California Orthopaedic Association

Sample Medical-Legal Report

This document is presented as an example of the form and general content of an orthopaedic QME/AME report. The specific diagnoses, conclusions, and opinions expressed herein are those of the author and not necessarily those of the California Orthopaedic Association or every California Orthopedist.

(Put on AME's Letterhead)

(Date of Evaluation)

Department of Industrial Relations
Division of Worker's Compensation
Disability Evaluation Unit
(Address)

Re:	Tom Patient
SSN:	(Social Security Number)
D/I:	(Date of Injury)
C/N:	(Ins. Co. Claim #)
WCAB:	(WCAB Claim #)
Imp:	(Name of Employer)
D/Exam:	(Date of Exam)
D/Dict:	(Date Report Dictated)

Agreed Medical Evaluation – Orthopaedic Surgery

The above-captioned patient was seen in this office on January 27, 2005 for an orthopaedic evaluation with the undersigned acting in the capacity of an Agreed Medical Examiner.

This examination was assisted by the presence of a professional Spanish interpreter, (Name & Certificate #).

The patient is a 33-year-old, right-handed, Hispanic male, who worked in a factory that made kitchen cabinets. His job was to paint the cabinets. He states he would have to lift cabinets and he would have to lift up to 200 pounds with assistance. This was a full-time job. He started this job in June or July 2004 and had no concurrent employment.

The patient gives the following history. (In spite of the presence of an interpreter, it is very difficult to get a good history from the patient who changes his history.)

The patient reports that on November 30, 2004 he was lifting a cabinet with a co-worker and the cabinet started to fall and he held onto it and felt a pulling in his lower back. He completed the remaining five hours of his work shift. He says the pain was not very severe initially.

He remained at work for the next two to three days. The pain was getting worse and he reported it. He was sent to a chiropractor at the end of his work shift. He says he was only examined and given no treatment. Initially he states he was not taken off work but later, in trying to find out when he stopped working, he says he was told not to work. He has never returned to work since then.

He says that rather than getting treatment in the office of that doctor he was advised just to apply ice or heat.

At the second evaluation in that office, he was also given no treatment.

Following that, the company sent him to a medical doctor whose name he cannot recall. He says x-rays were taken. He was given medication and started on physical therapy with electrical stimulation and aquatherapy three times weekly. He had the treatment for about two to three months. When this treatment ended, he was still feeling the same. He says he was then released from care and told to go back to work.

The patient did not go back to work. He called in and was told he would be called back but he was never called back.

He then got an attorney. The attorney sent him to Dr. B. He was prescribed a back support, a TENS unit for home use, and medication. Later he was started on physical therapy, going three times weekly for electrical stimulation and acupuncture. Exercises were given but they bothered his back. He is still getting physical therapy and in spite of this prolonged treatment he still feels the same.

Additionally he says he was sent by Dr. B to Dr. F who gave him injections twice a week for the neck and back. (These sound almost like epidural injections, but getting epidural injections twice a week for quite some time does not sound reasonable.) He indicates he cannot estimate how many of these injections he had, but he says he did have a lot. He says with the injections he only got relief that lasted for three days.

He has had diagnostic studies that sounds like an EMG and MRI study, but he does not know the results of these studies.

Present Complaints

The patient reports headaches. He says that since this injury he has to wear his glasses more frequently than previously. (Please note: a straining injury of the lower back should not have any effect on the need for use of glasses.)

He has neck pain. He indicates the neck pain first started approximately one and one half months after this injury. Initially it was only a very mild pain. He says he did tell the first doctor about the neck pain but the neck was not treated.

With reference to the neck he states there is a constant pain that is aggravated by looking up or down or lying on a pillow. The pain from the neck radiates into the lower back. The pain from the neck also radiates into both upper extremities to the fingers of both hands, more strongly in the left than the right. He says the pain going into his hands started when his neck pain got worse. He says the neck pain is stronger than the arm pain. Additionally there is tingling in both hands.

He reports low back pain that is a constant pain. The lower back pain is stronger than the neck pain. The lower back pain is aggravated by lying down, by standing and by sitting. (Please note: He did frequently change from standing to sitting while giving his history.)

He says that for relief of his back pain he takes medication and a change of position helps.

The lower back pain radiates to the toes of both feet, more strongly on the left than the right. The back pain is stronger than the leg pain. There is numbness and tingling in both legs. The back pain is aggravated by coughing and sneezing.

Previous Injury History

The patient reports no history of a previous injury involving his neck or back, and no previous injury of any kind whatsoever. He reports no subsequent injuries.

He states this was his only lifetime injury.

Personal History

The patient has a common-law living arrangement with one child. Tobacco: None. Alcohol: None. Medications: The patient is taking Tylenol, Ranitidine, Cardosoprol, and Naprosyn. Allergies: None.

Past Medical History

The patient has had the usual childhood diseases. Serious Illness: The patient states he has an ulcer history. Surgeries: None. Hospitalizations: None.

Physical Examination

The patient is a well-developed, well-nourished, Hispanic male. He comes to the evaluation utilizing a cane which he says he was given by Dr. B for the past month. He carries it in his left hand, but it was not used during the examination.

Generally throughout the examination the patient reports pain with almost every movement, and following performing range of motion studies he even says he feels "dizzy."

He gets on and off the examination table slowly. He walks very slowly. He says he cannot walk on his toes or heels because of pain. He does have a normal stance and habitus. He performs only 20% of a full squat with a complaint of back pain.

Vital Signs: Blood Pressure 110/90; pulse 80. Height 5 feet 8 inches. Weight 180 pounds. Right handed.

Examination of the Cervical and Dorsal Spine:

Inspection: The shoulders are level. The spine is straight. There is no deformity evident. There is a large hyperpigmented birthmark on the lower thoracic area.

Palpation: There is no muscle spasm. There is no localized tenderness. There is no increase in local warmth.

Motions (R/L): The patient flexes his chin to his chest. Extension is 60 degrees. Neck rotation is 60/40 degrees. Neck lateral bending is 30/30 degrees. (The patient complains of pain with all movement, and with rotation the pain is greater when he turns toward the left than the right.) Foraminal closure testing produces neck pain. Cervical compression produces marked low back pain but this is even prior to the application of any pressure whatsoever. Cervical traction similarly produces a complaint of pain in the neck area but before any pressure is applied that would produce traction on the neck. Shoulder depression testing is negative.

Motor Testing: Motor function in both upper extremities is intact.

Sensory Testing: The patient reports that he has relative diminution of sensation on the left side of his face (not including the forehead). There is also circumferential diminution of sensation in the left upper extremity that extends from the elbow to the fingertips. (This sensory distribution does not follow any anatomical neurological pattern.)

Reflexes (R/L): The biceps, triceps and brachioradialis reflexes are present and symmetrical.

Measurements (R/L = inches):

Circumference of upper arm	11	10-3/4
Circumference of forearm	10-1/2	10-1/4

Jamar Dynamometer Grip Strength Testing (R/L): 100/85, 85/80, 90/75.

Examination of the Lumbosacral Spine:

Inspection: The pelvis is level. The spine is straight. No deformity is evident.

Palpation: There is no muscle spasm. There is no localized tenderness including examination by punch percussion. There is no increase in local warmth.

Motions (R/L): The patient makes no attempt to forward flex his spine because of complaint of pain. Extension is limited to 5 degrees because of pain. Lateral bending is 10/10 degrees. Trunk rotation is 30/30 degrees. (He indicates that lateral bending and rotation are also limited by pain.)

Supine leg raising by the patient at 40 degrees on the right and 30 degrees on the left with complaint of low back pain, but not sciatic pain. Fabere test is negative. Fajersztajn test is negative bilaterally. The reverse Fajersztajn test is positive on the right. (That is, at the limit of supine leg raising, dorsiflexion of the foot does not increase his pain, but plantar flexion of the right foot does increase his back pain. This is a maneuver which should relieve any stretch irritability and is a non-organic finding.)

The flip test (seated leg raising) is resisted by the patient at 5 degrees short of full extension of the knees, although he does not arch his back. The Cram test is negative. The patella shift test is negative.

Motor Testing: Motor function in both lower extremities is intact. (He complains of pain with resisted flexion and extension of the feet and toes while he lies supine.)

Sensory Testing: The patient reports relative diminution of sensation in the posteromedial left thigh and the medial aspect of the left calf.

Reflexes (R/L): Knee jerks 1+/1+; ankle jerks 0+/0+. There is no ankle clonus.

Measurements (R/L = Inches):

Leg length	37-1/2	37-1/2
Circumference of thigh	18	18
Circumference of calf	14	14-1/4

X-Ray Report

X-rays of the cervical, thoracic and lumbosacral spine, and pelvis were obtained in this office January 27, 2005 by Certified Radiology Technician C (Certificate #), and interpreted by the undersigned.

Cervical Spine (7 Views): There is no evidence of fracture, dislocation of any other bony injury. Disc and joint spaces are well maintained. There is no arthritic spurring. The neural formina are patent.

Thoracic Spine (3 Views): There is a slight right thoracic scoliosis curve. There is no evidence of fracture, dislocation, or other bony injury. Disc and joint spaces are well maintained. There is no arthritic spurring.

Lumbosacral Spine (5 Views): There are six lumbar-type vertebrae. (This is an anatomical variant.) There is no evidence of fracture, dislocation, or other bony injury. Disc and joints spaces are well maintained. There is no arthritic spurring. There is no spondylolysis. There is no spondylolisthesis.

Pelvis (1 View): There is no bony abnormality of the pelvis. The hip and sacroiliac joints are well maintained.

Review of Records

Some records have been submitted for review. These will be summarized in chronological sequence for clarity of review.

There is a Doctor's First Report of Work Injury prepared by Dr. B. who saw the patient on December 3, 2004. (I am not sure of the exact date because the report is poorly typed.) The date of injury is listed as November 30, 2004, and it was stated he had low back pain after trying to remove a heavy cabinet from a wall. The history is of neck and low back pain since November 30, 2004 after trying to remove a heavy cabinet from a wall that weighed about 100 pounds. It was noted he had help. The examination revealed slight kyphosis. He could reach to the floor but it was painful to recover. He had full rotation. Flexion to either side was limited to 40% of normal. It was stated he had an antalgic gait. He could heel and toe walk. X-rays of the lumbar spine showed no fracture and the diagnoses were lumbar strain and cervical strain. It was stated he was given medications and was to be checked by a doctor again on December 6, 2004. Handwritten on the form are some work restrictions that appear to be a 10 pound lifting restriction and he was to avoid repetitive bending, stooping or prolonged standing or sitting and he was to do no climbing. (It is somewhat hard to read this form.)

There is a typewritten work status report prepared by Dr. B on December 3, 2004 noting the diagnoses were a lumbar and cervical strain, and this was the first visit for the injury and it was stated he has had x-rays and was given medication. It was felt he could do modified work with a number of restrictions.

From that same facility there is a work status report prepared by Dr. W. dated December 7, 2004. The same diagnoses are listed and it was stated he was improving slowly and he could be at modified work with a number of restrictions.

Another report from Dr. W of December 13, 2004 again states he could be at modified work with the same restrictions. It was stated he was improving but slowly.

Next from that facility there is a report of an orthopaedic consultation prepared by Dr. Y. who examined the patient on December 30, 2004. In this report it was stated he had worked for the last 10 years for the company as a machine operator. (Please note: He told me he was hired in June or July 2004, a few months prior to the industrial injury.)

The history of injury of catching a falling cabinet is noted, with the development of an immediate pull and sharp pain in the low back. It was stated he took some Tylenol and felt better but the pain started increasing and he reported it on December 2 and was seen at the care station on December 3, 2004. He was given medication. It was stated he was having ongoing pain and was referred for further evaluation. He denied prior injuries to the neck or back. He was now complaining of severe pain, mostly in the low back, aggravated by prolonged sitting or standing. He could not arise from a sitting position on his own because of pain. Tylenol and other medications had helped only temporarily. The pain was not radiating beyond the buttocks. He had difficulty sleeping. There was some sharp pain and heaviness in the neck area that did not radiate into the arms but the neck pain was minor compared to the low back. He was currently not working.

Physical examination revealed he was in moderate distress with pain, and his gait was very slow and antalgic on the left, but normal reciprocating. He could toe and heel walk. Neck range of motion was completely normal. There was some tenderness of the upper trapezius, but no spasm. Lower back examination revealed decreased lordosis and tenderness and moderate to severe spasm. There was limited motion in all directions (but the motion was much greater than that demonstrated by the patient to the undersigned currently). It was noted leg raising was negative at 90 degrees bilaterally with negative stretch signs. Neurological examination as described revealed symmetrical reflexes and no loss of strength or sensation. It was noted x-rays of the lumbar spine were normal and the diagnosis was a severe lumbosacral strain and a mild cervical strain. It was noted that his findings were consistent with a strain and the examination showed no evidence of a radicular component. It was felt he should have conservative

treatment with medication and a course of physical therapy. He was released to modified work with a lot of restrictions.

A brief work status report from Dr. Y of December 30, 2004 notes that he was given Motrin and Parafon Forte and was to have a home interferential unit and be at modified work. He was also to start physical therapy three times weekly.

A physical therapy evaluation dated January 6, 2005 notes the patient was complaining of constant severe pain in the mid lumbosacral spine with tingling and numbness to the left lower extremity and throbbing pain in the neck without radiation. The pain appeared to have been aggravated since injury. He was to have a treatment program with a pool program, modalities and other treatments.

On January 20, 2005 a work status report from Dr. Y notes he was still being followed with the same diagnoses, something is mentioned about getting an MRI study but I cannot read the handwritten note clearly, and he was still to be at modified work.

There is a report of an MRI study of the cervical spine that was performed on February 3, 2005. There was a 2-3 mm disc protrusion at C6-7 with no neurological involvement. (Please note: An isolated disc protrusion at one level in the neck would not be related to a straining injury that involved the lower back.)

A follow-up report from Dr. Y is dated February 10, 2005 and notes the patient was complaining of increasing pain and there was now pain radiating down the legs and he wanted a back support. There was numbness and tingling. He was taking over-the-counter Tylenol because the other medicines had upset his stomach. It was stated therapy was only helping “somewhat.” He was not working. Neck range of motion was normal, although it was noted that with extension there was “exaggerated facies.” Lumbosacral motion revealed only a 10 degree limitation of flexion and extension, and extension was painful. Other motions are normal. The neurological examination as described was normal. MRI findings were noted. It was stated there was also an MRI of the lumbar spine (not available to the undersigned) that showed mild desiccation at L3-4 with a mild bulge that did not impinge on neural elements. The diagnoses of Dr. Y were “Cervical and lumbosacral strain. Subjective complaints much greater than any objective findings.”

Under the discussion it was noted that although he still had significant subjective complaints, they were not backed by objective findings. It was noted the MRI showed the spine was “structurally sound with no evidence of any danger to any of the neural elements or the spine itself.” It was explained to the patient that the best thing to do would be to exercise and he was released to regular duty.

The only other report available is a very brief note from I. Boyarsky, D.O. which is a disability status report and not a full medical report. It was stated the patient was seen on March 22, 2005 and he was temporarily disabled from that date through April 28, 2005, and that he needed treatment. No diagnosis is made and no examination findings are reported.

This concludes the review of the submitted records.

Comment

After a review of the history as obtained directly from the patient and the records that have been submitted, my physical examination and the x-rays available, it is my opinion that the above-captioned patient has the following orthopaedic conditions:

1. History of cervical strain.
2. History of lumbar strain.

It has been more than six months since this patient's injury, and instead of showing any gradual improvement, his symptom complexity is expanding. I would concur with the final impression of Dr. Y that the best management program for this patient would be a progressive exercise program. I do not believe that intensive physical therapy treatments that are not reducing his pain are indicated, necessary or likely to be of any benefit.

I believe that for all practical purposes, it would be in the best interests of the patient and all parties concerned to consider his condition is at MMI at this time and settle his industrial injury claim.

The patient's condition has reached MMI subsequent to January 1, 2005, and will be rated according to the AMA Guides to Evaluation of Permanent Impairment, 5th Edition.

The patient's neck injury falls into the DRE cervical Category I.

It is noted there are no significant clinical findings. There is no muscle guarding or spasm. He has full range of motion, although he complains of pain at the extremes. He has some non-organic findings including the marked low back pain even prior to the application of any pressure with cervical compression. His sensory changes do not follow any organic neurological distribution. The motor function is intact, reflexes are normal and grip strengths are appropriate.

I see no evidence of permanent impairment and no objective signs. I recommend this patient do appropriate stretching and neck exercises before and after vigorous activity.

This patient's neck condition should be rated as 0% impairment of the whole person as per the AMA guides (pages 392).

With reference to his lower back condition, I would rate his impairment in the DRE category of DRE lumbar Category II.

It is noted his history and examination are consistent with a specific injury on a specific date. At the time of the examination he has marked restriction of motion; however, this appears to be more voluntary than objective impairment. He will not even attempt to perform any flexion. This is in contrast with his initial examination which shows excellent motion. His leg raising signs do not confirm any radicular finding and he has non-verifiable radicular complaints. There is no alteration of the structural integrity and no significant radiculopathy.

DRE Lumbar Category II rates to 5% to 8% impairment of the whole person, and I believe that the non-objective factors which predominate would put this patient in a 5% category of whole person impairment.

Using the combined value chart of a 5% impairment plus a 0% impairment results in a 5% whole person impairment for this individual.

At the current time, I do not believe that any ongoing medical care is indicated or necessary but the patient should be encouraged to pursue a regular home exercise program. He should be reassured regarding the absence of any significant pathology in his back or neck.

Giving the patient every benefit of the doubt, I believe that at most he should have a permanent work restriction in the category that would preclude very heavy lifting. Whether or not he could return to his usual and customary work would best be determined by reviewing an analysis of the physical demands of his usual and customary work. If an analysis can be obtained, I would be happy to review it and provide a supplemental report.

In terms of apportionment based upon causation, the information available indicated this patient has only had one injury in his lifetime. There is no evidence of any other factors contributing to his disability. Therefore, I would apportion all of his current condition to industrial causation, namely the lifting and straining injury that occurred at work on November 30, 2004.

The patient was seen at this time for orthopaedic evaluation purposes only. If there are any questions regarding these opinions, please do not hesitate to call upon me.

Please note, obtaining a history directly from the patient (with the assistance of an interpreter, if needed), reviewing and summarizing all records (if any), performing the entire physical examination and all measurements, reviewing x-rays (if any), and the preparation and dictation of this entire report were entirely and solely performed personally by the undersigned. The only exceptions were the measuring of vital signs and the transcription of my personally dictated findings onto an office work sheet which were done by (office manager), who has been my office manager and back office assistant for 20 years and has been instructed and monitored in these activities by me. The time spent in connection with this evaluation was in compliance with any available guidelines.

I declare under penalty of perjury that there has not been a violation of Labor Code Section 139.3 that the contents of the report are true and correct to the best of my knowledge, and any statements concerning any bill for services are true and correct to the best of my knowledge.

I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to the information that I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true.

Date______________ in the County of_____________________

Sincerely yours,

Joe AME
Diplomat of American Board of Orthopaedic Surgery

CC: Adjustor
Defense Attorney
Applicant Attorney