

## INTERNAL MEDICINE

### *Improving Outcomes When Red Flags Fly*



DWC Educational Conference

February 10, 2015

- Nachman Brautbar, M.D.
- Ernest C. Levister, Jr., M.D., F.A.C.P
- Arthur E. Lipper, M.D.

## The Grand Compromise 101 Years Ago



Enshrined in the California Constitution, the workers' compensation system must include "full provision" for such medical, surgical, hospital, and other remedial treatment as is **reasonably** necessary to cure or relieve the effects of injuries and illness. . . and shall accomplish substantial justice in all cases **expeditiously, inexpensively**, and without encumbrance of any character, all of which matters are expressly declared to be the social public policy of this State

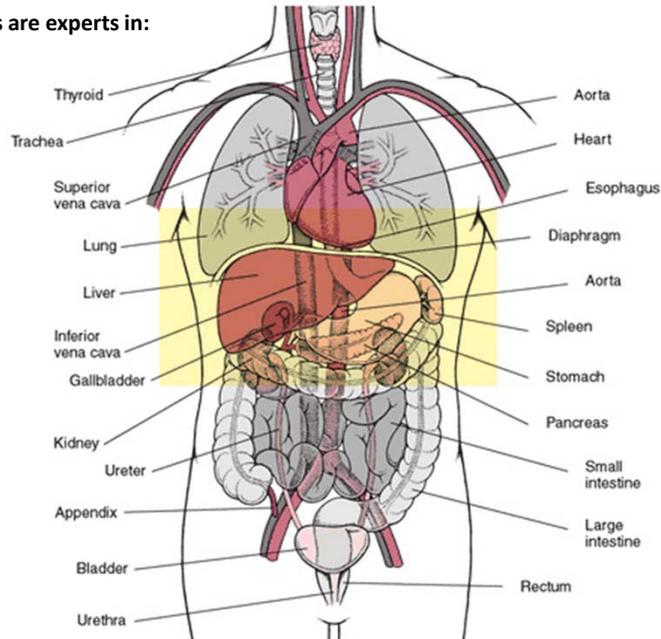
## Internal Medicine Physicians

- Medical Doctor (MD) and Osteopathic Physician (DO) Specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of internal injuries and illnesses

## Areas of Internal Medicine Expertise

- Internal Organs
- Adverse Outcomes of Treatment
  - Infections - Diabetes - Cancer
- Hypertension and Coronary Artery Disease
  - Endocrinology
  - Rheumatology
- Gastroenterology
  - Toxicology
  - Nephrology
  - Liver disease
  - Hematology

**Internists are experts in:**



## **Internal Medicine's Balancing Act**



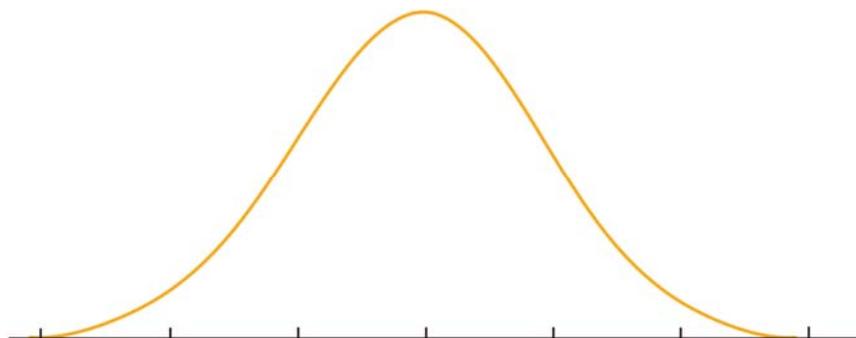
- Diagnostic problems
- Treatment problems
- Preoperative clearances
- Post operative complications
- Acute and chronic treatment of disease
- Mitigation of concurrent factors or co-morbidities

## Cost Drivers



- Medical Treatment: acute & chronic
- Temporary & Permanent Disability
- Interpreters
- Adjustors
- Utilization review
- Bill review
- Attorneys
- Medical-Legal evaluations
- Judicial system

## The Bell-Shaped Curve





## FDA

Generally same quality and performance  
Research shows performance & effect: generic = brand  
Generics & brands don't always work the same in all humans  
Generics are often 50 to 85% cheaper than the brand name product  
Generics -- no clinical trials, advertising, marketing or promotion  
More than one generic company = competition  
Monitor Adverse Events Reports for generic drugs to insure safety



## Label vs Off-Label

Label regulated by FDA  
Prescribing scope and practice of medicine  
Practice of medicine free to prescribe a drug for any reason Dr. thinks medically appropriate  
One in five outpatient prescriptions in US are for off-label therapies  
Not required to tell a patient that a drug is used off-label  
Off-label may be indication, age, dosage, length of time  
Off-label use often represents the standard of care (ingrained)  
Firm scientific rational and sound medical evidence support manner prescribed  
Prescribing physician is responsible for outcome

## Treatment Guidelines

- **Proposed § 9792.21.1. Medical Evidence Search Sequence**

1. Medical Treatment Utilization Schedule (MTUS)
2. Current version of ACOEM or ODG
3. National Guideline Clearinghouse
4. Current scientifically-based, peer-reviewed published articles



### **National Guideline Clearinghouse**

Agency for Healthcare Research and Quality  
U.S. Department of Health & Human Services  
Public resource for evidence-based clinical practice guidelines

[www.guideline.gov](http://www.guideline.gov)

**Hypertension**  
*The Silent Killer*

Normal 130/85

Stage 1 140-159/90-99  
 Stage 2 160-179/100-109  
 Stage 3 >180/>110

**Damage from high blood pressure**

Stroke

Heart attack

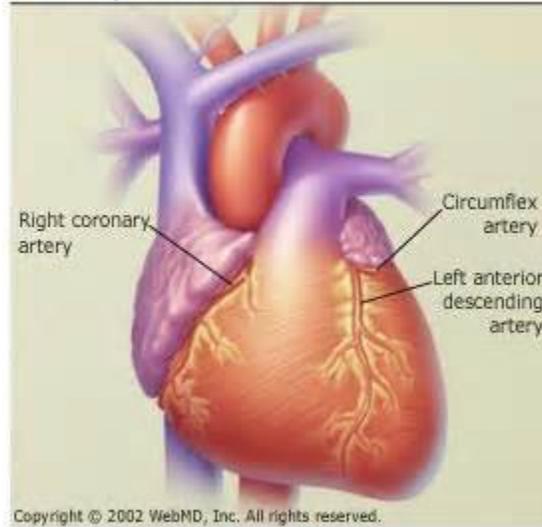
Heart failure

Kidney failure

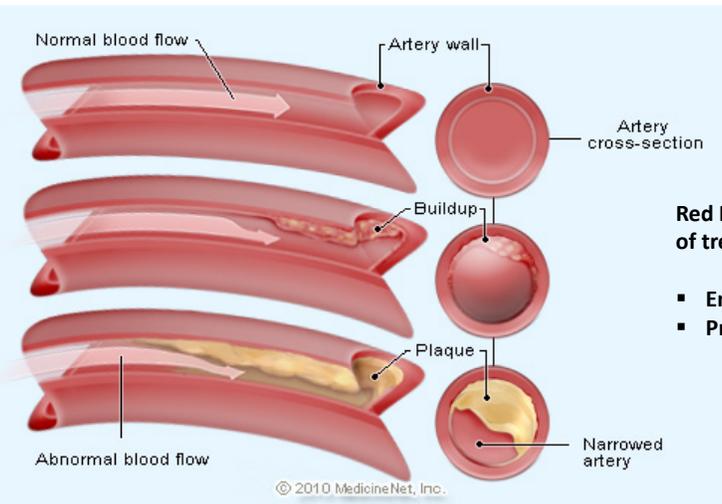
Blindness

**Red Flag! Cure < 5%  
 Treatment for life to  
 prevent damage**

### Coronary Arteries

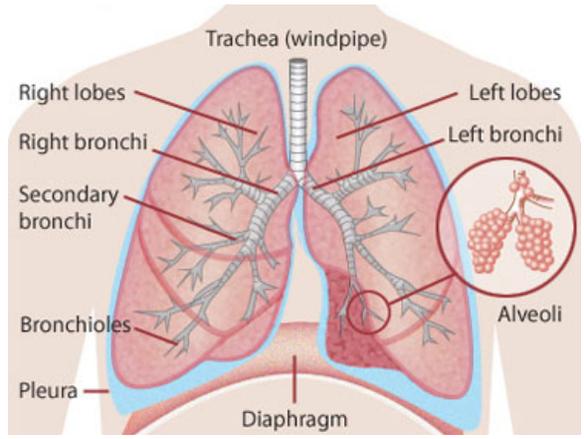


Supply v.  
Demand



**Red Flag! Timeliness of treatment is key**

- Enhance flow
- Preserve tissue

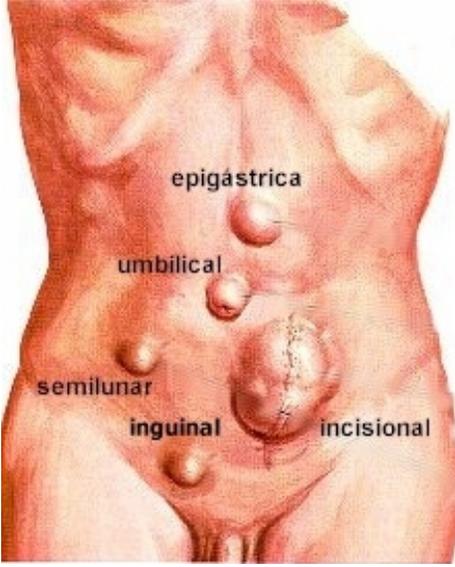


**Red Flag! What you breathe can infect, damage airways and tissue**

## The Lung

**Oxygen: You can't live without it!**

## Hernias



- Weakness developed in abdominal wall
- Straining increases pressure; tissue breaks through

**Red Flag! Laborers  
Timeliness of treatment**

## Cure or Relieve

- Internal medicine and its relationship to physical and mental injuries/diseases
  - Pre-op clearances
  - Treatment of hypertension
  - Treatment of diabetes
  - Weight loss to lessen low back pain
  - Etc.

## Medical Economics

- Risk vs. Benefit
- Damage control
- Early intervention to reduce long-term costs
- Etc.

# The Dilemma

Utilization Costs

	low	high
low		
high		

# Working with Treaters Better Outcomes when Red Flags Fly

**Steven Feinberg, MD - Moderator**

**Ernest Cheng, D.O.**

**Jacob Rosenberg, M.D.**

## What is the Goal?

- Efficient, cost-effective and appropriate medical care within evidence-based medicine guidelines
- Getting the IW
  - Healthy
  - Functional
  - Emotionally stabilized
  - Staying at work &/or returning back to work

## The Problem is What?

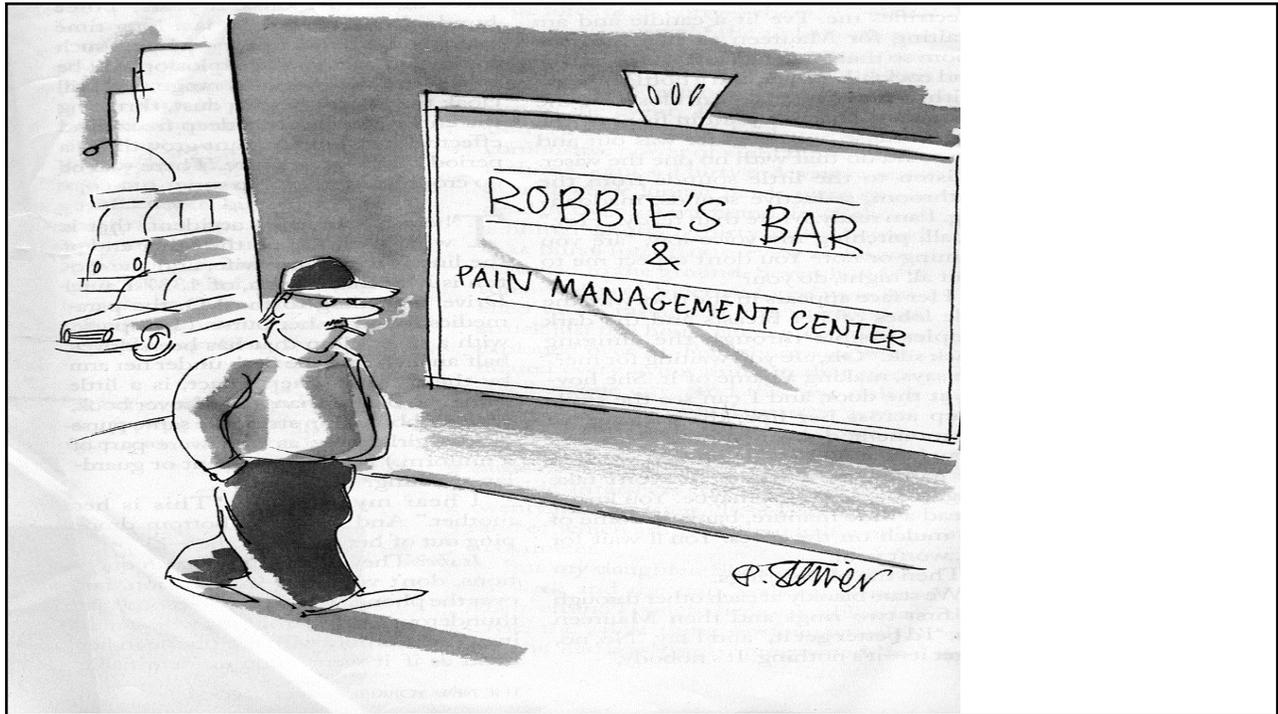
- Why are we failing so often with getting injured workers better and back to work?
- Why is there tension between treating doctors and payers?
- How can we identify problem cases and ineffective treatment?
- Once identified, can we change the course of treatment for better outcomes?
- What are the **RED FLAGS** from an employers/payers perspective?
- What are the red flags from a doctor perspective?

## What is a **RED FLAG**

- A red flag is defined as a warning signal or something that demands attention
  - From the physician perspective
  - From the employer/payer perspective
- A **RED FLAG** means that things aren't going well
- A **RED FLAG** means a need to change or adjust treatment direction
- It does not mean stop treatment

## RED FLAG #1

- Referral to a Pain Specialist



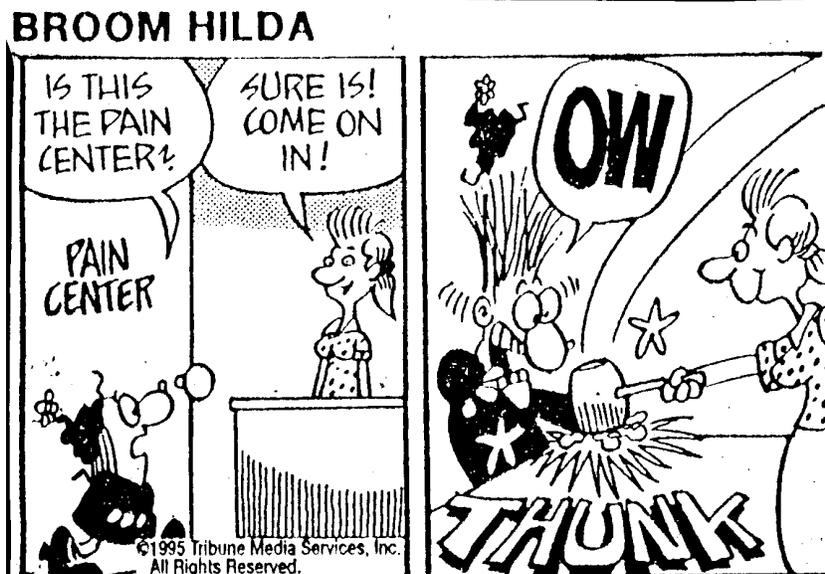
## RED FLAG #1

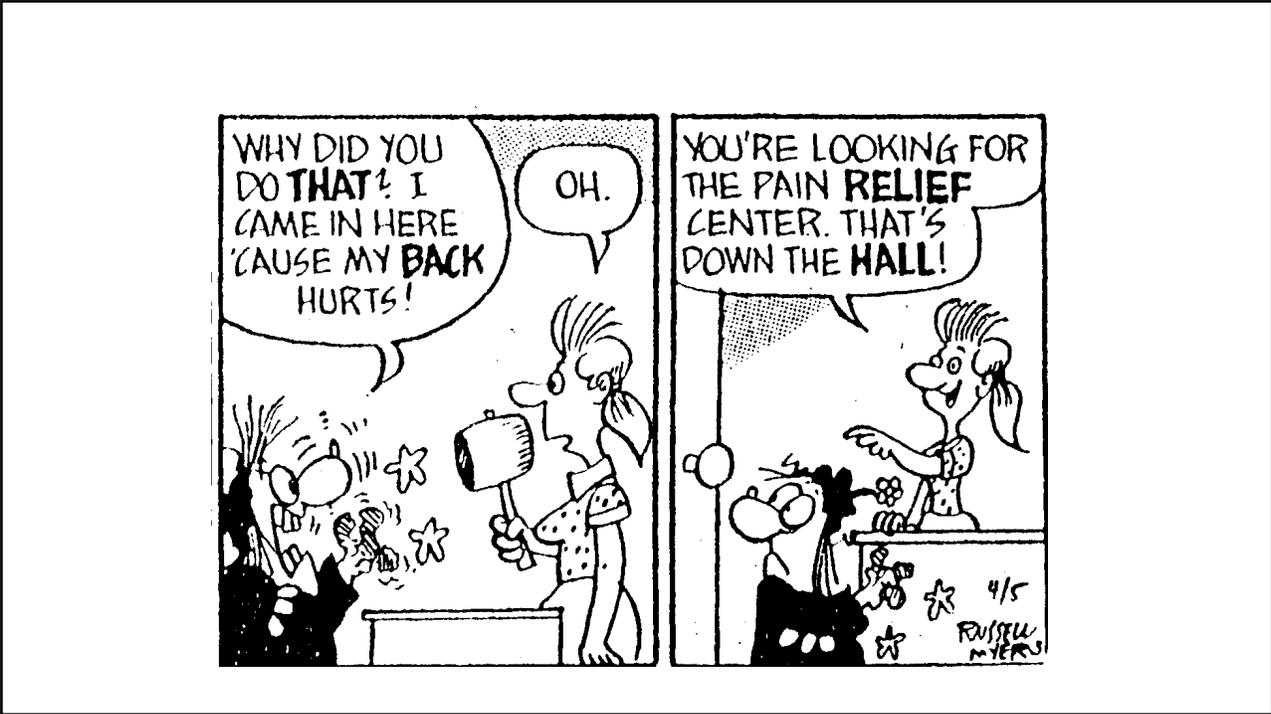
- Referral to a Pain Specialist (sometimes ☺)

-Expands the Claim or Salvages it?

A good pain specialist will identify and treat depression, sleep, and fear avoidance issues with appropriate medication and education. They should be able to facilitate to a HEP and emphasize the need for rehabilitation as opposed to a reliance on passive modalities

A bad pain specialist will try to fix or cure the patient with injections or opiates





## What Went Wrong?

- Biomedical versus biopsychosocial perspective

## Biomedical Model

- Explains pain through etiologic factors (e.g., injury) or disease whose pathophysiology results in pain
  - Cause →→ Effect
- The focus is on the lesion (the Pain Generator) and finding some way to numb or ablate it
  - Medication
  - Injection
  - Surgery
- This classic biomedical approach to understanding and treating chronic pain is incomplete

## Biomedical Model

- Its exclusive application can result in
  - Unrealistic expectations on the part of the physician and patient
  - Inadequate pain relief
  - Excessive disability in those with pain that persists well after the original injury has healed
  - An unnecessary & preventable chronic pain syndrome
  - High and ever increasing cost without clinical benefit

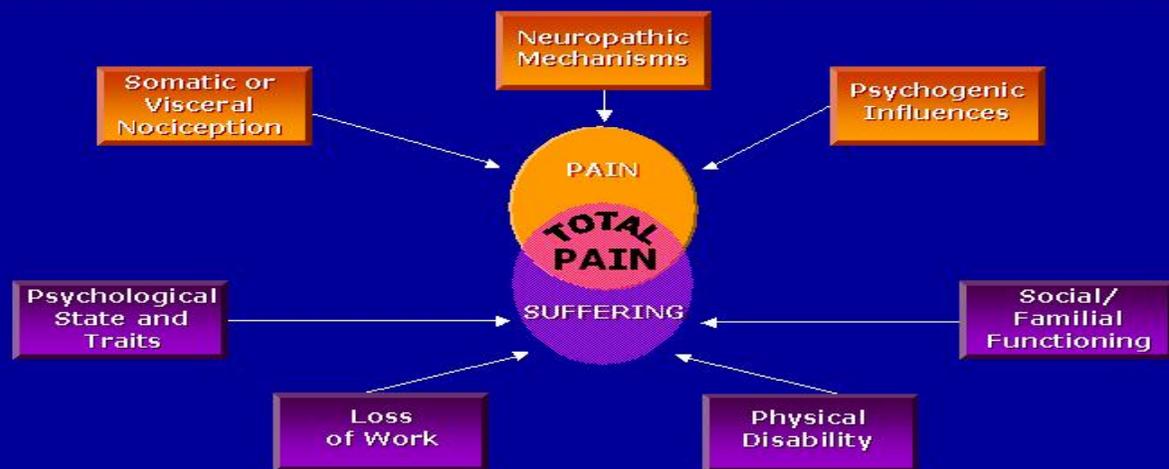
## Biopsychosocial Model

- Recognizes that pain is ultimately the result of
  - Pathophysiology (physical processes)
  - Psychosocial factors
  - Relationship/interactions with the environment
    - workplace, home, disability system, and health care providers

## MTUS Chronic Pain Medical Treatment Guidelines

- Strongly supports a biopsychosocial approach including early intervention to prevent delayed recovery and utilization of a functional restoration approach

## The Complex Nature of Pain



(Adapted from Barkin, 1996)

## RED FLAG #2

- Delayed recovery leading to a chronic pain state

## Risk Factors for Delayed Recovery

- Its all about the injured worker
- Baggage they bring to the work injury
  - When you hire someone, you hire their history and life experiences
- Perceptions (real or imagined) about how they are treated
- 5-10% of cases account for 80% of costs
  - These aren't just the catastrophic injuries but often limited injuries that should heal without major sequelae
  - Identifying them early should be a high priority
  - You can predict and prevent nightmare cases

## Risk Factors for Delayed Recovery

- Preventing the transition from acute to chronic pain is the most important under-recognized strategic treatment target
- It is more important to know about the patient who has the disease than about the disease the patient has (Sir William Osler 7/12/1849 – 12/29/1919)

## Characteristics & Predictors of DR

- Distress, depression, anxiety
- Fear-avoidance / Maladaptive beliefs
- Somatization
- Excessive pain behaviors (psychological overlay vs. malingering)
- Functional decline
- High pain ratings (subjective factors outweigh objectives)
- Early and prolonged use of opioids and drug dependency
- Disability out of proportion to objective findings
- Focus on litigation
- Job dissatisfaction / Prolonged work absence
- Psychosocial risk factors (child abuse)

## Preventing Delayed Recovery

- Disability prevention, not disability management, is the key strategic issue
- Good early communication with IW (and others) and a job to return to hastens recovery; insures a better, less expensive outcome
- Several validated brief instruments are available to accurately identify workers at highest risk of delayed recovery and disability
- Identify IWs with delayed recovery risk factors and refer to *appropriate* treaters

## RED FLAG #3: The Doctor Dilemma

- Do you have a Medical Director?
- Do you have internal Nurse case managers?
- How is your MPN quality?
- How does your MPN identify and use quality treating doctors?
  
- A Novel Approach: Partner with the patient and applicant attorney with joint goals of increased function and RTW

## Treatment Issues

- Think “outside the box” for treatment...don’t be penny wise and pound foolish
  - Avoid a cookie cutter approach and over-reliance on protocols
- Use the MTUS followed by ACOEM & ODG wisely
  - Maybe the RFA treatment request falls outside the guidelines but particularly if the cost is low, what are the ramifications of saying no?
    - Angry IW
    - Angry Doctor
    - Inadequate treatment
- Assign a nurse case manager (NCM)
- Be comfortable obtaining a multidisciplinary or interdisciplinary evaluation to best assess an injured worker’s medical care needs
- Use quality early intervention and functional restoration programs sooner rather than later early and wisely

## RED FLAG #5: Medications

- Opioids – what is appropriate use?
  - Weaning / Detoxification – what is appropriate?
  - What about legacy cases on high dose opioids?
    - Is dosage the primary risk factor for adverse event?
    - Cost shifting?
- Opioid & Benzodiazepine use
- Illicit drugs including marijuana
- Evidence of medication misuse, abuse, addiction

## RED FLAG #6: Office-based Dispensing

- Be suspicious of office-based dispensing of atypical medications (Norco 2.5/325, soma 250mg), but don't assume the physician is disingenuous either
- What is appropriate office dispensing?
  - Creams
  - Compounded drugs

## RED FLAG #7

- Physicians unwilling to interact with Employers/Payers
  - Working together with better communication
  - Making Team Conferences Efficient and Worthwhile
- UR & IMR difficulties (as perceived by the physician)
  - Encourage the UR physician to be more educational
  - Encourage UR physicians to authorize appropriate treatment not to look for any excuse to deny treatment
  - How to avoid IMR costs
  - Utility of Passport programs
    - Practice Selection Criteria?
- Physicians need better education re:
  - Report writing
  - Proper filling out RFAs
  - Using the MTUS Guidelines

## RED FLAG #8

- Denied claim & denied body parts
  - Increased IW anger, hostility, anxiety and depression
  - Increased lawyering up
  - PTP choice may be AA controlled
- Are body parts correctly classified?
  - Correlate with correct diagnosis
  - Missed diagnoses on preliminary evaluation?
- If a new body part makes sense then maybe a med-legal evaluation isn't necessary before treatment

## RED FLAG #9

- Invasive interventions & surgery
  - Facet Procedures
  - Epidurals
  - Spinal Cord Stimulators
  - Implanted Intrathecal Pumps
- Procedures need to be coordinated with a functional restoration rehabilitation approach
- Patient education and expectations are paramount

Questions?