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Medical Costs and How They Are Increasing the Costs of Your Claims[1]

I. Introduction

It has become axiomatic that the cost of workers' compensation claims has exploded in recent years, a trend that is not showing signs of slowing. What is interesting about this increase in costs is that much of it is now driven by the rise in health care costs, particularly when compared to the cost of indemnity benefits. Just as health care costs have risen exponentially, in other aspects of American life, they have become the "hidden" cost of the workers' compensation claim. Many studies suggest that they are now the greater cost of a workers' compensation case, and the cost that is most difficult to control. The claims professionals handling these cases must closely monitor the medical costs and become knowledgeable as to what the hidden costs are so that they can be controlled.

While indemnity costs still continue to rise, those costs are fixed by statute. Each state has its own way of calculating wage loss benefits, and the carrier knows how and if those costs can be capped in a given jurisdiction. Knowing what the indemnity exposure is helps the insurer accurately set its reserves and gives the carrier an educated idea as to how much that part of the claim will cost. There is no such calculation available for the health care costs of a claim.

Part of the reason for the high costs of medical bills in workers' compensation cases is historical. Traditionally, the workers' compensation system was one of the last areas where health care providers received dollar for dollar reimbursement for treatment. Many providers used the workers' compensation system as a way for making up for other income which had been capped by insurers. While insurers no longer pay for 100% reimbursement of costs, health care providers often receiver greater reimbursement for treating workers' compensation claimants than they do for treating "regular" patients. This creates little incentive for medical providers to reduce treatment and actually creates a tremendous economic incentive for them to increase the treatment that injured workers receive.

The challenge for the workers' compensation carrier is to recognize that these incentives to over-treat workers compensation patients do exist and to be aware of trends in treatment so that they can monitor treatment. It is important to remember that medical costs consist of many components, and each component should be closely monitored. These components include doctor visits, emergency room visits, diagnostic studies, prescription drug charges and physical therapy. While the insurance professional may not be able to cap treatment, being aware of the hidden pitfalls will help to keep costs under control. This type of analysis will help to keep medical costs under control.

II. Panel Facilities

While many carriers and employers think of the facilities which are on their panel list as places where they save money, these treatment centers can also be a source of hidden and unexpected costs. The panel facilities are places that the employer has recommended be used by its injured workers. It is important for carriers to remember that the panel is often charging for each visit and for the types of treatment that the injured worker receives. The panel facility often includes a physical therapy center and may include a place where diagnostic testing is done. These companies are profit making businesses. While they do provide services for employees at a reduced cost, they also charge for each visit. Claim professionals need to be aware of what their charges are and monitor those costs.

In the past few years, many states have enacted laws which require the injured worker to treat with an approved panel facility for a given period of time. The purpose of these laws was to control costs at the outset of a claim by essentially controlling the treatment that the claimant receives. The theory is that this limitation would keep the injured working from finding his own doctor, who theoretically was more likely to recommend that the employee not return to work.

While the development of these holding periods has helped to reduce indemnity costs by encouraging more people back to work at an earlier stage of the claim and has helped to direct the medical treatment, it is important to remember that an injured worker only has to treat at these facilities for a finite period of time. The claimant knows this and the panel facility knows it. This creates an inherent tension, as the panel facility is aware that in all likelihood the claimant will only be treating with them for a fixed period. The tension develops as the facility obviously wishes to maximize its profits, so it has an incentive to maximize the amount of treatment provided to the claimant.

One of the best ways for the insurer to reduce or eliminate this tension is by developing contracts with the panel facilities whereby they receive a fixed amount of money per year and income is not determined by how often or what types of treatment the claimant receives. In the event that this is not possible then the carrier needs to be aware of the costs associated with each of its panel providers, so that a determination can be made as to which facilities provide the best service (help the worker to reach maximum medical improvement at the earliest stage) and with the least amount of costs.

III. Emergency Room Visits

Many health insurers report that one of the main drivers of high medical costs in the United States is the excessive use of emergency rooms. Many people use the emergency room as a provider of primary care. Workers' compensation claimants are no different in this regard, as they frequently use the emergency room to provide relief for acute care that is not an emergency.

Hospital emergency rooms have a mandate to provide quality care to whoever comes for treatment. While emergency visits are often necessary as the first line of treatment following a work injury. They are not necessary, however, for flare-ups of existing injuries which are the results of the work injury. When carriers are dealing with an injured worker who goes to the emergency room because of persistent knee or back pain for which she is all ready receiving treatment, she will in all likelihood be subject to a battery of diagnostic testing such as x-rays, CAT scans and MRI studies despite the fact that she may have had these same tests done by the panel facility and/or her treating doctor at the outset of the claim. Once the claimant enters the emergency room the carrier is responsible for those costs even if it has already paid for those same studies elsewhere.

What this means is that the claim professional must do everything possible to eliminate the likelihood that the employee will go to the emergency room as a means of follow up treatment. One way of doing this is by increasing communication with the claimant. The claims professional should have a diary system in place to ensure that so that he/she is frequently in contact with the claimant to see how the claimant is feeling and how the treatment is progressing. Having this communication will help to subtly direct treatment, which in turn may result in fewer expensive and potentially unnecessary emergency room visits.

If pending claim levels inhibit the claim handler's ability to have ongoing communication with the client, then on those cases which appear to be either medically complicated or where the claimant appears to be "needy," one option may be to consider using a nurse case manager. The nurse case manager will then maintain the necessary contact with the claimant and help with managing treatment and reducing the "need" for emergency room visits.

IV. Diagnostic Testing

Diagnostic testing often generates significant costs in a workers' compensation case. It therefore presents an area where insurers must work hard to monitor their costs. There are different courses of treatment and different generally necessary testing procedures that are appropriate and necessary based on the underlying injuries. Below will be a discussion of some of the general issues seen in treatment of some of the most common workplace injuries involving an employee's back and knees.

For example, if a person sustains an acute injury such as a low back injury, it is reasonable to expect that person to have a set of x-rays to the lumbar spine. While this is necessary and expected, x-rays to the cervical spine and thoracic spine are probably not reasonable or necessary. The carrier will probably not be able to control what is done at the first visit to the emergency room, but carriers can generally explain to panel facilities that the carrier wishes to see diagnostic studies only to the effected body part unless there is a compelling reason to conduct a broader analysis. Make it clear that panel facilities should ask the emergency room for copies of any studies that were done. This is significantly cheaper than having new studies done which are not unnecessary and duplicative.

If this same worker with the injured back he continues to have lumbar pain, then a reasonable course of treatment could be expected to include an EMG and/or an MRI study. It is important, however, to note that EMGs are generally not recommended immediately following a nerve injury, as nerve damage takes at least three weeks to appear on an EMG. Further, once the claimant has an EMG or an MRI, then he/she does not need to have these studies repeated unless surgery is being contemplated. Upon seeing the first set of test results, the nurse, claim handler and defense attorney should discuss whether surgery is an appropriate option for the injured worker. If surgery is not an option, then there is no medical reason for another MRI to the same body party more than one time within a year. While the cost of this procedure may vary from region to region it is an expensive procedure, and one that should only be used when necessary.

The knee is another part of the body which is often subject to excessive diagnostic testing. If a person has a knee injury, the typical first line of diagnostic testing is an x-ray. If the x-ray shows degenerative arthritis and that diagnosis is consistent with the clinical examination, then an MRI may not even be necessary. If the x-ray suggests that the knee injury is more likely a ligament tear, then an MRI would be appropriate.

The third treatment step for a knee usually involves arthroscopy. It is here that the claims handler must be cautious and question the procedure before approving it. Many people with knee injuries, particularly those who are middle-aged, have preexisting conditions and the work injury may have

only exacerbated a preexisting problem. Before approving an arthroscopy, in this instance the claim handler should first try to determine if the work injury created a temporary flare-up of an issue which has since resolved. If that is the case then the carrier should not pay for a procedure which is unrelated to the work injury.

The other problem with arthroscopy is that it can also be used for diagnostic purposes only, rather than simply to fix a known injury. If a doctor suggests that he/she wants to do an arthroscopic procedure the claim handler must determine the reason for the procedure. Is the doctor simply trying to look at the knee internally? Is the doctor trying to fix a particular problem? Are there multiple problems with the knee and if so, are they all a result of a work injury?

A further ethical problem exists for surgeons who begin an operation in to repair a meniscal tear and then see during the procedure that the Anterior Cruciate Ligament also needs to be repaired. Does the Hippocratic Oath require the doctor to fix both the meniscus and the ACL while surgery is underway? Even if this is the case, there is insurance obligation under the worker's compensation program requiring the carrier to pay for services unrelated to the workplace injury. The claim handler should ensure that that the carrier does not pay for the total surgery and its associated costs (e.g. anesthesiology). The claim handler should identify the worker's private health insurer, and make sure that the costs are appropriately apportioned between the parties.

The costs of diagnostic tests can add up very quickly. This makes it necessary for the claim professional become involved in reviewing the projected course of treatment, closely monitor the types of tests that are being proposed by the treating facility, and carefully review and approve and the frequency of the proposed tests.

V. Physical Therapy

Physical therapy is often the treatment area involving the largest costs. It is very easy for an injured worker to incur significant charges when undergoing physical therapy. These treatments can occur three times a week, and often include bundled charges. The treatment may include a number of different modalities, each of which may be charged at a different rate.

Keep in mind that physical therapy is to be prescribed by a physician but it is supposed to be performed by a licensed physical therapist. It is designed to address an acute problem with a specific set of exercises. It should have concrete goals, such as to increase function or flexibility, and is not supposed to last for years. At each visit the therapist is supposed to record what exercises are done; the frequency of the exercises; and the success of the visit. Any other therapist who picks up the records should to be able to understand what treatment has been done; and the efficacy of that treatment. When physical therapy bills are received care should be taken to ensure that they are appropriately documented and that the facility is using established medical protocols. If the facility is not providing the necessary information to make this determination, then the claim handler can consider denying these bills or at the very least challenging them.

The claim professional handling these types of cases can expect submitted invoices to include traditional treatments such as massage and chiropractic manipulation. However, many physical therapy centers are now conscious that carriers are reviewing the necessity and frequency for these standard treatments, and may therefore switch to less conventional treatments in order to maintain a higher billing level. These newer, less traditional treatments may include items such as Moxibustion (a traditional Chinese therapy which uses the mugwort herb), Vax-D (Vertebral Axial Decompression) and TMR (therapeutic magnetic resonance). Vax-D in particular produces significant revenue a physician. The treatment consists of the use of a traction device and may be given 5 to 6 times a week at a significant cost. It is therefore important for the claim professional

handling these cases to be aware of the controversial nature of some of these treatments and to be ready to use the appropriate review protocol in his or her state to challenge that treatment.

VI. Conclusion

There is no doubt that medical costs are rising, and there is no way of knowing how the new health care legislation is going to impact health care costs. However, as certain areas of medicine become more regulated it is likely that the medical profession will seek to shift costs to other areas where they can receive the greatest payment possible. It is therefore incumbent upon the claims professional who handles workers' compensation cases to make certain that those costs are not shifted to his or her files.

For additional information or analysis about any of the subjects contained within this edition of the Bulletin, please contact the author directly.

The opinions and interpretations expressed by the authors of the articles herein are their own and do not necessarily reflect those of the Co-Editors or the ACE Group.

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