Welcome to the Spring 2012 edition of Pyramid. The goal of this publication is to keep our readers informed and up to date on trends in the workers’ compensation and disability markets.

Our industry has certainly seen its fair share of change since its inception in the early 1970s and GENEX has been no stranger to change over the years. We believe in staying abreast of industry trends, developing innovative products and services, and positioning our company to meet the needs of the market.

In this issue, we take an inside look at Catastrophic Case Management and how our long-tenured case managers handle critical care situations. Also featured are articles on opioid abuse, mental health stigmas, return-to-work challenges, and a column by one of GENEX’s Choice Network providers.

I look forward to communicating with you in future issues of Pyramid.

Best regards,

Peter C. Madeja
Top 5 workplace injury causes make up 72% of direct workers comp costs: Analysis

The five leading causes of workplace injuries drive nearly 72% of the nation’s direct workers compensation costs, according to research released Tuesday by Liberty Mutual Group Inc.

Overexertion—or injuries caused by lifting, pushing, pulling, holding and carrying—costs businesses $12.75 billion in direct annual expenses and accounts for more than 25% of the national burden, according to Liberty Mutual’s Workplace Safety Index.

The index, compiled by the Liberty Mutual Research Institute for Safety, relies on data that researchers collected on injuries causing at least six missed days of work.

2009 data

Injury types are ranked by total workers comp costs with the latest findings culled from 2009 data compiled from Liberty Mutual claims, the Bureau of Labor Statistics and the National Academy of Social Insurance.

“Fall on same level” ranks as the No. 2 cause of disabling injury that drives direct costs of $7.94 billion, or 15.8% of the total injury burden.

The other three leading causes of workplace injuries include:

- Fall to lower level, which caused $5.35 billion in costs.
- Bodily reaction—defined as injuries from bending, climbing, reaching, standing, sitting, and slipping or tripping without falling, which drove $5.28 billion in expenses.
- Struck by object, which accounted for $4.64 billion in costs.

Top 10

Injuries that round out the top 10 causes are highway incidents, “caught in/compressed by” mishaps, struck against object, repetitive motion and assaults. Each category accounted for less than 5% of the direct cost of disabling injuries in 2009.

Overall, the top 10 cause categories accounted for 89.3% of the entire cost burden of disabling work-related injuries in 2009.

Liberty Mutual also found that after adjusting for inflation, the overall direct costs of disabling workplace injuries decreased 4.6% in 2009 compared with 1998.

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WCRI Study Shows Hospital Outpatient Costs Higher in States without Fee Schedules

As legislators slash state budgets due to rising healthcare costs, a recent study, Hospital Outpatient Cost Index for Workers’ Compensation, by the Workers Compensation Research Institute (WCRI) provides policymakers and other stakeholders with a tool to identify and better understand hospital costs.

CAMBRIDGE, MA (PRWEB) JANUARY 10, 2012 — As legislators slash state budgets due to rising healthcare costs, a recent study, Hospital Outpatient Cost Index for Workers’ Compensation, by the Workers Compensation Research Institute (WCRI) provides policymakers and other stakeholders with a tool to identify and better understand hospital costs.

“Rising hospital costs have been a concern and focus of recent policy debates in many states. To manage this growth, WCRI has created a tool to help public policymakers and business decision makers compare hospital outpatient costs across states, identify key cost drivers, and measure the impact of reforms,” said Dr. Richard Victor, Executive Director of WCRI.

One of the most significant findings from the study shows states without fee schedules have higher hospital outpatient/Ambulatory Surgical Center (ASC) costs for common surgeries compared to states with fee schedules. The costs in states without fee schedules were 27 percent to 73 percent higher than the median of the study states with fee schedules.

In addition, states with fee schedule regulations that were based on a percentage-of-charges had higher costs compared to states with other types of fee schedules, such as per-procedure based or ambulatory payment classification (APC) based fee schedules, with the exception of Illinois.

The study also noted that after fee schedule changes, growth in hospital outpatient/ASC costs resumed at faster rates in states with fee schedule regulations that were based on a percentage-of-charges. An example of this is California and Florida who both enacted fee schedule reforms around the same time, but the APC-based fee schedule in California constrained cost growth more than the percent-of-charge-based fee schedules in Florida.

Significant variations in hospital outpatient/ASC costs were also found across states. Compared with the 17 state median, the average hospital outpatient/ASC cost per surgical episode in Massachusetts—the state with the lowest costs—was 60 percent lower than the median study state, while the average cost in Illinois—the state with the highest costs—was 45 percent higher, as of 2009.

WCRI’s study measures hospital outpatient/ASC costs actually paid over a seven year period from 2003 to 2009. It focuses on services that are associated with the most common surgeries performed in workers’ compensation cases since surgery-related costs make up approximately 60 to 70 percent of all outpatient costs.

The states included in the study, which represent 60 percent of the workers’ compensation benefits paid in the United States, include: California, Florida, Illinois, Indiana, Iowa, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, New Jersey, North Carolina, Pennsylvania, Tennessee, Texas, Virginia and Wisconsin.

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THE 10 MOST DANGEROUS JOBS IN AMERICA

1. Fishermen
2. Logging workers
3. Airplane pilots and flight engineers
4. Farmers and ranchers
5. Mining machine operators
6. Roofers
7. Sanitation workers
8. Truck drivers and delivery workers
9. Industrial machine workers
10. Police officers

Source: Oregon’s Department of Consumer and Business Services

The Top 10 Most Expensive States for Workers’ Comp

1. Montana
2. Alaska
3. Illinois
4. Oklahoma
5. California
6. Connecticut
7. New Jersey
8. Maine
9. New Hampshire
10. Alabama

Source: Oregon’s Department of Consumer and Business Services
Employers helping workers fight opioid abuse

By Sheena Harrison, Business Insurance

With opioid prescription abuse on the rise nationwide, workers compensation experts are seeking ways to help addicted workers return to sobriety.

Insurers, brokers and third-party administrators say they’re working with primary physicians to help wean claimants off Schedule II narcotics, such as oxycodone and methadone, if they start to develop a dangerous dependence on such drugs.

Some companies also are creating strategies to assist workers who already have become hooked in hopes of preventing opioid overdoses and deaths, as well as containing medical claim costs.

“A number of employers are looking at different ways to intervene earlier in the process,” said Nancy Decato, Los Angeles-based managing director and West zone practice leader for claims consulting with Marsh Risk Consulting.

Brokers such as Marsh and Lockton Cos. L.L.C. and insurer Liberty Mutual Group Inc. say “peer-to-peer” physician reviews are a standard in workers comp to help doctors head off addiction problems before they become too serious.

In such cases, a company’s medical director or another medical professional will review workers comp claims that appear to have excessive opioid dosages or prescription refill rates. From there, the medical director would talk with the claimant’s treating physician to create a plan for using a lower amount of such medications or transitioning an injured worker to less addictive prescriptions.

Physician peer review is one of the first steps for Liberty Mutual in helping workers comp patients who are in danger of dependence, said Dr. Constantine Gean, regional medical director for Liberty Mutual in Glendale, Calif.

“We try to work with primary care specialists when we can and give them options,” he said.

Such reviews are advantageous because they provide professional guidance for doctors who may not have much experience in safely prescribing opioids, said Keith Rosenblum, senior risk consultant with Lockton in Kansas City, Mo.

“When clinicians contact them and discuss it, (doctors are) quite open,” Mr. Rosenblum said.

Outside of early intervention, some workers comp experts are looking for ways to assist workers comp claimants who have developed opioid dependence.

For the last six months, TPA Broadspire Services Inc. has worked to create a chronic pain management program that targets opioid concerns in workers comp. The program, which has not yet been named, is being created in part to address the growing opioid epidemic, said Dr. Jacob Lazarovic, Broadspire’s chief medical officer in Sunrise, Fla.

“We wanted to make sure that we were getting the right treatment for the right person,” he said.

Atlanta-based Broadspire has a team of medical professionals who review difficult workers comp claims twice a week and craft specialized treatment plans. The company also performs regular physician peer reviews and analyzes other patient data for signs of opioid trouble.

If a patient has risk factors for dependence, such as depression, Broadspire’s team may recommend cognitive behavioral therapy or other treatments to help a claimant reduce his or her need for opioids, Dr. Lazarovic said.

“You can’t always eliminate pain,” he said. “You have to minimize it and help people cope with it. CBT is one way to do that.”

Broadspire’s medical team also connects some claimants
with addiction treatment specialists who use medications to wean injured workers off dangerous drugs, Dr. Lazarovic said.

Dr. Thomas Jan of Massapequa, N.Y., is on the front lines of such assistance. He specializes in physical therapy, as well as pain management and prescription addiction treatment. About 30% of Dr. Jan’s addiction patients are workers comp claimants, he said.

Much of Dr. Jan’s work focuses on using the medication buprenorphine to help patients become less dependent on opioids. The drug works by blocking the ability of powerful narcotics to produce a “high” feeling in patients.

Workers comp carriers have been willing to cover patients’ addiction treatment, including outpatient rehabilitation programs, Dr. Jan said. He believes insurers are amenable, in part, because their employees — namely claims adjusters — are saddened and frustrated by cases where claimants become hooked on opioids.

“Instead of hearing horror stories, they’re starting to hear solutions,” Dr. Jan said of how insurers view addiction treatment.

Dr. Gean of Liberty Mutual said the insurer has been willing to cover addiction treatment similar to what Dr. Jan provides if early intervention methods aren’t immediately effective for workers comp claimants.

“If a specialist is needed, it really behooves the insurance company and the patient to have that done as quickly as possible,” he said.

The main challenge to treating addiction or dependence is that the patient has to be willing to receive the help, Ms. Decato of Marsh said.

“You can’t really force someone,” she said. “They have to be ready and they have to be committed to it. You need the right patient from an insurer or a TPA perspective.”

Dr. Gean said screening tools, such as predictive models and patient questionnaires, can help identify claimants who are willing to receive help for dependence problems.

As workers comp experts look to stem opioid abuse, Lockton’s Mr. Rosenblum said he believes many in the industry will focus on preventing addiction rather than waiting to provide treatment after patients have become dependent on narcotics. “We can’t wait for that,” he said.

Still, Dr. Gean believes the workers comp industry can play a key role in helping to fight the prescription abuse epidemic nationwide.

“Anything that benefits the patients benefits us as well,” Dr. Gean said. “It’s really a win-win.”

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By Jonathan Berr, who has written for national media outlets for more than 15 years.

Workers struggling with mental-health issues make life more challenging for their colleagues and their employers. Skilled corporate risk managers, particularly at well-funded employers, have a tool to help: the Employee Assistance Program.

These programs are designed to help employees get the mental health services that they need. Yet, this wasn't always the case.

Before the Sept. 11 attacks, companies were reluctant to allow mental health services providers the opportunity to promote themselves, said Marina London, a former EAP executive and spokeswoman for the Employee Assistance Professionals Association.

London said that before Sept. 11, only about 4 percent of employees at all companies utilized the mental-health services, which were mostly outsourced. The services offer typically offer counseling on a range of issues from substance abuse to budgeting.

But after the Sept. 11 attacks, the number of employees seeking mental health help skyrocketed four-fold. “There is much less of a stigma” in seeking help nowadays, London said.

Business owners seem to welcome the growing use of EAPs.

Mental illness is one of the leading causes of workplace absenteeism. It also may be a harbinger of costly physical problems later in life such as obesity, which is costing employers billions of dollars in lost productivity every year.

The stakes for businesses are huge. An October 2011 survey conducted by ComPsych, the nation’s largest provider of EAPs, found that 29 percent of employees at more than 1,500 companies said they came to work on at least five days during the year when they were too stressed to be effective, and could not properly manage that stress psychologically. That is up from 19 percent a year ago.

“It’s good to make sure they seek [employee assistance] services because it affects lots of other things,” said Steve Wojcik, vice president for public policy for the National Business Group on Health in Washington, D.C. “A lot of times people have some sort of underlying medical condition.”

According to a 2011 government report, Americans spent $135 billion on behavioral health services in the United States in 2005, an amount equal to 7.3 percent of overall health care spending that year.

A 2011 report by Medco Health Solutions found that over a nine-year period from 2001 to 2010, the use of psychiatric drugs among adults increased by 22 percent. In 2010, as much as 10 percent of all adult men and 21 percent of adult women were using antidepressants.

Under the Mental Health Parity and Addiction Equity Act of 2008, insurance companies are required to treat mental and physical illness equally when both are covered.

When the law was passed nearly four years ago, employers feared it would raise their costs. While utilization to treat mental health did increase, fears of large cost increases have generally proved to be unfounded, said Rhonda Lessard, Aetna’s head of medical cost analytics.

EAPs cost companies between $2 and $4 per employee per month depending on the services offered, London said. EAP costs are falling even as their popularity soars thanks to industry consolidation that has kept prices low.

“Keep in mind that the right question is not whether mental health costs go up but whether overall health costs increase,” said Michael B. Friedman, adjunct associate professor at the Columbia University School of Social Work. “Many of us believe that effective treatment of mental health conditions, especially in people with chronic healthcare problems, will bring down utilization and costs of physical healthcare services.”

A recent Government Accountability Office survey found that most employers had enhanced benefits “the removal of treatment limitations, such as the number of allowed office visits” in response to the law.

Businesses that ignore the mental health problems of employees do so at their own peril as workers with mental health issues drag down productivity. Depressed workers who call out sick mean projects fall behind schedule, cutting into profits.

Many employees who need mental health services are un-
able to seek help. A 2008 survey conducted by the American Psychological Association found that 44 percent of respondents either lacked mental health coverage or were unsure if they did.

Other workers are unwilling to seek help. About half of people with mental and substance abuse problems go without treatment, the figures show.

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Hip Pain in the Injured Worker: Impingement and Labral Tears

By Marc F. Matarazzo, MD
Director of Sports Medicine, Orthopedic Center of Palm Beach County; Sports Medicine Champion, JFK Medical Center

Hip pain in the injured worker has often been unfairly dismissed as a muscle “strain” or “early arthritis.” However, with recent advances in the understanding of hip and its pathoanatomy, the differential diagnosis has become quite broad. Hip pain in the active patient can be intra-articular, extra-articular, central pubic, or referred pain. A thorough history and focused examination, combined with enhanced imaging tools, can usually lead to a more precise diagnosis and a more successful treatment plan.

Femoroacetabular impingement (FAI) of the hip is still a relatively unrecognized entity by many physicians, but has become well known in the sports medicine arena. It occurs intra-articularly when there is abnormal contact between the head/neck junction of the proximal femur and the rim of the acetabular socket. This can lead to acetabular labral tearing and chondral injuries, possibly resulting in early arthrosis of the hip joint. Labral tears can occur independently with isolated trauma or in conjunction with FAI.

There are two main types of FAI — Cam impingement (on the femoral side) and Pincer impingement (on the acetabular side), but more commonly (86%) a combination of the two exists. Labral tears, chondral injuries, and loose bodies are typical findings associated with FAI and these can also cause debilitating symptoms, particularly in the younger, active patient.

Cam impingement exists when an abnormal “bump” is found at the femoral head/neck junction or angular deformities of the prox femur that create shear stresses at the chondrolabral complex with acetabular chondral injury and labral tearing. Cam impingement is more common in the younger, active male.

Pincer impingement is due to abnormal overhang or “over coverage” of the acetabular rim that pinches the labrum between the rim and the femoral head/neck, leading to degeneration of the labrum, chondral injury on the acetabular side of the joint, and potential loose bodies. This type is more common in middle-aged women and can be related to developmental hip dysplasia.

Symptoms of FAI and associated conditions include anterior groin pain, “deep” hip pain, catching or pinching in the groin, lateral or posterior hip pain, pain with activity — particularly with high hip flexion and internal rotation. Signs include a positive “impingement” test, which is performed with the patient supine. Flexing the hip while adducting and internally rotating will reproduce symptoms. Also, a decrease in the amount of internal rotation can be seen.

The diagnosis of FAI is made with a thorough history, physical examination, and diagnostic imaging including plain radiography with specific views of the pelvis and hip, as well as MRI scanning with intra-articular contrast, and diagnostic joint injections. Imaging findings can be rather subtle and often not reported, especially if the radiologist is not familiar with FAI or is unaware of the symptoms of the patient and abnormalities being sought.

Initial treatment of FAI is conservative — stressing education and counseling, NSAIDs, activity modification, and sometimes intra-articular corticosteroid injections. However, because this condition is caused by abnormal anatomy, surgery is often indicated in this patient population. Surgical treatment consists of open procedures, arthroscopic procedures, or a combination of the two.

Open procedures require fairly large incisions, more blood loss, and the need to dislocate the hip with the risk of iatrogenic avascular necrosis (AVN) of the femoral head. Arthroscopic procedures are performed through a few portal incisions, utilizing a specialized traction table to distract the femoral head out of the acetabulum with little risk of AVN nor significant blood loss.

Using either technique, the goals are the same — to restore normal hip anatomy. Pincer and Cam lesions are removed. The labrum is partially excised or repaired back to the acetabular rim, loose bodies are removed, and any articular cartilage lesions are addressed with debridement or micro-fracture techniques.

Recovery is variable depending on the extent of the injury and/or procedure performed, but return to play can be as early as 3 months, although 6 months is not uncommon.

Continued, page 15.
The Accident

On a mid-winter morning in 2010, workers were onsite at a natural gas processing plant. Work on the plant was almost done and the site was scheduled to be completed in the fourth quarter of that year.

Workers were in the process of purging the gas line when a deadly explosion occurred. The explosion shook the plant site and surrounding area, blowing out huge sections of the plant, killing six, and hurting dozens of others.

Catastrophic Response

As the workers’ compensation case management provider for this construction project, GENEX immediately sent a team of 16 Catastrophic Nurse Case Managers to manage this tragic event. Our case managers began the process of quickly prioritizing those employees with the greatest need for case management services.

The nurses spoke with each employee to triage their injuries, develop a plan of care, and most of all to alleviate their anxiety and fear during this difficult time. They kept a detailed listing of all employee contacts to keep the employers apprised of communication and case management progress with each employee.

Their process allowed us to capture and track the following key factors for each employee:

- Employee’s whereabouts at the time of the explosion
- Impact (both physical and mental) of the incident and the employee’s current medical status, including a listing of all medical providers
- Documented whether the employee obtained legal representation
- Verified the employee’s claim status
- Outlined the nurse case manager’s plan of care

Many of the affected employees were from out of state and needed further medical case management and return-to-work services in their home states. We were able to leverage GENEX’s national network of medical and vocational case managers to transfer and assign nurse case managers to each out-of-state employee across the country. Each case manager provided daily updates to our customer on each employee and their progress. All affected employees were also provided access to a crisis hotline and temporary counseling support as well.
The Outcome

The injured employees sustained both emotional and physical trauma as a result of the explosion. These workers had held very physical jobs, and it was anticipated that many would experience long-term effects in their level of functioning, an inability to complete activities of daily living, an increased dependence on others, and a loss of their pre-injury lifestyle. Their families were affected as well, as they made adjustments and learned to handle the stress of dealing with an injured loved one. Our case managers worked with the injured workers and their families to address all of these issues.

The case management team ensured maximum outcomes for each injured worker by arranging treatment in appropriate medical settings, as well as through the use of home health care providers at negotiated discounts. The case managers kept close records on each injured worker and provided status updates to the employers on a monthly basis, tracking relatedness of multiple diagnoses, alternative treatment recommendations, and identifying the need for specialty physicians.

These actions resulted in cost savings for our customer, avoidance of litigation, and early return to work for many of the affected employees. Overall, our actions saved an average of $958 per case or approximately $208,000 in medical and rehabilitative care costs and produced an 85% return-to-work rate.

ICD-10

The U.S. Department of Health and Human Services is requiring all entities covered by the Health Insurance Portability and Accountability Act (HIPAA) to switch from International Classification of Disease (ICD)-9 codes to ICD-10 codes by 10/1/2013. The requirement applies directly to carriers, providers, and vendors involved in billing Medicare for services. Per WorkCompCentral, industry experts indicate it will carry over to workers' compensation, as ICD-9 codes are also embedded in fee schedules, treatment guidelines, and statutes.

For more information on ICD-10, go to: https://www.cms.gov/ICD10/.

FDA/opioids

The U.S. Food and Drug Administration (FDA) is educating medical providers nationwide on the use of opioids. The FDA stresses the use of prescription drug monitoring programs and is developing a training program as part of a risk-evaluation and mitigation strategy, required by regulation, to be developed by the nation’s drug manufacturers.

An Amazing Comeback

“Help! Help! Somebody help me!” screamed the little girl on the front lawn. “The house is on fire and my grandmother is inside! Please help!” John Riggs*, out on his package delivery route, pulled over and ran inside the house full of smoke. After locating the grandmother at the back end of the house, he carried her to the front door, just as the fire department arrived.

Then, as he opened the door to bring her out, a back draft occurred which ignited flames around them, burning them both severely. Sadly, the grandmother did not survive her injuries.

Diane Hamilton, GENEX Catastrophic Nurse Case Manager, received the call that she was needed at The Burn Center at The Medical College of Virginia. “I went to the center to assess his condition, and to let his family know that I would be coordinating John's care, and be there for them,” said Hamilton.

Hamilton was informed by the medical staff that Riggs had suffered second- and third-degree burns to 40% of his body, primarily on his torso, arms, and face. He was also put on a ventilator, IVs, and tube feedings for two months.

When he was ready to be discharged, Hamilton coordinated Riggs' home health care and DME needs, as well as his treatment by the burn clinic specialists. But his improvement was slow, which concerned her.

“I offered him the name of a burn specialist, who was also a plastic surgeon and expert in wound healing, and he opted to

Fires... explosions... serious car accidents... traumatic brain injuries. These are the tragedies you see on the news, or perhaps you know someone who has experienced serious injury. But for catastrophic case managers, they handle the most tragic and severe injuries on a daily basis. We wanted to find out just what happens in a catastrophic case, so we sat down with some of our Catastrophic Case Managers. Prepare to be enlightened, and have your tissues handy!

By Michele Ritchie, Marketing Communications Manager, GENEX
Diane Hamilton
Virginia

seek treatment from that doctor. He was going to need skin grafting and lots of physical therapy, and working with this doctor expedited the healing and recovery,” said Hamilton. Hamilton stayed on the case, constantly coordinating the care Riggs received. He had to endure hundreds of hours of physical therapy, along with multiple surgeries for tissue release and scar revision. Riggs is now back to work on full duty, three years after that fateful day. His recovery was promising because of the expert care that was coordinated throughout the whole process.

Aside from the challenges that lie in coordinating care, it is often tough to close a case because of the bond between the case manager and the patient. “After spending so much time with these patients, they feel like family. It’s hard letting go of that, for them and for me,” said Hamilton.

Hamilton says she occasionally runs into her patients, and it makes her day. “I recently ran into John one day as he was dropping off packages, and it was so good to see him back to work. He looked fabulous!”

Catastrophic Challenges

When a catastrophic case comes in, it can be referred by the employer, the insurance company, or the TPA. Initially, there may only be a little bit of information available. The case manager contacts the hospital to verify the injury, and if it is deemed catastrophic, they usually want a nurse case manager there right away.

“Generally, when you get to the hospital, the injured person is in the ER, the ICU, or the operating room. One of the challenges is to build a rapport with the family, and reinforce to them that I am going to be their point of contact and will do my best to expedite treatment. I also let them know what case management is, so that they understand what my role is, and I explain all the updates so that they can be involved in decisions about their loved one,” explained Marilyn Compton, a GENEX Catastrophic Case Manager from Texas. “If there is an attorney involved in the case, then I need to get permission from him or her to speak to the family.”

Compton has been handling catastrophic cases for 28 years, and insists that her background is everything. “I spent five years working in a trauma center in radiology, and it was the best thing for my career,” she said. “It is hard to know what the inside of a body looks like until you see it on a screen.”

Upon the patient’s discharge, Compton is responsible for coordinating the home health care, DME, acute care, rehabilitation, and visits with multiple doctors. She also needs to make sure the adjuster is completely onboard with treatments and diagnoses. Compton explained that many times, services need to be pre-authorized and sometimes they are denied. Denials can leave the case at a standstill, because they have to go back and figure out what caused the denial. Sometimes it is as simple as a wrong CPT code or a clerical error; but other times it could mean that a doctor needs to review it again and approve the service.

“It’s all a matter of orchestrating so many facets,” Compton said. “You want the best outcome for the patient. The sad challenge is when the outcome is not going to be what the family and patient are expecting, as can happen with brain or spinal cord injuries. You have to ready the patient and family for long-term management of their injuries so that they don’t fall through the cracks.”

What are the rewards in her job? “Everything is so different every day; I can’t wait to see what it is going to bring me,” Compton said. “I like knowing that I was able to make a difference in someone’s life; that they can get back to doing the things in life that they did before. It’s an amazing feeling!”

The Role of the Case Manager

Ask Marci Levin about her life as a case manager, and she will tell you that case management is really the 21st century primary nurse role. “We have gone from a society that used to have inpatient care for a long period of time,” said Levin. “Our job depends on a strong knowledge base of nursing, disease orientation, and health. We need to have education and experience, and nurses at GENEX have it.”

The shift of treatment has gone from the hospital to outpatient care, and the job of a case manager is a reflection of what is going on in society. “Nurse case managers save a lot of money for the employer and the insurer, because they manage the care correctly,” said Levin, who has been handling cata-
Every Day is a Miracle

“CAT cases are the most rewarding,” said Leslie Eldib, Catastrophic Case Manager. “The joy you feel when your patients start progressing...it is all a miracle. It helps you understand what is important.”

Eldib has been handling catastrophic cases since 1991, and has “done it all” clinically. She has been a nurse since 1974, and has experience in trauma units, the ER, ICU, medical/surgical care, and research studies.

“A lot of times, you want to jump in and fix everything right away, but you have to think about what is best for the patient long-term. You have to give them time and let them ‘catch up’ so that they can participate in their care and make the decisions that will impact the rest of their lives,” said Eldib.

When asked what gets her up in the morning, Eldib replied, “Wonder. What miracles are going to happen today? How can I make someone else’s life a little easier?”

Eldib has experienced many a miracle in her career, but there is one case that tops them all. “I had a case involving a 45 year-old man who worked as a lab engineer. One of the machines exploded, and he suffered severe chemical and thermal burns. The chemicals, arsenic and white phosphorus, were the highest level of chemicals the lab had ever seen,” she said.

“The man had almost complete body failure; he lost his left eye and much of his face, and burns to his upper body.”

“WHEN THE EMPLOYER IS 100% INVOLVED WITH THEIR EMPLOYEES’ RECOVERY, PATIENTS HAVE A MUCH BETTER OUTCOME.”

— Marci Levin

strophic cases for 23 years.

A typical day for Levin involves hours of phone calls with doctors, going to doctor visits with patients, documenting the cases, and visits to the hospital. “CAT nurses do a little bit of everything: telephonic case management, field case management, and of course, the catastrophic part.”

Levin’s passion for her job is apparent as she explains what she does. “Sometimes, we are the first people to speak to the family, and we have to use personal, social, and counseling skills to convey the information to them.”

“Everyone is angry in the beginning, and there is so much to filter and process. They cling to the case manager for knowledge and strength,” she said. “There has to be a calming voice, an advocate for the patient and their family when they are completely distraught. We are that calming voice for them; we educate them and give them options. The challenge is to get the patient to move past the anger and on to living their life and returning to work,” said Levin.

Levin said another challenge is working with patients who have pre-existing conditions when they are injured. “I had one case where the patient was injured on the job, and she was already suffering from end-stage renal disease. I was shocked that she was even working. That impacts the case even more.”

The real reward for Levin is seeing someone who has gone through an ordeal, survive, and take back their life, even if it is a modified-duty job. One of her favorite cases involved a retired accountant who was working as a security guard in a bank. There was an armed robbery, and the guard had suffered life-threatening gunshot wounds.

“He was in the ICU and CCU for over a month,” said Levin. “I breathed a sigh of relief once he was moved out of there and seen as an outpatient for several months. The best part was that the man’s employer came to see him frequently and kept in touch with him the entire time he was out of work. They celebrated him, and had a picture of him on their wall, naming him a hero. He went back to that job in nine months; it was amazing!”

Levin said that when the employer is 100% involved with their employees’ recovery, patients have a much better outcome.

Eldib did not think he was going to make it, and she prepared herself for the worst. Her biggest challenge was that the family was very private and did not want outside help. “I could not make contact with the family, and that was very frustrating because I wanted to help them understand what I was able to do for them,” said Eldib. “They are a very loving and supportive family and did not realize how much I could assist them.” But Eldib was determined, and finally made contact with the family after three months.

Ensuring that he was placed in a center of excellence as quickly as possible was essential. There he was on a heart/lung machine and dialysis for a few weeks and in the ICU for four months. He was then discharged from the ICU and was sent to an inpatient rehabilitation program for a few months.

“As a result of toxic exposure, he became a quadriplegic for six months. Finally, after six months of being in the hospital, we were able to get him home with supportive services and therapies. His family and team of providers were thrilled with his progress as he started to regain body function and movement,” said Eldib.

Eldib, along with the patient, was facing big challenges ahead, though. Since the patient had experienced a lot of damage to his face, the next step was to start the process of skin grafting and plastic surgery. It was crucial that he received rehabilitation at the same time, so they worked out an
arrangement where the therapists would go out to his home for a few months until he was able to get to an outpatient facility.

“There were many modifications that needed to take place in his home so that he could get around. He is still wheelchair-bound, but can now walk 40 feet with assistance,” said Eldib. “Each day is another miracle for him!”

Eldib also stated that there were many specialists involved through which she has to coordinate care, including an ENT, ophthalmologists, plastic surgeons, burn specialists, wound care specialists, therapists, the primary care physician, a psychologist, two orthopedists (one for the hands; one for the feet), transportation, home modification specialists, and 24/7 care. “You have to constantly be figuring out what is best, because you don’t see this level of coordination very often.”

Eldib is still on the case, and she is continually amazed at his progress. “He is a very brilliant man, and thankfully, he retained all of that. His next project is to get speech-recognition software for his computer so he can communicate better.

“I attribute a lot of his success to his sense of humor… he just has the best attitude! I am so excited at his progress, and can’t wait to see what miracles lie ahead for him in the future,” she said.

*Not the patient’s real name.*

Clinical Perspective, continued from page 9:

Hip pain in the athlete can be a challenging problem, but with a more complete understanding of the hip, superior imaging modalities, and the evolution of hip arthroscopy, we are much better able to recognize and treat a large array of injuries and conditions about the hip — particularly in the younger, active patient.


EVENTS CALENDAR

GENEX will be attending these upcoming industry events. We look forward to seeing you!

New Mexico Workers’ Compensation Association Annual Conference
May 16–18, 2012
Albuquerque, New Mexico

South Dakota Workers’ Compensation Summit
May 23–24, 2012
Sioux Falls, South Dakota

Michigan Self-Insurers Association
May 30–June 1, 2012
Traverse City, Michigan

Public Risk Management Association (PRIMA)
June 3–6, 2012
Nashville, Tennessee

WCCP Claims Management & Leadership Conference
June 10–13, 2012
Bonita Springs, Florida

California Coalition on Workers’ Compensation
July 11–13, 2012
Anaheim, California

New York Self-Insurers Association (NYSIA) Spring Workshop
June 13–15, 2012
Saratoga Springs, New York

Ohio Self-Insurers Association
June 20–22, 2012
Columbus, Ohio

Absence and Disability Management: Strategies for Today’s Workforce
August 12–15, 2012
Denver, Colorado

Florida Workers’ Compensation Institute Educational Conference
August 19–21, 2012
Orlando, Florida

Georgia State Board of Workers’ Compensation
August 26–29, 2012
Atlanta, Georgia

Comp Summit
August 26–28, 2012
Rockport, Maine
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