TREATING INJURED WORKERS

APA MEMBER JAMES WEIR EXAMINES PHYSIOTHERAPY INTERVENTIONS AND MANUAL THERAPY IN THE WORKERS' COMPENSATION ENVIRONMENT, AND EXPLAINS THE IMPORTANCE OF FLEXIBILITY IN A RIGID FRAMEWORK.

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You don't need to scratch far under the surface to uncover a clinician's true feelings about their local workers' compensation scheme. The typical responses tend towards the negative experience and we can each recall our frustrations with delayed and often denied approval for treatment. It is often perceived that the insurer has failed to consider our expertise in the matter and should simply let us do our job.

Insurers are often considered to have an insufficient knowledge of the application of manual therapy and other physiotherapy interventions, often leading to disillusionment on the behalf of the treating clinician.

It was certainly my own perception working as a clinician in a private practice setting in Western Australia for many years. It was, in fact, not until an improbable career swerve into injury management within a large national insurer, that I had the privilege of seeing things from the outside in, and from the inside out, simultaneously. Being in the hot seat to make decisions regarding accepting or declining treatment requests offered me an invaluable insight into the degree of variability in clinical reasoning and treatment applications that exist in our clinical community, locally and nationwide.

For several years, I spent time reading through treatment requests and communicating directly with treating physiotherapists via phone and email. It was my intention to remain anonymous in my professional standing as a clinician in these situations, in order to observe the spectrum of decision-making and treatment application among our peers. This provided me with useful insights in how best to direct requests for treatment and importantly, how to optimise approval.

The first step is acknowledging where you fit in the picture. The importance of the physiotherapist's role in a scheme can be viewed on a sliding scale, and can be very dynamic through the life of a claim. Yes, sometimes we are very important and necessary; however, sometimes we have the ability to be as big a barrier as any of the other multiple stakeholders involved in a claim.

Take for example a patient who has presented to you, their third treating physiotherapist, in the process of a two year old workers compensation claim. It is in our nature to be full of positivity regarding how we can be the problem solver at that stage and fill that patient with hope and expectation. All that is needed is for the insurer to simply accept that we have the solution they have been looking for, though it is rarely that simple. Consideration must be given to the parties who have been involved in the claim before you, those who are aware of factors that you are not aware of, and who may have a clearer insight into the bigger picture than yourself.

The next step is to determine how best to be a helpful, respectful and communicative member of a cooperative team empowering the injured worker. This can often require humility and patience in a challenging system environment. It may be frustrating, but you might need to remind yourself frequently that the injured worker's challenge is often greater and more varied than yours. And of course, they are the focus.

My insights from behind the scenes within an insurance company gave me a snapshot into just how extensive the network of influences can be around your patient. One of the most valuable things you can do as a clinician is to take the time to learn more about this network from your patient's perspective, the insurer's perspective, and the other influential treating parties prior to forwarding your treatment request.

It is important to consider the clinicians who will potentially form the essential framework around your injured worker, for example, general practitioners, specialists, treating allied health professionals and psychologists. The often multi-factorial nature of treatment in these systems will determine an insurer's willingness to accept and include your treatment proposal. This is facilitated greatly at times, through respectful conversation rather than written word. Getting to know your case manager or injury management advisor is a valuable element in facilitating treatment approval.

Demonstrating your willingness to be involved in a cooperative team and respecting those who are required to make difficult decisions, will shine a much more positive light on you as a professional treatment provider. Each scheme will offer differing modes of preferred lines of communication between stakeholders and insurers; however, determining the most appropriate avenue for those working in your immediate circle can make for much more fluid management and more effective clinical traction with the broader team.

Adhering to guideline-based care is a critical element in any delivery of physiotherapy service, yet it is often neglected in the compensation setting. Clinicians will often fail to consider that within the scheme, there are other parties with thorough knowledge of guideline-based care. Insurers employ physiotherapists, medical practitioners and other allied health professionals to aid in decision-making around treatment. These professional colleagues of ours should, and do, hold us to a high standard in this respect. Failure to operate within these guidelines can be a prompt for an insurer to look elsewhere for management, which may ultimately contribute to a further burden on your injured worker's experience, as well as a negative reflection on you, the clinician. It is essential that you are familiar with the Workcover clinical framework in the application of your services.

Manual therapy is a particularly sensitive topic in the insurance arena. There continues to be debate within our own profession regarding the appropriate application of manual therapy in musculoskeletal care. I can assure you that this discussion within our profession is very much noted in the insurance world. Insurers are particularly apt at adhering to guidelines and evidence bases, so are more likely to baulk at requests for substantial passive therapy modalities. Particularly when the evidence base supporting active and exercise-based management in musculoskeletal care continues to grow.

It is not uncommon to discover over-servicing in a compensation setting. Multiple drivers can contribute to this outcome including system limitations, inappropriate communication and dependency among others, but will ultimately reflect on the clinician's ability to communicate their intention and adhere to guideline-based care. It is naive of us as clinicians to expect that the only reason why an injured worker is not showing improvement, is due to insufficient treatment dose (eg, volume and frequency etc). Granted, this can be the case at times, but I would argue it is not for the majority.

What this means is: the onus is on you to provide a truly worthy line of clinical reasoning to support your request. You need to be prepared to discuss this and provide rationale to stakeholders who understand the evidence base and the complexities of compensation schemes. If a clinician fails to consider the multifactorial contributions to their patient's status at any given time, an insurer is more likely to consider your request unreasonable, and hence, decline it.

Insurers are under considerable and multi-directional pressures when it comes to making a decision about treatment. If there is not a clearly delineated reason for delivery of manual therapy, it is more likely to be disregarded in place of exercise-based rehabilitation, or any other treatment modality that is considered to be more reasonable in the context of your injured worker's claim.

There are many decision support tools to assist with musculoskeletal care, including for compensation settings. One example here is the *Musculoskeletal Clinical Translation Framework*. I have found this an exceptionally useful tool to aid in guiding the management of injured workers and patients within compensation settings. Providing care in these environments can be difficult and this framework offers a point of reference to keep your clinical reasoning in tune, in a dynamic environment. The framework is flexible and oriented towards person-centred care, helping you to weigh the various multidimensional factors that can influence a patient's trajectory into, and out of, work-related pain.

Utilising validated objective tools that are recognisable to insurers, such as the Orebro Musculoskeletal Pain Questionnaire short form, is an excellent way to bridge the gap between clinical priorities and financial, progress-based priorities. Reflecting that your intervention is actually making a positive impact is quite a useful way to rally support for your treatment request. I would not blame an insurer for declining a request for ongoing treatment based on a report that cervical rotation has improved by five degrees and nothing else. These clinical progressions and expectations need to be aligned to measurable impacts on return-to-work and ultimately, efficiencies for the insurer and the system.

Using terminology that matches the insurer's priorities is likely to be beneficial. Is the request reasonable? And if not, are you willing to be flexible? Does the treatment request facilitate clinical and work-related progress concurrently? How will your manual therapy treatment aid return-to-work? How will your manual therapy treatment reduce the need for wage compensation? How will your manual therapy treatment empower an injured worker towards self-efficacy and self-management? If you cannot answer these questions, I would not expect an insurer to approve your request.

Taking time to evaluate, re-evaluate and reconceptualise your role, and be flexible with the way you communicate, deliver treatment and accept the inevitabilities of unforeseen challenges, is vital. The more humble, respectful and self-reflective you can be, the more influence you will be able to have in a positive way for your patients and for your clinical development.

My tips for successful cooperative management and treatment approval optimisation:

- know the *Clinical Framework for the Delivery of Health Services* (see resources)
- make yourself aware of your case manager and injury management advisor, and determine their preferred mode of communication
- familiarise yourself with your injured worker's existing and expected multidisciplinary management plan to facilitate your clinical reasoning and treatment request
- offer meaningful objective measures and goals that align with the goals of the injured worker and insurer
- provide evidence-based reasoning and respect the limitations of the system and insurer
- identify and communicate psychosocial risk factors early and be a leader in the treatment team in order to facilitate appropriate management
- set clear timeframes to assist the insurer in planning further management strategies around the claim
- ensure your request is reasonable and be willing to modify if necessary
- take opportunities to meet with, and understand the roles of other stakeholders that surround your injured worker. Every encounter will assist in building your knowledge and increase your status as an effective treating clinician.

James Weir, APAM, graduated from the University of Notre Dame's inaugural cohort in 2006. He has since worked extensively in hospital, sporting and community primary care settings. He is the director of in clinic physiotherapy and senior physiotherapist at Pain Options, and was employed by CGU Insurance in the capacity of injury management advisor and early intervention specialist for the Western Australian workers' compensation department.

RESOURCES

Clinical Framework for the Delivery of Health Services:
https://tinyurl.com/y9mrek23
Musculoskeletal Clinical Translation Framework:
musculoskeletalframework.net