WEST VIRGINIA LEGISLATIVE AUDITOR

PERFORMANCE EVALUATION AND RESEARCH DIVISION

Full Performance Evaluation

Workers' Compensation

West Virginia's Workers' Compensation System Needs Greater Control Over Claims that Have Injury Durations that Significantly Exceed Reasonable Duration Guidelines and Have Questionable Medical Justification

January 2004
PE 03-35-310

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January 11, 2004

The Honorable Edwin J. Bowman
State Senate
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The Honorable J.D. Beane
House of Delegates
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Dear Chairs:

Pursuant to the West Virginia Sunset Law, we are transmitting a Full Performance Evaluation of the *Workers' Compensation*, which will be presented to the Joint Committee on Government Operations on Sunday, January 11, 2004. The issue covered herein is "West Virginia's Workers' Compensation System Needs Greater Control Over Claims that Have Injury Durations that Significantly Exceed Reasonable Duration Guidelines and Have Questionable Medical Justification."

We transmitted a draft copy of the report to Workers' Compensation on December 30, 2003. We held an Exit Conference with Workers' Compensation on January 6, 2004. We received the agency response on January 8, 2004.

Let me know if you have any questions.

Sincerely,

John Sylvia

John Sylvia

JS/tlc

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Executive Summary

Issue 1: West Virginia's Workers' Compensation System Needs Greater Control Over Claims that Have Injury Durations that Significantly Exceed Reasonable Duration Guidelines and Have Questionable Medical Justification.

The Legislative Auditor examined the Claims Department within the Workers' Compensation Commission. In general, it was found that the Claims Department works well in many respects. The Claims Department rules on the compensability of claims in a timely manner, it monitors claims well by timely requesting documentation from physicians on the progress of claimants, and it recently employed medical staff to improve its understanding of medical information and assist its decisions on claims. Another important development is the recent implementation of injury duration guidelines that establish expected lengths of time for workers to recover from various types of injuries. These guidelines provide efficiency for the Claims Department in that claims with longer duration guidelines do not have to be monitored as frequently as claims with shorter disability guidelines. The duration guidelines also provide a red flag so that when claims significantly exceed the guidelines, claims adjusters can provide closer monitoring of those claims.

While the Workers' Compensation Commission has made significant changes that have improved the claims process, there is evidence that the Commission should have greater control over the benefit costs.

While the Workers' Compensation Commission has made significant changes that have improved the claims process, there is evidence that the Commission should have greater control over the benefit costs. One of the reasons for implementing injury duration guidelines was to "*limit costs of indemnity benefits.*" However, the Legislative Auditor finds that 62% of lost-time claims that were filed under the new injury duration guidelines exceeded the guidelines. In most of these claims that exceed the duration guidelines, Workers' Compensation receives ample medical evidence from physicians to justify continued indemnity benefits. However, about 10% of lost time claims that exceed duration guidelines show evidence of: 1) Claimants not following their treatment plans completely; 2) Physicians having no medical explanation for claimants' pain; and 3) Claimants dictating to the physician when they will return to work. Also, physicians may be overly cautious in releasing workers to work because of potential lawsuits. Consequently, physicians may be liberal in providing return-to-work dates even though they indicate that claimants have reached nearly 100% maximum improvement.

Under the current law, when claims exceed duration guidelines without justification, all the Claims Department can do is request from the treating physician "*further justification as to why temporary total disability benefits must continue.*" Under the current law, regardless what the medical evidence indicates, if the physician indicates that maximum improvement has

not been reached by the claimant, temporary total disability (TTD) benefits will continue. If physiciansprovide a liberal amount of time before allowing the worker to return to work, or if physicians cannot explain why a worker is still in pain, Workers' Compensation simply pays the bill. **Therefore, expected duration guidelines will have limited effect in controlling indemnity costs under the current law.**

Under the current law, regardless what the medical evidence indicates, if the physician indicates that maximum improvement has not been reached by the claimant, temporary total disability (TTD) benefits will continue.

Furthermore, many lost-time claims are filed after the worker has returned to work. While this is currently not a major problem since most claims were for short durations, allowing claimants to file claims after they have returned to work could result in some claims having long injury durations that the Claims Department will have lost the opportunity to monitor or control.

Also, Workers' Compensation has one method to help control costs, the Independent Medical Evaluation (IME), which must be ordered when a claim exceeds 120 days of TTD Benefits paid. However, until the addition of medical staff, the backlog of IMEs was too high for them to be utilized effectively. Also, the Legislative Auditor found that IMEs are seldom being ordered for claims paying 120 TTD days or more, except for cases involving Permanent Partial Disability/Permanent Total Disability. By not ordering IMEs per code, Workers' Compensation is failing to utilize its primary tool for limiting costs.

Recommendations

1. The Legislature should consider amending the workers' compensation statute to allow the Workers' Compensation Commission to lower temporary total disability benefits in cases in which duration guidelines have been significantly exceeded and physicians are unclear as to the reasons for a claimant's long injury duration, or claimants do not appear to be fully complying with their treatment plan.

2. The Legislative Auditor recommends that the Workers' Compensation Commission begin tracking all temporary total disability claims over 120 days and requesting IMEs unless circumstances warrant otherwise.

3. The Legislature should consider disallowing claimants to file claims after they have returned to work.

Review Objective, Scope and Methodology

This is a Full Performance Evaluation of the West Virginia Workers' Compensation Commission. The Commission is responsible for administering the Workers' Compensation Fund. It was created in 1913, then established as a separate entity from the Bureau of Employment Programs in October 2003 with the intent "to provide superior customer service to West Virginia's employers, workers and medical community, emphasizing cost-effective safety, health and return-to-work programs."

Objective

The objective of this report was to examine the Claims Department of the Workers' Compensation Commission. In addition, the objective was to determine the effectiveness of the disability duration guidelines in limiting indemnity costs and claims management assistance.

Scope

The scope of this report focused on calendar and fiscal years 2000-2003 and provided some historical data for comparison and background purposes.

Methodology

The Legislative Auditor utilized several internet resources for national comparison, this included the National Academy of Social Insurance and the National Office of Workers' Compensation Programs. Comparable states were also contacted for specific information. The Legislative Auditor also requested individual case files from the agency, including a pre-sample of 30 claims, a random sample of 150 claims from 2002, and a smaller sample of 50 from June 2003. In addition, the Commission provided the financial information relating to individual claims. The Legislative Auditor also incorporated information from national health care publications. Every aspect of this review complied with the Generally Accepted Government Auditing Standards (GAGAS).

Issue 1

West Virginia's Workers' Compensation System Needs Greater Control Over Claims that Have Injury Durations that Significantly Exceed Reasonable Duration Guidelines and Have Questionable Medical Justification.

The Legislative Auditor's Office sampled 50 lost time claims that were processed under the newly implemented duration guidelines and found that 62% of the sampled cases exceeded the injury duration guidelines.

Issue Summary

In June 2003, the Workers' Compensation Commission implemented disability duration guidelines in an attempt to "*limit costs of indemnity benefits.*" These guidelines establish expected lengths of time for individuals to reach maximum recovery from various types of injuries. The Legislative Auditor's Office sampled 50 lost time claims that were processed under the newly implemented duration guidelines and found that 62% of the sampled cases exceeded the injury duration guidelines. The median length of time that the guidelines were exceed was 66 days and 24% of the claims exceeded the guidelines by more than three months (see Table 1).

Table 1
Percent of Lost Time Claims Exceeding Duration Guidelines by Days Exceeding

Days Exceeding Duration Guidelines	Percent of Total Claims*
Under 30 Days	14%
30-60 Days	16%
61-90 Days	8%
91-120 Days	8%
121-150 Days	10%
Over 150 Days	6%
Total Percent of Lost Time Claims that Exceed Duration Guidelines	62%
Median Number of Days Exceeding Duration Guidelines = 66 Days	

** Five claims remained open at the time of this report's release with the workers still off work and receiving temporary total disability payments.*
Source: Sample of 50 Lost Time Workers's Compensation Claims from June 2003.

The Legislative Auditor acknowledges that duration guidelines are just that, guidelines. Furthermore, in most claims that exceed the duration guidelines, Workers' Compensation receives ample medical evidence from physicians to justify continued indemnity benefits. However, about 10% of lost time claims that exceed duration guidelines show evidence of: 1) Claimants not following their treatment plans completely; 2) Physicians having no medical explanation for claimants' pain; and 3) Claimants dictating to the physician when they will return to work. Also, physicians may be overly cautious in releasing workers to work because of potential lawsuits. Consequently, physicians may be liberal in providing return-to-work dates even though they indicate that claimants have reached nearly 100% maximum improvement.

In these types of cases, Workers' Compensation has limited control over indemnity costs because by law as long as the treating physician states that maximum improvement has not been reached, temporary benefits will continue. The only step that Workers' Compensation can take in these types of cases is to order an Independent Medical Evaluation (IME). However, an IME is costly and may take months to arrange. Moreover, independent medical evaluators may be as hesitant to indicate maximum improvement has been reached as are treating physicians. The Legislature should consider amending the workers compensation statute to trigger reduced temporary total disability (TTD) benefits in cases that have limited justification for continued indemnity benefits. Under the current law, physicians and claimants have greater influence over indemnity costs than the Workers' Compensation Commission.

Under the current law, physicians and claimants have greater influence over indemnity costs than the Workers' Compensation Commission.

Disability Duration Guidelines

Since 1990, several corporations have developed guidelines on the length of time it should take for individuals to fully recover from various types of injuries. The benefit of injury duration guidelines are threefold:

1) they can help provide quality medical care by indicating the appropriate amount of time an injured person should be allowed to reach maximum recovery from an injury;
2) they can give physicians guidance in determining when an injured worker has reached maximum improvement and can return to work; and
3) they can assist insurance carriers in managing injury claims and controlling costs.

Insurance carriers throughout the country have gradually incorporated injury duration guidelines in their claims process. Duration guidelines provide efficiencies to the claims process in that when claims workers know expected

injury durations for each claim, they know which claims do not have to be monitored as frequently as cases with shorter duration guidelines. West Virginia's Workers' Compensation Commission implemented injury duration guidelines in June 2003, using the *Medical Disability Advisor*, published by Presley Reed, MD. The Medical Disability Advisor (MDA) is used by over 10,000 disability management practitioners. It has been developed through the collection of data representing more than 3.5 million workplace absence cases from a variety of corporations and government organizations. MDA covers hundreds of diagnoses codes and it provides minimum, optimum and maximum injury duration days for each diagnoses and by work classifications. The work classifications are sedentary work, light work, medium work, heavy work and very heavy work.

Incorporating the MDA guidelines this year is a major improvement for the Workers' Compensation Claims Department. However, disability duration guidelines were required by law to be incorporated in 1990. The current administration of Workers' Compensation does not know why injury duration guidelines were not incorporated earlier. The guidelines provide efficiency for the Claims Department in that claims with longer duration guidelines do not have to be monitored as frequently as claims with shorter disability guidelines. The duration guidelines also provide a red flag so that when claims significantly exceed the guidelines, claims adjusters can provide closer monitoring of those claims.

The duration guidelines also provide a red flag so that when claims significantly exceed the guidelines, claims adjusters can provide closer monitoring of those claims.

A Small Number of Claims Medical Reports Give Questionable Justification for Continued TTD Payments

In May 2003, the Workers' Compensation Commission announced the adoption of the optimum days according to the Medical Disability Advisor as the official guidelines for TTD benefits. The adoption was effective June 1, 2003. The adoption of the MDA guidelines had the stated goal to encourage quality medical care for all injured workers and limit the cost of indemnity benefits. The announcement also stated that:

> "*During the course of the claim, if the recommended period of disability is exceeded without just cause from the treating physician, the claims adjuster will request further justification as to why temporary total disability benefits must continue.*"

The above statement captures a major deficiency in the Workers' Compensation statute, which is that all the Commission can do in claims that exceed the expected duration guidelines check without justification is to

request from the treating physician "*further justification as to why temporary total disability benefits must continue.*" Under the current law, regardless what the medical evidence indicates, if the physician indicates that maximum improvement has not been reached by the claimant, TTD benefits will continue. If the physician provides a liberal amount of time before allowing the worker to return to work, or if physicians cannot explain why a worker is unable to return to work, Workers' Compensation simply pays the bill. **Therefore, expected duration guidelines will have limited effect in controlling indemnity costs under the current law.**

The Legislative Auditor observed through the sample of claims that the Claims Department makes its ruling on the compensability of claims within 14 days on average, which is within the 15 days as required by statute. The Claims Department also does well in many respects in monitoring claims and requesting documentation from physicians on the progress of claimants. It is noted that when claims exceed expected duration guidelines, claims workers send standard letters to physicians generally every two to four weeks requesting several items of medical information on the claimant. The Claims Department also employs a medical staff of 24 nurses, five part-time physicians and two full-time, in-house physicians who can understand the medical treatment plans, diagnoses and prognoses that are submitted. This procedure is necessary in order to encourage positive progress toward returning injured workers back to work. However, when physicians seem to have no explanation for why a claimant continues to experience pain, or when workers seem to have more say in when they will return to work, the Claims Department can only request further information the next month.

In the sample of 50 lost-time claims from June of 2003, the Legislative Auditor found 5 cases (10%) in which the justification for further temporary total benefits is questionable.

In the sample of 50 lost-time claims from June of 2003, the Legislative Auditor found 5 cases (10%) in which the justification for further temporary total benefits is questionable. However, given the current statutory authority, Workers' Compensation is limited in how it can limit the costs in such cases. Examples of these cases are illustrated below:

Case 1: One treating physician made several statements concerning a claimant that was not following her treatment plan consistently and appeared to be experiencing pain that could not be explained by objective medical evidence. The physician stated: "*I have asked her to improve her compliance with the physical therapy. She has only attended four visits with the therapist in the last 3 ½ weeks.*" The claimant also missed two physician's appointments. Also stated by the physician: "*I have told her that at nearly three months post injury, she should be much more functional by now and that we will need to taper off her narcotics.*" "*She still jumps with*

exaggerated pain behavior. It is my impression that [claimant's] subjective complaints outweigh her objective findings." The physician reiterated this statement on three separate occasions over a two month period, but the physician fails to return the individual to work. The optimal number of days for this claimant's injury was 14 days as indicated by the Claims Department; however, the claimant exceeded the guidelines by 135 days and was still off work at the time of this report's release. The claimant thus far received $3,200 in compensation and $5,429 was paid in medical costs.

Case 2: Over a two month period, a claimant's treating physician routinely states on the WC-219 and in the narrative reports that the claimant is able to return to work and is not temporarily and totally disabled. The treating physician routinely established the claimant's return-to-work date as either the same day of the office visit or the very next day; however, the claimant is paid for 56 TTD days by the Commission covering the entire two month period. The optimal number of days for the claimant's injury was 14.

The claimant dictated to the physician that she will not heal if she does not stop working and she is given three weeks off work.

Case 3: A claimant states that her wrist hurts her "*when she does a lot of heavy lifting and more complicated dental cases....she has purchased a wrist splint, which she has been using...while moving boxes.*" The claimant also tells the physician that she believes that she restressed the wrist while moving into a new home over the previous weekend. The claimant dictated to the physician that she will not heal if she does not stop working and she is given three weeks off work. However, after returning for a follow up visit, she informs the physician that she is planning to take another three to four weeks off work. The optimum number of days for her injury was 14. She exceeded the optimum number of days by 66 and received 80 days of TTD payments. The claimant received $8,068 in compensation and $730 was paid in medical payments. The concern in this case is that the claimant was determining how much time off from work would be needed rather than the physician.

Case 4: A claimant with a lower back injury had outpatient surgery. The treating physician examines him one month later. At this follow-up visit the physician states "he presents today with nearly 100 percent relief of his preoperative symptoms." However, the physician schedules his next visit (an exam to determine his ability to return to work) eight weeks later while the claimant continued to received TTD benefits. The claimant retired and did not return to work. He exceeded his disability guidelines by 119 days. The claimant received $10,009 in compensation. The issue one can take with this case is that

although it may be medically justifiable for the physician to give a worker three months total after surgery including one month of physical therapy, and then evaluate the worker for returning to work, Workers Compensation cannot object to the length of time the physician allows before he determines that the worker is ready to return to work.

Case 5: The treating physician states on a visit that *"x-ray examination...reveal healing at the fracture site."* However, the physician notes tenderness and waits two weeks for a follow-up visit to determine if the claimant is ready to return to work. At the follow-up visit the physician, again, notes "*x-ray examination reveals healing of the fifth metatarsal base fracture. There is no deviation of the fractured fragments. Upon examination there is tenderness... x-ray examination...reveal healing of the fracture."* The physician still keeps him off work for three weeks until another follow-up visit to determine if he can return to work. A total of five weeks elapse since the physician first states that the patient is healed. The optimum number of days for the injury was 21 days. The claimant exceeded the optimum number of days by 54 and received $5,644 in compensation and $782 was paid in medical costs. Again, the length of time the physician chooses before determining the return-to-work date cannot be objected to by Workers' Compensation, nor when the physician does not recommend the worker return to work on a trial basis. The claimant in this case was employed as a nurse.

The Legislative Auditor found that most claims that exceeded 120 days of benefits did not have an independent evaluation.

Independent Medical Evaluations Should be Ordered More Often to Control Costs

As part of a checks and balances system, West Virginia Code §24-4-7a(f) mandates that if TTD benefits continue longer than 120 days from the date of injury, the Workers' Compensation Commission is required to refer the claimant to a physician chosen by Workers' Compensation for an Independent Medical Evaluation (IME). The Legislative Auditor found that most claims that exceeded 120 days of benefits did not have an independent evaluation. A random sample of 150 claims from calendar year 2002 that contained 75 lost time claims revealed 10 cases extending 120 days in benefits from the date of injury. There was no evidence that Workers' Compensation ordered an IME. A second sample of 50 lost-time cases from June of 2003 revealed 11 claims that extended over 120 days from the date of injury with only one claim having an IME. The only evidence in reading through the case files that an IME was ordered was when a claimant was a candidate for permanent partial or permanent total disability, which is required by Code.

By not ordering IMEs in accordance with statute, Workers' Compensation loses the primary means it has to control claims costs. IMEs allow the Workers Compensation to seek a second opinion on whether a worker has reached maximum improvement, or an IME allows for a second opinion on the adequacy of the current treatment plan. The potential for these claims to run much longer than necessary is greatly increased. In addition, the costs of compensation and medical payments associated with extended disability claims has the potential to sky rocket without any means of control. In one case, an individual has been on TTD for 171 days. No IME has been ordered. After three months of treatment from one physician, the claimant goes to another physician to have him take his case because he doesn't feel his current physician is helping him. This case is still open at the time of this report's printing. Furthermore, in four cases an IME has been requested by a party other than Workers' Compensation. To date, there is no evidence that the IMEs have been arranged.

If claimants are allowed to file a claim after significant time off work, then the Commission's Claims Department cannot monitor these claims or seek justification from the physician for TTD benefits.

Many Lost-Time Claims Are Filed After Returning to Work

In the calendar year 2002 sample, 30% of lost-time claims were filed by claimants after the worker had already returned to work. For the 2003 sample, 14% of claims were filed after the return-to-work date. For these types of claims in 2002 and 2003, the average number of days off work was 9 days before filing a claim. This is not a particular concern because of the relatively short duration. However, if claimants are allowed to file a claim after significant time off work, then the Commission's Claims Department cannot monitor these claims or seek justification from the physician for TTD benefits. It is possible that in cases with long durations if the Claims Department is involved in the progress of the claim that some could be closed sooner.

Conclusion

The Workers' Compensation Commission has made significant changes over the last couple of years that have improved the claims process. Two years ago, medical staff was employed in the Claims Department who can understand the medical treatment plans, diagnoses and prognoses that are submitted. In addition, the Commission implemented duration guidelines that will also help the claims process and provide greater efficiency.

The Claims Department does well in monitoring claims and requesting medical information to justify continued TTD benefits. Most claims reviewed show that ample medical justification is provided by physicians to warrant continued TTD benefits. However, in a small number of cases, about 10%,

there is evidence that the Commission should have greater control over the benefit costs. These cases have indications that workers are not fully cooperating with treatment plans, physicians are unable to explain why claimants have not reached maximum improvement after long durations, or physicians may be providing liberal extensions of time for workers to reach maximum improvement. The Legislature should consider providing statutory authority to limit TTD benefits in such cases. Currently, the law only provides for the ordering of an Independent Medical Evaluation to limit costs in such cases. IMEs are expensive and time consuming to arrange.

In a small number of cases, about 10%, there is evidence that the Commission should have greater control over the benefit costs.

Workers' Compensation also has not used IMES primary tool to limit costs when they are appropriate and rquired by law. West Virginia Code §23-4-7a mandates that if TTD benefits exceed 120 days from the date of injury that the Commission have an IME for the claimant. The Commission does not use this tool adequately. Most claims that required an IME by law did not have one. Furthermore, many lost-time claims are filed after the worker has returned to work. The sample indicates that currently this does not present a significant problem since most of the claims were for relatively short periods of time on average. However, allowing claimants to file claims after they have returned to work could result in some claims having long injury durations that could present problems for the Commission.

Recommendations

1. The Legislature should consider amending the workers' compensation statute to allow the Workers' Compensation Commission to lower temporary total disability benefits in cases in which duration guidelines have been significantly exceeded and physicians are unclear as to the reasons for a claimant's long injury duration, or claimants do not appear to be fully complying with their treatment plan.

2. The Legislative Auditor recommends that the Workers' Compensation Commission begin tracking all temporary total disability claims over 120 days and requesting IMEs unless circumstances warrant otherwise.

3. The Legislature should consider disallowing claimants to file claims after they have returned to work.

Appendix A: Transmittal Letter

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Performance Evaluation and Research Division

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John Sylvia
Director

December 30, 2003

Greg Burton, Executive Director
Workers' Compensation Commission
4700 MacCorkle Avenue, SE
Charleston, WV 25304

Dear Mr. Burton:

This is to transmit a draft copy of the Full Performance Evaluation of the Workers' Compensation Commission. This report is scheduled to be presented during the January interim meeting of the Joint Committee on Government Operations. We will inform you of the exact time and location once the information becomes available. It is expected that a representative from your agency be present at the meeting to orally respond to the report and answer any questions the committee may have.

We need to schedule an exit conference to discuss any concerns you may have with the report. We would like to have the meeting on Monday, January 5, 2004. Please notify us to schedule an exact time. In addition, we need your written response by noon on Friday, January 9, 2004 in order for it to be included in the final report. If your agency intends to distribute additional material to committee members at the meeting, please contact the House Government Organization staff at 340-3192 by Thursday, January 8, 2004 to make arrangements.

We request that your personnel treat the draft report as confidential and that it not be disclosed to anyone not affiliated with your agency. Thank you for your cooperation.

Sincerely,

John Sylvia

John Sylvia

Enclosure

Appendix B: Agency Response

Insuring a Working West Virginia
Workers' Compensation Commission
Gregory A. Burton, Executive Director

4700 MacCorkle Avenue, S.E.
Charleston, West Virginia 25304
Phone: (304) 926-1710

January 8, 2004

John Sylvia
Joint Committee on Government and Finance
West Virginia Legislature
Building 1, Room W-314
1900 Kanawha Boulevard, East
Charleston, West Virginia 25305-0610

RECEIVED
JAN 08 2004
PERFORMANCE EVALUATION AND RESEARCH DIVISION

Dear Mr. Sylvia,

In response to the Full Performance Evaluation of the Workers' Compensation Commission dated December 30, 2003, we would like to provide the following:

ISSUE:

West Virginia's Workers' Compensation System Needs Greater Control Over Claims that Have Injury Durations that Significantly Exceed Reasonable Duration Guidelines and Have No Medical Justification.

Response:

Your report's review of Disability Duration Guidelines accurately reflects the benefits of using duration guidelines and correctly describes the Medical Disability Advisor as published by Presley Reed, M.D. There is great value in utilizing this type of system. There are some limits to the guideline that need to be kept in mind as we go forward.

> When the duration of disability significantly exceeds that published in the guidelines, a careful examination of the diagnostic accuracy is required. The disability period recommended by the guidelines varies significantly as we move from common simple diagnoses to more complex diagnoses. Failure to recover in the anticipated period of time should prompt serious look by the Office of Medical Management (OMM) and possibly a consultation to verify the diagnosis.
>
> The guidelines are developed from a large population database, which is not exclusive to industrial injuries and does not take into account the effects of age or co-morbidities. These factors may cause individual cases to fall outside the guideline for a given diagnosis. A careful review of each case may be needed. The impact of an aging workforce on return-to-work data may be particularly important.

The disability guidelines make some broad assumptions about the early treatment of injury. Failure to aggressively treat the early phase of the injury may lengthen the overall recovery time.

All things considered, these disability guidelines provide a valuable tool for claim management with the proper training, understanding and use. It is an ongoing project to incorporate these guides into our process.

ISSUE:

A Small Number of Claims Physicians' Medical Reports Do Not Justify Continued TTD Payments

Response:

We agree with the substance of this evaluation and feel that there is, at this time, an active plan to address many of theses issues. Several steps have already been taken to correct problems in this regard:

(1) Our OMM is actively involved in education programs for the health care providers in our state.
(2) Our Safety and Loss Teams are working to develop return to work programs to enable workers with restrictions to return to the work environment.
(3) The medical review process has been expanded. We now review approximately 2,200 2,500 claims per month for medical and treatment decisions.
(4) The claims teams are being re-organized, and there is greater integration of medical and rehab support for the claims process.

CASE REVIEWS

Case 1:

One treating physician made several statements concerning a claimant that was not following her treatment plan and appeared to be experiencing pain that could not be explained by objective medical evidence. The physician stated: *"I have asked her to improve her compliance with the physical therapy. She has only attended four visits with the therapist in the last 3 ½ weeks."* The claimant also missed two physician's appointments. Also stated by the physician: *I have told her that at nearly three months post injury, she should be much more functional by now and that we will need to taper off her narcotics." "She still jumps with exaggerated pain behavior. It is my impression that [claimant's] subjective complaints outweigh her objective findings."* The physician reiterates this statement on three separate occasions over a two-month period, but the physician fails to return the individual to work.

Response to Case 1:

There is evidence of the failure to adhere to treatment. Under the new rules, a claimant who fails to adhere to a treatment plan can have benefits suspended. Case one also indicates that there may be other issues that are impacting return to work. This is a case that in our current system would receive close review and would probably be referred out promptly for an Independent Medical Examination (IME) and possibly for a psychiatric/psychological evaluation. The Commission is regularly utilizing IMEs to evaluate issues of causality and compensability.

Case 2:

A claimant's treating physician states, on the WC-219 and in the narrative reports, that the claimant is able to return to work and is not temporarily and totally disabled, but the claimant fails to return to work. The treating physician, over a five-month period, routinely establishes her return to work date as either the same day or the very next day, but the Commission paid TTD Benefits for 56 days.

Response to Case 2:

This case suggests internal issues with claims management that would allow the claimant to continue to receive benefits, even though the treating physician has indicated that the claimant is not temporarily and totally disabled. This appears to be a claims management error. Changes in our claims handling will address the issues in case two.

Case 3:

A claimant states that her wrist hurts her "when she does a lot of heavy lifting and more complicated dental cases… she has purchased a wrist splint, which she has been using… while moving boxes." The claimant also tells the physician that she believes that she re-stressed the wrist while moving into a new home over the previous weekend. The claimant continues to dictate to the physician that she will not heal if she does not stop working and she is given three weeks off work. However, after returning for a follow up visit, she informs the physician that she is planning on taking another 3-4 weeks off work. She exceeded the optimum number of days by 66.

Response to Case 3:

This is a case, which today would receive close OMM review and probably would prompt a direct communication by phone with the treating physician to suggest a trial return to work. A second opinion consultation would be the appropriate action to address the delayed recovery. Also, the return to work may be compromised by the apparent lack of a modified duty program.

Case 4:

A claimant with a lower back injury had outpatient surgery. The treating physician examines him one month later. At this follow-up visit the physician states "he presents today with nearly

100 percent relief of his preoperative symptoms." However, the physician schedules his next visit (an exam to determine his ability to return to work) eights weeks later while the claimant continued to receive TTD benefits. The claimant retired and did not return to work. He exceeded his disability guidelines by 119 days. The issue one can take with this case is that although it may be medically justifiable for a physician to give a worker three months total after surgery to have physical therapy and then evaluate for returning to work, Workers' Compensation cannot object to the physicians treatment plan or the length of time the physician determines is necessary for the worker to be ready to return to work.

Response to Case 4:

The only recourse available to the Commission in this case would be an IME or consultant evaluation, however the individual social and economic issues of the specific situation with the pending retirement significantly impact the outcome.

Case 5:

The treating physician states on a visit that "x-ray examination… reveal healing at the fracture site." However, the physician notes tenderness and waits two weeks for a follow-up visit to determine if the claimant is ready to return to work. At the follow-up visit the physician, again, notes "x-ray examination reveals healing of the fifth metatarsal base fracture. There is no deviation of the fractured fragments. Upon examination there is tenderness… x-ray examination… reveal healing of the fracture." The physician still keeps him off work for three weeks until another follow-up visit to determine if he can return to work. A total of five weeks elapse since the physician first states that the patient is healed.

Response to Case 5:

This case reflects poor use of modified work status and requires better coordination of care by closer communication with the treating physician. An outside consultation may also be helpful.

ISSUE:

Independent Medical Evaluations Should be Ordered More Often to Control Costs

Response:

Your recommendations are fully supported by the Commission recognizing that paragraphs (b) and (d) of 23-4-7(a) permit discretion for the timing of an IME as individual medical results dictate.

There is currently a major redesign of the IME scheduling process underway and near completion. Stratification of requests by complexity and impact on return-to-work status is expected to greatly improve tracking and prompt evaluation. Furthermore, all IME scheduling will be monitored by the OMM, which will make sure that IMEs are scheduled with appropriate specialists and that clear communication of issues is performed.

An IME may not be medically appropriate at the 120-day window, however some claims can clearly be seen to require further treatment. Others may need consultations with outside specialists for second opinion input. These facts make it imperative that careful tracking of the IME requirement be done throughout the life of the claim.

ISSUE:

Many Lost-Time Claims Are Filed After Returning to Work

Response:

We concur that prompt filing of claims will result in overall better outcomes through early intervention and close monitoring. However, there are circumstances in which delay may not be within the control of the injured party. All parties must be encouraged to report claims immediately.

ISSUE:

Claims in Which the TTD Benefits Exceeded 120 Days

Response:

The nurses in the OMM reviewed the 21 files selected in detail. Below is a summarization of the findings of those reviews.

(1) All of the 21 cases did exceed the 120-day interval for payment of TTD benefits.

(2) No clear pattern emerged from review of these cases to suggest any single reason as predominately contributing to the claimant's delay in returning to work.

(3) Diagnostic accuracy emerges in several of these cases in which vague diagnostic criteria, initially attributed to the injury, later are discovered to involve more serious health problems, which affect the claimant's return to work by delaying really aggressive treatment.

(4) Several cases involved complex injuries involving multiple systems. The most serious of these included a closed head injury with subsequent neuropsych issues and pre-existing neuropsych issues that could not easily be sorted out.

(5) Several cases involved post-surgical complications, such as Complex Regional Pain Syndrome. Two cases were dominated by months of conservative treatment for what, eventually, turned out to be significant problems requiring surgical intervention. In two other cases, early management of the cases was not well documented and the claimants were allowed to go long periods of time without being seen by any physician, except a general practitioner. Eventually, the claimants in these cases did require more aggressive intervention, followed by physical therapy. Clearly, these factors contributed to the delayed recovery.

The OMM was not involved in review of some of these complex cases and it is felt that medical input may have been helpful, particularly in the case of one spine trauma that was reviewed, as well as in a case of a crush injury complicated by soft tissue infection.

As to the role of the IME schedulers, the IME unit, and the IME tracking process in-house, our comments are as follows:

(1) In twelve of the 21 cases reviewed, some element of the process of IME scheduling review and completion fell short of the standard we currently apply.

(2) In five cases, the IME process seemed to fall short as it arises from the claims teams. Cases were allowed to go on longer than appropriate without an automatic prompt to obtain an IME. There was also failure to review cases with the OMM or failure to follow recommendations made by the OMM or the claimant's treating physician to obtain an IME.

(3) In five cases, IMEs were requested but long delays in scheduling of these IMEs occurred followed by long waiting periods to obtain the IME and receive the report, which significantly added to the length of time until these cases were resolved. A closer look at these cases suggested that there were several situations where IMEs were scheduled but then canceled by the IME examiner and rescheduled at a later time.

(4) In only one case was the claimant found to not be at maximum medical improvement and there was no evidence of delay in the Commission's receipt of IMEs that were reported.

(5) One case appropriately used the value for impairment submitted by the treating physician. IME scheduling prior to January of 2003 seems to have been more delayed than any IME scheduling in the year of 2003.

CONCLUSION

We share your concern for the future of the West Virginia Workers' Compensation Commission. We appreciate your analysis and support your recommendations.

Sincerely,

Gregory A. Burton
Executive Director