Non-Musculoskeletal MMI/IR Case-Based Webinar
Module 6

Instructions

This document contains the Non-Musculoskeletal MMI/IR cases that will be addressed during the upcoming case-based webinar.

It's imperative that you work the cases in advance of participating in the webinar. The solutions to the cases will be discussed during the webinar. Please note any questions you have about these cases while you are working them.

Disclaimer

The material presented in this webinar is made available by the Texas Department of Insurance - Division of Workers' Compensation (TDI-DWC) for educational purposes only. The material is not intended to represent the only method or procedure appropriate for the medical situations discussed. Rather, it is intended to present an approach, view, statement, or opinion of the faculty, which may be helpful to others who face similar situations.

Non-Musculoskeletal MMI/IR Case 1

Traumatic Brain Injury

History of Injury
Injured employee fell 20 feet from scaffolding
Injuries sustained were:

- Traumatic brain injury with GCS 7/15
- Initial CT imaging of the head demonstrated
    - Small left temporal epidural hematoma with acute depressed (4 mm) skull fracture
    - Right frontal / temporal lobe hemorrhagic contusion (contra coup lesion)
    - No diffuse swelling or midline shift
- Initial GCS was 7/15
- Intubated and treated in ICU for 14 days
- Increased intracranial pressure (ICP) treated with mannitol.

- Craniotomy to elevate skull fracture.
- After 36 hours of LOC, was confused and intermittently combative, so he remained sedated
- On prophylactic Keppra x 14 days
- Initiated PT, OT, and Speech / Language Therapy as level of responsiveness improved
- Transitioned from NICU to the floor, inpatient rehabilitation for 4 weeks, then CARF accredited out-patient cognitive behavioral therapy for 6 months – completed 9 months post injury
- Over the year of formal treatment, confusion / orientation, impulsivity and safety awareness improved, but with some residual cognitive difficulties and mood lability.
- At 6 months after the DOI, the claimant had a witnessed Grand Mal seizure while in therapy. He subsequently suffered intermittent minor focal motor seizures in the right upper extremity
- EEG confirmed abnormal seizure activity in the left temporal lobe.
- Neurologist started the claimant on different anti-seizure medications, modifying over the following six months to eight months.
- There were no recurrences of Grand Mal seizures
- After titration of meds, there were intermittent, brief, mild focal motor seizures.
- At one year post-injury, the neurologist switched to every 6 month follow up.
- At 18 months post injury, the neurologist switched to every 6 mnth follow up.

- **DD Evaluation – 18 months post-DOI**
  - The IE has returned to work with some changes in duties; keeps a notebook and uses his phone as a memory aid.
  - He reports he functions at work, as the things he does are based on prior / old memory
  - He has more difficulties in new situations or social situations, and those can make him anxious.
  - He reported to the DD that by returning to work and figuring out how to compensate, he believes he has improved; he was promoted a few weeks prior to the exam.
- **DD Evaluation - EXAM**
  - Alert and oriented x 4
  - Mood / affect within normal limits, but appears anxious
  - Speech is without dysarthria
  - Mild difficulty following multi-step command.
  - Mild difficulty naming objects and remembering spans of numbers
  - No other obvious receptive or expressive aphasia
  - Cranial nerve function intact
  - Gait and Cerebellar Exam remarkably normal

- No sensory / motor deficits
- No spasticity, hyperreflexia, clonus, and negative Hoffman's / Babinski test
- No evidence of a movement disorder
- DD considered the medical evidence in the records, the certifying exam and the EBM.
- **Ordered Neuropsychological evaluation**
- Results were a valid representation with good effort, consistent with imaging and the records.
- Results consistent with residual **mild cognitive deficit** and **minimal anxiety in social situations.**
- **DD Ordered MRI with contrast including IAC**
- Imaging was compared to the CT of the head at acute care hospital
- There were no acute / subacute findings
- There was encephalomalacia seen at the inferior lateral left temporal area
- The skull fracture was healed and aligned
- No residual abnormalities in the brain on the right

What should the DD consider as the compensable injury?
In this case: consider Traumatic Brain Injury – Severe

Considering the compensable diagnosis and the evidence based medicine, what is the date of MMI for this case?

A. 9 months
B. 12 months
C. 18 months

Considering the compensable diagnosis and the evidence based medicine, what are the <u>appropriate impairment percentage ranges</u> for this case?

For Mental Status Impairment? ___% to ___%
For Epilepsy / Seizures? ___% to ___%
The above combined for whole Person? ___% to ___%

From the appropriate range(s) you would pick the IR percentage within the range that best fits clinical condition of IE.

Non-Musculoskeletal MMI/IR Case 2

Post-Traumatic Stress Disorder (PTSD)

History of Injury

- Convenience store clerk robbed and assaulted at gunpoint
- Diagnosed and treated for PTSD
- Treatment included focused cognitive behavioral therapy and Lexapro SSRI
- Psychological evaluation at MMI 12 months post injury:
    - Complains of disrupted sleep due to nightmares about the robbery
    - Met other criteria B - E for DSM-V DX of PTSD
    - Had RTW in a job as retail stock clerk

DD Evaluation

- Currently reports that therapy and medication have been somewhat helpful, but feels hopeless about future and disinterested in activities previously found enjoyable
- Wife reports he is "jumpy" and startles easily.
- Obsessively ensures that doors are locked and hypervigilant about knowing where wife is / that she is safe
- Mood highly irritable and fighting much more than normal with wife

History of Injury

- Not spending as much time with friends, including weekly "guys night out"
- Wife also reports he has begun to drink 5-6 alcoholic beverages most evenings, when he previously abstained
- Able to perform most basic ADLs independently, but requires reminders ~ 25 % of the time
- Has returned to work in a different capacity, but is reported to have difficulty getting to work on time (different than prior job performance)

DD refers for Psychological Testing. WHY?

- Validate if PTSD is the correct diagnosis.
- Criterion H of DSM-V is that there is no better – alternate explanations for the complaints
- Assess if MMI has been reached IF PTSD is correct
- Assign appropriate IR based on an OBJECTIVE assessment – claimant history alone is NOT reliable nor can be validated

Psychological Testing:

- Testing was a valid representation of effort without overreporting or significant atypical symptoms.
- Results of clinical interview and testing, including MMPI-2-RF consistent with
    - DSM-5 criteria for PTSD
    - Emotional disturbance that impairs some, but not all useful functioning in the 4 spheres of:
        - ADLs,
        - Social
        - Concentration / pace
        - Adaptation

On the MMI date, what is the appropriate percentage range of impairment Rating?

_____% to ____%

From the appropriate range you would pick the IR percentage within the range that best fits clinical condition of IE for the IE's final whole person impairment rating.