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TRAUMATIC BRAIN INJURY CLAIMS: USE OF NEUROPSYCHOLOGY EXPERT TO EVALUATE IF REAL OR BOGUS

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Cases involving severe to moderate traumatic brain injuries are generally easy to identify soon after the accident. The company driver may report that the claimant was unconscious or seriously injured. In such cases the claimant will be taken from the scene of the accident by ambulance and the EMS attendant, and/or emergency room physicians will document problems suggestive of brain injury (such as loss of consciousness, lack of responsiveness and low Glasgow Coma). The company may even call for an emergency response team to go to the scene of the accident. In these cases, the company or insurer knows they are probably dealing with a brain injury case and can prepare their defense of the claim accordingly.

Cases involving mild traumatic brain injuries are harder for companies and insurers to identify. The company driver may report this as a minor accident. The driver may have spoken to the claimant at the scene of the accident and reported back to the company or the insurer that the claimant did not appear to be hurt. Based on this initial report, the trucking company or insurer may or may not conduct an emergency response to gather more information at the scene of the accident. Despite the lack of early indicators, companies and insurers sometimes find themselves facing a mild traumatic brain injury case once the lawsuit is filed a year after the accident.

This panel will explore ways to identify mild traumatic brain injury cases soon after the accident. Further, the panel will identify and discuss some of the available diagnostic testing and discovery options, including the use of the neuropsychology expert, to try to distinguish the true mild traumatic brain from the bogus claim.

How are mild TBI’s defined

The attached chart shows categories of mild TBI’s. A mild TBI has been called the invisible injury because it can be diagnosed when the claimant may not have even suffered direct trauma to his head. The initial treating doctors may not even consider whether the claimant suffered a concussion. As such, cognitive assessments or diagnostic testing, if even performed, may be reported as normal. Yet, the claimant still complains of headaches, or other issues such as memory problems, confusion, forgetfulness or dizziness since the accident.

How to identify the mild TBI claim before the lawsuit

Studies show that 95% of mild traumatic brain injuries resolve within 3 months.

Delayed onset of symptoms does not happen with a true traumatic brain injury. In true mild traumatic brain injury cases, chemicals affecting the brain are released immediately after the injury.

The scenario that we are exploring is when the company driver reports the accident as minor with no identifiable injury to the claimant. The police report does not list any injuries at the scene.
The first contact with the claimant is usually through a phone call to request an interview. What should the company representative ask the plaintiff in the interview to look for as an indicator of a possible mild TBI claim in the future?

- Mechanism of injury
- Any striking of the head
- Any loss of consciousness or altered state
- If so, how long
- Were you interviewed by EMS
- Were you taken to the hospital emergency room
- Was any testing done on your head
- What symptoms did you have
- What symptoms are you currently having
- Are symptoms improving or worsening
- Does the Claimant have a history of any head trauma or TBI

Positive answers to any of these questions by the claimant should indicate to the company representative that further steps need to be taken to protect against the claimant later claiming a mild TBI.

The next step is gathering medical records. Typically, the company representative starts to receive medical records from claimant’s counsel or requests records through authorizations provided by the claimant.

In addition to the medical providers identified by the claimant, the company representative should request EMS and ER records as they provide the first information on any reporting of head trauma, loss of consciousness or complaints. They have information on functionality of the claimant at the scene and shortly thereafter. The adjuster should conduct an initial social media search to preserve any information and photos that may later be deleted.

As the records come in the adjusters should look for:

- Direct trauma to Claimant’s head, including impact with the windshield
- Brief loss of consciousness or altered state
- Any reports of confusion at the scene
- Any records containing a Glasgow Coma Score registered at the scene and/or hospital
- Diagnosis of concussion or PTSD
- Complaints of depression, memory problems, headaches, dizziness
- Still reporting symptoms of headaches, memory or concentration issues, are symptoms getting worse.
- Claimant’s reporting of any prior history of mental or emotional difficulties
- Claimant’s medical history, including stroke, diabetes, migraines, etc…
What to do when indicators of a possible mild TBI claim are found

Retain counsel and order surveillance if the claimant and counsel are not providing information and not cooperating – may be hiding something.

Hire experts - benefits:

- You get your choice of the best experts prior to claimant’s counsel
- Experts can review medicals to assist in rooting out if TBI claim being set up
- Experts can guide you in when to conduct IMEs by a neuropsychologist and medical doctor.

What to do when the lawsuit is filed

Now, lawsuit is filed, what to do next:

Take Plaintiff’s Videotaped Deposition as soon as possible.

Depose the plaintiff quickly to minimize plaintiff’s opportunity to review records and pick up terminology. Plaintiffs fabricating claims often learn more as the case progresses and can mimic symptoms their doctors identify as “typical” of brain injuries. By documenting their status early, it is less likely they have perfected their craft and you have a “baseline” to compare later conduct. In addition, because brain injuries do not get worse with time, documenting plaintiff’s status as early as possible either serves as a “floor” for their presentation, or provides a useful point of comparison if they try to increase their symptoms as the case progresses. For these reasons, it is highly recommended that the plaintiff’s deposition be videotaped. Other advantages of video-taping the plaintiff’s deposition are:

- The video will preserve Plaintiff’s current appearance and testimony in case he attempts to exaggerate his injuries at trial
- Your client’s decision makers will have an opportunity to view and assess the Plaintiff’s appearance, testimony and cognitive condition prior to mediation and trial
- The video can be used for a focus group or mock trial

Document requests are now available. More records are now available, consult with expert on records to assist in preparation for deposition of plaintiff and medical providers and opposing Neuropsychologist, such as:

- Underlying documentation and test results for neuropsychological testing
- Answers to individual questions on MMPI and personality testing
- School records – transcripts and any documentation of performance testing
- Employment testing and attendance records

Receipt of the Plaintiff’s Neuropsychology Report – What to look for:

- Validity Testing (to check for magnification if symptoms)
- Embedded test, i.e., memory etc.
Review with expert the Neuropsychology report from plaintiff’s expert

- What testing to look for
- Obtain a preview of your expert’s opinions
- Do we need a neuropsychology IME?
- Do we need to redo the testing? Testing may confirm plaintiff’s case
- Make sure to obtain the underlying data from the testing
- Should and can we do retesting on the plaintiff? 18 mo. – 2 years later? Declines should not occur. If declines are found during the retesting then other factors are in play, i.e. dementia in older claimants
- Can testing show a road map of the injury? Does the injury claim need to correlate to a certain part of the brain being injured?

Issues to consider in IME doctor testing of plaintiff:

- practice effect
- taking tests for the second time
- what tests and when given
- give alternate tests

Exacerbating factors to TBI claims to look for in the records:

- substance abuse
- concurrent health problems
- treatable health issues
- preexisting brain injury
- preexisting psychological or psychiatric difficulties
- preexisting learning difficulties
- Does claimant fall into a known risk group that makes recovery more difficult, such groups include:
  - Individuals over 65
  - Victims of prior or subsequent head trauma

What testing other than neuropsychological testing is relevant?

- Is baseline testing for athletes available?

New technology and tests are being introduced. The battle ground in many cases is the accepted testing versus the new technologies.

- Diffusion Tensor Imaging
- Diffusion Kurtosis Imaging
- Quantitative MRI
- Functional MRI
- Eye Tracking Synchronization Device
- Tesla MRI
- PET/SPECT Scans
If testing not available, how do we get baseline of plaintiff’s functionality before the accident? School records, employment records, disability records mental health records. Depose, teachers, co-workers, boss, family and friends.

Retain a private investigator specializing in social media investigation. Social media searches should be performed as soon as possible after the injury occurs. Then, the investigator should conduct regular follow up investigations. Once discovery commences, the defendant should issue a request for production for electronic files of Plaintiff’s social media accounts. In certain situations, defense counsel may want to seek production of the Claimants hard drive(s).

In cases with no objective findings, look to other reasons for subjective complaints. For example, complaints of lack of concentration are found higher in college student populations. Therefore, the complaints may be caused by factors other than a brain injury.

Consider other experts than just a neuropsychologist and medical doctor on TBI claims.

- You will frequently need a neuro-radiologist to review diagnostic tests that Plaintiff claims prove a TBI, or this expert may be able to explain why objective testing does not show any physical injuries or abnormalities that support Plaintiff’s complaints.
- Life care planners – consult first. Then decide if you want to hire to do report. Problem is, you are often suggesting a number that may be significant even if significantly less than plaintiff’s expert. Do you want to just defend against their expert?
- You may also need a vocational rehabilitation expert. Similar to a life care expert, this expert may serve to legitimate a portion of the Plaintiff’s damages.

**Procedural battle grounds with plaintiff counsel**

- Trends toward two full days of evaluation: Plaintiff counsel objects (see how long their expert tested the plaintiff. Courts have generally allowed this if plaintiff’s expert tested for 2 days.
- Plaintiff bar is requesting to video tape the neuropsychology IME. Court rulings hinge on whether the plaintiff’s expert video-taped their testing.
- Plaintiff bar is asking to allow a family member to be present during the testing. Courts have not allowed if the presence of the third party may affect the reliability of the testing. May allow them to be present for interview portion.
# Severity Rating for TBI

**Traumatic Brain Injury Description**

<table>
<thead>
<tr>
<th>Severity</th>
<th>GCS</th>
<th>AOC</th>
<th>LOC</th>
<th>PTA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>13-15</td>
<td>≤24 hrs</td>
<td>0-30 min</td>
<td>≤24 hrs</td>
</tr>
<tr>
<td>Moderate</td>
<td>9-12</td>
<td>&gt;24 hrs</td>
<td>&gt;30 min</td>
<td>&gt;24 hrs</td>
</tr>
<tr>
<td>Severe</td>
<td>3-8</td>
<td>&gt;24 hrs</td>
<td>≥24 hrs</td>
<td>≥7 days</td>
</tr>
</tbody>
</table>

GCS- Glasgow Coma Score  
AOC- Alteration in consciousness  
LOC - Loss of consciousness  
PTA- Post-traumatic amnesia
<table>
<thead>
<tr>
<th></th>
<th>HEADACHE</th>
<th>DIZZINESS</th>
<th>IRRITABILITY</th>
<th>MEMORY PROBLEMS</th>
<th>CONCENTRATION PROBLEMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>College students</td>
<td>36%</td>
<td>18%</td>
<td>36%</td>
<td>17%</td>
<td>42%</td>
</tr>
<tr>
<td>Chronic pain</td>
<td>80%</td>
<td>67%</td>
<td>49%</td>
<td>33%</td>
<td>63%</td>
</tr>
<tr>
<td>Depressed</td>
<td>37%</td>
<td>20%</td>
<td>52%</td>
<td>25%</td>
<td>54%</td>
</tr>
<tr>
<td>PI claimants</td>
<td>77%</td>
<td>41%</td>
<td>63%</td>
<td>46%</td>
<td>71%</td>
</tr>
<tr>
<td>MTBI</td>
<td>42%</td>
<td>26%</td>
<td>28%</td>
<td>36%</td>
<td>25%</td>
</tr>
</tbody>
</table>

Data are expressed as No. (%) of players with concussion. *Fisher's exact test (p = .03). From Guskiewicz et al.¹⁰
1. MTBI symptoms gradually resolve over a period of days to weeks in the overwhelming majority of cases.

2. Measurable impairments in cognitive functioning are evident during the acute phase following MTBI, in the absence of unconsciousness, amnesia, or focal neurologic deficits.

3. MTBI is most often followed by a favorable course of cognitive recovery over a period of days to week, with no indication of permanent impairment on neuropsychological testing by three months postinjury.

4. Preliminary findings illustrate neurophysiologic effects of MTBI that follow a course of recovery consistent with the natural course of symptom and cognitive recovery as the brain returns to a normal physiologic state within days to weeks of injury.

5. Acute injury characteristics (e.g., unconsciousness, amnesia) are noteworthy in diagnosing and grading the severity of TBI, but brief unconsciousness and amnesia are not predictive of recovery and outcome after MTBI.

6. Complicated MTBI characterized by structural injury visualized on acute neuroimaging may increase the risk of slow or incomplete recovery after MTBI but is not perfectly predictive of outcome in the majority of MTBI patients.

7. The overwhelming majority of MTBI patients follow a favorable course of functional recovery by returning to normal occupational, social, and independent functioning within days to weeks after injury.

8. Overall, the natural history of MTBI in children and adults is characterized by gradual, full recovery in symptoms, cognition, and general functioning within several days to weeks of injury, and the true incidence of persistent symptoms or impairments that negatively affect the patient's general functioning is very low.

9. In uncomplicated MTBI, persistent symptoms and poor functional outcome are often associated with non-injury-related variables, including demographic, psychosocial, medical, motivational, and other situational factors.