# Getting Case Management OFF AUTO PILOT

If your case management program only "takes off" when a situation escalates, you are headed for a systems crash. **By Ron Skrocki**

Clinical management (or intervention) services are a fundamental part of workers' compensation programs. Case management has been the keystone for clinical interventions since the late 1990s. Essentially, when an employee is injured, the case manager's role is to assess and interpret information related to a claim and to identify areas in need of intervention or support. Case managers collaborate with the worker and his family, coordinate and communicate with all providers on the care team, and provide valuable claims insights and updates to claims professionals and payers, including the carrier and/or employer.

It is an important role, yet many case management programs are often set on automatic pilot, and case managers are called in only if a claim reaches a certain threshold, or lingers for more than a prescribed number of weeks. Such attitudes contribute to the perception that case management programs are a commodity. However, those views invite the risk of accepting inefficient and underperforming programs. The situation is analogous to owning a car for a few years and suddenly discovering that it has built-in navigational capabilities—you wish you had known about that functionality sooner.

With all the complexity and pressure on workers' compensation program managers today, how can you ensure the most effective use of case management? To avoid missing opportunities for savings and better outcomes, it is essential that you regularly assess your case management program's performance.

### A More Dynamic Approach

With costs, outcomes, compliance, and even public perception on the line, many organizations need a targeted and more dynamic approach to the administration and reporting of case management. Effective programs allow for flexibility so that rules and decisions can be measured, monitored, and refined to provide true insight, guidance, and actionable information. A good case management platform should include the ability to:

- Provide configurable clinical and business rules that support customization and rapid deployment of changes in rule design and enforcement
- Utilize algorithms to show when and how to use clinical interventions
- Integrate with claims, medical bill review, and pharmacy management

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data streams to identify problems in utilization, such as narcotics and physical therapy
- Identify under- or over-utilization of case management
- Provide guidance on where and when to use telephonic case management (TCM), field case management (FCM), utilization review, and physician advisor services
- Measure the nature and effectiveness of the human decisions made in every case.

A proactive case management program also should consistently use a combination of data, experience, and best practices to yield better outcomes and gain more control over costs. To effectively put the program into practice, it needs to be embraced by employees, claims professionals, and even providers.

Creation of a sound case management program begins with a close examination of where the program is today, and scrutinizing what works and what does not. In general, there are three areas (or combinations) where case management programs may fail or be subject to leaks:

- Structure: how the program itself is designed
- System: the business rules and systems that indicate when case management kicks in
- People: including claims professionals who make decisions on when, where, and what kind of case management intervention is needed.

### Find the Fails

To find the fails in a case management program, an organization first must have a system in operation that does more than just react to a claim with a poor outcome. That system capability begins and ends with data analysis—the consistent review of specific and aggregate claims data to identify problems, including:

1 Under-utilization of early intervention TCM. Data analysis shows that the sooner case management is involved in a claim, the sooner it can be resolved. According to a GENEX study, more than 55 percent of injured workers who are referred to case management within three months have return-to-work rates within guidelines.

In TCM, a case manager contacts the injured worker by phone to gather basic incident information, identify the provider and care plan, and follow up to ensure that appropriate care is being received. Typically, claims professionals (often directed by institutional policies and guidelines), make the decision of whether or when to bring in TCM. All too often, TCM is not brought in on routine claims as a way to control costs. While TCM costs are nominal—about $300 per claim—many programs use case management only based on a claims professional's decision, which is often well-founded, but delayed.

Of course, case management is not required for every claim. Excess and inappropriate use of case management also signifies a "fail" in the program. However, the opposite is likewise true—under-utilization of case management is a program fail, as well. If your data show how the use of TCM is triggered, provided and evaluated, and if you compare that to claims outcomes and costs, you begin to get a handle on what leads to effective utilization. Using expert clinical resources early and often, as indicated by data, can help prevent relatively low-cost claims from creeping higher.

2 Inefficient use of FCM. Field case managers typically are brought in for more severe or high-cost injuries, often at the discretion of the claims professional. The manager may go to the injury site, visit the worker at the hospital, and accompany him to medical appointments. Some examples of situations indicating referral to a field case manager:

- Claimant needs to be seen by multiple providers
- Treating physician is non-responsive to requests
- Case is considered catastrophic or creeping toward same
- Physician's treatment plan is contrary to Official Disability Guidelines and the length of disability is beyond benchmarking
- Physician has a statistically significant history of poor outcomes and inefficient treatment.

Here, too, it is important for payers to understand the decision process and criteria for calling in FCM. Knowing how average costs and outcomes compare to industry benchmarks will point to how effective the process is. You should know when the timing and utilization of FCM is effective. Is it too late? Is there a lag that could affect the ability of the nurse to intervene?

Payers should also look at utilization. Are nurses being used appropriately, to provide relevant support and care? Or are they serving as an extension of the adjusting team to pick up medical records or to perform some administrative duty perhaps better suited to other personnel? Either through your own program or that of a managed care partner, you should be able to identify and compare when FCM was brought in, what tasks were performed, and the costs, outcomes, and outliers.

All of these questions and analyses should lead to the development of a standard baseline to measure and monitor the progress and results of claims involving case management. From there, frequent and relevant dashboard reviews will indicate when a program needs to be adjusted or refined.

### Target Your Approach

Once performance information is gathered and analyzed, payers can better identify risk profiles in terms of injuries, regions, locations, and the like, giving insights into what is driving claims and costs. You should look for emerging treatment patterns such as sudden spikes in narcotics use in a certain region or with certain types of injuries, changes in billing and diagnostic protocols, and when physical therapy is brought in.

The next step is to act on that information. When the managed care partner of a global retailer found an alarming increase in shoulder injuries, its managed care vendor created educational programs to help its claims staff more readily identify claims that could benefit from case management intervention. The company also created a safety program that focused on reducing injuries, and instituted an intensive provider evaluation review that helped claims professionals and case managers better identify top per-

forming physicians, surgeons, and physical therapists.

### Assess Your Current Program

Where should you start in terms of assessing your current program? Actions to consider include:

- Examine your current case management program. What processes and systems are you using? What criteria, if any, do you use for initiation of case management? What kind of reports and analyses are being provided, and how often do you receive them?
- Talk to your managed care vendors; know their capabilities, what they report, and how often they report it.
- Find out how your claims' resolution compares to industry benchmarks. Are you over or under?
- Where are your costliest injuries occurring—what locations, departments, positions? What are your most common injuries—shoulder, back, other? Who is getting injured—older workers, new hires? Answering these questions will help you determine whether the problem is systemic, or confined to certain areas, and whether you need more safety education and training.
- Look closely at your provider network—ask for data on how those providers compare to their peers.
- Check to see if you have the wrong mix of providers (e.g., a lot of primary care physicians, but few orthopedists; stratify your use of providers by statistical quality metrics).
- Find out who is treating your employees. Make sure you don't have the highest number of visits with your lowest-rated providers, and make sure you have a system to enable case managers to share their insights on local providers. You want case managers who can provide street-level insights into providers.
- Look at both underuse and overuse of case management. If some claims professionals are going to case managers too often, determine if the problem is just an inexperienced person in need of education, or if there's a particular problem in a region.
- Learn from your outliers. The ability to look at data and reports on performance provides tremendous opportunities to learn, such as whether structure, system, personnel, or a combination of factors lead to a failure in effective claims resolution. Use this information to continuously improve your program.

### Monitor Closely

The key to a structurally sound case management program is ensuring that someone is measuring, monitoring, and even obsessing about every element in the program. Analyzing how and when claims professionals are employing case management is a critical step. Decision-making must be monitored and measured to support feedback, coaching, and improvement.

However, creating sound case management programs is not exclusively about analyzing size or cost. It also is about being proactive and dynamic relative to finetuning the program to quickly respond to changing cost drivers. This is the only way to make sure the program continues to work as well as possible.

When properly developed, implemented, and monitored, strong case management programs can be the keystone of successful claims resolutions. They have the potential to provide highly beneficial services, or can fall to the wayside and become cursory and inefficient. Now is the time to examine your program. Doing so will help you identify leaks, manage litigation, control costs, and guarantee efficient claims management. ■

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