THE TRAUMA TRIFECTA:

Defending TBI, PTSD, AND CT Claims in an Evolving Legal Landscape

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Meet Our Panel

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LEARNING OBJECTIVES:

- **The Diagnostic Dilemma**
  - How to distinguish between TBI and PTSD symptoms using advanced comprehensive evaluation strategies including neuropsychological testing, brain imaging, neurological and psychiatric evaluation, and functional capacity assessment to identify isolated versus overlapping conditions and support accurate validation of impairment in complex and disputed claims.
- **Treatment & Mitigation**
  - Best practices for medical recovery, from acute cognitive rehabilitation to evidence-based therapies that support appropriate care and reduce barriers to recovery and prevent long-term psychiatric disability.
- **Strategic Defense in the CA WC System**
  - Navigating issues regarding correct diagnosis and finding the most appropriate evaluator
  - the potential for permanent and total disability

PART 1: THE DIAGNOSTIC DILEMMA

BEYOND THE BURN:

Case Study 1

When the Visible Injury Isn't the Whole Story.

A worker contacted an 880V AC electrical panel, sustaining third-degree burns to his upper extremity along with syncope and a ground-level fall; the burns ultimately required amputation of the arm, and he has since developed memory loss, insomnia, irritability, hyper arousability, and depressive symptoms. This case includes both TBI and PTSD.

Our Discussion:

One event, many body systems. Burns, amputation, and a psychological/cognitive overlay raise hard questions about compensability and apportionment across distinct injuries.

What's really driving the symptoms? Memory loss, irritability, and insomnia could trace to the electrical injury, head trauma from fall, or the trauma of amputation; untangling causation is the central challenge.

Who coordinates recovery? This case demands burn care, surgery, prosthetics, neuropsychology, and behavioral health all at once. What does a quarterbacked care plan look like?

TBI or PTSD? Reading the Signs

Symptomatology — Telling Them Apart

- Classic TBI symptoms vs. PTSD symptoms (re-living, avoidance, hyperarousal)
- Phenomenology: structure and function
- The anatomy of PTSD vs. TBI

Substantial Medical Evidence

- Standardized screening
  - » CAPS-5, PCL-5, SCAT5/6, GCS, NSI, RPQ, GOAT, GOSE
- Neuropsychological testing
- Brain imaging: CT, MRI, and beyond

DSM-5 CRITERIA FOR PTSD

All criteria are required for diagnosis. The following text summarizes the diagnostic criteria:

Criterion A (1 required)
Exposure to actual or threatened death, actual or threatened serious injury, or actual or threatened sexual violence

Direct exposure, witnessing, learning it happened to close relative/friend, or indirect professional exposure (e.g. first responders, medics)

Criterion B (1 required)
Traumatic event is persistently re-experienced in the following ways:

Unwanted upsetting memories, nightmares, flashbacks, emotional distress after exposure, or physical reactivity after exposure.

Criterion C (1 required)
Avoidance of trauma-related stimuli after the trauma:

Trauma-related thoughts or feelings

Trauma-related reminders.

Criterion D (2 required)
Negative thoughts/feelings began or worsened after trauma:

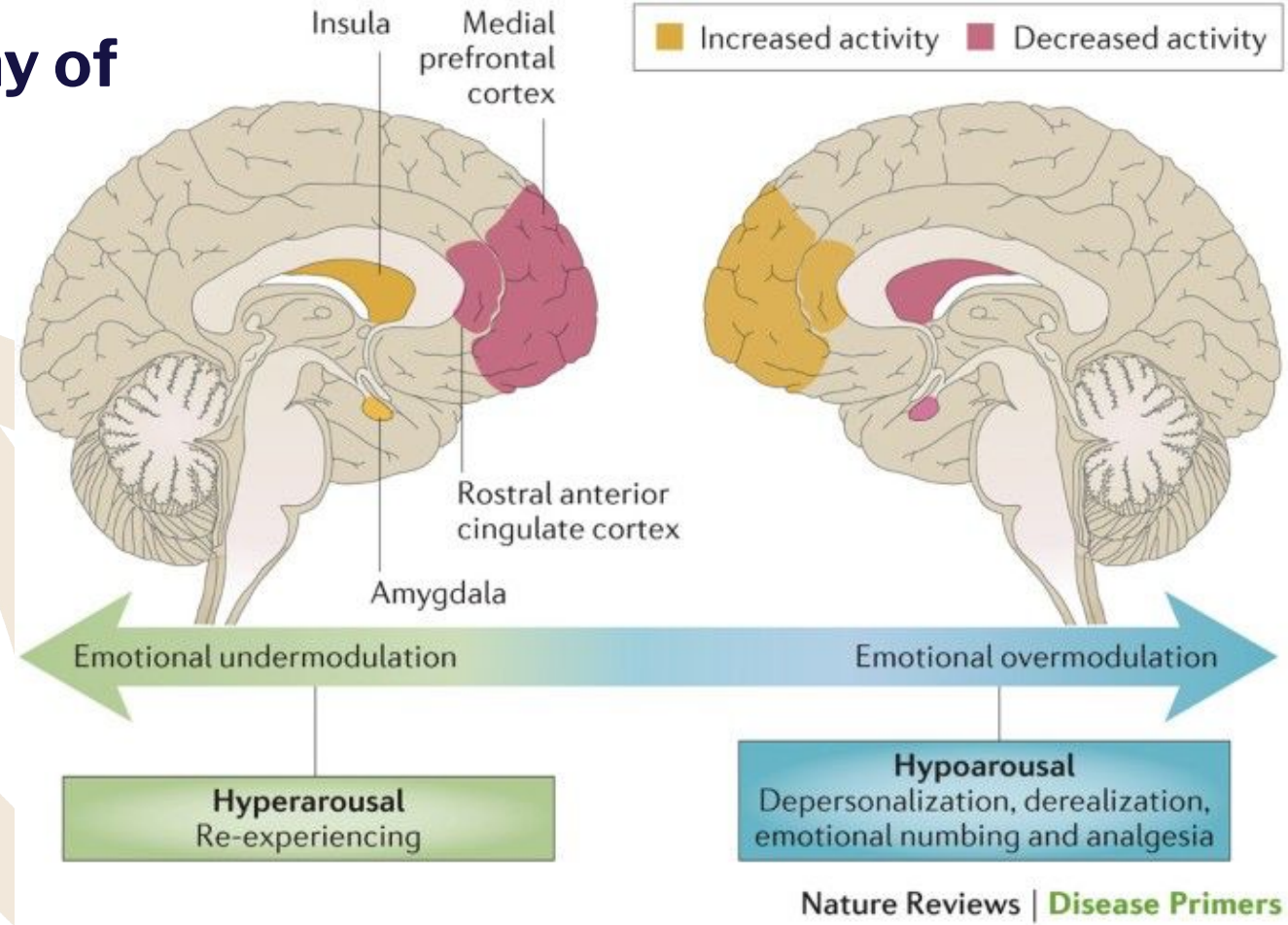
Inability to recall key features of trauma, overly negative thoughts/beliefs about self or world, exaggerated blame of self or others for the trauma, negative affect, decreased interest in activities/isolation, difficulty experiencing positive affect

Criterion E (2 required): Trauma-related arousal and reactivity that began or worsened after trauma:
Irritability/aggression, risky/destructive behavior, hypervigilance, heightened startle reaction, difficulty with concentration/sleep.

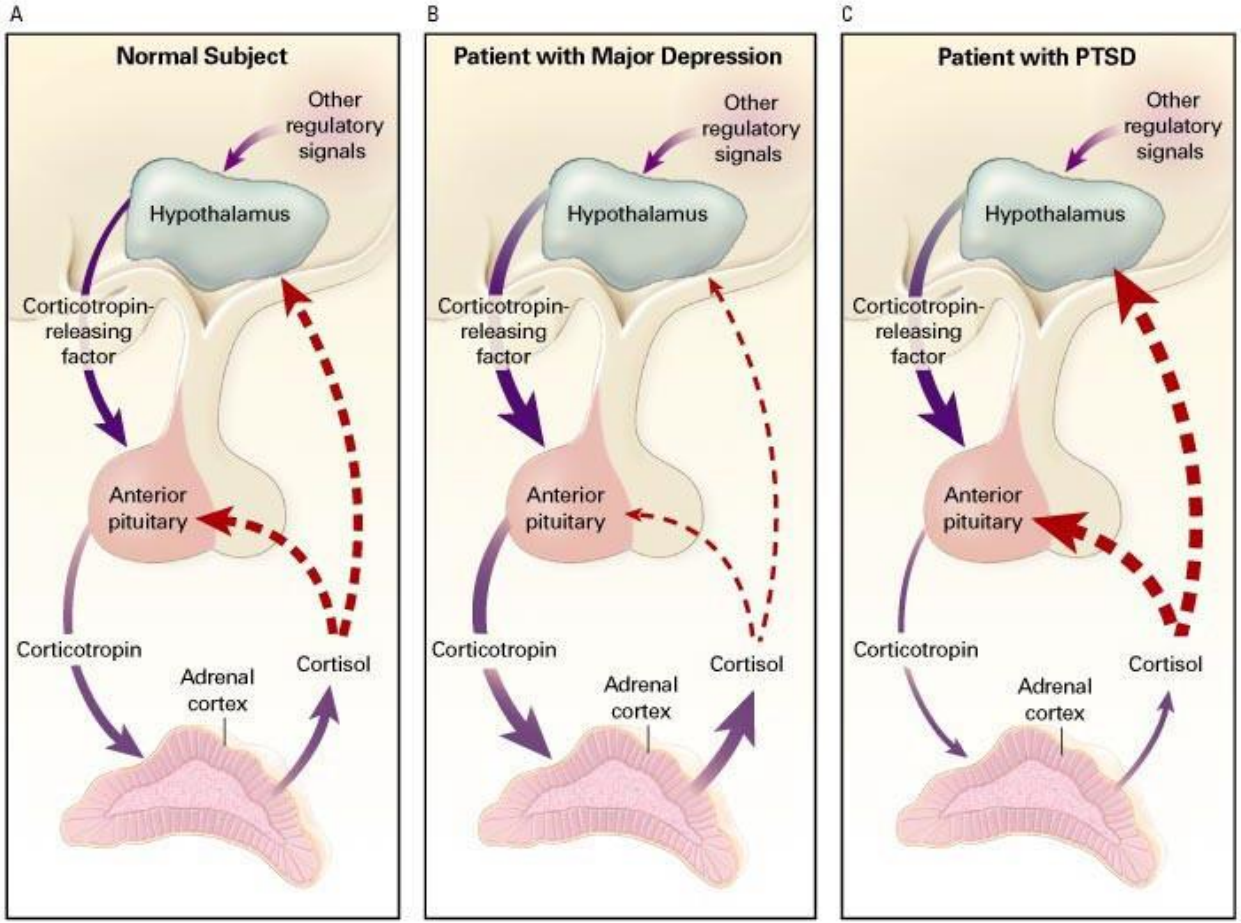
Criterion F: Duration > 1 month. **Criterion G:** Symptoms create distress or functional impairment. **Criterion H:** Not due to medication, substance use or other illness.

Two Specifications: Dissociative | Depersonalization or Derealization. **Delayed |** Full criteria met until at least **6 months** after trauma.

Neuroanatomy of PTSD



Neuroanatomy of PTSD



When It's Both: TBI and PTSD Together

The Concurrent Existence of TBI and PTSD

- When both can occur together
- Treating it: a biopsychosocial approach
  - Pharmaceuticals
  - Therapy
  - PTSD and brain injury rehabilitation
  - Comprehensive Neuropsych Evaluations

§ 9792.24.5 — California's TBI Guideline (MTUS)

California has a dedicated, evidence-based TBI treatment standard built on ACOEM guidelines.

- Section 9792.24.5 adopts the ACOEM Traumatic Brain Injury Guideline into the Medical Treatment Utilization Schedule (MTUS) by reference
- Amended effective January 2, 2026, now referencing the updated ACOEM October 7, 2025 guideline — emphasizing functional improvement, early cognitive and psychological screening, and a coordinated approach across neurology, neuropsychology, and therapy
- The MTUS is found in Title 8, California Code of Regulations §§ 9792.20–9792.27.23, and is presumed correct on the scope and extent of medical treatment
- Authority cited: Labor Code §§ 133, 4603.5, 5307.3, 5307.27 | Reference: Labor Code §§ 77.5, 4600, 4604.5, 5307.27

PART 2: CUMULATIVE TRAUMA CLAIMS IN CALIFORNIA

HOW MUCH CALIFORNIA IS ENOUGH?

Case Study 2

Example 1: A seven-season athlete filed a cumulative trauma claim against the California team where he played just his first season, three years after leaving, citing all seven seasons as the CT period.

Example 2: An 11-season athlete, traded to a California team only for the tail end of his final year, filed a cumulative trauma claim two years later citing his entire 11-season career as the CT period.

Our Discussion:

In both cases, a single season — or less — on a California roster became the hook for a cumulative trauma claim spanning an entire multi-state career. The question for the panel: how much California is enough to pull a whole career into our system?

Playing Defense: The Team's Risk Reality

Challenges Professional Sports Teams Face

- CA cumulative trauma laws: their misapplication and the burden on California teams
- When does the CT period actually start?
- The lack of apportionment

From Little League to the Pros

- Injury and treatment accumulate along the way
- More training, less downtime: does the body ever fully recover?

PART 3:
STRATEGIC DEFENSE in the CA WC System

The Million-Dollar Claim

Case Study 3

Exhibit A: The Bucket

A man experiencing long-term homelessness, who supported himself through occasional odd jobs, took part-time work as a painter. A half-full bucket of paint fell from above and struck him on the head.

The injury raises a tangle of legitimate questions: baseline health, pre-existing conditions, apportionment, and continuity of care, all complicated by the injured worker's unstable housing.

Several years later, the claim remains open, has surpassed $1 million in medical expenses, and shows no sign of resolution, exhausting everyone involved.

Invisible Injury, Limitless Liability

The Burden of Proof Challenge

- PTSD and TBI claims – where the burden of proof falls
- Litigating TBI cases is harder since neuropsychology was removed as a QME panel specialty

When Symptoms Are Self-Reported

- Many TBI and PTSD symptoms are subjective and self-reported, making these claims difficult to defend
- Given the exposure at stake, sub rosa surveillance can be a useful tool

FINAL TAKEAWAYS

Q's & A's