O ▪ M ▪ A ▪ C

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:
Examining Physician: Joseph Lynch, MD
Dictated by: Dr. Lynch

INTRODUCTION

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

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 Diagnoses and Recommendations and Discussion sections are solely those of the physician performing the examination.

A reminder letter was sent to the examinee that 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

This is an independent medical evaluation performed by myself, Dr. Lynch, on _____. Prior to beginning, I met the claimant and discussed the independent medical evaluation process, how there is no doctor/patient relationship implied or

established, how I am not a treating physician, and how the examination will be limited to the condition in question as outlined by the provided medical record and accompanying letter, which includes the claimant's low back, cervical spine, and left upper extremity. I also explained to her that this is in no way meant to be a general physical examination. We discussed how she is to have self-imposed limitation of motion or maneuvers during the examination process. I also instructed the claimant to let me know if anything bothers her or is uncomfortable, even minimally, during the examination process, and I will stop that portion of the examination immediately. Additionally, as the claimant is a female, we will have a female OMAC employee present during the entire physical examination as an observer. The claimant verbalized understanding of this agreement and with all points of the discussion and requested that I proceed.

CHIEF COMPLAINTS

Low back pain, right greater than left.

HISTORY OF PRESENT ILLNESS

_____ states that the date of injury was _____, 2007. In her own words, she states it was Saturday night, and she was housekeeping. She was running into the restroom to provide more toilet paper, and she slipped on what appeared to be soda and ice on the floor. The tiles were very slick. She states while she was running in the bathroom to refill the toilet paper, she had two large toilet paper rolls located on her left forearm. She states that she fell backward landing on her upper back, and she hit her head and left forearm. She states she was then taken out on a gurney to an emergency department where she was evaluated. She states that she obtained studies which were normal, and she was told to follow up with her primary care physician.

She then established care with _____, PA, and _____, DO, who recommended medications in the form of narcotic medication and muscle relaxants and prescribed massage therapy. She states that she had three months of massage therapy at the _____, which improved her symptoms, and then she reached a plateau with respect to her symptoms. She states that sometimes after massage therapy, her low back was uncomfortable.

She states that she went back to light duty as a greeter and door observer a week and a half after the injury. She states that approximately three to four weeks ago, she was trying to stop her brother from committing suicide, and her brother shoved her violently throwing her to the ground where she reinjured her back and had an aggravation of her symptoms. She states that she is not back to where she was prior to this incident, and that prior to this incident, she was doing

okay. She also states that two weeks ago, she felt that she threw her back out again doing laundry in the washer room.

Over the interim, she has been receiving most of her care by _____, DO, from _____. He prescribed physical therapy. She states that she has completed a course of physical therapy as prescribed by Dr._____l and then discontinued that therapy because she did not feel it was improving her symptoms. The medical record indicates that she has a new prescription provided by Dr. _____, but she is not interested in participating. However, she was considering setting up therapy or massage on her own through _____.

She states that she has not been back to work as a housekeeper, but that the most aggressive maneuvers that she would perform as a housekeeper would be lifting heavy garbage, which she says on occasion can weigh 20 to 30 pounds, but no more than that. She states that she is easily and very comfortably able to perform the light duty jobs that she is currently doing at the _____, and she has no concerns with regard to her ability to perform those jobs to her full ability.

She reports no prior injuries related to her upper extremity or back, although she does describe a history of a fracture to her left foot as a child. The injury to her left upper extremity manifested as a bruise to her left forearm, which she said has resolved on its own with no sequela. She states she has no limitations with her upper extremities and that they are back to baseline.

Current treatment includes physical therapy, which she states she has completed by Dr._____l, and she is not interested in doing the therapy as recently prescribed by Dr. _____, but is interested in doing some therapy through _____. She states she is prescribed muscle relaxants, which she takes on an as-needed basis as well as ibuprofen. She also has a prescription for Vicodin, but she states that she is not currently taking this.

CURRENT COMPLAINTS

The pain diagram demonstrates areas circled around the posterior cervical spine as well as lumbar spine mostly on the right side. The location of her pain currently is located in her low back, right greater than left. She experiences pain every morning. She describes the intensity as sharp. It does not radiate anywhere. She denies any paresthesias, numbness, or weakness. She says that ice and over-the-counter thermal patches make her symptoms better, and she states prolonged sitting and standing and sleep make them worse. She rates her pain at 7/10 on an average day, and today she states it is 6/10.

CHART REVIEW

This is meant to be a summary of the provided medical record as it relates to the musculoskeletal issue described above. It is in no way meant to be a substitute for the entire medical record. Should any questions arise regarding this review or independent medical evaluation in general, I would request that the entire medical record be available for further review.

Date — Work injury report. Supervisor, _____, was notified around 11:15 p.m. The accident was not witnessed. The cause of the accident is listed as, "Employee slipped on the floor in the restroom." The supervisor stated that he would inform the employees to monitor the floor before entering the restrooms. This also states that _____ sought care of a doctor named _____, MD, and that she missed work on _____, 2007, and _____, 2007. The nature of the injury was bump on the head, the arm, neck, and back.

Date — Physician's Initial Report signed by Dr. _____ with a diagnosis of strain of cervical, thoracic, and lumbar spines and left shoulder. It states there was no preexisting impairment to the area injured.

Date — **Radiograph report of the left shoulder.** Negative left shoulder series is the impression read by _____, MD.

Date — Radiologist's report from _____. **Lumbar spine films.** The impression is no evidence of fracture and no significant disc space narrowing. The interpreting physician is Dr. _____.

Date — Radiology report from _____. **Cervical spine films.** Impression was negative cervical spine series.

Date — A surveillance report stating that on Saturday,_____ , 2007, at approximately 11 o'clock in the evening, there was a note that an employee fell in the northeast women's restroom. At that time she stated that her entire back and left arm hurt and that she exited the restroom on a gurney and was taken to a hospital.

Date — Emergency physician's record. History states the patient complained of worsening neck pain and stiffness. Seen two days ago and had x-rays done. She had been holding her right arm. However, she experienced worsened pain. Clinical impression was acute myofascial strain of the cervical region and contusion of the left upper arm. The examination states that she had full range of

motion, but had a tenderness about the contusion of her left upper arm. All her extremities demonstrated full range of motion without tenderness. This is a handwritten note, and the remainder of the note is illegible. The end of the note, however, states that she was given Percocet for pain, provided a sling, and told to follow up with her primary care provider.

Date _____ with data entered by Mr. _____. Diagnoses are contusion left upper arm and cervical muscle strain. Plan was to take pain medication as prescribed and follow up with a private physician in 24 to 48 hours or return to the emergency department if worsened. Signed by Mr. _____.

Date Accident report. Name of injured is _____ _____. The description of the injury is, “It was Saturday night the _____ at about 11:00 p.m. I was focused on keeping the restaurant because it was really busy. I went to go to put the toilet paper in the restroom and walked in and slipped on soda, and I hit the floor hard and hit my head and arm.” It states that she informed her employer on _____, 2007, and that she was scheduled to return to work on _____, 2007.

Date Clinic note from Dr. _____. Chief complaints were lumbar strain and shoulder strain. At this point she denied any numbness or tingling and weakness or pain of the distal extremities. Neck examination demonstrated full motion. There was no pain with axial compression. The entire spine was palpated and nontender. Shoulder had full active motion bilaterally. She did have a bruise on her left shoulder. Straight leg raise was negative. Deep tendon reflexes in the upper and lower extremities were symmetrical. She was neurovascularly intact in all distal extremities. The assessment was lumbar strain and arm strain. Plan was temporary work restrictions as previously described from_____, 2007, to _____, 2007.

Date The next documentation is the Physician’s Initial Report with the date of _____, 2007. The diagnoses were lumbar strain and shoulder strain. Objective finding was a bruise in the left shoulder. Treatment recommendations were rest, ice, compression, and elevation. This was signed by Dr. _____.

Date The next document is a work release form from The _____ from Dr. _____. She was listed for modified duty from _____, 2007, to _____, 2007. After _____, 2007, she was stated to be allowed to return to her regular position.

Date Human resources light duty status change from maintenance customer to security customer service reports.

Date The next document is a _____ from _____ stating that the supervisor, _____, responded to the women's restroom to an employee who slipped on the floor named _____. It states that the claimant was lying in the middle of the floor when he arrived and was crying and stated that the back, head, and left arm were hurting. She was not moved due to suspect of an injury. There were no visual findings or physical deformities appreciated at that time. A 911 response was initiated. Aid was on site at 23:09, and Ms._____ was secured to a spine board and left the property at 23:32. It states the floor looked like there had been a drink spilled on it.

Date Document by _____, PA. This is a clinic note. The subjective portion of this note states that the patient was tearful and crying upon entering the room and that she had significant headache symptoms. There was report of a large hematoma on her head. Examination of her upper extremities shows 5/5 strength symmetric to the uninjured extremity. She had decreased adduction to approximately 120 degrees and elevation to 140 degrees. Her assessment was contusion of the head, left shoulder contusion and strain, and lumbosacral strain. She was advised to keep the appointment with _____ on _____, 2007. A head CT was offered for her headache, but she declined a head CT at that time.

Date Activity prescription form where the claimant was listed to perform modified duty from _____ to _____, 2007, signed by a physician's assistant and physician whose names are illegible.

Date The next document is a work release from _____stating that she was released for customer service representative, card clerk, and workout room attendant with a diagnosis of cervical spine strain and left shoulder strain. She was designated to return to work with restrictions on _____, 2007, with the duration of these restrictions until _____, 2007.

Date Clinic note by Dr. _____ describing the nature of the injury and present history. The diagnosis was lumbar strain, cervical strain, intermittent headaches, and poor sleep secondary to pain. He prescribed her diclofenac and also wrote her a refill of her Vicodin and for physical therapy with _____ for spine therapy. He felt that

she should not lift greater than 10 pounds and that she should not bend, stoop, kneel, crawl, or twist, with these restrictions to continue for one month.

There is an addendum to this report stating that this provider discovered that the patient has a history of admitting to a problem of narcotic addiction with medications of Vicodin or Percocet started in _____ 2006 when she was seen by Dr. _____, although the patient denied problems with alcohol or drugs during his visit.

Date — Progress notes by Dr. _____. The patient still complained of too much pain for light duty, and she was requesting a back brace. The impression was ongoing lumbar strain and left shoulder strain. The plan was to proceed with physical therapy and to refill the Vicodin and diclofenac.

Date — Work release form signed by Dr. _____ stating that she was able to return to work on _____, 2007, for two weeks with restrictions, but she was approved to be customer service representative, card clerk, and workout room attendant.

Date — Document by _____, MD, stated that this was a female who was on limited restricted duty secondary to injury sustained previously at her place of employment. Examination demonstrated range of motion, which was well preserved with some paraspinal tenderness in the thoracic spine. It states in the history that the patient was pushed over by her brother which aggravated her thoracic spine pain and developed lumbosacral pain and discomfort after this as well. The impression was lumbosacral sprain as well as thoracic and cervical strain, which were aggravated. The plan was to refill diclofenac, local heat, and Vicodin on an as-needed basis. She was to follow up with _____in two weeks' time as already arranged.

Date — The next document is an activity prescription form stating that the worker may perform modified duty until _____, 2007, at six hours a day. The restrictions are handwritten and illegible, as is the provider's signature.

PAST MEDICAL HISTORY

Injuries:
She reports an injury to her left foot. She also reports an injury that she cannot recall to her right knee.

Past/Recent illnesses:
High blood pressure. No other illnesses.

Surgeries:
She has had a tubal ligation in the past.

Hospitalizations:
She does not report any recent hospitalizations other than related to the current injury as described in the chart review.

Allergies:
None.

Medications:
Current medications are listed as atenolol 50 milligrams.

REVIEW OF SYSTEMS

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

Review of systems summarized from the intake form is positive for high blood pressure, appetite problems, heartburn, urinary difficulty, pelvic inflammatory disease, severe acne, tattoos, anxiety, sleep problems, neck pain, and back pain as well as a history of left foot fracture.

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 examiners.

Education level:
Her highest level of education is 10.

Habits:
Tobacco use is seven cigarettes. No alcohol and no illicit drugs.

Hobbies and activities:
None indicated.

Exercise:
Exercise is typically stated to be walking two times for 30 minutes.

Military history:
She does not mark whether or not she has had military service or note on the intake form.

Personal history:
She is single with three dependents.

Familial history:
Positive for high blood pressure, diabetes, and breast cancer for the mother. The father has had heart disease.

Work history:
She is currently working.

Benefits:
None.

PHYSICAL EXAMINATION

Height:	5 feet 2 inches
Weight:	175 pounds
Dominant hand:	Right

ORTHOPEDIC EXAMINATION

Ms. _____ is asked not to engage in any physical maneuvers beyond which she can tolerate comfortably.

Present for the entirety of the examination are myself, the claimant, and a female representative from OMAC acting as observer.

Her height is reported at 5 feet 2 inches and weight is 175 pounds.

On general appearance, she is a mildly obese female who appears comfortable while sitting and standing.

Upon the beginning of the examination in the examination room, the claimant stands and arises very smoothly from a chair, though does so very purposefully and slowly, exhibiting some pain behavior. She is able to walk with tandem gait without difficulty or limp.

Her posture demonstrates normal lumbar lordosis and cervical lordosis and a normal thoracic kyphosis. There is no apparent scoliosis.

Palpation demonstrates no spasm or paraspinal rigidity. She does report tenderness to palpation, however, over the lower lumbar spine and particularly over the right lower lumbar spine around L4 and L5.

Active range of motion with the inclinometer reveals cervical bending recorded as 30 degrees with significant pain behavior. Cervical extension is also noted to be 30 degrees. Lateral bending of the cervical spine is recorded as 45 degrees to the right and as well as to the left. Rotation is 80 degrees to the right and left, without hesitation.

Extension of the low back is 30 degrees with a moderate amount of pain behavior, and she states this reproduces the symptoms that she constantly experiences in her low back. Forward flexion is to 50 degrees with an inclinometer, although it was apparent during observation prior to entering the clinic that she was able to bend further than this in a more comfortable setting. Thoracic rotation is reported as 45 degrees to the right and to the left and is symmetric without exacerbation of symptoms.

Sensation to light touch is symmetric in all dermatomes with the exception of some mild decreased sensation over some varicose veins which she experiences on her left lower extremity.

Manual strength testing demonstrates 5/5 strength with extensor hallucis longus, dorsiflexors of the ankle, plantarflexors of the ankle, knee extensors, and knee flexors on both lower extremities with the exception of cogwheeling during right knee flexion against resistance. The claimaint refuses to perform strength testing on the left lower extremity with respect to knee extension and knee flexion as she is concerned that this may exacerbate pain related to her varicose veins. She demonstrates 5/5 strength with hip flexion in the seated position.

She is able to perform a seated straight leg raise to 90 bilaterally without discomfort or radiation of symptoms in her lower extremities.

She is able to do a single leg rise bilaterally with a negative Trendelenburg sign. She is able to toe walk and heel walk, although very cautiously and in a guarded

position exhibiting pain behavior, nevertheless she accomplishes these tasks without difficulty. She is unable to squat, as she is afraid that this will exacerbate her symptoms.

On supine examination, she moves to the supine position very cautiously stating that this exacerbates her pain in the low back. She exhibits positive straight leg raise at 10 degrees on the right and 20 degrees on the left – discrepant from the seated straight leg raise tested earlier in the examination. .

Arm circumference localized 10 centimeters proximal to the tip of the olecranon is 30 centimeters on the right and 31 centimeters on the left. Forearm circumference localized 5 centimeters distal to the tip of the olecranon is 22 centimeters on the right and 23 centimeters on the left. Thigh circumference localized one handbreadth above the patella is 44 centimeters on the right and 43 centimeters on the left.

Reflexes demonstrate 2+ reflexes at the biceps, triceps, and brachioradialis bilaterally. In the lower extremities she demonstrates 2+ quadriceps reflexs and Achilles reflexes bilaterally. She has a negative Hoffmann sign, no clonus and downgoing toes bilaterally.

Upper extremity examination in the standing position demonstrates full active forward elevation to 180 degrees and abduction to 170 degrees symmetrically bilaterally. She demonstrates 70 degrees of external rotation and 80 degrees of internal rotation bilaterally. She demonstrates 140 degrees of elbow flexion, 80 degrees of pronation, and 80 degrees of supination bilaterally. She demonstrates full extension bilaterally with a normal carrying angle of both upper extremities. She has full motion of her wrists demonstrating 60 degrees of extension bilaterally and 70 degrees of flexion bilaterally. She has 20 degrees of radial deviation bilaterally and 40 degrees of ulnar deviation bilaterally. She has full motion of her fingers and thumbs.

She reports intact sensation to light touch in all dermatomes of both upper extremities with no deficits.

She has no overlying skin lesions or bruises. There is possibly a faint mark where she states the bruise was located over the toilet paper roll on her forearm, although this is difficult to discern and not clearly identifiable. She has no tenderness to deep or superficial palpation of the entire upper extremity

Motor strength testing is finger flexors 5/5, wrist extensors 5/5, thumb extensors 5/5, biceps 5/5, triceps 5/5, deltoids 5/5, and shoulder shrug 5/5 and symmetric bilaterally.

Vascular examination demonstrates 2+ radial pulse.

She has no pain or discomfort to deep or superficial palpation around either shoulder and no parascapular rigidity. No pain to palpation about the elbows, forearms, wrists, or fingers of either extremity.

Of note, prior to entering the OMAC office, in a more comfortable setting, she was noted to bend over easily and smoothly to pick up a pack of cigarettes which she dropped in the parking lot forward flexing to 90 degrees at the waist. In addition her gait appeared smooth and without hesititation as she went to throw something away in nearest trash can. She appeared comfortable and calm in the waiting room.

IMAGING STUDIES

None were available for review.

DIAGNOSES

As it pertains to the left upper extremity and axial skeleton regarding _____, with a date of injury of _____, 2007:

1. Left forearm contusion, related to the industrial injury on a more-probable-than-not basis.
2. Cervical strain, related to the industrial injury with a date of injury of _____, 2007, on a more-probable-than-not basis.
3. Lumbosacral strain, related to the industrial injury with a date of injury of _____, 2007, on a more-probable-than-not basis.
4. Exacerbation of lumbosacral strain secondary to traumatic incident sustained by her brother as described in the history of present illness, not related to the industrial injury on a more-probable-than-not basis.

RECOMMENDATIONS AND DISCUSSION

The cover letter asks a series of questions to be answered as follows:

1. What is your diagnosis of the claimant's condition and your opinion of the relationship to the alleged incident? Please state on a more-probable-than-not basis whether the alleged incident caused the diagnosed conditions.

Please see above Diagnoses section.

2. Please advise as to whether there have been any intervening occurrences which are related to activities of daily living, or if they were the result of activity not customary to daily living.

The claimant, Ms. _____, appears to have sustained a cervical and lumbosacral strain related to the industrial injury sustained on_____, 2007, that was resolved on a more-probable-than-not basis and subsequently exacerbated by the violent interaction with her brother three weeks ago, according to her report. She was performing light duty without difficulties, she self-discontinued physical therapy and massage therapy according to her own report, and was able to perform daily activities with no significant restrictions until the traumatic incident sustained by the violent shoving action of her brother, which she states exacerbated her symptoms of lumbar strain. She also states that she injured it again while doing laundry at her home. There were no other intervening occurrences or history of prior injuries elicited by history or by review of the available medical record

3. Is the claimant's present condition a direct result (100%) of the incident described? Please explain fully.

In my opinion, the claimant's present condition of cervical and lumbosacral strain was the result of the alleged incident on _____, 2007 on a more probable than not basis, and is resolved. However, the current subjective complaints of pain and pain behavior exhibited during the examination today, along with the discordant exam findings such as seated and supine straight leg raise, the discrepancy between the range of motion measured with the inclinometer during the examination and that observed prior to entering the OMAC building while picking up a dropped object raise some concern as there were no objective findings on today's examination that strongly support the subjective complaints of pain. Nevertheless, it is my opinion that today's subjective complaints represent, on a more probably than not basis, an exacerbation of her low back symptoms sustained during the violent interaction with her brother, rather than residual symptoms from the original cervical and lumbosacral strain sustained on _____, 2007.

4. Is the claimant's condition more probably than not the result of a natural progression of a non-industrial condition or a preexisting disease, which has not been permanently affected by the claimed injury? If so, please explain.

It is my opinion that the claimant's condition is not the result of natural

progression of a non-industrial condition or preexisting disease.

5. Is the current treatment being provided curative or palliative in nature, on a more-probable-than-not basis?

The claimant is currently undergoing treatment in the form of as-needed muscle relaxants, as-needed narcotic pain medication, and self-medicating with anti-inflammatories, which in my opinion are not curative but rather palliative in nature on a more-probable-than-not basis.

6. Do you feel further curative treatment measures are indicated for the residual effect of the claimant's condition, and if so, what are your specific recommendations and duration of treatment?

I do not feel that there are further curative measures for any residual effects of the claimant's condition. In my opinion, the current treatment regimen is palliative in nature, and is likely treating residual effects of an exacerbation of a lumbosacral strain resulting from the violent interaction with the claimant's brother

7. Is the claimant capable of performing regular work activities? If no, please outline any restrictions you would impose on the claimant.

I found no objective findings during today's examination or history that would suggest that the claimant is unable to perform regular work activitities in relation to the injury associated with the incident on _____, 2007, on a more-probable-than-not basis.

8. What date was the claimant capable of performing regular duties without restrictions?

Based on today's examination and my review of the available medical record, it is my opinion that she is capable of performing regular duties without restrictions as of today's date.

9. Are the conditions as described considered to be fixed and stable? If no, please specify the objective findings and those subjective complaints upon which your determination is based.

With respect to the industrial injury occurring on _____, 2007, manifesting as a contusion of the left forearm, cervical strain,and lumbosacral strain, I would consider these conditions fixed and stable on a more-probable-than-not basis.

10. If no active treatment measures are recommended and the claimant's condition has reached a fixed and stable state, please advise of your opinion whether any permanent physical impairment has resulted. Please rate permanent partial disability using the most recent AMA, Guides to Evaluation of Permanent Impairment.

It is my opinion the claimant's condition has reached a fixed and stable state and that based on the AMA, Guidelines to the Evaluation of Permanent Impairment, she exhibits no permanent impairment with respect to the left upper extremity. With respect to the cervical strain and lumbosacral strain, she exhibits a rating of Category 1 according to Washington State workers' compensation regulations.

OMAC/dlm