



**Medical Litigation Strategies in High-Exposure
Workers' Compensation Cases**

NSRP Safety / Workers' Compensation Meeting

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**WORKERS' COMPENSATION:
A TWENTY-FIRST CENTURY MISNOMER**

Problematic cases involve employees who are **NON-WORKERS,
and
the individuals receiving most of the compensation are **DOCTORS!****

VEXIS

VEXING, HIGH-**EX**POSURE

WORKERS' COMPENSATION CASES

WITH COMPLEX MEDICAL ISSUES

REALITY: 21ST century medicine is very complex.



Two Fundamental VEXIS Problems

1. **VEXIS** claims are expensive
2. **VEXIS** cases are very hard to close

REALITY: 21ST century medicine is very complex.

Today's typical **VEXIS** claim:

- Multiple body systems
- Claims of multiple coexisting injuries
- Co-morbid chronic, degenerative conditions
- Stacked IDC-9 and CPT codes by “motivated” medical providers
- MMPs: The family “ping-pong party”



THE REAL COST DRIVERS

NEW TECHNOLOGY = HIGHER COSTS

- **New technology and diagnostic modalities provide an enhanced ability to detect subtle and chronic degenerative changes.**
- **Peer-reviewed studies of subjects without back pain find that certain MRI findings occur normally in up to 90% of individuals.¹ Jarvick, J.G., W. Hollingworth, and B. Martin. Rapid magnetic resonance imaging vs. radiographs for patients with low back pain. *JAMA* (2003) 287:2810–2818.**
- **These may be not clinically relevant or false-positive interpretations.**
- **These incidental anatomic findings are not reasonably related to the minor, work-related illness or injury.**
- **MMPs over-interpret the size and significance of such MRI findings.**
 - **Which creates justification for prolonged treatment and disability benefits**
 - **Which then supports indications for overly aggressive surgical intervention**



THE REAL COST DRIVERS

MORE SURGEONS AND SURGICAL OPTIONS = HIGHER COSTS

- **Spine surgery centers and pain management training programs and clinics have proliferated.**
- **According to peer-reviewed medical articles: *The best predictor of the frequency of spinal operations (including fusions) is the number of spine surgeons in a geographic area.***
- **There has been a dramatic increase in the number and scope of spinal fusions, rising 77 percent between 1996 and 2001.**
- **Spinal fusion surgery is expensive, with the average hospital bill more than \$34,000 (national average) for such a procedure (excluding professional fees).**
- **There is little evidence to support spinal fusion in association with diskectomy for patients with herniated disks.**



THE REAL COST DRIVERS

LOW CAUSATION STANDARD PROMOTES LINKAGE

- **An aging work force has, by definition, a high incidence of underlying , chronic degenerative diseases.**
- **Because the causation standard is so low, it is easy to link minor work-related injuries to chronic conditions.**
- **Additionally, such diseases are attributed to work-related “cumulative trauma,” even if “work” consists of the usual activities of daily living.**
- **The scope of minor injuries is enlarged into more ambiguous total body disorders.**
- **These ailments defy objective and reproducible diagnostic verification and do not generally respond to medical interventions.**
- **They justify claims of permanent total disability and awards of lifetime benefits.**

INFLATION OF INJURIES

- Very common when applicant attorneys choose medical providers
- System is “liberally construed” in favor of the applicant
- MMPs inflate minor injury into multiple complex “diseases”
- “Churn” patients — protracted, unnecessary, ineffective treatments
- Extend TD by imposing unrealistic work conditions
- Justify multiple needless and damaging surgical procedures
- Create disability where little or none ever existed

Overly aggressive surgical procedures transform a minor problem into a real disability due to complications.



“One of the main problems with applicant-driven medical care is that medical providers often do the wrong thing — poorly.”



**TRADITIONAL COST CONTAINMENT STRATEGIES
TYPICALLY DO NOT WORK IN VEXIS CASES**

21st century medicine has become very complex. Sophisticated diagnostic testing modalities and complex medical and surgical options:

- Fall outside any Workers' Compensation guidelines or bill review programs**
- Overwhelm the training and expertise of even the most competent case management nurses**
- Exceed the knowledge base of most single-specialty UR physicians or traditional managed-care companies**





THE REAL COST DRIVERS

THE PERMANENT NON-WORKER

- **Patients with open compensation claims have significantly higher costs, more disability, and worse outcomes than similar group health cases.**
- **Once a claim is started, admitting recovery will effectively end a litigated claim.**
- **Many applicants are poorly educated, barely speak English, and have no group health insurance.**
- **Such individuals are easily victimized by overtreatment = MMP annuities.**
- **Such patients see little advantage in returning to work, and instead, use their benefits as de facto “health insurance” through causation linkage.**
- **A significant percentage of individuals who are not seriously injured or disabled at the start of their claim, become disabled by medical and surgical overtreatment and poor-quality services.**



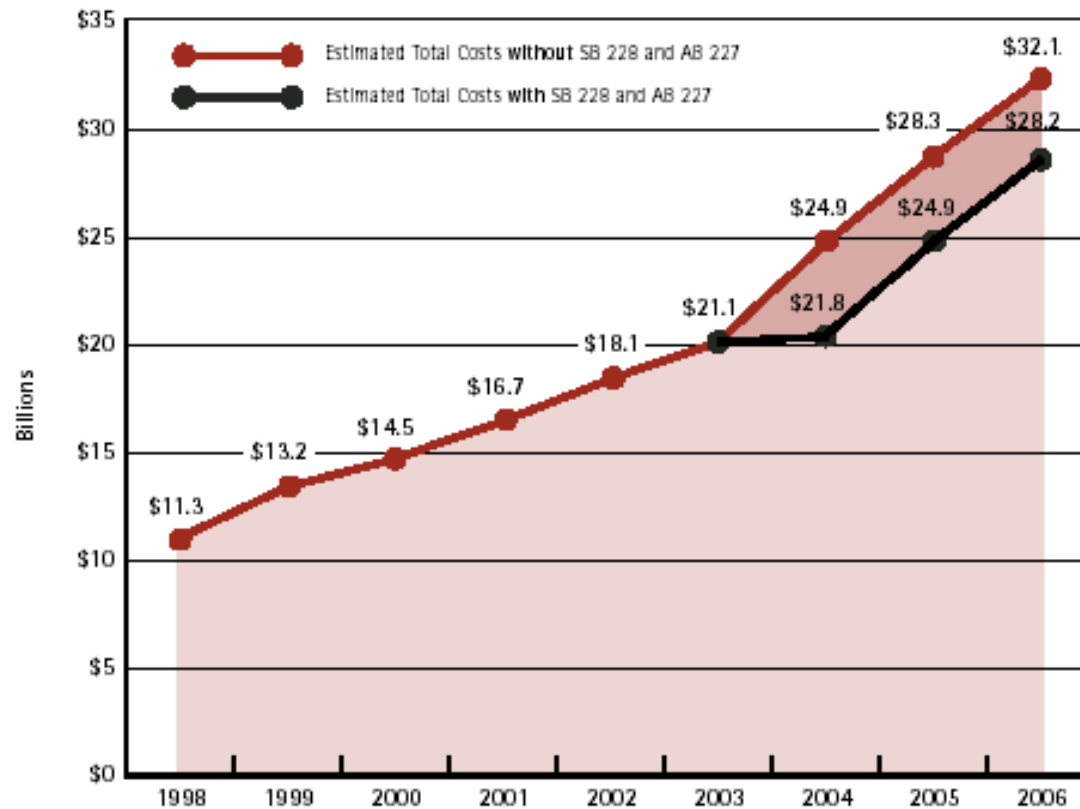
REFORM AIMED AT COST CONTAINMENT USUALLY FAILS

Because it is focused on the **SYMPTOMS** of the problems — high costs — and not the root **CAUSES** of the problems which are:

- A lack of quality medical care
- A lack of medical control of an applicant's care
- Incorrect, inaccurate, and dishonest assessment and reporting
- An increasingly pervasive feeling of entitlement in the minds of some applicants and their representatives

INITIAL REFORM EFFORTS IN CALIFORNIA

Projected Impact of the Passage of California's 2003 Reform Bills



Source: Workers' Compensation Insurance Rating Bureau



The Real Problem: Lack of Medical Control

The Solution: Employers and Payers Must Regain Medical Control

Employers must bring together the medical, legal, and claims management specialists as a multidisciplinary work group to develop and implement a single, integrated action plan to:

- **Identify ineffective and incorrect medical treatments and substandard medical care**
- **Identify unnecessary, unreasonable, and egregious treatment patterns**
- **Challenge exaggerated and incorrect interpretations of diagnostic testing, as well as unwarranted conclusions, which create “justification” for excessive and sometimes radical treatments**
- **Use evidence-based, peer-reviewed studies as medical litigation strategies**
- **W/C litigation briefs should be medical-litigation briefs that rely upon and cite medical evidence and evidence-based, peer reviewed literature—in addition to statutory interpretation and case law—as authority for contentions.**
- **Effect: Bring applicant’s expectations back to reality. Posture case for settlement.**

Case Study #1

- 42 y.o. A/A male warehouse worker. Feb. 1: 6-ft metal pipe fell off shelf, striking his head. Knocked him to the ground. No LOC. No laceration. “Bump” on left parietal area. No neck pain.
- Sent to clinic. No fx. No neck tenderness. Full ROM. No vertigo. No LOC. No amnesia. Neuro exam WNL. L scalp hematoma Neg skull X-rays. Sent home with NSAID, ice, rest, & “head sheet.” Diagnosis: Minor head trauma
- Next day: Headache, slightly lethargic, nauseated, slightly dizzy. Clinic re-exam. Head CT ordered to rule-out subdural: Negative. Diagnosis: Post-concussion Syndrome. Off work for 3 days.

Case Study #1

- Continues minimally improved X 3 weeks. Neuro consult. Notes “minor tremor.” DX: Post-Traumatic Parkinson’s Disease, citing 2003 article from the Mayo Clinic
- Employer requests IME/QME, who agrees that he has early PD, and also agreed that MC article confirmed association between PD with preceding head trauma.
- Employer had coverage for life-time medical care related to PD (Meds, Medical care, testing, eventually deep brain implants, etc.)



Case Study #1

- AXIOMS: Quality of care is poor in W/C
- Never believe any physician's report – even your QME's
- Go back to the beginning of the case to see true events
- Find the “smoking gun” early in the case
- Read and review source documents – **not** just the abstracts!
- Challenge flawed opinions

Case Study #1

- What did 2003 Mayo Clinic article really say?
 - 196 pts in Minn county, who developed PD 1976 – 1995
 - Defined head trauma as loss of consciousness, prolonged amnesia
 - Specifically excluded any subjects with LOC < 1 minute
 - Lag time between head trauma and PD: **21 years**
- Under new evidence standards, evidence-based analysis was successful in rebutting flawed opinions. Case was settled (C & R) for minimal amount, related to one isolated incidence of minor head trauma only.



Case Study #2

- 32 y.o. M/A male, pulling a cart, walking backwards, struck his right scapula on metal pole on June 21. Not witnessed. Didn't report incident.

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Case Study #3

- 38 yo M/A female, part-time worker who was assigned for several half-day shifts in tool cleaning area.

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Case Study #4

- 28 yo C/A incurred a shock on wet grass . . .

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Case Study #4

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