

Imagine Clinical



Reinventing Workers' Compensation

*Mastering Fundamentals to Produce
Extraordinary Results*

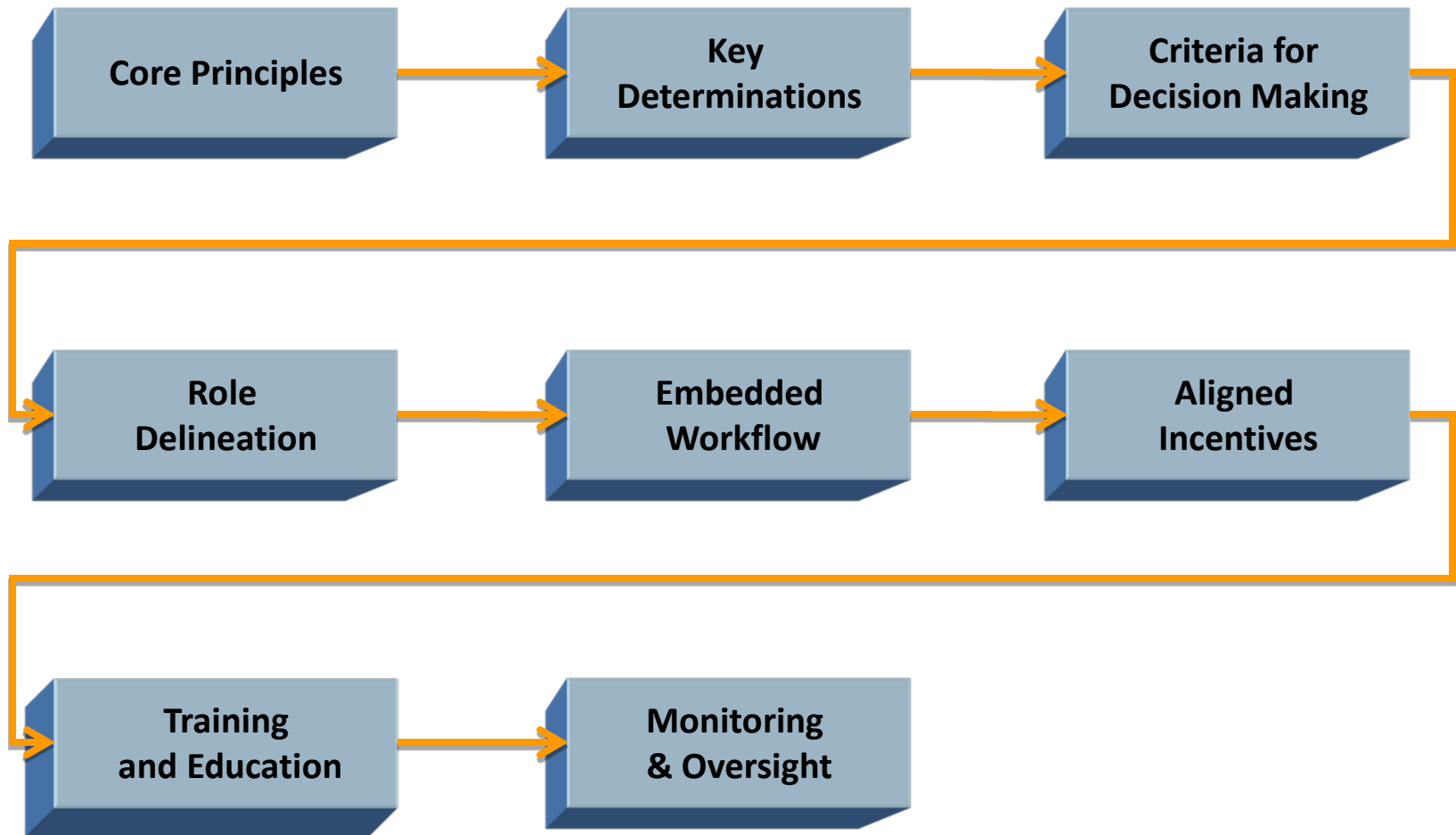
JERRY N. FOGEL, MS PT CHCQM
Health Care Consultant
President
Imagine Clinical

JFogel@ImagineClinical.com

Program Success

- Decreased overall WC costs
 - avg. cost per case
- Decreased overall medical costs
- Decreased lost time and disability
- Improved clinical and functional outcomes
- Increased patient satisfaction
- Decreased dispute and litigation

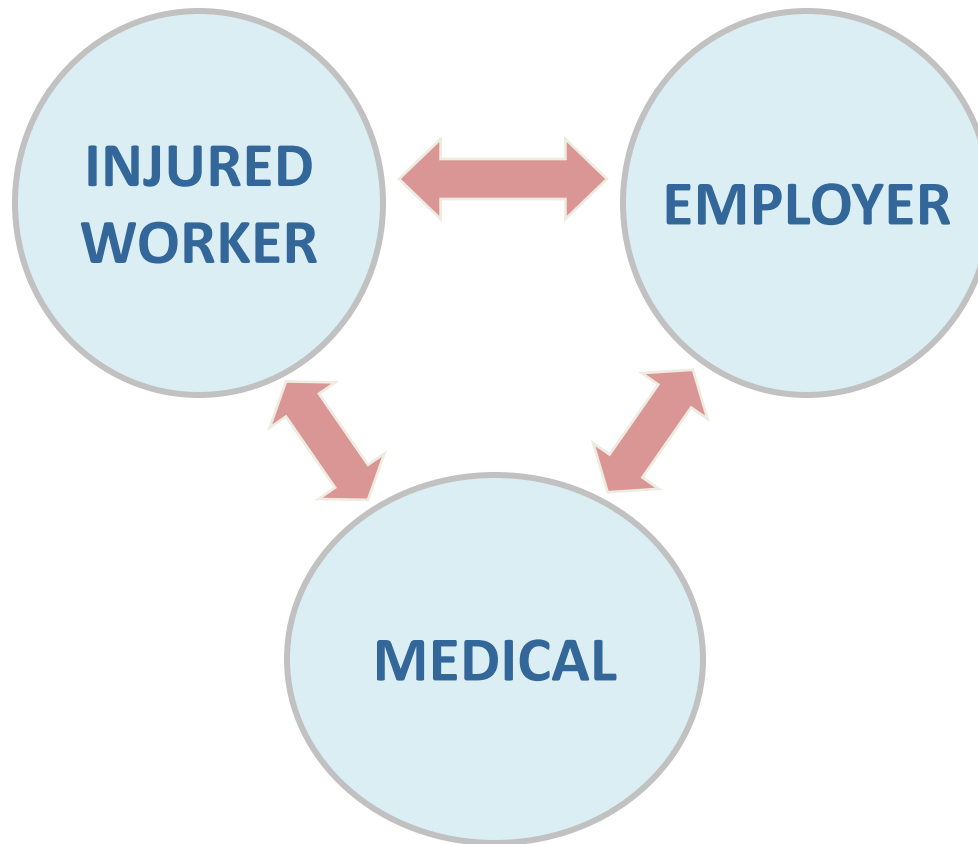
Program Model Components



7 Core Principles

- 1. Comprehensive and Integrated**
- 2. Criteria, Principle-Based**
- 3. Engaged Employer**
- 4. Medical Drives Claims**
- 5. Time is the Enemy!**
- 6. Function is Good**
- 7. Nothing is Routine**

Workers' Comp Triad



- Statute
- Regulation
- Case Law

Determinations

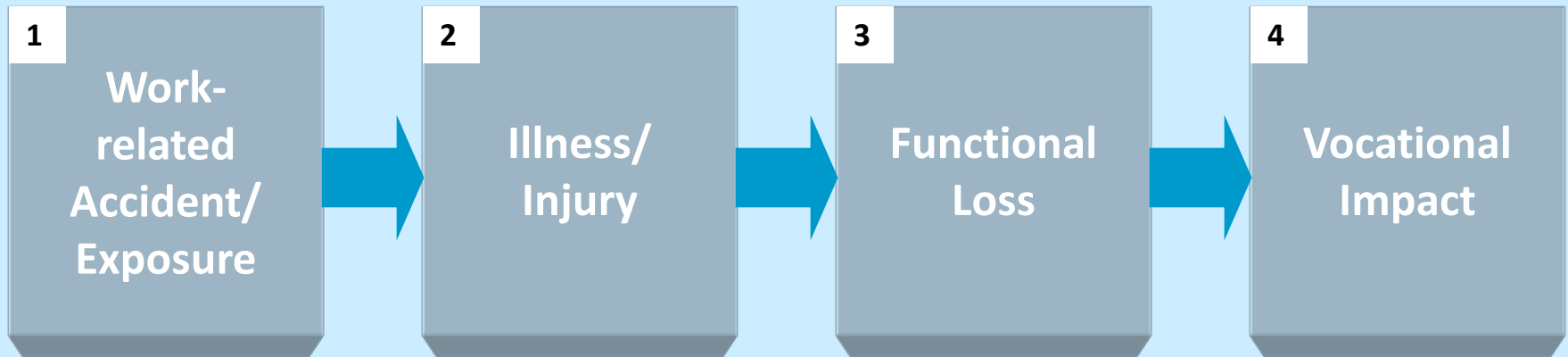


Medical
Science

Facts
of the
Case

Workers' Comp Criteria Framework

"Four Box Model"



Core Determinations

1. Is he ill/injured?
2. If yes, what's wrong with him? (Dx/C.A.R.P)
3. a. Is there any reason to think this is not work related? (causality/MCC)
b. Is there any reason to think it is not compensable?
4. Does he require treatment? If so, what?
5. Are there any functional restrictions/limitations? If so, what?
6. Do the above restrictions impede the way he does his job? If so, what accommodations can be made?
7. Prognosis – MMI, PIR, D/C, future medical?

Clinical Decision-Making Model

	<i>Evaluation (exam)</i>	<i>Norms</i>	<i>Relevancy</i>
Symptoms: pain functional disturbance	data or findings	abnormal or positive findings	Clinical Problem List (C.A.R.P.)
	50	15	5

Evidence-Based Practice

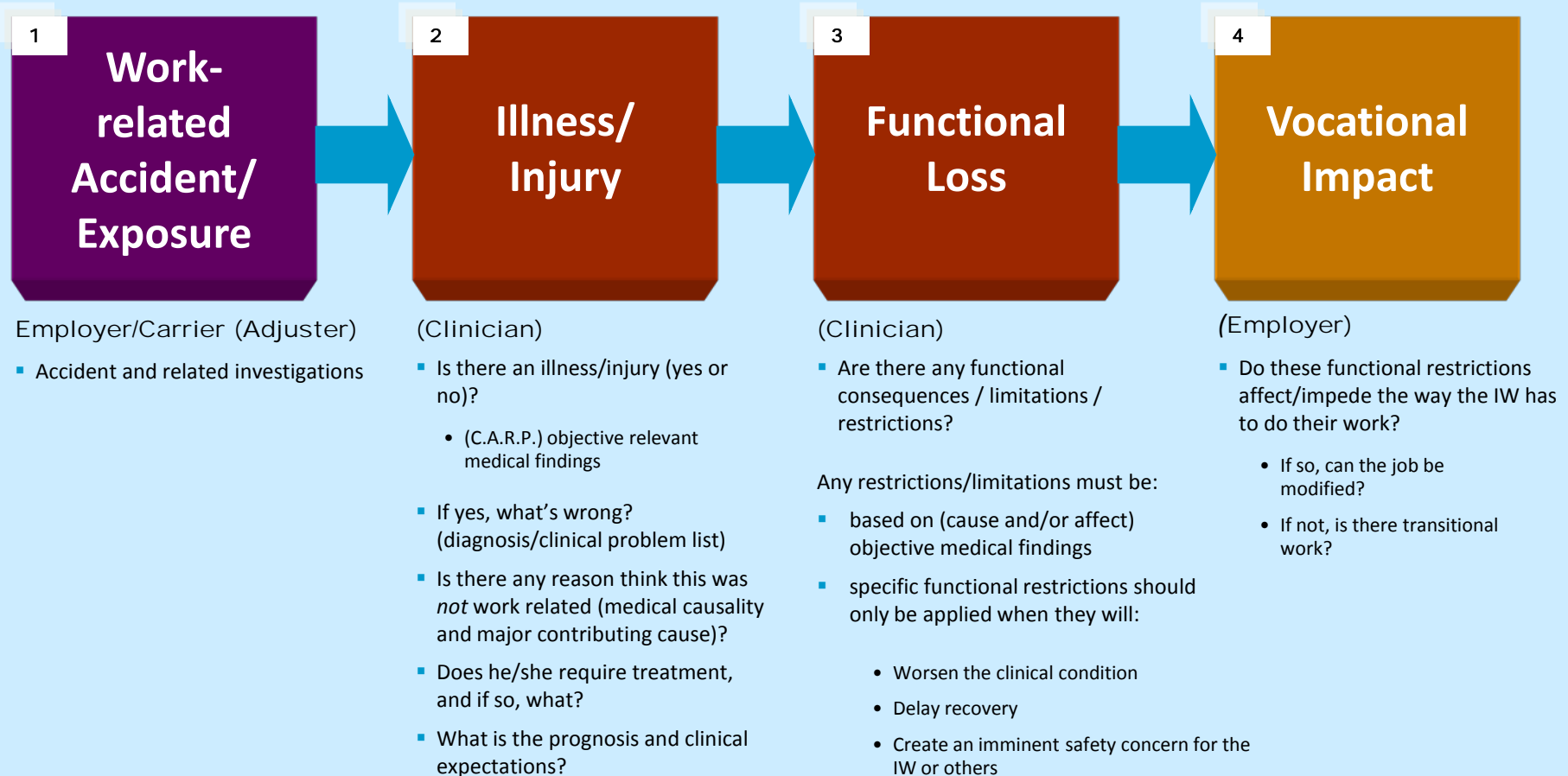


A clinical decision or procedure is considered **evidence-based** when it meets one or more of the following criteria:

CRITERIA		
Professional Consensus	Principle-Based	Research Support
<ul style="list-style-type: none">▪ AHCPR▪ ACOEM▪ AAOS▪ APA▪ NASS	<ul style="list-style-type: none">▪ Anatomy▪ Physiology▪ Pathology▪ Clinical Principles	<ul style="list-style-type: none">▪ Published▪ Peer-reviewed▪ Scientific Studies
<i>Frye</i>	<i>Inherent Logic</i>	<i>Daubert</i>

WC Criteria Framework

4-Box Model



Program Features

- ✓ Single source/integrated components
- ✓ 24/7/365 intake and medical triage
- ✓ High utilization of clinical specialists
- ✓ Criteria-based medical consumerism (vs. “Russian roulette” or “cook-book”)
- ✓ Telephonic nurse case manager/adjuster team assigned – every claim/life of claim
- ✓ Enhanced medical reimbursement
- ✓ Concentrated panel of trained clinicians
- ✓ Pre-agreed simplified coding & expedited bill payment
- ✓ Streamlined authorization process
- ✓ Real-time communication and information sharing

- ✓ Strategic partnerships rather than vendor relationships
- ✓ Aggressive Stay-at-Work/Return to Work program
- ✓ Front-loaded, sports medicine approach to care and management
- ✓ Outcomes vs. discounts (investment strategy rather cost-containment)
- ✓ Claims: managing vs. processing
- ✓ Team management – clear role delineation of all parties
- ✓ Clinical Science Advisory Panel

Florida Status Reporting Form



Florida Workers' Compensation Uniform Medical Treatment / Status Reporting Form

Page 1 of 2

Florida Workers' Compensation Uniform Medical Treatment/Status Reporting Form - PAGE 1		
BEFORE COMPLETING THIS FORM, PLEASE CAREFULLY REVIEW THE INSTRUCTIONS BEGINNING ON PAGE 3		
NOTE: Health care providers shall legibly and accurately complete all sections of this form, limiting their responses to their area of expertise.		
1. Insurer Name:	2. Visit/Review Date:	FOR INSURER USE ONLY
3. Injured Employee (Patient) Name:	4. Date of Birth:	5. Social Security #:
6. Date of Accident:	7. Employer Name:	8. Initial visit with this physician? <input type="checkbox"/> a) NO <input type="checkbox"/> b) YES
SECTION I CLINICAL ASSESSMENT / DETERMINATIONS		
9. <input type="checkbox"/> No change in Items 9 - 13d since last reported visit. If checked, GO TO SECTION II.		
10. Injury/Illness for which treatment is sought is: <input type="checkbox"/> a) NOT WORK RELATED <input type="checkbox"/> b) WORK RELATED <input type="checkbox"/> c) UNDETERMINED as of this date		
11. Has the patient been determined to have Objective Relevant Medical Findings? Pain or abnormal anatomical findings, in the absence of objective relevant medical findings, shall not be an indicator of injury and/or illness and are not compensable. <input type="checkbox"/> a) NO <input type="checkbox"/> b) YES <input type="checkbox"/> c) UNDETERMINED as of this date If YES or UNDETERMINED, explain: _____		
12. Diagnosis(es): _____		
13. Major Contributing Cause: When there is more than one contributing cause, the reported work-related injury must contribute more than 50% to the present condition and be based on the findings in Item 11. a) Is there a pre-existing condition contributing to the current medical disorder? <input type="checkbox"/> a ₁) NO <input type="checkbox"/> a ₂) YES <input type="checkbox"/> a ₃) UNDETERMINED as of this date b) Do the objective relevant medical findings identified in Item 11 represent an exacerbation (temporary worsening) or aggravation (progression) of a pre-existing condition? <input type="checkbox"/> b ₁) NO <input type="checkbox"/> b ₂) exacerbation <input type="checkbox"/> b ₃) aggravation <input type="checkbox"/> b ₄) UNDETERMINED as of this date c) Are there other relevant co-morbidities that will need to be considered in evaluating or managing this patient? <input type="checkbox"/> c ₁) NO <input type="checkbox"/> c ₂) YES d) Given your responses to the Items above, is the injury/illness in question the major contributing cause for: <input type="checkbox"/> d ₁) NO <input type="checkbox"/> d ₂) YES the reported medical condition? <input type="checkbox"/> d ₃) NO <input type="checkbox"/> d ₄) YES the treatment recommended (management/treatment plan)? <input type="checkbox"/> d ₅) NO <input type="checkbox"/> d ₆) YES the functional limitations and restrictions determined?		
SECTION II PATIENT CLASSIFICATION LEVEL		
<input type="checkbox"/> 14. LEVEL I - Key issue: specific, well-defined medical condition, with clear correlation between objective relevant physical findings and patients' subjective complaints. Treatment correlates to the specific findings.		
<input type="checkbox"/> 15. LEVEL II - Key issue: regional or generalized deconditioning (i.e. deficits in strength, flexibility, endurance, and motor control. Treatment: physical reconditioning and functional restoration.		
<input type="checkbox"/> 16. LEVEL III - Key issue: poor correlation between patient's complaints and objective, relevant physical findings, indicating both somatic and non-somatic clinical factors. Treatment: interdisciplinary rehabilitation and management.		
<input type="checkbox"/> 17. LEVEL UNDETERMINED AS OF THIS DATE.		
SECTION III MANAGEMENT / TREATMENT PLAN		
<input type="checkbox"/> 18. No clinical services indicated at this time. If checked, GO TO SECTION IV		
<input type="checkbox"/> 19. No change in Items 20a - 20g since last report submitted. If checked, GO TO SECTION IV		
20. The following proposed, subsequent clinical service(s) is/are deemed medically necessary. *** THIS IS A PROVIDER'S WRITTEN REQUEST FOR INSURER AUTHORIZATION OF TREATMENT OR SERVICES. ***		
<input type="checkbox"/> a) Consultation with or referral to a specialist. Identify principal physician: _____ Identify specialty & provide rationale: <input type="checkbox"/> a ₁) CONSULT ONLY <input type="checkbox"/> a ₂) REFERRAL & CO-MANAGE <input type="checkbox"/> a ₃) TRANSFER CARE		
<input type="checkbox"/> b) Diagnostic Testing: (Specify) _____		
<input type="checkbox"/> c) Physical Medicine. Check appropriate box and indicate specificity of services, frequency and duration below: <input type="checkbox"/> c ₁) Physical/Occupational therapy, Chiropractic, Osteopathic or comparable physical rehabilitation. <input type="checkbox"/> c ₂) Physical Reconditioning (Level II Patient Classification) <input type="checkbox"/> c ₃) Interdisciplinary Rehabilitation Program (Level III Patient Classification) Specific instruction(s): _____		
<input type="checkbox"/> d) Pharmaceutical(s) (specify): _____		
<input type="checkbox"/> e) DME or Medical Supplies: _____		
<input type="checkbox"/> f) Surgical Intervention - specify procedure(s): _____ <input type="checkbox"/> f ₁) In-Office: _____ <input type="checkbox"/> f ₂) Surgical Facility: _____ <input type="checkbox"/> f ₃) Injectable(s) (e.g. pain management): _____		
<input type="checkbox"/> g) Attendant Care: _____		

Florida Status Reporting Form



Florida Workers' Compensation Uniform Medical Treatment / Status Reporting Form

Page 2 of 2

Florida Workers' Compensation Uniform Medical Treatment/Status Reporting Form - PAGE 2			
Patient Name: _____		Soc. Sec. #: _____	D/A: _____
		Visit/Review Date: _____	
SECTION IV FUNCTIONAL LIMITATIONS AND RESTRICTIONS			
Assignment of limitations or restrictions must be based upon the injured employee's specific clinical dysfunction or status related to the work injury. However, the presence of objective relevant medical findings does not necessarily equate to an automatic limitation or restriction in function.			
<input type="checkbox"/> 21. No functional limitations identified or restrictions prescribed as of the following date: _____			
<input type="checkbox"/> 22. The injured workers' functional limitations and restrictions, identified in detail below, are of such severity that he/she cannot perform activities, even at a sedentary level (e.g. hospitalization, cognitive impairment, infection, contagion), as of the following date: _____ Use additional sheet if needed.			
<input type="checkbox"/> 23. The injured worker may return to activities so long as he/she adheres to the functional limitations and restrictions identified below. Identify ONLY those functional activities that have specific limitations and restrictions for this patient. Identify joint and/or body part: _____ Use additional sheet if needed.			
Functional Activity	Load	Frequency & Duration	ROM/ Position & Other Parameters
<input type="checkbox"/> Bend			
<input type="checkbox"/> Carry			
<input type="checkbox"/> Climb			
<input type="checkbox"/> Grasp			
<input type="checkbox"/> Kneel			
<input type="checkbox"/> Lift-floor > waist			
<input type="checkbox"/> Lift-waist > overhead			
<input type="checkbox"/> Pull			
<input type="checkbox"/> Push			
<input type="checkbox"/> Reach-overhead			
<input type="checkbox"/> Sit			
<input type="checkbox"/> Squat			
<input type="checkbox"/> Stand			
<input type="checkbox"/> Twist			
<input type="checkbox"/> Walk			
<input type="checkbox"/> Other			
COMMENTS:			
Other choices; Skin Contact/ Exposure; Sensory; Hand Dexterity; Cognitive; Crawl; Vision; Drive/Operate Heavy Equipment; Environmental Conditions: heat, cold, working at heights, vibration; Auditory; Specific Job Task(s); etc.			
NOTE: Any functional limitations or restrictions assigned above apply to both on and off the job activities, and are in effect until the next scheduled appointment unless otherwise noted or modified prior to the appointment date. Specify those functional limitations and restrictions, in Item 23, which are permanent if MMI / PIR have been assigned in Item 24.			
SECTION V MAXIMUM MEDICAL IMPROVEMENT / PERMANENT IMPAIRMENT RATING			
24. Patient has achieved maximum medical improvement?			
<input type="checkbox"/> a) YES, Date: _____ <input type="checkbox"/> b) NO <input type="checkbox"/> c) Anticipated MMI date: _____			
<input type="checkbox"/> d) Anticipated MMI date cannot be determined at this time. Future Medical Care Anticipated: e) <input type="checkbox"/> Yes f) <input type="checkbox"/> No			
Comments: _____			
25. % Permanent Impairment Rating (body as a whole) _____ Body part/system: _____			
26. Guide used for calculation of Permanent Impairment Rating (based on date of accident - see instructions):			
<input type="checkbox"/> a) 1996 FL Uniform PIR Schedule <input type="checkbox"/> b) Other, specify _____			
27. Is a residual clinical dysfunction or residual functional loss anticipated for the work-related injury?			
<input type="checkbox"/> a) YES <input type="checkbox"/> b) NO <input type="checkbox"/> c) Undetermined at this time.			
SECTION VI FOLLOW-UP			
28. Next Scheduled Appointment Date & Time: _____			
SECTION VII ATTESTATION STATEMENT			
<i>"As the Physician, I hereby attest that all responses herein have been made, in accordance with the instructions as part of this form, to a reasonable degree of medical certainty based on objective relevant medical findings, are consistent with my medical documentation regarding this patient, and have been shared with the patient."</i>			
Physician Group: _____		Date: _____	
Physician Signature: _____		Physician DOH License #: _____	
Physician Name: _____		Physician Specialty: _____	
(print name)			
If any direct billable services for this visit were rendered by a provider other than a physician, please complete sections below.			
<i>"I hereby attest that all responses herein relating to services I rendered have been made, in accordance with the instructions as part of this form, to a reasonable degree of medical certainty based on objective relevant medical findings, are consistent with my medical documentation regarding this patient, and have been shared with the patient."</i>			
Provider Signature: _____		Provider DOH License #: _____	
Provider Name: _____		Date: _____	
(print name)			

A green apple with a white question mark is the central focus. To its left, a yellow apple is visible but out of focus. The background is a solid light brown color.

Questions & Answers