



ODG by MCG Best Practices FAQ

ODG by MCG empowers stakeholders from Workers' Compensation, Disability, and Auto Injury with industry-leading tools and best in class processes built on a foundation of the most comprehensive and up to date source of evidence-based treatment guidelines as well as a robust repository of historical claims data, representing over 10 million lost-time claims from across these industries.

Leveraging these methodically researched guidelines ensures that the most appropriate treatments are rendered timely in addition to using data-driven solutions for evaluating treatment plans. This includes the ability to identify which treatments correspond with better outcomes, projecting goals, typical, and maximum recovery durations. Stakeholders can achieve superior outcomes using actionable information for informed decision-making.

A Note on Consistency

For many claim situations, there are often numerous methods and approaches for obtaining ODG data at the claim level. It is imperative to prioritize a consistent approach across the business.

While ODG provides a general framework and recommended concepts for utilizing the ODG content and leveraging the data consistently for maximum effectiveness, each stakeholder ultimately may leverage the data in a way they feel works best for them.

Whether using the ODG established guidance as the best practice approaches listed below or an alternative approach, ODG recommends each client utilizes the adopted method consistent with the intent to provide the safest and most effective care possible.

Clients can mitigate ambiguity in claims handling by following the standardization of best practice workflows. This increases the uniformity of internal data for benchmarking and maximizes the benefits available using the ODG tools and solutions.

Understanding ODG Disability Durations, M-A-B

ODG provides several variations for disability durations with three primary values:

- **M - Maximum** (Maximum Anticipated Return-to-Work) duration, which represents the true statistical mean disability duration based on similar real-world claims.
- **A - Average** (Claim Typical) duration, which represents the typical disability duration, the average disability duration after removing the top 5% of outliers.
- **B - Best Practice** duration, which represents the goal disability duration based on the uncomplicated physiologic recovery time.

The ODG Best Practice recommendation is to use the **B Value** (Best Practice Duration) for managing a claim, the **A Value** for benchmarking the claim against similar claims within the industry, and the **M Value** for benchmarking claims that could be considered outliers against similar claims within the industry such as claims with extenuating circumstances and/or multiple non-medical factors impacting recovery.



The disability durations are formulated by adding the total calendar days out-of-work, starting with the first day of lost time and ending with the first day back to work in any capacity. When there is more than one period of significant time out-of-work, ODG Best Practice recommends adding the periods of time out-of-work together.

Understanding Return to Work Dates

ODG disability durations provide valuable insights for creating and managing effective Return-to-Work (RTW) strategies, a critical element given multiple studies demonstrating prolonged disability durations correlate with poor outcomes.

ODG utilizes the Best Practice, Average, and Max disability durations to provide a goal RTW date in the refinement section.

The ODG Best Practice Recommendation is to use the Target RTW Date, which uses the Best Practice duration and adds this to the date of injury or date of surgery, whichever is most recent. This provides an RTW date based solely on physiologic recovery, allowing the user to identify the RTW date without the impact of any psychosocial or non-medical factors.

However, there may be cases where considering these factors is appropriate, such as a claim with multiple surgeries or multiple unrelated non-medical factors that would be reasonably expected to impact the recovery timeframe. For these situations, the Average (Claim Typical without outliers) duration, or the Maximum (Claim Typical with outliers) duration could be used for creating an effective strategy for managing RTW.

Prospective Surgery Dates

For claims with upcoming surgeries, ODG Best Practice recommends not adding a prospective date of surgery until the surgery has occurred. Adding the tentative date of surgery could artificially inflate disability durations and related claim information.

For example, if the target disability duration for a claim is 10 days and the first date out of work is 1/1/21, then the target RTW date would be 1/11/21. However, if a surgery with a disability duration of 90 days was planned for 3/1/21 and entered as such, that would inflate the disability duration of the claim by 49 days (the total duration from the initial target RTW date of 1/11/21 and the surgery date of 3/1/21).

Including prospective dates of surgeries can artificially inflate disability duration data and increase the likelihood of a disability mindset for injured workers from apparent extensive time off. For that reason, ODG Best Practice is to recalculate claim-level data when the surgery has been completed, which also eliminates artificially inflating the disability duration when the surgery is canceled or changed.

Remember to pin the surgical procedure at the top once the surgery has been completed to receive an accurate RTW date.



Previous Surgery or Pre-Existing Injury

When there is a pre-existing surgery, unrelated and prior to the injury that resulted in lost time, the ODG Best Practice recommendation is to include the surgery if it would reasonably be expected to impact the recovery timeframe for the related injury(s) and if the date of injury is prior to the target RTW date for the pre-existing surgery. This can be calculated by entering the pre-existing surgery, the date of that surgery, and then comparing the target RTW date to the date of injury for the current condition that is resulting in lost time.

In an example where a claimant suffered a lumbar injury on 2/1/21 but had a prior lumbar fusion on 4/1/20, we recommend not including the surgery or surgery date as the fusion has a best practice duration of 140 days and this injury would have occurred outside of that timeframe. Rather, if the claimant continues to have residual deficits related to the prior surgery, we suggest adding the surgery confounding factor in the refinement section.

However, if the claimant had a low back injury on 2/1/21 but the prior lumbar fusion was on 12/1/20, that injury would have occurred within the 140-day best practice duration for the procedure. For this situation, we would recommend still pinning the surgery and entering the surgery date as the impact of the lumbar fusion would still be relevant as the date of injury was only 62 days post-op.

Multiple Surgeries

When working on a claim with multiple surgeries, the system will not differentiate when each surgery is. There are multiple ways to handle this. The ODG Best Practice recommendation is to enter the multiple surgeries together and then enter the Date of Surgery (populates in the Refinement Section when a surgery is pinned) for the procedure that has the longest disability duration.

If a subsequent surgery is performed beyond the initial goal RTW date corresponding with the durations of the initial surgery, or if there is a prolonged period between surgeries, then the ODG Best Practice recommendation is to use one of two methods.

- The first method is to simply use the date of the subsequent surgery to calculate Target RTW Date and Durations. This will ensure that all recovery times will be included in the date projections.
- The second method is to determine the B Value Durations for the subsequent surgery alone without multiple surgeries pinned and use that as your goal or Target RTW Date.

We recommend continuing to use the A Value and M Value at the claim level with all surgeries included for accurate benchmarking.

When multiple surgeries are all related to the same underlying condition, ODG Best Practice recommendation is to include a single representation for the surgery. This is particularly important when using CPT codes as there are often many CPT codes for a single surgery.

Multiple Diagnoses

ODG Best Practice for adding additional diagnoses is to include any condition that would reasonably be expected to have an impact on the injured workers' recovery and subsequent return to the pre-injury functional level.



ODG recommends attempting to limit inputs to a primary and secondary ICD if possible, rather than including all billed ICD codes, unless the billed ICD codes would reasonably be expected to have an impact on the injured workers' recovery and subsequent return to the pre-injury functional level.

Secondary ICD codes actively impacting recovery or lost time should only be entered once.

Although there may be multiple ICD codes for a specific condition, only one ICD should be entered. Entering all the relevant ICD codes for an injury (i.e., S83.242, S83.512, M23.204 for a meniscus tear) would indicate there are multiple conditions when these are really all indicative of a single condition. To optimize ODG data, only a single ICD should be entered per active relevant condition.

Confounding Factors

Confounding factors, or comorbid conditions, do not need to be pinned as a primary diagnosis. Instead, they should be selected from the confounding factors listed in the search refinement section.

Any of the 9 factors should be checked when they would reasonably be expected to have an active impact on the injured workers' recovery, subsequent return to pre-injury functional level, or claim costs.

There is no need to add comorbid conditions/confounding factors unless they would actively be impacting a measurement of outcome.

Confounding factors

- | | | |
|---|--|---|
| <input type="checkbox"/> Depression/PTSD/Psychosocial | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Legal Representation | <input type="checkbox"/> Obesity | <input type="checkbox"/> Smoker |
| <input type="checkbox"/> Opioids | <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Surgery or Hospital Stay |
| <input type="checkbox"/> Preexisting Conditions | | |

Conversely, if one of the above conditions is the primary or even secondary reason for the claim or lost time, then instead of adding it as a confounding factor, it should be added as a pinned condition.

Conditions should not be redundantly added as both primary diagnoses and confounding factors as that will artificially inflate durations and cost data.

Surgery Confounding Factor

The "surgery" confounding factor should only be used if the surgery was recent and/or if the surgery (not the underlying pathology) is impacting return to work or recovery. This will be automatically checked when a surgical procedure is pinned as a primary factor and a dialog box for the date of surgery will appear. This will allow for real-time return to work predictions based on the durations of the procedure. In addition, a pinned surgery will auto-check other relevant confounding factors like opioid use and the length of stay.



See below for an example:

☒ ODG Medical Topics ☐ ICD-9 ☒ ICD-10 ☐ CPT® ☐ NDC ☐ HCPCS

Search for additional conditions Q REFINE

Meniscectomy or Meniscal Repair for Knee and Leg Conditions x

Refine Results Auto-Retrieve: Off ☒ On

DOL Job Class
Enter Job Title ▼

State
All States ▼

Claimant Age

Date of Injury
mm/dd/yyyy

Target RTW Date
mm/dd/yyyy

Claim Type
Any ▼

Confounding factors

<input type="checkbox"/> Depression/PTSD/Psychosocial	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Legal Representation	<input type="checkbox"/> Obesity	<input type="checkbox"/> Smoker
<input checked="" type="checkbox"/> Opioids	<input type="checkbox"/> Substance Abuse	<input checked="" type="checkbox"/> Surgery or Hospital Stay
<input checked="" type="checkbox"/> <15 Days	<input type="checkbox"/> 15-30 Days	<input type="checkbox"/> 30+ Days
<input type="checkbox"/> Preexisting Conditions		

Date of Surgery
mm/dd/yyyy

CLEAR CLOSE

If a surgery is being performed within the typical course of treatment on a diagnosis (i.e., within the expected time frame from initial date of diagnosis at the discretion of the client), ODG recommends including both the surgery and the diagnosis as pinned conditions to evaluation durations and costs together.

If a surgery is being performed outside of the typical course of treatment (i.e., outside of what would reasonably be expected or if delayed due to a unique claim situation), ODG recommends only including the procedure itself as a primary condition. When a surgery is outside of the typical timeline of treatment, the claim will likely no longer require any treatment or lost time leading up to the surgery (as would be included with the pinned diagnosis) but would rather only need to evaluate the surgery and any subsequent post-op treatment.

Including both diagnosis and treatment when a surgery is outside of the typical care timeline could result in artificial inflation of duration and cost data.

Non-Compensable Diagnoses

Depending on the state jurisdiction and type of claim, some injuries or diagnoses may not be compensable. When that is the case or in situations where a claim is still pending investigation for compensability decision, ODG recommends including all relevant and active diagnoses regardless of compensability.



ODG data is driven by physiological recovery time and claim-level information on average lost time duration and costs. These are driven by the specific diagnoses and confounding factors at play, not by the compensability status. ODG recommends including all injuries for the most accurate data and benchmark.

In situations where a designated physician, whether a treating doctor, IME, etc., indicates a diagnosis is compensable but the adjuster disagrees or excludes a diagnosis or body part from the claim, ODG recommends that the diagnosis still be included when determining projected claim data.

Compensability decisions are related to the administration of the claim and are not impactful on the physiological recovery and corresponding disability durations of the injured worker. Although a diagnosis may not be included on a claim, ODG Best Practice is to include it in the data as it may still impact recovery and return to pre-injury functional status.

Adding ICD Codes for Confounding Factors

Including diagnosis codes for comorbid conditions has a different effect on ODG data filtering than checking confounding factors or adding claim level information in the refinement section, so it is important to understand when to pin a code and when to refine results for optimal leveraging.

If you enter the ICD R54 (age-related disability) you will see an impact on durations and therefore risk score, but this change is in addition to the input in the age field on the refinement section. It is important to note that both inclusions are distinctly different. The age field is related to the age of the claimant, comparing durations for a condition among similarly aged claimants.

If you pin a back sprain and enter age 60, ODG is going to retrieve the average for all back sprain claims among claimants aged 60. When adding the ICD R54, it functions differently. ICD R54 is a medical diagnosis, used to indicate an age-related physical debility. Someone who is age 60 does not necessarily have an age-related physical debility. When this ICD is included it indicates that the age of the claimant is impacting the claimant's condition or recovery. Whereas entering the age of the claimant filters and retrieves data for claims with similarly aged claimants. As such, both the claimant's age and the use of ICD R54 will have their own impacts on the claim durations and risk score.

Physical Therapy Durations

ODG specific diagnoses and procedures will return physical therapy guidelines, including the number of visits and duration for physical therapy, chiropractic sessions, or both. These are average durations from evidence-based medical treatment guidelines and are structured in a format of the number of visits over maximum weeks.

These recommendations are averages for a physical therapy order and are not a cap on visits. Additional orders should be considered for approval depending on evidence of recovery, continued deficits, etc.

For example, a physical therapy duration of 9 visits over 8 weeks advises that the average order for physical therapy for the specified diagnosis or procedure is 9 visits over a maximum of 8 weeks. This order could be as often as ordered (i.e., 3 sessions a week for 3 weeks) to as infrequent as once a week over 8 weeks.



Non-Consecutive Lost Time

There are multiple frequently occurring scenarios that could result in periods of non-consecutive lost time and ODG recommends reviewing situations each with a unique approach to ensure data remains as accurate as possible.

For instances where an injured worker is out of work and returns for a very short period before being taken out of work again, ODG recommends creating a standard approach based on the length of temporary return. For example, if they returned for 7 calendar days or less, ODG Best Practice is to keep the first date of lost time as the very first date of lost time and to not change that date after the failed return to work trial. The exact number of days returned in this scenario should be established as a “trial period” length by each individual client.

If the injured worker would be out of work longer than the agreed-upon “trial period,” ODG Best Practice is to stop the lost time clock and restart at the next instance of lost time. So that might be after any time frame of return to work that lasts longer than 8 days.

However, if a new injury or condition arose while an injured worker was within a “trial period” of return to work, ODG Best Practice recommends a new date of injury and a new start of lost time durations for the new injury.

Practical Application of Appendix D

There are situations where injured workers require medical care outside of the ODG treatment guidelines. Appendix D outlines the process for allowing injured workers to receive appropriate medical treatment even when it is not covered in ODG.

Ultimately, treatment decisions should be through a collaboration between the patient and the clinician with full disclosure of benefits and risks. Shared decision-making is an approach to care that seeks to fully inform patients about the risks and benefits of available treatments and engage them as participants in decisions impacting their care. The ODG guidelines provide critical information for stakeholders to make these informed decisions, providing relevant information around treatment benefits and risks as well as a foundation for providing documentation to consider care outside the guideline recommendations.

Appendix D offers providers information on documentation requirements for exceptions to the ODG guidelines. For example, providers are asked to submit information such as how the expected result of the treatment in question leads to meaningful and sustained functional improvement, how any relevant comorbidities might impact the need for this care, and how any chronic conditions could affect recovery and necessitate the care being requested.

Changes to your ODG by MCG Configuration

Contact us at odghelp@mcg.com or 1-800-488-5548 for more information on ODG customization or to speak with the ODG Strategic Solutions team about obtaining a customized plan designed to meet the unique needs of your organization.