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# Managed Care in the Workers' Compensation Environment -- Part II

## THE DISABILITY DETERMINATION: IS IT RATIONAL OR REASONABLE?

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Impairment, and therefore the total cost of a case, is determined in large part by the attending physician's opinion. Many chiropractors are able to determine if there is an impairment, but rarely are they able to determine disability. Permanent impairment is defined as any anatomic or functional abnormality or loss, after maximum medical improvement has been achieved, which abnormality or loss the physician considers stable or non-progressive at the time of the evaluation. This is a purely medical condition. Permanent disability is when a patient's actual or presumed ability to engage in gainful activity is reduced or absent because of "impairment" which, in turn, may or may not be combined with other factors. This is not a purely medical condition. Most chiropractors are not fully aware of the physical or mental requirements of their injured patient's job. Most have never performed or even observed that job. Something else must be considered: Many employers have not constructed behaviorally-based or tested job descriptions. Lastly, there are few accepted standards for length of absence or recovery from specific illnesses or injuries.

On the individual level, whether a worker feels ready or interested in returning to work depends on his attitude towards the job, his boss, the company, his desire to work, his family, personal history of disability, pain perception, physical deconditioning, and recovery expectations. Modern chiropractic, even with our new Certified Industrial Consultant programs, is not designed or equipped to address many of these issues. Giving a diagnosis to a new patient, with marginal indications for that diagnosis, may lengthen disability by validating an emotional situation as a "disease." In many cases, within the chiropractic framework, it is not clear what is going on; all that is seen is an apparent delayed recovery. Illnesses and injuries now receiving compensation benefits differ from the acute traumatic injuries for which the system was originally designed. Data from the National Council on Compensation Insurance, the National Safety Council, Occupation Safety and Health Administration (OSHA), and Focus Health Care Management all show that "non-specific" diagnoses, or those without objective physical findings, account for the small number of long-term, higher than average cost cases that seriously affect the results for the total system.[8,9] I was recently called in to review a case where the patient suffered a relatively minor injury and was under continuous chiropractic care for 11 years. There definitely was an emotional/psychological overlay here that the attending chiropractor could not or would not address.

In practice, assignment of length of temporary impairment and a permanent impairment rating are non-standard and often guesswork. The American Medical Association (AMA) Guides has done an excellent job of delineating an impairment rating system, but it is not time-based, nor does it address length of impairment. Also, very few chiropractors are trained in current impairment ratings and the use of the AMA Guides.

The Difference Between Workers' Compensation Casualty and Group Health Environments

The basic premise of group medical insurance and workers' compensation are distinctly different. Group medical insurance (known as group health) pays for prescribed medical care within the

limits of the particular plan. The theory of insurance is to pay for unexpected but actuarially predictable illnesses or injuries. The emphasis is on providing medical/chiropractic care for, or to cure an episode of ill health. Causation of the problem and the ability to earn a living are issues external to the group health reimbursement system.

In contrast, in workers' compensation the emphasis is on management of the total liability of a case, as opposed to provision of all the care that is necessary within the limits of the group health plan design. Claims adjustors in the property and casualty environment must concern themselves not only with payment or medical treatment, but also with appropriateness of treatment, whether that treatment will improve the workers' health and functionality, the path and methods of returning workers to their jobs, obtaining permanent impairment ratings, and the cost of income replacement or lump sum awards.

Concerns of the Property and Casualty Adjustors

A central concern of adjustors is obtaining closure. This can occur either by returning the worker to work, or by settling the case. Since the settlement is often determined by the attending doctor's opinion of the workers' impairment, the adjustors must interact with physicians (including chiropractors) to obtain impairment ratings and/or release from treatment. This is an unequal match, and it is becoming more unequal. Adjustors, with the exception of a few cross-trained nurses, have never had medical training. Yet they are expected to understand and approve the medical necessity of treatment.

Medicine and physicians/chiropractors are becoming more and more specialized. The situation becomes worse when new technologies (such as MRIs, EMGs, and CMTs) and new services (diagnostic centers, rehab facilities, work hardening programs, and new techniques) are introduced. Often, these are competing for alternative methods (approaches) to a problem. Often, the evidence on their effectiveness is not available.[10] The results of the tests may not be definitive or may have only moderate correlation with the clinical presentation. It should also be noted that medically unnecessary treatment, especially with marginal indications, can frequently make the patient worse or, at the very least, prolong treatment. This increases rather than decreases total liability.

When adjustors deal with chiropractors, there is often a feeling of misunderstanding. They don't know who we are. Most of their work deals with allopathic medicine and the medical model. Some of the statements we make, the diagnoses we give, and the treatment plans we prescribe do not fit known healing times or the scientific understanding of anatomy and physiology. Some things get lost in the translation and sometimes we chiropractors are misinformed as to "what the insurance company wants to hear." At times, it makes it very difficult for the adjustor to determine medical necessity or efficacy. But whose fault is that? The insurance company's for not knowing who we are, or ours for not telling them who we are?

The legal primacy of the attending physician further skews the balance of power away from the insurance company and towards the health provider. In essence, the person (company) responsible for paying the bills has less and less control over their expenditures. What results is an increasingly adversarial environment. Chiropractors who feel they should have complete control of a case, (up to and including what information they will release, and to whom) react to claims management and external utilization review with irritation and hostility. These chiropractors are likely unaware that medicine has long had to deal with case management, not only in workers' compensation, but in the group health arena also. There is no legislation that precludes workers' compensation from implementing medical cost containment programs which: prospectively and concurrently monitor

providers; assures that injured employees are receiving reasonable, appropriate, and necessary medical/chiropractic care.

John C. Morrison, outgoing board chairman of the National Council of Compensation Insurers (NCCI), advised insurers to confront the escalating medical benefits crisis: "One of NCCI's objectives this year is the development of effective cost-containment measures. The workers' compensation system is about the last remaining public or private insurance scheme with few or no cost-containment provisions." Confirming this stance, the International Association of Industrial Accident Boards and Commissions (IAIABC), at its September 1988 annual convention, formally endorsed medical cost containment measures as a key way of managing workers' compensation medical benefits. As a first step towards this goal, the IAIABC revised existing standards to include reference to "reasonable and necessary medical care," so as to invite the opportunity for applying relevant medical cost-containment strategies similar to those now commonplace in the group health setting. For some reason, we chiropractors feel that we are the only ones singled out for claim reviews. This is far from the truth. In fact, we are scrutinized much less than our medical colleagues.

Unique Concerns of the Treating Physician

Many chiropractors do not understand the administrative requirements of the compensation system. We generally are not familiar with job requirements. There is tremendous misunderstanding of Maximum Medical Improvement/Maximum Chiropractic Improvement (MMI/MCI). A term I prefer is Maximum Therapeutic Benefit (MTB). It is unrealistic to expect a worker to be absolutely free from pain or symptoms before returning to work. Very few people are ever totally free from symptoms. This does not even address the issue of subluxation-free. Some chiropractors seem to believe that this is the condition that must be met before MMI and return to work is reached.

A second belief is that compensation payments should be left open for life, in case something reoccurs. This is a misunderstanding of the intent of workers' compensation. The system was intended to cover discrete episodes of illness or injury. These episodes do not spontaneously reoccur. Complaints associated with aging may supervene. You must ask the question, "Is this episode solely work related?" Once a person is injured at work, any mild ache or pain in the original area seems to automatically be the responsibility of the workers' compensation carrier.[11] As an example, the state of Florida has a two-year open medicals policy. This seems fair enough, since it will generously cover any exacerbation the patient/claimant incurs.

The absurdity of the system is revealed when the claimant exercises his rights under the two-year open medicals and seeks treatment for an exacerbation; the two-year open medicals start all over again from the date of the "exacerbation" visit. If it is one year and 364 days after the claimant reached MMI and he decides to seek treatment for the exacerbation, the two-year open medicals starts all over again. The system has handed the less than ethical chiropractor "womb to tomb" coverage. I wish I could say that this rarely happens.

Many chiropractors are not trained to determine impairment ratings, nor are they aware that a declaration of MTB (MMI/MCI) or possibly assigning the patient a rating is required to close a case. Conversely, there are chiropractors who indiscriminately hand out impairment ratings without regard to their ramifications. An impairment rating is a double-edged sword. There may be considerable financial gain associated with the rating, either in long-term disability pay or in a lump-sum settlement. There is also a down side. State law may allow the employer to fire the employee because he now has a permanent impairment, and that disability may not allow him to

perform his original job duties. A permanent rating may also affect future employability and future insurability. If a person truly deserves and needs an impairment rating, by all means, rate them. However, I would caution chiropractors against giving a questionable rating just because an attorney is pressuring you to do so, or because you think you're helping your patient. The short-term gain can be grossly overshadowed by the long-term complications.

Another problem frequently encountered is the assignment of casualty. The medical and chiropractic literature offers very little regarding casual connections between work (task performed) and the injury sustained. There are many conditions (microtraumas, repetitive movements, the whole issue of ergonomics), not including direct injury, which can result in work injuries. The research simply has not been done. The field is legally hazy as well. Chiropractors and other physicians are left in the awkward position of guessing at casualty. There are some chiropractors and physicians who will attribute almost anything to the job. An even more complex situation arises when there is a pre-existing condition, or an exacerbation of a pre-existing condition. The way the system is skewed, it appears that if a person has any disease, illness or health problem that becomes worse at work, workers' compensation may be held liable.[12] This is particularly prevalent in chiropractic offices where chronic aging changes, such as degenerative disc disease (DJD) or osteoarthritis, are a large part of our practice. These frequently may not be work related, but may be aggravated at work or after work. The issue becomes even more clouded on claims for work-related heart attacks or problems which include psychological overlay.[13]

None of the above-identified inconsistencies make the chiropractor or physician very happy with the system. Many are not aware of the mechanics of the workers' compensation system, nor are they aware of the job requirements or the workplace environment. Chiropractors and physicians have to make decisions in unfamiliar or gray areas and then "put up with" the management of cases by adjustors or external medical reviewers.

References will be included in Part IV of this series.

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