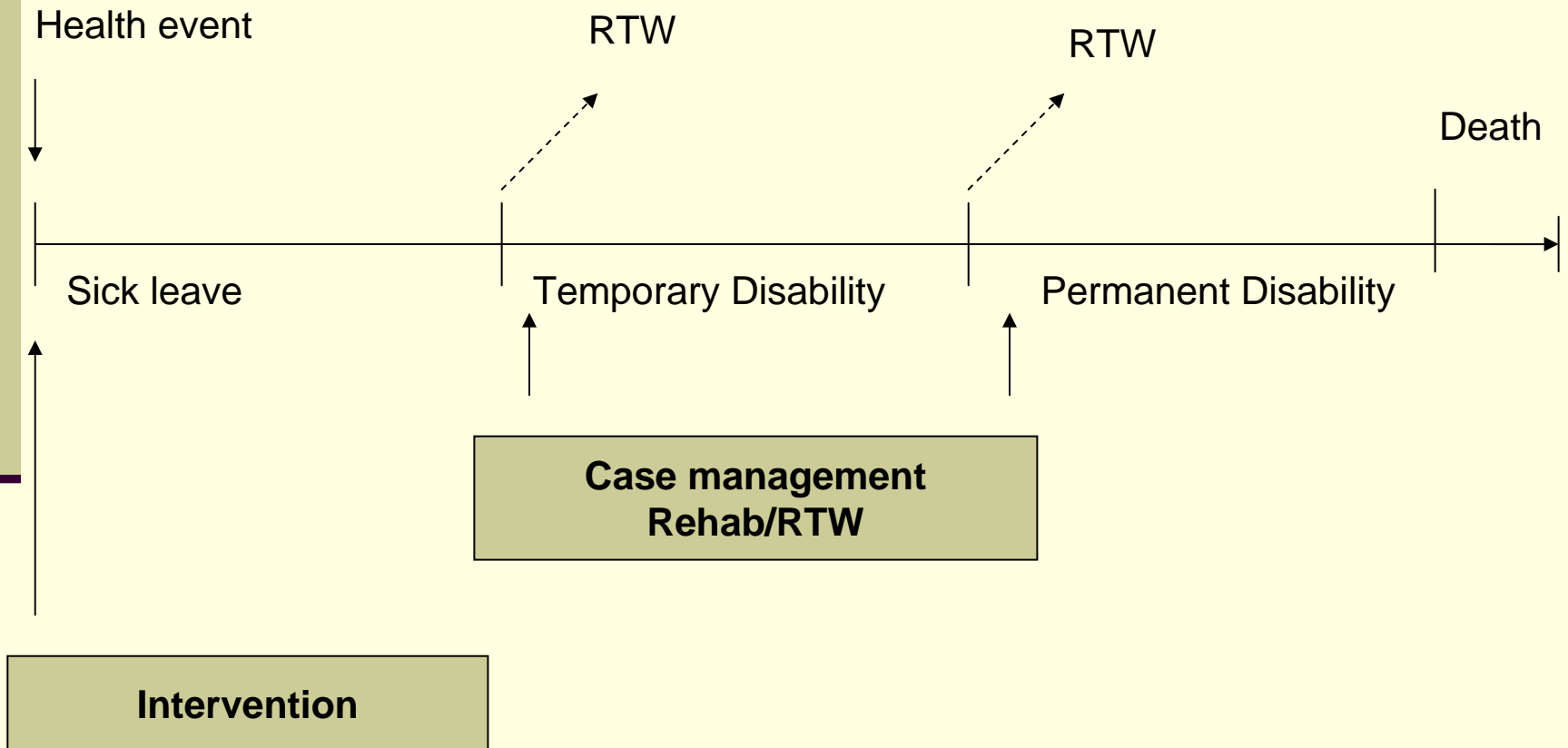
# Health Events: Natural Course



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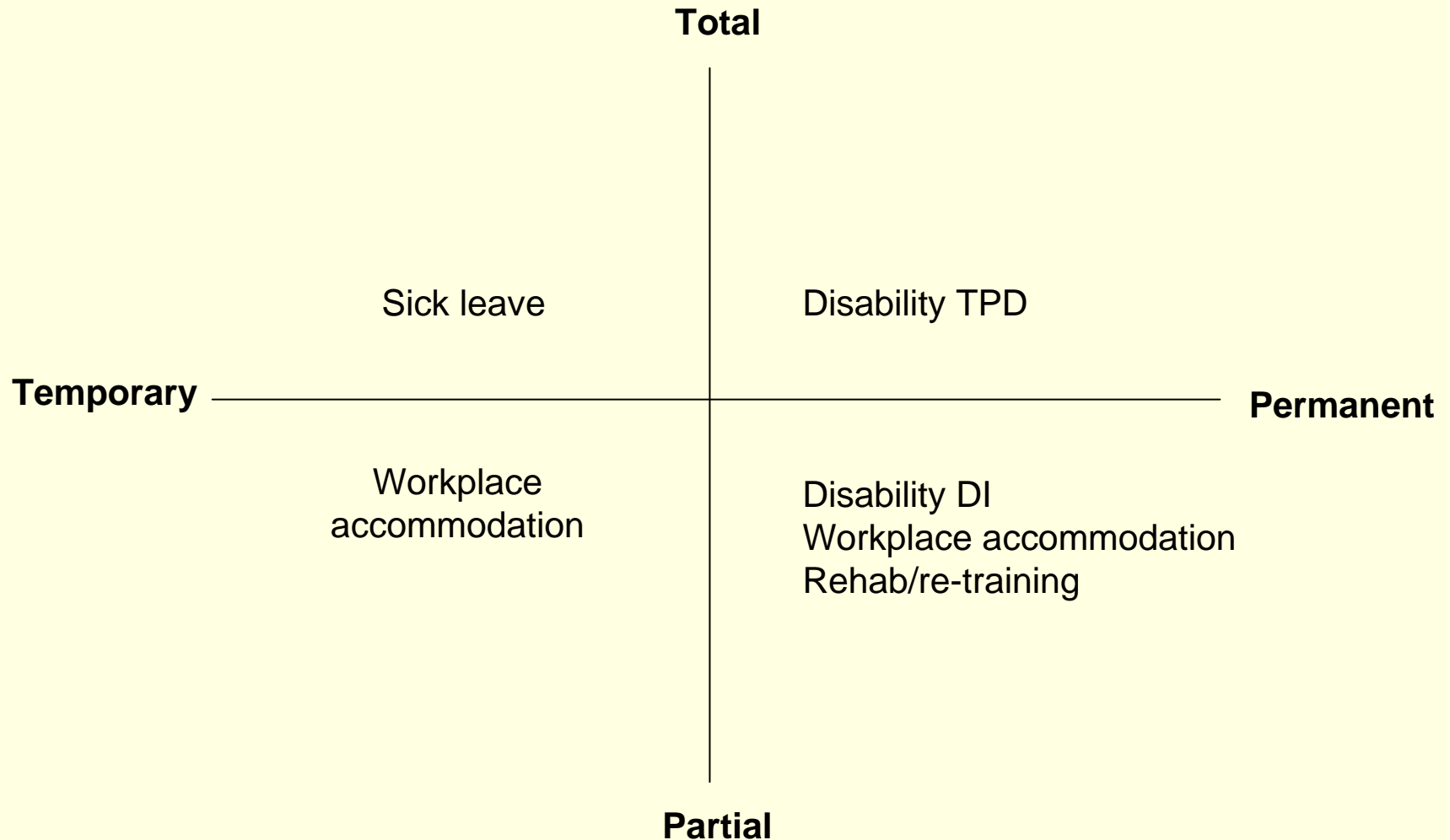
## Intervention at Treating Doctor level

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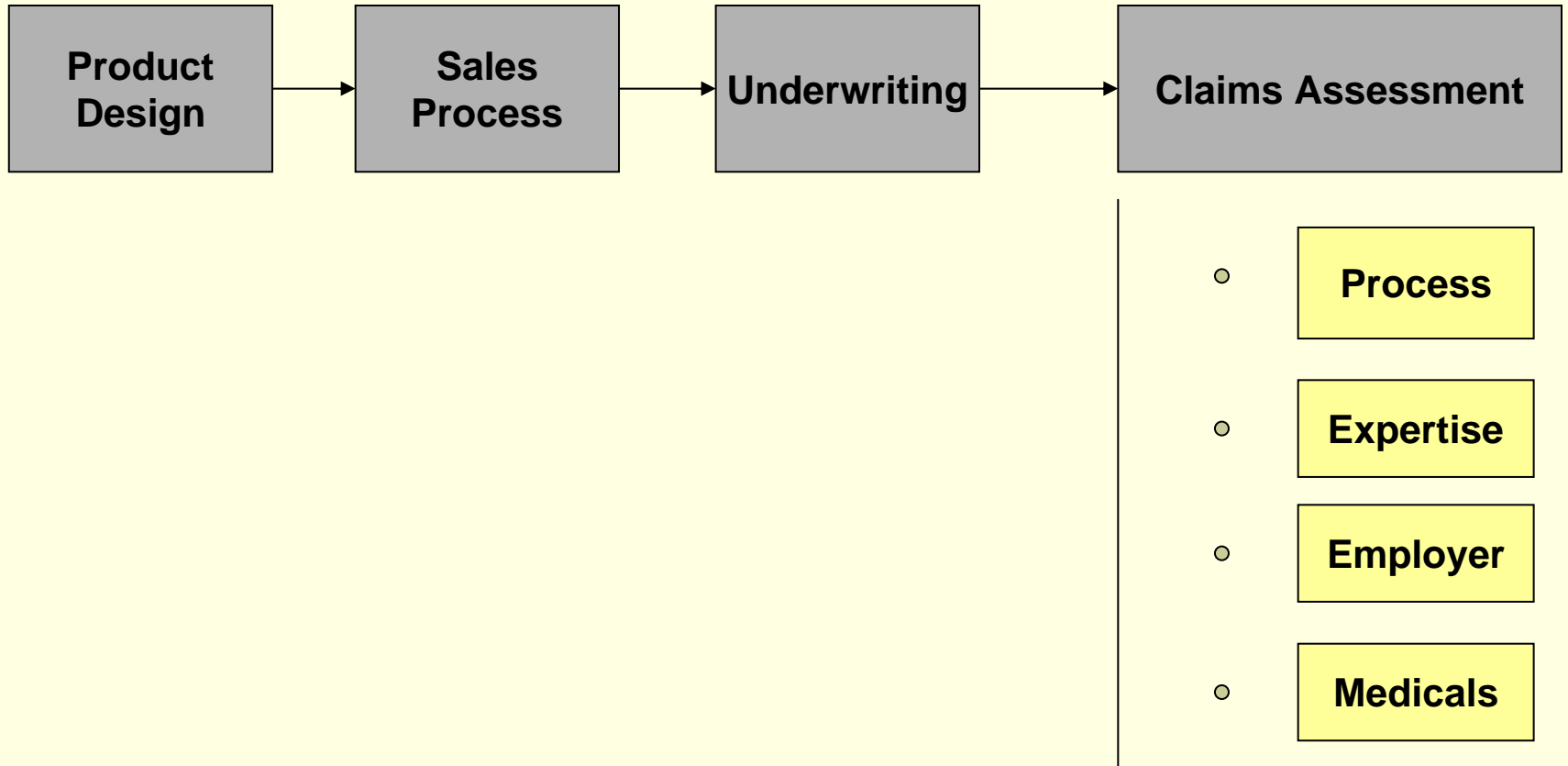
- **(1) Active discussions with doctors:**
  - Medical associations
  - Dept of Health
  - Preferred providers organisations about:
    - Utilizing appropriate recommendations of ill health
    - Proposing workplace accommodation
    - Following adequate treatment guidelines
    - Establishing fit-for-work guidelines
    - Commenting on impairment rather than disability.

# Appropriate management of ill health

## Absenteeism Grid



# Integrated process of effective claims management



# Product Design

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- **(2) Occupational disability definitions**
- Does contract allow for
  - Optimal treatment?
  - Re-training?
  - Rehab?

## Product Design

- **(2) Occupational disability definitions**
- Does contract allow for
  - Optimal treatment?
  - Re-training?
  - Rehab?

## Sales Process

- **(3) Prevent unreasonable consumer expectations**
- **(4) Prevent over-insurance**

## Underwriting

Socio-economical factors much more important than medical factors:

- Job satisfaction
- Years in current employment
- Remuneration
- Promotion probabilities
- Educational level
- Family factors

## Claims Assessment

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**Process**

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**Expertise**

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**Employer**

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**Medicals**



## Process

- Quick decisions
- Early intervention
- **(5) Good communication lines and SLA's with:**
  - Employer
  - Claimant
  - Service providers
- **(6) Effective review process of open claims**
- Grey cases:
  - **(7) Independent second opinions**
  - Private investigators
  - Settlement offers



**In-house expertise**

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- **(8) Must be better qualified than the claimant's doctor!**
  
  - Same applies to evaluation reports
    - OT vs orthopedic specialist
    - Review reports: specialist level
    - Weigh evidence for and evidence against

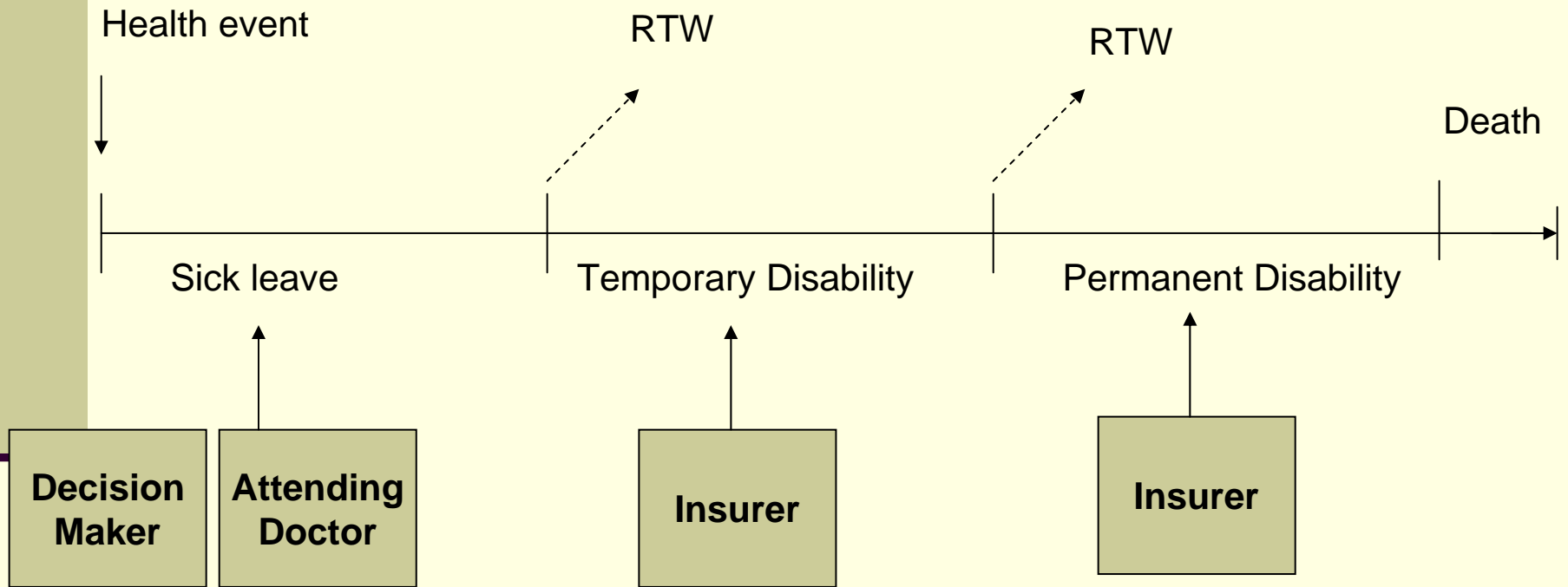
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**Employer**

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- Good communication essential
  - Workplace accommodation
  - Partial employment partial payment
  - **(9) Reward and recognition vs. victimisation**

- **Medicals**

## Important Principle: Who are the Decision makers?



# Medical Reports

## Role of the Attending Doctor

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- Full report re medical history
- Current symptoms, treatment, prognosis
- Impairment

**(10) No opinion on disability required from the examining doctor!**

Impairment is a medical decision.

Disability is a legal decision.

## Impairment vs. Disability

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Impairment is a loss of function following optimal treatment of a disease or injury.

## Impairment vs. Disability

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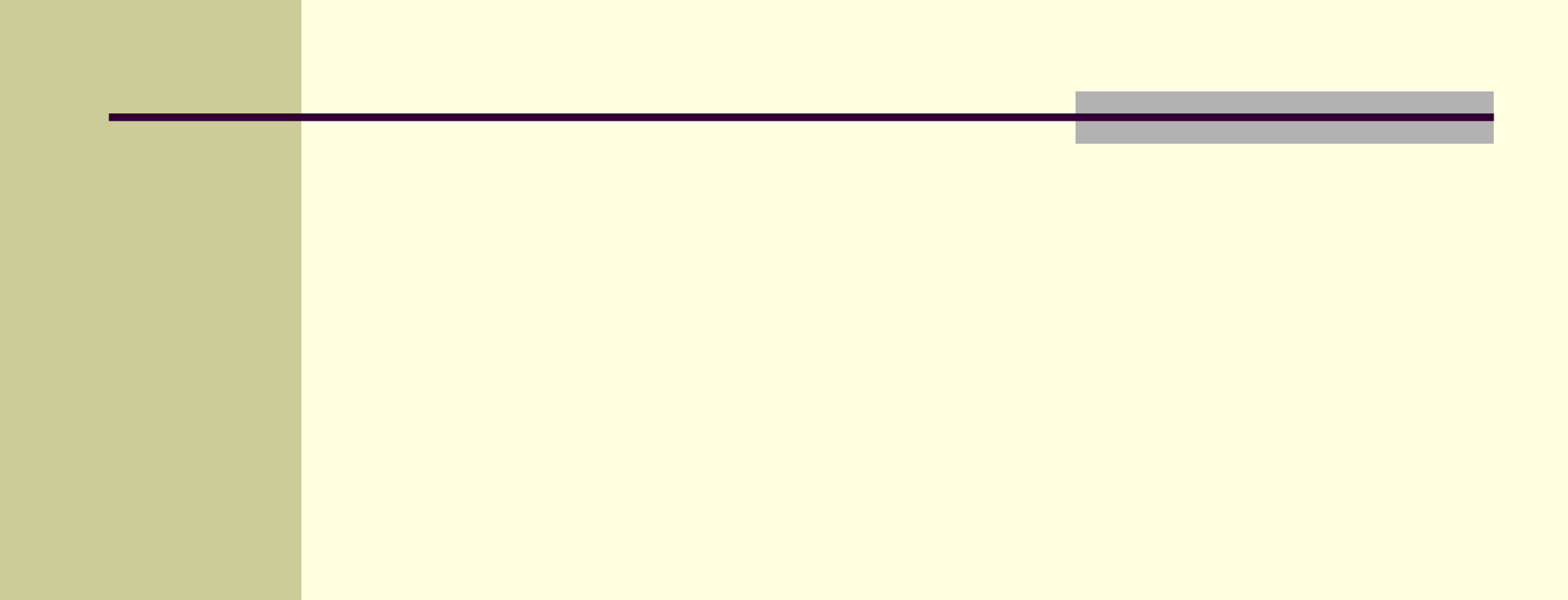
Impairment is a loss of function following optimal treatment of a disease or injury.

Disability matches the remaining abilities with the policy contract, the job requirements, and claimant's skills to determine whether it is reasonable for the claimant to be gainfully employed.

# Why should the Attending Doctor not decide on Disability?

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- Conflict on interest: best advice vs. best interest of patient
- Can ruin doctor/patient relationship
- Doctor usually has no knowledge of
  - Occupational history
  - Job description
  - Occupational skills, training, education
  - Contractual requirements
- Premature labeling.



### 3. Rehabilitation and Return to work

## Social barriers to effective RTW:

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- Job dissatisfaction or conflict
- DI disincentive
- Family dynamics
- Legal influences
- Financial security
- Limited education or vocational potential
- Age

# Predictive factors of Improved RTW Outcomes

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## 1. Individual factors

- Positive expectations and self-esteem
- Low levels of depression
- Low levels of work avoidance

## 2. Insurer factors

- Pro-active case management
- Fast claims processing
- DI income < 80%
- Counseling:
  - Psychological
  - Financial

# Predictive factors of Improved RTW Outcomes

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## 3. Healthcare factors

- Early intervention
- Positive recommendation for RTW
- Pro-active communication with employer
- Reassurance re prognosis, outcomes

## 4. Workplace factors

- Work accommodation
- Non-confrontational approach
- Incentivising RTW

## Medical view of Rehab

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In clinical setting: It works

In compensated setting: It seldom works!

The difference? : Motivation

Important: **(11) Apply pre-selection criteria for rehab/RTW programs**



## 4. Managing subjective claims

## Important principles

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- **(12) Apply the Absenteeism grid correctly**
- Get independent opinions
- **(13) Ensure that adequate treatment guidelines are followed**

# Subjective claim causes: South African Experience

## Disability Claims Causes: 2008 (2002)

|    |                        |              |
|----|------------------------|--------------|
| 1. | Musculoskeletal system | 20,75% (21%) |
| 2. | Central nervous system | 15,66% (12%) |
| 3. | Circulatory system     | 15,26% (11%) |
| 4. | Mental disorder        | 14,73% (36%) |
| 5. | Neoplasms              | 12,72% (9%)  |

# Managing subjective medical conditions

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## 4.1. Chronic fatigue

- CFS (chronic fatigue syndrome, ME syndrome)
- Fibromyalgia

## 4.2. Back pain

## 4.3. Psychiatric conditions

- MDE (major depressive episode)

## CFS: Treatment

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1. Patient informed, counselled, motivated
2. Periodic re-assessment important
3. Medical therapy:
  - NSAIDS
  - Non-sedating anti-depressants
4. Life-style: Aerobic conditioning. Avoid bed rest.
5. CBT

## Fibromyalgia: Treatment (latest)

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1. Education
2. Aerobic exercise
3. CBT
4. Medical treatment:
  1. TCA
  2. SNRI, NSRI
  3. Anticonvulsants (Lyrica)
  4. Tramadol
  5. SSRI
  6. Propanolol

# Assessing Fatigue and Chronic Pain

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- Principle: **(14) Obtain objective proof to substantiate subjective symptoms**

# Chronic Fatigue and Chronic Pain

## Objective Supporting Evidence

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| <b>Pain</b>   | <b>Fatigue</b>  |
|---|---|
| <ul style="list-style-type: none"><li>■ Pain questionnaire</li><li>■ Pain diagram</li><li>■ Objective proof of analgesic therapy: pharmacy records, copies of scripts</li><li>■ ADL impairment</li><li>■ ROM impairment where indicated</li></ul> | <ul style="list-style-type: none"><li>■ ADL impairment</li><li>■ Exercise capacity test</li></ul> |

## Look for:

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- Inconsistencies
- Improbabilities
- Non-physiological pain distribution patterns
- Mismatches between degree of pain and therapy

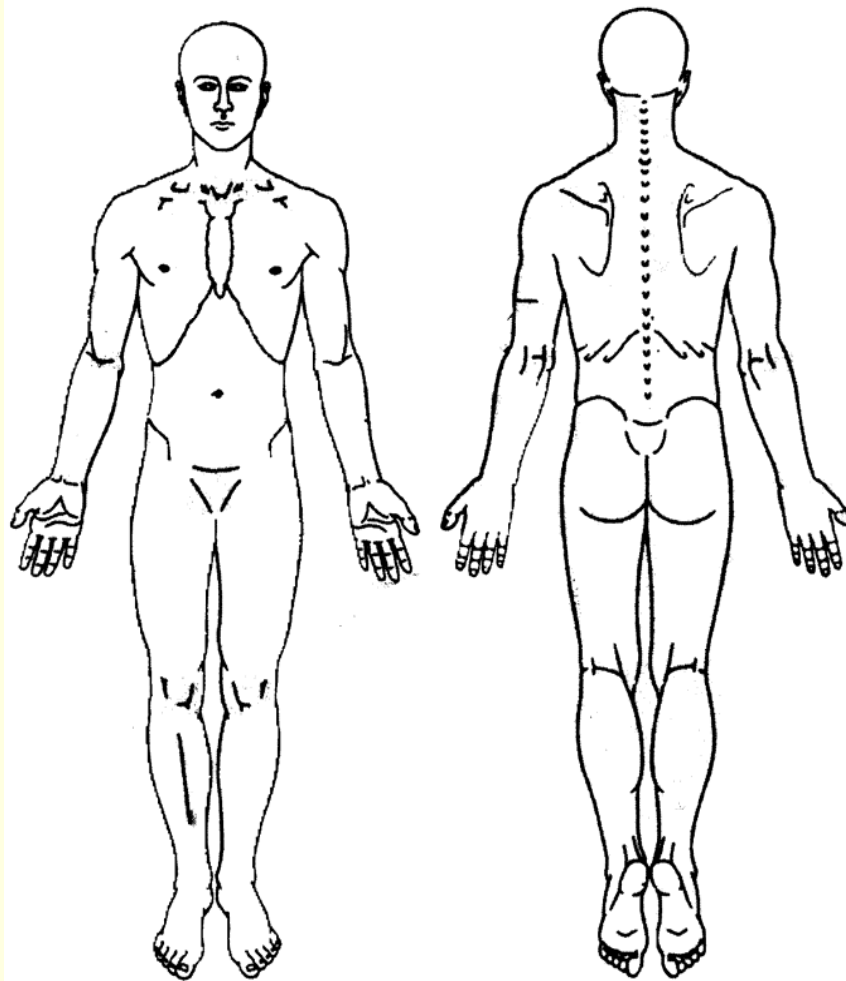
# Pain diagram

Annexure C

## PAIN DIAGRAM

In the diagrams below, mark the areas of the body, using the symbols, where you have experienced any of the following symptoms **this past week**.

| ACHING | BURNING | STABBING         | PINS & NEEDLES | NUMBNESS |
|--------|---------|------------------|----------------|----------|
| XXXXXX | =====   | //////////////// | OOOOOOOO       | -----    |
| XXX    | =====   | //////////////// | OO             | -----    |



## Exercise capacity test

| <b>WORK INTENSITY FOR 70<br/>KG PERSON</b> | <b>OXYGEN CONSUMPTION</b> | <b>METS</b> |
|--|---------------------------|-------------|
| Light work                                 | 7 ml/kg/min               | < 2 METS    |
| Moderate work                              | 8-15 ml/kg/min            | 2-4 METS    |
| Heavy work                                 | 16-20 ml/kg/min           | 5-6 METS    |
| Very heavy                                 | 21-30 ml/kg/min           | 7-8 METS    |
| Arduous work                               | > 30 ml/kg/min            | > 8 METS    |

## Validity of data

Consider symptom magnification or malingering if 2 or more of the following are present:

- Normal clinical examination
- Positive distraction test
- Normal psychometric evaluation
- Non-physiological or non-pathological pain distribution
- Non-correlation of exercise capacity test with stated physical abilities
- Inconsistencies between questionnaires (ADL, ROM, Pain Questionnaires)

## 4.2 Low Back Pain

### Fordyce's Law

People don't hurt as much if they have something better to do.

### Nature's Law

Back pain gets better, because back pain gets better.  
God made us that way.

NEJM (Oct 5 1995), 333 (14) : 913-917

## LBP: Activity Paradigm

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NEJM 351-6, vol 332 no. 6, 2/9/95

Anti Mamivaara et al.

Retaining activities with low back pain has better outcomes than bed-rest and passive exercises.

## LBP: Activity Paradigm

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Spine 2001: 26 (7): 778-87

Best treatment for low back pain is return to work, and exercises.

## Managing LBP

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- Employee's risk of future LBP claims (RR): (Spine)
  - Prior back pain 1.7 (1.17-2.46)
  - Don't enjoy job 1.7 (1.31-2.21)
  
- LBP is a psychosocial problem
  
- **(15) Rehab must focus on**
  - **Psyche**
  - **Social issues** (job satisfaction, income, familial factors)
  - **Physical rehab**

## Managing LBP

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1. Early: (1-4 wks)
  - De-medicalize the condition
  - Encourage early return to work, as treatment with encouragement that it will help recovery.
  - Avoid limitations of activity, review every 2 weeks
  
2. Medium: (4-6 wks)
  - Consider work conditioning
  - If employer has “no modified duty” policy, engage in active discussion.
  - Consider worksite visit by O.T.
  
3. Late: (6 months)
  - Rehab centre

## Assessing LBP Claims

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- No magic formula
  
- Rate pain as discussed
  - Pain questionnaires (Oswestry etc.)
  - Pain diagram
  - Analgesic use
  
- Check for
  - Credibility
  - Consistency
  - Pathophysiological sense

## LBP: General rules

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1. Pain without clinical or radiological evidence, is not a cause for disability.
2. Pain without clinical evidence, but with radiological evidence, may cause disability under certain circumstances (e.g. physical job).
3. Pain with both clinical and radiological evidence, can cause disability, but is usually treatable.

## 4.3 Depression: Claims Management

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1. Obtain complete report by treating doctor, but no opinion on disability.
2. Obtain second independent assessment by psychiatrist.
3. Use at least three rating scales. Rate the middle or median value.
4. Ensure optimal treatment according to acceptable guidelines

## DSM-IV Classification

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- I. Clinical disorders
- II. Personality disorders
- III. General medical conditions
- IV. Psychosocial and environmental problems
- V. GAF score (Global Assessment of Functioning)

# Impairment Rating Scales

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1. GAF score (blend of symptoms and role function)
2. BPRS: Brief Psychiatric Rating Scale (symptom severity)
3. PIRS: Psychiatric Impairment Rating Scale (role function)

# BPRS

24-Item detailed questionnaire: (severity scale 1-7 each)

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- Somatic concern
- Anxiety
- Depression
- Suicidality
- Guilt
- Hostility
- Distractibility
- Self-neglect
- Elevated mood
- Grandiosity
- Suspiciousness
- Hallucinations
- Unusual thought content
- Bizarre behaviour
- Mannerisms
- Disorientation
- Blunted affect
- Emotional withdrawal
- Motor retardation
- Tension
- Uncooperativeness
- Excitement
- Motor hyperactivity
- Conceptual disorganisation

# PIRS

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## 6 Impairment domains rated on severity scale 1-5:

- Self-care, personal hygiene and ADL
- Role functioning, social and recreational activities
- Interpersonal relationships
- Travel
- Concentration, persistence, pace
- Resilience and employability

# MDE: Treatment Guidelines

## Step 1

### Single antidepressant

- i) Start low dose
- ii) Increase dosage at 6 week intervals to maximum recommended dosage
- iii) If no effect -> change to different class.  
Repeat steps i to iii.
- iv) Continue until at least 4 classes have been attempted.

# MDE: Treatment Guidelines

## Step 2

### Combination of antidepressants

- Combine drugs of two different classes.
- Step up dosages to maximum recommended dosage.

## Step 3

### Augmentation

- Add mood stabilizer, or thyroid hormone, or anti-epileptic drug.

# MDE: Treatment Guidelines

## Step 4

## Lithium

- Consider changing to Lithium.
- Increase dosage to maximum recommended.

## Other measures

- Psychotherapy throughout in addition to drugs
- Hospitalisation for severe cases
- ECT has proven success rates in treatment-resistant depression.

## Eight classes of antidepressants

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- TCA
- Non-TCA
- MAOI
- RIMA
- SSRI
- Lithium
- Others

## Summary: 15 Points to Ponder

### A. Product

- Optimize occupational disability definitions
  - Provide for re-training, rehab, optimal treatment

### B. Sales

- Prevent over-insurance
- Align consumer expectations with policy realities

### C. Process

- Establish better in-house expertise than the claimant's advocates.
- Ensure good communication and SLA's with employer, claimants and service providers
- Maintain an effective review process of open claims.
- Obtain objective proof to substantiate subjective symptoms.

## Summary: 15 Points to Ponder

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### D. RTW/Rehab

- Apply pre-selection criteria for rehab/RTW programs
- Do comprehensive rehab:
  - Psyche
  - Social issues (job satisfaction, income, familial factors)
  - Physical rehab
- Aim for RTW reward and recognition, and not victimization.

### E. Doctors

- Involve doctor groups: Draft consensus guidelines
- Ensure correct application of the Absenteeism grid
- Examining doctor to report on Impairment only, not Disability.
- Ensure that adequate treatment guidelines are followed.
- Obtain independent second opinions.



Thank you for your time.



Questions?