INTERNAL MEDICINE
Improving Outcomes When Red Flags Fly

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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:

- 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
Hypertension

The Silent Killer

Normal 130/85

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

Red Flag! Cure < 5%
Treatment for life to prevent damage
Supply v. Demand

Coronary Arteries

Right coronary artery
Circumflex artery
Left anterior descending artery

Red Flag! Timeliness of treatment is key
- Enhance flow
- Preserve tissue

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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

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Health Risk

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 $\rightarrow$ 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

- It's 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

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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 dent 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?