ISSUES & STRATEGIES IN LARGE LOSS CASES

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Divide Large Loss claims into 2 categories:

1. Genuinely catastrophic
2. "DOGS" (Not all "dogs" go to heaven)

Catastrophic Injuries

- Serious motor vehicle accident
- Burns/explosions
- High falls
- Traumatic brain injury
- Failed back post surgery
- Amputations
- Post traumatic stress syndrome
- Drug resistant infections

"DOGS":

- Disproportionately bad outcomes when compared to other, similar injuries
- Seemingly impossible to close
- Excessive litigation
- Physical file fills multiple banker boxes
- Succession of different attorneys
- Unrepresented applicant makes claim his/her full-time job

Red Flags for "DOGS":

- Symptoms grossly out of proportion to initial accident.
- Multiple body parts alleged as injured when accepted claim is for single body part
- Psychosocial factors:
  - Family issues
  - History of substance abuse/drug seeking behavior
  - "Problem" employee
  - History of mental health problems
- "RED FLAG" Doctors – PTP or QME
- "RED FLAG" Attorneys

Regardless of which type of large loss case you are handling:

PICK YOUR BATTLES!

"He will win who knows when to fight and when not to fight."

Sun Tzu
The Art of War

Genuine Catastrophic Injuries:

- Higher dollar value exposure
- Greater scrutiny:
  - Claims administrator: supervisors, claims managers, VP
  - Employers
  - Brokers
  - Reinsurance
- Unique tools:
  - Life plan
  - MSA
  - Structured settlement

Genuine Catastrophic Injuries:

- Extra attention justified:
  - Investigation/witness interviews
  - Surveillance
  - Deposition of applicant
  - Depositions of AMEs or QMEs
  - Depositions of treating doctors
  - Use of experts: Advisory medical vocational

"Ordinary" Cases: Watch for Red Flags/Look for Opportunities

- When reviewing files with lengthy histories there is always a point when the case could have been resolved and a decision was made, or avoided, which resulted in the claim remaining open and ultimately increasing in value, sometimes exponentially.

How are decisions made in your organization?

- Many of our clients are changing their corporate culture to make it easier to identify those points when claims (or issues) can be resolved and to foster an environment which supports seizing those opportunities.

Tension: Fight v. Resolve

Red Flags at Diagnosis Stage:

- **Fibromyalgia** – controversial diagnosis. Unexplained, non-anatomical pain.
- **Reflex Sympathetic Dystrophy (RSD)** OR **Complex Regional Pain Syndrome (CRPS)** – Accepted diagnoses, but often misused in WC cases. Check for OBJECTIVE FINDINGS. Use the tool provided in the AMA Guides, 5th Ed., on page 496. Table 16-16 provides Objective Diagnostic Criteria. If you have 8 or more the diagnosis of RSD or CRPS is "probable."

Objective signs of RSD/CRPS

- Vasomotor changes:
  - Skin color; mottled or cyanotic
  - Skin temperature cool
  - Edema
- Sudomotor changes:
  - Skin dry or overly moist
- Trophic changes:
  - Skin texture smooth, nonelastic
  - Soft tissue atrophy; especially in fingertips
  - Joint stiffness and decreased passive motion
  - Nail changes, blemished curved, talon like
  - Hair growth changes: fall out, longer, finer

Objective signs of RSD/CRPS (cont'd)

- Radiographic signs
  - Radiographs (x-rays): trophic bone changes, osteroporosis
  - Bone scan: findings consistent with CRPS

Q: Has the doctor making the diagnosis made any effort to identify objective signs of RSD or CRPS?

Post-Traumatic Stress Disorder (PTSD)

- Proper diagnosis requires extreme trauma, such as fear of death with no escape.

Traumatic Brain Injury

- Beyond post concussion syndrome. Violent blow to the head or body. Object penetrating skull.

Q: Diagnosis based on injured worker's subjective description of symptoms:

- Memory loss
- Dizziness
- Headaches
- Loss of balance

Sexual Dysfunction and Sleep Disorder

Q: True diagnosis with organic basis or interference with normal functioning due to pain from other injuries?

Problem: True diagnosis may require expensive sleep study, or evaluations by urologist or internal medicine specialist.

Watch for Non-Industrial Comorbidities:

- High blood pressure
- Coronary artery disease
- Diabetes
- Obesity
- Smoking history
- Alcoholism/substance abuse
- Mental health history

Multiple QMEs:

- How many is too many?

Q: To what extent do you need specialized expertise, or is applicant simply using a "shotgun" approach?

Regulation 31.7: Can obtain QME in different specialty with showing of "good cause."

Multiple QMEs (cont'd):

- "Good Cause" is defined as:
  1. Agreement by the parties;
  2. Where an acupuncturist refers the parties to the Medical Unit because disability is in dispute;
  3. When ORDERED by the WCAB;
  4. In an UNREPRESENTED case, and an agreement is reached with input from the Information and Assistance Officer.

Using a SINGLE QME is preferred according to the regulation.

Multiple QMEs (cont'd):

- Strategy
  1. PICK YOUR SPECIALTY: Be first to object and first to request a QME (when possible).

Liberal	Conservative
Chiropractor	Orthopedic surgery
Physical medicine & Rehabilitation	Neurology
Pain management	Occupational Medicine

Multiple QMEs (cont'd):

2. Use Reg 31.7 to:

Get additional QME
OR
Limit additional QMEs

DEPENDING ON THE INDIVIDUAL CASE

To get additional QME, show MEDICAL BASIS for evaluation and seek either agreement or order from WCAB.

Multiple QMEs (cont'd):

- To limit QMEs try to force the applicant to show a medical basis for the additional specialties

Q: Is mere allegation of injury on application enough?

A: Maybe

Permanent Disability:

- Almaraz/Guzman
- Ogilvie
- LC 4662

Almaraz/Guzman

Milpitas Unified School District v. WCAB (Guzman) 75 CCC 837

Elements:

1. AMA Guides Rating;
2. Doctor finds AMA "inaccurate";
3. Rating by ANALOGY using table or method from within the "four corners" of the AMA Guides.

ISSUE:

- What is "inaccurate?"
- Think: Incomplete

Q: Inaccurate compared to what?

The WCAB and the Court of Appeals have not provided any alternate metric against which the AMA Guides rating can be compared.

Q: Can A/G rating be an "add-on?"

The cases contemplate an alternative rating by analogy. Many doctors throw an "A/G" rating on top of the AMA Guides rating.

Q: Can A/G rating "misuse" the AMA Guides?

Can doctor combine lower extremity impairments in prohibition of table 17-2 on p. 526?

Can doctor add impairments when AMA Guides requires combining?

Can doctor place injured worker in DRE category without objective criteria?

Q: % of "loss of use" ratings allowed?

Many doctors apply a percentage of loss of use to the total value of a body part.

Answer: These are <u>all</u> probably allowed but **should** be challenged.

Cannon v. City of Sacramento

(2013) 79 CCC 1

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- Injured worker was police officer
- Diagnosed with plantar fasciitis
- No objective findings/no AMA Guides method of evaluation
- Doctor used "station and gait" to produce 7% WPI

Cannon v. City of Sacramento

- Third district Court of Appeals held:
  - "Extraordinary or complex" cases is NOT the threshold for applying A/G
  - No requirement of objective findings for A/G rating
- How to distinguish *Cannon*:
  - Medically accepted diagnosis?
  - AMA Guides provide method of evaluation?

A/G Strategy

- If WPI is now based largely on overall impact on ADLs, look for **OVERLAP**. Be sure the doctor is not increasing WPI for every body part based on the same ADLs.
- Consider depo of AME/QME:
  - Diagnosis
  - Proper application of AMA Guides
  - Accuracy of AMA Guides (how measured?)
  - Overlapping WPI
- Consider ADVISORY opinion for expert medical opinions.
  - Not admissible, but useful in preparing for deposition of AME/QME.

Ogilvie/Le Boeuf

LeBoeuf v. WCAB (1983) 48 CCC 587

If injury prevented injury worker from being retrained (VR), then injured worker found to be 100% permanently and totally disabled.

Ogilvie v. WCAB (2011) 76 CCC 624

Vocational evidence can be used to rebut diminished future earning capacity ranking in 2005 Schedule for Rating Permanent Disability. No practical guidance regarding how to rebut rating, other than in cases of 100% loss of future earning capacity.

Ogilvie/Le Boeuf (cont'd)

- Some WCALJ's are relying on the VR expert's % of loss of earning capacity as the rebuttal % of PD. NO BINDING SUPPORT FOR THIS APPROACH.
- In *LeBoeuf* situations analysis is required of how much inability to return to work (loss of earning capacity) is actually due to work injury.

LC 4664(a)

The employer shall only be liable for the percentage of permanent disability directly caused by the injury arising out of and occurring in the course of employment.

- Employer is <u>not</u> responsible for:
  - Lack of education
  - Language barrier
  - Labor market

LC 4662(a) Conclusive Presumptions of Permanent Total Disability:

- Loss of both eyes or sight in both eyes
- Loss of both hands or the use thereof
- Practically total paralysis
- Brain injury resulting in permanent mental incapacity

LC 4662(b) "In all other cases, permanent total disability shall be determined in accordance with the fact."

Q: What is "the fact"?

The answer has never been given by the Courts of Appeal or the California Supreme Court.

The WCAB has held that this statute provides a different standard for establishing 100% PD from the rating manual. Doctor (or VR expert?) can conclude injured worker is permanently totally disabled without rating.

BUT

Conclusion must be "substantial evidence."

Strategy: Attack Conclusion

Q: Is medical expert providing vocational opinion?

- **Use your own expert to attack finding of total loss of earning capacity.**
- **Consider investigation/surveillance**

COLA – Cost of Living Adjustment

- 100% PD (permanent total disability) cases and Life Pensions are subject to annual COLA increases commencing January 1 of the year following the date the injured worker becomes entitled to the life pension or permanent total award.
- % of COLA is % increase in State Average Weekly Wage. In last 9 years increase in State AWW has varied from 0% to 5.6%.
- When calculating present value of benefit subject to COLA **NEGOTIATE** the % used annually for the COLA. The DEU will automatically use 4.5%, but this is **ARBITRARY**.

Don't let applicant's attorney argue that 100% PD cases under LC 4662 can't be apportioned

see: *ACME Steel v. WCAB* (Borman) (2013) 78 CCC 751

100% finding based on vocational testimony. AA argued no apportionment since permanent total disability found via rebuttal to FEC ranking in rating schedule. The Court of Appeal found that the judge should have considered apportionment based on the medical evidence to support apportionment.

Q: Would the injury produce permanent total disability in the absence of other factors?

Where Apportionment REALLY Counts?

99% to 100% PTD

69% to 70% Life Pension

3 types of apportionment:

1. LC 4664
2. LC 4663
3. *Benson* between industrial injuries

Benson v. WCAB
74 CCC 113 (2009)

- When Permanent Total disability or Life Pension are at stake, extra investigation or discovery are justified to uncover prior injuries, prior medical treatment, or prior Awards or permanent disability.
  - Index search
  - Deposition(s)
  - Subpoenaed records
  - Private Investigation

Q: When to hire investigator?

A: When there is a lot at stake; when the applicant begs for it:

- "I never leave my house."
- "I don't do any of my own shopping."
- "I can't lift even one pound."

Sometimes surveillance film is valuable because it confirms applicant's allegations.

TTD (Temporary Total Disability)

- **Post-cap**
  - **Applicant is now only entitled to 104 weeks of temporary disability.**
- **Despite the cap it is as important as ever to limit TTD**

The effects of long periods of temporary disability:
- Lack of routine
- Loss of social contact
- De-conditioning from work
- Depression

Nothing turns a routine case into a large loss case like a lengthy period of time off work.

MEDICAL TREATMENT:

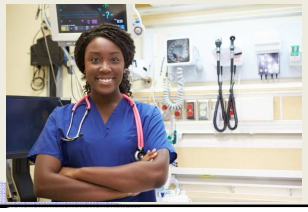
- Medical Management
  - In large loss cases consider using a nurse case manager for the coordination of medical care for multiple body parts among multiple medical treatment providers.
  - But be careful: If you decide to dismiss your nurse case manager it might be more difficult than you think!

Jennifer Patterson v. The Oaks Farm; CIGA (2014) Significant Panel Decision 79 CCC 910

- WCAB found that the nurse case manager was a medical benefit which could not be eliminated by defendant unilaterally.

Medical Management (cont'd)

- But if your nurse case manager is too partisan applicant's counsel will limit contact with applicant, or refuse to work with the nurse case manager. Nothing can prevent your nurse case manager from contacting the Primary Treating Physician, but your nurse case manager can be prevented from contacting applicant or attending appointments.



Medical Management (cont'd)

- In catastrophic cases you might need to develop a **LIFE CARE PLAN**.
- Outlines lifetime medical needs, and provides cost estimate. Used in cases in which injured worker needs lifetime assistance or is institutionalized.
- Can be used to settle future medical care in cases not requiring a Medicare Set-Aside. Can be used in connection with vendor which actually coordinates the care (medical management).

YOUR CASE IS DEPENDENT ON THE QUALITY OF YOUR VENDORS

MEDICARE

Federal law requires that Medicare's interests be "protected" in all settlements which include resolution of medical treatment.

CMS – Centers for Medicare & Medicaid Services

Administers Medicare, and has developed review thresholds and guidelines for protecting Medicare's interests in the form of a Medicare Set-Aside trust. The trust is an amount of the settlement set-aside to cover medical treatment related to the industrial injury. The trust can be managed by a trustee (third party) or by the injured worker.

Submission of MSA to CMS is <u>not</u> a statutory or regulatory requirement

Medicare WCMSA Reference Guide 2014 section 8.0

THE MSA SUBMISSION PROCESS IS VOLUNTARY

BUT
If not submitted/approved MSA:

Medicare is not bound by the settlement and may refuse to pay for medical expenses.

CMS will have a priority right against ANY entity that received a portion of the settlement (including attorneys). *U.S. v. Harris* (2009) (Federal case).

Medicare asserts lien, despite your settlement of future medical care.

CMS Review Thresholds:

- Injured worker eligible for Medicare:
  - Settlement in amount of $25,000 or more
- Injured worker anticipated to be eligible for Medicare w/in 30 months:
  - Settlement in amount of $250,000 or more
- MSA can be paid in lump sum or in the form of a structured settlement

STRUCTURED SETTLEMENTS

- Always consider structured settlement in large value cases. Typically involve large up front payment and then annuity thereafter for lifetime or fixed period of time.
  - Can represent significant cost savings.
  - Can protect injured worker by guaranteeing income.
- **Try to create a "win-win" proposal** in which carrier realizes savings, but injured worker also benefits from payout higher than cost of annuity when spread out over time.

SUMMARY:

- **In typical case** take control and move case forward. Try to control specialty of QME and limit evaluations. Get injured worker back to work and MMI as quickly as possible.
- **Don't get side-tracked** in peripheral fights with injured worker or attorney. Use the WCAB to move case forward and resolve interim disputes when needed, but **AVOID UNNECESSARY LITIGATION.**

Keep your eye on the goal of file closure.

In genuinely catastrophic case

- Rely on your valued partners: The nurse case manager, life plan preparation, MSA vendor and structured settlement broker.
- If your medical experts are not optimum, consider advisory opinions from trusted experts.

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