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EVIDENCE-BASED DURATION GUIDELINES



THE USE OF EVIDENCE-BASED DURATION GUIDELINES

CHARLES PREZZIA, M.D. AND PHIL DENNISTON

Charles Prezzia, MD, MPH, is General Manager, Health Services and Corporate Medical Director, USX Corporation: U.S. Steel Group in Pittsburgh, PA., and Editorial Columnist, *Occupational Health Management* newsletter. He was also Director, Occupational Health Services, St. Charles Hospital, Oregon, OH, and Founder/President, Occupational Care Consultants, Toledo, OH.

Phil Denniston is Editor-in-Chief, Work Loss Data Institute, Corpus Christi, TX. He was also Founder/President of Medical Device Register Inc., President of Medical Economics Data and responsible for *Physicians' Desk Reference*, *Medical Device Register*, *Occupational Health Management*, and *Case Management Advisor*, and Founder/President of Physicians' GenRx.

Disability duration guidelines can be important tools in helping to get injured workers back on the job.¹ For guidelines to have maximum effectiveness, they need to be accepted by all parties in the workers compensation process as defensible, fair, and evidence-based.

There are a variety of disability guidelines available, and they each have their own strengths and weaknesses. In attempting to apply these guidelines, users need to understand at what point in the workers compensation process they can be helpful and should know what data support the guidelines.

TRADITIONAL USES OF DURATION GUIDELINES

Traditionally, disability duration guidelines have been used prospectively by workers compensation claims professionals or case managers when managing the details of a case.² The expected duration of disability can be compared to the guidelines and additional management resources can be applied to the case if it seems the guideline will be exceeded. This has been shown to benefit not only the employer, but also the employee.³

Guidelines have also been used retrospectively to evaluate return-to-work performance and to benchmark the success of case management efforts.⁴ Case managers can demonstrate their value to management or to their clients by showing that they “beat the guidelines.”⁵

USING GUIDELINES TO TRIAGE CLAIMS

Recently, with increased computerization of the claims process, new uses are being found for disability duration guidelines. One of the most promising of these new uses is to triage claims using computer software, in order to maximize the return on claims and case management efforts. Claims management professionals and case management nurses are in demand and costly to employ and support with the appropriate resources. Insurers, third party administrators (TPAs), and employers are receptive to opportunities to accomplish more with less people when managing the workers compensation claims process. Besides saving money on claims by not needing case management, claims triaging also results in greater employer and employee satisfac-

tion in that patients and providers are not forced to spend their time with utilization review representatives when they are not beneficial. In evaluating a workers compensation vendor, many employers also consider how many complaints they receive from employees who have had coverage decisions questioned.

When duration guidelines are integrated into claims management software, the return on these expensive resources can be improved. For example, duration guidelines can be used to assign an initial claim into three categories based on the distribution of disability duration data for a particular condition or group of similar conditions: “low-touch” claims, “detail-management” claims, or “long-term planning” claims. If 80 percent of cases are expected to return to work in less than 14 days, these may be “low-touch” claims that are allowed to pass through the system with little human involvement. However, the “long-term planning” claims may have a disability duration profile that requires a long time off from work or the likelihood of no return to work at all. For these claims, there may be little that intense case management can do except for putting into place the necessary long-term plans, including rehabilitation, job replacement, and social security. The middle level of the claims triage is called “detail-management” because the data show that there is great deal of variability in disability duration. This is where the talents of a good claims professional or case manager can be best put to use. These claims justify the expense of case management to ensure proper treatment, job accommodation, and especially communication among all parties.

PROVIDING GUIDELINES TO PROVIDERS AND PATIENTS

Disability guidelines can help reinforce one of the most important determinants in return to work — good communication among all parties.⁶ Along with early reporting of injuries, early involvement and communication among all parties is important in establishing an effective return-to-work process. With communication, the worker will feel the employer misses him or her, they are valued and needed, the worker’s job is important, and the employer is interested in the worker’s return to health and productivity. If communication is good, providers will know that they are not making return-to-work decisions in a vacuum because they will know someone is monitoring the decisions. Disability duration guidelines can facilitate this process if they are shared with all parties so everyone is “working on the same page.” There needs to be buy-in from all parties that the guidelines are fair and defensible for this to happen. But once there are agreed upon expectations, results typically fall within those expectations.

In order to establish these shared expectations, the duration guidelines need to be shared with the treating physician and other providers.⁷ The ultimate outcome of the case will be up to the treating physician. On the one hand, the treating physician knows that every case is different and he or she has the training, knowledge, and experience to make the correct decisions on that case. On the other hand, the treating physician also knows that one thing he or she did not learn in medical school is the normal disability duration for each condition. The treating physician may question another expert telling him or her how to treat the patient, but he or she can be open to verifiable data that provide norms. When physicians have these norms, they may identify why their case is different or they may change their expected duration plans to be more consistent with the norm. Consequently, employers and insurers are increasingly making these duration guidelines available to providers treating their employees.

More recently, with increased consumerism and interest by consumers in taking charge of their own health-care, employers and insurers are sharing these disability duration guidelines with their employees. After an injury or illness, a patient may have questions about his or her injury, including how long he or she will be affected by the injury or illness. If patients know when they would be expected to return to work, they can make plans accordingly.

IMPORTANCE OF DURATION GUIDELINES

As duration guidelines increasingly become the focal point of the entire return-to-work process — and as they are shared with the treating physician and even with the patient — they must be based on credible data. If they are viewed as a one-sided tool to force employees back to work earlier than they should, the process will become adversarial and any potential benefits from using the guidelines will be negated. In this new environment, the most important feature of disability duration guidelines is that all constituents perceive them as fair and independent. They need to represent what is actually happening, not what some “expert” thinks should be happening.

Furthermore, to be useful, the guidelines need to take into account all factors that could significantly affect return to work. In addition to having norms for all cases within a diagnosis, the guidelines should identify what makes a difference in return to work for that condition. Guidelines should describe:

- differences in disability duration based on type of therapy (e.g., conservative treatment versus different surgical procedures);
- severity (e.g., measurable indicators of severity that distinguish some cases from others); and
- type of job.

When identifying differences by type of job, it is necessary to identify job restrictions and modified duty possibilities unique to a particular diagnoses. For example, repetitive use of the wrist (e.g. typing) may be light duty for back strain but not carpal tunnel, or lifting 10 pounds overhead may be light duty for a minor cut but not for a rotator cuff injury.

TYPES OF DISABILITY DURATION GUIDELINES

There are basically two types of disability duration guidelines: those that are recommendations made by knowledgeable sources and those that represent actual experience data. In the past, success could be achieved by using any duration guidelines. Just by questioning disability duration on certain cases, return to work could be improved.

Now times have changed. As treating physicians and even employees take a greater role in determining their return-to-work expectations, they want to know that the guidelines are fair, independent, and represent actual practice. Successful return-to-work efforts need to make the employee and his or her physician part of the team — and all parties need to be comfortable with the expectations being placed on them.

SUPPLIERS OF DURATION GUIDELINES

There are four major suppliers of disability duration guidelines used by employers, providers, and insurers:

- the *Official Disability Guidelines*,⁸ published by the Work Loss Data Institute (Corpus Christi, TX);
- the *Medical Disability Advisor — Workplace Guidelines for Disability Duration*,⁹ published by the Reed Group Ltd. (Boulder, CO);
- the *Health Management Guidelines*,¹⁰ published by Milliman & Roberson (Seattle, WA); and
- the ACOEM Guidelines,¹¹ published by OEM Press (Beverly, MA).

Each set of guidelines has a strong following and has clients who have achieved considerable success from using the guidelines.

In addition, there are various proprietary duration guidelines that are typically available only in electronic form. These include:

- the QualityFIRST guidelines,¹² produced by the Institute for Healthcare Quality (Minneapolis, MN), a subsidiary of Health Risk Management, a utilization review company;
- the CGOG guidelines, produced by Intracorp (Philadelphia, PA), a subsidiary of Cigna, the third largest health management organization (HMO) in the United States;
- the WorkAbility guidelines, produced by Core, Inc. (Irvine, CA), a disability managed care company; and
- the InterQual guidelines,¹³ produced by InterQual (Marlborough, MA), a subsidiary of McKessonHBOC.

Since these proprietary guidelines are not available in printed form and it is not possible to review their underlying data, they were not compared in this article.

Official Disability Guidelines (ODG)

The 2001 edition of the *Official Disability Guidelines* is the sixth annual edition. For every possible condition, organized by diagnosis using ICD9 codes, ODG provides normative data on disability duration, with a database of over 3 million cases. The data is presented in several forms, including number of calendar days by decile, at 10 percent, 20 percent, etc., up to 100 percent. Users can determine their own cutoff. For example, some may choose the median, 50 percent, whereas some might pick 80 percent or 90 percent if they are interested in less intense management or there is concern that their cases may be more severe. There are also bar charts showing where the data falls, so that specific “clumps” of data can be identified, and the number of cases not missing any work is also identified. The bar charts clearly identify the number of cases in the sample. Since every diagnosis is covered, some sample sizes are small, but that is helpful in knowing that these are relatively rare conditions and that there will not be much data available anywhere. But, with over 3 million cases, the more common injuries and illnesses have large sample sizes. From this database, ODG also shows incidence and prevalence information — for example, the percent of total lost-workdays this condition represents and what this means in lost days per 100 workers for the average employer. This is helpful for employers to identify not only those conditions where their employees are out longer, but also those that they incur more frequently than other employers, which they can use for targeted improvement efforts such as safety or ergonomics programs.

ODG has a section for each condition called Return-To-Work “Best Practice” Guidelines, which is a result of drilling down into the data and identifying what made a difference in disability duration for that diagnosis. It may cover type of therapy, type of job, or indicators of severity. The information on type of job can be used to identify modified duty work, isolate when the modified duty work can commence, and for how long it should be continued before return to full duty.

The primary data source for the *Official Disability Guidelines* is the National Health Interview Survey (NHIS), which is conducted annually by the National Center for Health Statistics (NCHS) of the Center for Disease Control and Prevention (CDC). The NHIS is compiled annually and is based on a complete household health experience record for a sample of U.S. households. ODG uses these data from the most recent ten years and also uses OSHA data and

data from selected employer claims. The CDC data are the most valuable data set because they are consistent and contain a wealth of detail on each record, including employee demographics, type of therapy, and type of job.

The organization by ICD9 allows grouping similar conditions together, since the ICD9 coding structure is hierarchical with five different levels. Both the calendar-days-by-decile tables and the incidence and prevalence information are available at group levels, e.g. all mental conditions, as well as for individual diagnoses under the group levels. There is a keyword index to find the correct ICD9 diagnosis or the correct procedure.

The 2001 edition of *Official Disability Guidelines* also includes a description of each diagnosis in lay terms, along with symptoms and other names. There are also Physical Therapy “Best Practice” Guidelines and benchmark indemnity costs for each work-related condition. Because ODG has incidence data, it is able to rank the most common conditions, using a number of criteria.

ODG is available in a 1,200-page reference book for \$165, a “Top 200 Conditions” version for \$79, a CD-ROM for \$195, a paid Web site for \$149 per user, a “Pocket Guide” with just the “Best Practice” Guidelines for the top 50 conditions for \$19, and via license of the raw data. The *Official Disability Guidelines* are less expensive than other guidelines, but since they are updated every year and the publisher recommends that only the latest guidelines be used, they can actually cost more than other guidelines that are updated every 3 or 4 years, or not at all.

Medical Disability Advisor (MDA)

The *Medical Disability Advisor* is one of the favorite textbooks used by occupational health nurses because it has extensive descriptions for each diagnosis and a glossary of medical terms and anatomical drawings that help the nurse or nonmedical claims professional understand each condition. Conditions and procedures are arranged alphabetically. Under each condition, subsections are begun with standard questions, including:

- What Is It?
- How Is It Diagnosed?
- How Is It Treated?
- What Might Complicate It?
- What Is The Predicted Outcome?
- What Are Possible Work Restrictions And Accommodations?
- What Else Might It Be?
- What Type Of Rehabilitation Might Be Appropriate?
- Who Are The Appropriate Specialists For Treatment, Referral, Or Independent Examination?
- What Are The Factors That Might Influence Length Of Disability?

The MDA is updated every 3 or 4 years, and the latest available edition is the third edition, published in 1997. A fourth edition is expected. The MDA is fairly comprehensive; while it does not cover all 10,000 ICD9 diagnoses, it does cover about 1,000 conditions. ICD9 codes are identified and cross-referenced.

There are two sets of disability duration guidelines in the *Medical Disability Advisor*. A table is provided under the heading “What Is The Expected Length Of Disability?” showing minimum expectancy, optimum, and maximum expectancy for five types of jobs — sedentary, light, medium, heavy, and very heavy work. There is typically a broad range from the minimum expectancy to the maximum expectancy, and for most conditions the numbers are identical for the different job types.

The second set of disability duration guidelines is labeled “What Is The Duration Trend From The Normative Data?” and it shows a graph of cases versus days from “Reed/Core” data (raw data norms). Guidelines from the *Medical Disability Advisor* are available as a 2,000-page hardcover book for \$345, as a CD-ROM for \$545, or as a raw data license.¹⁴

M&R Health Management Guidelines

The *Health Management Guidelines* cover a variety of specialties in a nine-volume series and are widely used among managed health-care providers and insurers. They are known primarily for their hospital length-of-stay guidelines, and their subscribers include almost every large HMO. Volume 7 of the M&R guidelines covers workers compensation.

Despite claims that these guidelines are not evidence-based,¹⁵ the M&R guidelines have extensive references to peer-reviewed journals supporting their recommendations. There are no tables or graphs of actual disability duration norms in the M&R guidelines because M&R does not report what the norms are. Instead, they are providing “optimals,” what their editors think should be possible, based on their judgment and what studies have shown can be achieved. The M&R guidelines say, “The guidelines should be used considering the unique characteristics of each patient and should not be used as a basis for denying payment for treatment received.”

The workers compensation volume of the M&R guidelines is organized by body part, including ankle/lower leg, back, burns, elbow/forearm, eye, finger, foot/toe, hand, hernia, hip/pelvis/upper leg, knee, neck, psychiatric, shoulder/clavicle/upper arm, and wrist. For each diagnosis the ICD9 code is identified. The workers compensation guidelines are somewhat comprehensive, covering about 300 different diagnoses. A separate volume, “Return to Work,” covers nonoccupational conditions and has about 100 different diagnoses.

The two volumes covering workers compensation were last updated in 1998. Volume 7 of the M&R guidelines, “Workers Compensation,” is available in a 400-page loose-leaf book for \$525, and they are also available for raw data license. Volume 8, “Return to Work,” is another \$525.¹⁶

The ACOEM Guidelines

ACOEM is the American College of Occupational and Environmental Medicine, and they established a practice guidelines committee to prepare their own guidelines. Called *Occupational Medicine Practice Guidelines, Evaluation and Management of Common Health Problems and Functional Recovery in Workers*, the ACOEM guidelines cover 54 different diagnoses organized into eight sections by body part.

In addition to advice on disability duration, the ACOEM guidelines provide information on differential diagnosis, including initial assessment, medical history, physical examination, and diagnostic criteria. They also cover work relatedness, initial care, activity alternation, work activities, follow-up visits, special studies, diagnostic and treatment considerations, and surgical considerations, all grouped by eight major body parts, i.e., neck and upper back, shoulder, elbow, forearm/wrist/hand, low back, knee, ankle/foot, and eye. ICD9 codes are not referenced in the ACOEM guidelines. There are references in each section to peer-reviewed medical studies, but there is no display of actual normative disability duration data in the ACOEM guidelines. The disability duration guidelines in ACOEM are the recommendations of the authors.

The ACOEM guidelines were last published in 1997 and are available in a 300-page loose-leaf book, which sells for \$180. There are no electronic versions at this time.

CONCLUSIONS

There are significant benefits to be achieved by incorporating disability duration guidelines in workers compensation claims management. There are a variety of excellent choices in available duration guidelines, and any one of these choices can more than pay for itself.

Whatever guidelines are selected, users should understand their source. Do they represent actual experience data, or are they the recommendations of a few experts in the field? And if they are only recommendations, are these recommendations supported by peer reviewed studies in the medical literature?

As duration guidelines become more widespread, and are used as communication tools in dealing with treating physicians and patients or employees, it is important that the guidelines be based on data that these stakeholders can also “buy into.” To avoid developing adversarial situations, including lawyer involvement, the guidelines should give an accurate picture of what is actually happening, and not just what someone thinks should happen. This is especially important because the guideline purchaser may be perceived to have a financial interest in promoting guidelines that are not in the best interest of the employee or the treating physician.

ENDNOTES

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14. As noted in the book’s introduction, the guidelines are based on “the collective experience of the author, the Reed Publications research staff, the members of the medical advisory board, and reviewers from the health care profession.”
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16. A few caveats are mentioned in the M&R Guidelines. First, Chapter 2 specifically states that: “The guidelines presented in the HMGs should be viewed as a starting point for discussion among those responsible for patient-care management, not as final standards that apply without consideration of the specific objectives and circumstances involved.” In addition, Chapter 3 states that: “Appropriate individual plans must take into account not only the health status of the patients, but also the options at the workplace.” Chapter 3 further states “A RTW guideline should not be a basis for the development or evaluation of a treatment plan for a specific patient without the evaluation by a qualified medical professional of the guideline's appropriateness to the specific circumstances involved.” These caveats should be sufficient for anyone who utilizes the M&R guidelines.