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Physician Peer-to-Peer Intervention as an Absence Management Tool for Workers Compensation

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It is well known that work absence is associated with societal economic loss as well as individual worker distress. Labor sociologists indicate that "unemployment is more destructive to physical and mental health than all but the most dangerous jobs."[1] According to a consensus opinion statement from The American College of Occupational and Environmental Medicine:

> … prolonged absence from one's normal roles, including absence from the workplace, is detrimental to a person's mental, physical, and social well being; … a return to all possible functional activities relevant to the patient's life as soon as possible after an injury or illness has many beneficial effects … With careful planning and appropriate physician input and advice to both the employee and the employer, in most cases an employee may successfully return to work before full recovery. [2]

In workers compensation (WC), both medical utilization and work absence must be managed. In 2003, indemnity costs for wage replacement represented 45 percent of total losses in WC.[3] When continued absence from work is not clinically supported, physician peer-to-peer contact is often helpful. A peer-to-peer contact is a telephonic intervention in which the managed-care physician reviewer (PR) contacts the treating provider (TP) for a clinical discussion about the injured worker. Traditionally, this exercise focuses on the question of work capacity, and the primary outcome of the review is a determination as to whether given periods of work absence are medically necessary. It might be presumed that appropriate use of peer-to-peer contacts would result in shortened durations of WC absence, lower costs for lost wages benefits, and improved communications with TPs. This study explores that presumption.

Two events are key in WC case management: facilitation of return to work (RTW) and establishment of maximum medical improvement (MMI) status. Early and appropriate return to work is the initial, critical milestone in WC case management. When work-related illness and injury cannot be prevented, effective medical care and early accommodation of impairment are essential in minimizing the associated social and economic costs. Also important for WC claim resolution is the certification of MMI status (known in some states as "permanent and stationary" or "fixed and stationary"). This status allows the claim to move toward closure once the injury or illness has resolved or is manageable. For example, in the Texas WC system, "[c]linical MMI is based on the reasonable medical probability that no further material recovery from, or lasting improvement to, an injury can reasonably be expected."[4] A host of factors may complicate the case manager's efforts to accomplish RTW and MMI status.

The variety of state-specific regulations and adjudication systems for WC makes administration difficult for employers, third party administrators, and insurers, especially those that operate across state lines. These complex and conflicting systems create confusion and maladaptive behaviors on the part of claimants and medical providers. Appeals, hearings, and other bureaucratic proceedings can prolong work absence for months or years.

While absence management systems look to physicians to determine whether a claimant is, in fact, functionally impaired, treating physicians are often poorly prepared for such determinations. As Talmage and Melhorn indicate: "Return to work is not a subject about which physicians have received extensive training in their medical educations."[5] The medical system often focuses more on illness behaviors, such as refraining from work, than on functionality. Doctors, in general, tend to think about work

in terms of restrictions (what a patient can't do) rather than capabilities (what a patient can do). It is no surprise that the medical system, rather than encouraging return to work, often creates barriers instead. In fact, studies indicate that medical care alone is ineffective in reducing lost time without an effective return-to-work program.[6]

Kosny et al[7] found that TPs can play an important role early in the RTW process when there is direct contact with the workplace and proactive communication with the patient. However, many TPs are unaware of employer light-duty accommodations and are often uncomfortable with specifying work restrictions. Providers sometimes view the case management process as intrusive and, therefore, impede case resolution by withholding their cooperation. Providers may feel that the claimant cannot comply with the medical treatment program while working, even if work-limiting impairment is not present.

The complexity of the system makes it easy for confusion to arise. When multiple physicians are involved, it may be difficult to identify the physician that is responsible for determining work restrictions. Communication among TPs, insurers, case managers, employers, injured workers, and attorneys is often fragmented. Increasingly, stringent legal requirements regarding transfer of medical information compound these problems. A single claim may involve the WC system, a short-term disability plan, family medical leave, and Social Security benefits. Given the complex and litigious nature of WC systems, it is not surprising that RTW clearance is difficult to obtain.

There are many additional factors that have an impact on the timely accomplishment of RTW and MMI status. Workers over age 55 are out of work longer than younger workers. Those with only a grade school education are out of work 2 to 4.5 times longer than high school graduates. Part-time workers are out of work longer than their full-time counterparts.[8] Claimants may try to avoid returning to work for a variety of reasons. Light-duty assignments are often perceived as demeaning or undesirable and are sometimes used as a punitive measure by employers. Other social factors, including various kinds of secondary gain as well as fear of reinjury, may make employees avoid returning to work. Claimants may pressure their providers to prolong their furlough by insisting that accommodations are not available or that the employer will not comply with work restrictions.

Various tools are used to manage WC claims so that approved work absence and treatment are both clinically appropriate. These include the use of disability duration guidelines, case tracking by adjusters, physician case review (with or without peer-to-peer discussion), inde-

pendent medical evaluations, functional capacity evaluations, medical bill review, telephonic case management, field case management, and surveillance.

Opinions by PRs regarding work absence and MMI often carry less weight than those of TPs. However, because of time constraints, unfamiliarity with the process, and patient expectations, TPs are often reluctant to establish work restrictions. Also, the definition and implications of MMI status are often misunderstood by medical providers. Given these factors, it was felt that the use of a PR with expertise in RTW might be an effective strategy for securing TP engagement in the process. The most desirable process is one resulting in consensus of claim managers, TPs, claimants, and employers through a non-adversarial interaction. The peer-to-peer contact is a potentially valuable tool in such a process. This study attempted to evaluate the effectiveness of, and identify techniques useful for, peer-to-peer discussions aimed at accomplishing RTW or MMI designation in difficult cases.

Methodology

This study was conducted within a large third party administrator (TPA) for WC insurers or self-insured companies. The organization includes a telephonic case-management unit, a field case-management unit, claim adjusters, and a medical department with a panel of independent, board-certified, peer-review physicians in all specialties.

Telephonic case managers were encouraged to identify and refer their most difficult cases, with respect to achieving RTW or MMI. All such claims remained unresolved despite multiple interventions by experienced WC adjusters and case managers using standard methods. The challenging nature of the referred cases is evident in the mean absence duration of over one year. The TPA's designated PR made at least two attempts to contact the TP over a period of four business days. A systematic process was used that included a thorough file review, formulation of questions and issues for the TP, and a telephonic discussion with the TP. Peer-to-peer contact included discussion of diagnosis, clinical findings, clinical progress, future treatment plan, expected recovery date, complicating social and workplace issues, and current work limitations. The PR was also able to provide information to the TP regarding the benefits of RTW, employer RTW programs, the claimant's work history, and the availability of work accommodations. The designated PR was board certified in occupational medicine and internal medicine with nine years of experience in disability case management and peer interventions.

The interventions provided were evaluated in a structured way based on three task areas:

- RTW status — a preliminary determination was made by the reviewer regarding the appropriate work status for the claimant (full disability, restricted work, or full-duty work) and, if the PR felt that full or restricted RTW was feasible, he attempted to secure a consensus on this issue in a teleconference with the treating physician.

- MMI status — the PR made a preliminary determination regarding MMI status and then pursued a consensus with the TP through the process described above.

- RTW plan — if the PR concluded the claimant could return to work immediately in some capacity, but the TP did not agree, the provider was offered an opportunity to commit to a plan of action directed at return to work at a future specified date.

A successful outcome was defined as an improvement in any one of the three task areas. Success rates were calculated as the percentage of the total cases for which a change within any one of the three task areas was deemed appropriate by the PR and that change was subsequently endorsed by the TP. Confidence intervals of 95 percent (95 percent CI) were calculated in order to evaluate whether the result obtained was significantly better than the expected baseline resolution rate for this population. All previous tactics on referred cases had failed, so that the baseline successful resolution rate was effectively zero prior to this final intervention.

The case series had the following characteristics.

- The number of WC cases reviewed was 126.
- Claimants' mean days of work absence since date of injury at the time of the intervention was 385.
- Claimants' median days of work absence since date of injury at the time of the intervention was 264.
- Claimants' mean age was 45 years.
- Claimants' gender distribution was 63 percent male and 37 percent female.
- Claimants were primarily involved in aircraft manufacturing (61 percent) or were temporary agency workers (25 percent).

Results

The overall success rate is presented in Exhibit 1 by task area along with 95 percent confidence intervals. The total sample size (N) is comprised of 111 of the 126 WC cases reviewed and determined to be deficient in at least one of the task areas. All rates are significantly higher than zero, the expected baseline resolution rate for this population. In fact, all rates had a lower bound CI level of at least 23 percent.

The PR was able to establish contact with the TP in 81 percent of the cases where a request was made and was able to obtain at least one positive outcome in 48 percent (95 percent CI = 38 percent, 57 percent) of the cases in which such an outcome was possible.

Specifically, concerning each task area, the PR was able to elicit clearance to return to work in some capacity from the TP in 34 percent (95 percent CI = 23 percent, 44 percent) of the cases in which such clearance was deemed appropriate. Further, the PR was able to secure TP agreement to MMI in 38 percent (95 percent CI = 27 percent, 50 percent) of the cases in which MMI was deemed appropriate. Finally, the PR was able to elicit TP agreement to a specific RTW plan in 48 percent (95 percent CI = 36 percent, 60 percent) of the cases in which such a plan was deemed appropriate.

Discussion

Treating medical providers are significant contributors to high costs in the WC system. While inappropriate or excessive treatment is a significant part of this problem, provider behavior regarding RTW is also a contributing factor. For various reasons, doctors are often reluctant to constructively engage in the WC case-management process. The above results demonstrate that considerable value can be added through a focused RTW effort utilizing a peer-to-peer intervention. By selecting appropriate claims with no resolution

Exhibit 1

Overall Success Rates by Task Area

Task Areas	N	Successful Outcomes	Success Rate	95% CI
RTW	77	26	34%	28%, 44%
MMI	73	28	38%	27%, 50%
RTW Plan	69	33	48%	36%, 60%
Overall	**111**	**53**	**48%**	**38%, 57%**

in sight and then targeting peer-to-peer intervention toward cases where there appeared to be clinical evidence of MMI or functionality, half the cases demonstrated a positive outcome. While a formal cost-benefit analysis was not performed, the typical market price for a peer-review intervention of this type is $500, yielding a clearly favorable return on investment. The use of physician peer-to-peer intervention can be an effective tool in breaking down barriers to effective case management by employers, TPAs, and insurers and in facilitating claim resolution. The outcomes of the present study may also be useful as a benchmark in evaluating similar programs of physician intervention. Future studies should evaluate additional strategies for enhancing RTW outcomes.

It was observed by the PR during this study that the following techniques were particularly useful in peer-to-peer interventions.

- Helping providers to articulate restrictions that are specific, detailed, and understandable for non-clinical persons in the workplace is essential to a successful process.

- Informing the provider of light-duty availability can be helpful. The provider often has a false impression that accommodations cannot be offered at the workplace.

- Adopting a collegial, courteous approach that avoids browbeating, arguing, and criticism of the TP is essential.

- Provider cooperation can be encouraged by explaining that this is the provider's opportunity to advocate for his or her patient to get the benefits they are seeking.

- Implementing a problem-solving effort jointly with the TP rather than a unilateral benefit determination decision leads to a less contentious process.

Endnotes

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