ManyMedical

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HOW TO CRITIQUE CUMULATIVE TRAUMA CLAIMS & AME/QME REPORTS

A. California Culture: a. CT claims endemic.
   b. How applicant attorneys paid.
   c. UR denials endemic.
   d. Beliefs ingrained & accepted without evidence.
   e. Limits of AMA Guides 5th Edition.

For CT, the job must demand excessive repetition and force beyond normal physiologic limits to cause injury.

B. Cumulative Trauma.

1. Definition: Injury (not pain) that is caused by a job that demands excessive repetition and force beyond physiologic limits.
2. Corollary: Normal, low velocity activities without excessive repetition does not lead to injury.
3. Aging, ie. natural degenerative processes, are not due to cumulative trauma. High incidence of idiopathic rotator cuff tears in people older than 60-years old.
4. Is there substantial evidence to support cumulative trauma disorder? Controversial because there are studies that support both sides of the argument. Most of the studies are of poor quality. Example: Harkness, McFarland study: "mechanical and psychosocial factors predict new onset shoulder pain"; problem with the study: Pain does not equate with injury. Example: occupational risk factors for low back pain: frequent heavy lifting over 25 pounds; problem – focus is pain, not injury.
5. AOE – causal connection between employment and injury (not pain).

6. Carpal tunnel syndrome; cubital tunnel syndrome – accepted in California and CT injuries. Other causative factors frequently missed.
7. Epidemiologic evidence between work – relatedness and musculoskeletal disorders.
    A. Neck: High static loads, extreme work posture.
    B. Shoulder: Highly repetitive work, sustained shoulder posture greater than 60° flexion.
    C. Carpal tunnel syndrome: Highly repetitive work alone or in combination of risk factors (forced and repetition, force and posture), vibrations.
    D. Wrist tendinitis: force, repetition, posture.
    E. Low back pain: Heavy lifting and forceful movements.

8. Pain:
    Subjective
    Somatization: anxiety manifest as pain.
    Chronic wide spread pain.
    Unlikely due to CT
    Psychological factors, low job satisfaction; minimal social support, monotonous work.
    Malingering
    Financial gain.

Bottom line: The injury or lack of injury needs to be proven in Orthopedic AME reports.

C. What to focus on in AME reports:
    1. History – a. Mechanism of injury.
        b. Does it correlate with pleadings? Consistent with prior histories? Has it changed? Body parts added?
        c. Early treatment records.
        d. Has patient responded to treatment? Improved.
        e. Are there prior injuries or WC claims.
        f. Was injury witnessed or reported.
        g. Post-termination.
        h. Was treatment delayed by UR?
        i. Litigated?

    2. Job Description / Job Analysis:
        a. Few jobs lead to CT injuries.

    3. Current complaints:
        a. Do they relate to injury? Proportional?

b. Embellished? Multifocal?

4. Physical Examination:
    a. AMA Guides worthless in determining whether patient truthful or amplifying symptoms.
    b. Pain diagram.
    c. Waddell's sign for lumbar spine.
    d. Brourman's signs: Nonanatomic tenderness determiner if patient magnifies symptoms. (wrist: tender along subcutaneous border of the ulna and Lister's tubercle), the patient exaggerating symptoms.

At this point of the evaluation, I know if the patient has real, objective, organic injury versus non-organic pain without objective support. In the latter situation, the pain may be psychological (eg. somatic where anxiety manifests in pain), or secondary gain. (disgruntled employee seeking financial gain)

5. Testing: (EMG/NCV, MRIs, Ultrasounds)
    a. Reports must be based on substantial medical evidence and proper work-up provides substantial medical evidence.
        1. Reasonable medical probability.
        2. Avoid speculation.
        3. Based on pertinent facts and evidence.
        4. Reasoning in support of conclusions.
    b. Avoids missing pathology that could explain symptoms and provide basis for apportionment.
    c. Gives accurate data for rating reports eg. NCV's gold standard for loss in CTS (carpal tunnel syndrome) and needed for proper rating.
    d. Determines degenerative and pre-existing conditions (Escobedo).
    e. Protects against misinformation and unscrupulous complaints and misleading applicant reports.

6. Medical Records:
    a. Records at the time of injury crucial.
    b. Superior evidence than depositions.
    c. Demonstrate cases that take on a life of their own.

D: RED FLAGS:
    1. Litigated cases.
    2. Compensable consequence injuries:
        a. An injured body part does not cause overuse of another body part. (eg. a knee scope for a meniscal tear doesn't cause the other knee to be "overused").

b. Exceptions: If after hip surgery, the patient trips on their crutches and sprains an ankle.
c. Essex-Lopresti lesion of the wrist, secondary to radial head excision.

3. Multiple subjective orthopedic complaints plus adding in GERD, sleep, Psyche, and sexual dysfunction.
4. Multiple body parts claimed to be injured in low velocity, specific injury of CT claim.
5. Almaraz – Guzman (only consider if asked)
   a. Must be well-reasoned; a report should just say " I think" or "I feel".
   b. AMA Guides deeply flawed (tables from non-orthopedic tests from half century ago, author bias and ignorance of common orthopedic conditions, ignores function and pain.
   UE chapter doesn't mention lateral epicondylitis or subacromial impingement syndrome is poorly and inaccurately determined.
   Why: Modern studies (Mayo Clinic, UCLA) give very different PD
   Because they include pain and function solution page 499, table 16-18 stays within four corners of the Guides.
6. Controversial methods (grip) must be explained based on reasonable medical probability.
7. Controversial diagnoses (Fibromyalgia, TOS, CRPS) Fibromyalgia is not objectively determined.

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