PROGRAM PERFORMANCE: 2017 CASE STUDIES

1. **A bricklayer laid block for most of his career.** Over time he began to have persistent back pain. Eventually ice, ibuprophen and stretching no longer alleviated his symptoms and he knew he had to see a doctor. He informed his employer who assisted in making an appointment at a designated Occupational Medicine Clinic within the Exclusive Provider Organization (EPO). After investigating the claim and reviewing his prior medical records the insurer accepted liability for the repetitive back injury, also known as a *Gillette* injury.

   The initial evaluation included an MRI scan which revealed a single level disc herniation in his low back. The worker was sent with the MRI scan to see an EPO back specialist who recommended surgery. The insurer approved the procedure which occurred the following week. Following the surgery a short course of pain medication was provided along with physical therapy, and the contractor provided light duty work. The employee stayed within his restrictions and gradually performed heavier work. Once the recovery was complete the bricklayer returned to his pre-injury job, wages, and benefits.

2. **A carpenter suffered for years with a sore left hip that felt unstable whenever he got up from kneeling.** He didn't feel much pain so he didn't complain. After many years of working off and on for different contractors, he stood up on a specific day from the work he was doing while kneeling and heard his hip "snap like a rubber band". He felt severe pain beyond the usual soreness of the past.

   The company's Safety Director immediately took him to the designated Exclusive Provider Organization (EPO) clinic. The treating doctor referred him to a surgeon who was in the same EPO facility. Both doctors described the injury as a specific injury at work which occurred that day when he stood up from kneeling. Pain medication and a release to sedentary work were given. He was not allowed to drive or operate equipment pending surgery and further treatment.

   The employer filed the injury report and the release to sedentary work the next day. The EPO facility also forwarded the medical records and surgical recommendation to the insurer. Surgery was approved and performed the following week. The employer was unable to provide light duty work so the insurer paid wage loss benefits. He began driving again and his restrictions were gradually increased to "moderately heavy work". The employer could now provide appropriate job duties. When these restrictions became permanent the company moved their employee into a different union position within the company at journeyman wages and benefits.

3. **The program received a letter from an attorney complaining that the insurer was not paying temporary total disability benefits after the injured worker was laid off from a light duty job.** He argued that although the layoff was an expected seasonal event his client's restrictions entitled him to wage loss benefits. The facilitator called the adjuster to review the case law regarding this particular situation, which appeared to support the attorney's position. After getting confirmation from the insurer's attorney, the adjuster willingly commenced payment of wage loss benefits.

4. **An employee filed an incident report after tripping on materials at the work site.** Several weeks later he made a claim for knee problems he believed were related to the incident. The employer submitted a First Report of Injury to their insurer.

   After conducting their investigation the insurer denied liability citing significant pre-existing knee conditions contained in the medical records. The short period of medical treatment was paid for by the union's Health and Welfare Fund pending the outcome of the disputed claim. The employee fully recovered and went back to full duty work for a new employer.

   The parties retained attorneys who requested a facilitation to discuss the disputed claim. Both sides were well prepared for the meeting and motivated to settle the case. The employer, the employee and the insurer attended the meeting with their attorneys, which after several hours of intense negotiations resulted in a full, final and complete settlement of the case, including the intervention claim by the union's Fund.

5. **An employee was helping lift materials into the back of a truck when he began to experience pain in his low back.** The employer filed the First Report of Injury with their insurer, the claim was accepted and proper benefits were paid.

   A number of months after the injury the employee complained about knee, neck and shoulder pain. The insurer denied liability for these conditions and the parties requested a neutral medical examination through the program. The neutral doctor found that the low back condition was work-related, but that the knee, neck and shoulder pain were pre-existing conditions unrelated to the accepted claim.

   A mediation session with a program mediator was scheduled to attempt settlement. The mediator helped the parties settle the claim at the session, but the settlement documents were held up while the insurer's attorney negotiated with the medical providers who treated the knee, neck and shoulder conditions. Eventually those negotiations were completed and the mediator received a Stipulation for Settlement and then signed the Award.

6. **An employee made a claim for benefits six months after he was laid off.** He alleged that he injured his low back when he jumped off a crane tread a couple months before the layoff. The initial medical records for treatment two weeks after the claimed date of injury reported a slip and fall at his home was the cause for his pain. Records after the layoff related the pain to the jump from the tread. During the insurer's investigation the employee's named witnesses stated that they were unaware of any injury at work. Based on the investigation the insurer denied liability for the claim.

   The case went through the program's entire dispute resolution process including a full hearing before an arbitrator. After considering the conflicting testimony of the witnesses and the inconsistent history given by the employee in the medical records the arbitrator found the employee's claim was not credible and upheld the insurer's denial of liability.

7. **A carpenter was injured on the job and required emergency care for a fractured hand, a fractured vertebra in his neck, and the loss of a portion of his ear.** The doctors stabilized the fractures and pieced back the damaged ear. The ear would require a significant amount of wound care which home nursing services could not provide. The injured worker's spouse agreed to be trained by the doctor and the nursing staff on how to properly care for the wound.

   The insurer paid for the medical care provided by the doctors, paid for wage loss benefits, and assigned a UCWCP Qualified Rehabilitation Consultant (QRC) who was a registered nurse. The wife kept meticulous notes about the wound care including the expenses for supplies, her time providing care, and the mileage for medical appointments. She submitted her itemized claims to the insurer, but the insurer refused to pay for the wound care claim. She asked the QRC what could be done and was told to call the program's dispute resolution facilitator.

   During the lengthy initial call the facilitator reviewed all aspects of the case. He discovered that the average weekly wage was incorrectly calculated resulting in an underpayment of benefits. The claimed value of the wound care was also discussed. He contacted the adjuster about the issues and she agreed to pay wage loss benefits using the statutory construction industry formula for calculating the average weekly wage. She also agreed to consider the possible legal basis for the payment to a spouse for wound care. The parties, however, were very far apart on what should be paid for the care.

   The facilitator asked the QRC to research the rate paid to home care nurses trained in wound care. The QRC provided the information, but discovered that home service would not make the required number of visits. After sharing this information with the parties, the facilitator made a determination on the value of the care and served notice of his decision. The parties agreed to accept the facilitator's calculation.

8. **The attorneys for the parties in a denied low back claim requested a Dispute Resolution Examination by a neurosurgeon on the program's neutral doctor list.** The employee's attorney provided medical records that supported the claim that a back injury resulted from the work he performed for the employer. The defense attorney provided medical records that the employee had a pre-existing low back condition for which he received treatment before working for the employer. The neutral examiner agreed that the employee had a pre-existing condition, but that his current employment permanently aggravated it resulting in his disability and need for treatment. The parties reviewed the report and submitted a Stipulation for Settlement resolving the issues to date and providing that the insurer would pay ongoing benefits.

9. **A Laborer strained his back lifting materials on the job.** An "incident only" report was sent to the insurer, as no medical care was needed. Eventually his symptoms worsened and the employer sent him to an Exclusive Provider Organization (EPO) physician for medical treatment. The insurer accepted the claim because of the documentation provided by the employer.

   The employee was later referred to an orthopedic back specialist who recommended surgery. The insurer contacted the program's Dispute Resolution Facilitator to request a neutral physician's opinion regarding the surgery. A Dispute Resolution Examination (DRE) was expedited due to the surgery recommendation. Medical records and the Facilitator's cover letter explaining the issues were provided to the neutral physician within days.

   The neutral examiner's report was issued two weeks later, with the specialist also recommending surgery. The insurer immediately approved the request and following the successful surgery the employer provided their employee with union work within his restrictions at full scale and benefits.

10. **An Operating Engineer injured his low back at work.** The claim was filed by the employer and accepted by the insurer. After receiving medical care and a small amount of wage loss benefits he returned to full duty work. The insurer closed the case as a resolved temporary injury.

    At the end of the season a number of employees were laid off including the employee who had injured his back. He collected unemployment and returned to the employer the following spring. He worked his regular duties until his next seasonal layoff. Approximately one month after their layoff he returned to the doctor with low back pain. The insurer denied that the treatment was related to the original injury or to any new injury. The Union Health and Welfare Fund (Union Fund) picked up the medical costs with the agreement that their interests would be protected in any workers' compensation claim.

    Once the claim was filed by the employee's attorney the insurer also assigned counsel. The attorneys brought the matter to the UCWCP for resolution. Following a conference call between

the attorneys and the Dispute Resolution Facilitator a deposition of the employee took place, medical records were gathered and a Dispute Resolution Examination (DRE) took place. The attorneys decided to submit a joint letter for the neutral doctor's consideration.

The doctor's report found that there was no new injury, but that the original injury was a substantial contributing factor for the current need for treatment. The insurer reimbursed the Union Fund and agreed to pay for ongoing treatment. A Stipulation for Settlement for the to-date agreement was presented and signed by a program arbitrator.