MANAGED CARE DRIVES THE WORKERS’ COMPENSATION TRAIN

Workers’ compensation is all about managed care. If that philosophy is not driving your workers’ compensation program, then the odds are that your approach to claims cost containment is both out of date and costing you plenty.

As this graphic indicates, managed care (medical management for our purposes here) has been growing with intensity over the past two decades from 48 percent of total average claims cost in 1992 to more than 62 percent today. With increasing facility (hospital/surgi-centers) and brand medication costs, medical expense should be pushing 70 percent of developed claims cost by the end of this decade. While U.S. healthcare costs are slowing, the drivers of this slowdown—the Great Recession, higher individual deductibles,
Medicare cuts to hospitals and physicians, and more—do not have much influence on workers’ compensation.

The road to full or transitional return to work, negotiating permanency ratings and settlements, and even managing fraud and abuse of the system are all directly influenced by the activities, or lack thereof, of your medical management program. This is why managed care drives the train. When this ratio is inverted—indemnity costs are greater than medical management costs—it suggests that the employer may not be actively engaged and is allowing indemnity losses to run unabated.

The Principle Components of Managed Care

Whether your comp program is large or small, nearly all of the various components of managed care should play a role at some point in time. The question is whether you are able to influence those roles. With small programs (annual WC loss picks of less than $3-5 million), unless you are self-insured, your managed care program should be bundled by your carrier or TPA, with limited room for direction by you. With larger programs, unbundling your managed care program from the TPA or carrier’s claims adjusting is far easier, but great care must be taken to create a program that can be beneficial to the employer.

While unbundling does not in and of itself imply a better managed care program, it does create the opportunity. In many cases, TPAs and carriers will have developed their managed care vendor relationships or internal programs from years past and have not stayed abreast of the newest cost-containment strategies. Additionally, pricing for some of these services may not be fully negotiable or competitive with unbundled players. In turn, employers with larger loss picks who like their TPA or carrier but want to shave additional points off of their ultimate developed claims costs are driven toward pressing for unbundled programs.
The following is a list of the primary components of a comprehensive managed care program:

- Medical Bill Review
- Pharmacy Benefits Management
- Outsourced Medical Director
- Telephone or Field Nurse Case Management
- PPO Networks (providers, imaging, DME)
- Texas Health Care Network
- California Managed Care Network
- Illinois Preferred Provider Programs
- Return to Work Advocacy
- Catastrophic Case Management
- Chronic Pain Management

- Medicare Set-aside
- Peer Review/Independent Medical Review
- Utilization Review
- Independent Medical Examiners
- Physical/Occupational Therapy
- 24/7 Nurse Triage and Claims Intake
- Functional Capacity Evaluations
- Medical Records Search
- Postaccident Drug Testing
- Urine Drug Screening (prescribed controlled substances monitoring)

It's a long list and each with a required expertise to manage effectively. Thus, it is best for smaller programs to stick to bundled, integrated, managed care programs even if many components are less than optimal. This is not to say that large, bundled programs are all ineffective or too costly. We are seeing more TPAs stepping up to the plate with well-integrated managed care to include enhanced attention to the psychosocial aspect of treating chronic pain, promoting 24/7 nurse triage, and improving pharmacy clinical utilization management. The pace, however, remains slow.

When it comes to larger programs, we see many risk managers struggling to identify competitive pricing and best-in-class component programs. Overcoming these obstacles can mean big savings for companies with millions in annual workers’ compensation expense.

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OUR TOP 10 LIST OF BARRIERS TO SUCCESSFUL MANAGED CARE PROGRAMS

Lockton's comprehensive managed care audits during the past two years have identified a consistent pattern of common barriers to clients’ success in reducing their overall cost of workers’ compensation risk. Following is our top 10 listing of our most commonly observed barriers specific to managed care.

1. Pharmacy

Pharmacy, and opioids in particular, is now the single largest obstacle to effectively managing disability and, ultimately, permanency ratings with or without Medicare Set-aside funding. Adjusters, in most cases acting as the gatekeeper in controlling pharmacy, are essentially unprepared in dealing with this obstacle resulting in larger indemnity expense.

2. Medical Expense

Controlling medical expense is not only about PPO discounts. It’s about channeling injured workers to providers demonstrating the best treatment outcomes at the lowest cost. Too many employers are primarily focusing on discounts. Simply look at the graphic on Workers’ Compensation Analytics Variance. A discount off of a facility’s higher-than-average-cost procedure, particularly in Usual and Customary billing states, is not as beneficial as a more competitively priced provider. Procedure costs have an exceptionally wide variance among healthcare facilities.

3. Medical Bill Review

Medical bill review practices, pricing, and outcomes are not all alike. Medical bill review is one of the most profitable vendor services associated with managed care. Very few employers understand how their medical bills are priced, the variability of PPO network discounts, and options available for negotiating vendor fees.
Nurse Triage Services

The lowest-hanging fruit in controlling medical costs is channeling the injured worker to the right provider, at the right time, for the right service, or simply channeling the injured worker to self-care. Yet, the majority of employers do not take advantage of 24/7 nurse triage services to effortlessly accomplish these objectives.

Physical Therapy

Physical therapy (PT) costs rank second to the overall cost of pharmacy as the primary contributor to managed care expenses. On average, we see less than 50 percent of PT run through PT PPO networks, and many of the networks are not performing well in clinically controlling PT costs for the ones that they do manage. There are options for negotiated capped visit rates, monitoring excessive PT visits, or considering another concept using condition rate (flat fee) programs in selected states.

Nurse Case Management

Nurse case management is an essential tool to influence earlier return to work for more difficult claims. But it is frequently a disjointed, unorchestrated, process with individual adjusters making assignments with little to no TPA or vendor oversight in monitoring case-specific outcomes. Vendor direct and indirect incentive practices for their nurses’ billing vary as well. For larger programs, there is a more effective approach using an outsourced nurse facilitator to orchestrate and monitor the program while providing other valuable medical consultation services at a program level.
Chronic Pain

Chronic pain cases tend to be the most costly indemnity losses. Physicians have great difficulty in discerning soft tissue pain from neuropathic pain from psychosocial pain. In some cases, it may be a combination of one or more of the above or all three requiring multiple treatment plans. There is an overwhelming tendency for physicians to treat these cases with more and more drugs, unending physical therapy and, in too many cases, unnecessary and damaging surgery. Thus, longer TTD and higher disability ratings. A large percentage of chronic pain cases have a psychosocial component that can be assessed and treated through cognitive behavioral therapy. New CPT codes have been created just for this purpose. There is also new technology permitting neurologists and orthopedic physicians to differentiate between the three forms of pain noted above. We see very few adjusters and risk and claim managers even aware of the resources available to control this huge area of claims costs.

Utilization Review

There are frequently ineffective or irrational utilization review (UR) practices in place by an insured’s UR vendor and TPA/carrier in which the insured was not consulted in establishing operational policies. While UR is a needed equalizer for qualifying large expenses as medically necessary and in keeping with states’ medical treatment guidelines, automated processes can lead to overuse of UR. The California Workers’ Compensation Institute’s 2014 UR/IMR study indicated that only 4.7 percent of medical treatment UR requests were denied by the UR/IMR process. This suggests that all of the treatment requests flooding UR are probably not necessary.

It is also not uncommon to see UR fees reach 50 percent of total approved treatment fees that most likely should have been approved by the adjuster based on the facts of the claim and a lot of common sense. Which CPT codes are appropriate for adjuster approval and in which states? That's where a very detailed discussion between the UR vendor, the payer (TPA or carrier), and the employer should take place. Unfortunately, this is quite rare.

The second issue with UR is that there are instances in which utilization review is performed and the procedure is denied, yet the treatment is rendered and the bill is paid. This is the case where UR and bill review are not speaking to each other in a timely manner. Michael Gavin, President of Prium, has communicated this quite clearly. “The daily reality of claims management is that bill review is paying for things that utilization review has properly denied. Integration is critical and, in our experience, driven by the payer. Utilization review and bill review systems can talk to each other, but the payer has to ensure it’s happening.”

Employers not taking adequate time to address this area with their TPA or carrier are throwing money to the wind.
Medical Access Card or Health Ticket

Only a small percentage of employers make use of a medical access card or health ticket in cases where claim intake is both centralized and very timely following an injury. Incredibly, these state- and client-specific cards or tickets are available at no charge to an insured and can effectively support channeling injured workers to a company’s provider-specific network. Additionally, they contain valuable pharmacy first-fill authorizations, specialty PPO network requirements, return-to-work policies, and much more for the treating physicians’ consideration.

Injured Workers’ Advocacy

It costs so very little to appoint and train a part-time employee to act as the company’s injured workers’ advocate, communicating care and concern not on behalf of the insurance carrier, but the employer. A few phone calls, a get well card, and assisting the injured worker in overcoming barriers to recovery are all it takes to shorten the length of disability and create a positive employer image for the injured worker. It has been long understood that when injured workers feel neglected by their employer, their recovery takes longer and the claim becomes more costly.

So, how do employers customize solutions to eliminate these and other obstacles to an effective managed care program?

The answer is not so simple. Carriers and TPAs will certainly market their wares as an all-inclusive solution to your workers’ compensation problem. But there aren’t many claims-administering organizations that cover and competitively price 100 percent of our top 10 obstacles without some or moderate tweaking and negotiations.

So, is it your insurance broker/consultant who should act as your workers’ compensation managed care train engineer? Possibly if that is a service that is offered and for which the broker/consultant has the requisite expertise to customize a program specific to your organization. Having experienced claims consultants alone is not necessarily reflective of that expertise.

Workers’ compensation has been and is expected to continue to be a fast-changing field of insurance. Brokers who fail to allocate internal resources to focus on these changes, especially in managed care, will simply not have the expertise to design, create, implement and evaluate a best-in-class customized solution for their clients.
Our Mission

To be the worldwide value and service leader in insurance brokerage, employee benefits, and risk management

Our Goal

To be the best place to do business and to work