

Great Falls - 9/2/2010

Number of "Primary Care" Docs	See New Workers Compensation Patients?			
	Yes	No	Only Acute (<2 weeks) & briefly for limited care in "Immediate Care walk in Setting"	Only under rare special circumstances
Int. Medicine (10) Family Practice (14) Physiatry (3) Hosp. Inj. Doc (1) 28	2 (7.1%)	20 (71%)	5 (17.8%)	1 (3.5%)
Unrestricted Access	2 (7.1%)	26 (92.8%)		

One example:

Abandonment and physical and sexual abuse

A disproportionately high number of chronic back pain patients have been the victims of abuse or abandonment as either adults or as children. In one study, more than half of the patients evaluated at a multidisciplinary pain clinic had a history of at least one form of such abuse. In 90% of the cases the abuse occurred during adulthood. These figures are substantially higher than the base rate in the US population.

One unfortunate consequence associated with victimization is that such patients respond poorly to spine surgery. Shofferman and colleagues **found an 85% failure rate from spine surgery among patients with a significant history of childhood abuse and abandonment, compared with a 5% failure rate among patients lacking such a traumatic history.** A study by Litton suggest that experiences of sexual and physical abuse may predispose individuals, especially women, toward chronic pain, thereby reducing overall spine surgery results.

work by one year postoperative than were individuals who have not been working prior to surgery. Interestingly, this association was independent of worker's compensation status and number of levels treated.

Responses to treatment by patients receiving workers compensation may be influenced by a number of other job and workplace factors such as job dissatisfaction, heavy physical job demands, and high levels of anger or blame toward the employer. **Regardless of the cause, workers' compensation is so widely recognized as a risk factor that Frymoyer and CatsBaril have proposed that compensability is one of the strongest predictors of excessive disability among back injury patients.** Thus, compensation status should be noted as a strong potential risk factor for poor outcome following surgery, especially if the patient is not working up to the date of surgery. We should be cautious however, in noting the compensation is a relative risk factor and may not be predictive of treatment response in any particular case. Rather, it should be included as one factor along with other factors described throughout this chapter.

PRESURGICAL PSYCHOLOGICAL SCREENING RISK FACTORS FOR POOR SURGICAL OUTCOME

Personality Factors (assessment by objective test such as the MMPI-2)

- Pain sensitivity
- Anger
- Depression
- Anxiety and obsessions

Poor Coping Strategies (assessed by objective test)

- Catastrophizing
- Low self efficacy or pain control

Behavioral Factors

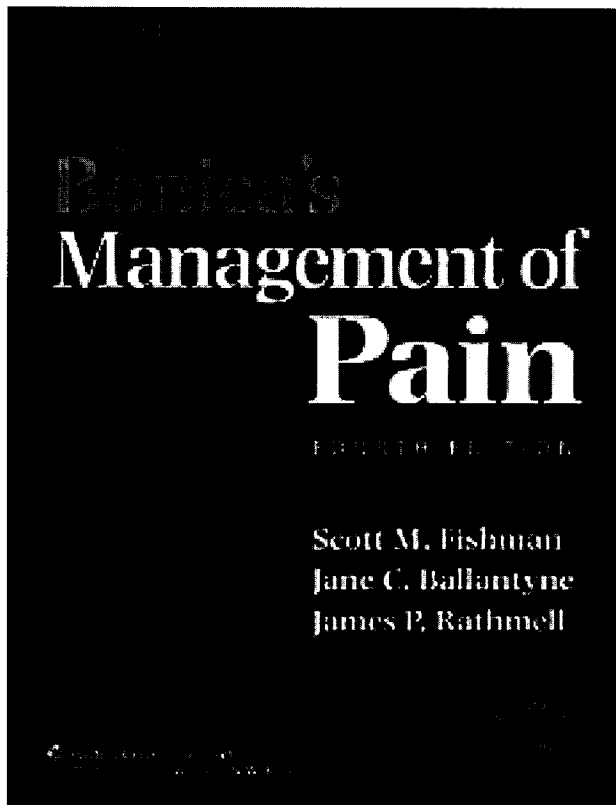
- Spousal reinforcement of pain (Westhaven-Yale multidimensional pain inventory)
- Litigation pending
- Worker's compensation
- Blame employer for injury

Historic Factors

- Abuse and abandonment
- Past psychological treatment
- Multiple previous medical problems
- Substance abuse

Presurgical Psychological Screening Prognosis

- Good: Zero-4 risk factors
- Failure: 5-8 risk factors
- Core: 9-14 risk factors



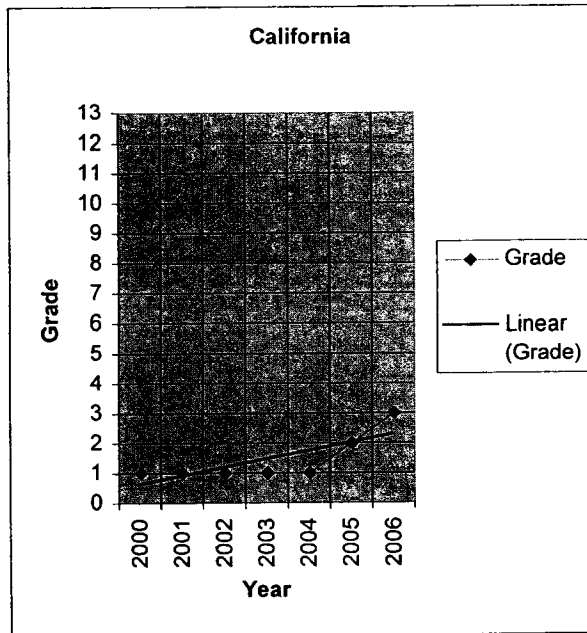
Workers' Compensation

Another source of potential reinforcement for pain comes in the form of worker's compensation and other disability payments to those injured on the job. Such payments often begin at the time of injury and continue until the patient has been declared to have reached maximum medical improvement. A number of studies have shown that spine surgery outcome is reduced in patients receiving workers compensation payments. Hudgins, for example, examining patient's one year posterior laminectomy found that those receiving workers compensation were the least likely to be working and to report pain relief. Klecamp, McCarty, and Spangler found that 81% of patients obtained a good result from lumbar discectomy compared to a success rate of 29% of litigating workers compensation patients. Similarly, Trief et al. found that receiving disability funds was negatively associated with return to work and improvement in work-leisure functions at 12 months postoperatively.

Poor treatment results among workers compensation payments may not arise solely from economic considerations. Rather workers compensation patients have a number of additional issues that may lead to reports of high pain levels and poor treatment outcome. First, these patients have frequently been unable to work for extended periods at the time of surgery. Research on chronic pain has clearly shown that the length of time the patient has been nonfunctional strongly influences treatment outcome. Dworkin et al, using multiple regression to examine the relationships among compensation, litigation, and employment status (time off work) in 454 patients undergoing treatment for chronic pain, found that only time off work (and not worker's compensation or litigation) predicted treatment outcome. In similar and even more dramatic fashion Anderson et al found that **patients who were working up to the time that they went in for anterior lumbar interbody fusion were 10.5 times more likely to return to**

California (CA) – **Tier / Ranking**

California (CA)	2000	2001	2002	2003	2004	2005	2006
Incidence Rates	28	25	28	29	24	16	15
Cases Missing Work	28	30	30	27	24	16	17
Median Disability Durations	42	42	43	43	44	41	43
Delayed Recovery Rate	42	42	43	44	44	42	43
Low Back Strain	41	40	43	43	37	36	38
Carpal Tunnel Syndrome	30	40	43	N/A	N/A	N/A	N/A
Overall ranking	35.2	36.5	38.3	37.2	34.6	30.2	31.2
Grade	F	F	F	F	F	D-	D



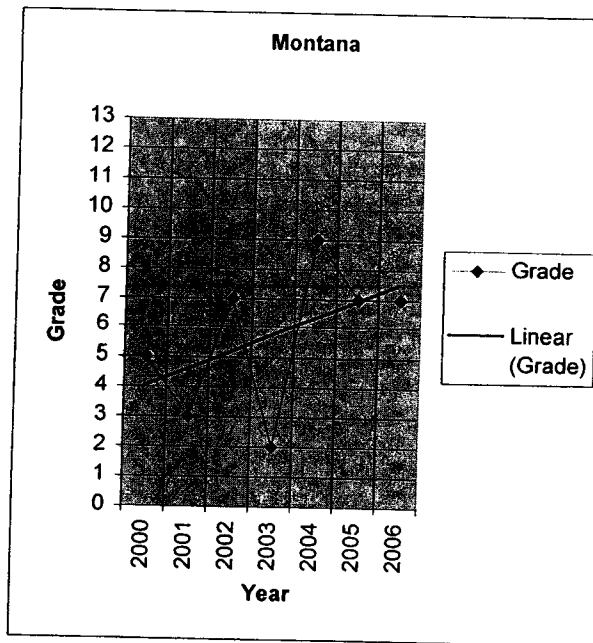
Grade	F	D-	D	D+	C-	C	C+	B-	B	B+	A-	A	A+
Number	1	2	3	4	5	6	7	8	9	10	11	12	13

Comments: California, the largest state, is showing a slight upward trend, but obviously has a long way to go from flunking grades for the first five years of data. Performance is not good on all measures, although it did improve when it comes to incidence rates and cases missing work. Overall negative outcomes such as seen in California often precede a major impact on costs as insurers are forced to raise rates in a “catch-up” mode, and, in fact, by 2003-2004 the California system was in a crisis, with annual costs exceeding \$30 billion per year, and the system was driving many employers out of the state. Major legislation was passed in late 2003 and again in 2004 in an attempt to get the system under control. Included in the legislation was a requirement to use evidence-based guidelines. Estimated savings from the new legislation are projected to be about \$10 billion. The California State Compensation Insurance Fund (SCIF) is the dominant carrier in the state, with over half of the business, and prior to the new legislation, they were not a user of evidence-based guidelines. (Unfortunately, SCIF was also under pressure from their for-profit competitors, limiting their ability to spend money on improved claims management.) It is also interesting to note that prior to the new legislation, California had their own treatment guidelines (9 of them) but withdrew them, to adopt nationally recognized guidelines.

Link to complete outcomes by ICD9 code for this state for each year (2000-2006):
[CA ICD9 2000-2006.xls](#)

Montana (MT) – Tier III Ranking

Year	2000	2001	2002	2003	2004	2005	2006
Incidence Rate	37	37	39	40	40	40	40
Days Off Work	26	22	31	30	29	31	24
Median Disability Durations	28	19	6	17	4	11	12
Delayed Recovery Rate	25	23	14	23	8	10	8
Low Back Strain	15	34	8	36	8	9	15
Carpal Tunnel Syndrome	14	21	20	N/A	N/A	N/A	N/A
Overall ranking	24.2	26.0	19.7	29.2	17.8	20.2	19.8
Grade	C-	D	C+	D-	B	C+	C+



Grade	F	D-	D	D+	C-	C	C+	B-	B	B+	A-	A	A+
Number	1	2	3	4	5	6	7	8	9	10	11	12	13

Comments: Montana also is in the middle of the pack, fluctuating between “C”s and “D”s and the one “B” in 2004. They have actually seen an improvement trend in disability durations and delayed recovery rate, but prevention and safety (as reflected by incidence rates) are some of the worst in the nation. There seems to be limited use of managed care techniques. The Montana State Fund is the dominant insurer, with over half the market. Montana’s ranking may show improvement with more recent data since the State Fund began using ODG in 2007.

Link to complete outcomes by ICD9 code for this state for each year (2000-2006):

[MT ICD9 2000-2006.xls](#)

Background

As workers' compensation costs continue their upward spiral, it becomes increasingly important to identify those factors contributing to the cost increases, especially those that may be controlled. History has shown that there are major differences in costs from state to state. In the past the ratio of workers' compensation insurance costs from state to state has been over 4 times from the upper to the lower end.¹ These cost differences can play a major role in the competitiveness of companies operating in these various states, and also on decisions to expand or relocate in those states.

There are two major drivers of these workers' compensation costs. The first is outcomes, specifically the success within a state in preventing injuries, and when they occur, the success in returning the injured worker to health and productive endeavor, thus avoiding prolonged absence and medical treatment costs. The second driver of these costs is administrative burden, sometimes referred to as the "friction" inherent in that state's workers' compensation system. "Friction" is the accumulation of rules, procedures, disputes, delays, discretionary charges and patterns of practice, including lawsuits, which press upon the resolution of claims.²

This report will focus on the first driver of costs, outcomes, and this is the third edition of "State Report Cards for Workers' Compensation." The first edition was published in 2000 and covered data from a single year, 2000. The second, published in July 2004, was based on data over a three-year period, 2000 through 2002. This report, published in July 2009, is based on data over a seven-year period, 2000 through 2006. Because of the amount of data included in this report, this edition does not include all of the data as tables within the report, but instead includes links from within the report (as a Microsoft Word document) to the data in spread sheet files (using Microsoft Excel) for the detailed files providing outcomes by ICD9 code for each state for each year. Besides keeping this report document to a manageable size, this offers the additional benefit of providing the raw data to users in a format that can easily be manipulated for additional analysis.

A key requirement for production of this report was the proprietary crosswalk program that has been developed by Work Loss Data Institute, which converts OSHA-reported data into an ICD9 code format. This allows condition adjusted analysis and comparison among different states. This is also a requirement for the use of techniques to improve outcomes, such as evidence based treatment and disability duration guidelines, since these guidelines cannot be applied without a correct diagnosis. WLDI developed this program for use in publishing guidelines used to improve outcomes in workers' compensation, including *Official Disability Guidelines* and *ODG Treatment in Workers' Comp*. More information on these is in Appendix C.

¹ Based on data from Actuarial and Technical Solutions, Inc., and a study by the Oregon Dept. of Consumer & Business Services, which shows a high of \$7.20 per \$100 of annual payroll for California (the highest cost state) to a low of \$1.62 per \$100 of payroll for Virginia (the lowest cost state).

² Rousmaniere PF, Denniston PL, "Spiraling workers comp insurance costs: a disturbing trend?", *Risk & Insurance Management*, March, 2003

State Report Cards For Workers' Compensation 2009

**A WLDI Special Study
based on data from 2000-2006 BLS OSHA Form 200/300
July 2009**



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1. Cost Drivers
-Montana, California

2. More Complex than any of us thought

3. We Already have an access problem

4. Solutions?