

How?

How to Select an Occupational Health Provider

Clinic Visit

- Accessibility/Parking
- Cleanliness
- Staff Appearances
- Waiting Room

Interview

- Physician
 - Lead Nurse
 - Front Office Personnel
- Not Just the Clinic's Sales and Marketing Staff

Interview Content

- Credentials
- Experience
- Accessibility
- Practice Philosophies
- Approach to Specific Situations/Problems

How Much?

- Frank Discussion of Fees

Check References

- Clinic's Clients
- W/C Insurance Carrier / TPA

THE TRUST FACTOR

“You're Only as Good as Your Last Case.”



**THE TEN COMMANDMENTS
OF
MANAGING OCCUPATIONAL ILLNESS & INJURY CASES**

In addition to the usual requisites of high quality medical care – i.e., care that is competent, compassionate, and cost-effective – there are several aspects of caring for occupationally-induced injuries and illnesses which are somewhat unique to workers that are essential to the success of our Occupational Health Program. Some of the most important of these concepts are addressed in “The Ten Commandments” delineated hereunder, which must be adhered to by all physicians/practitioners in the Community Hospitals Indianapolis Network Occupational Health Program – including all Occupational Health Centers and MedChecks. These “Commandments” are obligatory, not optional – i.e. these are indeed commandments not mere guidelines. Failure to comply with these is unacceptable absent there being a well-documented, clear-cut, and unambiguous medical contraindication to adherence with these precepts.

1. No triage directly to E.D. All Occupational Health patients are to be seen and adequately evaluated in the OHC or MedCheck prior to any referrals.
2. Occupational Health patients are not to be placed off work (unless there is well-documented evidence that the patient is indeed totally disabled). Work restrictions should be placed only when medically necessary and then these should be as minimally limiting as is necessary in order to ensure that the worker-patient’s recovery is as prompt and complete as possible.
3. The question of work-relatedness should always be addressed thoughtfully by the treating physician and should be predicated upon “reasonable medical probability” – i.e. “is the condition more likely than not to be work-caused or substantially work-aggravated?”
4. Non-occupational medical conditions are not to be treated on an occupational health record or under a worker’s compensation claim. Occupational Health patients with non-occupational conditions should be referred to their personal physician, hospital

emergency department, or MedCheck (on an Immediate Care record), absent there being a bona fide need for emergency medical care.

5. A conservative approach to the use of medications in Occupational Health patients should be followed. For most occupational injuries and illnesses, non-prescription, over-the-counter medications (e.g. acetaminophen, Non-Rx ibuprofen, Non-Rx-naproxen, etc.) will suffice. Narcotics, sedating, and central nervous system affecting agents should be avoided whenever possible, and should only be used when there is a definite serious condition and the benefits of using these agents outweigh the risks. Following these approaches to the prescription of medications to injured or ill workers will enhance worker/patient safety, minimize adverse effects from pharmaceutical's, promote cost-effective medication utilization, and allow for optimal compliance with OSHA recordkeeping regulations.
6. Similarly, a conservative approach to the utilization of diagnostic testing (including imaging, laboratory, and EMG/NVC studies) is to be employed. Premature and/or extensive diagnostic testing is to be avoided, as most occupational injuries do not require the utilization of these resources and recovery is typically prompt and complete without these procedures. Also, although rehabilitation services (physical therapy and occupational therapy) are often efficacious in the management of work-related injuries, and should be employed whenever these are likely to optimize or expedite an injured worker's clinical recovery and functional restoration, these services should always be utilized in a judicious and cost-effective manner, with adherence to definite time-specific treatment parameters and goals. Inordinately frequent PT/OT referrals and/or excessively long durations of PT/OT services, in a fashion that is not likely to be cost-effective, are to be assiduously avoided.
7. All Occupational Health patients should be seen for appropriate follow-up in a Network OHC (or MedCheck in some circumstances). Occupational Health patients are not to be referred to their personal physician for the treatment of occupational illness or injury.
8. The assessment and treatment of all Occupational Health patients must be thoroughly documented in the medical record, not only to ensure proper medical care, but also to provide adequate documentation for worker's compensation claim handling and reimbursement purposes.
9. The "Physician's Report of Treatment of Occupational Illness/Injury" form must be completed in its entirety with explicit documentation of the diagnosis, work-relatedness, work capacity status, medical recommendations, and specific arrangements for follow-up delineated on the "Physicians Report".
10. Physicians treating Occupational Health patients in Network facilities must communicate freely and cooperate fully with Occupational Health client employers and workers' compensation insurance carriers, realizing that when a worker patient

seeks medical care under a worker's compensation claim, that the worker's employer and the worker's compensation insurance carrier are legally entitled to all medical information relevant to the condition and the worker's compensation claim.

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