Increasing rates of duty disabilities for Police & Fire Plan members have caused concerns amongst stakeholder groups. These concerns have been heightened by both recent observed experience and by reports of an upcoming surge of applications coming primarily from the Minneapolis Police Department. If reports are accurate, the number of applications in the next year may be three to four times what has been experienced by the Plan in recent years.

The number of Police & Fire disability approvals has risen from 61 in 2017 to 81 in 2018 to 105 in 2019. This is an annualized rate increase of over 30%. In addition to an increase in the total number of approved disability applications, the percentage of approved duty disabilities due to Post Traumatic Stress Disorder (PTSD) have increased from about 42% of disabilities in 2018 to 71% of disabilities in 2019. The vast majority of cases expected in the upcoming applications are expected to be PTSD-related based on communication from attorneys representing Police & Fire Plan members.

The Police & Fire Plan member disability landscape is clearly changing. Our goal is to identify and understand those changes and to ensure PERA’s disability process and benefits are fair and appropriate. An equitable process addresses employers’ concerns about costs and members’ concerns that they will receive benefits when deserved.

As part of our internal process evaluation, we discussed claims review methods with MMRO, our third-party administrator. MMRO has proposed a modification to their services to provide further clinical rigor to assess the unique aspects of a PTSD claim. Rather than the current process, which includes PTSD claims in the usual process where claims are initially evaluated by disability nurse case managers, PTSD claims will be reviewed by a board certified psychiatrist at the outset of the process. The board certified psychiatrist will review whether the diagnostic criteria for PTSD has been met and whether the claimant meets Police & Fire Plan disability standards. If necessary, the board certified psychiatrist will recommend further independent psychological testing and independent psychological evaluations. The proposed approach is outlined in the attached memo from MMRO dated July 31, 2020.

As noted in the MMRO memo, there is only an additional cost in the cases that are identified for further assessment. The rate of cases identified for that assessment is difficult to predict. As a result, the
ultimate total cost is uncertain. Staff will monitor usage and results closely and report an estimated total annual cost to the Board in October.

**Staff Recommendation**

Staff recommends that the PERA Board of Trustees approve the modified services as proposed by MMRO.
In follow up to our joint conference call, and in further response to your email requests regarding potential clinical enhancements to our disability retirement claim workflow for Police & Fire Plan claims that center on a diagnosis of Posttraumatic Stress Disorder (PTSD), below please find MMRO’s proposed plan for handling such claims. Please note that this Memorandum is meant to lay out our conceptual thoughts on ways to add additional clinical rigor to these unique claim reviews, and welcomes further discussion with the PERA team in an effort to jointly modify the current workflow process to handle the anticipated influx of PTSD claims.

1. Diagnostic Criteria for PTSD

As discussed during our recent joint conference call, when dealing with the unique aspects of a Posttraumatic Stress Disorder (PTSD) claim, a crucially important part of the analysis is ensuring that the diagnostic criteria has been met before working to analyze the level of functional impairment that stems from PTSD. This will be handled by utilizing the most current diagnostic criteria as set forth by the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). As applicable, the IPE process will include the application of the diagnostic criteria per the DSM-5 in support of diagnostic validation.

Diagnosing PTSD in adults using the DSM-5 requires a certain type and level of traumatic event, a combination of required symptoms, and the absence of exclusionary criteria, in accordance with the following:

A) Causation: The victim was exposed to actual or threatened death, serious injury or sexual violence in one of four ways:
- Directly experiencing the traumatic event(s)
- Witnessing, in person, the event(s) as it occurred to others
- Learning that the traumatic event(s) occurred to a close family member or friend
- Experiencing repeated or extreme exposure to aversive details of the traumatic event(s); this does not apply to exposure through media such as television, movies, or pictures

B) The traumatic event is persistently re-experienced:
- Nightmares
- Intrusive thoughts of the traumatic event
- Flashbacks
• Marked emotional distress when exposed to traumatic reminders
• Strong physiologic reaction when exposed to traumatic reminders

C) Avoidance in one of two ways:
• Avoidance of thoughts, feelings, or conversations associated with the event
• Avoidance of people, places, or activities that may trigger recollections of the event

D) Negative alterations in cognition and mood. To include two of the following:
• Inability to remember an important aspect of the event(s)
• Persistent and exaggerated negative beliefs about oneself, others, or the world
• Persistent distorted cognitions about the cause or consequences of the event(s)
• Persistent negative emotional state
• Markedly diminished interest or participation in significant activities
• Feelings of detachment or estrangement from others
• Persistent inability to experience positive emotions

E) Hyperarousal: To include two of the following:
• Irritable behavior and angry outbursts
• Reckless or self-destructive behavior
• Hypervigilance
• Exaggerated startle response
• Concentration problems
• Sleep disturbance

F) The duration of symptoms is more than 1 month

G) Disturbance causes clinically significant distress or impairment in functioning

H) The disturbance is not attributable to the physiological effects of a substance or other medical condition

The DSM-5 recognizes a “with dissociative symptom” specifier when the PTSD symptoms are accompanied by persistent or recurrent depersonalization or derealization. The specifier “with delayed expression” should be included if the full criteria for PTSD are not met for more than 6 months following the trauma.

The DSM-5 further recognizes a “Severity Rating”, based on the following scale from 0 - 4:

• (0) Absent: The respondent denied the problem or the respondent's report doesn't fit the DSM-5 symptom criterion.
• (1) Mild / subthreshold: The respondent described a problem that is consistent with the symptom criterion but isn't severe enough to be considered clinically significant. The problem doesn't satisfy the DSM-5 symptom criterion and thus doesn't count toward a PTSD diagnosis.
• (2) Moderate / threshold: The respondent described a clinically significant problem. The problem satisfies the DSM-5 symptom criterion and thus counts toward a PTSD diagnosis. The problem would be a target for intervention. This rating requires a minimum frequency of 2 x month or some of the time (20-30%) PLUS a minimum intensity of Clearly Present.
• (3) Severe / markedly elevated: The respondent described a problem that is above threshold. The problem is difficult to manage and at times overwhelming and would be a prominent target for intervention. This rating requires a minimum frequency of 2 x week or much of the time (50-60%) PLUS a minimum intensity of Pronounced.
• (4) Extreme / incapacitating: The respondent described a dramatic symptom, far above threshold. The problem is pervasive, unmanageable, and overwhelming, and would be a high-priority target for intervention.
2. **Proposed Revisions to the Workflow Process**

Attached please find a proposed claim workflow to address these PTSD claims. As you can see from the attached, in these cases, the revised workflow will shift a majority of the clinical review burden from the MMRO Disability Nurse Case Managers (DNCMs) to the reviewing/examining psychologists and psychiatrists. In these cases, MMRO is further proposing that our written work product back to PERA will consist of the report(s) of the physician reviewers that can address the aspects of the PERA disability standard, as opposed to our normal MMRO Recommendation Letter.

3. **Conceptual Cost Estimate**

Based on the revised workflow as set out above, MMRO proposes first having the claim reviewed by board-certified Psychiatrist, and a Disability Peer Review Report being issued. These Disability Peer Review Reports would be billed at the current New Claim rate of $760.00 per review (and in these cases, no separate New Claim fee would be charged, so there would be no cost difference to PERA for those cases that could be approved without psychological testing and IPE). For those cases that require further assessment, MMRO proposes using a Clinical Psychologist to perform an initial battery of psychological testing, followed by an Independent Psychiatric Evaluation by a board-certified Psychiatrist (IPE). For those testing batteries and IPEs that can be administered in the Twin Cities metropolitan area, we believe the following conceptual cost estimate will apply:

- Psychological Testing: $2,350 - $2,750 per testing session
- IPE: $2,475 - $2,850 per IPE

We do recognize that there may be a need for testing and/or IPEs to be performed outside of the Twin Cities metropolitan area. In these instances, costs will need to be obtained and quoted for PERA approval on a case-by-case basis.

4. **MMRO Resource Allocation for Approx. 200-250 Additional Claims**

MMRO’s revised workflow for these claims proposes to utilize a panel of reviewing psychiatrists to first review the submitted claim file, and provide an opinion on those claims that clearly meet the PTSD diagnostic criteria and, in turn, can be approved on a “fast track” basis (and without the need for a battery of psychological testing or an IPE to be performed). These physician reviewers may not be located in the Twin Cities area (or in Minnesota, for that matter), and will only be reviewing the claim file. MMRO, and its subsidiary, CoreVisory, have a large, nationwide panel of fully credentialed reviewing psychiatrists, and this estimated volume, especially if spread out over a period of 6-9 months, will not present an issue to the timely completion of claims. This approach will allow select cases to be “fast tracked”, and will not require the proposed psychological testing and subsequent IPE.

Likewise, for those claims where psychological testing and an IPE are needed to validate the claim, MMRO will utilize a panel of psychologists and psychiatrists located within the Twin Cities metropolitan area. MMRO recognizes that there may be a need for psychological testing and IPEs to occur in other areas of Minnesota, and those will be handled on a case-by-case basis. In this regard, please also note that the Conceptual Cost Estimate above is based on psychological testing and IPEs to be performed in the Twin Cities metropolitan area. Other regions will need to be quoted on a case-by-case basis. As we would expect a fraction of the overall anticipated claim volume to require psychological testing and IPEs, and have access to a strong panel of such physicians in the Twin Cities metropolitan area, we do not believe that this claim volume will present an issue to the timely completion of claims. *It does need to be noted, however, that given the fact that two (2) assessments will be required in succession, these claims will take longer than our average 45-75 day period depending on physician appointment schedules, etc.*
Finally, MMRO’s revised workflow for these claims does shift a majority of the clinical review burden from the MMRO Disability Nurse Case Managers (DNCMs) to the reviewing/examining physicians. As such, we believe that the assigned PERA DNCMs will be able to handle a larger claim load, and, in turn, we do not believe that this claim volume will present an issue to the timely completion of claims or place an unreasonable burden on MMRO’s existing internal resources. In addition, MMRO will take proactive measures to establish “block time” from select providers (psychological testing and IPEs) to help ensure timely scheduling of appointments.
File receipt and review:
DNCM to review disability claim file and determine whether additional clinical triage is needed

DNCM Outreachs (IF NEEDED):
If needed, DNCM to complete outreach attempts to the member and Attending Physicians to confirm/clarify info provided.

Referral for Disability Peer Review (Psychiatric):
• Claim file referred to a board certified Psychiatrist for Disability Peer Review
• Opinion received as to whether DSM-5 diagnostic criteria met for a diagnosis of PTSD, and whether the claimant meets the PERA disability standard.

Yes

Case Closure/Recommendation
DNCM to complete Case Closure activities. Disability Peer Review Report (or IPE, as applicable) submitted to PERA as claim recommendation

No

Psychological Testing
• Claimant referred to psychological testing with clinical psychologist
• Psychological testing report forwarded to Psychiatrist for use in IPE

Yes

Independent Psych. Eval. (IPE)
• Claimant referred to IPE with board certified Psychiatrist
• Psychiatrist to incorporate psychological testing results into IPE Report

No

Addendum or Additional Assessment Needed