



Australian Government

Comcare

Body Stressing Injuries

KEY MESSAGES FOR CASE MANAGERS

Background

'Body stressing' injuries include a range of soft tissue injuries sustained through activities such as manual handling or repetitive movement. These injuries are significant drivers of workers' compensation premiums for Australian and ACT Government premium paying agencies. For these agencies for 2004-05, claims for body stressing injuries accounted for 40.7 percent of all workers' compensation claims and 45 percent of the total cost of such claims.

Over recent years, there has been a trend for employees injured at work to stay off work for longer periods. In many cases the time off work for a work related body stressing injury is extending beyond the expected recovery period of 6 to 12 weeks, including in cases where the initial injury was apparently minor.

Comcare engaged SANO Consulting (SANO) to undertake a review of a sample of body stressing workers' compensation claims for Australian and ACT Government employees. The research included a review of jurisdictional claims data, analysis of existing claims management systems and processes in Comcare and agencies, meetings with key Comcare stakeholders, and structured telephone interviews with claimants, agency case managers and Approved Rehabilitation Providers.

Delays in providing rehabilitation/return to work assistance

To achieve early recovery and return to work (RTW), effective management of an injured employee by their employer needs to commence as soon as practicable after the injury occurs, and preferably before any claim for compensation is made. Against this background, SANO assessed:

- the elapsed time between key intervention points – those being points in the timeline from date of injury through to the employee returning to work;
- the activities of key stakeholders at these key points – key stakeholders such as the employer, Comcare, rehabilitation providers and treatment providers;
- the interactions between the key stakeholders; and
- risk factors for extended claims duration – that is factors that increase the risk of an injury becoming chronic.

With appropriate rehabilitation/return to work and treatment, the recovery times for body stressing injuries, including relatively severe soft tissue injuries, should be no more than 12 weeks (or 84 days), and in many cases no more than 6 weeks (or 42 days). Despite this, the research found that the average time taken from the date of injury to the date of first rehabilitation intervention for these injuries was 87 days for Australian Government agencies and 73 days for ACT Government agencies for 2004-2005. For the cohort of claims in the SANO sample, it was 74 days. This means that, in most cases, assistance was not provided until after the normal recovery period for the injury. It also means that by the time assistance was provided, it was often no longer appropriate. This is because different forms of treatment and assistance are needed once a body stressing injury progresses beyond 12 weeks of incapacity and becomes a 'chronic' injury.

SANO's research identified the need to improve employers' culture and systems for reporting injuries so that injured employees can be provided with assistance at an earlier stage. This requires employers to develop clear policies or guidelines for early intervention and to allocate resources to enable early rehabilitation assistance. If intervention is made contingent upon the employee submitting a claim, or a claim being accepted by Comcare, then opportunities for recovery will be missed and the risk of extended incapacity will be increased, leading to increased workers' compensation claims.

Delays in lodging workers' compensation claims

The SANO research found considerable delays between the date of the initial injury and the date of lodgement of a claim with the employer – across the claims sample this delay averaged 38 days. In some cases, this delay was because employees did not lodge a claim until it became apparent that their injuries were going to involve time off work, or extended periods of treatment or rehabilitation. In other cases, it was due to the stigma that injured employees felt was attached to lodging a claim, or to the employee's belief that they could manage their injury.

These delays were more prevalent for injuries that were characterised by slow onset. These injuries had an average time to lodgement with the employer of 64 days, compared to an average of 35 days for injuries that were sustained suddenly. This highlights the need to provide employees with information about reporting, contact procedures and the assistance that is available if symptoms develop over a period of time.

Delays were also found to occur following the receipt of the claim by the employer. For the body stressing sample, the average time taken from receipt of the claim by the employer to lodgement with Comcare was 12 days. However, in the more complex cases, the research found that it was taking employers longer to lodge a claim with Comcare. Cases that were not back at work by 12 weeks had the longest average time from receipt of the claim by the agency to its lodgement with Comcare of 17 days.

Delay in lodging a claim should not delay provision to the injured employee of appropriate treatment. Such a delay can signal to an employee that the agency does not support their claim and thereby increase the risk of higher rates of ill-health and time off work, and present an obstacle to early recovery.

SANO's research identified the need for employers to review their arrangements for lodgement with Comcare of workers' compensation claims. It also recommended that agencies benchmark their performance in terms of time between date of injury and date of lodgement of a claim by the employee, and date of lodgement of a claim by an employee and date of submission of that claim to Comcare by the employer.

Identifying and managing risk factors

International research has shown that psychosocial and other risk factors are far more important in predicting which injured employee will fail to recover or return to work following a workplace injury, than are physical factors such as the nature of the injury^{1,2}. These risk factors (sometimes called 'flags') include an individual's beliefs and perceptions (for example about pain and injury), and perceived features of the work or the social environment (such as unsupportive management, perceived time pressure or low job control). These risk factors, together with practices in medicine, employment and compensation systems, can lead injured employees to experience periods of incapacity that can be quite disproportionate to the nature of their injury.

SANO's research confirmed these findings. Claims in the sample that had experienced more than 12 weeks of incapacity were found to have on average 5.8 identified risk factors – compared with 2.9 risk factors for claims of 4 to 12 weeks of incapacity, and 2.0 risk factors for claims of 1 to 4 weeks of incapacity. The most prevalent risk factors were found to be non-evidence based medical treatments, delayed rehabilitation efforts and unsupportive line management.

Cases at risk of poor return to work outcomes can be identified early on using the 'flags model' (Table 1). Identification and management of psychosocial risks (yellow flags) and other risks related to perceived or actual features of the workplace (blue and black flags) needs to become a priority. It is important that a sense of urgency is applied to the management of these factors within the first 12 weeks – preferably, return to work planning should address these factors by the 6 to 8 week mark.

Approved Rehabilitation Provider management

Approved Rehabilitation Providers (ARP) have a key role in assisting employers to address the risks of poor rehabilitation. However, the SANO research found that ARP assessments and rehabilitation planning showed little evidence of moving beyond a narrow biomedical model of injury management to consider non-medical factors. The research found only one documented example of an ARP using a validated tool for the assessment of risk factors.

Service agreements/contracts with ARP's should make it clear that assessments and rehabilitation planning should address all relevant risks. Such arrangements should require providers to complete documentation that summarises identified key barriers to recovery and strategies to address such barriers for discussion with other key stakeholders.

Proactive injury management and coordination

Proactive management of injured employees and effective communication and coordination between line managers, case managers, claims managers, doctors, rehabilitation providers and claimants is essential to achieve effective and safe return to work.

SANO's research found many instances where large numbers of stakeholders were involved in claims management, case management, rehabilitation and treatment with inadequate information sharing and coordination of interventions.

Structured case conferencing of high risk cases is needed to promote collaborative problem solving related to identified issues. These conferences should include the case manager, claims manager, and the ARP, and may also involve the treatment provider, line manager and injured employee as appropriate.

Case managers need to be proactive in escalating issues to more senior management when local workplace factors constitute a barrier to RTW (for example, where relationships have broken down and the case manager is unable to facilitate return to work through the employee's direct line manager).

Comcare will be working actively to help coordinate claims and case management to address risk factors and to facilitate early and safe return to work.

1 Psychology, Personal Injury and Rehabilitation, A Report of a Working Party of the International Underwriting Association of London and the Association of British Insurers, 2004.

2 Guide to Assessing Psychosocial Yellow Flags in Acute Low Back Pain; Risk Factors for Long-Term Disability and Work Loss, Accident Compensation Commission, New Zealand, January 1997.

Table 1

Indicators of poor outcomes or delayed recovery – the flags model

Red flags: Medical	Serious pathology/diagnosis
	Co-morbidity (i.e. co-existence of other diseases)
	Failure of treatment
Yellow flags: Psychosocial	Beliefs about pain & injury (e.g. that there is a major underlying illness/disease, that avoidance of activity will help recovery, that there is a need for passive physical treatments rather than active self-management)
	Psychological diseases (e.g. depression, anger, bereavement, frustration)
	Unhelpful coping strategies (e.g. fear of pain and aggravation, catastrophising, illness behaviour, overreaction to medical problems)
	Perceived inconsistencies and ambiguities in information about the injury and its implications
	Failure to answer patients' and families' worries about the nature of the injury and its implications
Blue flags: Perceived features of work or the social environment	High demand/low control
	Unsupportive management style
	Poor social support from colleagues
	Perceived time pressure
	Lack of job satisfaction
	Work is physically uncomfortable
Black flags: Not matters of perception, affect all workers equally	Employer's rehabilitation policy deters gradual reintegration or mobility
	Threats to financial security
	Litigation/disputation over liability or contribution
	Qualification criteria for compensation (e.g. where inactivity is a qualification criterion)
	Financial incentives
	Lack of contact with the workplace
	Duration of sickness absence
	Poor co-ordination between employers and those responsible for medical care



For further information contact

Comcare
GPO Box 9905
Canberra ACT 2601

Telephone - 1300 366 979

Internet – www.comcare.gov.au

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