Utilization Management in Workers' Compensation: *A Strategy to Improve Quality While Managing Costs*

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Case management is a service that has been provided in the workers' compensation arena for more than 40 years. Still, the governing laws and insurance aspects of the workers' compensation system present the case manager with a unique set of challenges and opportunities.

Workers' compensation is a social insurance concept developed to provide no-fault coverage for defined benefits available to employees who have been injured on the job. In general, employers are liable for occupational injuries (and certain illnesses) incurred in the course of employment, without regard to the party at fault. Unlike all other social insurance programs in the United States, the federal government has limited involvement in workers' compensation programs; this includes a few select programs for longshore workers, miners, railroad workers, and federal employees (Lencsis, 1998). Therefore, each jurisdiction (i.e., state or territory) creates its own benefit program on the basis of the legislative mandates, including what is covered, what is excluded, and how providers are reimbursed.

Coverage for workers' compensation benefits is afforded through several options. There are insurance carriers who provide traditional insurance by offering premiums to employers who can purchase coverage. In certain states, there are state funds that function as state-owned and operated workers' compensation insurance companies. Some of the state funds are competitive, meaning that traditional insurance coverage is also available. Others are monopolistic, which means no other forms of insurance are available. In addition, some jurisdictions allow for self-insurance, whereby an employer can assume the risk for workers' compensation coverage. Typically, employers must meet specific funding and administration requirements to qualify. There are also newer forms of managed care available in some workers' compensation jurisdictions that allow entities such as health maintenance organizations and risk-bearing provider groups to extend coverage.

Case managers must accept accountability for provider outreach and patient education concerning insurance coverage. It is imperative that case managers have access to resources that provide compliance assistance and other necessary information so that interpretation of benefits can occur with ease. The following two Web sites can be helpful in accomplishing this task: http://www.dol.gov/esa/regs/compliance/owcp/wc.htm and http://www.comp.state.nc.us/ncic/pages/all50.htm#dol

One distinguishing feature of most workers' compensation programs is that the covered benefits include an allowance for medical care and back-to-work rehabilitation services, disability payments, and other benefits. For instance, in addition to covering medical services to treat the occupational illness or disability, workers' compensation typically pays for time loss (also known as wage loss or indemnity) for injured workers who have such severe occupational injuries that they cannot return to work for a period of time. Another common benefit under workers' compensation is a *settlement*, which gives an injured worker who sustains some form of permanent disability and corresponding limitations a monetary award at the time of claim closure. Although the administration of this benefit depends on the jurisdiction, workers' compensation payers are concerned about controlling what they call their exposure to large monetary settlements. These payers have typically turned to case managers to assist them in controlling costs.

The wide variation in workers' compensation coverage and benefits by jurisdiction results in a myriad of regulatory requirements that create challenges not only for case managers, who are likely to handle cases from multiple jurisdictions, but also for other involved parties (e.g., injured worker, employer, provider(s), and payer). As soon as possible, the case manager must establish a position of patient advocacy and assist the injured worker with putting things into perspective so that mutually agreed-upon goals can be established. The employer, too, must display a genuine interest in the injured worker. The case manager should encourage positive communication between the employer and the employee because this provides assurance of the worker's importance to the company. Employers who are willing to work closely with providers and case managers to develop transitional work plans are more likely to be successful with return-to-work efforts.

Return-to-work efforts and employability of the injured worker may be coordinated by a vocational rehabilitation counselor or other similarly qualified professional. The case manager needs to be aware of the vocational issues while managing

the case and must remain knowledgeable about the usual procedures followed and the applicable jurisdictional requirements for the injured worker. Because workers' compensation typically provides coverage for both medical expenses and time loss payments, the case manager has three key goals that are as follows:

- control or manage medical costs,
- mitigate the impact of the occupational injury on the injured worker's ability to return to work or become employable, and
- reduce the overall impact of the occupational injury to diminish the exposure for the settlement.

The National Council on Compensation Insurance Inc. has reported that the double-digit growth in medical costs in recent years has pushed the medical share of total workers' compensation benefits to all-time highs, and has made it the leading cost driver of workers' compensation rates in many states (Klingel, 2005). During the course of their work, case managers are expected to assist with managing the medical costs for injured workers, which requires the application of core case management skills such as communication, facilitation, coordination, advocacy, and monitoring. Regardless of the source of the referral, case managers must always remember their role and function in promoting proactive, collaborative, and positive interactions with all involved stakeholders. Although the workers' compensation system has been known to be adversarial at times, the case manager can help reduce the animosity by maintaining professionalism and adhering to nationally recognized standards of practice. The health and safety of the injured worker must always be paramount.

One traditional form of medical management has been the use of independent medical examinations (IMEs). The IMEs may involve a single physician or several physicians, representing applicable specialties, depending on the medical condition(s) of the injured worker. DiBenedetto (2008) indicates that the IME may be arranged by the payer to "confirm, rebut, or supplement medical findings offered by the injured worker's chosen physician or other provider."

The case manager may be involved in facilitating the referral for the IME and must be judicious in selecting and coordinating the referral (Brabham, Mandeville, & Koch, 1998). The IME may also be used toward the end of the active medical treatment phase of the case to obtain an independent opinion regarding injured worker's level of disability.

The IME involves review of the appropriate clinical records as well as the physical examination of the injured worker. There is typically little or no direct communication between the IME panel and the attending physician. At the completion of the review and evaluation, the IME physician or panel produces a written report that describes the examination findings and treatment recommendations. Generally, guidelines or criteria for medical treatment are not utilized; however, the IME panel may apply disability rating guidelines. There is some evidence that case managers may be overusing IMEs as well as other forms of medical treatment of complex medical cases (Kelley, 2008). There are also applicable regulations that impact the use and frequency of IMEs that must be considered (DiBenedetto, 2008).

Utilization management (also called utilization review) evaluates the medical necessity, appropriateness, and efficiency of the use of healthcare services, procedures, and facilities under the provisions of the applicable health benefits plan (URAC, 2006). Utilization management reviews may be conducted through multiple channels, including telephone, fax, and the Internet. Providers typically submit these review requests to utilization review organizations (UROs) along with the clinical information needed to justify the requested healthcare service. There are three primary types of reviews performed:

- Prospective reviews—conducted before the service is delivered, primarily for elective surgeries and services
- Concurrent reviews—conducted to evaluate ongoing services, such as reviewing ongoing hospital days or therapy visits
- Retrospective reviews—conducted after the services have been rendered

In the largest study of the roles and functions of case managers in the United States (Tahan, Huber, & Downey, 2006), utilization management was identified as one of the six essential activity domains of case managers. This study included case managers in a variety of settings, including, but not limited to, those in the workers' compensation system. This was the first evidence-based demonstration that utilization management is a critical part of case management practice. Thus, it is the expectation that case managers understand and apply best practices in utilization management processes.

Clinical guidelines (also called medical necessity criteria or clinical protocols) are used as the key tools in the utilization management process and are expected to be based on professional practice and literature-based evidence (URAC, 2006). The utilization management process is similar for all review types. The case manager (or some other nonphysician clinical reviewer) screens for medical necessity

by applying the applicable clinical guideline.

If the case meets the guideline, then it is certified and the claims manager is notified. When the case does not meet the guideline, there should be an attempt to reach out to the requesting provider to obtain information that may lead to certification. If additional information is not made available, then the case is referred to a physician for clinical peer review. The physician reviewer offers a peer-to-peer discussion with the attending physician to garner further clinical rationale for the requested service. The physician reviewer renders a decision after this conversation, which may result in certification or noncertification for the requested service. The claims manager is notified of the physician reviewer's decision, including clinical rationale for a noncertified case.

Although there are some mixed findings from utilization management, many payers continue to employ this strategy to control costs and service utilization. Recent studies on utilization management indicate that utilization management denials are now around 2%–3%, with concurrent reviews reducing hospital stays by 5%–10% (Flynn, Smith, & Davis, 2002). In Washington State, there is evidence indicating that using guideline-based protocols while conducting utilization management reviews can improve the effectiveness of the program by identifying potentially inappropriate care, especially thoracic outlet syndrome surgery and lumbar fusion (Wickizer, Franklin, Gluck, & Fulton-Kehoe, 2004). Despite the evidence that utilization management can control costs, there are indications in the state of California that utilization management negatively impacts physician perceptions regarding access to quality care in that state's workers' compensation system (Pourat, Kominski, Roby, & Cameron, 2007).

All of these indicators provide case managers with the opportunity to demonstrate leadership through collaboration with providers and other stakeholders when performing all medical management functions, especially utilization management. Although providers may

TABLE 1
Comparison between Utilization Management and Independent Medical Examinations

Utilization Management	Independent Medical Examinations
Communication and interactions	
Direct communication with providers about the clinical rationale for the requested services	Evaluation performed through interviews conducted with the injured worker
Limited or no interaction with injured worker	Little or no direct communication with attending physician; communication occurs through exchange of medical records
Goals	
Evaluate the medical necessity of requested services	Evaluate general medical needs and injured worker's clinical condition, including possible review for causality
Referrals	
To review a specific episode of care such as hospitalizations	To review the overall treatment plan
Process and procedures	
Review of clinical information in medical record with no physical examination	Review of clinical record
Standardized process with use of specific clinical guidelines or criteria to screen the specific medical service	Physical examination of injured worker by one or more physicians, depending on the medical condition(s)
Nonphysician clinical reviewers (e.g., nurses and therapists) apply guidelines and criteria to screen for medical necessity	Variation in process depending on injured worker characteristics, rarely are explicit clinical guidelines or criteria applied
Only those cases not meeting the guidelines or criteria are sent for physician peer review	Physicians almost always involved in each case
Physician peer review offers a direct telephonic conversation with the attending physician	Little or no direct telephonic communication between the IME physician and the attending physician
Report or letter documents the outcome of the review process indicating whether the service is certified and the number of certified units of care (e.g., number of hospital days or therapy visits)	Written narrative report documents the results of the medical evaluation and record review

consider utilization management to be administratively burdensome and a barrier to healthcare access, the case manager can intervene with the provider to help ensure that the injured worker receives timely and medically appropriate treatment. Possible interventions by the case manager might include:

- providing education for the provider about the utilization management process,
- describing and distributing the clinical guidelines and criteria to the provider, and
- facilitating communications between the provider and the claims manager regarding the utilization management review recommendations.

Payers, too, have a responsibility to the healthcare providers who deliver services to their beneficiaries. Provider outreach has proved to be a critical component in the delivery of timely and appropriate healthcare. The more familiar providers are with the system, the greater the likelihood that injured workers will be promptly and safely returned to their employer of injury.

Some payers are enlisting the services of UROs to assist not only with medical necessity review and case management services but also with provider outreach and program education. Utilization review organizations may accomplish this by inviting providers to educational seminars, conducting webinars, or by providing Web-based information sources. All these methods are excellent means by which to expose providers to resources that help them better understand program requirements.

Strategic alliances between payers, UROs, and healthcare providers have resulted in the identification of potential opportunities for program enhancements. Increased efficiency is a mutual goal and direct provider feedback is encouraged. Extensive data is collected through the utilization management process. The data are used to study trends, evaluate program impact, and identify superior provider performance. This may lead to reduced utilization management requirements for providers who demonstrate excellent healthcare delivery, as evidenced by consistent recommendations to certify requested services, or pay-for-performance incentives.

Table 1 contains a comparison between key aspects of utilization management and IMEs that highlights the similarities and differences between these two medical management strategies.

Both of these can be useful depending on the circumstances of the case. Workers' compensation programs have been adopting utilization management as an effective way to control costs and actually improve quality. This presumes that case managers are using standardized processes as well as evidence-based utilization management guidelines. As one health policy expert indicates (Harris, 2006), "care managers, whether adjusters or nurses, should have an adequate fund of knowledge and access to evidence-based guidelines and criteria to make payment and case management decisions that are consistent with evidence of effectiveness." This will require case managers to focus on controlling costs, improving quality, advocating for injured workers, establishing a solid relationship with the healthcare provider(s), increasing knowledge and skills, and adhering to professional practice standards.

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