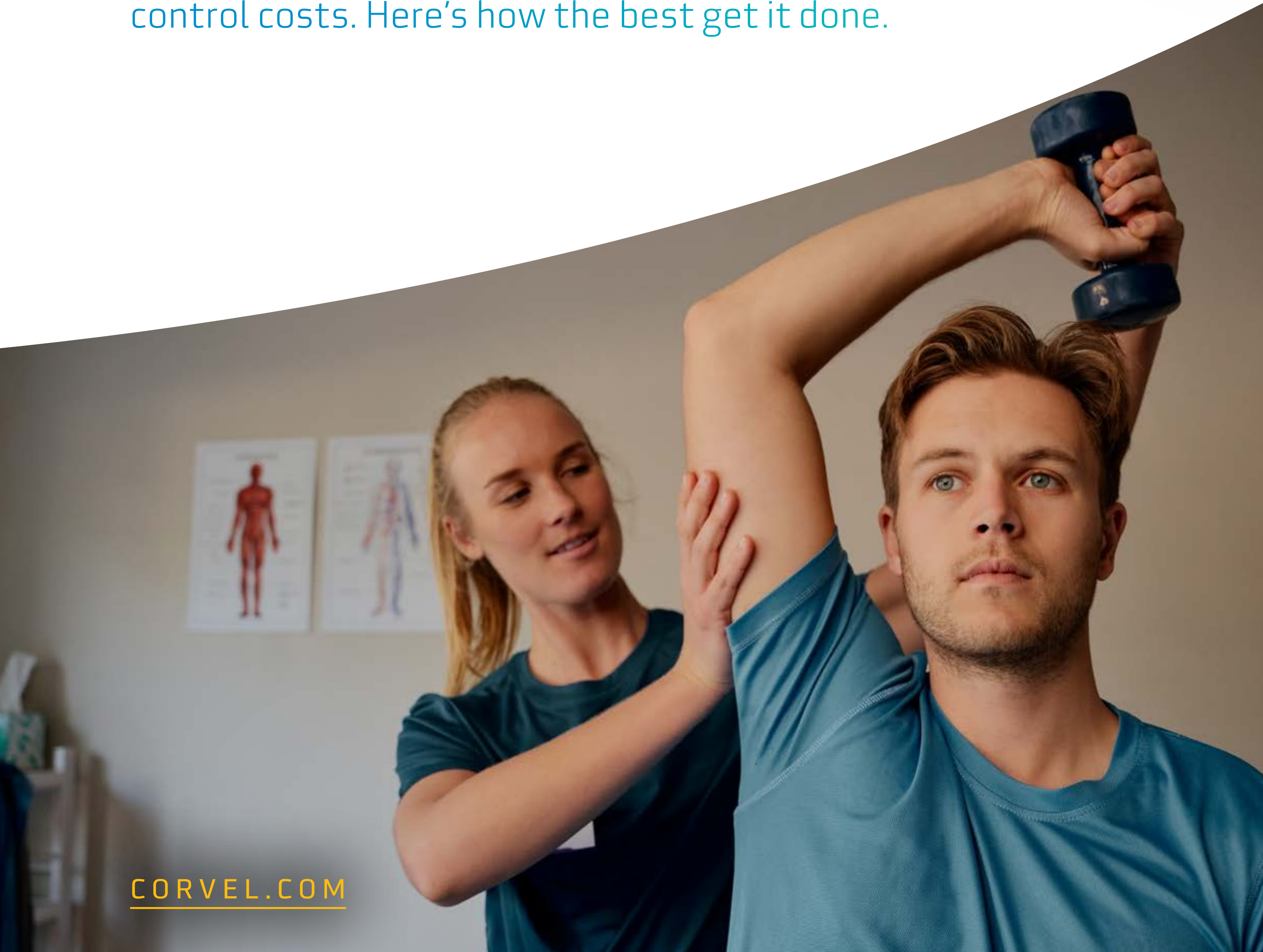
CORVEL

WHITE PAPER

3 Traits of a Best-in-Class Ancillary Benefit Manager

Efficient coordination of ancillary services is critical to promote a speedy recovery for injured workers and control costs. Here's how the best get it done.



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Workers' compensation professionals recognize that timely delivery of care demands a higher level of coordination and organization. Between the injured worker, employer, carrier, case manager and provider, there are multiple stakeholders involved in even the simplest of claims.

In many cases, treatment will also demand ancillary services such as diagnostic imaging, home health care, durable medical equipment, physical therapy, transportation and translation assistance.

"It's what happens outside the primary physician's office that really determines how quickly the injured worker will recover," said Brian Nichols, Vice President of Network Services, CorVel. That's also reflected in claim costs. Together, ancillary services make up an average of 48% of the medical spend.

Efficient coordination of these services is critical to reduce delays and streamline treatment, which helps to both control costs and get injured workers back on the job faster. Ancillary benefit managers (ABMs) sit at the center of this web of providers and stakeholders, and therefore play a crucial role in keeping claims on track.

The best ABMs do more than just make appointments based on doctors' orders. They are actively involved in the quality evaluation and contracting of the services provided, ensuring access to care and clinical decision-making is timely, while serving as a compassionate voice and advocate for injured workers.

HERE ARE JUST THREE TRAITS THAT IDENTIFY ABMS WHO GO ABOVE AND BEYOND.

1.) CONCIERGE-STYLE SERVICE

One of the biggest obstacles in an injured worker's recovery is fear. The stress of an injury is often compounded by feelings of uncertainty and lack of control when facing a complex workers' comp process.

A recommendation for physical therapy, for example, may seem straightforward to a primary care physician, but the injured worker may find navigating the complex waters of healthcare overwhelming, and they may feel unsure about the selection of their therapist or how to make an appointment. So, they put it out of their minds for a few days before moving forward.

"It may only be a three- to five-day delay, but at every milestone of ancillary services, three to five days can equal almost a month of indemnity payment or month of salary while they're out of work," Nichols said. "Lack of trust prevents patients from actively engaging in their care, and that can be very detrimental to the outcome of the claim."

A concierge-style approach to ancillary benefit management helps to dispel that fear, build trust and keep recovery moving in the right direction. The hallmark of this approach is proactive and streamlined communication.

"We actively engage the injured worker as soon as we become involved in their care, and from that point on we are their central point of contact, connecting them with providers and claims professionals. If they have any questions or need help setting up appointments, arranging for home health or even getting a ride to an appointment, we handle it," said Brian Nichols, Vice President, Network Solutions, CorVel.

"They don't have to make five phone calls to figure it out. That's huge from a stress reduction standpoint, and it helps to expedite care in a cost-effective and quality manner."

2.) COST CONTAINMENT THROUGH CLINICAL OVERSIGHT

Quality ancillary benefit management should be about more than just connecting patients to services ordered by the primary care provider. A high-quality ABM will be an integral stakeholder in the patient's care, actively working with providers to establish treatment goals and an evidence-based care plan.

"We have our own clinical staff that review all physician orders to ensure they make sense for the diagnosis, and if not, we pick up the phone and reach out to make certain that the orders are clear and appropriate for the care that needs to be delivered to move the case forward," Nichols said.

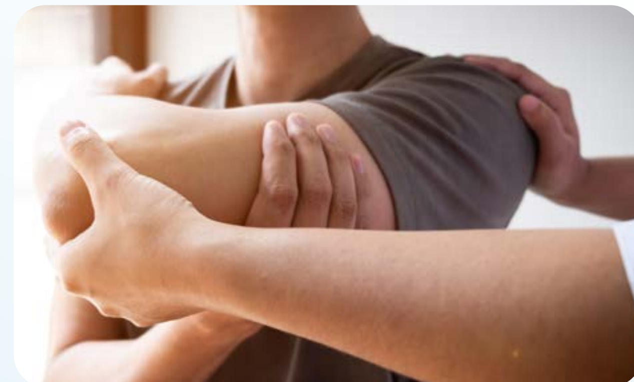
Determining the suitability of care starts with evidence-based guidelines like ODG and is supplemented by the judgement of in-house staff of clinical experts who know when deviations are necessary and how to execute them.

"Not every patient's situation will benefit from strict adherence to guidelines. We consider individual factors like age, comorbidities and psychosocial factors. We start with guidelines and adjust based on those factors to create targeted, individualized plans of care," Nichols said.

That level of clinical expertise also assists the claim team, alleviating the need for further intervention on their part. Claims professionals are kept informed and can feel confident in the clinical care decisions being made.

Active engagement on the care plan also reduces expenses that arise from inappropriate care or over-utilization.

"If, for example, the doctor prescribes 12 physical therapy appointments, but the worker meets his functional goals after eight, there's no need to complete the remaining four. It's about being diligent about tracking outcomes, checking in with patient and providers, and continually reassessing the plan," Nichols said.



3.) A COLLABORATIVE PROVIDER NETWORK

An ancillary benefit manager is only as good as the providers in their network.

Achieving optimal clinical and cost outcomes requires partners who not only demonstrate dedication to quality care but are also willing to work as part of a team. When providers, payers, claims professionals and injured workers are on the same page, care becomes more synergistic and streamlined, helping to eliminate costly back-and-forth.

"We create a collaborative environment with the claimant, the provider and the claim staff. One way we do that is by establishing work-related functional goals at the beginning of the process and ensuring that those goals are communicated from the rendering provider to the claimant, the claims handler and referring physician so that every stakeholder has buy-in to the outcome of the treatment," Nichols said.

Ensuring that network providers stay on track toward these goals is key. Responsible ABMs are attuned to the level of communication coming from their providers and intervene if it is insufficient.

"Usually, we check in with at least one provider involved in a patient's care a couple of times per week. If we're not hearing from the providers when we need them, we know that that's not a provider that we want in our network," Nichols said. "We'll do a remediation first, but if the pattern continues, we will end the partnership."

Emphasis on quality should also be maintained as the network scales. Part of delivering quality care involves having providers geographically accessible to patients. Maintaining national coverage with local focus calls for an extensive network and continual investments.

"Thanks to the longstanding relationships we have with providers, we're able to quickly build our network according to the customer's needs — but the driver is always to ensure the patient receives quality treatment that is also timely and convenient," Nichols said.

OUTCOMES ACHIEVED THROUGH TOP NOTCH ANCILLARY BENEFIT MANAGEMENT

Ancillary benefit management that is service-oriented and clinically focused produces measurable improvements in claim outcomes.

"Over the last five years, for example, WCRI reported steadily increasing physical therapy utilization, year over year. Over those same five years, CorVel has achieved consecutive decreases in utilization using our CareIQ management model," Nichols said.

CareIQ has also delivered results exceeding the industry standard through its transportation services. In this case, success is measured as the percentage of trips that resulted in getting the patient to their appointment on time without rescheduling.

"Generally, the industry average is somewhere between 99.3 and 99.6%. Our national average is at 99.7%," Nichols said. "That 0.1% may not seem like a great deal to many; however, when it's your claim, and this is the appointment to establish maximum medical improvement, a missed ride becomes the obstacle preventing claim closure. Especially during the pandemic when appointment times are more limited, you could be stuck waiting several months to reschedule. That 0.1% can translate to a big difference in overall claim cost."

One factor that sets CorVel's ABM services apart — and enables them to quarterback treatment plans executed by multiple providers — is its access to complete medical records. Because CorVel is a managed care organization complete with a national PPO, IME, PBM and bill review capabilities, its ABM arm has full transparency into a patient's medical history and provider notes. With that, in-house physical therapists, physicians and pharmacists can make more informed decisions around the need for and efficacy of prescribed treatment.

"THE INTEGRATION OF OUR PROGRAM MAKES US UNIQUE AND ALLOWS US TO FOCUS ON WHAT REALLY MATTERS – DRIVING BETTER OUTCOMES FOR THE INJURED WORKER"

TO LEARN MORE ABOUT CORVEL'S ABM SERVICES, VISIT:

https://www.corvel.com/services/workers-compensation/network-solutions/provider-networks