KNOWLEDGE NUGGETS

PROACTIVE STRATEGIES FOR THE DIFFICULT CLAIMS

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The “10/70” Theory: A well-known actuary once said: “You need to find the 10% of the claims which are chasing about 70% of the money.” What he meant was that in order to control any large inventory of w.c. claims, the claims administrator must have an established system and effective handling methods in which the “difficult claim” (“DC”) is identified and then differentiated in a manner which is intended to achieve the maximum impact. In other words, these claims must be handled in the most effective way possible. If you handle and ultimately control these claims successfully, then you really can “impact” the money.

Average paid medical per indemnity claim has been on the rise from AY 2002-2013. For medical payable at 60 months post injury, the increase from AY 2002-2009 is 58.3% (CWCI Cal. Work Comp Med and Indemnity Benefit Trends AY2002-2014 by John Ireland 11/2014). A CWCI study in 11/2014 confirmed that average amounts paid for medical at 24 months also rose from AY 2005 to AY 2009 but not as sharply as at 60 months (http://www.cwci.org/research.html)
THE DIFFICULT CLAIM EXPLAINED

The “DC” is a claim which seems to be self-perpetuating, most often propelled by never-ending medical treatment and often resulting from one or more authorized spinal surgeries. More likely than not, the “DC” features on one or more of these common characteristics:

1. Ongoing and prolonged usage of opioid medications for pain;
2. Claim expands to multiple additional body parts;
3. Compensable consequences involving other body parts and bodily systems;
4. Multiple treating physicians, often left “unguided” by the primary treating physician. These are the claims which carry large reserve increases, usually for the medical treatment inflation component. And, these cases may often feature “difficult” applicants and very aggressive attorneys.
ADVERSE CLAIM DEVELOPMENT

- **AXIOM**: The general view is that the longer the claim stays open, the more expensive the ultimate cost. Most “DC” claims begin with admitted injuries, even simple and seemingly minor sprains and strains.

- **TIME AS THE ANTAGONIST**: In the adjustment of a WC claim, “time” is the element which drives the challenge of affording timely benefits under proper and timely notice.

- **WATCHING FOR “RED FLAGS”**: Watching for “red flags” is important. These may include one or more of the following:
  
  1. Applicant is represented by a very aggressive well-known “Alpha” law firm, whose tactics and behavior can contribute to prolonged litigation;
  2. Very slow recovery from surgery;
  3. The medical reports start to feature “sleep” problems and “;”;
  4. Injured worker is continuing to take opioids for pain;
  5. You start seeing “depression” and “anxiety” being featured in the treatment reports;
  6. Applicant is repeatedly changing treating physicians;
  7. Addition of new body parts;
  8. Applicant is not getting any better despite ongoing care;
  9. The treating physician is delegating ongoing treatment mostly to a physician’s assistant.

This is only a partial list.
A so-called “red flag” is an event or occurrence which tends to increase claim exposure and which also makes it less likely the claim can be closed in the ensuing 12 months.

SOME RED FLAGS

- Alpha attorney
- Body parts are added upon representation
- The primary treating physician (“PTP”) is notorious for prolonged care
- PTP refers applicant to multiple specialties
- Sleep, psychiatric and sexual dysfunction appear
“RED FLAGS EXPLAINED”

- Prolonged use of opioid medications for pain
- More than one spinal surgery (“failed back syndrome”)
- Injured worker has greater pain over time
- Secondary gain potential
- Applicant changes treating physicians too often
- Applicant changes counsel
- Unreasonable demands for settlement
- Exotic demands for medical treatment
- The use of one or more Agreed Medical Examiners
“RED FLAGS EXPLAINED”

- Comorbidities: These can include things like diabetes, heart disease, obesity, certain underlying conditions which complicate recovery, such as arthritis and pre-existing spinal and other anatomical defects.
- Applicant’s attorney is demanding treatment which goes beyond the scope of the injury.
- Prior litigation history, including prior WC claims.
- PTP recommends spinal cord stimulator.
- Durable medical equipment recommended by PTP.
- Psycho-social interplay.
- Prolonged “gaps” between medical treatment reports.
Agreed Medical Examiners ("AME’s") are often used in cases, but all too often for the wrong reasons. For many attorneys, getting the defense to consider an AME is like playing the first “X” in the middle or on the corner in Tic-Tac-Toe. They know that their “X” means they can’t really lose. While it is unfair to generalize, nevertheless there is a widely held view that most AME’s are “injury finders,” who will routinely find an industrial injury irrespective of the record referred to them for review. That record may include, for example, a 100 page applicant deposition, surveillance DVD’s, prior medical records and other compelling evidence, which would have a material impact on the medical conclusions. However, it is the common experience that despite a convincingly assembled medical record, the typical AME will predictably declare there is an industrial injury
“THE MYTH ABOUT AME’S”

- Most “Alpha” attorneys love AME’s? Why? Because they know that the “odds” are highly their favor that the AME will find “something” favorable and that “something” can be effectively leveraged into a large exposure potential case.

- AME’s are usually in high demand, with volume outpacing supply, so that it is often difficult to obtain a medical appointment within a reasonable time frame. It is not unusual to book an exam in the month of April of 2015 and the appointment may not take place until January, 2016. And, what if the claimant fails to appear? Or, what if temporary total disability is in issue? Time here is on the applicant’s side, not yours.
Another problem: When is the AME report coming? In using a PQME, the Labor Code and the A.D. Regulations require the QME to have the report out in 30 days, or either party may request a replacement panel. But, there is no such similar requirement for an AME. There are known instances where the applicant was examined and the AME did not produce a report until a full year or more later!

MORE EXAMS - MORE TESTS: Another frustrating problem is that some AME’s want to re-test the applicant or obtain new diagnostics and they will refer out for unnecessary repeat testing or further testing. Or, they might just write a “preliminary” report with the final report not due for over a year hence
“THE MYTH ABOUT AME’s”

- KING SOLOMON SYNDROME?: It is often the case that an AME will find industrial injury and resulting temporary and permanent disability, however he or she may also offer some concessions to the defense, usually in the form of the elimination of a contested body part or the finding of some apportionment for the PD. But, his approach may often leave both parties generally dissatisfied. Also, specific questions and considerations presented by the parties are often simply ignored or given scant attention and conclusionary responses. And, in psychiatric cases, some AME’s will simply “defer to the trier of fact” for contested factual disputes, so that the very purpose in utilizing that AME seems for naught.
“THE MYTH ABOUT AME’s”

- Many AME’s are so seasoned at being deposed that they will rarely change their conclusions or if prompted by a good applicant’s attorney, you may now be looking at further consultations in other fields of medicines and more disability and impairment.

- It is believed by some, that using an AME can add more than a year to the life of a litigated case and remember time is not on your side.

- Back in the 1980’s using AME’s was much less risky. The law and regulations were much less complex and many AME’s could produce reports quickly, which then facilitated a settlement. However, it is now often the practice that one or both parties will object to the AME findings and then proceed to take their depositions. This just makes the process go on much longer and the longer the risk the greater the exposure. Most AME’s know the “game” so even a deposition can still render the findings contestable, if not inconclusive.
STRATEGIES FOR DEALING WITH THE DC

- “Watch for the “red flags”
- Use “out-of-the box” thinking and don’t be afraid to try something creative
- The goal is to shut down the case, so the DC claims need to be critically analyzed for this very purpose
- Use action plans which are intended to be time effective, which means avoiding AME’s in the DC cases, unless there are compelling reasons
- **Alpha Attorneys**: These are the attorneys who are the most aggressive and efficient. They want to trap you into using an AME, so don’t fall for the trap
  - No AME’s in psychiatric cases, without a compelling reason
  - No AME’s in a factually denied case, since AME’s are not fact finders
Strategies for Dealing with the DC

- Have a “plan” for dealing with the Alpha’s. Your plan should include how and when to respond to their aggressive demands and their “edgy” litigation tactics.

- Deploy your best resources to “staff,” or “roundtable” these claims. The idea is to encourage critically thinking and creativity in order to advance the DC claim to a timely completion. Active management oversight of these DC claims is essential.

- **SPEED:** Move your cases as fast as you can. The inverse of the longer the case sits is that the faster it moves the better off you probably are. So, have a plan which completes discovery quickly and gets the case ready either to settle or to go to hearing at the WCAB.

- **POST SURGERY:** Watch very carefully for the use opioids for pain. Some PTP’s simply ignore the Chronic Pain Treatment Guidelines and you may want to notice the deposition of the physician who does. Even if you have a good UR denial upheld by IMR, some applicant’s will simply self-procure their drugs and this keeps the case open.
STRATEGIES FOR DEALING WITH THE DC

- **PROMOTE SETTLEMENT**: Most cases ultimately resolve without a WCAB hearing and determination. But the DC cases are considerably harder to settle. Here, you may want to deploy some creativity, such as **simply packaging a case for settlement**, preparing the settlement papers and then transmitting the unsolicited settlement documents to applicant’s counsel. This may really “get their attention” and it could otherwise turn a settlement offer letter, often ignored, into real settlement dialogue, leading to a settlement.

- **EARLIER RESOLUTION**: Once the “red flags” emerge, you should think about a potential closure strategy, so that the claim becomes closed before it becomes a DC.
SETTLE CASES WITH OPEN MEDICAL AWARDS

- Under the Labor Code, the injured worker, may within 5 years from the date of injury, petition the WCAB to re-open a case for which there has been a stipulated findings and award, to alleging “new and further” disability.

- After the 5 years, this cannot be done and you have a future medical care award; these can also be resolved with a compromise and release and these are often the DC claims which need to be resolved by closure.

- While Medicare’s interests may be required (Medicare Set Aside) still, there are opportunities. Remember, morbidity is sometimes a real consideration for someone to settle his or her future medical award.

- Developing a program for the identification of the DC future medical cases and then devising a plan for the settlement of these these large reserve cases, open to medical inflation.

- Applicant’s attorneys are also incented because they get to earn another attorney’s fee on a compromise and release.
The often repeated adage that "bad cases only get worse, if otherwise left open", is illustrated by the observation that often, claims and legal folks are simply stymied over how best to advance a vexing claim to its ultimate closure point. In many instances, the DC claims originated from a initial, simple, admitted injuries, but with the passage of time, and with abundant levels of failed treatment and even after surgeries, these once controllable and outcome-predictable claims, eventually migrated into lengthy and chronic medical "nightmares," which effectively transformed a simple injury into a "worst case scenario."
The concept of Doubleplay is borne from the thought that help should be delivered within the framework of a collaborative, non-confrontational team approach and within an environment which harnesses the highest energy and best skills from its multiple discipline participants. The environment should nurture learning and promote education and knowledge transfer. It isn’t about “one claim at a time” but rather about creating a program which provides not only claims oversight governance, but permits claims management to integrate the best resources from their “team,” including the claims examiners, supervisors, managers, nurses, return to work experts, medical management, UR, Medicare Professionals and the attorneys.
THE CONCEPT OF DOUBLEPLAY

- Sometimes both claims examiners and attorneys are “stuck” on DC, so rather than apply high energy and creative thinking; they sometimes just retreat from the claim and therefore allow the problems to simply evolve their way to a critical state. While it is often difficult to “un-spill the milk,” there are still many creative ways to attack these “worst case scenario” claims,’ and to get the best outcomes, circumstances considered.

- Doubleplay is simply a program in which a group of passionate claim and legal professionals assemble as a committed leadership group, in order to review the DC claims, with the intention of fostering “action plans” and promoting good “ideas” which come from integrated thinking and collaborative dialogue. In turn, the Doubleplay group should be charged with the additional assignment of ensuring that “knowledge nuggets” which often come from on-the-spot inspiration, are captured and then exported across the organization so that everyone may benefit from these products.
THE CONCEPT OF DOUBLEPLAY

- THE DOUBLEPLAY GROUP: The Doubleplay group should be inclusive so it is built upon a model which encourages group participation. It would include the Claims Examiner, Claims Supervisor and/or Claims Manager, as well as Zachary Gifford (Cal State), Jacki Graf (Alliant), Trish Daniels (Sedgwick CMS) and the handling defense attorney. When appropriate, others should attend, including the Nurse Case Manager, MSA Expert, Structured Settlement Specialist and the Investigator. It is important that the group meet on a regular basis, so there is structure to the program. Also, there should be a standard by which claims are reviewed. Past experience has produced the idea that there should be a menu of services which can be provided by the Doubleplay Group: This can span the gamut from “high exposure” cases, to cases where there have been multiple reserve increases or any increase over a certain period; claims where there has been chronic opioid treatment, old claims with no “action plan on the horizon,” and new claims, for which someone is seeking guidance, help or support.
THE CONCEPT OF DOUBLEPLAY

• **PRESENTATION FORMAT**: Agreed upon format for presentation: It is recommended that a short form or claim summary be provided to the group, prior to or at the time of presentation. This should contain enough to provide information but should not form a “barrier” by containing too much detail, so that the form effectively serves to discourage the seeking of help. The form should be “user friendly.” It is also recommended that the form set forth the type of help or assistance being sought.

• **PRESENTATION**: Presentation by Claims Examiner or defense attorney. Facts and issues are presented, together with the essential call for help and assistance. It is suggested that the presentation generally follow the form, so that the group can follow along easily. The presentation should take place within an environment, where the presenter is assured that the purpose of the program is to secure support and assistance rather than feeling they are under “fire.”
GROUP DISCUSSION: Following the presentation, the group discussion begins. This should be a healthy “give and take,” where questions are asked and thoughts are given freely and without fear of criticism or judgment. The discussion centers on the important issues, featuring “out of the box thinking” and “creative” solutions to move the matter forward and towards closure. It is generally thought that a single session should not extend more than 3 hours, nor should the review cover more than 8-10 cases. Also, the discussion should take place within the context of how to export and therefore leverage the Doubleplay “knowledge nuggets” across the organization.
THE CONCEPT OF DOUBLEPLAY

- AGREED UPON ACTION PLAN: Agreed upon Doubleplay Action Items: This should be confirmed and placed into the Notes or other claims management system. The plan should include the strategy and the action items to support that strategy, including designation of who is responsible and the time frames applicable. A *Doubleplay staffing summary* is recommended on a file-by-file basis, in order to achieve and maintain claims handling continuity.

- FOLLOW-UP: The second element of Doubleplay is the follow up on the action items and if appropriate, a repeat Doubleplay visit by the group. Everyone therefore knows that the group is continuing to monitor the progress of the claim and may call the file back for further review.
The benefit of handling the DC claims by using some central strategies, plans of action and responses, is that you gain leverage with the purpose of **having a centralized approach to handling the DC claims**.

For example, you may have a very productive Doubleplay staffing on a particularly complex and difficult claim but you come upon a good game plan for handling the matter. **This hard work and good product can then be leveraged across other DC claims**.

Levering effective strategies across other DC claims is a hallmark of this program.
**EXAMPLE:** Your DC handling team decides to settle a claim where the applicant has had a partial meniscectomy to the left knee but the prolonged recovery is now in its second year. You rate the case based upon the AMA Guides, 5th, obtain an impairment rating and that you decide upon a reasonable settlement value. Applicant’s counsel is in agreement but you do not have a permanent and stationary PQME report or AME and the PTP is still issuing treatment reports, but the applicant is only getting some medicine re-fills. The attorney prompts the PTP to write a discharge report and the case resolves. *This creative settlement opportunity runs against the common belief “that we can’t settle yet because.....”*
EXAMPLE: You have a very stubborn injured worker and a non-responsive applicant’s attorney to whom your defense attorney has written three letters proposing settlement. You set the deposition of the PTP and then you let the applicant’s attorney know that you want to spend additional time discussing settlement. You have your defense attorney draft the compromise and release documents and bring them to the deposition. That can often have a material affect in getting a response from an otherwise disinterested applicant.
THE KNOWLEDGE NUGGET

- **KNOWLEDGE NUGGET:** Having four or five people in a room examining one DC claim, can reap enormous exponential benefits, well beyond the confines of the single claim, if you believe that when you come across something interesting, something valuable and something which impacts, then you need to share this with the claims organization. This is the so-called rule of the knowledge nugget. Take the best of what is cooked in your DC kitchen and make sure it is served to the others. Leveraging your collective knowledge by exporting those precious knowledge nuggets across the organization. That way, you further the mission and provide invaluable help to everyone.