The Case for **Telephonic Case Management**

WHITE PAPER

Why, When and **How to Use** this **Strategic Tool**

A SAMPLE SCENARIO

Assessing Claim Factors for Telephonic Case Management

When Michael, a 44-year old sanitation worker, fell off the back of a waste removal truck, he injured his right hip, elbow, and knee. Upon calling his employer's nurse triage line, Michael and the nurse determined it wasn't necessary to call 9-1-1 but that Michael did need a medical assessment right away. The triage nurse arranged a doctor's appointment with a bilingual provider as Spanish was Michael's first language. When x-rays revealed he would likely need hip surgery, he was concerned. He was a single father of two young daughters and had never had surgery before.

When Pam, a veteran claims adjuster, was assigned Michael's claim, she did her usual research. She listened to the recording of Michael's call with the triage nurse and reviewed the triage report. She noted in the nurse's report that Michael mentioned he was a type I diabetic. She also noted he stated the truck handle was slippery and he wasn't issued non-slip gloves, which was a violation of company policy and could indicate possible attorney involvement.

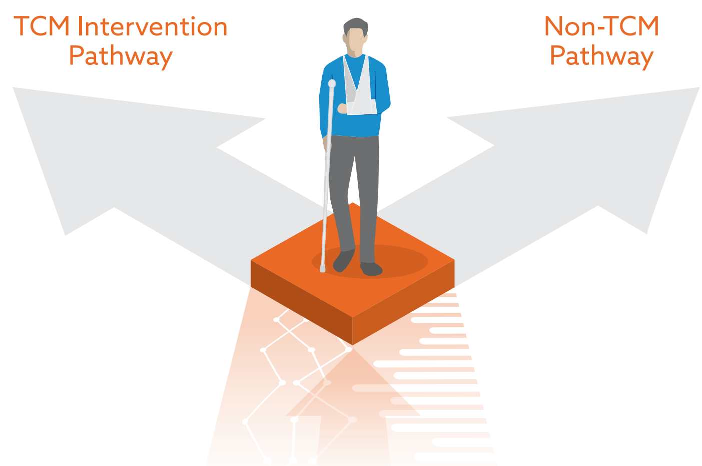
Due to the type of injury Michael sustained, the likelihood of surgery and extensive physical therapy, his diabetes comorbidity, and the attorney red flag, Pam determined this claim had the potential for high cost and extended lost time, so she assigned a telephonic case manager to support Michael's recovery.

Why This is a Good Claim for Telephonic Case Management (TCM)

Not every claim merits escalation to a nurse case manager. However – with medical costs averaging over 60% of claims costs in many jurisdictions,[1] claims with comorbidities having longer durations[2] and costing twice as much as like-matched claims,[3] and attorney involvement in 13% to 52% of claims (depending on the state)[4] – targeted use of nurse case management can have a dramatic impact on claim costs and disability durations.[5]

For employers, strategic use of nurse case management and a "whole person" approach helps build trust with employees who've sustained occupational injuries and demonstrates the importance of employee safety and their overall health. Establishing a caring and compassionate workplace culture may not only impact open claims but can significantly impact future claims as well.

According to the U.S. Bureau of Labor Statistics, the rate of nonfatal occupational injuries and illnesses among private industry employees in 2018 was 2.8 cases per 100 full-time equivalent workers. Moreover, 32% of these cases resulted in days away from work.[6] It is these lost time claims that require determination on whether nurse case management is needed.



When to Use Telephonic Case Management

Early intervention can significantly impact claim outcomes. For instance, a URAC study of 13,648 claims identified a positive association in return-to-work outcomes when nurses are assigned to claims. The results demonstrate that timing of the nurse referral/involvement is critical. Over 50% of employees return to work within 90 days when their claims are referred to case management within seven (7) days of injury. Alternatively, when cases are referred to case management after 30 days, only 27% of employees return to work within 90 days.[7]

Successful programs also use established criteria to determine when to engage a case manager. Such a systemic approach helps adjusters, especially those with less experience, identify which claims will benefit most from telephonic case management (TCM).

Intervention criteria can be based on a number of factors present early in the claim or as the claim progresses. Therefore, establishing protocol for both early and mid-case intervention is recommended.

Early Intervention Determinants for TCM Involvement, include:

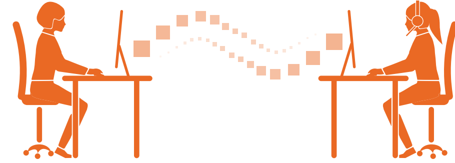
- Severe lacerations of tendons, ligaments, or muscles
- Injuries to certain body parts, such as back, shoulders, knees, joints, and/or multiple body parts
- Back surgery indicated or requested
- Presence of certain comorbidities such as diabetes, hypertension, heart disease, obesity, smoking, or substance abuse
- Presence of psychosocial issues
- Narcotic opioids prescribed at high-risk thresholds
- History of previous injuries or surgeries

Additional triggers for early intervention may include employees with early legal representation, prior workers' compensation claims, high reserves, or extended lost time expectations.

In Michael's case, his adjuster's instincts were correct. Michael met several of the criteria for determining early TCM involvement, including sustained injuries to multiple high-risk body parts. In addition, his comorbid diabetes condition also served as a risk factor that could complicate his care path.

Top Medical Management Program Ranked by Claims Leaders & Frontline Staff as Most Critical to Claim Outcomes:

NURSE CASE MANAGEMENT



Source: Rising Medical Solutions – 2017 & 2019 Workers' Compensation Benchmarking Studies

Unlike Michael's case, some claims don't initially present signs that a case manager should be engaged but become more complex over time. Reassessing cases periodically is recommended to prevent a claim from spiraling, especially if the injured employee is showing little or no improvement. For mid-claim assessments, additional variables should be considered.

Mid-Case Determinants for TCM Involvement, include:

- Treating with multiple physicians
- Surgery indicated or requested
- Extended physical therapy or chiropractic care
- High dosage of narcotic opioids or other controlled medications; addition of antidepressant medications
- Identification of developing psychosocial issues
- Case has stalled and is not moving towards resolution
- Case is ready to transition to TCM after field case management is no longer necessary
- Treatment outside of evidence-based guidelines, or return to work not scheduled with benchmark approaching

Many organizations also use mid-claim screening tools, such as pain screening questionnaires, to identify at-risk employees. High-risk claims are then flagged for intervention, including assignment to case management.

Biopsychosocial Determinants

Biopsychosocial models of care examine an injured employee's injuries through three lenses: biological (such as the injury/illness itself, comorbid conditions, and other factors such as age, weight, and gender); psychological (such as the person's beliefs and expectations, and their mental and emotional health); and social (such as family and home conditions, cultural background, relationships, societal expectations).

In recent years, some payers have begun to incorporate the biopsychosocial model of care into their claims approach, including the use of screening tools. Psychosocial conditions help explain why two individuals suffering near identical injuries can experience vastly different health and financial outcomes. Studies have found that it can cost as much as three times more to treat the physical health of a patient with underlying behavioral health issues than it does to treat the same physical health of those patients without co-occurring behavioral issues.[8]

Top Barrier Ranked by Claims Leaders as Most Detrimental to Achieving Positive Claim Outcomes:

PSYCHOSOCIAL / COMORBIDITY ISSUES

Source: Rising Medical Solutions – 2016 Workers' Compensation Benchmarking Study

As case managers establish relationships with injured employees, they can identify psychosocial conditions that may impact claim outcomes. Effectively addressing psychosocial risk factors – such as pain catastrophizing, perceived injustice, and disability mindset – require understanding the whole person, including their fears, beliefs, coping skills, and resilience to stressors. Such discoveries help all claim stakeholders address these conditions holistically in order to support injury recovery.

Triggering Data-Driven Interventions

It's imperative to use data analytics to identify high-risk claims that require intervention. Your medical bill review data can integrate information from all sources, including claims, bill review, utilization review, case management, pharmacy, and ancillary services. Ideally, the analytics platform should also integrate benchmark data, such as Official Disability Guidelines (ODG), to assess how a claim is trending against benchmarks. Operational dashboards are also a best practice for claims and clinical staff to easily identify cases that need intervention (e.g. drug/opioid utilization dashboards). This level of data integration and visualization enables claims to be identified and acted upon before they escalate.

Claim file reviews can also be an effective tool for uncovering data that can be integrated into your analytics platform. Such data is critical for not only building *predictive* risk assessment models, but also building *prescriptive* intervention models. Using both models can identify *when* intervention is needed, as well as *what* intervention(s) and treatment adjustments to deploy. These can range from physician outreach to initiate step-down therapy for certain prescribed medications to changes in durable medical equipment or physical therapy treatment.

Working together with all claim stakeholders enables employers to provide injured employees with the support needed to achieve maximum medical improvement (MMI) and timely return to work in modified or full duty capacity.

How Telephonic Case Managers Impact Claims

Once a decision has been made to engage a telephonic case manager, it is important to understand their role in overseeing the medical care component of the claim.

Telephonic case managers help guide injured employees to providers known for positive outcomes. In direction of care states, they may be able to steer treatment, whereas soft channeling may be needed in states where direction of care is prohibited. The nurse case manager also understands state-specific utilization review (UR) regulations and can help navigate the medical approval process to avoid regulatory fees and fines.

Sample best practices for telephonic case managers include:

- Engaging injured employees in their own recovery process
- Serving as a clinical resource for employees and their families, answering questions, allaying concerns
- Coordinating and continually monitoring care plans with a focus on return to work, including:
    - Directing care or soft channeling to quality providers
    - Contacting the employee and treating provider's office within 24 hours of each appointment completion to obtain office visit notes, medical records, verify work status, and identify next office visit appointment date
    - Contacting providers the day after surgery to obtain operative report and post-op visit date
    - Arranging any ancillary services, such as physical therapy, occupational therapy, imaging, transportation, translation, and delivery of durable medical equipment
    - Rescheduling missed appointments
- Monitoring ODG guidelines and benchmarks for evidence-based care and disability durations
- Addressing barriers to recovery
- Facilitating return-to-work processes

Overall, telephonic case managers wear many hats: patient advocate, provider liaison, and communications facilitator.

Patient Advocate

It can be difficult for claims adjusters – who are responsible for managing so many competing priorities, while also managing escalating caseloads[9] – to provide proactive outreach to injured employees as frequently as desired. Case managers help fill this gap by making regular contact with injured employees and keeping the claims adjuster updated on case progression.

Initially, the case manager's role is to assess the employee's medical status, determine next steps in treatment, assist in identifying and scheduling appointments, and, most critically, build a trusting relationship that encourages and promotes positive health outcomes. While the injured employee's relationship with his or her claims adjuster is important, nurse case managers can often establish trust with the employee more quickly due to their role as a medical professional. In fact, early case management intervention is often attributed to healthier relationships being established between all parties involved in a claim.

As the claim progresses, so does the role of the case manager. Mid-claim, the case manager's responsibilities may include getting a stalled treatment plan back on track, coordinating interventions to address emergent issues, reducing or eliminating prescription narcotic usage, pursuing modified return-to-work arrangements, or addressing failure to thrive issues.

Importantly, as a healthcare practitioner, nurse case managers are specifically trained to serve as patient advocates, ensuring patients receive appropriate medical treatment while reinforcing the intent of all parties – providers, the claims adjuster, and employer –

in helping the injured employee achieve a desired health and functional outcome.

Top Two Most Important Claims Outcomes Ranked by Claims Leaders & Frontline Staff:

Employee return to the same or better pre-injury functional capabilities

Return to work achieved by anticipated outcome/ benchmark

Source: Rising Medical Solutions – 2017 & 2019 Workers' Compensation Benchmarking Studies

Absent a trusted resource, many injured employees seek attorney counsel to advocate for them, further complicating the claim process and increasing overall claim costs.

As attorney involvement varies by state, it is worth noting that case management assignment may be prudent in states known to have higher rates of attorney involvement with claims, such as Illinois, New Jersey, Georgia, California, and North Carolina.[2]

By advocating for the injured employee to receive all necessary care and encouraging return to work, while also assessing treatment and working with providers to reduce or eliminate unnecessary treatments, the nurse case manager is able to champion the claim through successful conclusion.

Provider Liaison

Another essential role provided by case managers is discussing a case's progression with the medical provider(s) and helping coordinate any additional or ancillary services. They may also impart critical education to providers on workers' compensation regulations, state guidelines, and industry benchmarks.

Additionally, the nurse case manager may discuss requirements of the employee's job with treating providers to support return-to-work (RTW) decisions. Often, these discussions can lead to RTW in modified or full-duty capacity earlier than without nurse intervention, as the physician better understands the work environment and the employer's willingness to adjust working conditions to support a return to employment.

Moreover, nurse case managers are often able to provide additional information about other providers treating the employee. As happens in other models of care, workers' compensation providers are frequently unaware of other professionals treating the patient, including, but not limited to, knowledge of other medications that have been prescribed. Lack of coordinated care can be detrimental to the patient and overall claim outcomes.

Communications Facilitator

As the case manager has discussions with various claim stakeholders, it is imperative that case notes are not only documented and submitted timely, but also created in a format that makes it easy for the adjuster to add the information into the employee's claim file.

Ideally, the nurse case manager will provide short email reports after each doctor visit, weekly written reports, and quarterly reports on complex claims. Quarterly meetings should also be held on complex claims so that all parties can review progress and determine next steps.

Weekly reporting should specify ongoing communication with the primary treating provider to obtain work capabilities, treatment plan, work status, expected RTW date and/or RTW barriers, upcoming appointment dates, expected maximum medical improvement (MMI), comparison of employee's recovery to ODG-anticipated disability timeframe, attorney discussion summaries, and the nurse case manager's plan of action.

Ultimately, the case manager is responsible for ensuring a continuous flow of communication about the medical aspect of the claim between the injured employee, treating provider, claims adjuster, employer, and other stakeholders.

The Outcomes

As we've established, nurse case management is not necessary for all workers' compensation claims but engaging a nurse case manager on certain claims can improve claim outcomes, resulting in earlier RTW, decreased medical and indemnity costs, and avoidance or mitigation of legal involvement.

An analysis of 42,000 workers' compensation claims that included nurse case management involvement found:[5]

Even though case management is an additional expense on the claim file, the outcomes demonstrate that strategic use of nurse case management can help reduce overall workers' compensation costs in most cases.

Sources

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About Rising Medical Solutions

Rising Medical Solutions is a national medical-financial solutions firm that provides medical cost containment and medical care management services to the workers' compensation, auto, liability, and group health markets. Rising also directs and publishes the annual Workers' Compensation Benchmarking Study, a national research program examining the complex forces impacting claims management in workers' compensation today.