Improving Disability Management in the Workplace

Insurance Implications

Carolyn L. Vash, PhD
Senior Researcher
Conwal Incorporated
Falls Church, Virginia

Introductory Summary

The National Institute of Disability and Rehabilitation Research (NIDRR) contracted with Conwal Inc. of Falls Church, Virginia, to gather experts' perceptions of the state of the art in disability management, and their opinions as to major problems experienced by disability management personnel. Four focus groups were conducted for this purpose on topics agreed on by experts as needing problem-solving and improvements: psychiatric disabilities, pain disabilities, educating disability management personnel, and communications. Also, NIDRR sought experts' perspectives on workable avenues to solution and recommendations to inform NIDRR's priority setting and planning efforts. A National Issues Forum was conducted for this purpose, at which the focus groups' emergent priorities were deliberated. The topics included reforming professional's academic curricula; depression in the workplace; an ideal model of disability management; maintaining occupational bonding until return-to-work is accomplished; and establishing standards and criteria for determining the presence, severity, and changes in compensable disability. The last of these has clear implications for insurance-related decision making, but many of the other topics pursued in the focus groups also devolved upon insurance payment/reimbursement decisions at some point in the discussions.

Study Procedure

First, an advisory committee of disability management experts was convened to select the top priority focus group topics and suggest experts in each area who might participate. Each group has approximately eight participants, chosen to represent the major disciplines involved in disability management on each given topic—employers, physicians, nurses, insurers, attorneys, physical therapists, vocational consultants, work evaluators, and so forth, plus researchers. Typescripts of the discussions were subjected to content analysis with the following goals: to delineate the separate issues, state them clearly and succinctly, reduce them to a conceptually manageable set of clusters, estimate their priorities, and recommend those which should be addressed by invited papers on "avenues to solution" to be presented at the National Issues Forum. This article concentrates on conveying information about the insurance-related issues identified in the focus group discussions. Readers interested in the full report, which includes the six papers presented and refined at the Forum, may wish to secure copies of the report titled Linking Disability Management in the Workplace with Healthcare and Rehabilitation Resources from the National Rehabilitation Information Center (NARIC).

Insurance-related Issues Identified in the Focus Groups

Focus group participants shared their experiences and perspectives on a broad array of disability-management issues. Issues bearing explicit or implicit relationships to insurance decision making will be briefly encapsulated and illustrated by quotations from the participants themselves.

Focus Group on Psychiatric Disabilities

The participants generally agreed that psychiatric treatment is extremely expensive. Many questioned the effectiveness of treatments that are traditionally used and reimbursed by third-party payors despite an absence of validating evidence. In some cases, e.g., psychiatric hospitalization, widespread ineffectiveness may have been documented, yet, because the approach is traditional, insurers are comfortable in paying/reimbursing for such services. On the other hand, many non-traditional treatments considered state-of-the-art are denied by insurers simply because they are non-traditional. Frustration was expressed over this perceived disjunction between expert estimates of treatment effectiveness and insurers' reimbursement policies.

"If I can keep somebody out of the hospital and keep him working for years, I can't collect a penny of third-party reimbursement. But if he gets sick because he doesn't have my kind of services [the third party payors] are right there writing checks to a hospital that will cost a lot and won't help him return to work or maintain employment."

"With psychiatry, many people get the same treatment whatever the disease, particularly in patients."

"The private insurance industry had invested a fortune in private psychiatric hospitals without one scintilla of evidence that they are effective in returning people to work. The public mental health system has invested billions in private psychiatric hospitals which [research makes clear] for 30 years have been doing a great deal of damage to a great many people. We have another system that says it has an answer but nobody will give it enough rope to give it a decent try... despite some evidence that it is more effective and more cost effective."

The common failure of mainstream community medicine—primary and acute care—to know enough, or anything at all, about rehabilitation arose in this context.

"In deciding what is reimbursable, carriers rely on a panel of psychiatrists... It's going to be a long time before
psychiatrists tell you that psychiatric rehabilitation is the preferred intervention . . . we're talking about a psychiatric community that largely doesn't know what psychiatric rehabilitation is, much less support it."

The absence of vocational rehabilitation programs in many private psychiatric hospitals is, perhaps, even more frustrating to disability management team members. One participant saw this as a leverage point for getting more relevant, potentially effective, services from them.

"The private insurance industry can say to a hospital 'We're not going to pay you one penny unless you develop a vocational rehabilitation component.'"

A service provider urged third-party payors to take money now wasted on ineffective programs and put it to better use:

"Set up regulations, establish what you will and will not pay for, what you expect as outcomes, and hold people to certain performance levels."

Several others thought that employers should routinely demand this of their carriers in negotiating benefit packages.

The group did not delve more deeply into the costs issues, and the analyst observed that "until we can talk with some assurance about what treatment modalities are effective for what psychiatric condition, we cannot speak defensibly about whether the costs are high or low."

An insurance representative acknowledged that the industry's own state-of-the-art is not sufficiently advanced to let it set standards to guide payment/reimbursement decisions so readily.

"It's hard to tell what treatment is effective. Another problem is the variety of providers in psychiatry . . . we don't know how much each one contributes to the outcome. Our expectations are cloudy about what intensity and duration of treatment is required. You need rules to decide if a patient can progress from more to less intensive care, and to make reimbursement decisions. How much money can you apportion when all the new technology is competing with something that is not well defined? We need parameters, standards, guidelines that define effectiveness and appropriateness and cost-effectiveness. If you give us those, we can develop reimbursement policies and amounts that are much better than they are now. A plan for new procedures has to be well documented. If you (non-traditional providers) can define a subset of the population you're dealing with, where you've got a good batting average on reducing healthcare costs and getting the people employed, then you can sell your services."

"Non-traditional services" virtually equates to "services not heretofore reimbursed by third-party payors" and include most alternates to psychiatric hospitalization and out-patient psychiatric visits for medication and perhaps support. Approaches using the rehabilitative model and personnel other than psychiatrists are paid to be rarely reimbursed. Several participants knew of in-house program evaluation data in many service settings that could supply evidence on the effectiveness of such "non-traditional" psychological, social, and vocational rehabilitation interventions. The analyst observed that such data might be amenable to pooling, as a starting resource for establishing needed standards for industry-wide application.

Focus Group on Chronic Pain Disabilities

Project staff has been perplexed by the fact that only psychiatric and pain disabilities were chosen by the advisory committee to be featured in the focus groups. When the transcripts were analyzed, the reason was obvious. They share a lethal gene when it comes to third-party funding. Neither mental disorders nor pain can be counted on to produce measurable, physical, tissue evidence of the presence, severity, of a compensable disability.

A recurring theme in the pain group was that the insurance benefit plans and coverages that companies offer their employees are generally inadequate. There are typically gaps in coverage that employees do not know about until they try to get payment/reimbursement for health services they and their primary care providers consider necessary. Often company officials who negotiated the coverage were unaware of the gaps as well. The problem boils down to knowledge gaps at several levels. Solving it calls for better utilizing knowledge that is available, and doing research to fill actual knowledge gaps.

The primary cause of inadequate benefit plans and coverages was thought to lie in this fact: There are not uniform standards or valid criteria by which to define and establish the presence of compensable disability, to measure its degree of severity, or to measure changes in its severity or functionally limiting effects resulting from treatment or rehabilitative interventions. The following comments came from a physician.

"What constitutes disability for back pain? One physician, if a patient with five scars on his back doesn't have a definite neurophysiological deficit, will tell him to take any job he can get. Another, no matter what your findings, will say he can't go back to work at all because he's had five operations."

At the same time, a usable body of knowledge exists on assessing what people can do functionally, safely, which has applicability to establishing the needed disability determination standards. A work evaluator had this to say.

"We know how to analyze jobs, determine what a person can do safely, so we can match individuals' physical abilities with jobs' physical demands. We already have the ability to assess disabling pain, with or without equipment, using a standardized behavioral approach with demonstrated reliability. You can take subjective complaints and quantify them using a reliable method. You can't measure pain, but you can quantify someone's perspective and use that for setting standards."

The reason for this need to establish disability determination standards is the inextricably related need to establish standards for treatment and rehabilitative interventions. Although a start has been made, years of validating research will be required to establish uniform standards that could guide the insurance industry as a whole. Until then, whatever evidence exists can be used by whomever is informed about it, as it
becomes available. Oddly enough, there may be more sound data available today on innovative interventions than there is on traditional approaches. Apart from negative evidence cited earlier in the psychiatric area, traditional approaches have been used for so long in both the psychiatric and pain areas, with little competition from alternative, that some degree of efficacy is expected even though no data exists to support such presumptions. On the other hand, certain non-traditional, innovative approaches are being developed by clinician-researcher teams who know they don't have a chance to compete for third-party funding without supportive data, so they are getting it as quickly as they can.

The participants in this focus group agreed that in order to improve the quality of disability management practices in all disciplines, treatment guidelines should be set and providers should be trained to meet them and should be monitored for conformity to the guidelines. One participant observed:

“This would increase awareness among insurance adjusters and employers as to what they should be looking for ... give them guidelines by which to monitor the physicians, PTs, and so forth ... and let clinicians know they are being monitored so that the process can be educational, to improve quality.”

Faulty attitudes toward people with chronic pain and simplistic cost containment strategies, coupled with poor understanding of pain's external influences and psychological ramifications, were implicated as causes of inadequate benefits plans. Although pain is generally believed to have a psychological component, and it has been documented that family dynamics sometimes reinforce pain, benefit plans/coverages for mental health services for insureds with chronic pain were said to be very poor. A third-party payor representative observed:

“We're going through a phase of cost containment and employers are looking for limitations and exclusions. Attorneys and doctors are emphasizing physical aspects that won't have limitations. If you don’t have the coverages written into the medical plan to put someone in a chronic pain center, you can’t do it. Make sure you have coverage for PT that’s not limited to five visits per year, and for all the things an employee might need.”

Focus Group on Educating Disability Management Team Members

Although this group did not focus specifically on insurance, a few insurance-related issues were mentioned as “system symptoms.” For example:

• “Providers’ interests conflict with payors’, and payors’ with employers.”

• “Less than two percent of medical payments are for rehabilitation; the rest are for acute care.”

• “Insurance adjusters tend to see clients as magnifying their symptoms and send them to physicians they know are similarly oriented so they’ll get the information they want to cut costs and reduce liability.”

Insurers were mentioned in “educational solutions” suggested to remedy system symptoms which were identified. For example:

• “Insurance carriers, managed care systems, PPOs, HMOs, self-insureds must be educated that less is not always better. Case management to them often means controlling costs. Specifically, they need to be educated that a larger initial outlay may save money in the long run.”

• “Insurance adjusters should be included in education programs on early intervention.”

A participant in this group made an observation suggesting the possibility of a future government-industry research partnership. “Industry spends half its profits on medical programs, so it should be interested in supporting research to reduce the costs.”

Focus Group on Disability Management Communications

The last group did not address insurance issues directly, but their discussion of an ideal model for disability management does have implications for third party payors. For example:

“Work hardening doesn’t belong in a hospital setting, it belongs right in the company. A consortium for small employers might be defined more as a work-return-transition program than as a work-hardening program like we see in clinics and hospitals. It makes economic sense for a large company to do their own. You’re talking maybe $6,000 a crack for a worker to go to an outside work-hardening program, and you’ve taken the worker out of the work environment for 6 to 8 weeks. Time is the enemy in rehab. The longer you keep people away from the work environment, the longer they'll stay away. The staff in hospital or clinic-based programs may not understand the labor relations and other issues going on at the plant. Also, there is little employer involvement. But if disabled workers are coming into the workplace every day for a program, they'll be maintaining contact with supervisors.”

An exemplary disability management model will only qualify as “ideal” if it is cost effective as well as effective in returning workers with disabilities to work.

The Researcher's Conclusions

From the analysis of all four focus group discussions, the top priority insurance-related issue was judged to be that of establishing standards and criteria. According to the final report, the task looms far too large and intertwined with related tasks to be handled by a single project or designed by a single theorist or researcher.

“The first task is to develop standards and valid criteria by which to identify the presence of compensable disability, its severity, and changes following treatment or rehabilitative interventions. The second task, which depends on the findings from the first, is to establish treatment and quality-of-care standards and valid criteria. The third task, dependent on the accomplishment of the second, is
to establish commensurate professional training standards and valid criteria. This work would be valuable for all areas of disablement, but it is of crucial and immediate need to establish such standards for mental/emotional and chronic or prolonged pain conditions for which physical tissue evidence does not exist or is not detectable/measurable by today's state-of-the-art instruments. It is also crucial to establish exactly which treatments work and which don't in these areas. Insurers acknowledge that they do not know; and in the absence of certainty, they will rely on traditional rather than innovative treatments if they lack access to evidence in favor of innovative approaches.

The critical nature of the needs, combined with the enormity of the task, suggests establishing something akin to the NIDRR-supported Rehabilitation Research and Training Centers. It would be devoted to establishing standards and criteria for disability determination, treatment/rehabilitation interventions, and professional training for mental/emotional, pain, and other disabilities whose presence, severity, and changes of status are difficult to confirm and measure.

Interested readers may wish to make their concurrence or disagreement with this recommendation known to Dr. William Graves, Director of NIDRR.

PORTAMEDIC®
Health Information for the Insurance Industry.
A Service of Hooper Holmes, Inc.

A commitment to accuracy, efficiency, precision. A Hooper Holmes policy since 1899, that PORTAMEDIC® strives to deliver.

Serving the Insurance Industry, PORTAMEDIC helps deliver the paramedical information professionals rely on.

And PORTAMEDIC offers an extensive range of services:

Attending Physician’s Statements — Traditionally a time consuming report, the Attending Physician’s Statement is offered accurately and effectively by PORTAMEDIC’s staff of Professionals.

ECG’s and Blood Draws — When more comprehensive medical information is required, PORTAMEDIC is able to meet the need.

Physician Services — For larger insurance policies requiring a Physician’s examination, PORTAMEDIC can and will make the necessary arrangements.

Personal Statements — When more information is needed, PORTAMEDIC provides full services.

Referral Services — Stress/Treadmill/ECG, Timed/Vital Capacity (TVC), and X-Ray Services.

... from PORTAMEDIC in the Hooper Holmes tradition.

For the PORTAMEDIC office nearest you, call: 800-782-7373, or write: PORTAMEDIC, 170 Mt. Airy Road, Basking Ridge, NJ 07920.

® © Copyright 1999. Hooper Holmes, Inc.