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COLD CASE FILES: FORENSIC STRATEGIES FOR RESOLVING LONG-TERM CHRONIC PAIN DISABILITIES

BETSY ROBINSON

Chronic pain is not a new problem in the workplace, but it is a significant problem and one that, despite the industry's best efforts to date, is not going away. In fact, estimates of health-care expenditures, lost income, and lost productivity put the cost of chronic pain in the United States at \$100 billion annually.¹

Disabilities caused by chronic pain continue to deplete the financial reserves of employers, insurers, and government programs as well as to severely diminish the quality of life of the afflicted individuals and their families, despite increased focus on treatment over the last two decades. Too many cases turn "cold." Months, and often years, after the initial injury or illness, the employee remains unproductive and is still suffering a reduced quality of life. Increasingly, we are coming to understand that chronic pain is a vicious cycle: pain, lost productivity, depression, more

pain, and, too often, substance abuse. The claim remains open, and the costs for medical care and wage replacement accumulate. The longer the status quo continues, the less likely it is to change.

In most situations, clinical case management and return-to-work programs do help people who are suffering from pain associated with an injury to recover their productive function and ability to work. Certain outlier cases, however, may require a different approach. In this article, we will discuss solutions for targeting “cold cases” and analyze successful examples of how a consumer-centric and integrated approach to cold-case management benefited the lives of two individuals and removed them from a cycle of chronic pain.

A LARGE AND PAINFUL PROBLEM

According to the National Institutes of Health, an estimated 76.2 million Americans suffer chronic pain.² While chronic pain can take many forms, including joint disorders, migraines, and fibromyalgia, back pain is the most common, with more than 26 million Americans between the ages of 20 and 64 experiencing frequent back pain.³ It is also the leading cause of disability in Americans under 45 years old.⁴

Chronic pain costs an estimated \$100 billion each year and drives direct *and* indirect costs — which are felt by both the employee and the employer.⁵ The Workers Compensation Research Institute (WCRI) recently analyzed data from claims with an average of three years’ experience in 14 states and found that nonspecific back pain represented one in seven cases and 11 percent of medical payments in those states.⁶

Direct costs — for physician visits, medications, physical therapy, and wage replacement — are high, but they are just a fraction of the indirect costs. The cost of lost productivity often dwarfs the direct costs, and the numbers don’t lie. Each year, more than 50 million workdays are lost due to pain.⁷ In fact, an Integrated Benefits Institute study found that lost productivity due to pain-related absence represented nearly half of employers’ costs for group health, workers compensation, and disability.⁸

But productivity also suffers as a result of presenteeism — the result of employees who show up for work, but do not perform well. A study based on data from 28,900 working adults found that, overall, workers lost an average of 4.6 hours per week of productive time due to pain.⁹ The same study estimated that the cost of lost productive time from common painful conditions was \$62.1 billion per year; it found that 76.6 percent of lost productive time was due to reduced work performance, *not* absenteeism.¹⁰

That shouldn't be surprising. Forty percent of those with pain say that their pain interferes with their productivity and ability to work.¹¹

Beyond the costs associated with lost productivity due to both absenteeism and presenteeism, employers face medical and pharmacy-related costs too. The National Pharmaceutical Council recently funded a study of health-related lost productivity relative to medical and pharmacy costs and found that back/neck pain was the second highest driver of costs, behind cancer, costing employers an average of approximately \$170,000 per 1,000 full-time employees annually.¹² But when the study looked at combined medical, pharmacy, and lost productivity costs, back/neck pain rose to the top of the list, and each year back and neck conditions cost employers an average of more than \$500,000 per 1,000 full-time employees.¹³ Second on the combined list was depression, which was in tenth place on the list of medical cost drivers and fifth on the list of pharmacy drivers.¹⁴ Combined medical, pharmacy, and lost productivity costs for depression averaged more than \$400,000 per 1,000 full-time employees per year.¹⁵

BEYOND COSTS: EXPLORING THE HUMAN ELEMENT OF CHRONIC PAIN

The impact of chronic pain goes beyond costs and productivity. At the core of the issue are the employees who are left to cope with these unexpected situations.

Most employers' current approach to addressing an individual's chronic pain issues is to intervene through clinical case management during the acute phase of the injury or illness, generally within the first 30 days. Many employers, insurers, and third party administrators (TPAs) have such early intervention case management models in place, and in most instances, the approach works well.

The employee returns to work or is deemed medically stable, and the case is closed. But some cases are never resolved. Perhaps these individuals were misdiagnosed initially or didn't get the quality of care they might have; maybe there was no clinical case manager engaged to coach and counsel the individual to be compliant with care and take responsibility for his or her recovery. For whatever reason, two-thirds of pain sufferers in a 1999 study said they had lived with their pain for more than five years.¹⁶ The pain continues, the employee suffers, and — in many states — the insurer is looking at a lifetime of medical payments as the case turns "cold." The challenge in managing these types of cases is to use a multidisciplinary approach that is flexible in addressing a problem with as many different faces as there are individuals who suffer chronic pain.

CHRONIC PAIN: AN EVOLVING PERSPECTIVE

What is pain? The answer might seem obvious — and yet, in recent years, knowledge and understanding of pain has grown and changed significantly. New insights into the complex nature of pain can provide a solid foundation upon which to build an effective program to address chronic pain.

The International Association for the Study of Pain defines pain as “an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.”¹⁷ For many years, chronic pain was defined as pain that lasted six months or more. That definition fit the prevailing view that pain was the result of nerve signals that were transmitted from the injured tissue to the brain. From this perspective, all pain had a direct correlation to a physical insult. This “specificity theory,” however, does not fully explain all pain phenomena.

Today, chronic pain is defined as pain that persists longer than the temporal course of the natural healing that is associated with a given injury or disease process.¹⁸ Subjective in nature, pain is ultimately defined by the individual experiencing it. The medical community’s understanding of chronic pain now includes the impact that the mind has in processing and interpreting pain signals. The biopsychosocial model is replacing the historical view of the mind and body as two separate systems. Pain may exist independently of any tissue damage.

The medical community also recognizes that chronic pain is often one component in a self-perpetuating cycle. Pain may generate other adversities, including affective symptoms of depression and anxiety, which can negatively color the individual’s perception of his or her pain, as can anger. In fact, adults suffering from low back pain are four times more likely to experience serious psychological distress as people without low back pain.¹⁹ It makes sense. Most often, chronic pain forces the patient to make lifestyle adjustments that are undesirable: eliminating physically demanding leisure activities, for example; taking disability leave; or becoming unable to work altogether. These adjustments can precipitate grief, fear, sadness, and other feelings that could contribute to depression and anxiety.

The medical community now recognizes that pain increases when the patient experiences stress. In addition, substance abuse is common in a pain population that is being treated with narcotics. According to a recent government study, narcotic pain medications have surpassed marijuana as the most commonly abused drug.²⁰ Conversely, pain may have a psychosomatic or psychogenic component to its cause.²¹ Regardless of which came first, experience on the health-care side shows that mental health, mental illness, and substance abuse are clearly confounding factors that significantly affect

an individual's ability to manage pain. Pain also contributes to decreased physical activity, given the apprehension of exacerbating pain.²² Inactivity may actually make the individual more vulnerable to reinjury.

CHALLENGES TO SUCCESSFUL RESOLUTION

So how do we manage these chronic pain cases to successful resolution? Despite the growing knowledge about pain, the large number of outlying chronic pain cases reflects the continuing challenge at hand. There are many ways to treat chronic pain. Providers who treat pain include anesthesiologists, internists, orthopedists, neurologists, physiatrists, chiropractors, and psychologists. Each has a different perspective and a different approach, and not every approach is effective for every patient.

One in four chronic pain patients in a 1999 study made at least three changes in doctors, primarily because he or she still had pain after treatment.²³ Two-thirds of chronic pain sufferers surveyed for the 2003 Pain in America study could not perform routine tasks due to pain, despite their use of medications.²⁴ The problem is not necessarily that any given approach is better than another, or that a particular approach is wrong for a patient. The issue is the extreme complexity of the pain experience, which frequently calls for an approach to treatment that may integrate multiple medical specialties along with a behavioral health component.

Some pain management providers are beginning to offer a comprehensive approach that includes psychologists, nutritionists, and alternative medical practitioners, along with more traditional medical/surgical specialists. It would be desirable to identify the most effective of these comprehensive pain management providers and ensure that injured or ill employees have access to them in the network.

Sometimes the problem does lie with treatment. The underlying cause of the pain may have been overlooked or misdiagnosed. The patient may not respond to the first therapy — or the second or the third. Ibuprofen may be adequate for one individual's lower back pain but not provide any relief for another — even though both present with the same injury.

The patient, as the end consumer of these treatment and intervention services, plays a key role in the outcome that occurs. Some injuries require lifestyle adaptations that the patient may be unable or unwilling to adopt. Compliance may be an issue if the patient is concerned with the medication's side effects, which can range from ulcers to addiction. If the chronic pain patient fails to take responsibility for reversing the cycle of pain and disability, then this change cannot occur. In a very real sense, the best outcomes for cold chronic pain cases are those that are consumer-centric.

EMOTIONAL AND SOCIAL FACTORS

Until relatively recently, the roles of emotions and attitude in managing chronic pain have largely been ignored. Today, an overwhelming 84 percent of adults surveyed believe that a person's state of mind influences the experience of physical pain a great deal or a fair amount, suggesting that a person can control his or her pain.²⁵ Co-morbid depression, anxiety, and anger have an impact in the brain that can stand in the way of an improved outcome. As a result, a patient who believes that there is no hope for a successful treatment could be less likely than an optimistic individual to continue to seek a solution or to comply with a treatment regimen. An employee who harbors anger against the boss or the company that he or she holds responsible for a debilitating injury is also less likely to hold hope of a successful treatment. It doesn't matter whether the affective disorder existed prior to the precipitating injury or illness or whether it exists subsequent to the experience of chronic pain. Many believe that medical treatments will have limited success when the patient does not demonstrate a readiness to change.

Gain is another issue that may need to be addressed. A number of complex psychosocial factors that impede successful resolution may be at work. Depending on the structure of the workers compensation or disability claim, it may be financially attractive to remain out of work. As a result of his or her limitations, the patient may receive sympathy, care, and attention from family members. Addiction-prone personalities may not want to — or be able to — give up prescribed narcotic pain relievers. For individuals like these, the perceived benefits at some level outweigh the pain, and so they are not highly motivated to get better.

With all this in mind, it makes sense to integrate behavioral health concepts and resources into a solution designed to close cold chronic pain cases.

SOLUTION: A CONSUMER-CENTRIC APPROACH

Current perspectives on the nature of pain and chronic pain point to one conclusion: Each chronic pain case is representative of a unique individual with highly complex problems. Therefore, the approach that is most likely to achieve successful resolution is consumer-centric, personalized, and multidisciplinary. A specialized case management program designed for chronic pain could incorporate a wide range of resources and techniques, including cognitive-focused interventions and coaching programs; physician advisors, including behavioral health specialists; pharmacy and narcotics management programs; coordination with other disease management and

health advocacy programs; and more.

A specialized chronic pain program utilizing a new case management model to determine the genesis of the pain and coordinate an individualized treatment plan in a multidisciplinary program can work. Nurses and counselors who conduct a case-by-case, root-cause analysis can identify key issues and determine who can actually benefit from such an intervention when all prior attempts have failed. In all instances of long-term unresolved chronic pain, the first forensic test is to evaluate the individual's ability and interest in changing his or her life circumstances. For cases selected for management, a comprehensive evaluation to identify a history of the pain and of the medical management is required, as well as an analysis of the claimant's desire to return to productivity at home and at work.

Not every cold case can or will be solved. It is critical to be able to quickly identify those individuals who can reverse the cycle if given the right support.

ADDRESSING PSYCHOSOCIAL ISSUES

Traditionally, it has not been desirable, or even acceptable, to acknowledge or address the behavioral aspects of chronic pain for workers compensation claims. Employers and insurers, fearing that they would assume the burden of a broad psychological disability, have focused interventions on the medical care for the initial work-related injury. However, as this population of claims continues to grow in numbers and expense, a new view is emerging that recognizes the impact of pain on the individual and his or her emotional well-being. It is becoming clear that the case manager must also look at psychosocial factors that can affect the treatment outcome. These factors might include an ingrained expectation of failure, financial fears, fears of losing one's disability income, or even lack of available child care. A number of simple, short, standard, validated screening tools for depression and substance abuse could be adapted for use in this population to identify co-morbid chronic pain and mental health issues that are in the way of resolving the cycle of chronic pain.

Case managers and other clinicians can more effectively engage consumers by coaching them on how to manage their pain so they can function better and motivating them to comply with the treatment plan. Case managers working with patients who have been disabled by injury can leverage the cognitive behavioral coaching model that has been demonstrated to be successful in disease management programs for irritable bowel syndrome, temporomandibular joint disorders, migraine, fibromyalgia, and similar conditions that involve chronic pain.

Some employee benefits providers have programs in place that invite individuals to participate based on diagnosis or high utilization, with both telephonic and printed communications being used for outreach. These types of programs, which usually last 10 to 12 weeks, provide patients with management skills through individual and group sessions facilitated by a trained wellness coach. They also utilize telephonic outreach and a workbook to prompt discussions of triggers, stress management, and lifestyle modification. In some cases, these types of programs have shown that when a more intensive behavioral intervention is applied, individuals tend to take better care of themselves in general, and medical utilization decreases.

The key to this approach in chronic pain management for workers compensation cases is using case managers who understand chronic pain and have a strong background in psychosocial issues. They must be able to identify what motivates the patient. For each individual, the motivators are likely to be different, and it is important to bear in mind that returning to work may not be a key motivator. However, as the individual starts to feel better, he or she may be more inclined to comply with the treatment program, which may support better long-term outcomes. Ultimately, the individual may want to return to work.

A chronic pain program must also address issues related to substance abuse. Opioids are commonly prescribed for pain, and their use can create problems for some individuals. With this in mind, it makes sense to incorporate a focused narcotics therapy management approach into the overall case management program. In an integrated program, drug utilization review reveals patterns of opioid use and inappropriate prescription patterns. In turn, problematic patterns are brought to the attention of the treating physician by the case manager or a peer physician along with recommendations for a behavioral health evaluation and referral to a detoxification and rehabilitation program.

SUCCESSFULLY RESOLVING THE COLD CASE

In September 1999, Tom, a 22-year-old construction worker, injured his lower back at work.²⁶ Tom was diagnosed with a herniated lumbar disc that prohibited him from returning to work. The condition worsened with time, and in June 2002, doctors performed a lumbar laminectomy and disc excision. He remained out of work and his back pain continued. Two years later, in June 2004, he had bilateral foraminotomies and L5-S1 fusion. Neither surgery improved his condition. Tom's physicians diagnosed him with failed back syndrome with chronic pain. He started taking numerous

pain medications, was then diagnosed with depression, and became severely deconditioned after losing a significant amount of weight. Believing he was disabled for life, Tom retained an attorney who began arguing for a permanent total classification.

In January 2006, over five years after the initial injury, Tom's case was referred to a nurse case manager. The case manager met with Tom and his doctors and also sought the advice of a vocational case manager on the case. Tom expressed both a desire to have a better life as well as a sense of failure with all he'd tried to do through medical interventions. Through the help of his doctors and nurse case manager, Tom was weaned off all narcotics and entered an extensive work hardening program. Upon completion of the program, he was granted a return-to-work release in a medium-to-heavy capacity. Tom successfully returned to work in July 2006, seven months after entering into a multidisciplinary case management program.

In just seven months, Tom's life was turned around. At 27 years old, he thought he could never work again, but with the right mix of case management, vocational training, drug rehabilitation, and work hardening, he was able to change his life for the better. Additionally, the success of this case saved the insurer over \$18,000 on an annual basis and upwards of \$200,000 in reserves. This positive outcome was the result of the combined impact of Tom's readiness to change and an effective plan of care.

In April 2006, another injured worker, Mark, who had also undergone two failed back surgeries and had not worked in five years, was referred for case management intervention. At the time, Mark was seeing a pain management specialist and abusing numerous narcotic medications. During the initial assessment, Mark voiced his desire to enter a detox program. He also admitted to being severely depressed and suicidal. He and his wife had lost their home and their car. They were currently living in a motel, and he had no means to get to a rehabilitation center. He admitted to taking an entire 14-day supply of narcotics in one day in an attempt to ease his pain.

After communicating her concerns to the adjuster on the case and getting agreement that both behavioral and rehabilitative care was needed, the case manager arranged for Mark to have immediate admission to a prevention and recovery center and assisted with transport to the facility. Mark was admitted less than 24 hours later. He spent two weeks in the rehab facility, first in detox and then in the residential unit where he participated in routine group and individual counseling. Although Mark continued to complain of some cervical pain, it was much less

severe than before and he expressed great emotion and gratitude about being able to participate in the rehab. Mark told his case manager that it was the first time in five years that he was actually able to think clearly. Following his discharge from the program, the case manager arranged for Mark to enter a chronic pain management program in June 2006. The case manager met with Mark on a weekly basis to evaluate his progress and encourage his continued compliance. Mark soon found that once weaned off all medications, he had minimal to no pain. He started attending Alcoholics Anonymous meetings and was discharged from the pain management program in 20 days.

Soon after returning home, Mark was offered a job by an old co-worker. He discussed the opportunity, which did not require heavy lifting, with his case manager and physician. His physician agreed to an early discharge, and Mark was granted a full-duty release to return to work in July 2006. The case was closed after being open for less than four months. The insurer estimates a conservative net saving of over \$20,000 on the claim.

To manage this cold case successfully, the injured worker, case manager, adjuster, and the treatment facilities all worked together to provide the proper treatment plan for success. Mark commented that the case management experience completely changed his life. After working with his case manager, he pledged never to take narcotic medications again and said he looked forward to living a happy, normal life.

WHAT DEFINES A PAIN MANAGEMENT SPECIALIST?

There are many chronic pain programs and specialists practicing today. Both Tom and Mark were treated by pain management specialists, and neither of their physicians either recognized or reacted to their addictions. Currently, there are no nationally recognized pain management specialty provider networks. So how do we locate and recognize qualified, credentialed pain management specialists to deliver the best possible care?

The National Committee for Quality Assurance (NCQA) is a private, not-for-profit organization that is starting to address the issue of recognizing best-in-class pain management providers. NCQA's Healthcare Effectiveness Data and Information Set (HEDIS) is currently the most widely used performance measurement tool in the health-care industry. Their new Back Pain Recognition Program (BPRP), launched in April 2007, seeks to recognize physicians and chiropractors who deliver superior care to millions of Americans who suffer from low back pain. The BPRP program consists of 13 clinical measures and 3 structural standards, such as the elements of the physical exam and advice for

the return to normal activities. These requirements address the broad spectrum of low back pain and focus on underuse, misuse, and overuse of treatment modalities.

NCQA developed BPRP requirements from widely accepted medical evidence, with significant input from physician specialists and health plan and employer representatives. Eligible physicians will abstract data from the charts of 35 low back pain patients and submit this information to NCQA for review along with documentation of patient education and evaluation of patient experience.

This is the first attempt of its kind to deal with setting national standards for evaluating clinicians on their best practices and outcomes in treating chronic pain for the low back. Until now, the practice of pain management has been variable in approach and impact to patients.

MEASURING SUCCESS

The multifaceted and subjective nature of chronic pain disorder makes measuring the impact of a management program a challenge. What works very well for one person may not work for someone else with the same pain profile. There are several variables that could make that difference — attitude, education, expectations, genetics, support network, faith, and life and work circumstances. Still, a number of validated tools exist that can provide objective scoring of pain. For example, the Semmes-Weinstein evaluation measures sensitivity of nerve endings. Progress can also be measured by changes in the patient-reported McGill Pain Rating Index. Tools such as the Waddell Non-Organic Findings test can be used to help identify psychosocial issues involved in low back pain, and many other psychometric tests can be adapted to measure changes in the patient's perception of pain. Tracking long-term outcomes will require collaboration with employers and insurers in order to review pre- and post-program claim data and trends.

The impact of an aggressive, integrated chronic pain program that is consumer-centric is likely to be clear as patients who have suffered for months or years experience improvement and require less medical treatment. Depending on the actual severity of the injury, some long-standing cases may reach resolution. While early intervention and identification of those at risk for persistent chronic pain is a key management strategy, there remain thousands of individuals like Tom and Mark who have missed that window but who can still regain the quality of life they desire. In our work to encourage prevention of chronic pain as a best practice, we should not overlook those who can still be served.

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