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Deconstructing the ESI Buildup - The Proactive Approach

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The insurance industry faces a financial crisis from injury buildup cases involving epidural steroidal injections. Minor accidents where participants are citing subjective injuries (or in some cases, no injury) are becoming limits cases based on aggressive medical evaluations and treatments. This session will focus on whether these issues are legitimate; how an insurance company evaluates the claim, what the company and its legal counsel can do to get to the truth of the matter; and determine whether it is a claim or a crime.

Part I - What does a typical ESI Buildup claim look like? Is there a criminal element in this situation?

I. The Facts of Loss

A. Light to moderate impact

It all begins with an auto accident. One car hits another and someone is at fault. The damage estimate to the not-at-fault vehicle is normally in the area of \$2500. Case study - \$2800.

B. Minimal or no injury claimed at scene

The passengers in the not-at-fault vehicle claim injury, usually subjective pain/strain. They may not claim injury at the scene, but claim injury at a later date. Case study – no injury claimed at the scene. Claimant – Hispanic male, 52yoa, 6’4”, 175 lb.. Sought initial medical treatment 5 days post-accident with chiropractor where he treated only 8 times, and then had no treatment for the next approx. 30 days.

II. Post loss timeline

A. Claimant is attorney represented

The not-at-fault parties are directed to an attorney. This usually happens by a referral from the tow truck driver, EMT, accident investigator, or anyone else present at the

accident scene. The referral may also be made by a “capper/runner” who obtains the accident report either legally or surreptitiously and makes contact with the not-at-fault parties, suggesting that they might want to contact an attorney. Any of these referring parties is normally compensated for their referral. Case study – attorney represented approx. 6 weeks post-accident.

B. Claimant is referred to a chiropractor

Once the not-at-fault parties meet with the attorney, they are then referred to a chiropractor. The chiropractor, in his “examination” notes that each of the parties has subjective injury requiring 4-6 weeks of treatment. Case study – Diagnosis: Sprain/strain on unspecified parts of the back, unspecified site elbow or shoulder.

C. Chiropractic treatment produced insufficient results.

The chiropractor reviews the treatments but notes little to no improvement. This is normally noted in his daily notes. (However, the treatment protocol seldom changes in spite of lack of improvement.) Treatment costs between \$3000 and \$5000 per patient. Case study - \$3720. Treatment – hot/cold packs, electric stimulation, massage therapy, therapeutic procedures. No change throughout treatment. Treated from 06/27 to 08/27.

D. Claimant is referred to a pain management specialist

In order to better serve his patient(s), the chiropractor will refer the patient(s) to a pain management specialist, normally a local MD. This medical provider is either openly or covertly linked to the referring chiropractor.

E. Claimant is referred out for MRI

In order to properly diagnose the problem, the pain management provider will then refer the patient(s) to an MRI facility, normally one that has been used in the past by the provider. Case study - \$5470.

F. MRI is read by medical professional who diagnoses spinal issues

Once the MRI has been completed, the results are sent to a radiologist. The radiologist will diagnose any back/spinal problem as related to trauma received in the auto accident. The diagnosis will be sent to the pain management provider. Case study - Finding – L5-S1 central posterior disc herniation measuring 5mm, with evidence of S1 nerve root effacement. L4-5 disc bulge measuring 2mm. Left elbow bone contusion and post traumatic capsular-synovitis.

G. Medical professional recommends epidural injections to reduce/eliminate pain

The pain management provider accepts the findings of the radiologist and prescribes epidural steroidal injections as the only way to manage the pain.

H. Injections are given

Once the diagnosis and pain management prescription is recommended and accepted by the patient(s), the injections are given. Case study - \$10754. 2 injections – 1 week apart.

III. Demand for policy limits is made based on medical history above

A. Demand is sent to the carrier by the attorney.

The demand is invariably for policy limits. Case Study - \$20,000

Part II – What is an Epidural Steroid Injection

I. Epidural Steroid Injections (“ESI’s”)

A. Defining ESI’s

An ESI is a procedure which can help relieve neck, arm, back and leg pain caused by inflamed spinal nerves.

Epidural steroid injections (ESIs) are a common treatment option for many forms of low back pain and leg pain. They have been used for low back problems since 1952 and are still an integral part of the non-surgical management of sciatica and low back pain.

The goal of the injection is pain relief; at times the injection alone is sufficient to provide relief, but commonly an epidural steroid injection is used in combination with a comprehensive rehabilitation program to provide additional benefits. In addition to the low back (the lumbar region), epidural steroid injections are used to ease pain experienced in the neck (cervical) region and in the mid spine (thoracic) region.

B. Common conditions treated by ESI’s

May be performed to relieve pain which is caused by:

- Spinal stenosis;
- Spondylolysis; or
- Disc herniation/Disc Degeneration
- Sciatica

II. Candidates for ESI’s

A. Spinal Stenosis

- Spinal stenosis is a narrowing of the open spaces within your spine, which can put pressure on your spinal cord and the nerves that travel

through the spine. Spinal stenosis occurs most often in the neck and lower back.

- While some people have no signs or symptoms, spinal stenosis can cause pain, numbness, muscle weakness, and problems with bladder or bowel function.
- Spinal stenosis is most commonly caused by wear-and-tear changes in the spine related to aging. In severe cases of spinal stenosis, doctors may recommend surgery to create additional space for the spinal cord or nerves.

B. Spondylolysis

- Spondylolysis is a specific defect in the connection between vertebrae, the bones that make up the spinal column. This defect can lead to small stress fractures (breaks) in the vertebrae that can weaken the bones so much that one slips out of place, a condition called spondylolisthesis. Spondylolysis is a very common cause of low back pain.

What causes spondylolysis?

- Spondylolysis results from a weakness in a section of the vertebra called the pars interarticularis, the thin piece of bone that connects the upper and lower segments of the facet joints. Facet joints link the vertebrae directly above and below to form a working unit that permits movement of the spine.
- The exact cause of the weakness of the pars interarticularis is unknown. One theory points to genetics (heredity) as a factor, suggesting that some people are born with thin vertebrae, which places them at higher risk for fractures. Another theory suggests that repetitive trauma to the lower back can weaken the pars interarticularis.

C. Herniated/Degenerative Discs

- A herniated disk refers to a problem with one of the rubbery cushions (disks) between the individual bones (vertebrae) that stack up to make your spine.
- A spinal disk is a little like a jelly donut, with a softer center encased within a tougher exterior. Sometimes called a slipped disk or a ruptured disk, a herniated disk occurs when some of the softer "jelly" pushes out through a crack in the tougher exterior.

- A herniated disk can irritate nearby nerves and result in pain, numbness or weakness in an arm or leg. On the other hand, many people experience no symptoms from a herniated disk. Most people who have a herniated disk don't need surgery to correct the problem.
- **Disk herniation is most often the result of a gradual, aging-related wear and tear called disk degeneration.** As you age, your spinal disks lose some of their water content. That makes them less flexible and more prone to tearing or rupturing with even a minor strain or twist.
- Most people can't pinpoint the exact cause of their herniated disk. Sometimes, using your back muscles instead of your leg and thigh muscles to lift large, heavy objects can lead to a herniated disk, as can twisting and turning while lifting. **Rarely, a traumatic event such as a fall or a blow to the back can cause a herniated disk.**

D. Sciatica

- Sciatica refers to pain that radiates along the path of the sciatic nerve — which branches from your lower back through your hips and buttocks and down each leg. Typically, sciatica affects only one side of your body.
- Sciatica most commonly occurs when a herniated disk or a bone spur on the spine compresses part of the nerve. This causes inflammation, pain and often some numbness in the affected leg.
- Although the pain associated with sciatica can be severe, most cases resolve with just conservative treatments in a few weeks. People who continue to have severe sciatica after six weeks of treatment might be helped by surgery to relieve the pressure on the nerve.

Part III – Legal Strategies

The purpose of this section is to initiate and foster discussion among the group aimed at the development of a coordinated and systematic approach and the selection of an appropriate legal strategy in the effective handling of epidural steroid injection buildup cases.

Recognition - What are the Hallmarks of a “Buildup” case? (Referral Pattern?)

What strategies have worked in the effective management of such claims?

What strategies have failed in the effective management of such claims?

How do you develop strategies for handling suspected ESI Buildup claims?

Typical:

- Low speed or minor impact collision
- Chiropractic involvement
- Physical Therapy
- Referral to X-ray, MRI generally not supported by fact based medical evidence
- Over-read MRI
- Referral to Orthopedic, Neuro-Surgeon or Pain Management Physician
- Additional “diagnostic” testing
- Opinion to proceed to ESI
- Multiple ESI events – many reporting patient improvement
- Continued complaints of pain despite the reports of improvement
- Referral to surgeon for surgery opinion
- Recommendation for costly surgery
- Surgery recommendation sometimes at facility the surgeon owns or has financial relationship in.
- Demands which increase over-time

Recognizing the Factual and Legal Issues – Singular vs. Complex/ Project Claims

- First Party vs. Third Party obligations
- Risk Assessment

Factual Data/Non-legal Research – Identifying the Players

Intelligence Gathering/Background Information

Sources:

- Internal and Analytics
- SIU/NICB
- Medical Task Forces
- Fraud Bureau – (where permitted)
- Informants/Whistleblowers
- Examination Under Oath
- Recorded Statements
- Deposition Before Suit or to Investigate Claim (where permitted)
- Litigation

Corporate or other legal entity status

- Secretary of State – status of entity to legally operate in the jurisdiction
 - Owner, Managers, Agents for SOP
- Comptroller of Public Accounts
 - Officer’s, Director’s,
 - Determine if any relationships exist – Why?
 - (Such as Medical and Litigation Funding owned/controlled by physician or attorney)

Potential Impact on “Paid & Incurred” and what may be admissible at trial
Security & Exchange Commission
Attain all filings made with the SEC – Key Employee’s, Investor’s,
Shareholder’s
State and Federal Tax ID’s
Identification of Internal Data
Analytics – Identifying Your Sources of Intelligence and Exposure
Pattern Analysis – Critical in Determining the Best Strategy
Web-site Review
Social Media Investigation (where permitted)
Prior Litigation filings (including divorce records)
Attempt to determine if policy limit information was attained within days of the
accident. See Arizona Corporations

Legal Data/Legal Research

Statutory Provisions
Criminal and Civil
Possible/Probable Evidentiary Issues
Seek out all potential sources including those more obscure (eg. State
Insurance Codes)
Common Law
Familiarity with current case law and trends
Regulatory Provisions
Exclusive Remedy Provisions
Mandatory Remedy Provisions

Commitment to Seeing the Case/Project Through Conclusion

Short and Long Term Cost vs. Benefit – Risk Tolerance
What are your legal obligations?
What is the cost of doing nothing?

Analysis of Jurisdiction and Venue Requirements

Litigation – Passive or aggressive approach
Civil or Criminal roadmaps
Who should be involved and when
Arbitration – mandatory vs. voluntarily
Regulatory – What regulations control attorney, physician and facility conduct.
Administrative
Medical Boards
State Bar
Fraud Bureau (mandatory/permissive reporting requirements)

Assessment of Weaknesses and Strengths of Each Proposed Strategy

Criminal vs. Civil (Arbitration)

Phased progression
Investigation
EUO, Recorded Statements, Factual Analysis – Analytics
Passive/Aggressive
Risk Assessment

Assessment of Weaknesses and Strengths of Your Case – Legal & Factual

What does the evidence support?

Assessment of the Players

Will they be strong adversaries
Have they had disciplinary issues
Do they have money issues
How well do they present at deposition/trial

Careful Expert Selection and Management

Objectivity of the Expert
Vetting the Expert
Cost Management
Testifying vs. Consulting Experts
Non-Disclosure of Consulting Expert Opinions
Communications with the expert
Who should engage and communicate with the expert