CASE MANAGEMENT GUIDELINES

Recommended by
PHYSICIAN ADVISORY COMMITTEE

Adopted by
ADMINISTRATOR OF THE OKLAHOMA WORKERS' COMPENSATION COURT

Effective January 1, 2001

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(Adopted by the Administrator of the Oklahoma Workers' Compensation Court on November 27, 2000.)

Effective January 1, 2001

Introduction

The Physician Advisory Committee (PAC), a statutorily created advisory body to the Oklahoma Workers' Compensation Court, has been directed by Oklahoma Statute to propose, adopt, and recommend treatment guidelines and utilization controls. The PAC is composed of nine members; three appointed by the Governor, three appointed by the President Pro Tempore of the State Senate, and three appointed by the Speaker of the Oklahoma House of Representatives. By statute, the Governor's appointees must include a doctor of medicine and surgery, a family practitioner in a rural community of the state, and an osteopathic physician; the President Pro Tempore's appointees must include a doctor of medicine and surgery, a doctor of medicine or an osteopathic physician, and a podiatric physician; and the Speaker's appointees must include an osteopathic physician, a doctor of medicine or an osteopathic physician, and a chiropractic physician.

We received input from a wide variety of sources; a special subcommittee of case managers and attorney representatives, and from employers, insurance carriers, and health care providers. Case management literature and statutory provisions (85 O.S., Section 14.3[1]) were reviewed, including information from the Commission for Case Manager Certification, American Accreditation HealthCare Commission/URAC Case Management Organization Standards, and National Coalition of Associations for the Advancement of Case Management. Case management rules from other jurisdictions also were utilized.

This document is designed to function as a guideline and should not be used as the sole reason for denial of treatments and services. These guidelines do not affect any determination of liability for an injury under the Oklahoma Workers' Compensation Act, 85 O.S., Section 1, et seq., and are not intended to expand or restrict a health care provider's scope of practice under any other statutes. These guidelines are not intended to supersede applicable provisions of the Oklahoma Workers' Compensation Court's Schedule of Medical and Hospital Fees.

The guidelines are organized as follows:

1) Definitions

2) Benefits of Case Management

3) The Process of Case Management

4) Criteria for Referral for Case Management

5) Criteria for Termination of Case Management

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[1] Title 85 O.S., Section 14.3(B)(1)(f) requires certified workplace medical plans to provide aggressive case management.

6) Case Manager Qualifications

7) Exhibit A

National Coalition of Associations for the Advancement of Case Management. Case Management, A Resource That is Working … *Quality Care* and *Cost Containment*. May 17, 1993.

I. DEFINITIONS *(Reproduced with permission of the American Accreditation HealthCare Commission/URAC and Commission for Case Manager Certification.)*

a) **Case Management:** The Physician Advisory Committee has chosen to adopt the definition of case management accepted by the American Accreditation HealthCare Commission/URAC which is as follows:

> "A collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options and services to meet a client's health needs through communication and available resources to promote quality, cost-effective outcomes."

(American Accreditation HealthCare Commission/URAC Case Management Organization Standards, Version 1.1.)

b) **Client and Payor:** For purposes of this document, "client" is used to refer to the individual for whom a certified case manager provides services; likewise, "payor" is used to refer to the certified case manager's customer.

II. BENEFITS AND ROLE OF CASE MANAGEMENT

The benefits of case management have become more apparent over the last several decades. Case managers can now be found in a wide variety of health care settings and insurance arenas. In Oklahoma, case management within the workers' compensation system began approximately twenty years ago. Case management has been found to be an effective tool to coordinate medical care, communicate expeditiously to all involved parties, promote quality, control costs and increase the satisfaction of the injured worker. When managed care entered into the Oklahoma Workers' Compensation system in 1994, "aggressive case management" was considered an important enough component to be set forth legislatively for those programs.

The cost containing benefits of case management is not a theory. They have been proven over the years through numerous studies in varied settings. See, Exhibit A.

a) Case management provides clients with a "professional guide" who can:[2]

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[2] National Coalition of Associations for the Advancement of Case Management. Case Management, A Resource That is Working … *Quality Care* and *Cost Containment*. May 17, 1993.

i) Focus on the full spectrum of client needs rather than just those of concern to a particular provider or payor, thus identifying comprehensive needs.

ii) Provide information about resources available to clients, whether public or private and how to appropriately access these resources.

iii) Negotiate with providers and payors, obtaining diverse services with controlled costs.

iv) Work with clients throughout their entire contact with the health care system, promoting coordinated care, minimizing fragmentation and facilitating appropriate referral to alternate or supplemental providers.

v) Focus on outcomes of care, aiding providers in selecting treatments aimed toward a common goal and assisting clients in recognizing the usefulness or limitations of services.

vi) Provide information to payors regarding health needs and services options to achieve cost effective, outcome based care, thus facilitating coverage decisions and timely provision of care that can reduce length of health care needs and future complication.

b) Case management is not biased toward any group; it endeavors to define and resolve real client needs while using the defined parameters of providers and payors to meet those needs. Case management assists each group in meeting their needs.[3]

c) The case manager facilitates the exchange of job information to the physician so return to work issues are made from an informed standpoint. The case manager may obtain from employer a job description, physical demands, information on alternative work positions, and job accommodations. The case manager also provides necessary information to the employer regarding expected time frames for return to work.

d) In addition, the nurse case manager's role in a Certified Workplace Medical Plan is subject to the certification rules and terms of the Certified Workplace Medical Plan in which the injured employee is an enrollee, and as approved by the Commissioner of Health.

III. THE PROCESS OF CASE MANAGEMENT[4]

Case management exists within a wide variety of organizations and practice settings, but is fundamentally a collaborative process provided by skilled professionals with multiple outcome objectives which include quality care, cost containment and client empowerment. The *process* of case management includes the following components:

a) Assessment of individual needs

i) Assess/collects data

ii) Conducts case screening

iii) Obtains necessary approvals for contact(s)

iv) Interviews individual's support systems and care providers

v) Identifies health and psychological needs

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[3] Ibid.

[4] Ibid.

vi) Reviews current status and treatment plan
vii) Identifies barriers to wellness within treatment plan/environment
viii) Reviews past history
ix) Determines implications of resources, availability and limitations of insurance benefits
x) Evaluates environment for accessibility and adaptive needs

b) Development of individualized case management plans
i) Identifies services, treatment and funding options
ii) Screens identified options to meet needs
iii) Reviews plan for consensus and agreement
iv) Advocates for individuals needs as indicated
v) Identifies gaps in treatment
vi) Develops plans including life care needs assessments and their costs as indicated

c) Facilitation/implementation/coordination of services
i) Coordinates treatment planning
ii) Communicates regularly with individuals and support systems
iii) Understands and implements cost management strategies
iv) Promotes efficient and coordinated care
v) Determines implications of resources, availability and limitations of coverage
vi) Conferences on-site with patient/client and involved professionals
vii) Identifies needs for additional/ancillary services/equipment

d) Monitoring and evaluation of services and outcomes
i) Assess benefit value to cost
ii) Reviews plans for continuity of care
iii) Facilitates plan modification as indicated
iv) Assesses individual's satisfaction and compliance with services
v) Assesses benefit value to quality of life

e) Documentation of activity
i) Records services and outcomes
ii) Reports to legally responsible parties

IV. CRITERIA FOR REFERRAL FOR CASE MANAGEMENT

The committee recognizes that due to the individuality of each case, no all-inclusive list of appropriate criteria can exist. The following is a list of the most commonly referred case types or situations which benefit from case management services:

a) Catastrophic injuries, including burns, amputations, crush injuries, head injuries, spinal cord injuries (SCI) and complex regional pain syndrome (RSD).

b) When noncompliance issues with the medical treatment plan have been identified.

c) When multiple medical providers or frequent changes in physician have occurred.

d) When problems with certain issues would be more appropriately evaluated in person, which may include but are not limited to: language barriers, transportation obstacles and socioeconomic dynamics.

e) In the event of re-injury of the same body part.

f) When the injured worker, physician, payor, employer or attorney request Medical Case Management.

g) When treatment plan exceeds usual and customary parameters as set forth in the Oklahoma statutes, the Oklahoma Physician Advisory Committee Guidelines and protocols substantially similar to those established for use by medical service providers, which have been recommended by the Physician Advisory Committee and adopted by the Workers' Compensation Court Administrator pursuant to subsection B of Section 201.1 of Title 85 of the Oklahoma Statutes.

h) In cases where pre-existing medical conditions could impact the extent or duration of rehabilitation.

i) Compromised communication.

j) When assistance is needed with return turn to work issues.

V. CRITERIA FOR TERMINATION OF CASE MANAGEMENT

The termination of case management may include but is not limited to the following:

a) The injured worker achieves maximal medical improvement as determined by the authorized treating physician.

b) The case is determined by the payor to no longer meet the criteria for case management.

c) The case management assignment has been for the achievement of certain directives which have been addressed.

d) The injured worker achieves successful return to work.

e) The court orders cessation of medical case management.

VI. CASE MANAGER QUALIFICATIONS

The following minimum qualifications are recommended by the committee:

a) Registered nurse with a current, active unencumbered license from the Oklahoma Board of Nursing.

b) Complete the current application process for the Oklahoma Workers' Compensation Court if they desire consideration of appointment for court-ordered medical management cases.

c) Possess, or be working toward the possession of, one or more of the following certifications which indicate the individual has a minimum number of years of case management experience (typically two years), has passed a national competency test and regularly obtains continuing education hours to maintain certification:

i) Certified Disability Management Specialist (CDMS)
ii) Certified Case Manager (CCM)
iii) Certified Rehabilitation Registered Nurse (CRRN)
iv) Case Manager – Certified (CMC)
v) Certified Occupational Health Nurse (COHN)
vi) Certified Occupational Health Nurse Specialist (COHN-S)

VII. EXHIBIT A

National Coalition of Associations for the Advancement of Case Management. Case Management, A Resource That is Working … *Quality Care* and *Cost Containment*. May 17, 1993.

EXHIBIT A

CASE MANAGEMENT

A Resource That is Working . . .
Quality Care and *Cost Containment*

National Coalition of Associations for the Advancement of Case Management

Case Management

Case Management is a collaborative process that promotes quality care, and cost effective outcomes which enhance the physical, psychosocial and vocational health of individuals. It includes assessing, planning, implementing, coordinating and evaluating health related service options.

Who Are We?

The National Coalition of Associations for the Advancement of Case Management is a coalition of professional organizations representing case management members. Representatives of the organizations in the coalition include executive board members such as presidents, presidents-elect and past presidents as well as members of the legislative committees.

Who Do We Represent?

The NCAACM represents case management members in various disciplines and practice settings. These include rehabilitation professionals, social workers and nurses involved in case management. Case managers work in private practice, insurance companies, industry, managed care organizations, hospitals, rehabilitation and vocational settings as well as in public settings. At the present time, coalition members collectively represent approximately 20,000 health care professionals.

Who Do We Serve?

Members of the various organizations represented by the NCAACM serve a wide variety of clients in need of medical, vocational or other coordinated care which is provided by case management and care management professionals. These clients include but are not limited to the following:

- Acutely ill patients in various areas of specialization including AIDS, oncology, mental health, neonatology, pediatrics, high risk obstetrics, head injury, spinal cord injury, as well as general medical/surgical
- Catastrophically injured clients
- Ill/injured workers
- Elder clients
- Disabled clients

Case management has touched the lives of thousands in a very positive way with advocacy, coordination and creativity aimed at enhancing the client's short term and long term goals while helping to contain costs.

The Process of Case Management

Case management exists within a wide variety of organizations and practice settings, but is fundamentally a collaborative process provided by skilled professionals with multiple outcome objectives which include quality care, cost containment and client empowerment. The *process* of case management includes the following components.

Assessment of individual needs:

- Assesses/collects data
- Conducts case screening
- Obtains necessary approvals for contact(s)
- Interviews individuals support systems and care providers
- Determines health and psychological needs
- Reviews current status and treatment plan
- Identifies barriers to wellness within treatment plan/environment
- Reviews past history
- Determines implications of resources, availability and limitations of insurance benefits
- Evaluates environment for accessibility and adaptive needs

Development of individualized case management plans:

- Identifies services, treatment and funding options
- Screens identified options to meet needs
- Reviews plan for consensus and agreement
- Advocates for individuals needs as indicated
- Identifies gaps in treatment
- Develops plans including life care needs assessments and their costs as indicated

Facilitation/implementation/coordination of services:

- Coordinates treatment planning
- Communicates regularly with individuals and support systems
- Understands and implements cost management strategies
- Promotes efficient and coordinated care
- Determines implications of resources, availability and limitations of coverages
- Conferences on-site with patient/client and involved professionals
- Identifies needs for additional/ancillary services/equipment

Monitoring and evaluation of services and outcomes:

- Assesses benefit value to cost
- Reviews plans for continuity of care
- Facilitates plan modification as indicated
- Assesses individual's satisfaction and compliance with services
- Assesses benefit value to quality of life

Documentation of activity:

- Records services and outcomes
- Submits confidential reports as required
- Reports to legally responsible parties

Case Management is Necessary

Case management directly addresses many of the issues in today's health care system. It is commonly understood that access to care, allocation of resources, cost containment, and effectiveness of care are problems with which clients, payors, providers, and policy makers struggle every day. As the health care system evolves, and our nation's population changes, case management becomes increasingly critical to meet everyone's needs.

Case Management for Today

The health care system is complex, diverse, and fragmented. Services are offered through public agencies and the private sector. There is a lack of coordination between all levels of providers and payors. Health care clients usually lack the sophistication and knowledge to guide themselves through the health care maze and garner holistic, comprehensive care efficiently. This results in compromised outcomes, wasted time and dollars, and dissatisfaction between clients, providers, and payors.

There is currently a growing trend toward managed care, a concept focusing on utilization control for groups of people. Payors and policy makers are increasingly using this approach to contain costs. This, along with increased competition for health care dollars, may create bias in determining what care is offered and rendered. An adversarial relationship is often established between clients, providers and payors.

Case management provides clients with a "professional guide" who can:

- Focus on the full spectrum of client needs rather than just those of concern to a particular provider or payor, thus identifying comprehensive needs.
- Provide information about resources available to clients, whether public or private, and how to appropriately access these resources.
- Negotiate with providers and payors, obtaining diverse services with controlled costs.
- Work with clients throughout their entire contact with the health care system, promoting coordinated care, minimizing fragmentation, and facilitating appropriate referral to alternate or supplemental providers.
- Focus on outcomes of care, aiding providers in selecting treatments aimed toward a common goal and assisting clients in recognizing the usefulness or limitations of services.
- Provide information to payors regarding health needs and services options to achieve cost effective, outcome based care, thus facilitating coverage decisions and timely provision of care than can reduce length of health care needs and future complications.

Case management transcends the parochial interests of clients, providers and payors. It is not biased toward any group; it endeavors to define and resolve real client needs while using the defined parameters of providers and payors to meet those needs. Case management assists each group in meeting their needs.

Case Management for the Future

The nation's health care delivery system is under intense scrutiny and is poised for significant change. In addition, the people served by the system are also changing. Important changes to note that affect the demand on the health care system include.

- Health care reform is intended to create access for people who currently are under-served or have no health care coverage. Estimates are as high as 34 million people who will be "novice" users of the system and will enter the system with existing health needs.

- The elderly population is rapidly growing. Survival rates with chronic illness are improving, extending the time that the health care system is used to control disease progression. Within the next 20 years the "baby boom" generation will begin to dramatically increase the growth of the elderly population. There will be significant increases in the number of people living beyond 100 years.

- Survival from catastrophic injury and illness has been increasing over the past decades, resulting in a growing "disabled" population. The recent passage of the Americans With Disabilities Act underscores the needs of persons with hearing, vision, mobility, speech, mental, and cognitive deficits.

- The cultural mix of the nation continues to change, bringing many health issues, from cultural response to illness and how health care is used, to illnesses associated with particular groups of peoples.

- Certain diseases are increasing, correspondingly increasing the need for health services. The most dramatic example is AIDS. Other "older" diseases are also increasing, such as tuberculosis.

The U.S. Department of Health and Human Services, Public Health Service has published *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*, which was developed by a consortium of over 300 national organizations, State health departments, and federal agencies. This document identifies many national health objectives that can be facilitated through case management. For example, the "Objectives Targeting People With Disabilities" include:

- Reducing the proportion of people with disabilities who engage in no leisure physical activity

- Reducing the incidence of secondary disabilities associated with head injury and spinal cord injury

- Extend systems linking prehospital, hospital, and rehabilitation services to prevent long-term disability

- Increase the proportion of people with chronic and disabling conditions who receive education about community and self-help resources

- Increase the proportion of worksites that have a policy or program for hiring of people with disabilities

Clearly, these federal health objectives require coordination of all health service, knowledge of the full continuum of services available, the ability to assist people in moving efficiently through the health system, and the ability to facilitate full community integration regardless of health status. Case management is a logical process for addressing these needs.

Health care reform and the changing population of health system users will create new challenges. Proactive use of case management can anticipate needs, design solutions and facilitate changes that will benefit the efficacy and cost-effectiveness of the health system. The need for case management services will grow in the future.

Outcomes of Case Management

Case management results in:

- Meeting individual needs
- Optimizing quality of care
- Cost containment

INDIVIDUAL NEEDS

Case Management allows the individual client/patient/family to have *ownership* in their treatment plan and/or services. To the extent possible, it puts people first. Case management assists individuals in accessing the health system which can be a confusing maze of treatment options, funding limits, and regulations.

Different types of case management address individual needs in the following manner:

- Case management assists individuals with medical - physical - emotional problems by maximizing the appropriate care, efficiency of services and recovery. Focus can be catastrophic, acute and/or long term. Diagnosis and a sensible individualized treatment plan is rendered through case management.

- Case management assists individuals with vocational rehabilitation needs acquire occupational independence and return-to-work through vocational case management. Vocational assessment, coordinated rehabilitation training plans and return to the work force are outcomes of case management.

- Case management accommodates long term care recipients' restorative needs. Autonomy is maximized in balance with selective community or private medical and non-medical services. Geriatric case management provides the required gentle and dignified service the elderly need.

Individual needs often cross over these aforementioned areas, i.e.: medical, physical, emotional, vocational, long term, social work, geriatric. Good case management is equipped to deal with the holistic nature of the client/patient. The family and society may also benefit after the individual need is satisfied.

QUALITY OF CARE

Quality assurance/outcomes in the health system are important results of case management. Their value cannot be overlooked. The fragmented and superfluous nature of our health system can generate unnecessary time lags, inappropriate services, client confusion and adversarial problems.

Through the following components our health system is improved with objective continuity and quality, comprehensive closures instead of patchwork outcomes and exorbitant costs. . .

- Focus on full spectrum of services
- Information regarding services
- Identification and coordination of services
- Negotiation/communication
- Facilitation of decisions
- Monitoring progress

Examples:

- Medical case management is involved with coordination of services between medical facilities, physicians and other professionals for an individual to maximize recovery.

- Vocational rehabilitation case management coordinates services between evaluation - diagnostic facilities, occupational - physical therapeutic providers, medical authorities, training facilities and employers with the outcome of employment as its focus.

- Geriatric/social work case management emphasizes communication and negotiation between medical - nonmedical facilities, community agencies and family with the outcome of life quality achieved.

The health system is improved via case management because goals are met through *the right* treatment/service with *the right* providers at *the right* cost.

COST CONTAINMENT

Controlling the costs of health care is an immense challenge. The annual national health bill is reported to be approaching one trillion dollars! Case management is not just a cost containment theory, it is a proven resource that is having major impact by *substantially* reducing costs.

- Medical expenses dropped a combined $30 million for 1,430 Met Life group medical clients who entered a voluntary case management program in 1990, the company reported. A recent internal Met Life study of the program found managed cases cost 63% less, with $21,000 average savings per case. The cost-effectiveness of the program was $23 saved in medical expenses for every $1 spent on case management administration.

  National Underwriter, February 24, 1992

- U.S. Managed Care, Inc. claimed its practice guidelines for providers, combined with a case management approach, have cut workers' compensation costs for some employers to just under $800 per injury, compared to the national average of $4,000.

  Health Week, November 18, 1991

- Honeywell Corp., Minneapolis, spends 54 percent of its health care dollars on 4 percent of its insureds. Says Anne Widtfeldt, Corporate Manager of Health Services, "We've set a system in place so that when patients reach certain triggers, our carriers and vendors assess the case and decide whether it should be managed. Probably 3 percent of the cases can be turned over to case management. But maybe 1.5 percent of those cases require intensive, large, medical case management."

  Business & Health, July, 1991; p.60

- Bank of America found that for every $1 spent on case management, it saved $6.70 in health care costs. For certain categories – circulatory care problems, for instance – those savings went as high as $28.

  Business & Health, July, 1991; p.62

- Wal-Mart, the nation's largest retail chain with more than $31 billion in sales for 1990, documented over $200 million in savings through case management in 1990 alone . . . for every dollar spent on case management, Wal-Mart saved $7.46 on both open and closed cases. At the five-month mark for 1991, that ratio climbed to 9.79 for open cases.

  Driving Down Health Care Costs: 1992 Strategies and Solutions,
  A Panel Publication, p.218

- The Alexander Consulting Group has published results of a survey of 484 employers regarding their benefits program. 70-75% of the respondents have a medical cost increase averaging 2.1%. Of the various types of costs-management programs, employers perceived *large case management* had the greatest support at 75%.

  The Case Manager, January, 1992; p. 72

- A 1993 Towers Perrin survey showed more employers turning to managed care to contain workers' comp costs. Specifically, the numbers of employers using *case management* was up 177% to 83% of the total.
  Workers' Comp Managed Care, April, 1993

- The Health Insurance Association of America (HIAA) Survey (1993) found a savings of $11.00 for every $1.00 invested in rehabilitation services. This equates to a savings per client/patient of between $1,500.00 and $250,000.00.

- Northwestern Life found that catastrophic medical case management saved over $30,000.00 per case over a four year period. This equates to return on investment of $53.00 for every $1.00 spent of case management.

Conclusion

Case management is not a theory or an academic concept. It is a resource that works, provided by caring professionals, with a 30 year history of success in a wide variety of settings. Promoting both quality care and cost containment, it is a "win-win" solution for all parties. It should be recognized and utilized in America's health delivery system.

COALITION ORGANIZATIONS

Association of Rehabilitation Nurses
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