

DURATION DISABILITY GUIDELINES: Tools for Disability Management

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Introduction:

Disability duration guidelines are used internationally by many types of disability payer systems including workers' compensation, Social Security disability, third party liability, and private disability insurers. These guidelines provide tools for establishing "benchmarks" for the management of appropriate disability duration. In Workers' Compensation, disability duration guidelines (or return-to-work (RTW) guidelines as they are also commonly called) utilize actual reported data, to reflect the most current science. Updates to the data are crucial. Logically, as less invasive or non-operative treatments are developed, tested and determined to be as effective as other invasive treatment modalities, disability durations will decrease. Thus, duration guidelines are not self-defined but rather are a by-product of the type of treatment performed.

Disability duration guidelines are a resource for the employer, insurer, physician, case manager and the injured worker. Each plays an important role in the return-to-work process and should be aware of what has been and is achievable, based on the type of injury or illness involved, the treatment administered and the type of job the individual is expected to return to. If comprehensive and effectively presented, duration guidelines establish parameters for expected time away from work that assist employers in reassigning job responsibilities or arranging for temporary or overtime help to insure "business as usual" while an injured worker is out; assist a physician in writing a return-to-work order outlining what capability or activity restrictions are necessary until the patient is ready to resume full duty; identify what job modifications need to be made by the employer to accommodate early return-to-work opportunities without risking relapse or re-injury to his employee; provide case managers reported expectations for return to work by diagnosis as a goal to realistically achieve in managing an injured workers' return to functionality; and outline at-risk summary durations to be used by insurers to conservatively reserve a claim. In addition, duration guidelines can assist companies internally. Comparing duration data by location or department within an organization can red-flag areas that need attention. For example, if one plant has far more absences or on-the-job accidents than another plant within the same organization, a question is raised: "Why?" Perhaps there is a problem with management or a need for better or increased safety, prevention or education measures.

There are two major companies that have developed, and provide access to disability duration guidelines: The Reed Group www.reedgroup.com, and the Work Loss Data Institute www.worklossdata.com. Both companies provide their products to a wide range of clients both in the United States and internationally. Each company uses different approaches in development of the guidelines including different data sources, different analytical processes and unique architecture for presenting the information. As a result of these differences, in some instances they have different recommendations for disability duration.

This paper provides a comprehensive overview of the MDGuidelines developed by the Reed Group and the Official Disability Guidelines (ODG) developed by the Work Loss Data Institute for anyone involved in disability management to better understand what each guideline product represents. Each guideline product is profiled in terms of the data sources used in developing the guidelines, what the data

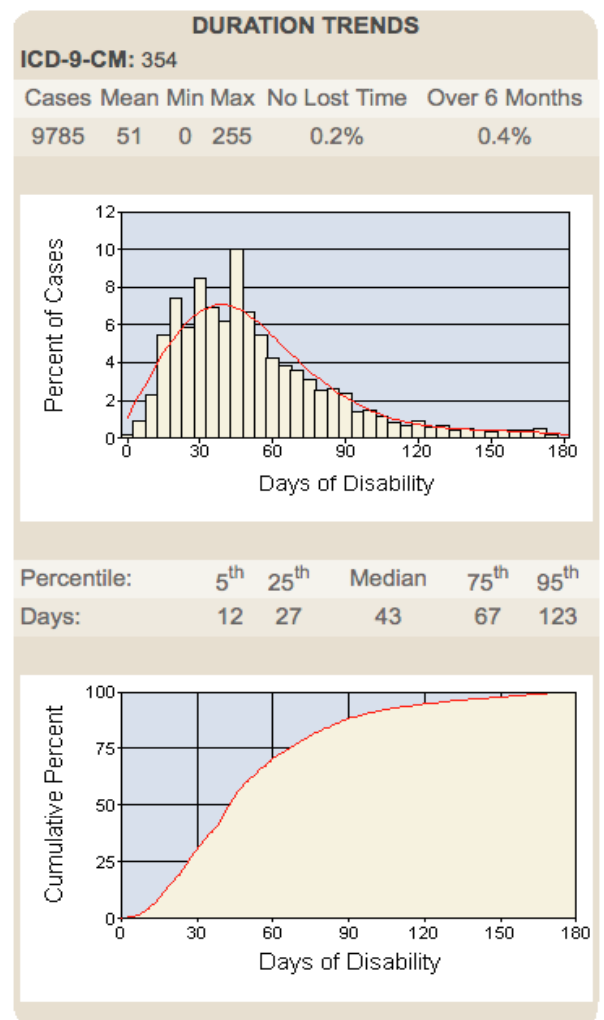
represents, how the data is collected and processed, the updating process, and the structure of the guidelines. It also includes an example of the disability duration guidelines presented by each company for two specific diagnoses ICD9 354.0 Carpal Tunnel Syndrome and ICD9 847.2 Lumbar Sprains and Strains, to understand the differences in their recommendations of disability duration for specific types of injuries or illnesses. Although there have been relatively few published studies on the impact of the use of the guidelines the evidence and information that is available, including user documented results, can be reviewed on the web site of the two companies.

The Reed Group MDGuidelines:

MDGuidelines was conceived by Presley Reed, MD, a psychiatrist who had developed an expertise in disability issues after consulting with employers over several years. Dr Reed is widely considered to be the inventor of disability duration guidelines; the first edition of his book, *The Medical Disability Advisor*, was published in 1991, and the “durations” have been in continuous production for over 20 years.

Although supporting text describing return-to-work strategies, starting with a fundamental understanding of each medical condition from an occupational health standpoint, has always been a part of the guidelines, Dr Reed realized that the “evidence” in disability is the duration itself, defined as the actual time from the onset of the employee’s injury or illness to his return to the same type of job. In collecting a database of case outcomes as the foundation for a larger body of work, Dr Reed established a publishing paradigm that is as current today as it was in the early 1990s—that decisions can and should be driven by the data.

Reed Group both provides disability management services for large employers and also establishes data integration partnerships with companies and governments around the world. Using these two sources of direct case evidence, it has compiled a proprietary data set of over 5 million records spanning every medical condition known to cause absence from work, whether resulting in “occupational” (workers’ compensation) or “non-occupational” (short-term and long-term disability) benefits. The cases have all been coded, and the durations reported, by professionals in case management and/or clinical medicine. About 2.5 million of the cases are considered current enough to be included in today’s publication, although the older data does have value in determining long-term trends. After thorough processing for the removal of outliers and other statistical anomalies, the data is presented in graphs under the heading “Duration Trends” and is commonly referred to as real-world or “normative” data. All of the data is indexed and cross-referenced by diagnostic and procedural medical codes (ICD-9, ICD-10, and CPT).



The normative data is continuously updated as new cases become available, and, concurrently, summarized and sent for review and consensus to members of the MDGuidelines Medical Advisory Board for translation into another, complementary set of durations. This second set of durations, for which Reed Group is probably best known, is published as “Duration in Days” tables, containing “physiological recovery times”. The challenge presented to the Medical Advisory Board is to parse out the “psychosocial” or non-medical part of the return-to-work process from the truly medical or physiological in order to provide an idealized healing period for the illness or injury. The psychosocial component of an individual’s return to work comprises both employee behaviors and employer conditions.

The MDGuidelines physiological durations are presented as tables with job class on one axis and “Minimum, Optimum, Maximum” on the other. The job classes correspond (although some interpretation is required) to the Department of Labor’s official characterizations of sedentary, light, medium, heavy, and very heavy work. The differences in healing times provides users with an expected path for functional recovery that can be used in planning return visits to the physician and accommodating restricted and/or modified duty for the employee.

The Minimum, Optimum, and Maximum labels have specific meaning that is essential to the proper usage of the durations. The Minimum duration is the medically necessary time off work for the medical condition and job class. Reed claims that any shorter of an absence could constitute a significant *risk* to the employee and employer. When the minimum duration is zero, then the employee may not need to miss work at all—a critical piece of information for physicians to have at the point of care. The minimum duration is also considered to be the most aggressive timetable for the return of a highly motivated, healthy employee. The Optimum duration is the expected time frame for functional recovery in an uncomplicated absence. This closely corresponds to the concept of *capacity*. At the Optimum duration, most people without substantial medical comorbidities will have the capacity to function in the type of work represented by the job class. As such, the Optimum is often used as the target for case managers. The Maximum duration is the time at which the case is clearly complicated and should be “red-flagged” by the stakeholders. To the extent that medical comorbidities cannot be assigned as root causes, the remainder of the absence can be considered primarily an issue of *tolerance*, which is very often the most significant problem in excessive or “long-tail” recoveries. Put another way, for reasons that cannot be scientifically assessed, because they are subjective, the employee cannot tolerate the condition while performing the duty.

Medical treatment, carpal tunnel syndrome.

DURATION IN DAYS			
Job Classification	Minimum	Optimum	Maximum
Sedentary	0	7	21
Light	0	7	21
Medium	0	14	28
Heavy	0	21	42
Very Heavy	0	28	63

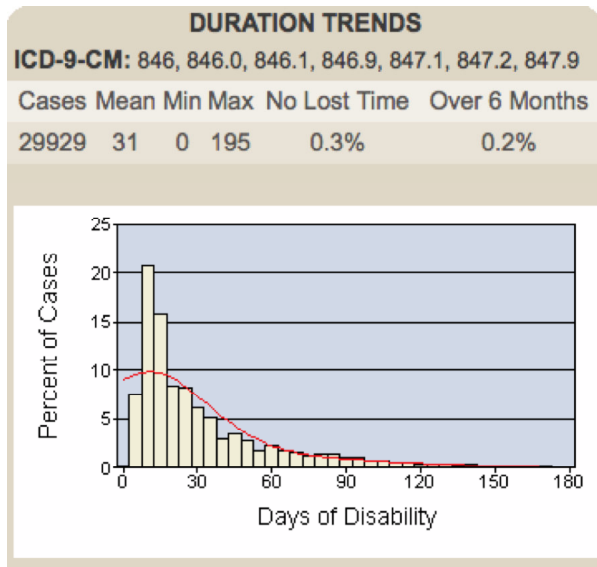
Surgical treatment, open or endoscopic carpal tunnel release.

DURATION IN DAYS			
Job Classification	Minimum	Optimum	Maximum
Sedentary	1	14	42
Light	3	21	42
Medium	14	28	56
Heavy	21	42	84
Very Heavy	28	56	91

When used properly, the normative guideline provides a real-world benchmark (what *does* happen), while the physiological guideline provides a shorter, more aggressive target (what *should* happen) for functional return to work for physicians, case managers, employers, and employees. Typically, the normative duration is used to reserve for a claim and to retrospectively gauge the outcome, whereas the physiological duration is used proactively to drive toward the best-possible outcome.

In this example using lumbar sprain or strain, the difference between the normative benchmark (mean = 31 days) and the physiological healing time for sedentary work (optimum = 3 days) suggests most of the time off work for these cases is attributable to psychosocial factors. Also, it should be noted that even

employees performing very heavy work need not *necessarily* be absent more than one week for lumbar sprain.



Supportive treatment, lumbar or lumbosacral spine sprain or strain.

DURATION IN DAYS			
Job Classification	Minimum	Optimum	Maximum
Sedentary	1	3	7
Light	1	7	14
Medium	3	21	42
Heavy	7	35	84
Very Heavy	7	42	91

In May 2009, Reed Group introduced the concept of an individually-customized duration calculator with the introduction of the MDGuidelines Predictive Model. This model uses the normative and physiological durations together to help provide a tangible return-to-work strategy for physicians and case managers. The Predictive Model employs linear regression to identify statistically significant relationships between independent variables and the observed durations for each medical condition. This results in several novel uses: the identification of the contribution of up to three medical comorbidities (and demographic factors like age, gender, job class, benefit type, and geographical location) for each individual; the creation of an accurate real-world benchmark in every clinical scenario (useful in segmenting cases into high-touch and low-touch “buckets”); and the quantification of the psychosocial component of each individual case.

Benchmark Against the Predicted Duration

354 - Mononeuritis of Upper Limb and Mononeuritis Multiplex
 296.2 - Major Depressive Disorder, Single Episode
 311 - Depressive Disorder, Not Elsewhere Classified

ICD-9-CM Code 60.7 Days
 Age +21.9 Days
 Gender +5.1 Days
 Job Class -1.7 Days

Co-existing Medical Conditions:
 Primary, Secondary and Tertiary

ICD-9-CM 1 +51 Days
 ICD-9-CM 2 +11.4 Days
 ICD-9-CM 3 0 Days

Workers' Comp 0 Days
 Inside U.S. 0 Days
 Region by Zip Code
 U.S. Region 0 Days
 Year Incurred 0 Days

Predicted Days of Disability 148.5 Days

Manage Toward the Optimum Duration

Physiological Recovery Times in Days for the Sedentary Job Class

In a small percentage of cases, individuals may experience chronic problems because of nerve damage that may result from carpal tunnel syndrome.

Medical treatment, carpal tunnel syndrome.

Minimum	Optimum	Maximum
0	7	21

Surgical treatment, open or endoscopic carpal tunnel release.

Minimum	Optimum	Maximum
1	14	42

In the above example, we see the effect of major depression and diabetes mellitus as secondary and tertiary medical conditions (comorbidities) on the primary diagnosis of carpal tunnel syndrome. The result is a benchmark of real-world expectations in this specific case. The model suggests early treatment of the depression could improve this employee’s outcome. Also, by subtracting the total effect of the medical comorbidities (61.4 days) from the predicted duration (148.5 days) and noting the difference (87.1 days) is still far above even the physiological maximum, one would again conclude there are substantial psychosocial influences. Finally, the minimum of zero days again suggests the employee does not necessarily need to miss work at all.

Reed Group supports the importance of human intervention and communication in improving disability outcomes. For this reason, their Medical Advisory Board has, through the years, developed thousands of pages of didactic text to support the recommendations in the duration tables. For example, in the section entitled “Factors Influencing Duration”, specific notes are made in relation to the physiological durations regarding severity, complexity, and surgical vs. non-surgical approach. MDGuidelines also contains sections on definition, diagnosis, differential diagnosis, prognosis, specialists, treatment, comorbid conditions, complications, rehabilitation, restrictions and accommodations, failure to recover, and hospital costs for each condition. Reed Group considers the educational text to be a fundamental part of its disability duration guidelines, and encourages the sharing of the information between physician, insurance company, employer, and employee.

The Work Loss Data Institute (WLDI) Official Disability Guidelines (ODG):

The Official Disability Guidelines (ODG), now in its 15th annual edition, provides both Summary and Best Practice Guidelines for disability duration. The ODG Summary Guidelines are data-driven tables that show the “Midrange” and “At-Risk” disability durations for the different datasets. The Midrange is defined as the time at which 50% of cases return-to-work and the At-Risk date is the time at which 90% of cases return-to-work. The ODG Best Practice Guidelines are case specific and are developed by drilling down into the raw data to identify each of the distinct “return-to-work pathways” that account for variance in disability duration for each condition. These pathways include indicators of severity, type of treatment, and type of job (light, medium, heavy, etc). They are also data driven, and undergo an annual peer-review process by the Editorial Advisory Board. They are evidence-based, with consensus input.

There are three major data sources used in the development of the ODG duration guidelines:

- Actual STD, LTD, and workers’ compensation insurance claims data is collected annually from clients including national disability and workers’ compensation carriers and major employers. Files are submitted to WLDI on an annual basis by clients engaging WLDI’s benchmarking services. This data is physician-coded, and includes both medical and lost-time.
- National Health Interview Survey (NHIS) – A combination of occupational and non-occupational disability data is collected by ODG from NHIS. NHIS is one of the oldest, most respected national health surveys in the United States, in continuous operation since July of 1957 and the principle data collection program for the National Center for Health Statistics under the Centers for Disease Control & Prevention. The Bureau of the Census under a contractual agreement is the data collection agent for the NHIS. The NHIS questionnaire is conducted using a computer assisted personal interviewer (CAPI). This computerized mode offers distinct advantages in terms of timeliness of the data and improved data quality.
- Survey of Occupational Injuries and Illnesses (SOII) – Occupational data for ODG is collected from SOII, a Federal/State program in which employer reports are collected annually from over 176,000 private industry establishments and processed by State agencies cooperating with the Bureau of Labor Statistics. Information on injuries and illnesses is copied by the employers directly from record keeping logs to the survey questionnaire and conform to definitions and record keeping guidelines set by OSHA, U.S. Department of Labor.

Both the National Health Interview Survey and the OSHA Survey of Occupational Injuries and Illnesses are conducted annually through present time, although there is a two-year lag before the data becomes available. Each supports the accuracy of the ODG duration guideline. In addition, WLDI conducts a comprehensive and ongoing medical literature review to use the latest studies published in peer-reviewed medical journals through December 2009 to support the ODG guidelines.

The use of these three different, unique data sources ensure ODG has sufficient data that is both occupational and non-occupational, insurance claims and non-benefit related, as well as self-reported, employer-reported, and physician-coded. Survey instruments were chosen in addition to client data

because they are population-based and appropriately stratified. And, they are described as “the most direct form of evidence that can be offered in court” under the Federal Rules of Evidence.

The initial development (selecting, extracting and calculating the appropriate information from the raw data, as described above) of the ODG Summary and Best Practice Guidelines is done by medical editors and computer programmers on staff at WLDI and overseen by Philip L. Denniston, Jr., MBA (Editor-in-Chief) and Charles W. Kennedy, Jr., MD (Senior Medical Editor). Dr. Kennedy is a current board member and former president of the American Academy of Disability Evaluating Physicians (AADEP) and a founding member of the Evidence-Analysis Committee for the American Academy of Orthopedic Surgeons (AAOS).

A sophisticated three-dimensional relational database computer system (PICK) is used to store and manipulate the data. Once the initial guidelines are developed according to the ODG formulas, they are distributed to members of the ODG Editorial Advisory Board for their annual peer review and consensus process. The ODG Board is composed of approximately 100 leading disability medicine specialists from across the country and throughout the world. They play a major role in the annual update process of ODG by reviewing and validating the updated version of each edition’s ODG guidelines for disability duration and medical treatment.

ODG has developed a comprehensive, reversible mapping program from ICD9 to ICD10. Since the U.S. is still ICD9 driven, “ODG on the Web” is currently organized by ICD9 code, and the corresponding ICD10’s are provided for each condition (both on the Webversion and in the raw data files). Once the U.S. moves to ICD10 (currently scheduled for October 2013), ODG on the Web will switch to the ICD10 organization already developed. However, at any point now and in the future, using the Web version or data integration, users can access the ODG guidelines by either ICD9 or ICD10.

Disability duration for 847.2 (low back Sprain or Strain):

847.2 Lumbar sprains and strains

Return-To-Work Summary Guidelines		
Dataset	Midrange	At-Risk
Claims data	17 days	59 days
All absences	10 days	37 days

Return-To-Work "Best Practice" Guidelines
Mild (grade I), clerical/modified work: 0 days
Mild, manual/heavy manual work: 7-10 days
Severe (grade II-III), clerical/modified work: 0-3 days
Severe, manual work: 14-17 days
Severe, heavy manual work: 35 days
With radicular signs, see 722.1 (disc disorders)
Obesity comorbidity (BMI >= 30), multiply by: 1.31

Capabilities & Activity Modifications for Restricted Work:

Clerical/modified work: Lifting with knees (with a straight back, no stooping) not more than 5 lbs up to 3 times/hr; squatting up to 4 times/hr; standing or walking with a 5-minute break at least every 20 minutes; sitting with a 5-minute break every 30 minutes; no extremes of extension or flexion; no extremes of twisting; no climbing ladders; driving car only up to 2 hrs/day.
Manual work: Lifting with knees (with a straight back) not more than 25 lbs up to 15 times/hr; squatting up to 16 times/hr; standing or walking with a 10-minute break at least every 1-2 hours; sitting with a 10-minute break every 1-2 hours; extremes of flexion or extension allowed up to 12 times/hr; extremes of twisting allowed up to 16 times/hr; climbing ladders allowed up to 25 rungs 6 times/hr; driving car or light truck up to a full work day; driving heavy truck up to 4 hrs/day.

more narrow range that is identified through key determinants of a case: the severity, the type of treatment (i.e. open vs. endoscopic surgery, etc., if applicable) and what type of work the employee does. If you don't know this info, you would use the Summary Guidelines. But when you do know this information, the Best Practice Guidelines should be used. For example, the line in the Best Practice Guidelines: Severe, heavy manual work: 35 days. This means a severe case of 847.2, who performs heavy manual work, is ready to return to work in 35 days.

Also, with the Best Practice Guidelines, you can use the information to create an early-return-to-work pathway. For example, by looking in the Best Practice Guidelines, this same case would be ready for just "manual work" in 14-17 days. ODG clients use these pathways to create early return to work situations for their employees. When they do this, they also use the information that is called Capabilities &

The Return-To-Work Summary Guidelines provide a general idea of what to expect. They show estimated days out of work for each condition using check-points defined as mid-range and at-risk. The summary guidelines box presents two datasets and is especially useful for retrospective benchmarking based solely on the diagnosis.

Claims data only are cases out more than 7 days. These are the ones that are actually a claim, typical of lost time insurance claims. The other row is titled All Absences. This data includes all absences, including cases out for 7 days or less, that may never be a claim under most workers' comp rules or disability benefit programs.

The mid-range is the duration at which 50% of cases return to work. The at-risk is the duration at which 90% of cases return to work. This is 90% of the total number of all cases, whether it's mild or severe. If a case goes beyond this point they are the 10% that drop off and may never return, these are outliers. These are the type of cases that trigger a red flag. Users should not manage to the at-risk date. This is the time at which a claim is "at risk" of not returning to work. Instead, users should try to manage to the mid-range or Best Practice Guidelines.

The Best Practice Guidelines are a target or

Activity Modifications for Restricted Work. For each level of job in the best practice guidelines, specific modifications or restrictions may be provided to alter the

Workers' Comp Costs per Claim (based on 95,654 claims)					
Quartile	25%	50%	75%	Mean	% no cost
Indemnity	\$1,281	\$2,510	\$5,103	\$5,202	80%
Medical	\$242	\$546	\$1,628	\$1,780	4%
Total	\$242	\$609	\$2,352	\$2,862	4%

Disability Duration Adjustment Factors by Age						
Age Group	18-24	25-34	35-44	45-54	55-64	65-74
Adjustment Factor	0.66	0.74	1.07	1.10	1.35	1.64

RTW Claims Data (Calendar-days away from work by decile)										
10%	20%	30%	40%	50%	60%	70%	80%	90%	100%	Mean
10	12	14	15	17	19	34	37	59	365	29.06

RTW Post Surgery (Calendar-days away from work by decile)										
10%	20%	30%	40%	50%	60%	70%	80%	90%	100%	Mean
Low back disk surgery (CPT 63030)										
41	51	58	92	142	205	321	365	365	365	182.98

The next section is the Workers' Comp Cost Per Claim section. This feature is provided for workers' comp insurance companies, self-insured employers, and TPAs to help in their efforts to improve outcomes by reserving claims, triaging, managing claims and benchmarking.

This information is based on about 2 million claims from our own multi-year, multi-state workers' compensation database and covers almost 50 million paid invoices on medical encounters for those claims. The medical costs cover office visits, surgeries, physical therapy, hospital costs, pharmaceuticals, and durable medical equipment. The information provided shows cost distribution by quartile for both indemnity and medical costs: The 25% is the lowest quartile of costs; the 50% is the median costs; 75% is the highest quartile of costs. The mean is the average. When setting reserves, you would want to look at the mean.

It's important to note that when looking at the data, the last column shows that there are claims that had no costs. Therefore, the numbers in the boxes represent data based on claims that HAD costs.

Underneath this, you have the Disability Duration Adjustment Factors by Age -- these are factors that affect disability. Since age plays a role in returning to work, these numbers can be used as a multiplier to tailor the range or number used for return to work. For example, if you were using the Best Practice Guidelines, and it says 35 days, you would look up the person's age, and multiply that adjustment factor by 35. If you have a range, such as 17 and 58 you would multiply that number by 17 and then by 58, and it will "tailor" the range.

Disability duration for Carpal Tunnel Syndrome (354.0)

The following is an example of the ODG tables for determining disability duration for Carpal Tunnel Syndrome.

354.0 Carpal tunnel syndrome

Return-To-Work Summary Guidelines

Dataset	Midrange	At-Risk
Claims data	41 days	144 days
All absences	24 days	91 days

Return-To-Work "Best Practice" Guidelines

Conservative treatment, modified work (limit repetitive use of hand/wrist): 0 days
 Conservative treatment, regular work (if not aggravating to disability/use of splint): 0-5 days
 Conservative treatment, regular work (if work related & electrodiagnostically confirmed): 28 days
 Conservative treatment, regular work (with severe nerve impairment): indefinite
 Endoscopic/mini-palm surgery, modified work: 3-5 days
 Endoscopic/mini-palm surgery, regular work, non-dominant arm: 28 days
 Endoscopic/mini-palm surgery, regular/repetitive/heavy manual work, dominant arm: 42 days to indefinite
 Open surgery (median nerve neurolysis), modified work: 10-14 days
 Open surgery, regular work, non-dominant arm: 42 days
 Open surgery, regular/repetitive/heavy manual work, dominant arm: 56 days to indefinite
 Open surgery, regular/repetitive/heavy manual work, bilateral: 84 days to indefinite
 Pregnancy comorbidity, modified work until 28 days after delivery

Capabilities & Activity Modifications for Restricted Work:

Modified work: Repetitive motion activities (w or w/o splint) not more than 4 times/hr; repetitive keying up to 15 keystrokes/min not more than 2 hrs/day; gripping and using light tools (pens, scissors, etc.) with 5-minute break at least every 20 min; no pinching; driving car up to 2 hrs/day; light work up to 5 lbs 3 times/hr; avoidance of prolonged periods in wrist flexion or extension.

Regular work (if not cause or aggravating to disability): Repetitive motion activities not more than 25 times/hr; repetitive keying up to 45 keystrokes/min 8 hrs/day; gripping and using moderate tools (pliers, screwdrivers, etc.) fulltime; pinching up to 5 times/min; driving car or light truck up to 6 hrs/day or heavy truck up to 3 hrs/day; moderate to heavy work up to 35 lbs not more than 7 times/hr.

Workers' Comp Costs per Claim (based on 10,642 claims)

Quartile	25%	50%	75%	Mean	% no cost
Indemnity	\$3,087	\$5,849	\$11,382	\$10,009	31%
Medical	\$2,300	\$4,547	\$8,127	\$6,713	2%
Total	\$3,938	\$8,411	\$15,981	\$13,682	1%

Disability Duration Adjustment Factors by Age

Age Group	18-24	25-34	35-44	45-54	55-64	65-74
Adjustment Factor	0.34	0.75	1.08	1.15	1.10	NA

RTW Claims Data (Calendar-days away from work by decile)

10%	20%	30%	40%	50%	60%	70%	80%	90%	100%	Mean
12	15	22	29	41	45	57	83	144	365	68.40

RTW Post Surgery (Calendar-days away from work by decile)

10%	20%	30%	40%	50%	60%	70%	80%	90%	100%	Mean
18	33	47	55	62	69	90	118	218	365	85.60

Remove wrist/forearm lesion (CPT 25115)

18	33	47	55	62	69	90	118	218	365	85.60
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Wrist endoscopy/surgery (CPT 29848)

16	26	32	40	46	57	68	83	130	365	65.88
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Carpal tunnel surgery (CPT 64721)

18	30	39	46	54	65	81	107	185	365	81.96
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The multipliers provided for age and co-morbidities can be enabled such that when integrating the ODG guidelines the duration guidelines are adjusted automatically by these factors. This is an optional feature, and can also be used selectively.

Official Disability Guidelines

[ODG: Good to Go!](#) (link to complimentary online self training tool)

**Work Loss Data Institute
ODG Comorbidity Calculator**

ICD9 Code 1: Carpal tunnel syndrome

ICD9 Code 2: Lumbar sprains and strains

Employee Age:

Median Disability Duration 167 Days.

A new tool has been added to ODG called the Comorbidity Calculator which allows the user to enter the ICD9 codes for comorbidities an injured worker may be diagnosed with, as well as the worker's age and ODG calculates expected disability duration. Though most multiple injuries heal simultaneously and one would expect the duration to be simply based on the time the most severe diagnosis, there are times when co-morbid diagnoses have a much greater impact than you would think on the return-to-work process.

A recent White paper published by the Disability Management Employer Coalition (DMEC) provides a summary and an analysis of the 2010 DMEC's biannual survey which tracks employer strategies, advancements, prevalence and effectiveness, in the area of Behavioral Risk Management. Illustrative of the impact a mental health condition might have when coupled with an injury, DMEC states the following: "Mental health conditions also frequently co-occur with physical health conditions – and when these co morbidities occur, work loss can grow markedly. As an example, the Work Loss Data Institute shows that the expected median disability duration for a lumbar sprain is 10 days. The expected median disability duration for lingering depression with anxiety is 26 days. Combined, the expected median disability duration jumps to 153 days."

Summary:

The two major companies that have developed disability duration guidelines; The Reed Group and Work Loss Data Institute, use different data sources, different comorbidities and different approaches in the development of their guidelines. These different approaches result in somewhat different disability duration recommendations for the same diagnoses. Both companies offer unique value in both the content and presentation of the disability duration recommendations.

However, we must always be aware that any disability duration guidelines only provide a benchmark for estimating when an injured worker might be able to return to work. There is an ongoing need to continue to refine disability duration guideline products such as these to account for additional specific patient variable such as additional co-morbidities such as obesity, etc. and treatment variables that look at the type of treater and the treatment that results in best outcomes.

For further information regarding this study, please contact:

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