

A REAL PAIN IN THE NECK

Detecting Malingering And Symptom Magnification In The Injured Worker

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Why?

We have a passion for our injured workers

- We invest money in our patients
- We invest time in our patients
- We invest emotional energy our patients

When patients magnify their symptoms or malingering

- We have less to give to other patients...

Why?

Each of us has a story....

We all know malingerers, but what can we do about them?

- How can we identify them earlier?
- How can we decrease the costs they divert?
- How do we decrease “False Positives”
- How do we decrease the aggravation

Scope of the Problem

- Studies have shown only 1-2% of Employees are engaged in claims fraud¹
- Malingering – Rates vary by differential diagnosis²
 - 39% of Mild Head Injury Cases
 - 31% of Chronic Pain Cases
 - 22% of Electrical Injury Cases

1 - “Workers’ Compensation Fraud: Perception and Reality,” Trial Briefs, July 1999

2 – “Base Rates of Exaggeration and Symptom Magnification,” Journal of Clinical And Experimental Neuropsychology, 2002

Who Am I?

Fellowship trained, Board Certified Pain Management Physician

- Training at Ivy-League Institution
- Familiar with Missouri Workers
- Familiar with Workers Compensation

I care about you and your Workers.

Let's Define the Issues

Malingering

A conscious and willful feigning or exaggeration of a disease or effect of an injury in order to obtain specific external gain. It is usually motivated by external incentives, such as receiving financial compensation, obtaining drugs, or avoiding work or other responsibilities.

Malingering

No Syndrome is as easy to define

No Syndrome is as difficult to diagnose

Malingering as a Diagnosis

DSM-IV-TR Criteria

“intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs.”

Key Point: INTENTIONAL

Intent has legal implications

AMA 6th Edition

Patients may malingering to:

- Avoid responsibility
- Obtain Monetary Reward

Malingering is a spectrum –

- Embellishment
- Exaggeration
- Fabrication

Examiners should consider mental and behavioral disorder, physical disorders, or both when evaluating patients.

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“The use of the term *Malingering* can polarize case analysis and may lead to personal attacks on examiner/rater by administrators or judicial decision makers”

Intent has legal implications

May imply that Health provider knows the patient is intentionally defrauding the examiner and others

Recommends *Symptom Exaggeration* or *Symptom Magnification* instead of *Malingering*

I DIDN'T LIE



I JUST MIS-REMEMBERED

Symptom Magnification

*A **conscious** or **unconscious** self-destructive, socially-reinforced, behavioral response pattern consisting of reports or displays of symptoms which function to control the life circumstances of the sufferer.*

Symptom Magnification does NOT imply
Intent!!

Symptom Magnification

- Unconscious Motivation
- Somatoform Disorders
- Schemas
- Factitious Disorders
- Other Physical Diagnoses Affecting Function
 - Aging and Degeneration
 - Missed Diagnoses
 - Old injuries

Unconscious Motivation

- We are each a victim of our own reality
- Patient is not entirely faking
- Problems are not simply physical
- How motivated is the patient to return to work vs not?
- How positive is the patient in general thought patterns?
- How supportive is the patients familial environment?
 - Support to return to work?
 - Support to push the system?

Somatoform Disorder

- Patient presents with symptoms that can't be traced back to any physical cause.
- They are NOT the result of substance abuse or another mental illness.

People with *Somatoform Disorders* are not faking their symptoms – their symptoms are real

“I can't figure out what's causing it so it must not be physical!”

Schema

A mental concept that informs a person about *what to expect* from a variety of experiences and situations.

Schemas are developed based on information *provided by life experiences* and are then stored in memory.

Our brains create and use schemas as a short cut to make future encounters with similar situations easier to navigate.

Schemas

- Preconceived notions on what to expect from Workers Compensation
- Expectations framed by perception
- We develop expectations about other people based on the social role that they occupy
- Patient understanding and perception may have compelling effect on RTW
- Fear of loss of function motivates to pursue treatment

Aging isn't painless

- Degeneration happens.
- Develops Gradually, but the pain can occur suddenly
- Are workers job descriptions appropriate for age?
- Arthritis may predispose to injury
 - Movement becomes more difficult
 - Reflexes become diminished

Doctor Bias

- Who do you work for?
- Attorney vs Insurance Company preference
- Doctors care about financial gain too...

- Reluctance to be the bad guy

At the end of the day, if your chosen provider is working, first and foremost for the *PATIENT* you are probably OK.



“You say the pains in my left leg are caused by old age. But doctor my right leg is just as old and it doesn't hurt at all!”

Getting Real

- How do we know?
- Its hard initially
- Team based approach
- Providers you trust
- Good Physical Exam
- OBSERVATION
- Surveillance

YOU GOTTA FOCUS ON WHAT'S

REAL

MAN.

YOU'RE GETTING ALL HUNG UP ON

IMAGINARY PROBLEMS



Identification of Malingering

- Difficult to prove
- Its hard to feign symptoms for the long term
- Employee may be hard to contact
- Gaps in treatment compliance
- Resist Independent Medical Examinations
- Disability extends longer than expected recovery
- Disagreement between doctors as to disability
- Claimant frequently requests change of provider
- Irrational refusal for tests or imaging to substantiate symptoms

Identification of Malingering

- Malingerers often **Overact**
- Description of symptoms and problems is not clear, **Lacks Detail**
- Struggle to answer when asked about **coping strategies**.
How do they manage in their day-to-day life?
- Report symptoms more **bizarre** than real symptoms
- Catch term – **Sudden Onset**
- Report **constant symptoms**, in disorders that usually cause intermittent effects

The Role of a Meticulous History

- Well defined Chief Complaint
- Mechanism of Injury
- Temporal history of symptom development
- Contributory Medical Conditions?
- Prior history of pain/injury
- Pharmacy/Prescribing History (but MO doesn't have prescription monitoring)
- Social History
- Prior Claims/Litigation?

Historical Red Flags

- History of Depression and Anxiety
- History of Chronic Pain and Opioid use
- New Hire
- Mentions attorney before hiring one
- Changing story, modifying details
- Prior Work Comp Claims
- Poor Job Satisfaction or Performance

Historical Red Flags

- Symptoms worsen despite treatment and rest
- Patient generally angry at employer and former treatment
- Patient critical of previous doctors
- Patient demonstrates setbacks every time return to work is imminent
- Multiple return to work extensions

Examine the Patient

- Observation
 - Gait
 - Movement
 - Best findings are those observed when patient not being “examined”

Waddel's Signs

- Detect Non-organic physical signs (specifically for back pain)
- Non-Anatomic Weakness or sensory loss
- Non-Anatomic superficial tenderness

The Power of Waddell's Signs

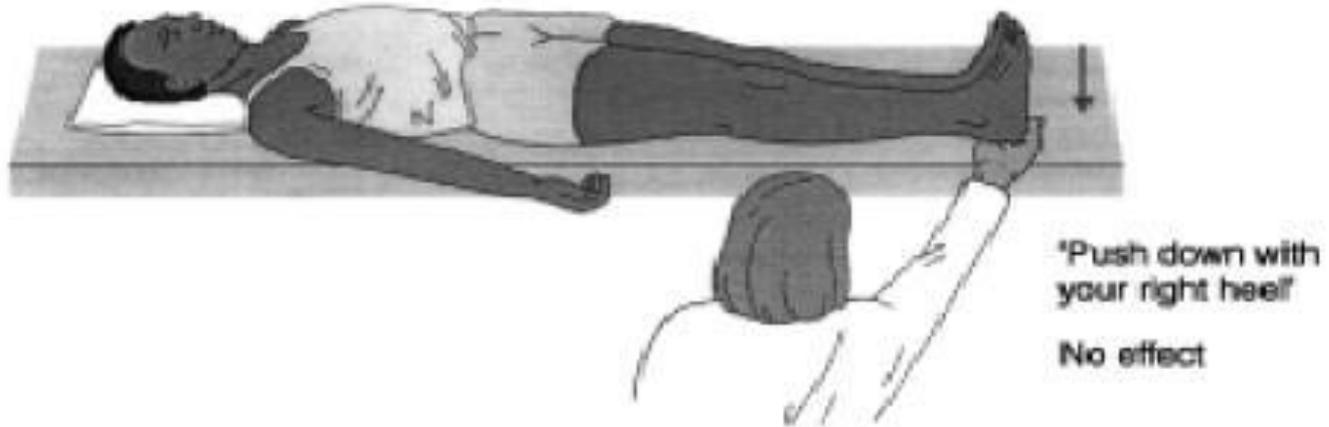
- One sign present in 47% of patients whose works status DID NOT improve
- One sign present in 12% of patients whose work status DID improve

Specific Tests:

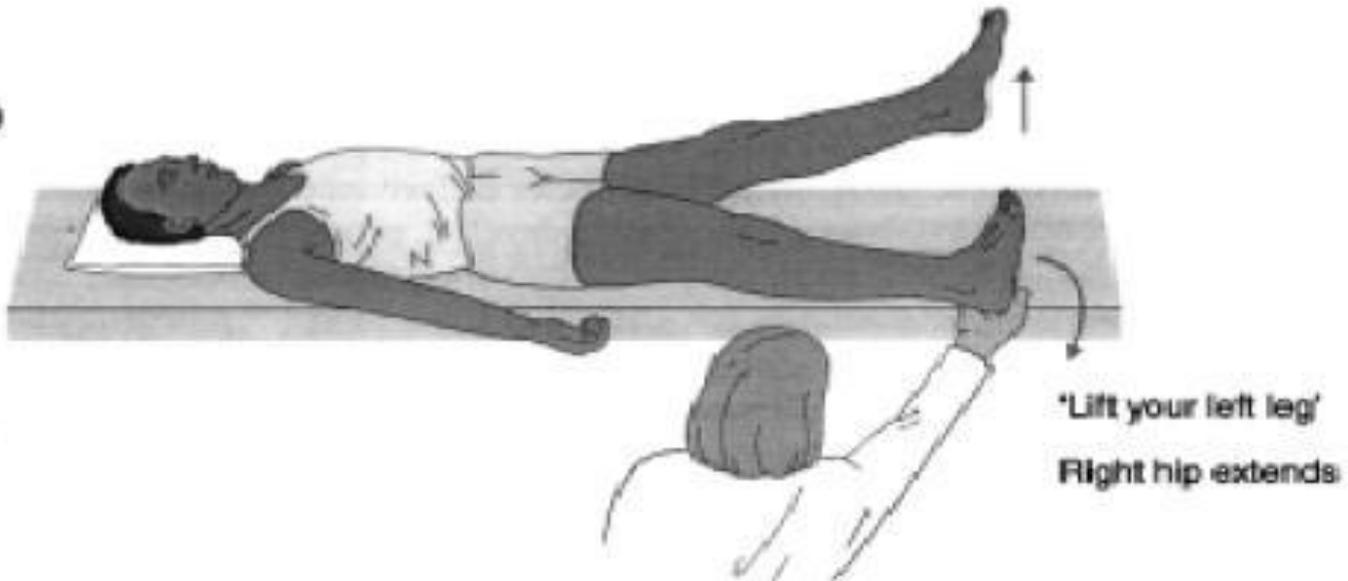
- Waddell's Light Pinch
 - Non-Anatomical tenderness to light pinch
- Waddell's Axial Vertical Loading
 - Vertical loading on a standing patient's skull produces low back pain
- Waddell's simulated rotation
 - Passive rotation of shoulders and pelvis in same plan causes pain
- Distraction
 - Discrepancy between sitting and lying straight leg raise test
- Overreaction
 - Disproportionate facial expression, verbalization, or tremor during examination

Hoover Test

(a)



(b)





Isokinetic Testing

- Supported by evidence
- Uses accommodating resistance to measure force produced
- Creates a torque curve
- Identifies malingering using objective data
- Can be full-body or Joint comparison testing
- Useful for pre-employment

Functional Capacity Evaluation

- Tells you what a patient **will** do
- Documents consistency of effort
- Heart rate correlation is helpful
- Limited predictive validity
- Helpful for ratings when malingering not in question

Independent Medical Examination

- Know your examiner
- Complete record review
- Thorough, objective history
- Complete Exam
- Documentation of factual observations

Surveillance

- Perhaps the best way to diagnose malingering is to catch it on videotape
- Expensive
- Not useful in every case

Trust

- We have a desire to be supportive of our patient's
 - We don't want to cause harm
 - We don't want to miss a diagnosis
 - We want to be the patient's advocate
-
- Missed Malingering harms the system, harms other patients,

Confronting the issues?

- Act neutrally and professionally
- Document facts, not opinions
- Physicians are not prosecuting attorneys or judges
- Set appropriate expectations for recovery
- Sometimes a patient needs to hear that “No further treatment is indicated”