

# III. How Has Managed Care Affected Workers' Compensation Outcomes?

## *Introduction*

In a 1993 special session, the Florida Legislature adopted major reforms to the state's workers' compensation system in response to a looming crisis. Costs had risen rapidly over the past decade to the point where workers' compensation coverage was becoming unaffordable for many employers, and businesses wishing to locate in Florida had begun to reconsider their options. One of the reforms adopted in the 1993 special session involved managed care: Beginning January 1, 1997, all medical treatment under workers' compensation was to be provided exclusively through managed care arrangements. Employers opting for managed care prior to that date were allowed a discount on their insurance premiums. The move toward managed care was the direct result of preliminary findings of a managed care pilot project that demonstrated significant potential for savings through the application of a managed care medical delivery system in a workers' compensation setting. Some of the findings of the pilot project included a reduction in the cost of medical only claims, reduced frequency of claims involving more than seven days of missed work (i.e., lost-time claims), reduced indemnity costs, and a shorter duration of disability.

While the crisis in workers' compensation was averted, it is currently unclear whether managed care, other policies adopted in 1993, favorable trends in workers' compensation injuries, or some combination of these factors was responsible. Analysis to better identify the source or sources of system change is needed to ensure that policies previously implemented

are having their intended effect and that future revision to policy retains and builds upon what has already proven effective.

Since its implementation, considerable effort has gone into trying to measure whether the promise of managed care, as shown by the pilot project, has been realized when applied system wide. The approach taken in this chapter is to identify some broad system outcomes that might be expected to reflect the impact of managed care, to provide measures of those outcomes during the years preceding and following the introduction of mandatory managed care, and then to consider whether, or to what extent, the outcomes may be viewed as reflecting the impact of managed care. The overall aim is to clarify what can be known using data collected by the Division of Workers' Compensation and to suggest critical deficits requiring additional data and further research.<sup>1</sup>

## *Key Goals of the Workers' Compensation System*

Though no statement of intent introduces the managed care section of the statute, s. 440.015, F. S., prefaces the workers' compensation law with a statement of broad goals that are pertinent for assessing managed care. Two goals are particularly apt: the quick and efficient delivery of disability and medical benefits to injured workers, and the working of the overall system in an efficient and self-executing way that precludes economic or administrative burdens. These broad goals imply several subsidiary ones that

can be identified as potentially affected by a large-scale change in the medical service delivery system.

*Cost Containment.* This goal is implicit in the intent statement of the law. Effective medical management of workers' compensation cases may help to contain costs in a number of ways. The injured worker may recuperate more quickly and return to work sooner, requiring less in total indemnity payment. Prompt, appropriate medical treatment may forestall the need for more expensive treatment later. Satisfaction of the injured worker with his/her treatment may obviate the need to litigate for benefits, thus avoiding costs associated with litigation, including those resulting from delayed case closure.

*Less severe workers' compensation injuries and illnesses.* High quality, early medical treatment, as intended by s. 440.015, F. S., may prevent the development of a permanent disability or reduce the degree of impairment.

*Quality medical care.* Promptness as specified in the intent statement of Ch. 440 is a critical aspect of quality medical care.

*Injured worker satisfaction with treatment within the system.* Injured worker satisfaction with medical care can have a direct impact on response to treatment, propensity to litigate, and return to work. Satisfaction and costs may be inversely related for certain aspects of the system.

*Early, appropriate return to gainful employment.* Quality medical care for injured workers includes frequent communication among the employer, the adjuster, and the injured worker, the goal of which is to get the injured worker back to work as soon as possible. Well-designed managed care should facilitate communication and, thus, the worker's return to the workforce, reducing the need for prolonged payment of benefits.

*Reduced litigation rate.* In a self-executing

system, disputes among the parties would be resolved equitably, quickly, and informally. The best deterrent to litigation is to promptly provide injured workers with all due and appropriate benefits and services, including medical services. When medical disputes occur within a workers' compensation managed care arrangement (WCMCA), the law stipulates that they be resolved through a well-defined grievance procedure. Successful resolution of these disputes may forestall the need for litigation.

Table B3.1 contains suggested measures for these goals based on data collected by the division. As reported in the following section, these measures utilize data available as of February 29, 2000, for workers with lost-time injuries sustained in or after 1993.

## ***Outcome Measures***

### ***1. Medical Costs***

Undoubtedly, one purpose of mandatory managed care is to contain medical costs. The most direct and immediate way to achieve this might involve more restraint in the use of tests and procedures and reduced provider compensation compared with fee-for-service arrangements. Figure B3.1 shows that, at a comparable vintage of 18 months after the year of injury, average medical costs have risen slowly and steadily for injury years since 1993. However, inflation in medical costs during the period must be considered to avoid comparison of dollar amounts unequal in purchasing power. Figure B3.1 illustrates the impact of inflation by displaying what medical care costing \$4,757 on January 1, 1993, would have cost at the end of each injury year factoring in the average yearly inflation for medical care reported in the Consumer Price Index. By December 31, 1997, \$5,870 would have been required to purchase the same medical care valued at \$4,757 nearly five years earlier. The fact that medical costs for workers injured in 1997

**Table B3.1**

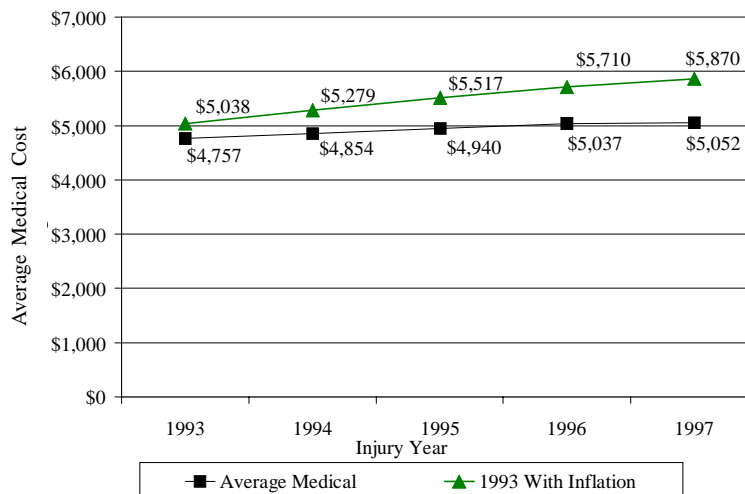
**Workers' Compensation System Goals and Measures**

Goal	Measures
Cost containment	1. Average medical cost per case 2. Average indemnity cost per case
Less severe workers' compensation injuries and illnesses	1. Percent of cases qualifying for permanent disability status
Quality medical care	1. Customer satisfaction with medical care 2. Injured worker's view of quality of communication with health care provider
Early, appropriate return to gainful employment	1. Return-to-work trends
Reduced litigation rate	1. Percent of cases with Petitions for Benefits (PFBs) by 18 months after the date of injury 2. Percent of issues on Requests for Assistance (RFAs) that are medical in nature 3. Percent of issues on PFBs that are medical in nature

Source: Chapter 440, Florida Statutes, and data available from the Division of Workers' Compensation

**Figure B3.1**

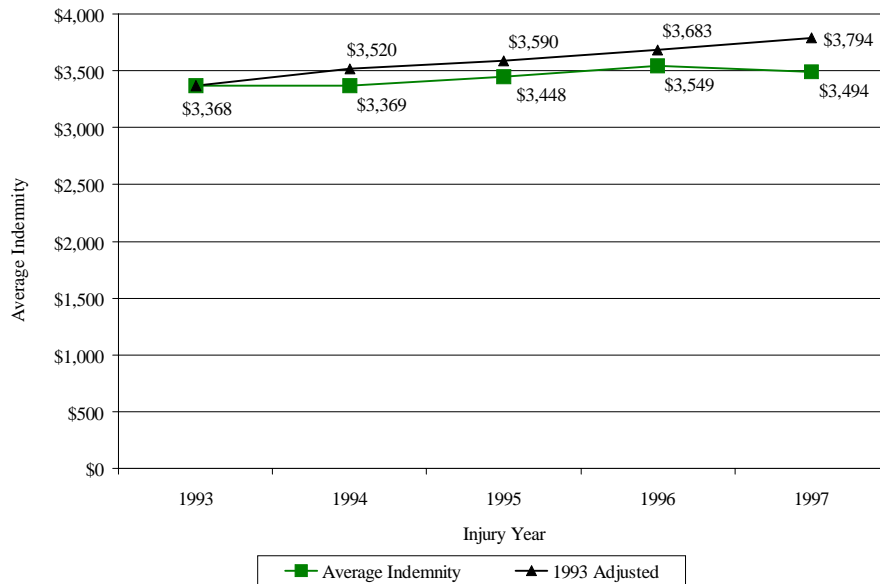
**Average Medical Cost Per Lost-Time Claim by Year of Injury at 18 Months Post-Injury Year (1993-1997)**



Source: Division of Workers' Compensation Claims Files as of June 30, 1995, 1996, 1997, 1998, and 1999, and the Consumer Price Index, Bureau of Labor Statistics, U. S. Department of Labor

Figure B3.2

**Average Indemnity Cost Per Lost-Time Claim by Year of Injury at 18 Months Post-Injury Year (1993-1997)**



Source: Division of Workers' Compensation Claims Files as of June 30, 1995, 1996, 1997, 1998, and 1999, and the maximum compensation rate 1993-1997

averaged \$5,052 suggests an actual decline in medical costs using dollars held constant in purchasing power. This trend of decline can be seen in the incrementally widening distance between the lines in the figure with each subsequent injury year. Trends in benefit costs at later points of case maturity may or may not reflect a similar pattern, and any characterization of such costs would require examination of data beyond 18-month maturity.

the year of injury for workers injured between 1993 and 1997. Juxtaposed with this information is the 1993 indemnity average adjusted to reflect increases in the annual statewide growth in average wages, a proxy for wage inflation. Measured in constant dollars, indemnity costs have declined over the period. The decline that occurred after managed care became mandatory on January 1, 1997, is apparent even without adjustment for inflation.

2. Indemnity Costs

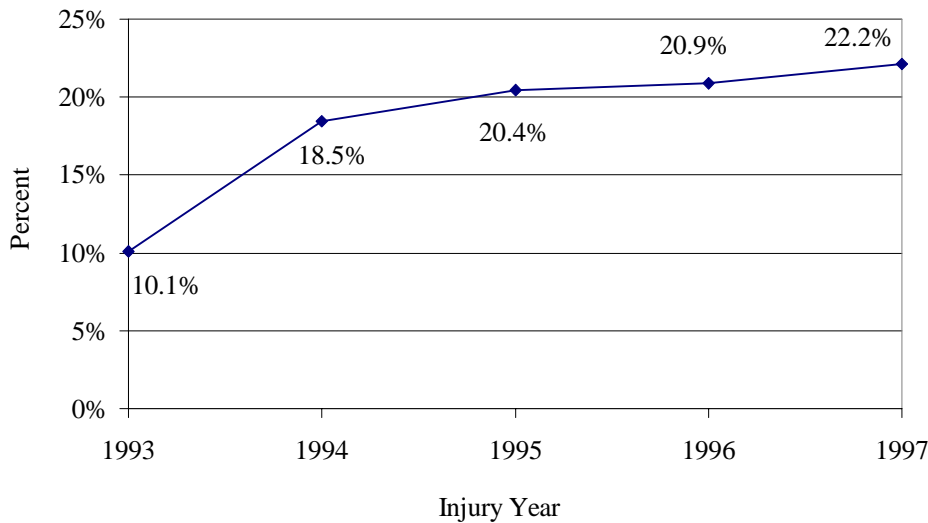
High quality medical care might be expected to reduce work time lost by an injured worker, thereby reducing the period of eligibility for indemnity benefits and, thus, the amount of those benefits. Figure B3.2 shows average indemnity benefits at 18 months after

3. Less Severe Workers' Compensation Injuries and Illnesses

Improvement in the quality of medical care might be expected to mitigate case severity. One way of examining injury severity is to evaluate the percent of cases reaching permanent disability status (either

**Figure B3.3**

**Percent of Lost-Time Cases Reaching Permanent Disability Within 18 Months After Year of Injury (1993-1997)**



Source: Division of Workers' Compensation Claims Files as of June 30, 1995, 1996, 1997, 1998, and 1999

partial or total) at a fixed interval after injury. Other things being equal, fewer cases reaching permanent disability status would reflect well on the quality of medical care provided to injured workers. Rates of permanent disability are summarized in Figure B3.3 at 18 months after the year of injury. The sharp increase in this measure for 1994 injuries is directly attributable to the change in statute allowing all workers with impairment ratings to receive Impairment Income benefits regardless of their employment status or wage level. The increase in the percentage of cases at the 18-month interval may also be partially due to the statutory truncation of the duration of temporary benefits. Since 1994, however, there has been a gradual increase in the percent of lost-time cases qualifying for permanent benefits.

*4. Quality Medical Care and Injured Worker Satisfaction with Treatment within the System*

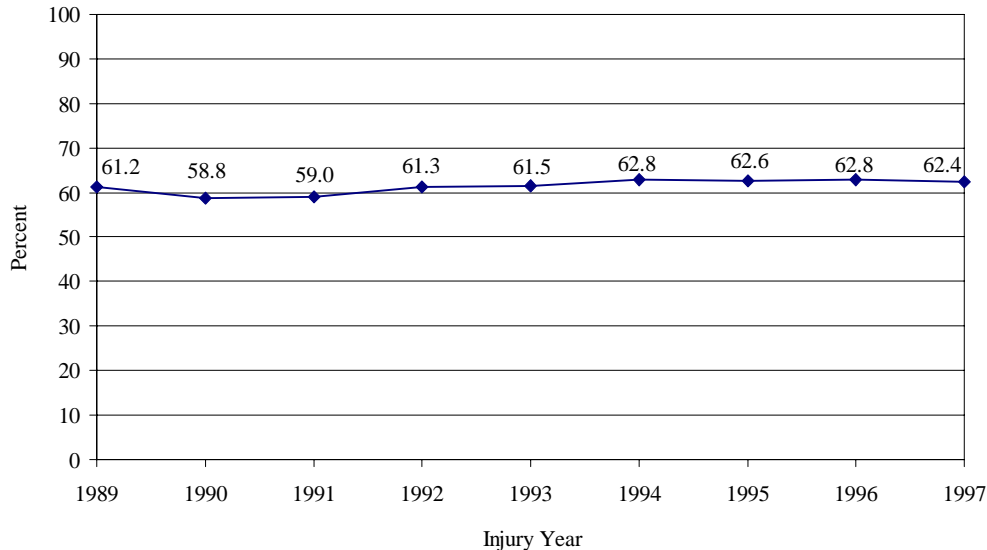
Results of a survey of 1,050 workers injured in late 1998 and early 1999, conducted by the Division of Workers' Compensation within three months of the date of injury, show that only 23.8% of respondents expressed any dissatisfaction with the medical care provided. More than 80% felt that their treating physician communicated effectively with them about their condition. Presumably, all workers surveyed were treated within a managed care arrangement. Unfortunately, we have no historic data on these measures, but these 1999 data may be used as a baseline against which future survey results can be compared.

*5. Early, Appropriate Return to Gainful Employment*

Successful return to work requires cooperation among many parties: the adjuster, the health care provider, the employer, and the injured worker. To the extent that the managed care arrangement can fa-

Figure B3.4

**Percent of Lost-Time Cases Returning to Work at 80% or More of Previous Wage within One Year of Injury (1989 - 1997)**



Source: Division of Workers' Compensation Claims File as of February 29, 2000, and Unemployment Compensation Wage File

cilitate this cooperation, the chance of timely return to work increases. Figure B3.4 shows a gradual increase in overall return-to-work rates for 1992 through 1994 injuries following a two-year slump. For 1994 through 1997 injuries, these rates have leveled off.

6. Reduced Litigation

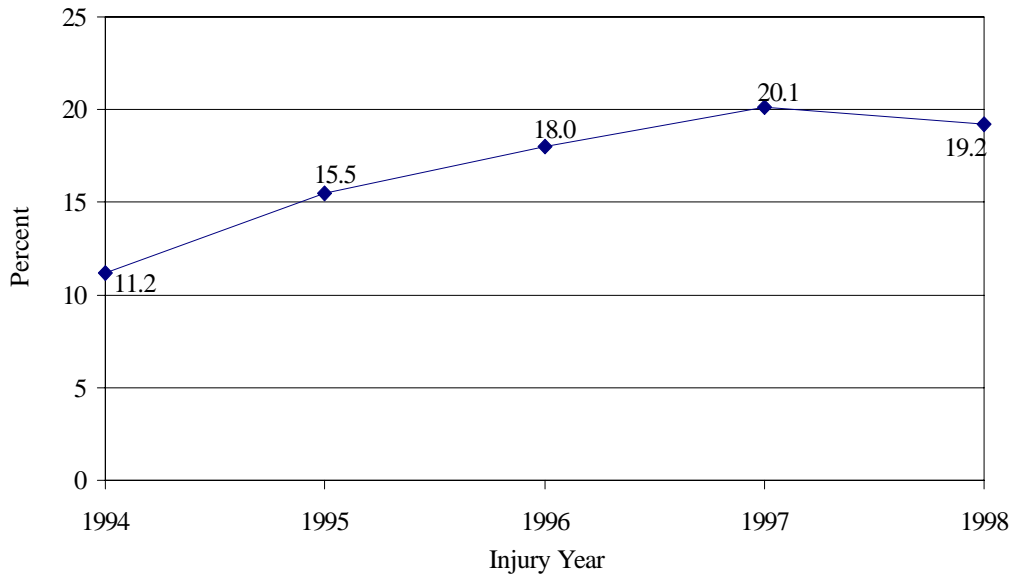
If managed care arrangements are providing quality medical care to the satisfaction of injured workers, there might be an overall reduction in litigation rates, especially if medical disputes are being effectively resolved within the WCMCA. Certainly, if the WCMCA grievance procedures are effective, there should be an evident drop in medical issues submitted on Requests for Assistance (RFAs). There might even be a reduction in medical issues on Petitions for Benefits (PFBs).

Depicting litigation rates as the percent of lost-time injuries with PFBs filed within 18 months of the date of injury, Figure B3.5 illustrates a consistent increase in litigation for injury years 1994 through 1997, with a slight decline for 1998. Interestingly, 1997 shows the highest litigation rate of all years reported in the figure, and 1997 and 1998 both show higher litigation rates than the preceding injury years.

Figure B3.6 focuses on medical issues on RFAs and PFBs. The percent of issues on RFAs that are medical in nature did decline slightly since the introduction of mandatory managed care. A similar downward trend beginning in 1997 is seen for the relative share of medical issues on PFBs. These two results could reflect the success of managed care grievance procedures in curtailing litigation of some medical issues through early resolution. Moreover, the decline in medical issues may suggest that the increase in litigation depicted in Figure B3.5 is unrelated to man-

**Figure B3.5**

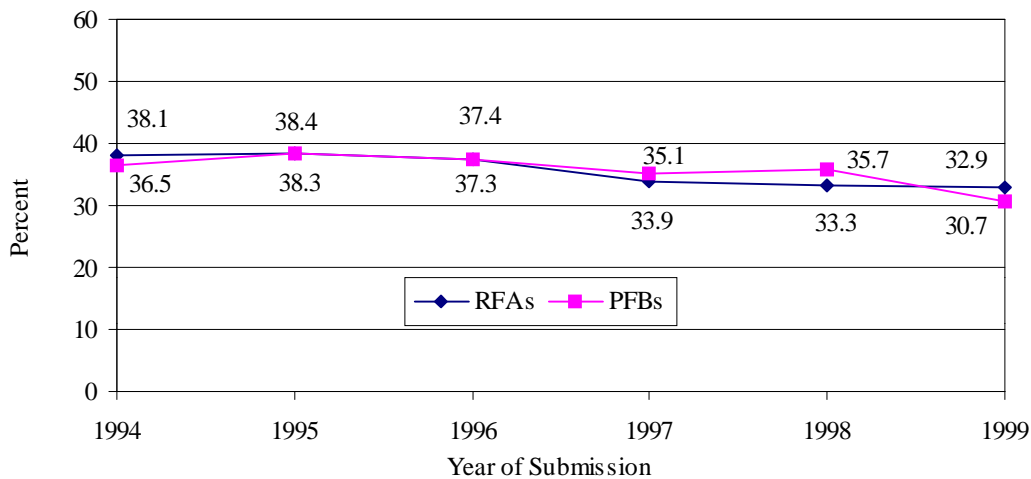
***Percent of Lost-Time Cases with Petitions for Benefits within 18 Months Post-Injury (1994 - 1998)***



Source: Division of Workers' Compensation Claims File and Total Dispute Resolution Database as of February 29, 2000

**Figure B3.6**

***Medical Issues as a Percentage of All Issues on Requests for Assistance and Petitions for Benefits by Year of Submission (1994 - 1999)***



Source: Division of Workers' Compensation Total Dispute Resolution Database as of February 29, 2000

aged care.

### 7. Summary

Overall, four of the outcome measures discussed in this section are consistent with the desired impact of managed care:

- Average medical costs figured in constant dollars have diminished.
- Average indemnity costs figured in constant dollars have diminished.
- Most injured workers appear to be satisfied with the medical care they are receiving.
- The relative frequency of medical issues on RFAs and PFBs has declined.

Conversely, other outcome measures may appear at first glance to be inconsistent with the desired impact of managed care. These include the increasing percentage of permanent disabilities and the static return-to-work rate. But imputing impact or lack of impact specifically to managed care rather than to other factors raises some deeper issues. The following section discusses the most pressing of these.

### ***Outcomes and Impacts***

The fact that a system outcome occurs concurrently with managed care does not suffice to establish that managed care brought about the outcome; the two may be completely unrelated apart from coincidental simultaneity. Given the numerous and diverse forces driving workers' compensation, isolating the impact of a single factor is exceedingly difficult even when requisite data are available. With regard to managed care, many of the data required for isolating its impact are simply not collected by the division. Particular areas where this problem is most pressing are delineated below.

#### *1. The Implementation of Managed Care*

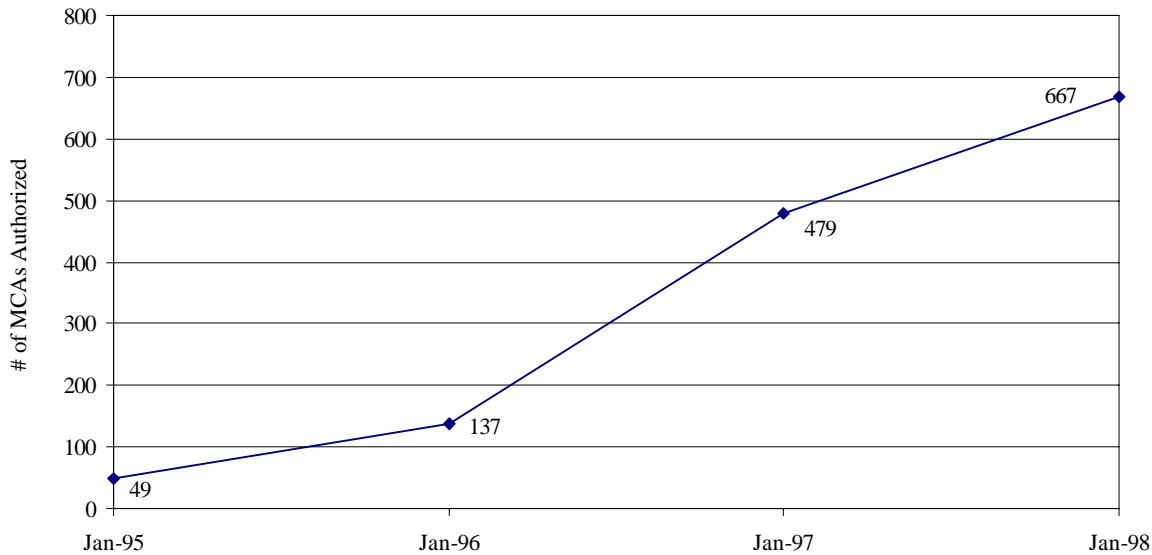
Though managed care became mandatory for treatment of workers' compensation injuries on January 1, 1997, managed care had already established itself within the system well before that date. The 1993 reform legislation allowed carriers who used managed care to offer premium discounts to participating employers. Some employers took advantage of this option; what the *division* does not know is who these employers were. Given that identification of individual workers treated under managed care is not collected by the division, the missing information on employer utilization of managed care results in an inability to separate managed care from non-managed care treatment. This very basic identification is essential for assessing the impact of managed care.

To compensate for the lack of employer-specific information, assumptions about the implementation of managed care may be considered as a proxy for identifying treatment under its auspices. Two distinct emphases are possible. The first stresses a gradualism in the implementation of managed care such that the years following the 1993 reforms saw a steady, incremental rise in the utilization of managed care that did not reach 100% even when workers' compensation managed care became mandatory on January 1, 1997. The other view of implementation, while acknowledging managed care participation prior to 1997 and a continuation of some non-managed care treatment after 1997, emphasizes 1997 as having a unique surge in the treatment of workers' compensation injuries under managed care. From this perspective, measuring the impact of managed care could reasonably employ a before and after comparison based on January 1, 1997, as the treatment date.

Figure B3.7 shows the number of workers' compensation managed care arrangements authorized by AHCA as of the beginning of 1995 through 1998. Under the assumption that the number of authorized managed care arrangements is correlated with the ex-

Figure B3.7

**Number of Workers' Compensation Managed Care Arrangements Authorized as of January 1, 1995 - 1998**



Source: Agency for Health Care Administration

tent of treatment under managed care, it would be expected that 1997 did, in fact, register an upsurge in managed care treatment exceeding an incrementalist interpretation. Still, the fact that there were nearly 29% as many authorized managed care arrangements at the beginning of the preceding year suggests that managed care was already a significant factor in workers' compensation prior to 1997.

Questions surrounding the implementation of managed care have a direct bearing on the attempt to link outcome measures to the specific impact of managed care rather than to other factors. For example, the data on average medical cost per case provided in Figure B3.1 show an incrementally increasing decline for the 1993 through 1997 injury years when measured in constant dollars. If managed care was utilized to an insignificant extent in the years prior to 1997, the decline in average medical costs noted for those

years could not be regarded as its impact. The 1993 reforms did include a number of other provisions that could have reduced medical costs (maximum fee schedules, health care provider certification, expanded authority for utilization reviews, and limitations on chiropractic treatment, to mention the most prominent). To show an impact for managed care would require (a) precisely characterizing its utilization in workers' compensation and (b) isolating its impact from that of other factors. With its differing interpretations, the implementation of managed care is sufficiently questionable that its use as a proxy for (a) is open to objection. Therefore, without additional data on the utilization of managed care in workers' compensation, no link of impact can be established between managed care and system outcomes. Only statements of a weaker kind, such as "some system outcomes are consistent with the desired impact of managed care," can be made.

2. Medical Only and Lost-Time Cases

Most of the data collected by the division pertain to lost-time cases, yet these represent only a minority of workplace injuries. A recent report published by the Workers Compensation Research Institute, *Benchmarking the Performance of Workers' Compensation Systems*,<sup>2</sup> states that, for injury year 1996, about 18% of Florida's workers' compensation injuries became lost-time cases. The remainder, termed *medical only* cases, were instances of injury not resulting in loss of work time beyond seven days. Medical only cases are subject to the same health care delivery system as lost-time cases.

The lack of data on medical only cases suggests a specific problem for assessing managed care: Any impact on medical only cases, including an increase in the proportion of these cases relative to lost-time cases, would not be evident in the division's outcome measures. This could be a critical omission contributing to erroneous conclusions. For example, the data on rates of permanent disability in Figure B3.3 and the return-to-work rates in Figure B3.4 may be inflated in the first instance and diminished in the second because of an increase in the ratio of medical only to lost-time cases resulting from improved medical treatment. Any reduction in the proportion of workplace injuries requiring loss of significant work time would imply that remaining lost-time cases resulted from more serious injuries, which would help to make sense of the data in Figures B3.3 and B3.4. Oddly enough, the very effectiveness of managed care could result in a seeming deterioration of these outcomes. Examination of data on lost-time cases alone would not disclose this. Furthermore, even if it were established that managed care had no impact on system outcomes for lost-time cases, the same conclusion could not be *assumed* with respect to medical only cases. Assessment of workers' compensation managed care requires a broader perspective on workplace injuries than is available through division data.

3. Variations in Managed Care Practices

Whatever may be generic to the concept "managed care," it should not be automatically assumed that practices pertinent to outcomes are invariant from one arrangement to another. In fact, evidence gathered through surveys of managed care arrangements by AHCA staff demonstrates considerable variability. Recently, the number of AHCA-approved WMCAs has varied from 500 to 600. One approved WCMCA may contain several distinct configurations that vary with respect to overall administration, provider network, provider of utilization review, provider of quality assurance, case manager, and administrator of the grievance procedures. Therefore, although there may be only 500 approved managed care arrangements, there may be as many as 800 different configurations of services at any one time. AHCA separately surveys each unique configuration.

When AHCA conducts a survey, it evaluates the WCMCA's practices using 43 standards. For the 54 surveys conducted in 1999, eight WMCAs (14.8%) passed all the standards; 43 WMCAs (79.6%), including the eight with perfect scores, were deficient on five or fewer standards. The remaining 11 (20.4%) surveyed WMCAs were deficient on six to 14 standards. These deficiencies were spread across the entire spectrum of standards; only seven of the 43 standards (16.3%) did not emerge as deficient practices among any of the 54 WMCAs surveyed. Eighty-four percent (36) of the 43 standards were violated by at least one WCMCA. This finding supports the hypothesis that WMCAs differ significantly in their practices. Parenthetically, discounting the fact that close to 25 of the unique WCMCA configurations surveyed fell under one particular WCMCA, there were a few standards that were more likely than others to be violated. Standards violated by at least eight of 54 survey respondents were:

- Inclusion of trend analysis in the evaluation of grievances
- Evaluation of injured employee satisfaction

- A process for conducting quality assurance and for disseminating findings pertaining to quality assurance

- An ongoing, systematic process for evaluation of completeness of medical records

Given that 14.8% of WCMCAs passed on all survey items, the fact that an equal or greater number of WCMCAs failed on the important practices listed above is another indication of variability in practices. Once this variability is acknowledged, the task of evaluation research is to study outcomes relative to specific practices rather than to assume the equivalence of WCMCAs in producing outcomes. Generic attribution of impact or lack of impact may be inappropriate as a research objective.

***Benchmark Workers' Compensation Managed Care Arrangements?***

Three WCMCAs have offered themselves to the division as illustrative of successful results: Employer A (an employer that has developed and implemented its own authorized WCMCA), Blue Cross/Blue Shield (BC/BS), and Occupational Health Systems (OHS). With regard to outcomes, what is interesting about all three is their relative infrequency of lost-time cases compared to the statewide average. While lost-time cases in Florida have been running about 18-20% of workplace injuries, the three WCMCAs considered here show lower percentages. During 1999, just 15% of injuries for two employers served by OHS, and 2% of the third OHS employer's injury cases, were lost-time. For employers served by OHS, the percent of injuries that were lost-time dropped significantly when OHS began providing medical services. For the same injury year (and the three years preceding its use of managed care), Employer A's lost-time rate hovered around 5%. BC/BS reports a 50% drop in lost-time cases the first year an employer is covered under their WCMCA. These data may imply that minor injuries do not develop into

lost-time cases as frequently for these employers as for the general population. To the extent—here unknown—that such results stem from practices of the WCMCA rather than other factors, the impact of managed care could be viewed as encouraging.

Table B3.2 juxtaposes some minimal practices of managed care arrangements with specific practices of these three putatively model WCMCAs. Practices of particular note common to all three include:

- Specialized and in-depth training for health care providers;
- Encouragement of teamwork and communication among individuals involved in each case;
- Aggressive return-to-work programs;
- A well-articulated quality-of-care system.

Subsequent research must define and develop measures for the practices that may be particularly effective in reducing the relative frequency of lost-time cases.

***Conclusion: The Evidence in Perspective***

Based on data collected by the division, some system outcomes have shown trends consistent with the desired impact of managed care. These include diminished medical and indemnity costs (figured in constant dollars) and a reduction in disputed medical issues submitted through workers' compensation resolution processes. Additional data collected in a survey of injured workers indicate that a large majority of injured workers were satisfied with the medical treatment they received. Clearly, cost containment and worker satisfaction are encouraging system outcomes; what remains unclear is the extent to which these outcomes represent the impact of managed care rather than the impact of other factors.

Data collected by the division simply do not

allow answering this question. Missing is a way to separate treatment provided under managed care from other treatment provided to injured workers. Without this very fundamental information, isolating the impact of managed care is not possible. System outcomes may be described but not explained.

Complicating the matter further is the question of whether data pertaining to lost-time cases could in principle capture the full impact of managed care. The problem is that lost-time injuries are only about a fifth of all workplace injuries, so any impact of managed care on outcomes for the other four-fifths of injured workers would escape detection through sole use of lost-time data. This is not just an issue of overlooking an impact on medical only cases, but of misinterpreting observed outcomes for lost-time cases: If there are different aggregate characteristics of lost-time cases before and after managed care resulting from an increased frequency of medical only cases, outcome measures for lost-time cases may reflect these population differences rather than an impact of managed care on some supposedly homogeneous population. Data on medical only cases are needed both to examine the full range of managed care's potential impact and to avoid misinterpreting outcomes associated with dissimilar populations.

The Workers' Compensation Research Institute has compiled some fairly recent and preliminary data on the frequency of lost-time cases in Florida. At an average of 12 months after the date of injury, the percent of workplace injuries that result in a lost-time case has remained fairly constant in Florida, 19% of 1994 injuries and 20% of 1998 injuries.<sup>3</sup> These data in themselves do not support the conclusion that managed care has altered the distribution of medical only and lost-time cases. Nonetheless, three managed care arrangements have provided information to the division claiming substantial success in reducing the frequency of lost-time cases. Though the division lacks data to verify these claims, the possibility that such results could be achieved invites further investigation. Differences in outcomes suggest further need

for an investigation of practices underlying those outcomes. The assumption that managed care is a generic "independent variable" should be put to an empirical test.

In all, the division cannot settle the debate surrounding managed care in workers' compensation. Encouraging outcome measures noted above may or may not represent an impact of managed care. Policymakers considering an abandonment of mandatory managed care should carefully assess the evidence before proceeding. Using data not collected by the division, further research is needed to probe questions surrounding the implementation of managed care, the net impact of managed care on both medical only and lost-time cases, and variations in practices relative to differences in outcomes. Without more information on these and other topics, policymaking is proceeding by hunch and conjecture.

### *Footnotes*

<sup>1</sup> It should be noted that responsibility for the regulation of medical care under workers' compensation was transferred from the division to AHCA as a result of a memorandum of understanding drafted under instruction of the Governor's Office. The effective date of the transfer was August 29, 2000. This chapter was prepared using data obtained prior to the transfer.

<sup>2</sup> *Benchmarking the Performance of Workers' Compensation Systems: CompScope Multistate Comparisons*. Workers Compensation Research Institute, 2000.

<sup>3</sup> Personal communication with Carol Telles of the Workers Compensation Research Institute, January 4, 2001.

**Table B3.2**

***Managed Care Practices***

<b>Minimal Practices</b>	<b>Employer A</b>	<b>Blue Cross/Blue Shield</b>	<b>Occupational Health Systems</b>
Network of “willing providers” given some training in workers’ compensation	<ul style="list-style-type: none"> <li>■ All physicians in network receive enhanced education regarding WCMC.</li> <li>■ Network consists of experienced workers’ compensation providers.</li> <li>■ “Fair” reimbursement rate for services provided</li> </ul>	<ul style="list-style-type: none"> <li>■ Physicians required to have workers’ compensation experience.</li> <li>■ “Fair” reimbursement rate for services provided</li> </ul>	<ul style="list-style-type: none"> <li>■ Provider network members receive special education regarding WC.</li> <li>■ Select highly qualified WC physicians</li> </ul>
Health care providers provide treatments only as they would in the general health arena	<ul style="list-style-type: none"> <li>■ Care is a team effort involving regular communication with adjuster and supervisor.</li> <li>■ Physicians play a valued role in disability management.</li> <li>■ Medical care coordinator (MCC) and primary care physician (PCP) serve as team leaders of a team consisting of employer, injured worker, adjuster, nurse.</li> </ul>	<ul style="list-style-type: none"> <li>■ Physicians play a valued role in disability management.</li> <li>■ Medical care coordinator (MCC) and primary care physician (PCP) serve as team leaders of a team consisting of employer, injured worker, adjuster, nurse.</li> </ul>	<ul style="list-style-type: none"> <li>■ Health care providers are rewarded based on quality of care and cooperation with employers regarding return to work.</li> <li>■ Health care providers have a return-to-work focus with workers’ compensation patients.</li> </ul>
Case oversight by adjuster, nurse case manager, or occasionally by a physician	<ul style="list-style-type: none"> <li>■ Medical oversight of every case by a physician medical care coordinator</li> <li>■ Nurse case manager communicates medical information between MCC or PCP and adjuster.</li> </ul>	<ul style="list-style-type: none"> <li>■ MCC oversees every case meeting established criteria.</li> <li>■ Nurse case manager communicates medical information between MCC or PCP and adjuster.</li> </ul>	<ul style="list-style-type: none"> <li>■ Cases are managed by RN skilled care managers, providing medical care coordination and/or catastrophic management.</li> <li>■ Medical and case management oversight by Medical Director and Clinical Director</li> <li>■ RN case manager coordinates patient care among medical provider, employer and adjuster.</li> </ul>

**Table B3.2**

***Managed Care Practices***

<b>Minimal Practices</b>	<b>Employer A</b>	<b>Blue Cross/Blue Shield</b>	<b>Occupational Health Systems</b>
Return to work (RTW) is recognized as a system goal but implementation is left up to the individual WCMCA.	<ul style="list-style-type: none"> <li>■ All parties are aware of active RTW program.</li> <li>■ RTW is primary goal that all involved in case work towards.</li> <li>■ MCC held accountable for preventing cases from attaining lost-time status.</li> <li>■ MCC verifies work restrictions and evaluates work site.</li> </ul>	<ul style="list-style-type: none"> <li>■ MCC held accountable for preventing cases from attaining lost-time status</li> <li>■ MCC verifies work restrictions, evaluates work site, and assists with job modification.</li> </ul>	<ul style="list-style-type: none"> <li>■ Proactive and aggressive RTW focus</li> <li>■ Assist employers in development of RTW programs, identifying transitional and modified work</li> <li>■ Use of job analysis for prompt RTW</li> </ul>
Some type of quality assurance in place	<ul style="list-style-type: none"> <li>■ Quality of care is overseen by medical care coordinator.</li> <li>■ Quality assurance committee makes global policy and procedure decisions.</li> </ul>	<ul style="list-style-type: none"> <li>■ Quality of care overseen by MCC</li> </ul>	<ul style="list-style-type: none"> <li>■ Open cases are reviewed by Clinical Director based upon clinical milestones.</li> </ul>
Some type of utilization review (UR) process	<ul style="list-style-type: none"> <li>■ UR trends are analyzed retroactively.</li> <li>■ UR is conducted by MCC in conjunction with case management.</li> </ul>	<ul style="list-style-type: none"> <li>■ Fair reimbursement to medical providers reduces UR issues.</li> </ul>	<ul style="list-style-type: none"> <li>■ System integration for better utilization review and management</li> <li>■ Utilization of integrated practice parameters and disability management protocols</li> </ul>
No particular emphasis on communication and teamwork among the parties	<ul style="list-style-type: none"> <li>■ Integrated approach in case management—medical care coordinator, treating physician, adjuster, nurse</li> <li>■ Physician is a key member of the team.</li> </ul>	<ul style="list-style-type: none"> <li>■ MCC and PCP serve as team leaders (other members: employer, injured worker, adjuster, nurse).</li> </ul>	<ul style="list-style-type: none"> <li>■ Aggressive communication strategies among injured worker, provider, employer</li> <li>■ Utilization of telecommunication and internet communication strategies</li> </ul>

Source: Personal communication with managers at Employer A, Blue Cross/Blue Shield, and Occupational Health Systems