

# Medical Management Best Practices

*2014 Annual Report to the Legislature*

January 2015



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# Executive Summary

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## Introduction

This report responds to the legislature's request for the Department of Labor & Industries (L&I) to share its progress in implementing medical management best practices. The legislature funded medical management best practices in 2013. L&I is required to report back to the legislature by December 1, 2014 in an interim report on the implementation of medical management and its impacts on reducing disability and increasing return to work. This report will be followed by a full report by December 1, 2016.

Washington's workers' compensation system provides benefits to workers who are injured on the job or who suffer from an occupational disease. It pays for medical treatment and partial wage replacement and provides disability benefits.

One of L&I's goals is to help injured workers heal and return to work, while keeping costs sustainable. Lack of adequate clinical staff (Occupational Nurse Consultants, or ONCs) was a chief cause of delays in closing claims so that injured workers can return to work. Injured workers not only faced delays in resolving medical issues, but claim decisions about medical care were made without clinical input. A recent random sampling of 200 L&I claims showed 48 percent of claimants did not get the on-time expert medical advice they needed.

In the 2013 biennium, the legislature provided funding for additional clinical staff at L&I. This enabled the department to hire more ONCs to provide medical advice and expertise for claim managers. In addition to this staffing increase, L&I conducted a Lean improvement project to streamline processes.

## Progress and achievements in 2014

To provide the medical expertise and intervention (medical management best practices) to help claimants heal and return to work, L&I:

- Hired 11 additional ONCs to support claim managers (CMs) and their caseloads. Previously, 11 ONCs supported 255 CMs, for a ratio of one to 23 -- compared to the industry norm of one ONC to six to 10 CMs. WorksafeBC, a similarly-sized system, has a ratio of one to five. The additional ONCs resulted in an L&I ratio of one ONC to 10 CMs.
- Hired an associate medical director (physician) with occupational medicine expertise to address the increasing number of occupational disease claims with longer time loss (the days an injured worker is paid for lost wages resulting from time off work or time doing lower-pay work due to work-related injury or illness).
- Completed a Lean process improvement project to standardize ONC referral criteria and processes. This will help ensure ONCs provide input into claims with the highest priority clinical issues, such as pre-existing opioid use, new conditions, time-loss, or occupational disease.

Eleven additional ONCs and one associate medical director specializing in occupational medicine help ensure L&I has the necessary resources to help injured workers get the care they need. Clinically-based referral criteria and work standards ensure that critical medical issues receive clinical expertise efficiently and consistently.

## **Conclusion**

L&I is a recognized national leader in health policies and strategies that keep medical costs and growth below national trends. With appropriate resources, L&I can make improvements to reduce the length of disability for injured workers -- a key measure of performance within the industry. L&I has implemented criteria and process changes and has hired staff needed to respond more effectively to important medical issues with the ultimate goal of reducing disability by improving medical care for injured workers.

## **Plans for 2015**

- Engage in a “plan, do, check, act” cycle of improvement. Ensure medical management processes and criteria are appropriate and make changes and improvements as needed. Consider additional actions to engage ONCs in L&I’s efforts to help injured workers return to work.
- Continue to improve training for and communication between clinical staff and claim staff.
- Develop more measures to assess results (for example, impact on opioid authorizations or appropriateness of occupational disease claim acceptance).

## **Next report**

L&I’s next legislative report on medical management best practices is due December 1, 2016.

# Introduction

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## Background information

Washington's workers' compensation system provides benefits to workers who are injured on the job or who suffer from an occupational disease. It pays for medical treatment and partial wage replacement and provides disability benefits. One of L&I's goals is to help injured workers heal and return to work while keeping costs sustainable; however, according to an industry benchmarking report from 2012, in 48 percent of L&I claims, injured workers did not get the on-time, expert medical advice they needed.

## Additional clinical staff

In the 2013 biennium, the legislature provided funding for additional clinical staff at L&I to provide medical advice and expertise for claim managers.

L&I's administrative costs are less than half those of comparable carriers -- 11 percent of the costs of benefits compared to 22 to 37 percent for other state fund and private carriers. These low administrative costs resulted in a lack of resources for clinical staff (Occupational Nurse Consultants, or ONCs) to provide adequate medical consultation, driving up overall delays and claim costs. The workers' compensation insurance industry norm is one medical expert on staff for each six to 10 claim managers. At L&I, this ratio was one medical expert to 23 claim managers, meaning eleven clinical staff supported 255 claim managers.

"If we had more ONCs, I'd be able to do more review," said Matthew Hutchinson, an ONC with L&I. "For example, if I had the time to follow the 10 most complex claims in each unit, I could catch a lot of costly and unnecessary problems."

Recently, Matthew was able to review a problem claim and realized that L&I was paying for a \$3,500-a-month medication when a less costly medication would work just as well. Unfortunately, he caught it 10 months into the regimen.

With the funding provided by the legislature, L&I hired 11 additional ONCs. This staffing increase helps injured workers heal and reduces disability by providing timely, high-quality medical expertise and care.

## Lean process improvements

In addition to hiring staff, L&I completed a Lean process improvement project during late 2013 and 2014 regarding medical management to address gaps in ONC review of claims that meet certain criteria. Medical management and best practice standards require input from a nurse and/or physician on complex claims and those involving clinical issues. Relying on a claim manager to initiate a question to the nurse or physician can result in missed opportunities for clinical input on medical decisions, resulting in delays and inappropriate decisions. Promptly involving clinical staff guides decision-making, reduces injured workers' time spent and frustration and ensures the right medical issues are quickly addressed.

Ensuring effective clinical interventions early in a claim can reduce disability and claim costs. The Lean improvements focused on setting and using standard referral criteria and work processes and using quality oversight. Interim results show significant positive impacts.

### **In this report**

This report includes information about:

- The importance of medical management best practices.
- Actions on medical management best practices L&I completed during 2014.
- Success measures for the actions taken.
- Progress toward L&I's long-term goals.
- Next steps.



# Progress and Achievements in 2014

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Washington's workers' compensation system provides benefits to workers who are injured on the job or who suffer from an occupational disease. It pays for medical treatment and partial wage replacement and provides disability benefits.

This section describes L&I's progress on using medical management best practices to improve medical claim processes and reduce length of disability for injured workers in 2014.

## SUMMARY OF ACTIONS TAKEN

- L&I hired 11 additional ONCs to support a manageable number of claim managers (CMs) and their caseloads. Previously, 11 ONCs supported 255 CMs, for a ratio of one to 23 -- compared to the industry norm of one ONC to six to 10 CMs. WorksafeBC, a similarly-sized system, has a ratio of one to five. The additional ONCs resulted in an L&I ratio of one ONC to 10 CMs.
- Both occupational diseases claims and lengths of time loss for workers (the days an injured worker is paid for lost wages resulting from time off work or time doing lower-pay work due to work-related injury or illness) have been increasing. To help focus limited clinical resources on the most problematic medical issues, L&I hired an associate medical director with expertise in occupational medicine.
- L&I completed a Lean process improvement project to standardize referral criteria and processes. This will help ensure ONCs provide input into claims with the highest priority clinical issues, such as pre-existing opioid use, new conditions, time-loss, or occupational disease.

These actions ensure L&I has the necessary resources to provide efficient clinical expertise and help injured workers get the care they need.

## HIRING AND STAFFING OCCUPATIONAL NURSE CONSULTANTS

L&I requested additional clinical expert resources to ensure appropriate medical decisions are made on workers' compensation claims. ONCs provide:

- Review and timely authorization of medically-necessary treatments.
- Treatment planning.
- Assistance with medical issues regarding returning to work.
- Coordination with and between providers to ensure timely, appropriate treatment.

L&I's small number of ONCs were spread too thin to perform these needed services. In addition, most of the ONCs' time was being used to respond to impromptu questions from claim managers, which kept them from being available and effective on every claim needing clinical intervention.

### ONC staffing

L&I's goal is to have each ONC physically located with his or her assigned claim unit(s). In addition to claim unit support, ONCs with specialized knowledge and experience in a variety of medical areas may be used as peer resources on complex or unusual medical issues. For example, some ONCs with backgrounds in surgery, critical care, home health, psychiatry, and rehabilitation are regularly consulted for guidance on issues that arise in these types of claims.

ONC units previously consisted of one clinical nurse lead overseeing 11 ONCs. Before increasing the number of ONCs, L&I reviewed the cases being referred to them to develop an ideal unit structure. The resulting structure, positions, and functions for each unit are:

- One clinical nurse lead responsible for overall program development, overall leadership, clinical education leadership, clinical research, supervision of ONC supervisors, specialized clinical expertise, and claim escalation.
- Two ONC supervisors responsible for supervising nine to 10 ONCs, mentoring and training staff, overseeing quality assurance, implementing clinical programs, and performing limited claims work such as back-up, triage, or specialty- area work.
- Nineteen ONCs responsible for providing clinical expertise on claims. This includes serving as a peer resource in specialty areas and potentially rotating to provide support in other areas.

### Recruitment and hiring

Starting in July 2013, L&I hired approximately two ONCs per month until all positions were filled. Hiring was deliberately paced to allow proper training, orientation and unit redistribution. L&I finished the initial hiring in February 2014; however, as a result of promotions, retirements, and other internal movements, the department continued recruiting and hiring through May 2014. The units are now fully staffed with a total of 24 ONCs. Any future recruitments will be due to normal attrition.

## Orientation

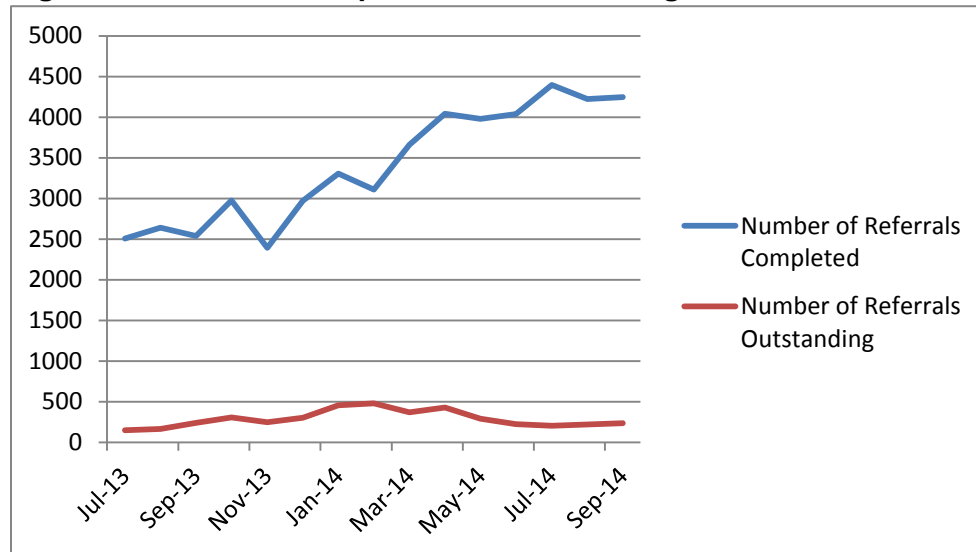
L&I requires ONCs to undergo at least six weeks of intensive mentoring before assuming a semi-independent role. Each new ONC is assigned a mentor for the entire orientation process. Orientation is very structured for the first three weeks with readings, one-on-one discussions with the ONC supervisor and peer ONCs and a variety of selected claim reviews.

Although all positions were filled in early 2014, new staff does not work independently for at least two months and generally does not carry a full claim load for at least three to six months. Staffing and full orientation of the staggered hires were completed between May 2014 and September 2014.

## ONC workload and results

While hiring additional ONCs, L&I also proactively identified referral criteria to ensure these new resources were reviewing the appropriate types of claims. L&I expected ONC workload to increase between 30 and 50 percent due to new required referral criteria and automated referrals from a new time-loss review process. Starting in the fall of 2013, referrals increased steadily, starting at about 2,500 per month and ending at about 4,300 per month. Despite rising referrals, ONCs were able to keep outstanding referrals below the performance target of 10 percent except for a very short time as new ONCs were trained and deployed. Currently, outstanding referrals are at about five percent.

**Figure 1: Number of completed and outstanding case referrals to ONCs**



## HIRING AN ASSOCIATE MEDICAL DIRECTOR

L&I hired an associate medical director in 2014. The department has some physician consultants who provide referral-based written responses; however, L&I needed a specialist with occupational medicine expertise to address the growing number of occupational disease claims with increasing time loss lengths.

An occupational disease is a medical condition that may develop over time, resulting from required work activities unique to a job. With the aging workforce, many occupational disease claims are being filed for degenerative joint conditions. State Fund system data indicates occupational disease claims have increased from two percent overall in Fiscal Year (FY) 2000 to five percent overall in FY 2009. The percentage of occupational disease-related time loss claim costs has risen dramatically over the same 10-year period, from six percent in 2000 to 16 percent in 2009.

### Responsibilities of the position

This position requires a unique combination of key skills including strategic planning and high level policy experience, stakeholder management expertise and advanced analytic skills for resolving high-level, complex technical clinical issues. The associate medical director/occupational disease expert advises, researches and develops evidence-based policy on degenerative diseases in the workforce (including aging workforce issues) and early indicators of potential long-term disability. The physician is an active participant in team conferences and provides occupational disease training to ONCs and CMs.

This position's responsibilities include:

- Direct, specific consultation for claim managers and ONCs on medical issues. Better and earlier medical decision support will help reduce ineffective treatment and time loss duration, especially with occupational disease claims.
- Coordination of department data analysis and clinical expertise to develop proactive treatment guidelines for care management.
- Development of policies for implementing consistent disability prevention best practices that identify and target claims with higher disability risk. This will foster more timely action on claims and better coordination between agency programs.
- Development and implementation of up-to-date, clinically-based referral criteria, quality oversight measures, and training activities for claim managers and nurses.
- Helping develop and implement agency-wide treatment guidelines for high-cost, ineffective, and high-risk clinical procedures.

## Recruitment and hiring

L&I has a national reputation for innovation in health policy and is one of the largest workers' compensation payers in the nation. The department conducted a nationwide search and was able to attract several top candidates, ultimately hiring Dr. Nicholas Reul, a physician board-certified in occupational medicine and with a master's degree in public health. Dr. Reul has an uncommon depth of clinical experience from formal job experience and training in areas of medicine important to L&I. Dr. Reul is initiating a first-time analysis of catastrophic claims and will lead discussion on and implementation of evidence-based or industry standard measures. Dr. Reul is also taking the lead to ensure L&I is organized and prepared to respond to the very unlikely but high-impact issue of potential workplace exposure to Ebola.

## LEAN IMPROVEMENT PROJECT

L&I committed to a medical management Lean project to address gaps in ONC review of claims that meet certain criteria and move closer to industry norms for clinical expertise. Medical management and best practice standards require input from a nurse and/or physician on complex claims and those involving clinical issues. Relying on a claim manager to initiate a question to the nurse or physician can result in missed opportunities for clinical input on medical decisions, resulting in delays and inappropriate decisions. Promptly involving clinical staff guides decision-making, reduces injured workers' time spent and frustration and ensures the right medical issues are quickly addressed.

### Lean: standardizing and improving processes

Ensuring effective clinical interventions early in a claim can reduce disability and claim costs. The Lean improvements focused on setting and using standard referral criteria and work processes and using quality oversight.

### Claims evolution

L&I chartered the medical management project as one of six initiatives under an overall improvement program called claims evolution. The claims evolution project aims to effectively use ONCs' expertise to reduce the time it takes for a worker to return to normal function and to improve injured worker clinical outcomes. Tools for accomplishing these goals include:

- Standard referral criteria for clinical intervention.
- Standard basic workflow processes, including appropriate references and guidelines and priority of application.
- Standard response times that reflect best practices.
- Performance expectations and accountability.
- Standard referral and report templates.
- Consistent education, training and materials for clinical staff.
- Standard measures to review quality.

## **How the Lean process worked**

The claims evolution project addresses limited clinical resources by focusing L&I's resources on medical issues having the most unnecessary delays. The department created standard, mandatory referral criteria and standard referral and report processes using Lean. Two teams worked to determine the types of medical issues ONCs should review and how referrals to ONCs should be made:

- The referral criteria team developed a list of prioritized claim issues with identified triggers for when a referral to an ONC is either required or recommended. The required referrals are intended to allow the ONC to intervene early in the life of the claim to reduce length of disability time and improve outcomes for injured workers.
- The referral process team refined the CM workflow when sending a referral to the ONC, how the ONC responds to the referral and how the response is sent back to the CM for action.

The Lean teams also designed new referral standards and report templates to ensure accurate and complete information is included.

## **Outcomes**

*Standard referral criteria:* Between 80 and 93 percent of referrals during the pilot met referral criteria.

*Standard response times:* ONCs responded to most issues within three business days during the pilot, compared to 10 days pre-pilot. For certain critical issues such as discharge planning or surgery, response time is 24-48 hours. Surveys of CMs showed high satisfaction with ONC response times.

*Standard referral and report templates:* Quality assurance reports showed 73 to 95 percent compliance with standard templates. Eighty-five percent of CMs found the new standard templates helpful to medically manage their claims during the pilot. One hundred percent of ONCs agreed that the new standard templates were clear and included critical elements.

*Standard processes:* Staff used 53 to 90 percent of standard processes during the pilot. They adhered well to standards in referral criteria, but there were gaps in other areas. The department made adjustments at the end of the pilot to change certain processes, reinforce requirements with system changes and clarify expectations.

# Conclusion

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Investing in ONCs and an associate medical director specializing in occupational diseases provides L&I with sufficient resources to implement medical management best practices. These actions are projected to reduce claim costs. They are also expected to improve the quality of life injured workers experience when they are able to quickly return to work. The medical costs for workers' compensation currently represent nearly half (46 percent) of claims costs -- about \$600 million annually. Medical management helps to ensure appropriate care, and ultimately to reducing the length of disability and time loss (wage replacement) benefits paid.

L&I has implemented criteria and process changes and has hired staff needed to more effectively use clinical resources. The department continues to monitor implementation and measure results of these actions to reach the ultimate goal of reducing disability by improving medical care for injured workers.

## PLANS FOR 2015

L&I will continue to apply Lean principles to improve medical management, consistent with our overall approach to ensure return-on-investment of our limited resources by reducing costs through improved health and return-to-work outcomes for injured workers. In 2015, the department will:

- Engage in a “plan, do, check, act” cycle of improvement. Ensure medical management processes and criteria are appropriate and make changes and improvements as needed. Consider additional actions to engage ONCs in L&I’s efforts to help injured workers return to work.
- Continue to improve training for and communication channels between clinical staff and claim staff.
- Research and develop more methods for assessing results, in addition to current process measures.

## NEXT REPORT

L&I’s next legislative report on medical management best practices is due December 1, 2016.

# Appendix A: Referral Criteria

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*Note: These are the criteria developed and tested in the Lean project. Claim managers now use these criteria to identify situations needing ONC involvement.*

## When to Involve the ONCs: Updated Referral Criteria<sup>1</sup>

Getting the nurse involved **early** in a claim can save you a lot of headaches and can ensure the worker receives the best possible care.

### Referrals to ONCs required:

Time-loss <ul style="list-style-type: none"><li>• Time-loss that has reached 2 weeks (based on weekly data runs that will be sent directly to the ONC). If applicable, ONC will include expected disability duration in response.</li></ul>
Triage of all non-initiated claims requiring inpatient hospitalization from UR
Discharge planning: <ul style="list-style-type: none"><li>• Authorization of long term attendant care</li><li>• Home health care requests including skilled nursing, PT, OT, and speech therapy</li><li>• Skilled nursing facility admission</li><li>• IV antibiotics</li><li>• New catastrophic injury</li><li>• DME necessary for hospital discharge or long term care including wound vac, hospital bed rental or purchase, specialty mattress, wheelchair rental or purchase, rental of portable ramp</li><li>• Residential care including adult family homes, group homes, assisted living</li></ul>
Newly contended conditions that were not a part of the body originally allowed per the Report of Accident (ROA): <ul style="list-style-type: none"><li>• To include, but not limited to:<ul style="list-style-type: none"><li>• Notification when psych is contended and review of psych evaluation</li><li>• Thoracic outlet syndrome (TOS), or when contended on the ROA</li><li>• Complex Regional Pain Syndrome (CRPS), also known as RSD</li><li>• Degenerative condition/diagnoses, or when contended on the ROA</li><li>• Creeping diagnoses to different parts of the body</li><li>• Post injury incident(s)</li></ul></li></ul> <p>Excluded from this requirement would be sprains/strains with diagnosis clarified later</p>

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<sup>1</sup> This document is for internal L&I use only.



<ul style="list-style-type: none"> <li>To include, but not limited to: <ul style="list-style-type: none"> <li>Shoulder sprain later found to be rotator cuff tear</li> <li>Knee sprain later found to be meniscus tear</li> <li>Wrist sprain later found to be DeQuervain's or CTS</li> </ul> </li> </ul>
<p>Controlled substance issues:</p> <ul style="list-style-type: none"> <li>Opioids per new opioid guideline process</li> <li>Abuse of prescribed or illegal drugs</li> <li>Evidence of opioid diversion (i.e., negative on UDT)</li> <li>Suboxone/Subutex/Buprenorphine</li> </ul>
All occupational disease claims prior to allowance or rejection
Chemical exposure rejections (send to CRI unit)
<p>Assignment and monitoring of nurse case managers</p> <ul style="list-style-type: none"> <li>To include, but not limited to: <ul style="list-style-type: none"> <li>New catastrophic injury</li> <li>On site coordination of complex medical issues</li> </ul> </li> </ul>
Requests for myoelectric or microprocessor upper or lower extremity prosthetic limb
Request for authorization for a chemical/alcohol dependency or opioid detoxification program
<p>A head injury which includes post-concussion symptoms/syndrome or contention of cognitive difficulties</p> <ul style="list-style-type: none"> <li>Request for brain injury rehab (e.g., speech therapy, behavioral therapy, physical therapy, etc.)</li> <li>Request for neuropsychological exams</li> </ul>
<p>Referral to OMD internal medical staff or consultants need to go through an ONC</p> <ul style="list-style-type: none"> <li>To include, but not limited to: <ul style="list-style-type: none"> <li>UR re-review denials (for OMD internal staff review only)</li> <li>Ratings (unclear or excessively high)</li> <li>Unclear causal relationship</li> </ul> </li> </ul>
Review psych at 90 days
Requests for ultrasonic or electrical bone growth stimulator
Botulinum toxin (BTX) injections (e.g., Botox, Myobloc, Xeomin, Dysport)
Obesity treatment

**Referrals to ONCs recommended:**

Reopenings <ul style="list-style-type: none"><li>• To include, but not limited to:<ul style="list-style-type: none"><li>• Unclear to CM if there is objective worsening</li><li>• Newly contended condition</li><li>• Unclear if treatment plan is curative</li></ul></li></ul>
Questionable causal relationship of diagnosis compared to description of injury on ROA
DME (e.g., CPM, prosthetics, or orthotics)
Dental plan or treatment as related to original injury
Continued subjective complaints without objective findings <ul style="list-style-type: none"><li>• Unclear to CM if there are objective findings</li><li>• Physical restrictions inconsistent with physical exam findings</li></ul>
Unusual/unclear treatment plan – guidance to develop the appropriate clarifying questions
Drugs/medications <ul style="list-style-type: none"><li>• Prescriptions for unaccepted conditions / unclear relatedness</li><li>• Off label medication(s)</li><li>• Non formulary drug requests</li><li>• Multiple medications (e.g., antipsychotics, antidepressants, anticonvulsants)</li><li>• Anticoagulants post op not approved by Provider Hotline</li></ul>
Hyaluronic acid injections
Outpatient SIMP <ul style="list-style-type: none"><li>• Surgical candidate prior to lumbar fusion or lumbar artificial disc</li><li>• Unclear to CM if candidate for SIMP following initial evaluation</li></ul>
Questions regarding which specialist to use for an IME
Unusual requests: special shoes, glasses, etc.
Multiple open claims to clarify diagnosis and treatment plan