Claims Management Insights from an Occupational Physician’s Perspective

Understanding the Assessment of Ability vs Disability: A Psychiatrist’s Perspective

MLO Breakfast Seminar
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Claims Management Insights from an Occupational Physician’s Perspective

Dr Andrew Keller
Occupational Physician
Dr Andrew Keller – Occupational Physician

- Dr Andrew Keller
- Bachelor of Medicine, Bachelor of Surgery
- Fellow of the Royal Australian College of General Practice
- Fellow of the Australian Faculty of Occupational and Environmental Medicine
- Fellow of the Australasian College of Aerospace Medicine
- Fellow of the Australian Medicolegal College
- Occupational Physician
- WorkCover Permanent Impairment Assessor
- Master Health Admin – UNSW
- Master Aerospace Medicine – Griffith UDAME Australia & NZ, Brunei
- Designated Diving Medical Examiner
- Medical Inspector of Seamen
- Medical Examiner Maritime Pilots
- Medical Review Officer, MROCC
- Board Member Australian Medical Review Officer Association
- Committee member CH-036: Standards Australia committee on urine drug testing
- Committee member CH-039: Standards Australia committee on oral fluids drug testing
Dr Andrew Keller – Occupational Physician

• Occupational Physicians are specialists on how the environment and work affects the health of workers and how the health of the workers affects their occupations.

• Our knowledge comes from specialist training in work related health issues, injuries and environmental influences.

• Our privilege is to be exposed to a wide range of workplaces
How can an Occupational Physician help in claims management?

- Confirmation of Diagnosis
- Consistency with reported cause
- Liability: weighing the evidence
- Reasonable and Necessary treatment
- Current work capacity/Fitness for duty
- Future Capacity Recovery
- Assessment of Permanent Impairment
- Assessing Total and Permanent Disability
How Can You Help The Occupational Physician?

• A Good Referral leads to a good opinion.
• Send all of the appropriate information.
• Get the file to the Specialist before the appointment.
• File Housekeeping.
• Don’t ask all of the questions all of the time: be specific.
Managing Expectations

• Some cases are clearly not what they seem.
• Claims managers are gate keepers to compensation funds.
• Some claims are appropriate within the sold policies.
Indirect Observation

• Surveillance can be useful.
• Clinical observations in a single setting are helpful but limited.
• Withholding information can mislead clinicians.
Heart-sink Cases

• Stay on top of them.
• Take a deep breath and identify the next main issue.
• Get help
The value of the Occupational Physician
Understanding the Assessment of Ability vs Disability: A Psychiatrist’s Perspective

Associate Professor Michael Robertson
Psychiatrist
Case example

• The troubling tale of Mr B.
Mr B (1)

• 45 year old man with a family
• Australian born to Balkan descent family (parent’s post war immigrants)
• Long-term employee with same company
• Only limited transferable skills
• New management structure
• Made redundant from role and job detached
Mr B (2)

• Unable to find work for 12 months
• Role as groundskeeper at university – poor job performance
• Terminated
• Increased alcohol use – referred with depressive illness to psychiatric care
• Makes worker’s compensation claim – back dated – declined on “reasonable actions” grounds
Mr B (3)

• Referred to psychiatrist – diagnosed with Major Depression
• Multiple trials of antidepressants and augmentation strategies
• Outpatient depression management program
• Referred to inpatient care when suicidal
• Refuses then submits to electroconvulsive therapy (ECT)
Mr B (4)

- Main themes in sessions focus on anger, betrayal, sense of shame
- Feels increasingly despondent and demoralised
- Worries about marriage
- Worries about example to children
- Constantly ruminating on “injustice” and seeking legal advice
How do we conceptualise Mr B?

• Biochemical disturbance?
• Narcissistic injury?
• Developmental crisis?
• Cognitive distortions?
• Disordered self?
• All of these??
How do we treat Mr B?

- Polypharmacy
- Neuromodulation
- “Therapy”
- Apology?
- Employment...
Psychiatric Disability

The components of disability
Freud was once asked what he thought a normal person should be able to do well. The questioner probably expected a complicated answer. But Freud, in the curt way of his old days, is reported to have said: 'Lieben und arbeiten' (to love and to work).

(Sigmund Freud)
Disability from psychological injury

- DISEASE or DISORDER
- DYSFUNCTION
- IMPAIRMENT
- DISABILITY
Acute-v-Chronic Illness

• Acute illness - understandable, elicits favourable responses, expectation of recovery
• Chronic illness - marginalisation, empathic failure, accumulated disadvantage, loss of status, limited expectations of recovery
Chronic Illness - social construction

• “Sickness” versus “Illness”
• “Disability” largely a social construction
• “Illness” transformed into “Disability” by the assumption of a social role characterised by:
  – Assumption of incapacity
  – Marginalisation
  – Loss of status
  – Dependency as a theme in relationships
Quantification of Disability

• AMA-5 has moved to a more qualitative assessment for psychiatric disorders
• Measures such as Social Functioning Scale, Quality of Life Measures, HoNOS, SF-12
• How to translate into $$?
“Human all too human”

• Relate to others
• Intimacy
• Engage in productive labour
• Maintain health
• Care for self
• Freedom from pain
• Apply Reason
• Seek pleasure
• Dignity
• Flourishing
• Seek Meaning in life narrative
Derangements arising from mental illness
Disability in psychiatric disorder

Disability

- Social
- Interpersonal
- Vocational
- Existential
Assessment of Work Capacity

- Voc Assess
- Psychiatric
- Psychometric
- Physical
What determines work capacity from a psychiatric disorder?

- Symptoms
- Cognitive impairment
- Interpersonal efficacy
- Resilience
- Life history
- The benefits of the sick role
- Iatrogenic factors
- The function of the illness
Psychiatric Disability

The sociological dimension of disability
The “Sick Role” - 1
The “Sick Role” - 2

- Parsons took the view that society moulded an individual's thoughts and behaviour into certain roles that compelled humans act in a non-voluntary way.
- Parsons described the “sick role” as a temporary, medically sanctioned form of deviant behaviour.
- In order to be excused their usual responsibilities, the person compelled into the “sick role” is expected to seek appropriate help and to strive towards recovery and resume normal life.
The “Sick Role” - 3

“...the role of motivational factors in illness immensely broadens the scope and increases the importance of the institutionalised role aspect of being sick...The privileges and exemptions of the sick role may become objects of a "secondary gain" which the patient is positively motivated, usually unconsciously, to secure or to retain”

-Talcott Parsons The Social System (1951)
Benefits of the sick role

1. Exemption from social responsibilities
2. Expectation of care

Obligations of the sick role

1. Motivation to recovery
2. Seek and accept appropriate interventions to achieve recovery
“Illness Behaviour”

“the way in which symptoms are perceived, evaluated, and acted upon by a person who recognises some pain, discomfort or other signs of organic malfunction”

- David Mechanic (1968)
Abnormal Illness Behaviour

- Continuous assumption of the sick role and associated dysfunctional behaviours despite *adequate* medical reassurance
- Best example is the issue of centrally mediated pain
- Counterargument is of “medicalization”
Beyond Biology

• How to Manage Mr B?
Management

• Psychiatry has a place
• Contextualisation of Mr B’s symptoms
• Understanding the sociological “role” of his illness
• The insurance process another means of persecution
• Is there a “face saving” way ahead
Summary

• Psychiatric disability is a complex, multiply determined phenomenon
• The sociology of mental illness is as significant as the biology - particularly the subtleties of the sick role and illness behaviour
• Deeper understanding of these contributing factors will improve determination of entitlements
• This is beneficial for all stakeholders