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CASE STUDY

# The Slow Drift of a "Routine" Ankle Claim

How the loss of clinical focus turned a simple ankle sprain into a six-month, high-exposure workers' compensation claim.

**Clinical Clarity.**
**Better Decisions.**
**Stronger Outcomes.**

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# 1. The Original Injury

*Every claim begins with a story. In this case, the story appeared remarkably straightforward.*

In this case, this is a 42-year-old warehouse employee who stepped down from a pallet suffered an inversion injury to his right ankle. The mechanism of injury was clean, direct, and limited in scope. There was no fall from height, no secondary trauma, there is no significant past medical history and no report of additional body parts involved at the time of injury.

The initial medical evaluation supported exactly what you would expect from the clinical scenario outlined. The treating provider, a certified physician's assistant documented mild swelling, localized tenderness, a normal neurologic exam, and a negative x-ray. Pain was reported at a manageable level (3/10), and there was no indication of instability or structural compromise.

From a clinical standpoint, this was a routine lateral ankle sprain. These cases typically resolve within a few weeks (as per ODG 5-15 days) with conservative management. At this stage, there was nothing about the file that would suggest elevated exposure or prolonged disability.

And for a brief period, the claim followed that expected path. Over the first six weeks, the injured worker attended physical therapy and transitioned to light duty. Follow-up exams demonstrated gradual improvement. Objective findings were consistent with healing. The clinical picture matched the natural course of recovery.

> **If the file had remained anchored to this trajectory, it would have closed as expected.**

**MECHANISM OF INJURY**

The mechanism of injury was clean, direct, and limited in scope.

- There was no fall from height.
- There was no secondary trauma.
- There is no significant past medical history.
- There was no report of additional body parts involved at the time of injury.

**INITIAL EVALUATION**

- Mild swelling
- Localized tenderness
- Normal neurologic exam
- Negative x-ray
- Pain reported at 3/10
- No instability or structural compromise

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# 2. Where the Claim Began to Drift

*The shift did not happen all at once. It began with small changes that gradually altered the direction of the claim.*

If the file had remained anchored to this trajectory, it would have closed as expected.

Instead, the shift began subtly.

At approximately eight weeks, a new provider entered the case. This routine ligamentous injury was being addressed by a chiropractor. This is often where the clinical narrative begins to change, particularly when the original injury has not been clearly defined and reinforced early in the claim.

**WEEKS 1–6**

- Physical therapy
- Light duty
- Gradual improvement
- Objective findings consistent with healing

**WEEK 8**

- A new provider entered the case.
- This routine ligamentous injury was being addressed by a chiropractor.

**WEEK 8+**

At this visit, the injured worker reported increased pain and a sense of instability. Advanced imaging was requested. The MRI revealed mild degenerative findings, which are common and frequently unrelated to the acute injury event.

To be clear, there were no markers of acute injury on the T2 or STIR images.

> **What appeared to be a routine injury was beginning to move beyond the objective findings and away from the original mechanism of injury.**

# 3. When the Clinical Picture No Longer Matched the Injury

*This is the point where experienced claim professionals should pause.*

However, these unsupported findings have begun to influence the direction of care. What had been a straightforward sprain now had additional clinical language attached to it. The scope of the claim began to expand, not because of new objective injury, but because the interpretation of existing imaging shifted the conversation.

Over the following weeks, the progression became more pronounced. Pain reports escalated significantly (7/10), despite a lack of corresponding change in the physical examination findings reported. The injured worker described increasing difficulty with ambulation. New complaints emerged involving the opposite ankle, which had not been part of the original mechanism of injury. It was suggested that because there were compromises to the original injured ankle, this altered the gait pattern of the unrelated ankle.

At the same time, objective measures remained largely unchanged. Strength, sensation, and structural integrity were stable. Imaging did not reveal new pathology. The clinical data no longer aligned with the reported symptoms.

**CLAIM IMPACT**

- Pain reports escalated significantly (7/10)
- Increasing difficulty with ambulation
- New complaints emerged involving the opposite ankle
- Objective measures remained largely unchanged
- Imaging did not reveal new pathology
- The clinical data no longer aligned with the reported symptoms

This is the point where experienced claim professionals should pause. When subjective complaints escalate without objective support, it is no longer sufficient to simply move the file forward. The claim requires reassessment. The question is no longer “what treatment is next,” but rather “what, if anything, still relates to the original injury.” In this case, that question was not clearly answered.

Without an early baseline to anchor the injury, each new complaint was effectively accepted into the claim narrative. Additional providers became involved, to include behavioral health professionals, treatment extended beyond expected guidelines and return to work timelines continued to move further out.

> **The claim requires reassessment.**

# 4. The Cost of Clinical Drift

*What began as a routine ankle sprain no longer resembled the original injury. The file had gradually evolved into something much larger.*

By the six-month mark, the file bore little resemblance to the original presentation. What began as a routine ankle sprain had evolved into a complex, multi-provider case involving ongoing therapy, pain management considerations, and discussion of long-term work restrictions. The exposure on the claim increased steadily, not due to a catastrophic event, but due to a gradual loss of clinical focus. This is what claim file creep looks like in practice.

It is not the result of a single decision. It is the accumulation of small deviations that go unchallenged over time. A new symptom is accepted. A diagnostic finding is overinterpreted. A treatment plan extends beyond what the mechanism supports. Without a clear clinical anchor, the file begins to drift.

**WHAT CLAIM FILE CREEP LOOKS LIKE**

- It is not the result of a single decision.
- It is the accumulation of small deviations that go unchallenged over time.
- A new symptom is accepted.
- A diagnostic finding is overinterpreted.
- A treatment plan extends beyond what the mechanism supports.
- Without a clear clinical anchor, the file begins to drift.

> **The exposure on the claim increased steadily, not due to a catastrophic event, but due to a gradual loss of clinical focus.**

> **The outcome was not inevitable. There were clear opportunities to change the trajectory of the claim.**

# 5. Where This Case Could Have Been Stabilized

*Cases like this are not unusual. What is instructive is that the outcome was not inevitable.*

Cases like this are not unusual. What is instructive is that the outcome was not inevitable. There were clear points in the life of this file where a more structured clinical approach would have changed the trajectory.

## EARLY BASELINE CLINICAL ASSESSMENT

Early in the claim, the injury presented with a well-defined mechanism, objective findings, and a predictable recovery path.

That is the moment where a formal baseline clinical assessment should be established and documented as the reference point for the life of the claim. With that baseline in place, every subsequent complaint, treatment request, and diagnostic finding can be measured against what actually occurred on the date of injury.

That did not happen here. When the clinical picture later began to drift, there was no agreed-upon anchor to return to. As a result, the file expanded rather than being questioned.

### WHY IT MATTERS

- Well-defined mechanism of injury
- Objective findings
- Predictable recovery path
- Reference point for the life of the claim
- Measures future complaints against the original injury

> **The strongest opportunity to control claim exposure often exists at the very beginning of the claim.**

# 6. How This Could Have Been Prevented

*Cases like this rarely unravel because of a single event. More often, the outcome is shaped by the systems and decisions surrounding the claim.*

In cases like this, there are three practical interventions that consistently make a difference.

## ESTABLISH CLINICAL CLARITY AT THE OUTSET

First, establish clinical clarity at the outset. A structured clinical review (such as a Baseline Clinical Assessment) early in the claim defines the injury in plain language. It translates the mechanism of injury into expected pathology and expected recovery. That alone often prevents unnecessary expansion later.

## IDENTIFY AND ADDRESS DEVIATION EARLY

Second, identify and address deviation early when complaints escalate or new body parts are introduced without objective support, that is not a routine progression. It is a signal. Early clinical comparison of current findings to the original presentation allows adjusters to act while the file is still manageable.

## MAINTAIN ALIGNMENT BETWEEN TREATMENT AND THE ACTUAL INJURY

Third, maintain alignment between treatment and the actual injury.

Treatment should follow the injury, not the evolving narrative. When care begins to extend beyond what the mechanism supports, that is the moment for a focused clinical review, not passive acceptance.

> **The most effective interventions occur before claim drift becomes claim exposure.**

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# 7. The Role of Targeted Clinical Support

*The right clinical intervention at the right time can fundamentally change the trajectory of a claim.*

This is precisely where specialized clinical support changes the outcome of a file. In a case like this, an Early Baseline Clinical Assessment would have clearly defined the ankle sprain, the involved structures (e.g. ligaments), and the expected recovery timeline. That documentation becomes the standard against which all future care is evaluated.

When the second provider introduced a different narrative, a focused clinical review (Physician Peer Review) could have compared those findings to the original injury. The degenerative MRI findings could have been placed in the proper context. The file could have been re-centered before the scope expanded.

Later, when the symptoms escalated without objective change, a timely peer review could have addressed the mismatch between subjective complaints and clinical findings. That type of intervention provides adjusters with clear, defensible medical rationale they can rely on when making decisions. Instead of reacting to the drift, the claim can be actively managed with a clear understanding of what is related and what is not.

## PRACTICAL TAKEAWAY FOR ADJUSTERS

The difference between a controlled claim and an expanding one is rarely the injury itself. It is the presence or absence of early clinical clarity.

Files that perform well over time share a common thread.

The injury is defined early.

The clinical picture is anchored to objective findings.

Treatment decisions remain aligned with what actually occurred.

When that structure is in place, claim creep is not eliminated, but it is far easier to identify and address. Without it, even the most routine injury can evolve into something far more complex than it ever needed to be.

> **Files that perform well over time share a common thread: the injury is defined early, the clinical picture remains anchored to objective findings, and treatment decisions stay aligned with what actually occurred.**