John W. Alchemy, MD, AAFP, QME, CIME, MRO
Impairment Rating Specialists, Unlimited
John W. Alchemy, MD, A Medical Corporation

Validated Certified Final Comprehensive Written Ratable Permanent and Stationary Report

Impairment Rating Specialists SAMPLE

Employee: XXXX, XXXX

Employer: XXXX, Inc.

Date of Birth: XXXX

Social Security #: XXXX

Date of Evaluation: XXXX

Date of Injury: XXXX, Time: 2:00 p.m., XXXX, CA

Insurance Carrier: XXXX

Adjuster: XXXX

Claim #: XXXX

Examining Physician: John W. Alchemy, MD

Location of Examination: XXXX, CA 95405

Type of Examination: California Workers' Compensation

Level of Examination: Comprehensive Written Ratable Permanent and Stationary Report.

Impairment Ratings Specialists

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Section 1. Executive Summary Statement

The applicant is referred today by XXXX, M.D. for evaluation regarding left shoulder per report document dated XXXX.

Referring Individual: XXXX, M.D.

I take this review at the request of Dr. XXXX pursuant to California Labor Code §4061.5 and California Code of Regulations §9785 in that Dr. XXXX has designated me to render an opinion on the medical issue of the patient's eligibility for compensation with attention to the issue of compensability of the claim, impairment rating, need for future medical care, and all such related questions.

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Written authorization by the carrier has been obtained in advance of the examination today for the services to be performed as a "Validated Certified Comprehensive Final Written Ratable Report"

I verify under penalty of perjury that the total time I spend on the following activities is true and correct:

Time spent face-to face with patient:.....1.28 Hours
Time spent in medical chart review: .....4.22 Hours
Time preparing report:.....3.30 Hours

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Comment to Reader: For our purposes in this report I am only reviewing and rating the left shoulder.

Section 2. Preliminary Introduction & Exam Metrics

Mode of Transportation to Exam: Self Drive

Additional Parties Attending Exam: No

Request for Audio or Video Taping: No

Exam Start Time: 14:23 p.m.

Exam End Time: 15:40 p.m.

Interpreter: No

Disclosure to Employee:

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1)The employee is informed that there will be no treating physician/patient relationship.

2)Information shared by the employee will be included in the examiner's report.

3)The employee should not engage in any physical maneuvers that may cause injury, and that the employee should immediately report any discomfort encountered during the examination.

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Section 3. Description of Records Relied Upon

Chart Review Time: 4.22 Hours

Total # Pages: 5 ½" of Dr. XXXX's office medical chart.

Review And Summary of Medical Records

1. Records from XXXX, M.D., dated XXXX through XXXX.

Medical Records Review: Left Shoulder

Types of Encounter: C=Consult, H=Hospital, I=IME/Impairment Assessment, M=Medical Visit, O=Operation, R=Report/Letter, P=PT/OT Visit, S=Diagnostic Study, X=X-ray (Imaging) Study, *=Other

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1. Date: XXXX, Provider: XXXX, Provider signature illegible, Type: M, Summary: Left Should Non Industrial: Slight improvement after second steroid injection. Persistent decreased range of motion. Ortho evaluation ordered.
2. Date: XXXX, Provider: XXXX Provider signature illegible, Type: M, Summary: Left Should Non Industrial: Can't raise arm to level. Taking 3 Vicodin bid. Exam: sensation decreased all of left hand. Nothing felt over radial and medial nerve distribution. Bruising over left anterior ribs. Left shoulder pain check x-ray, MRI if not revealing suspect rotator cuff injury. Bruising on Plavix.
1. Date: XXXX, Provider: XXXX, Provider signature illegible, Type: M, Summary: Left Should Non Industrial: Severe left shoulder pain and hand numbness. Exam

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numbness of 1st through 3rd fingers. X-ray left shoulder possible impingement. Trial steroid injection today. Check MRI c-spine and shoulder. Vicodin rx.

2. Date: XXXX, Provider: XXXX, Provider signature illegible, Type: M, Summary: Left Should Non Industrial: c/o pain in upper back left arm left axillae worse when lying down. Aleve helps. Exam left hand decreased sensation. Normal MRI MRA with 5 cigs/day. TIA may return to work. Back pain check x-ray t and c spine. Labs ordered.
3. Date: XXXX, Provider: XXXX, Provider signature illegible, Type: M, Summary: Left Should Non Industrial: Back pain seen in ER. Felt ill threw up. Difficulty sleeping. Sweating with pain over upper back. X-rays. If ok then to chiropractor if worsening pain MRI r/o rotator cuff tear.
4. Date: XXXX, Provider: XXXX, MD, Type: X, Summary: Left Shoulder Non Industrial: Three views. Acromioclavicular degeneration with possibility of impingement noted. No additional abnormalities.
5. Date: XXXX, Provider: XXXX, Provider signature illegible, Type: M, Summary: Left Should Non Industrial: Awaiting MRI approval. Ran out of baclofen and Flexeril. Check MRI awaiting approval.
6. Date: XXXX, Provider: XXXX, Provider signature illegible, Type: M, Summary: Left Should Non Industrial: Continued left shoulder pain with elevation.Awaiting MRI approval. Pain medications of minimal effect. Injection left shoulder provided 40mg Kenalog and Marcaine.
7. Date: XXXX, Provider: XXXX MRI, Dr. XXXX, MD, Type: S, Summary: Left Shoulder Non-Industrial MRI: Negative for rotator cuff tear. AC joint osteoarthritis with minimal mass effect on supraspinatus muscle. Possibility of impingement symptoms. Glenohumeral degenerative arthrosis involving the inferior joint. Possible anterior labral tear.

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8. Date: XXXX, Provider: XXXX, M.D., Type: M, Summary: Left Shoulder Non Industrial: Works as carpenter for WGF and has had insidious onset of left shoulder pain which began in XXXX. Seen by Dr. XXXX MD who treated with conservative care NSAIDs. Temporary relief from two cortisone injections XXXX and XXXX. MRI left shoulder XXXX MRI XXXX showed AC joint arthritic changes with a mass effect over the supraspinatus musculotendinous junction, signal changes consistent with glenohumeral joint arthrosis, and possible anterior and posterior labral tears. Continues to have pain left shoulder with overhead activities, pain that awakens him at night, and pain with activities of daily living such as dressing himself. Past medical history: Osteomyelitis fibular XXXXs treated with IV antibiotics, Questionable stroke admitted to XXXX Hospital XXXX diagnosis severe migraine. Surgical history: Left total knee replacement Dr. XXXX, appendectomy XXXX. Current medications Ultram. Allergies: Tetracycline. Tobacco 1 pack per day cigarettes. Patient is a carpenter for XXXX. Not working because of left shoulder pain and weakness. Examination: Left shoulder: painful arc of motion, abduction greater then forward flexion. Positive impingement. Tender over the anterior acromion and sub deltoid bursa and greater tuberosity with the shoulder in extension with internal and external rotation. Negative rent sign, negative Adson. Negative Yergason test. Negative apprehension and upper cut test. Negative AC and SC joint tenderness to palpation and aggravating maneuvers. Rotator cuff testing is 4/5 for isolation of left supraspinatus isolation. Long head of the biceps belly contour is symmetric and bilateral to resisted elbow flexion and supination. Fluoroscan left shoulder XXXX: Moderate degeneration of AC joint with inferior directed spurs and type 2+ acromial configuration, normal appearing acromiohumeral interval, normal appearing glenohumeral joint. Impression: Left shoulder subacromial impingement, stage 2 doubt stage 3 with possible underlying glenohumeral joint

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DJD and possible glenoid labral tears refractory to maximum ongoing conservative therapies. The patient wishes to proceed with left shoulder diagnostic arthroscopy and bursoscopy, subacromial decompression and other corrections as indicated

9. Date: XXXX, Provider: XXXX, M.D., Type: O, Summary: Left Shoulder Non Industrial: Procedure: left shoulder arthroscopic labral debridement, capsular release posterior capsule and rotator cuff interval, grade IV microfracture 2x3 cm lesion, subacromial decompression with excision of the CA ligament and coplanar claviculoplasty and bursal rotator cuff scuff debridement.
10. Date: XXXX, Provider: XXXX, M.D., Type: M, Summary: Left Shoulder Non Industrial: Performing home exercising and attending formal therapy. Continue home exercises and physical therapy and Relafen.
11. Date: XXXX, Provider: XXXX, M.D., Type: M, Summary: Left Shoulder Non Industrial: Status post left shoulder arthroscopic labral debridement, capsular release rotator capsule and rotator cuff interval, chondroplasty with micro fracture of the humeral head and subacromial decompression with excision of the CA ligament with coplanar claviculoplasty on XXXX. His left shoulder continues to do well. He is performing home exercises. He is not working. Forward flexion 170d, abduction 130d. Rotator cuff testing is 5/5. Continue Relafen and he plans to return to work on XXXX.
12. Date: XXXX, Provider: XXXX, M.D., Type: M, Summary: Left Shoulder Non Industrial: Unable to have strength to overhead lift a beam and boss does not want him to return to work until more left shoulder strength.. Positive impingement and mild painful arc of motion. Distal neurovascular exam intact. Left shoulder has near full active range of motion. Rotator cuff testing is 5/5. Home exercise program with heat and ice. Continue Relafen. Recheck in 6 weeks.

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13. Date: XXXX, Provider: XXXX Hosp Radiology Dr. XXXX, MD, Type: X, Summary: :1)Left shoulder complete x-ray: Anterior inferior dislocation of the humeral head of the glenoid. No fractures or subluxations. 2)Left shoulder limited x-ray. Shoulder reduced to anatomic alignment. Lucency along superior aspect probably related to a Mach band, but Hill-Sachs fracture could be considered.
14. Date: XXXX, Provider: XXXX ER, Dr. XXXX MD, Type: C, Summary: Left shoulder and knee pain after fall. Seen at XXXX Hospital for relocation shoulder, reduced then discharged with immobilizer to follow up XXXX. Told might be a tiny crack in left shoulder. Exam: Left shoulder with partial numbness in hand. Normal axillary nerve sensation. Left shoulder back in position. Proximal humerus minimally tender. Given IM Dilaudid and to follow up with his doctor.
15. Date: XXXX, Provider: XXXX MRI Dr. XXXX MD. Type: S, Summary: Left shoulder MRI without contrast. Postoperative changes with probable debridement and partial resection of the acromioclavicular joint. Possible associated rotator cuff repair. Probable supraspinatus tendinosis with a partial articular surface tear or post operative change. Worsening degenerative arthrosis of the glenohumeral joint with associated degeneration of the labrum. Defect in the anterior capsule. Small joint effusion. Probable adhesive capsulitis. Biceps tendon intact. Biceps anchor sub optimally seen and possibly degenerated.
16. Date: XXXX, Provider: XXXX, M.D., Type: M, Summary: Left Shoulder: Status post left shoulder arthroscopic labral debridement, capsular release, chondroplasty with microfracture of the humeral head, and subacromial decompression with excision of the CA ligament with coplanar claviculoplasty on XXXX. Pain free when returned to work XXXX. On XXXX he tripped in a hole in a living room floor when his foot hit a pipe, causing him to fall backwards. Left shoulder was

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dislocated and reduced under anesthesia at XXXX Hospital. X-rays were performed and follow up with Dr. XXXX at XXXX XXXX. MRI showed postoperative changes with probable debridement, probable supraspinatus tendinosis with partial articular surface tear or postoperative changes, worsening degenerative arthrosis of the glenohumeral joint with associated degeneration of the labrum, defect in the anterior capsule and small joint effusion, probable adhesive capsulitis with intact biceps tendon. Pain with movement of the shoulder and weakness with pain that awakens him at night. He has experienced subluxation with showering. Denies subsequent dislocation. Left shoulder exam: Flexion 75d, abd 75d, positive painful arc potion. Positive impingement. +/- upper cut test, no tenderness bicipital groove. Negative Yergason test. Positive apprehension. Rotator cuff 4/5 with isolation supraspinatus 4/5. Slight decreased sensation axillary nerve distribution on left compared to right. Deltoid function anterior middle and posterior is 4/5 left. MRI and x-ray with addendum pending. Impression: Post traumatic anterior dislocation with resultant rotator cuff tear. Patient wishes to process with surgery diagnostic arthroscopy and bursoscopy, subacromial decompression, possible labral repair, rotator cuff repair and other corrections as indicated. . Prescription Norco 5/325 and Lunesta 3mg.

17. Date: XXXX, Provider: XXXX, M.D., Type: M, Summary: Left Shoulder: Ongoing left shoulder pain. In process of QME appointment. No recurrent dislocations or subluxation episodes. Kenalog Marcaine injection provided. Enroll in therapy. If symptoms persist will be a candidate for surgery.
18. Date: XXXX, Provider: XXXX, M.D., Type: M, Summary: Left Shoulder: Continues to have pain. QME scheduled with Dr. XXXX on XXXX. Kenalog Marcaine injection provided. Physical therapy denied. Wishes to proceed with surgery.

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19. Date: XXXX, Provider: XXXX, M.D., Type: *, Summary: Left Shoulder: Peer to Peer Dr. XXXX regarding MRI approval (done prior). Date: , Provider: XXXX, M.D., Type: M, Summary: Left Shoulder:
20. Date: XXXX, Provider: XXXX, M.D., Type: *, Summary: Left Shoulder: X-rays XXXX Hospital reviewed. One view with anterior inferior subcoricoid dislocation of the humeral head. No obvious fractures. Second set of films with anatomic reduction.
21. Date: XXXX, Provider: XXXX, M.D., Type: M, Summary: Left Shoulder: Continued pain and stiffness and weakness refractory to ongoing conservative modalities. Fluoroscan: 1-2 acromial configuration, mild to moderate degenerative changes of the AC joint, mild to moderate degenerative changes of the glenohumeral joint, concentric reduction seen on axillary lateral. No evidence of bony Bankhart or Hill-Sachs impression defect. Again requested is surgery arthroscopy.
22. Date: XXXX, Provider: XXXX, MD, Type: C, Summary: ML 102 Exam. Impression: Dislocation reduction left shoulder with internal derangement. Work related. Apportionment for left shoulder prior surgery 50%. Not MMI. Recommended is arthroscopic surgery.
23. Date: XXXX, Provider: XXXX, M.D., Type: M, Summary: Left Shoulder: Agreement with Dr. XXXX, MD ML102 report XXXX (proceeding with surgery). Patient wishes to proceed with surgery.
24. Date: XXXX, Provider: XXXX, M.D., Type: M, Summary: Left Shoulder: Status post left shoulder arthroscopy XXXX with reinjury XXXX with anterior dislocation and rotator cuff tear. Increasing left shoulder pain with overhead activity and pain that awakens him at night. Temporary relief from Kenalog Marcaine injection XXXX. Patient wishes to proceed with surgery. Kenalog Marcaine injection provided to left shoulder.

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25. Date: XXXX, Provider: XXXX, M.D., Type: M, Summary: Left Shoulder: Status post left shoulder arthroscopic labral debridement, capsular release, chondroplasty with microfracture of the humeral head, and subacromial decompression with excision of the CA ligament with coplanar claviculoplasty on XXXX. Pain free when returned to work XXXX. On XXXX he tripped in a hole in a living room floor when his foot hit a pipe, causing him to fall backwards. Left shoulder was dislocated and reduced under anesthesia at XXXX Hospital. X-rays were performed and follow up with Dr. XXXX at XXXX. MRI showed postoperative changes with probable debridement, probable supraspinatus tendinosis with partial articular surface tear or postoperative changes, worsening degenerative arthrosis of the glenohumeral joint with associated degeneration of the labrum, defect in the anterior capsule and small joint effusion, probable adhesive capsulitis with intact biceps tendon. He had temporary relief from a subacromial injection of Kenalog/Marcaine XXXX. Continues to have pain with overhead activities, pain that awakens at night and activities of daily living. Past history of osteomyelitis in the fibula treated in XXXXs with IV antibiotics. History of migraine headaches. Past surgical history of left total knee replacement Dr. XXXX. Appendectomy in XXXX, laminectomy/diskectomy L3-4 Dr. XXXX in XXXX, Left shoulder arthroscopy and correction XXXX Dr. XXXX. Current medications Norco and Lunesta. Allergies Tetracycline. Tobacco cessation XXXX. Negative for alcohol. Prior carpenter. Exam left shoulder flexion 140d, abd 90d, positive impingement. Negative AC and SC joint tenderness. Internal rotation to L4-5 level. Negative Yergason test. Plus minus apprehension. Rotator cuff testing isolated is 4/5 left supraspinatus isolation. Deltoid anteromedial and posterior is 4+/5. Imaging: Left shoulder fluoroscan XXXX Dr. XXXX: 1-2 acromial configuration, mild to moderate degenerative changes of the AC joint, mild to moderate degenerative changes of the glenohumeral joint, concentric

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reduction seen on axillary lateral. No evidence of bony Bankhart or Hill-Sachs impression defect. MRI left shoulder XXXX MRI: Cystic changes in the greater tuberosity, glenohumeral joint degenerative changes, partial tear vs. full thickness tear supraspinatus tendon, possible anterior capsular deficiency, inferior capsule demonstrates findings consistent with adhesive capsulitis, small joint effusion, long head of the biceps tendinosis, and findings consistent with previous acromioplasty and coplanar claviculoplasty. XXXX Hospital left shoulder x-ray XXXX. One view with anterior inferior subcoricoid dislocation of the humeral head. No obvious fractures. Second set of films with anatomic reduction. Impression: status post left shoulder arthroscopy and correction XXXX with posttraumatic anterior dislocation and resultant rotator cuff tear. Plan: surgery is elected for diagnostic arthroscopy and bursoscopy, subacromial decompression, possible labral repair, rotator cuff repair and other corrections as indicated.

26. Date: XXXX, Provider: XXXX, MD, Type: O, Summary: Left shoulder arthroscopic rotator cuff interval, posterior capsular release, posterior glenoid, 50% microfracture grade IV, chondroplasty of the humeral head, subacromial decompression, redo with coplanar claviculoplasty.
27. Date: XXXX, Provider: XXXX, M.D., Type: M, Summary: Left Shoulder: Slight erythema around incision. Sutures removed. Keflex seven days provided.
28. Date: XXXX, Provider: XXXX, M.D., Type: M, Summary: Left Shoulder: Noted erythema at inscisional ports XXXX and provided Keflex. Exam: Temp 98.1, ribbon of erythema 2x3 cm wide superior anterior portion of shoulder to the axillae, warm to touch. No drainage. Continue seven days Keflex more.
29. Date: XXXX, Provider: XXXX, M.D., Type: S, Summary: Left arm NCS/EMG: Findings of mild left cubital tunnel syndrome with no acute ulnar denervation. No left carpal tunnel syndrome or entrapment. Decreased motor unit recruitment

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corresponding with upper trunk innervated muscles and/or C5-6 inervated muscles. No evidence of isolated left axillary or suprascapular neuropathy.

30. Date: XXXX, Provider: XXXX, M.D., Type: M, Summary: Left Shoulder: Erythema noted on prior shoulder wound check XXXX. Provided Keflex. Erythema resolved.
31. Date: XXXX, Provider: XXXX, M.D., Type: M, Summary: Left Shoulder: Doing well.
32. Date: XXXX, Provider: XXXX, M.D., Type: M, Summary: Left Shoulder: MRI review XXXX MRI: Findings consistent with subacromial decompression and coplanar claviculoplasty, supraspinatus tendinosis, degenerative changes of the glenohumeral joint, consistent with rotator cuff interval release, small joint effusion. The long head of the biceps tendon appears within normal limits.
33. Date: XXXX, Provider: XXXX, M.D., Type: M, Summary: Left Shoulder: Doing well.
34. Date: XXXX, Provider: XXXX, M.D., Type: M, Summary: Status post left shoulder arthroscopic correction as described. He has done well in the last few months. Impression: Doing reasonably well status post left shoulder revision arthroscopic correction as described. PLAN: I anticipate permanent stationary status XXXX. We will refer the patient to John W. Alchemy, M.D. for permanent and stationary evaluation concerning his left shoulder.

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Section 4. Identifying Employment Background Information

Job Title: Carpenter/Foreman

Employee's Self-Reported Job Description: He is a Foreman who performs demolition work which includes heavy pushing/pulling/carrying of power tools. He also drives for the employer. His work hours are 40 hours per week with occasional overtime.

Work Attendance History: 2 weeks off per year.

Promotions/Disciplines: Promoted to Carpenter Foreman 2 years / No disciplinary actions.

Employer: XXXX, Inc.

Length of Employment: 4 years

Current Work Status: Not working

Hand Dominance: Right

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Section 5. Injured Body Location(s) & Mechanism of Injury

Injured Body Location:

1) Left shoulder

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Mechanism of Injury:

This is a XXXX year old, right hand dominant male, who on XXXX, was injured while stepping backwards while at work for XXXX, Inc.

He was framing windows with holes in the floor to expose the support beams. He was called to check a measurement. While holding a tape he stepped back into a hole and his left foot got stuck under some pipes. He fell backwards and landed on his left elbow, dislocated his left shoulder, injured his lower back, right knee and neck.

The incident was witnessed by the owner, XXXX. He was held down to wait for an ambulance. He was taken to the emergency room at XXXX. X-rays were performed in the emergency room and he was told he had a "dislocated" shoulder. He was sedated, the shoulder re-set, provided with a sling and pain medication for use at home. He was then released.

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He went to XXXX Hospital for pain control three days later. He was given Toradol and Dilaudid.

He was then seen at XXXX and given a pain shot for uncontrolled pain. He was directed to see Dr. XXXX, at XXXX Occupational Division.

He saw Dr. XXXX three weeks later for low back (low back pain started one week after the fall from his wearing of a tool belt), right knee pain and ongoing left shoulder pain. The right knee had been hurting since the fall. Dr. XXXX did order an MRI – no therapy was ordered. She referred him to Dr. XXXX, orthopedics.

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He saw Dr. XXXX three months later. An MRI showed a rotator cuff tear and microfracture. Physical therapy and a cortisone injection were provided, without relief.

Eight months later surgery was performed.

The shoulder surgery caused increased pain for 4 months post operatively. Post-operative therapy consisted of 23 visits. Overall, he feels a 40% improvement. His last visit with Dr. XXXX was XXXX with regards to the left shoulder. He avoids heavy lifting and carrying because of shoulder pain.

Of note: he was known to Dr. XXXX who did a prior non-Workers' Compensation surgery on his left shoulder in XXXX; with return to work.

A QME was ordered by the Insurance, Dr. XXXX. He saw Dr. XXXX for three visits. He was diagnosed with a left neck injury with Nerve Studies. An MRI of the knee was recommended.

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The above history was reviewed and found to be complete and correct with the employee.

Section 6. Prior Treatment Summary & Relevant Information

<u>Medication Trials to Date:</u>

1) Relafen

2) Norco

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3) Ativan

4) Aleve

5)Dilaudid

6)Cortisone injection/Kenalog/Marcaine

Physical Therapy Visits to Date: 23 for shoulder

Current Splints or Supportive Devices: No current shoulder splint.

Imaging to Date for this Injury:

X-ray:

1) XXXX, XXXX Hosp Radiology Dr. XXXX, MD, 1)Left shoulder complete x-ray: Anterior inferior dislocation of the humeral head of the glenoid. No fractures or subluxations. 2)Left shoulder limited x-ray. Shoulder reduced to anatomic alignment. Lucency along superior aspect probably related to a Mach band, but Hill-Sachs fracture could be considered.

2)XXXX Fluoroscan: 1-2 acromial configuration, mild to moderate degenerative changes of the AC joint, mild to moderate degenerative changes of the glenohumeral joint, concentric reduction seen on axillary lateral. No evidence of bony Bankhart or Hill-Sachs impression defect. Again requested is surgery arthroscopy.

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MRI:

1)XXXXMRI Dr. XXXXMD. Type: S, Summary: Left shoulder MRI without contrast. Postoperative changes with probable debridement and partial resection of the acromioclavicular joint. Possible associated rotator cuff repair. Probable supraspinatus tendinosis with a partial articular surface tear or post operative change. Worsening degenerative arthrosis of the glenohumeral joint with associated degeneration of the labrum. Defect in the anterior capsule. Small joint effusion. Probable adhesive capsulitis. Biceps tendon intact. Biceps anchor sub optimally seen and possibly degenerated.

Electrodiagnostic Nerve Testing:

1)XXXX, Dr.XXXX, M.D., Left arm NCS/EMG: Findings of mild left cubital tunnel syndrome with no acute ulnar denervation. No left carpal tunnel syndrome or entrapment. Decreased motor unit recruitment corresponding with upper trunk innervated muscles and/or C5-6 innervated muscles. No evidence of isolated left axillary or suprascapular neuropathy.

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Surgery for this Injury:

1) Dr. XXXX: Left shoulder arthroscopic rotator cuff interval, posterior capsular release, posterior glenoid, 50% microfracture grade IV, chondroplasty of the humeral head, subacromial decompression, redo with coplanar claviculoplasty on XXXX.

Administrative Consultations for this Injury:

1) Dr. XXXX – Seen three times as QME

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2) XXXX Hospital Emergency Room

3) XXXX Hospital Emergency Room

4) Dr. XXXX, XXXX Medical Center

5) Dr. XXXX, Orthopedics

6) Dr. XXXX, Neurosurgeon, XXXX

7)Dr. XXXX, Physical Medicine

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Significant Past Medical History:

1) XXXX (stated by employee)– Left shoulder pain. Non-Workers' Compensation. Surgery with Dr. XXXX. "Bone spur removal". No pain or disability stated, but the employee does note he had a baseline 1-2/10 pain. No disability of his recall.

2) Prior Motor Vehicle Accidents: No permanent injuries.

3) Prior Litigation History: XXXX – Attorney XXXX was retained for this claim for treatment assistance. No prior litigation.

Review of Systems: "An inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms that the patient may be experiencing or has experienced".

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Constitutional, eyes, ENT, throat, cardiovascular, respiratory, gastrointestinal, genitourinary, musculoskeletal, skin/integumentary, neurological, psychiatric, endocrine, hematological/lymphatic, allergic/immunologic. Positive: Gained 55 pounds since the injury, tired all the time, digestive problems, pain in all injured joints, severe headaches, general weakness, depression, swelling in lower legs, ankles and feet.

Section 7. Current Symptoms & Complaints

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History of Present Illness (Eight Elements)

Body Location: Left shoulder

Pain Quality: Ache

Pain Intensity/Severity: 5-6/10

Pain Frequency/Duration: Frequent

Modifying Factors/Improves Pain/Timing/Context: Rest, ice, stretching.

Modifying Factors/Worsens Pain/Timing/Context: Lifting, twisting.

Current Medications for Condition: Relafen-twice daily, Norco as needed.

Comments/Associated signs and symptoms: none.

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Section 8. Activity of Daily Living Affected by Injury

Adopted from Table 1-2 Activities of Daily Living Commonly Measured in Activities of Living (ADL) and Instrumental Activities of Daily Living (IADL) Scales, page 4, Guides to the Evaluation of Permanent Impairment, Fifth Edition, American Medical Association, AMA Press:

1)Self Care/Personal Hygiene: Combing hair, bathing, dressing oneself, cannot tie shoes.

2)Communication: No Limitations.

3)Physical Activity: Standing, sitting, reclining, walking, climbing stairs difficulty with all.

4)Sensory Function: No Limitations.

5)Non Specialized Hand Function: Very hard to lift anything with the left hand.

6)Travel: Difficult.

7)Sleep: No normal sleep pattern.

8)Sexual Functioning: Sexual intimacy is 5% functioning.

Impairment Rating Specialists SAMPLE

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Section 9. General Past Medical, Family & Social History

Past Medical History: None

Past Surgical History:

1) XXXX or XXXX: Lower back surgery at levels L3-4, L4-5

2) XXXX – Left shoulder – bone spur removal.

Current Medications:

1) Relafen twice daily
2) Norco 10-325 as needed
3) Aleve OTC as needed

Allergies: Tetracycline – hives

Family History:

Health/status/cause of death for parents, siblings (identify diseases or hereditary conditions)

Parents: Father deceased age XXXX; Pipe Layer-Industrial injury. Mother age XXXX; knee problems; alive and well.

Siblings: Sister; alive and well.

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Children: Daughter age XXXX, Son age XXXX - Alive and well.

Social History:

Marital status/ living arrangements: married; living together.

Current Employment Status: Not working.

Occupation history: Carpenter 26 years, Mechanic.

Use of drugs, alcohol, tobacco: No drugs or alcohol. Tobacco; smoke ½ pack per day x XXXX years.

Level of education: XXXX, numerous trade schools.

Other relevant social factors:

Military Service: No

Second Jobs/Self Employment: No

Hobbies: Fishing, camping, archery, no injuries related.

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Section 10. Physical Examination Findings

Physical Exam:

Vital Signs: BP: 141/91 HR: 87 RR: 16 Ht: XXXX" Wt: XXXX# BMI: XXXXkg/m2

Ideal BMI (25 kg/m2) = XXXX#, this applicant is XXXX# over his ideal body weight.

General Appearance: No Acute Distress. Obese.
Psychiatric: Alert and Oriented x 3
Head: Clear to include oropharynx, conjunctiva, external nares and ears
Neck: Supple, without adenopathy
Chest: Clear to Auscultation all fields
Cardiac: Regular, No Murmur, no extremity cyanosis or edema
Abdomen: Soft, Normal Bowel Sounds
Skin: No rash, tightening, ecchymosis or erythema in areas examined.

Ortho:

Arm Measurement:

Mid Bicep: Right (43)cm Left (38)cm

Mid Forearm: Right (36)cm Left (33)cm

Wrist: Right (22)cm Left (21)cm

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Shoulder: (x)Right (x)Left

Inspect: No Swelling. Left shoulder scars. Left shoulder tattoo.

Palpation: AC joint and supraspinatus belly tenderness.

Shoulder Ranges of Motion Figure Table A1 page 596:

Motion is measured with goniometer, and is reported right over left side in Degrees (D).

AMA Estimated Normal: Flexion (150D), Extension (40D), Abduction (150D), Adduction (30D), External Rotation (90), Internal Rotation (80D).

Flexion:(160, 161, 165 / 145, 142, 137) Right Valid. Left Valid.

Extension:(30, 30, 30 / 27, 27, 30) Right Valid. Left Valid.

Abduction:(185, 170, 180 / 142, 150, 142) Right Valid. Left Valid.

Adduction:(45, 45, 43 / 37, 37, 37) Right Valid. Left Valid.

External Rotation:(80, 65, 80 / 65, 62, 65) Right Invalid. Left Valid.

Internal Rotation:(51, 49, 49 / 45, 50, 40) Right Valid. Left Valid.

Rotator Cuff Motor Testing: 5/5 All Directions Without Pain

Special Testing: Positive: Left shoulder impingement,Crank, OBrien's Positive Left.

Distal Neurovascular Exam Intact: Normal.

Impairment Rating Specialists SAMPLE

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Section 11. Summary Claim Diagnoses

Assessment:

1) Left Shoulder Strain 840.9. Status post Left shoulder arthroscopic rotator cuff interval, posterior capsular release, posterior glenoid, 50% microfracture grade IV, chondroplasty of the humeral head, subacromial decompression, redo with coplanar claviculoplasty on XXXX. Industrially related.

2) Left Shoulder Degenerative Changes/Arthritis 716.11, Pre-existing, Non-Industrial. Status post Left Shoulder Non Industrial: Procedure: left shoulder arthroscopic labral debridement, capsular release posterior capsule and rotator cuff interval, grade IV microfracture 2x3 cm lesion, subacromial decompression with excision of the CA ligament and coplanar claviculoplasty and bursal rotator cuff scuff debridement on XXXX.

3) Hypertension Essential 401.9. Non-Industrial. The employee should have follow up with his pcp for further evaluation, and NSAIDs should be avoided until cleared.

Impairment Rating Specialists SAMPLE

Section 12. Summary Discussion and Opinion

Summary Discussion:

This is a XXXX year old, right hand dominant male, who works for XXXX, Inc. ,who on XXXX, was injured while stepping backwards while at work. He fell backwards and landed on his left elbow and dislocated his left shoulder.

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He was seen by orthopedist, Dr. XXXX, who after a conservative course of physical therapy and multiple cortisone injection performed a left shoulder arthroscopic rotator cuff interval, posterior capsular release, posterior glenoid, 50% microfracture grade IV, chondroplasty of the humeral head, subacromial decompression, redo with coplanar claviculoplasty on XXXX.

NOTE TO THE READER:

This history is complicated, as it was preceded by a prior history of left shoulder, non-industrial shoulder pain that dates back to at least XXXX by available record review. At this time x-ray (XXXX) showed Acromioclavicular degeneration with possibility of impingement noted. A MRI (XXXX) showed Negative for rotator cuff tear. AC joint osteoarthritis with minimal mass effect on supraspinatus muscle. Possibility of impingement symptoms. Glenohumeral degenerative arthrosis involving the inferior joint. Possible anterior labral tear.

Impairment Rating Specialists SAMPLE

He was treated with injections and conservative care with his primary care doctor, Dr. Ashcroft.

He was referred to Dr. XXXX for further consultation. Dr. XXXX noted on XXXX the nature of the pain was noted to be “insidious” in nature with onset XXXX. Fluoroscan of the left shoulder at this visit showed moderate degeneration of AC joint with inferior directed spurs and type 2+ acromial configuration, normal appearing acromiohumeral interval, normal appearing glenohumeral joint. He was given a diagnosis of left shoulder subacromial impingement, stage 2 doubt stage 3 with possible underlying glenohumeral joint DJD and possible glenoid labral tears refractory to maximum ongoing conservative therapies.

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Surgery was recommended and a left shoulder arthroscopic labral debridement, capsular release posterior capsule and rotator cuff interval, grade IV microfracture 2x3 cm lesion, subacromial decompression with excision of the CA ligament and coplanar claviculoplasty and bursal rotator cuff scuff debridement was carried out on XXXX.

He was followed for what appears to be three postoperative visits, with the last visit being on XXXX where he noted loss of strength that precluded his ability to do his usual work to the boss' satisfaction, particularly weakness with overhead lifting. His exam demonstrated a painful arc of motion with impingement. The range of motion was listed as "near full active range of motion", however, the exam documented was not of the level of precision as to be appropriate for AMA 5th Edition Guides impairment calculations. By the patient's own admission on history obtained today, he was not pain free after the surgery, prior to this work injury, but rather, had ongoing 1-2/10 pain.

He did state that he had no disability, however, this is in conflict with the chart review (inability to lift overhead was reported in the chart).

Apportionment for his prior non-industrial, pre-existing left shoulder condition will be further discussed in Section 19, Apportionment. The elements used for the apportionment will be based on the review of the chart documents, and the subjective statements that are congruent with the notes.

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The claim present industrial claim elements are as follows:

The extent and scope of medical treatment:

The extent of this claim is to include the left shoulder. The scope of medical treatment is to include future medical management for pain flares related in the form of quarterly medical office visits for the prescription and management of non-habit forming medication, six visits per year for supervised therapy, and access to orthopedic provider for additional imaging, cortisone injections and surgery consideration should conservative treatment fail.

The employee's preclusion or likely preclusion from engaging in his/her usual occupation:

I am unable to determine the employee's preclusion from engaging in his/her usual occupation at this time, as no job description or RU91 is available. Please consider this a formal request to release the entire chart to me for review with a provided RU91 format job description and a cover letter authorizing a ML-106 supplemental report.

Impairment Rating Specialists SAMPLE

Current functional Status and/or restrictions:

No lifting > 10#; No above left shoulder-level work; no crawling or climbing.

Adopted from Reference: JB Talmage, JM Melhorn. A Physician's Guide to Return to Work. American Medical Association Press; 2005. Table 9-1 Physical Demand Characteristics of Work, Page 129 and Table 9-2 General Patterns of Activity Descriptors, Page 130.

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Light Work: Occasional (0%-33% of the Work Day) 20 lbs. Frequent (34%-66% of the Work Day) 10 lbs. and/or walk/stand, push/pull, or arm/leg controls. Constant (67%-100% of the Work Day) Push/pull or arm/leg controls while seated. Exerting up to 20 lbs. of force occasionally, and/or up to 10 lbs. of force frequently, and/or a negligible amount of force constantly to move objects. Physical demand requirements are in excess of those for sedentary work. Even though the weight lifted may be only negligible, a job should be rated light work: (1) when it requires walking or standing to a significant degree, or (2) when it requires sitting most of the time but entails pushing and/or pulling of arm or leg controls; and/or (3) when the job requires working at a production rate pace entailing the constant pushing and/or pulling of materials even though the weight of those materials is negligible. NOTE: The constant stress and strain of maintaining a production rate pace, especially in an industrial setting, is physically exhausting.

Impairment Rating Specialists SAMPLE

The level of permanent disability:

The employee is limited to light work, as that is defined above, with regards to the left shoulder.

Are medical findings consistent with the mechanism of injury alleged by the employee?

This mechanism and force of injury is to be considered medically sufficient to have caused the anatomic disruption found on the objective imaging and operative report. This injury is therefore considered work related, however, due to limited chart availability and imaging reports, this is a provisional opinion and the right is reserved to revise comment if new and additional chart becomes available. By mention of this here, please consider

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this formal request for the entire industrial chart. If provided, please attach a cover letter pre-authorizing a ML 106 supplemental addendum.

Please comment on the disputed findings of the treating physician. Do you agree or disagree with the treating physician's findings? Please be specific regarding the basis of your findings.

There is no conflict or disagreement with treatment provided to date in this claim.

What medical treatment is reasonably necessary to cure or relieve the effects of the injury? In accordance with Labor Code §4604.5, the Medical Treatment Utilization Schedules is to be utilized and shall be presumptively correct on the issue of extent and scope of medical treatment. Please use the Medical Treatment Utilization Schedule or other evidence based criteria to substantiate your medical opinion and to describe the scope, frequency, and duration of such treatment.

Impairment Rating Specialists SAMPLE

Future Medical Care for pain flares related to this claim: Four visits per year for non narcotic/non habit forming pain medications. Six visits per year of therapy for pain flares. Access to orthopedic provider for additional imaging, cortisone injections and surgery consideration should conservative treatment fail.

Are there any periods of temporary total (TTD) or temporary partial disability (TPD) as a result of the industrially caused or aggravated injury? Please indicate these periods and the basis of your opinion?

I am unable to determine TTD and/or TPD at this time, as no job description or RU91 is available. Please consider this a formal request to release the entire chart to me for review

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with a provided RU91 format job description and a cover letter authorizing a ML-106 supplemental report.

Pursuant to recent changes to Labor Code Section 4663, apportionment of permanent disability shall be based on causation. Any physician preparing reports on the issue of permanent disability must address the issue of causation. The physician must make an apportionment determination by finding what approximate percentage of the permanent disability was caused as a direct result of the work-related injury, and what portion was caused by other factors, including prior industrial injuries or other non-industrial factors.

Pursuant to recent changes to Labor Code Section 4664, if an injured worker has received a prior award of permanent disability, it shall be conclusively presumed that the prior permanent disability exists at the time of any subsequent industrial injury. Based on the foregoing, please indicate what the approximate percentage of the applicant's current disability is due to the industrial injuries alleged in this case and which percentage is due to a) any previous industrial injuries; b) any subsequent industrial injuries; c) and any non-industrial injuries including asymptomatic prior conditions, retroactive prophylactic work preclusions, illnesses or pathology.

Impairment Rating Specialists SAMPLE

Please provide a basis for any apportionment you give in your report. To be substantial evidence on the issue of apportionment, "a medical report must be framed in terms of reasonable medical probability, it must not be speculative, it must be based on pertinent facts and on an adequate examination and history, and must set forth reasoning in support of its conclusions." [WCAB En Banc Decision Escobedo v. Marshalls]:

Indicated. See apportionment discussion in section 19.

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Has the employee's disability reached maximum medical improvement and considered permanent and stationary as that term is defined by page 601 of the AMA Guides 5th Edition? If yes, please note as of what date and list all factors of permanent residuals and or if requires future medical care. If not yet considered at maximum medical improvement, please provide an estimate of when his MMI status can be expected?

The employee is to be considered MMI as of XXXX, the date of referral by the primary treating physician, XXXX, M.D.

Chapter 18 Pain Rating Assignment:

There is no known indication for Chapter 18 Pain, given that the conventional rating has fully captured the character of the employee's impairment. AMA Guides 5th Edition instruct on page 20, section 2.5e Pain, "The impairment rating in the body organ system chapter make allowance for any accompanying pain."

Impairment Rating Specialists SAMPLE

Section 13. Decision Making and Impairment Calculations

High Level Medical Decision Making; to include: The number of diagnoses, the amount and/or complexity of data (medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed), the risk of significant complications, morbidity, and/or mortality, as well as comorbidities, associated with the employee's presenting problem(s), the diagnostic procedures(s) and/or the possible management options, and/or additional referral for surgical or invasive diagnostic procedures.

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Impairment Calculations/Rating:

Source: Guides to the Evaluation of Permanent Impairment, Fifth Edition, American Medical Association, AMA Press.

Rating Chapter: Shoulder/16 Upper Extremities

Rating Table/Figure: 16-40; page 476, 16-43; page 477, 16-46; page 479 Shoulder
Comment: AMA Guides 5th Edition: Page 453 "If a contra-lateral "normal" joint has less than average mobility, the impairment value(s) corresponding to the uninvolved joint can serve as a baseline and are subtracted from the calculated impairment for the involved joint".

Page 20: "Two measurements made by the same examiner using the Guides that involve an individual or an individual's functions would be consistent if they fall within 10% of each other."

Impairment Rating Specialists SAMPLE

Calculations:

Non Injured Right Side % Upper Extremity Impairment= Flexion (1) +Extension (1) + Abduction (0) + Adduction (0) + External Rotation (Invalid) + Internal Rotation (2) = (4)% Total Upper Extremity Impairment

Injured Left Side % Upper Extremity Impairment= Flexion (2) +Extension (1) + Abduction (1) + Adduction (0) + External Rotation (0) + Internal Rotation (2) = (6)% Total Upper Extremity Impairment

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Injured Side minus Non Injured Side:

Flexion: (2) – (1) = (1)% Upper Extremity Impairment

Extension: (1) – (1) = (0)% Upper Extremity Impairment

Abduction: (1) – (0) = (1)% Upper Extremity Impairment

Adduction: (0) – (0) = (0)% Upper Extremity Impairment

External Rotation: (0) – (Invalid) = (0)% Upper Extremity Impairment

Internal Rotation: (2) – (2) = (0)% Upper Extremity Impairment

Final Adjusted Total Impairment for Injured Side Shoulder ROM: (2)% Upper Extremity Impairment

Additional Rating Considerations:

Instability ( )Yes/(x)No; Table 16-26; page 505 = 0% Upper Extremity Impairment

Arthroplasty (x)Yes/()No; Table 16-27; page 506 = 24% Upper Extremity Impairment. Comment: The XXXX industrial shoulder arthroscopy included both an end clavicle and humeral head arthroplasty, therefore the “Total Shoulder” rating value is selected.

Weak Rotator Cuff ( ) Yes/(x) No; Table 16-35 page 510 = 0% Upper Extremity Impairment

Impairment Rating Specialists SAMPLE

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Values combined on Combining Table page 604:

DRE for Total Shoulder Arthroplasty (24%) Upper Extremity Impairment / ROM (2%) Upper Extremity Impairment = 26 % Upper Extremity Impairment

Upper Extremity Impairment Conversion to Whole Person Impairment (WPI)Table 16-3 (page 439) = 16%WPI

**

Rating Chapter: 18 Pain

Rating Table/Figure: Figure 18-1 Algorithm for Rating Pain-Related Impairment in Conditions Associated with Conventionally Ratable Impairment page 574.

Calculations: If pain-related impairment appears to increase the burden of the individual's condition *slightly*, the examiner can increase the percentage found in step 1 (Use of the conventional rating system) by up to 3%. No formal assessment of pain-related impairment is required.

Whole Person Impairment Rating = 0% WPI under Chapter 18

The conventional rating has adequately captured the character of the impairment.

Impairment Rating Specialists SAMPLE

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Section 14. Final Claim Summary and WPI

Final Claim Summary:

Location #1: Left shoulder 16%WPI

Final Claim Left Shoulder WPI= 16%

Section 15. Permanent Functional Restrictions/Limitations Analysis

Impairment Rating Specialists SAMPLE

Reference: JB Talmage, JM Melhorn. A Physician's Guide to Return to Work. American Medical Association Press; 2005.

Definition; "A work restriction is something a patient can do, but should not do, as opposed to as work limitation, which is defined later in this chapter (under capacity) as something the patient cannot physically do." (Chapter 2, page 8)

Risk: Definition; "Risk refers to the chance of harm to the patient, or to the general public, if the patient engages in specific work activities." (Chapter 2, page 7)

Risk Opinion: There is no risk associated with this employee returning to the workplace, as this term is defined above.

Capacity: Definition; "Capacity refers to concepts such as strength, flexibility, and endurance." (Chapter 2, page 9)

Capacity Opinion: The employee demonstrates objective, reproducible, limitations in his

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capacity of the right shoulder with regards to overhead reaching, external and internal rotation as this term is defined above.

Tolerance: Definition; "Tolerance is a psychological concept. It is the ability to tolerate sustained work or activity at a given level. Symptoms Such as pain and/or fatigue are what limit the ability to do the task(s) in question." (Chapter 2, page 10)

Tolerance Opinion: Functional limitations (based on report of tolerance):

No lifting > 10#; No above left shoulder-level work; no crawling or climbing.

Impairment Rating Specialists SAMPLE

Section 16. Causation

Causation: This mechanism and force of injury is to be considered medically sufficient to have caused the anatomic disruption found on the objective imaging and operative report. This injury is therefore considered work related, however, due to limited chart availability and imaging reports, this is a provisional opinion and the right is reserved to revise comment if new and additional chart becomes available. By mention of this here, please consider this formal request for the entire industrial chart. If provided, please attach a cover letter pre-authorizing a ML 106 supplemental addendum.

Section 17. Future Medical Care

Future Medical Care:

Future Medical Care for pain flares related to this claim:
-4 visits per year for non narcotic/non habit forming pain medications

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-6 visits per year of therapy for pain flares

-Access to orthopedic provider for additional imaging, cortisone injections and surgery consideration should conservative treatment fail

-Comments/Rational: Medical treatment utilization schedule (MTUS)

Presumption of correctness

The MTUS is presumed to be correct on the issue of extent and scope of medical treatment and diagnostic services it addresses. However, that presumption can be set aside by a preponderance of scientific medical evidence using strength of evidence criteria to show that a variance from the schedule is reasonably required to cure or relieve the injured worker from the effects of his or her injury. For all conditions or injuries not addressed by the MTUS, authorized treatment and diagnostic services must be in accordance with other scientific, evidence-based medical treatment guidelines that are nationally recognized by the medical community as set forth in § 9792.25 of Title 8, California Code of Regulations.

Impairment Rating Specialists SAMPLE

Medical evidence evaluation advisory committee (MEEAC)

To ensure California's injured workers have access to effective and appropriate treatment, the MTUS regulations also created a medical evidence evaluation advisory committee (MEEAC), which meets regularly to review the latest medical evidence and advise the division about incorporating new evidence-based guidelines into its MTUS.

MEEAC provides recommendations to the administrative director on matters concerning the MTUS and advises the DWC medical director on potential revisions, updates and supplements that will keep California's treatment guidelines current.

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MEEAC's recommendations are advisory in nature and do not constitute scientifically based evidence. The MEEAC members represent various medical fields. The regulations concerning the MEEAC are set forth in § 9792.26 of Title 8, California Code of Regulations.

Jan. 1, 2004 - The Legislature charged the DWC administrative director (AD) with adopting an MTUS that would be presumed correct on the issue of extent and scope of medical treatment, and made the American College of Occupational and Environmental Medicine Practice Guidelines, 2nd Edition, (ACOEM) the standard until the adoption of an MTUS by the AD.

June 15, 2007 - The date the MTUS became effective. Among other provisions, the MTUS regulations incorporated the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines (ACOEM Practice Guidelines) and acupuncture guidelines. The rules also laid out the strength of evidence rating methodology by which specific medical treatments or diagnostic services are evaluated. The rules also established the medical evidence evaluation advisory committee (MEEAC).

Impairment Rating Specialists SAMPLE

July 18, 2009 - The date the MTUS was updated. The current version of the MTUS added new guidelines for chronic pain and postsurgical physical medicine treatment. The MTUS was also reorganized to restructure the MTUS into a clinical topics format, which will allow for easier updates of the guidelines.

MTUS/ACOEM 2nd Edition and AMA Guides 5th Edition Recommendations:

Medications:

Table 3-1 Summary of Recommendations and Initial Approaches to Treatments (page 49)

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A=Strong research-based evidence

B=Moderate research-based evidence

C=Limited research-based evidence

D=Panel interpretation of information not meeting inclusion criteria for research-based evidence.

Recommended: Acetaminophen and (C) NSAIDs (B)

Optional: Opioids, short course (C) and Steroid Injections (D)

Not Recommended: Muscle relaxants (C) NSAIDs (C) Opioids > 2 weeks (C), Topical Medications

ACOEM Chapter 6-Pain, Suffering, and the Restoration of Function, page 115 "Drugs or immobilizations that prevents appropriate physical activity can hamper recovery. Prolonged use of narcotic medication may cause both physiologic and psychological addiction ad may reduce the body's supply of endorphins, causing depression and delayed recovery."

Impairment Rating Specialists SAMPLE

Specialty Referral

Per ACOEM (For referrals or consults) -Per ACOEM guidelines chapter 5 other health care professionals who treat work related injuries can make an important contribution to the appropriate management of symptoms.

ACOEM's Occupational Medicine Treatment Guidelines, Second Edition, 2004, Chapter 7, page 127, endorse the use of referrals for: "Consultation: To aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. A consultant is usually asked to act in an advisory capacity, but may sometimes take full responsibility for investigation and/or treatment of an examinee or patient."

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Medical treatment utilization schedule (MTUS) Shoulder complaints

These guidelines are based on the shoulder complaints chapter as adopted from the ACOEM Practice Guidelines, 2nd edition (2004), chapter 9 and are set forth in § 9792.23.2 of Title 8, California Code of Regulations.

ACOEM Second Edition: Shoulder-Table 9-6.
A=Strong research-based evidence
B=Moderate research-based evidence
C=Limited research-based evidence
D=Panel interpretation of information not meeting inclusion criteria for research-based evidence.

Impairment Rating Specialists SAMPLE

Recommended: Maintain activities of other parts body while recovering (D); Maintain passive range of motion of the shoulder with pendulum exercises and wall crawl (D); Treat initially with strengthening or stabilization exercises for impingement syndrome, rotator cuff tear, instability, and recurrent dislocation (C,D)
Optional: At home applications of heat or cold packs to aid exercises (D); Short course of supervised exercise instruction by a therapist (D)
Not Recommended: Passive modalities by a therapist (unless accompanied by teaching the patient exercises to be carried out at home) (D)

MRI Shoulder Imaging Shoulder:

Absent a "red flag" for a systemic condition (e.g. infection or tumor, or cardiac problem presenting as a neck or shoulder problem), the ACOEM Guidelines support special imaging studies when there is a need for anatomic clarification prior to consideration of an invasive procedure, unequivocal objective evidence of nerve root compromise on

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neurological examination or other “physiologic insult”, when there is concern about a complete rotator cuff tear, and when there is failure to progress in a strengthening program (e.g. physical treatment) intended to avoid surgery.

ACOEM Second Edition: Shoulder-Table 9-6.
A=Strong research-based evidence
B=Moderate research-based evidence
C=Limited research-based evidence
D=Panel interpretation of information not meeting inclusion criteria for research-based evidence.

Recommended: MRI for preoperative evaluation of partial thickness or large full thickness rotator cuff tears (C, D).
Optional: Arthrography for preoperative evaluation of small full-thickness tears (C).
Not Recommended: Routine MRI or arthrography for evaluation without surgical indications (D). Ultrasonography for evaluation of rotator cuff (C).

Impairment Rating Specialists SAMPLE

Section 18. Pain Assessment

Pain assessment: As Adopted by the DWC Form PR-4 (Rev. 06-05) STATE OF CALIFORNIA Division of Workers’ Compensation

If the burden of the worker’s condition has been increased by pain-related impairment in excess of the pain component already incorporated in the WPI rating under Chapters 3-17 of the AMA Guides, 5th Edition, specify the additional whole person impairment rating (0% up to 3% WPI) attributable to such pain. For excess pain involving multiple impairments, attribute the pain in whole number increments to the appropriate

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impairments. The sum of all pain impairment ratings may not exceed 3% for a single injury.

Additional Pain Award for this Claim: None Indicated.

Section 19. Apportionment

Apportionment: As Adopted by the DWC Form PR-4 (Rev. 06-05) STATE OF CALIFORNIA Division of Workers' Compensation

Effective April 19, 2004, apportionment of permanent disability shall be based on causation. Furthermore, any physician who prepares a report addressing permanent disability due to a claimed industrial injury is required to address the issue of causation of the permanent disability, and in order for a permanent disability report to be complete, the report must include an apportionment determination. This determination shall be made pursuant to Labor Code Sections 4663 and 4664 set forth below:

Impairment Rating Specialists SAMPLE

Labor Code section 4663. Apportionment of permanent disability; Causation as basis; Physician's report; Apportionment determination; Disclosure by employee

(a) Apportionment of permanent disability shall be based on causation.

(b) Any physician who prepares a report addressing the issue of permanent disability due to a claimed industrial injury shall in that report address the issue of causation of the permanent disability.

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(c) In order for a physician's report to be considered complete on the issue of permanent disability, it must include an apportionment determination. A physician shall make an apportionment determination by finding what approximate percentage of the permanent disability was caused by the direct result of injury arising out of and occurring in the course of employment and what approximate percentage of the permanent disability was caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries. If the physician is unable to include an apportionment determination in his or her report, the physician shall state the specific reasons why the physician could not make a determination of the effect of that prior condition on the permanent disability arising from the injury. The physician shall then consult with other physicians or refer the employee to another physician from whom the employee is authorized to seek treatment or evaluation in accordance with this division in order to make the final determination.

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(d) An employee who claims an industrial injury shall, upon request, disclose all previous permanent disabilities or physical impairments.

Labor Code section 4664. Liability of employer for percentage of permanent disability directly caused by injury; Conclusive presumption from prior award of permanent disability; Accumulation of permanent disability awards

(a) The employer shall only be liable for the percentage of permanent disability directly caused by the injury arising out of and occurring in the course of employment.

(b) If the applicant has received a prior award of permanent disability, it shall be conclusively presumed that the prior permanent disability exists at the time of any

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subsequent industrial injury. This presumption is a presumption affecting the burden of proof.

(c)(1) The accumulation of all permanent disability awards issued with respect to any one region of the body in favor of one individual employee shall not exceed 100 percent over the employee's lifetime unless the employee's injury or illness is conclusively presumed to be total in character pursuant to Section 4662. As used in this section, the regions of the body are the following:

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A) Hearing.

(B) Vision.

(C) Mental and behavioral disorders.

(D) The spine.

(E) The upper extremities, including the shoulders.

(F) The lower extremities, including the hip joints.

(G) The head, face, cardiovascular system, respiratory system, and all other systems or regions of the body not listed in subparagraphs (A) to (F), inclusive.

(2) Nothing in this section shall be construed to permit the permanent disability rating for each individual injury sustained by an employee arising from the same industrial accident, when added together, from exceeding 100 percent.

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Apportionment for this claim: SB899 and Almaraz/Guzman I/II are considered.

The employee's history, documented chart review and imaging reveal pre-existing, non-industrial contributory factors of a prior non-industrial, pre-existing left shoulder surgery on XXXX. These findings are not consistent with the stated mechanism of a fall injury on XXXX, however, they have contributed to a less than full recovery with medical probability. These conditions will be further addressed in the apportionment section below.

Non-Industrial and/or Pre-existing Contribution: These are objective factors that have prevented a more full and complete recovery, and have resulted in the left shoulder being more vulnerable to injury.

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1)Arthroplasty Non-Industrial Apportionment: 17% of calculated disability from this industrial total shoulder arthroplasty is apportioned to the non-industrial, pre-existing left shoulder surgery acromioplasty on XXXX. This is calculated by taking the total 30% upper extremity value of a total shoulder arthroplasty (performed as a result of the 9/16/10 industrial surgery) and subtracting off the contribution of a clavicle arthroplasty, which is 10% upper extremity value. The contribution of the clavicle arthroplasty is therefore 33.3% contribution (10/30). Now, considering the employee had one clavicle arthroplasty on a non industrial basis, and a second due to this industrial injury, the 33.3 is split 50%, and the resultant 16.65 (%) is found. This is rounded to 17%.

2)Degenerative Joint Disease Non-Industrial Apportionment: 10% is apportioned to the non-industrial, pre-existing left shoulder as objectively documented as mild to moderate on fluoroscopy, and interval degenerative changes worsened by MRI report of the glenohumeral joint and labrum.

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3)Range of Motion Non-Industrial Apportionment: Unable to objectively document with medical certainty and verifiable, reproducible exam which would be the best approximation of actual function based on available documentation. Following the XXXX pre-existing, non-industrial surgery, the employee had a postoperative follow up exam on XXXX, approximately three months prior to this industrial injury. This is the last documented exam before the industrial injury of XXXX. Dr. XXXX's notes stated a "near full" active range of motion, intact rotator cuff testing 5/5, and a positive impingement with regards to the left shoulder. These "measurements" are not appropriate for translation to AMA 5th Edition Guides impairment calculations for the following reasons: a) it was not made clinically clear the employee was at MMI, b)degrees of motion were not documented, c) measurements are presumed NOT to have been obtained with a goniometer, d) measurements are presumed NOT to have been performed at least twice to document a less than 10% variance as required. It would therefore be inappropriate to use this exam as comparison to the measurements obtained today, which meet these requirements (a thorough d).

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For similar reasons, Dr. XXXX's pre-injury exam documented XXXX of left shoulder flexion to 170 degrees and abduction to 130 degrees cannot be deemed as adequate with medical certainty.

4)Functional Limitation Non-Industrial Apportionment: 13% is apportioned to the non-industrial, pre-existing left shoulder function as prior documented. Following the XXXX pre-existing, non-industrial surgery, the employee had a postoperative follow up exam on XXXX, approximately three months prior to this industrial injury. This is the last documented exam before the industrial injury of XXXX. At this visit the employee reported weakness of the left shoulder insufficient to perform work (i.e. lifting a beam) to

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the satisfaction of his boss. This would be equivalent to a functional limitation of no very heavy lifting overhead of the left shoulder which I would approximate to a maximum weight of 75 lbs. The employee's current limitation for function is no lifting > 10#; No above left shoulder-level work. The percentage difference between 75 lbs prior ability, and the current 10 lbs ability is an 87 % loss of change in lift ability (10/75 = 13%, 100-13 =87%). Put another way, the employee has retained 13% of his prior lifting functional ability following this industrial injury.

There is no non-industrial, pre-existing apportionment for loss of ability to work over shoulder level, as it is presumed by my read of the chart, that he could work over shoulder, just not tolerating heavy work.

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Industrial contribution: These are objective factors that have directly contributed to the current level of disability and or impairment.

1) Arthroplasty Industrial Apportionment: 83% Industrial. See reasoning above (100-17 = 83%).

2) Degenerative Joint Disease Industrial Apportionment: 0%. No findings of degenerative changes are to be attributed to this industrial injury at the time of MMI. This opinion is further supported by review of Dr. XXXX's fluoroscopy reposts of XXXX vs. XXXX, which are essentially the same findings.

3) Range of Motion Industrial Apportionment: Unable to objectively document with medical certainty. See reasoning above in Non-Industrial and/or Pre-existing Contribution discussion.

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4) Functional Limitation Industrial Apportionment: 87%. See reasoning above in Non-Industrial and/or Pre-existing Contribution discussion. (100-13 =87%)

If additional comment on apportionment is requested, a supplemental report will be issued upon receipt of supporting medical documentation. Please consider this as formal request for release of the entire industrial chart to me for review. Please send any requested documentation with a pre-approval cover letter pre-authorizing a ML 106 supplemental report.

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Comment on Dr. XXXX's QME opinion on apportionment: The reader will recall Dr. XXXX, MD offered an opinion on XXXX that there was a 50% apportionment for the prior left shoulder surgery AND the employee was NOT MMI, as arthroscopic therapy was still indicated. After reading his opinion I have two concerns.

The first concern is that Dr. XXXX offered an opinion on apportionment when the employee, by his own finding, was not MMI. "The Physician's Guide of Medical Practice in the California Workers' Compensation System, Third Edition 2001" states on page 50, "When a *permanent* disability results from the aggravation of an existing disabling condition or underlying disease process, then the permanent disability benefits are apportioned (or distributed) between the current injury and the pre-existing condition." I will submit to the reader that Dr. XXXX was, although well intending to be helpful, was premature in his recommendation of apportionment, as the shoulder condition had NOT yet become permanent and stationary, or MMI.

My second concern, absent the employee not being MMI at the time of the opinion, is that Dr. XXXX did not offer any reasons as to his selection of 50/50% apportionment. He did not develop any reasoning, cite specific chart entries to support the opinion, nor did

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he provide any weighted analysis held to "the standard of reasonable medical probability" (page 55 The Physician's Guide of Medical Practice in the California Workers' Compensation System, Third Edition 2001).

Section 20. Displaced Worker Benefits & Vocational Rehabilitation

Vocational Rehabilitation: If the employer is unable to accommodate the above restrictions, then the employee is to be considered eligible for access to vocational training.

Section 21. Affidavit and Examiner Signature

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Affidavit:

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, as to information that I have indicated I 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.

I further declare under penalty of perjury that I personally performed the evaluation of the patient or, in the case of a supplemental report, I personally performed the cognitive services necessary to produce the report on said date of this visit and that, except as otherwise stated herein, the evaluation was performed and the time spent performing the evaluation was in compliance with the guidelines, if any established by the Industrial Medical Council or the administrative director pursuant to paragraph (5) of subdivision (j) of Section 139.2 or Section 5307.6 of the California Labor Code.

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I further declare under penalty of perjury that I have not violated the provisions of California Labor Code Section 193.3 with regard to the evaluation of this patient or the preparation of this report.

I further declare under penalty of perjury that the name and qualifications of each person who performed any services in connection with the report, including diagnostic studies, other than clerical preparation, are as follows:

Dr. John W. Alchemy, MD

Date of Report: Signed this__XXXX__day of __XXXX__2011, at Sonoma County.

Additional Disclaimer: Adopted from Reference: JB Talmage, JM Melhorn. A Physician's Guide to Return to Work. American Medical Association Press; 2005.

The above statements have been made within a reasonable degree of medical probability. The opinions rendered in this case are mine alone. Recommendations regarding treatment, work, and impairment ratings are given totally independently from the requesting agents. These opinions do not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.

This evaluation is based upon the history given by employee, the objective medical findings noted during the examination, and information obtained from the review of the prior medical records (if) available to me, with the assumption that this material is true and correct. If additional information is provided to me in the future, a reconsideration

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and an additional report may be requested. Such information may or may not change the opinions in this report.

Medicine is both an art and a science, and although this employee may appear to be fit to work with the abilities and restrictions described above, there is no guarantee that he/she will not be injured or sustain a new injury if he/she chooses to return to work.

John W. Alchemy, MD
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Diplomate of the American Board of Family Practice
Qualified Medical Examiner State of California
American Academy of Medical Review Officers
American Board of Independent Medical Examiners Certificate
ACOEM Compliant
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