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Objective Medical Assessments Corporation

401 Second Avenue South, Suite 110, Seattle, WA 98104

To:

_____
_____
_____

Medical Examination of:

Employer:
Claim Number:
Date of Exam:
Date of Birth:
Date of Injury:

Location of Exam: Anchorage, Washington
Examining Physician:
Dictated by:

INTRODUCTION

Thank you for requesting OMAC to schedule an independent medical examination on _____. The following is a report of an examination performed by Dr. _____.

This report is intended to provide you with a fair and objective review of the medical facts relating to the examinee's circumstance, including those particular issues presented for our consideration.

The opinions expressed in the report are solely those of the physician performing the examination.

A reminder letter was sent to the examinee which included an explanation of the purpose and procedures of the examination. The letter also informed the examinee that a written report will be sent to the agency requesting the examination. The examinee should contact that agency for information regarding the report.

The dictated report is as follows:

ORTHOPEDIC EVALUATION

CHIEF COMPLAINT

Right knee pain.

HISTORY OF PRESENT ILLNESS

The claimant is a 32-year-old male who worked as a journeyman roofer, doing construction work. He was injured in early October 2005. He states that he had a sudden pop in his right knee while moving some pavers around. The exact date of the injury was early October 2005, and the injury report claim was filed and dated October 13, 2005.

He continued to work for approximately one week after his injury but began to have severe pain, especially trying to go up and down ladders. This led him to cease work and seek medical care. He has been off work since October 13, 2005.

He ultimately was referred for a magnetic resonance image (MRI) scan and orthopedic care. On November 17, 2005, he underwent arthroscopy and partial medial meniscectomy by _____, M.D. This procedure was uncomplicated and his postoperative course has been a normal recovery.

CURRENT COMPLAINTS

On the pain diagram today, the claimant has circled the anterior portions of the right and left knees and the posterior midback and right wrist. Of note, he states that he has a history of a left knee injury and arthroscopic surgery in 2002.

He states overall that he is much improved after his right knee surgery. He still has some pain and aching in the knee. He cannot tolerate kneeling on his knee yet. Squatting is okay but he notes that the knee is a little stiffer than it used to be. Daily activities and walking around on level ground are not painful. He feels like he is close to normal.

Although he has been off work since the time of the injury, he has been released to return to work as of January 16, 2006. There is a job starting within the next one to two weeks, which he plans on returning to.

CHART REVIEW

10/13/05: There is a report of an occupational injury for _____. The injury was described as occurring on _____, “moving pavers, knee popped loudly. It was a little sore and as the week progressed and we moved to _____ it got worse up and down ladders.”

10/14/05: There is an evaluation for right knee pain from urgent care. The physician was _____ M.D. The examination showed medial joint space pain, no joint instability, and some moderate crepitus. Radiographs were normal. Assessment was knee pain of unclear etiology. The recommendation was for a knee immobilizer and a referral for orthopedic consultation as well as light duty.

10/14/05: A light duty prescription was given.

10/19/05: There was an evaluation by _____, M.D. On examination, the claimant was noted to have no instability of the knee and tenderness with medial McMurray’s test. X-rays were normal. His impression was knee pain consistent with articular cartilage damage versus meniscal tear. He ordered an MRI scan with follow up to be in approximately one week. He also ordered him to be off work until followed up.

10/19/05 There is a Department of Labor progress report for the injury. This states that he was not released to work for approximately seven days until he followed up after the MRI scan.

10/25/05: An **MRI scan** report of the right knee listed an impression of horizontal cleavage tear of the posterior horn of the medial meniscus. The lateral meniscus, collateral ligaments, and cruciate ligaments were intact.

10/26/05: He was seen in follow up by Dr. _____. They reviewed the MRI scan and noted the medial meniscus tear. They discussed operative treatment with a right knee arthroscope. The claimant agreed to proceed and this was scheduled for November 17, 2005.

10/26/05 There is an interval progress report for the Department of Labor stating that knee surgery was planned for a medial meniscus tear.

11/09/05 There are some laboratory chemistry results from _____ in Palmer, Alaska.

11/17/05: There is an **operative report** by Dr. _____. The preoperative and postoperative diagnosis was medial meniscus tear, right knee. The procedure performed was diagnostic knee arthroscopy and partial medial meniscectomy. The procedure was stated to be without complications.

11/23/05: The claimant followed up for a postoperative examination with Dr. _____. The sutures were removed and he was healing well. The plan was progression of activities as tolerated. He was to be out of work for approximately five more weeks. A workers' compensation interval progress report for this date states essentially the same thing.

Prior Records

06/12/02: There are records regarding the claimant's left knee. The first one is an evaluation by _____, M.D. Chief complaint was left knee pain. Impression was internal derangement of the left knee and an MRI scan was ordered.

06/17/02: An MRI scan report of the left knee listed an impression of complex tear, posterior horn, medial meniscus and focal cartilage defect, posteromedial femoral condyle.

06/19/02: He followed up with Dr. _____. The MRI scan showed an osteo-chondral defect of the posteromedial aspect of the lateral femoral condyle as well as a complex medial meniscus tear. At this point in time, they discussed arthroscopic surgery.

07/02/02: There is a preoperative history and physical noting the plan for arthroscopic left knee surgery.

07/02/02: An operative report for left knee arthroscopy indicated debridement of medial meniscus tear. The surgeon was Dr. _____.

07/15/02: The claimant was in for follow up. He was doing well, healing well, and progressing with activities.

08/20/02: He was released by Dr. _____ to return to full work.

PAST MEDICAL HISTORY

Injuries:
Left knee injury.

Surgeries:
Left knee surgery.

Allergies:
None listed.

Medications:
None.

REVIEW OF SYSTEMS

The review of systems is historical, based upon the medical documentation provided and an interview with the examinee.

HEENT:
Positive for glasses or contact lenses.

Cardiocirculatory:
Negative.

Pulmonary:
Negative.

Gastrointestinal:
Negative.

Genitourinary:
Negative.

Hematologic:
Negative.

Dermatologic:
Negative.

Endocrinologic:
Negative.

Neurologic/Psychiatric:
Negative.

Musculoskeletal:
Negative.

SOCIAL AND FAMILY HISTORY

Information in the Social and Family History section of this report was obtained from a form completed by the examinee and an interview with the examiner.

General background:
Mr. _____ is single with two dependents.

Military history:
None.

Education level:
College.

Hobbies and activities:
Sports, fishing, and camping.

Exercise:
Work and weights.

Habits:
Tobacco use is 3/4 pack per day and alcohol and illicit drug use is denied.

Work history:
He is currently not working.

Benefits:
Workers' compensation benefits.

Familial history:
His mother 's history is positive for high blood pressure and colon cancer.

PHYSICAL EXAMINATION

Height:	5 feet 11 inches
Blood pressure:	152/88
Pulse:	72 beats per minute
Dominant hand:	Right

In general, the claimant is a healthy fit-appearing male. He is alert, oriented, and in no acute distress. He shows a nonantalgic gait pattern.

ORTHOPEDIC EXAMINATION

Examination of the right knee shows well-healed arthroscopic portal incisions. Range of motion is from 0 to 135 degrees. He has no effusion. He has normal patellar tracking, no crepitus, and mild medial joint line tenderness. There is a negative McMurray's test. Ligamentous examination is stable to varus and valgus at 0 and 30 degrees. He has a firm end point with Lachman's maneuver.

The left knee shows no effusion or joint line tenderness. Range of motion is from 0 to 135 degrees. There is no ligamentous instability.

The hips show full painless range of motion bilaterally. There is no atrophy noted. Thigh circumference is 44 centimeters on the right and 43 centimeters on the left. Calf circumference is 36 centimeters on the right and 36 centimeters on the left.

Neurologic examination shows 2+ and symmetric deep tendon reflexes. Sensation is intact to light touch and pinprick in all dermatomes. Motor is 5/5 in all muscle groups throughout.

IMAGING STUDIES

Three views of the right knee show no evidence of fracture or degenerative changes.

The MRI scan of the right knee shows a complex longitudinal posterior horn medial meniscus tear and no other noted pathology.

DIAGNOSIS

Right knee posterior horn medial meniscus tear, status post arthroscopy and partial medial meniscectomy, related, on a more-probable-than-not basis, to the occupational injury of October 13, 2005.

RECOMMENDATIONS AND DISCUSSION

1. Please provide your diagnoses of any and all conditions related to the October 13, 2005, report of injury. Please examine and report all diagnostic findings.

Please see above for diagnosis and diagnostic findings.

2. Is the October 13, 2005, work injury a substantial factor in the claimant's current condition(s)? Causation in Alaska Workers' Compensation system turns on whether the alleged injury is a substantial factor in bringing about the harm. The substantial factor test involves two parts. First, the injury is a substantial factor if the harm would not have occurred at the time id did in the way it did or to the degree that it did but for the alleged injury. Second, that reasonable people would regard the injury as a cause and attach responsibility to it. If both of these parts of the substantial factor test are answered affirmatively then the injury may be a substantial factor in bringing about the harm. Please keep in mind there may be multiple substantial factors that cause a particular harm.

a) If work was a substantial factor in causing any condition(s), please detail the reasons why you believe it to be work related. If there is an alternate explanation for any of the current diagnoses, please identify the alternate explanation clearly outlining any other contributing factors.

I find that the October 13, 2005, work injury was a substantial factor in the claimant's current condition. His stated mechanism of injury and clinical history of the injury are consistent with sustaining a traumatic meniscus tear. In the absence of any prior history of knee problems, I find that the cause of the knee condition should be attributed to the work injury on a more-probable-than-not basis.

3. Have any conditions for which the October 13, 2005, injury is a substantial factor reached medical stability? Alaska State Workers' Compensation Statutes define medical stability as: The date after which further objective measurable improvement from the effects of the compensable injury is not reasonably expected to result from additional medical care or treatment, notwithstanding the possible need for additional medical care of the possibility of improvement or deteriorating resulting from the passage of time; medical stability shall be presumed in the absence of objectively measurable

improvement for a period of 45 days; this presumption may be rebutted by clear and convincing evidence.

a) If yes, what is the specific date of medical stability? Has the claimant returned to preinjury status as it relates solely to the incident of October 13, 2005?

At this point in time, I do feel like the claimants' condition has reached medical stability. In fact, he has been cleared to return to work by his treating orthopedic surgeon. I feel like medical stability has been reached as of this date and he is essentially at his preinjury status.

4. If not yet medically stable in regard to the conditions for which the October 13, 2005, injury is a substantial factor, what medically necessary treatment will result in objective medical improvement of the claimants' complaints? Please include specific recommendations regarding modalities and timeframes for each treatment recommended. If other diagnoses require treatment, not related to this incident, please provide recommendations for those conditions as well.

a) With the provision of additional medical treatment, what further objective medical improvement can be expected to result?

b) Please advise whether any specific medications would be warranted relative to the October 13, 2005, injury? If so, please specify the type of medication that is/would be reasonably effective and necessary for the process of recovery. Please also comment on the effectiveness and necessity of the medications prescribed to date to the claimant.

I do not find that any further diagnostic modalities are necessary and I do not feel like any additional medical treatment is needed at this point time. Also, no specific medications are being taken by the claimant at this time and no medications are necessary for the October 13, 2005, injury.

5. If medically stable, does the claimant have a ratable permanent impairment as a result of the reported injury of October 13, 2005, or to an earlier preexisting condition? If related to some condition other than the incident of October 13, 2005, please segregate those conditions from your permanent impairment rating.

a) If yes, please rate whole person impairment pursuant to the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition, citing specific pages and tables within your report and, again, segregating out all preexisting and nonrelated conditions.

The claimant does have a ratable condition for permanent partial impairment according to the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition, as a result of the injury sustained on October 13, 2005. He has no evidence of loss of motion, strength, or muscle atrophy on examination but he does have a diagnosis-based impairment of 2 percent lower extremity or 1 percent whole person impairment as a result of a partial medial meniscectomy. Please see Table 17-33 in the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition. Therefore, this would give him a whole person permanent partial impairment rating of 1 percent as a result of this injury on October 13, 2005.