

Undiagnosed femoral neck fracture in a workers' compensation patient that lacked a self-choice medical treater

Abstract

Workers compensation was instituted as a no-fault system that ensured workers injured at work would receive compensation without delay and without regard to fault. The injured worker desires timely and quality medical treatment while the insurance company often seeks the most economical resolution as possible. Situations often arise where the injured workers access to medical care is delayed or denied through procedural roadblocks. This case report demonstrates how employer directed medical care as well as procedural delay such as utilization review can result in a poor medical outcome.

Keywords: workers compensation, access to care, insurance, legal, hip fracture, patient choice

Volume 2 Issue 5 - 2015

Blair A Rhode

Orland Park Orthopedics, USA

Correspondence: Blair A Rhode, Orland Park Orthopedics, 16450 S 104th AV, Orland Park, Illinois 60467, USA, Tel 708-364-8441, Email blairbones@gmail.com

Received: May 11, 2015 | **Published:** May 15, 2015

Abbreviations: UR, Utilization Review; CPGs, Clinical Practice Guidelines; EBM, Evidence Based Medicine

Introduction

Workers' Compensation traces its origins back to Germany, where Chancellor Otto Von Bismarck introduced a compulsory state run accident compensation system in 1884. Nine states passed workers' compensation legislation in 1911, and by 1948 every state had some form of workers' comp law on the books. Workers' Compensation is a state mandated *no-fault system* form of insurance that ensured that workers injured at work would receive compensation without delay and without regard to fault (820 ILCS 305/1(a)(3)).¹ It was started in response to serious societal problems caused by a dramatic rise in the number of people injured in industrial settings. It is a benefit provided in exchange for mandatory relinquishment of the employee's right to sue his or her employer under the common civil law of negligence.²

The relationship between the legitimately injured/sickened worker and the insurance carrier paying the medical bills and other compensation is by nature somewhat adversarial. The injured worker wants quality medical treatment to enable a full recovery, and the insurance carrier wants as inexpensive resolution as possible. Disputes can arise when the claims administrator contests employee claims. We believe that the spirit of worker's compensation is to achieve timely treatment of the injured worker such that the earliest return to work in an economical fashion can be achieved. It is our belief that procedural delays (defer, delay, deny) are used to limit access to care in certain environments that ultimately increases the cost to the system.³

Case report

A 43 year-old female sustained a work related left hip injury due a fall on an icy surface. She sustained a direct impact to her left hip. Due the pain, she crawled into the office and was transported by her employer to an employer directed urgent care. An AP pelvis x-Ray was obtained and interpreted as normal (Figure 1 & 2). The patient was then returned to full duty by the urgent care physician. The patient experienced persistent, severe left hip pain such that

she took 2 personal days off from work. She subsequently returned to work using a walker that she brought from home. She continued to complain of severe left hip pain to her employer and was, subsequently, was required to follow up with the employer directed urgent care physician. She had 5 follow up visits over the course of 2.5 months. On two separate occasions, she asked the doctor if she could undergo an MRI or further diagnostic testing. She was told that she could not undergo an MRI because the insurer would not approve the study. No repeat x-Rays were obtained. Finally, an MRI was obtained 2.5 months after the injury which demonstrated a mildly displaced femoral neck fracture. The urgent care doctor then referred the patient to the employer directed orthopedic surgeon. The orthopedic surgeon told the patient that she required surgical intervention but that he could not perform the procedure until receiving authorization from the insurance company (Figure 3).



Figure 1 AP Pelvis at index visit.

Several days passed and the patient became fearful of her treatment course and sought advice from a worker's compensation attorney. After being explained her rights, she subsequently sought evaluation from an independent orthopedic surgeon who repeated radiographic studies

and agreed with the need for surgery and performed the procedure on an emergency basis without insurance authorization. She underwent a femoral neck pinning with 7.3 mm cannulated screws (Figure 4 & 5). Post-operatively, a prescription for DVT prophylaxis was written. The insurer enacted utilization review (UR) to determine the necessity of the DVT medication. Two utilization review phone calls (physician to UR representative) were placed over the course of 72 hours (time allotted to provide determination). After the second denial, the patient was 14 days post-operative and further pursuit of the medication was felt not to significantly lower the patient's DVT risk.



Figure 2 AP pelvis demonstrating cortical break along femoral neck.

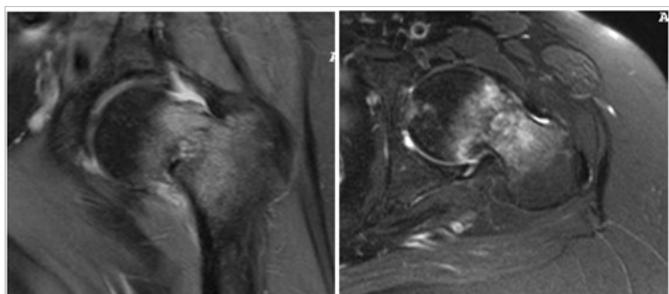


Figure 3 Coronal and axial MRI cuts demonstrating displaced femoral neck fracture.



Figure 4 Pre-operative AP pelvis x-ray demonstrating displaced femoral neck fracture.



Figure 5 AP and frog lateral fluoroscopic post-surgical images.

Discussion

Workers' Compensation was implemented as a state mandated *no-fault system* form of insurance that ensured that workers injured at work would receive compensation without delay and without regard to fault. We believe that enabling the insurer to direct care can place the injured worker's access to care at risk. This is due to the fact that the injured worker's interests lie in access to quality medical treatment while the insurance company's alignment is directed towards cost containment. This case demonstrates multiple potential pitfalls with a worker's compensation system that allows the employer to direct care. Patients often feel that their interests are not represented by the physician that has an alignment with the insurer/employer. This alignment may have an implied or written agreement to limit costs.

The Illinois Workers Compensation law currently states that the employer has the right to direct care to their choice of initial treating physician using a preferred provider program (820 ILCS 305/8.1(a)).¹ The patient has a right to choose one doctor outside of the employer chain of referral, although patient is often unaware of this choice of treating physician (820 ILCS 305/8(a)).¹ The patient in the above case report continued to follow up with the employer physician for a total of five visits. She repeatedly asked for further diagnostic testing that was repeatedly refused on the basis that the insurer would not approve the diagnostic test. Surgical intervention in this emergency situation would have been delayed by the orthopedic referral on the basis that the surgery had to be pre-authorized. Although this author can find no requirement for preauthorization in the Illinois Workers' Compensation law, health care providers are frequently told by insurance providers that treatment cannot be rendered to the patient due to non-authorization. The patient was further placed in harm's way in her post-operative course when utilization review denied post-operative DVT prophylaxis.

Insurance companies often practice a pattern of delay and denial in order to limit healthcare expenditures and increase their float income. Utilization review is often used to delay care by creating scenarios where physicians must wait on long phone calls to explain their treatment choices to nurse practitioners sitting within the confines of their employer, the insurance company (820 ILCS 305/8.7).¹ Clinical practice guidelines (CPGs) and evidence based medicine (EBM) are also used to delay and deny treatment. Although studies have shown that only 50% of CPGs were found valid at 5 years and that there are often conflicting recommendations in the 2,373 guidelines (present in 2009), there is a movement afoot to make these recommendations

binding for payment.⁴ Perhaps the greater problem with enforcement of EBM is the inherent conflict of interest that arises when determining the treatment and course of action based on research studies that often have weak, biased, commercial or political overtones. These guidelines often conflict with one another and do not take into account the individual variables of each clinical scenario.

Conclusion

We believe that the intent of the workers compensation system is to provide prompt, appropriate treatment to the injured worker. The preamble to the law itself states: "An Act to promote the general welfare of the people of this State by providing compensation for injuries occurring in the workplace" (820 ILCS 305, et al.). Studies have shown that earlier access to care actually lowers the cost of treatment and lost work time.^{5,6} We believe that the treating physician should be free of potential treatment bias that can occur when insurance companies choose the treating physician. In this scenario, the physician is placed across the table from the injured worker. These physicians must be cognizant of the desire of the insurer to limit costs. This often takes the form of limited treatment based upon authorization denial and using treatment algorithms to slow treatment.

It is our opinion that an independent treating physician is more aligned with the interest of the patient. One merely needs to look at the final rite of passage for a graduating medical doctor when they swear the Hippocratic Oath to see where the doctor's responsibility should lie. It requires a new physician to swear upon a number of healing gods that he will uphold a number of professional ethical standards. An excerpt of the oath swears, "*I will apply dietetic measures for*

the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice... Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice." – Hippocrates, 5th century B.C.

The intent of worker's compensation is to treat the injured worker who was harmed at no fault of their own to receive timely and appropriate treatment. The worker willingly gave up their right to pursue civil damages in return for a no fault insurance program. Unfortunately, the spirit of the system has been systematically violated through insurer directed care, algorithmic care (CPGs), and procedural delay via utilization review denials.

References

1. (820 ILCS 305/) Workers' Compensation Act.
2. Bible JE, Spengler DM, Mir JM. A primer for workers' compensation. *Spine J.* 2014;14(7):1325–1331.
3. Dember AE. Access to medical care for occupational disorders: difficulties and disparities. *J Health Soc Policy.* 2001;12(4):19–33.
4. Rhode BA, Rhode WM, Rhode BJ. Removal of Barriers to Care Result in Improved Outcomes for Manual Laborers with Compressive Neuropathies. *MOJ Orthop Rheumatol.* 2015;2(2):1–5.
5. Rhode BA. Clinical Practice Guidelines: Cookbook Medicine vs. Hippocrates. *Orthopreneur.* 2013.
6. Gallagher RM, Myers P. Referral delay in back pain patient on workers' compensation: Costs and policy implications. *Psychosomatics.* 1996;37(3):270–284.