

California Orthopedic Association

Common Mistakes Doctors Make In Their Reports

By: Hon. Robert G. Rassp

Presiding Workers' Compensation Judge, Los Angeles

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Editor-In-Chief: "Rassp & Herlick, 7th Edition"

Author: "Lawyer's Guide To The AMA *Guides* and California Workers' Compensation," 2020 Ed.

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- Disclaimer: *The written materials and opinions stated in this presentation are the personal opinions of the individual presenter and are not the opinions or positions of the State of CA Department of Industrial Relations, the Division of Workers' Compensation, nor of the Workers' Compensation Appeals Board.*

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- ▶ Section E of the *Escobedo* decision applies to all medical legal issues and not just apportionment.
- ▶ In AMA Guides case, did the physician perform the correct measurements?
 1. Who performed ROM testing?
 2. Was a computer used?
 3. Active ROM or assisted or passive ROM testing? (Only active is valid).
- ▶ Did the physician use UE, LE, WPI correctly?
- ▶ Orthopedic surgeons ignore other chapters of the AMA Guides, especially Chapters 1, 2 and 13

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Knees and Legs

- Table 17-33 is mostly used by physicians because it is diagnosis based and does not depend on treatment outcomes (except for knee and hip replacements – see Tables 17-35, 17-34 respectively)
- Table 17-33 has the easiest ratings to rebut
- Table 17-2 cross-usage chart is rarely used because it is contrary to work disabilities even though some impairments overlap (this is the “anti-Kite” method)

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Table 17-6 Impairment Due to Unilateral Leg Muscle Atrophy

Difference in Circumference (cm)	Impairment Degree	Whole Person (Lower Extremity) Impairment (%)
a. Thigh: The circumference is measured 10 cm above the patella with the knee fully extended and the muscles relaxed.		
0-0.9	None	0
1-1.9	Mild	1-2 (3-8)
2-2.9	Moderate	3-4 (8-13)
3+	Severe	5 (13)
b. Calf: The maximum circumference on the normal side is compared with the circumference at the same level on the affected side.		
0-0.9	None	0
1-1.9	Mild	1-2 (3-8)
2-2.9	Moderate	3-4 (8-13)
3+	Severe	5 (13)

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Table 13-15 Criteria for Rating Impairments Due to Station and Gait Disorders

Class 1 1%-9% Impairment of the Whole Person	Class 2 10%-19% Impairment of the Whole Person	Class 3 20%-39% Impairment of the Whole Person	Class 4 40%-60% Impairment of the Whole Person
Rises to standing position; walks, but has difficulty with elevations, grades, stairs, deep chairs, and long distances	Rises to standing position; walks some distance with difficulty and without assistance, but is limited to level surfaces	Rises and maintains standing position with difficulty; cannot walk without assistance	Cannot stand without help, mechanical support, and/or an assistive device

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Table 17-5

Table 17-5 Lower Limb Impairment Due to Gait Derangement

Severity	Individual's Signs	Whole Person Impairment
Mild	a. Antalgic limp with shortened stance phase and documented moderate to advanced arthritic changes of hip, knee, or ankle	7%
	b. Positive Trendelenburg sign and moderate to advanced osteoarthritis of hip	10%
	c. Same as category a or b above, but individual requires part-time use of cane or crutch for distance walking but not usually at home or in the workplace	15%
	d. Requires routine use of short leg brace (ankle-foot orthosis [AFO])	15%
Moderate	e. Requires routine use of cane, crutch, or long leg brace (knee-ankle-foot orthosis [KAFO])	20%
	f. Requires routine use of cane or crutch and a short leg brace (AFO)	30%
	g. Requires routine use of two canes or two crutches	40%
Severe	h. Requires routine use of two canes or two crutches and a short leg brace (AFO)	50%
	i. Requires routine use of two canes or two crutches and a long leg brace (KAFO)	60%
	j. Requires routine use of two canes or two crutches and two lower-extremity braces (either AFOs or KAFOs)	70%
	k. Wheelchair dependent	80%

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EXAMPLE #1

- Police Officer from 1988 through April 2014
- Cumulative Trauma claim to lumbar spine (duty belt presumption per Labor Code Section 3213.2), both thumbs

DIGITAL X-RAY FINDINGS:

→ X-ray of the right thumb - 1 view: There appears to be a carpometacarpal thumb excision arthroplasty. There are two washers in the thumb and second metacarpal noted.

X-ray of the left wrist - 1 view: There are degenerative changes of the carpometacarpal thumb base with subluxation of the joint.

X-ray of the lumbar spine - 1 view: No fracture or dislocation is seen. There is decreased L5-S1 disc space.

DIAGNOSIS:

1. Osteoarthritis, right and left hand thumb carpometacarpal joint.
- 2. Status post excision arthroplasty, right thumb carpometacarpal joint.
3. Myofascial sprain, lumbar spine.
4. Degenerative disc disease, lumbar spine, rule out lumbar radiculopathy.

DISCUSSION:

I had the opportunity of evaluating Mr. ~~Wiseano~~ for an Agreed Medical Orthopaedic Evaluation at the request of the parties with regard to the continuous trauma of his work from May 10, 1988 to March 26, 2014.

Mr. ~~Wiseano~~ is a 64-year-old, right-handed, retired police officer who worked for the City of ~~Portland~~ Police Department. He started in 1988 and retired in April of 2014. He states that throughout the years he had pain in his hands, and he also had a specific injury in February of 2012, at which time he injured his low back. He was seen at ~~St. Vincent~~ Hospital for the back injury and referred to Dr. ~~Robinson~~. The patient states that lumbar surgery was recommended; however, the patient declined at that time. He was referred to Dr. ~~Robinson~~ for pain management and

EXAMPLE #1

EXAMPLE #1

the degenerative process in the hands and 70% to the continuous trauma of work ending on March 26, 2014.

IMPAIRMENT PER AMA GUIDELINES:

The impairment is determined by the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition.

With regard to the lumbar spine, the patient has nonverifiable lumbar radiculopathy. The DRE method is used, page 384, Table 15-3, category II, and an 8% whole person impairment is calculated.

With regard to the hands/thumbs, the loss of motion is calculated using Figure 16-12 on page 456 and Figure 16-15 on page 457.

Regarding the right thumb, loss of thumb MP flexion is a 1% hand impairment and loss of thumb IP flexion is a 4% hand impairment. A 5% hand impairment is calculated, which is converted to a 5% upper extremity impairment, which is a 3% whole person impairment.

Regarding the left thumb, loss of thumb MP flexion is a 3% hand impairment and loss of thumb IP flexion is a 4% hand impairment, totaling 7% hand impairment. This is converted to a 6% upper extremity impairment, which is a 4% whole person impairment.

COMMENT:

I am making arrangements for this patient to undergo an EMG/NCV study of the lumbar spine to rule out radiculopathy, and an updated MRI of the lumbar spine will be done to see if there is any change in his condition. I reserve the right to amend my opinions with regard to the impairment after reviewing these diagnostic tests.

I trust this information has been of help to you. If you require further information, please do not hesitate to contact me.

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Right Thumb rating
should be 5% UE for
ROM loss and 11% UE
for CMC arthroplasty:
5UE combined 11UE =15
UE = 9% WPI

Table 16-27 Impairment of the Upper Extremity After Arthroplasty of Specific Bones or Joints

Level of Arthroplasty	% Impairment of Upper Extremity	
	Implant Arthroplasty	Resection Arthroplasty
Total shoulder	24	30
Distal clavicle (isolated)	—	10
Proximal clavicle (isolated)	—	3
Total elbow	28	35
Radial head (isolated)	8	10
Total wrist	24	—
Radiocarpal	16	—
Ulnar head (isolated)	8	10
Proximal row carpectomy	—	12
Carpal bone (isolated)	8	10
Radial styloid (isolated)	—	5
Thumb		
CMC	9	11
MP	2	3
IP	4	5
Index or middle finger		
MP	4	5
PIP	2	3
DIP	1	2
Ring or little finger		
MP	2	2
PIP	1	1
DIP	1	1

CMC: thumb carpometacarpal; IP: thumb interphalangeal; MP: metacarpophalangeal; PIP: proximal interphalangeal; DIP: distal interphalangeal.

Modified from Swanson AB, de Groot Swanson G. Principles and methods of impairment evaluation in the hand and upper extremity. In: Engelberg AE, ed. *Guides to the Evaluation of Permanent Impairment*. Third ed. Chicago, Ill: American Medical Association; 1989:47; prepared with the assistance of DM Lichtman, Fort Worth, Texas, and EG McFarland, Baltimore, Maryland.

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Shoulders

- Six ranges of motion, all are in UE
 - You add the impairments (Figures 16-40, 16-43, and 16-46; pages 476-479)
- Muscle strength also in UE
- Different diagnoses:
 - Rotator cuff tears (“SITS”)
 - Labral tears
 - Sub-acromial impingement
 - Distal Clavicle Resection Arthroplasty

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- Rotator cuff injuries:
 - Supports the Gleno-humeral joint, Table 16-18 (complete loss of the joint is 36% WPI)
 - “SITS” or “SIItS” = Supraspinatus, Infraspinatus, Teres Minor and Subscapulis muscles and tendons.
 - Compare Tables 16-27 with Table 16-18

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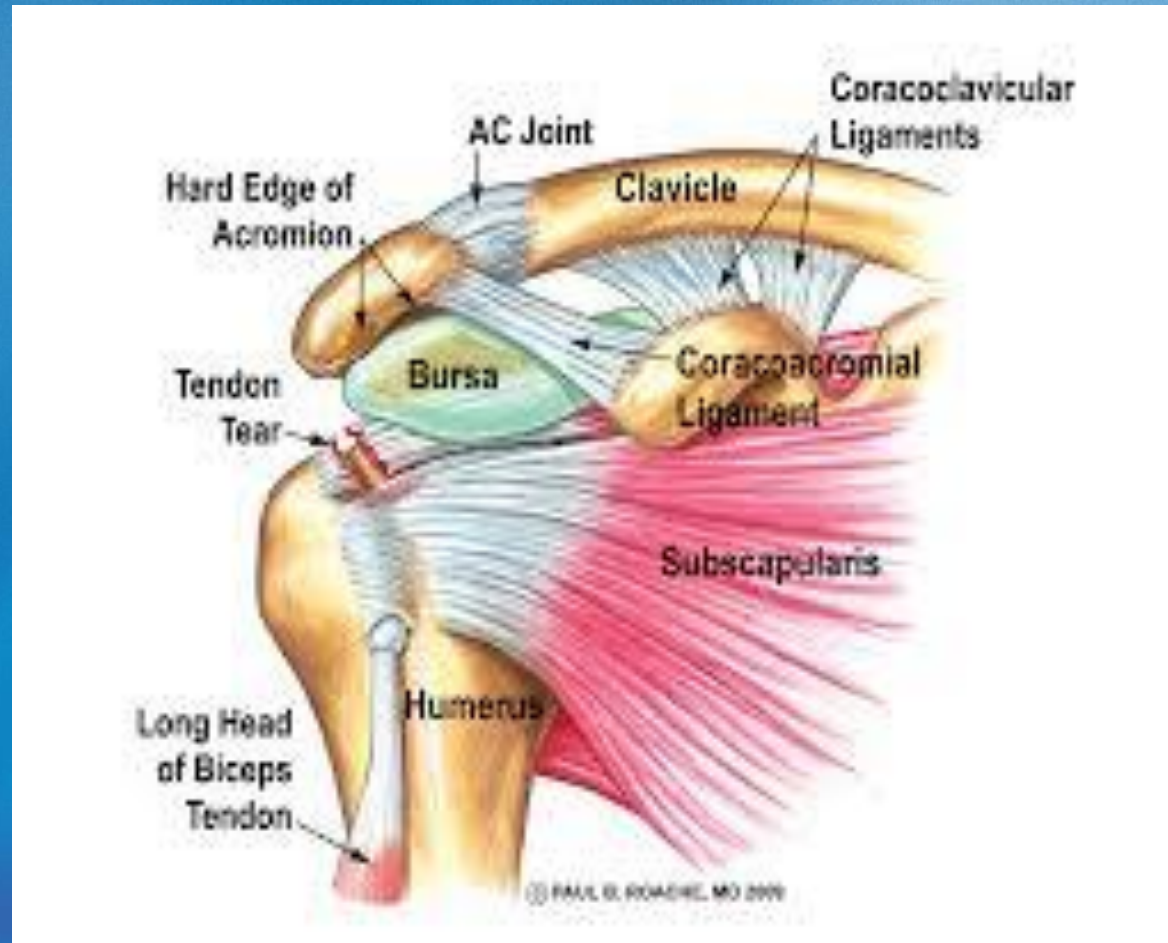
EXAMPLE #2

Long term assembly worker trips and falls on the company's campus and lands on her right shoulder.

Diagnosis: Right humeral head/proximal humerus in four-part fracture

Surgeries: Two arthroscopic surgeries, first one SLAP debridement (Superior Labrum from Anterior to Posterior), second one to release adhesive capsulitis

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PHYSICAL EXAMINATION: (Cont'd)

Compression and distraction test of neck are negative.

→ Upper extremity motor function shows that deltoid 3 to 4/5, biceps 4/5, triceps 4/5.

Sensory function appears to be normal for upper extremities.

DORSAL SPINE:

Examination indicates that on palpation, she has 1+ tenderness over the lower thoracic spine interspinous spaces. Thoracic spine range of motion is normal otherwise.

LUMBOSACRAL SPINE EXAMINATION:

Shows no palpable tenderness in the lumbar spine nor the trochanteric area. Straight leg raising is negative both in the sitting and supine positions. The lower extremity motor strength in quadriceps, hamstrings, anterior tibialis are normal. There is no lower extremity sensory dermatome deficit.

Deep tendon reflexes biceps 1+/1+, triceps 1+/1+, patella tendon 1+/1+, Achilles tendon 1+/1+, Babinski plantar bilaterally. Straight leg raising is negative both in sitting and supine positions. Babinski is plantar.

SHOULDER EXAMINATION:

On inspection, the healed right shoulder arthroscopic portals are barely visible. The portals are located posterior and lateral, not tender. Palpation of the shoulder for tenderness shows that she has bicipital groove 1+/0, AC joint 0/0, lateral edge of the acromion 0/0. Shoulder range of motion abduction 80/180, adduction 60/70, forward flexion 80/180, external rotation is 60/60, internal rotation 90/80. Extension 25/40. → Right shoulder strength is 3/5 throughout shoulder girdle. There is no UE sensory deficit. Kennedy-Hawkins sign 2/0.

ELBOW EXAMINATION:

Examination of her elbow shows that there is no medial or lateral epicondylar tenderness. Elbow range of motion appears to be full.

EXAMPLE #2

Grade 5 = 0% loss
Grade 4 = 25%
Grade 3 = 30-60%

DISCUSSION: (Cont'd)

The unanswered questions are whether supervised conservative treatment will help her to reduce shoulder pain and increase strength. It is my opinion claimant has no better than even chance of improvement or satisfied with supervised conservative treatment.

CURRENT DISABILITY STATUS:

Temporary total disability: Two months after each arthroscopic surgery. Followed by TPD for two additional month.

MMI 02-23-2012.

SUBJECTIVE FACTORS OF DISABILITY:

Right shoulder pain with light lifting, lying on that side, reach overhead, sudden shoulder movement or place arm in a dependent postural.

OBJECTIVE FACTORS OF DISABILITY:

Plain x-rays and MRI showed right humeral head/proximal humerus in four-part fracture. There appears to be tendinosis of the rotator cuff. No obvious or acute tear.

WORK RESTRICTIONS:

Semi-sedatary work. Right arm usage limited to light lift, less than 10 pounds and elevate shoulder to less than 80 degrees.

IMPAIRMENT RATING:

Right shoulder.

Motion reduction.

Flexion 80 degrees. 7% UE impairment. Fig 16-40.

Extension 25 degrees 3% UE impairment. Fig 16-43.

Abduction 80degrees, 5% UE impairment. Fig 16-43.

Adduction 0 UE impairment.

EXAMPLE #2

EXAMPLE #2

IMPAIRMENT RATING: (Cont'd)

External rotation 1% UE impairment. Fig 16-46.

Total 16% UE impairment, conversion table. Table 16-3 10% WPI.

Chronic pain add 3% WPI.

Grand total 13% WPI.

APPORTIONMENT:

100% of the injury is from work.

CAUSATION:

AOE/COE injury from work.

AOE/COE impairment from work.

FUTURE MEDICAL:

The claimant should be allowed work injury shoulder aggressive conservative medical care, including medications, judicious use of physical modalities, injections. May require new right shoulder MRI with contrast and CT scan to determine the current status of the humeral-glenoid joint and proximal humerus. Further right shoulder arthroscopic surgery is not recommended. Claimant's right shoulder joint condition is likely beyond the remedial capability of arthroscopic technique. Right shoulder joint pathology may require total shoulder joint replacement.

This concludes the Orthopedic Panel Qualified Medical Evaluation regarding Elena Guzman. If you have any questions please feel free to contact me.

DISCLOSURE:

Section 139.3, I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except to the information I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately described the information provided to me and, except as noted herein, that I believe it to be true. I further declare that I am in compliance with the Labor Code 4628 and 5703 and have not violated section 139.3. I have not offered, delivered, received, or accepted any rebate, refund, commission, preference, patronage, dividend, discount or other considerations, whether in the form of money or otherwise as compensation or inducement for any referral, examination, or evaluation.

EXAMPLE #2

Table 16-35 Impairment of the Upper Extremity Due to Strength Deficit From Musculoskeletal Disorders Based on Manual Muscle Testing of Individual Units of Motion of the Shoulder and Elbow

% Upper Extremity Impairment			
Joint Relative Value	Unit of Motion Relative Value	Strength Deficit*	
		5%-25%†	30%-50%‡
Shoulder (60%)			
Flexion	24	1-6	7-12
Extension	6	0-2	2- 3
Abduction	12	1-3	4- 6
Adduction	6	0-2	2- 3
Internal rotation	6	0-2	2- 3
External rotation	6	0-2	2- 3
Elbow (70%)			
Flexion	21	1-5	6-11
Extension	21	1-5	6-11
Pronation	14	1-4	4- 7
Supination	14	1-4	4- 7

* Use clinical judgment to select the appropriate percentage from the range of values shown for each severity grade.

† Complete range of motion against gravity only without resistance.

‡ Complete range of motion against gravity with some resistance.

Derived from Section 16.4 and Table 16-11 by G. de Groot Swanson, Grand Rapids, Michigan.

EXAMPLE #2

Correct ROM
UE

Correct manual
muscle strength

On page 6 Dr. Tsou states: "Upper extremity motor function shows that deltoid 3 to 4/5, biceps 4/5, triceps 4/5." Then, under the Shoulder Examination section on the same page, Dr. Tsou states: "Right shoulder strength is 3/5 throughout shoulder girdle." What this means is that Dr. Tsou failed to apply Table 16-35 which is manual muscle strength testing along with the range of motion measurements he did find later in his report. He provided this Court with the raw data needed to rate the manual muscle strength loss but he did not carry those objective findings forward to his discussion of permanent impairment. This Court is able to do so since the raw data is provided by the physician and Table 16-35 is easily applied.

The AMA Guides indicate that loss of motion combined with loss of strength should not be combined unless there is a pathophysiological reason to do so that is explained by a physician and the patient is not inhibited from using maximum effort.

In this case, the Court is absolutely convinced that both range of motion and strength loss are applicable because of the severe degeneration of the Applicant's entire right shoulder joint four years after her specific injury of April 16, 2010. She was examined by Dr. Paul Tsou in August 2014 by which time the devastating effect of the four-part proximal humeral head fracture with two shoulder surgeries including a SLAP debridement and release of adhesive capsulitis after a frozen shoulder joint had occurred. The Applicant had multiple fractures of her humeral head with post-traumatic arthritis and changes to her glenohumeral joint. This involves separate pathophysiological causes that resulted in her loss of strength and loss of shoulder motion.

Accordingly, this Court has concluded that the Applicant has the following permanent disability based on a review of the entire record:

Based on the conclusions of Dr. Paul Tsou loss of range of motion, pages 13-14:

Right shoulder Flexion 80 degrees:	7% UE
Extension 25 degrees:	3% UE
Abduction 80 degrees:	5% UE
Adduction normal:	0% UE
External Rotation:	1% UE
Internal Rotation:	<u>0% UE</u>
Total UE for loss of motion:	16% UE

Grade 3/5 muscle strength testing Table 16-35:	
Flexion: 30% of 24 UE =	7% UE
Extension: 30% of 6 UE =	2% UE
Abduction: 30% of 12 UE =	4% UE
Adduction: 30% of 6 UE =	2% UE
Internal Rotation: 30% of 6 UE =	2% UE
External Rotation: 30% of 6 UE =	<u>2% UE</u>
Total UE for muscle strength loss:	19% UE

19% UE strength loss **combined** 16% UE range of motion = 32% UE = 19% WPI plus 3% for pain related impairment = 22% WPI.

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Table 16-18 Maximum Impairment Values for the Digits, Hand, Wrist, Elbow, and Shoulder Due to Disorders of Specific Joints or Units*

Units and Joints	% Impairment of			
	Unit	Hand	Upper Extremity	Whole Person
Shoulder				
Glenohumeral	—	—	60	36
Acromioclavicular	—	—	25	15
Sternoclavicular	—	—	5	3
Elbow				
Entire elbow	—	—	70	42
Ulnohumeral	—	—	50	30
Proximal radioulnar	—	—	20	12
Wrist				
Entire wrist	—	—	60	36
Radiocarpal	—	—	40	24
Distal radioulnar	—	—	20	12
Proximal carpal row	—	—	30	18
Entire hand	—	100	90	54
Thumb				
Entire thumb	100	40	36	22
CMC	60	24	22	13
MP	15	6	5	3
IP	25	10	9	5
Index and middle				
Entire finger	100	20	18	11
MP	50	10	9	5
PIP	30	6	5	3
DIP	20	4	4	2
Ring or little				
Entire finger	100	10	9	5
MP	50	5	5	3
PIP	30	3	3	2
DIP	20	2	2	1

* Each value is related to the next larger units and the whole person

Table 16-27 Impairment of the Upper Extremity After Arthroplasty of Specific Bones or Joints

Level of Arthroplasty	% Impairment of Upper Extremity	
	Implant Arthroplasty	Resection Arthroplasty
Total shoulder	24	30
Distal clavicle (isolated)	—	10
Proximal clavicle (isolated)	—	3
Total elbow	28	35
Radial head (isolated)	8	10
Total wrist	24	—
Radiocarpal	16	—
Ulnar head (isolated)	8	10
Proximal row carpectomy	—	12
Carpal bone (isolated)	8	10
Radial styloid (isolated)	—	5
Thumb		
CMC	9	11
MP	2	3
IP	4	5
Index or middle finger		
MP	4	5
PIP	2	3
DIP	1	2
Ring or little finger		
MP	2	2
PIP	1	1
DIP	1	1

CMC: thumb carpometacarpal; IP: thumb interphalangeal; MP: metacarpophalangeal; PIP: proximal interphalangeal; DIP: distal interphalangeal.

Modified from Swanson AB, de Groot Swanson G. Principles and methods of impairment evaluation in the hand and upper extremity. In: Engelberg AE, ed. *Guides to the Evaluation of Permanent Impairment*. Third ed. Chicago, Ill: American Medical Association; 1989:47; prepared with the assistance of DM Lichtman, Fort Worth, Texas, and EG McFarland, Baltimore, Maryland.

Occupational Medicine
9353 Imperial Highway
Downey, CA 90242-2812
Phone: 562-657-2200
Date of Injury: 4/27/2017

Kaiser Permanente
Southern California Permanente Medical Group
Kaiser MRN:
Patient Name:

State of California - Division of Workers' Compensation
PHYSICIANS PERMANENT AND

State of California - Division of Workers' Compensation
PRIMARY TREATING PHYSICIANS PERMANENT AND STATIONARY REPORT (PR-4)

Skin: Clear warm and dry
Psychiatric: Pleasant

Psychiatric: Pleasant, alert, no distress, mood and affect normal

EXAM LOCATION(S): Shoulder

Right Shoulder Range of Motion (ROM)
Flexion: 160.

Flexion: 160.

Extension: 50 degrees

Abduction: 180 degrees (160)
Adduction: 50 degrees

Adduction: 50 degrees

Internal Rotation: 90 degrees
External Rotation: 90 degrees

External Rotation: 90 degrees (60)

Right Shoulder Inspection/Palpation
Swelling, Scarring, Atrophy

Swelling, Scarring, Atrophy: Negative
Tenderness: Negative

Tenderness: Negative

Acromioclavicular Joint: Negative
Sternoclavicular Joint: Negative

Sternoclavicular Joint: Negative
Coracoid Process: Negative

Coracoid Process: Negative
Bicipital Groove: Negative

Bicipital Groove: Negative

Medial Scapular Border: Negative
Lateral Scapular Border: Negative

Lateral Scapular Border: Negative

CURRENT ENCOUNTER DIAGNOSIS/DIAGNOSES:
S46.011A RIGHT SUPRASPINATUS TENDON
M75.91 TENDONITIS

ENCOUNTER DIAGNOSIS/DIAGNOSES:
S46.011A RIGHT SUPRASPINATUS TENDON TEAR, INIT
M75.91 TENDINITIS OF RIGHT SUPRASPINATUS TENDON
M75.21 TENDINITIS OF RIGHT BICEPS TENDON

M75.21 TENDINITIS OF RIGHT BICEPS TENDON

Other Pertinent Diagnosis/Diagnoses:

APPORTIONMENT
This

This permanent disability is directly caused by an injury or illness arising out of, and in the course of, employment. This permanent disability is not caused, in whole or in part, by other factors besides this industrial injury or illness, including any prior industrial injury or illness.

Medical Rationale for Apportionment:

1996

Medical Rationale for Apportionment:
100% apportioned to symptoms of severe right supraspinatus tendonosis with partial full-thickness tear caused by the patient's work-related injury (i.e. Using right shoulder regularly to check inventory of supplies incl. envelope boxes, file folders, construction paper)

FUTURE MEDICAL TREATMENT:

Future Medical Care Needed: Yes

EXAMPLE #3

STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION

Case No.: ADJ118

**ORDER SUSPENDING ACTION
ON STIPULATIONS WITH REQUEST
FOR AWARD**

Applicant,

vs.

**UNIFIED SCHOOL
DISTRICT, permissibly self-insured,
administered by YORK RISK SERVICES
GROUP,**

Defendants.

The above document is on file herein. Approval thereof will be stayed and will be considered again only after the additional information requested below has been filed or the required action taken. In the absence of response from the parties within twenty (30) days from the date hereof, this matter will be: Set for Conference by separate notice of hearing.

Action has been suspended for the following reason(s):

The MMI report from the primary treating physician from Kaiser Permanente Occupational Medicine Department, Dr. [redacted] fails to provide proper and accurate impairment ratings. Dr. [redacted] conclusion of 0% WPI is inaccurate since the Applicant has 160 degrees of flexion of the right shoulder which rates 1% WPI based on Figure 16-38 of the AMA Guides 5th Edition (page 4 of 8 of his PR-4 report dated 11/29/18) and the primary treating physician did not follow Table 16-35 (muscle weakness of the six ranges of motion of the shoulder joint) of the AMA Guides 5th Edition since the Applicant has severe right supraspinatus tendinosis of the right shoulder with a partial full thickness tear of the rotator cuff.

The Applicant is encouraged to have an examination by a Qualified Medical Examiner with a specialty in orthopedic surgery.

Dated: January 8, 2019


ROBERT G. RASSP
WORKERS' COMPENSATION APPEALS BOARD JUDGE

Filed and Served by mail on:
On all parties on the Official Address Record.

ATTENTION: SERVICE UPON ALL INTERESTED PARTIES AND FILING OF PROOF OF SERVICE WITHIN
TEN DAYS IS DELEGATED TO: YORK RANCHO CUCAMONGA

EXAMPLE #4

Occupational Medicine
1526 N Edgemont St
Los Angeles, CA 90027-5260
Phone: 323-783-6621
Date of Injury: 6/28/2016

Kaiser Permanente
Southern California Permanente Medical Group
Kaiser MRN:
Patient Name

State of California - Division of Workers' Compensation
PRIMARY TREATING PHYSICIANS PERMANENT AND STATIONARY REPORT (PR-4)

This report electronically signed by Kenneth Riemer, MD on 7/13/2016
4:08 PM

OBJECTIVE FINDINGS:

Vital Signs:

BP 101/68 mmHg | Pulse 66 | Temp(Src) 97.6 °F (36.4 °C) (Tympanic)

The injured body part was warmed up prior to the examination and an inclinometer/goniometer was used
I confirm that I have performed the following examination(s):

Constitutional: Well developed and well nourished and Alert and conversant
Ears, Nose, Throat, and Mouth: No signs of trauma, or deformity
Eyes: Conjunctivae and EOMs are normal
Cardiovascular: Normal pulse and rhythm
Respiratory: No respiratory distress
Neurological: No muscle wasting, tremor, or coordination deficits
Skin: Clear warm and dry
Psychiatric: Pleasant, alert, no distress, mood and affect normal

EXAM LOCATION(S): Wrist

Left Wrist Range of Motion (ROM)

Flexion: 60 degrees
Extension: 60 degrees
Radial Deviation: 20 degrees
Ulnar Deviation: 30 degrees

Right Wrist Range of Motion (ROM)

Flexion: 60 degrees
Extension: 60 degrees
Radial Deviation: 20 degrees
Ulnar Deviation: 30 degrees

Left Wrist Inspection/Palpation

Tinel's: Negative
Phalen's: Negative
Finkelstein: Negative
Swelling, Scarring, Atrophy: Negative
Crepitation: Negative
Radial Styloid: Negative
Ulnar Styloid: Negative
Carpals: Negative
Tendons: Negative

DWC Form PR-4 (Rev. 10/2015)

Doctor
See sheet for signature

Sheet 4 of 9

Date: 6/15/2017
Print Date: 6/15/17

Page 5 of 10 received on 6/15/2017 6:38:48 PM Pacific Daylight Time on server VLTELPRPA12 from Fax Server.

EXAMPLE #4

Page 6 of 10 received on 6/15/2017 6:34:48 PM Pacific Daylight Time on server VLTLSPPAX2 from Fax Server.

Occupational Medicine
1526 N Edgemont St
Los Angeles, CA 90027-5260
Phone: 323-783-6621
Date of Injury: 6/28/2016

Kaiser Permanente
Southern California Permanente Medical Group
Kaiser MRNT: ~~00000000000000000000000000000000~~
Patient Name

State of California - Division of Workers' Compensation

PRIMARY TREATING PHYSICIANS PERMANENT AND STATIONARY REPORT (PR-4)

Carpal Tunnel: Negative

Right Wrist Inspection/Palpation
Tinel's: Negative
Phalen's: Negative
Finkelstein: Negative
Swelling, Scarring, Atrophy: Negative
Crepitation: Negative
Radial Styloid: Negative
Ulnar Styloid: Negative
Carpals: Negative
Tendons: Negative
Carpal Tunnel: Negative

CURRENT ENCOUNTER DIAGNOSIS/DIAGNOSES:
M25.532 LEFT WRIST JOINT PAIN
Z98.890 HX OF CARPAL TUNNEL SURGERY
M67.432 GANGLION CYST OF LEFT DORSAL WRIST

Other Pertinent Diagnosis/Diagnoses:

IMPAIRMENT RATING:

IMPAIRMENT SYSTEM AND RATIONALE Organ System and whole person impairment
All calculations are based on the Guides to the Evaluation of Permanent Impairment, Fifth Edition.
Combined values chart (Page 604) has been used throughout the application to combine impairments
wherever necessary.

Body Part or System	Chapter No	Impairment %
Upper Extremity	16	0

CALCULATED TOTAL WHOLE PERSON IMPAIRMENT: 0 %.

APPORTIONMENT
This permanent disability is directly caused by an injury or illness arising out of, and in the course of, employment.
This permanent disability is not caused, in whole or in part, by other factors besides this industrial injury or illness, including any prior industrial injury or illness.

DWC Form PR-4 (Rev. 10/2015)
Doctor: ~~Dr. [Name]~~
See s

Sheet 5 of 9

Date: 6/15/2017
Print Date: 6/15/17

California Orthopedic Association

Carpal Tunnel Syndrome

- For strict WPI ratings, use Tables 16-10, 16-11, and 16-15
- Sensory Deficits or Pain
- Motor Deficits

Carpal Tunnel Syndrome

Page 495

5% UE = 3% WPI

If, after an *optimal recovery time* following surgical decompression, an individual continues to complain of pain, paresthesias, and/or difficulties in performing certain activities, three possible scenarios can be present:

1. Positive clinical findings of median nerve dysfunction and electrical conduction delay(s): the impairment due to residual CTS is rated according to the sensory and/or motor deficits as described earlier.
2. Normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal EMG testing of the thenar muscles: a residual CTS is still present, and an impairment rating not to exceed 5% of the upper extremity may be justified.
3. Normal sensibility (two-point discrimination and Semmes-Weinstein monofilament testing), opposition strength, and nerve conduction studies: there is no objective basis for an impairment rating.

Why do KP
doctors do this?

Page 7 of 10 received on 6/15/2017 6:35:48 PM Pacific Daylight Time on server VLTENRPPAX2 from Fax Server.

Occupational Medicine
1526 N Edgemont St
Los Angeles, CA 90027-5260
Phone: 323-783-6621
Date of Injury: 6/28/2016

Kaiser Permanente
Southern California Permanente Medical Group
Kaiser MRN
Patient Name

State of California - Division of Workers' Compensation

PRIMARY TREATING PHYSICIANS PERMANENT AND STATIONARY REPORT (PR-4)

FUTURE MEDICAL TREATMENT:

Future Medical Care Needed: Yes

Estimated time to remain in treatment: 2 years

EXPECTED FUTURE ORDERS:

NSAIDS: I expect no more than 2-3 refills per year and each refill up to 40 tablets

Topical Medications: I expect no more than 2-3 refills per year

Occupational Therapy: No more than 6 visits each set, no more than 2-3 sets per year

Consult: Should flare-ups not subside with the treatment listed above, the patient should have access to orthopedic consultation

ACTIVITIES ALLOWED:

Work restrictions related to current industrial injury:
FULL DUTY

THE FOLLOWING DOCUMENTS HAVE BEEN REVIEWED IN PREPARING THIS REPORT:

I have reviewed the Kaiser electronic medical record for this patient.
I have reviewed the written job description(s) for this patient.

DURATION AND LOCATION OF VISIT:

Time spent with patient (Including physical exam):

Examination took place in the specialty of Occupational Medicine and Family Medicine located at Los Angeles County, California.

---End of DWC Form State Form (PR4) (Rev. 06-05)---

EXAMPLE #5

STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION

Case No.: ADJ119

**ORDER SUSPENDING ACTION
ON STIPULATIONS WITH REQUEST
FOR AWARD**

Applicant,

vs.

**LOS ANGELES UNIFIED SCHOOL
DISTRICT, psi, adjusted by SEDGWICK
CMS,**

Defendants.

The above document is on file herein. Approval thereof will be stayed and will be considered again only after the additional information requested below has been filed or the required action taken. In the absence of response from the parties within twenty (20) days from the date hereof, this matter will be:

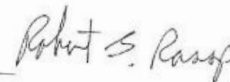
Set for Conference by separate notice of hearing.

Action has been suspended for the following reason(s):

The MMI report from the physician from Kaiser Permanente Occupational Medicine Department fails to provide an accurate WPI rating. His conclusion of 0% WPI is inaccurate since the Applicant has MRI imaging evidence of Grade III lateral femoral condyle chondromalagia and the evaluating physician did not follow Table 17-31 of the AMA Guides 5th Edition on page 544 which indicates this patient has at least a 3%, 8%, or 10% WPI rating. It is inaccurate to provide work restrictions of "sitting and standing alternatively as needed" with a 0% WPI rating.

The Applicant is encouraged to have an examination by a Qualified Medical Examiner with a specialty in orthopedic surgery.

Dated: February 1, 2019



ROBERT G. RASSP
WORKERS' COMPENSATION APPEALS BOARD JUDGE

Filed and Served by mail on:
On all parties on the Official Address Record.

California Orthopedic Association

Knees

- Knee joint has three compartments, with 4mm of cartilage intervals plus meniscus, ACL, and PCL
 - Medial side
 - Lateral side
 - Patellofemoral side (under the knee cap)
 - Patellar tendon

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California Orthopedic Association

Table 17-31 Arthritis Impairments Based on Roentgenographically Determined Cartilage Intervals

Joint	Whole Person (Lower Extremity) [Foot] Impairment (%)			
	Cartilage Interval			
	3 mm	2 mm	1 mm	0 mm
Sacroiliac (3 mm)*	—	1 (2)	3 (7)	3 (7)
Hip (4 mm)	3 (7)	8 (20)	10 (25)	20 (50)
Knee (4 mm)	3 (7)	8 (20)	10 (25)	20 (50)
Patellofemoral†	—	4 (10)	6 (15)	8 (20)
Ankle (4 mm)	2 (5) [7]	6 (15) [21]	8 (20) [28]	12 (30) [43]
Subtalar (3 mm)	—	2 (5) [7]	6 (15) [21]	10 (25) [35]
Talonavicular (2-3 mm)	—	—	4 (10) [14]	8 (20) [28]
Calcaneocuboid	—	—	4 (10) [14]	8 (20) [28]
First metatarsophalangeal	—	—	2 (5) [7]	5 (12) [17]
Other metatarsophalangeal	—	—	1 (2) [3]	3 (7) [10]

* Normal cartilage intervals are given in parentheses.

† In an individual with a history of direct trauma, a complaint of patellofemoral pain, and crepitation on physical examination, but without joint space narrowing on x-rays, a 2% whole person or 5% lower extremity impairment is given.

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- Footnote under Table 17-31: “In an individual with a history of direct trauma, a complaint of patellofemoral pain and crepitation on physical examination, but without joint space narrowing on x-rays, a 2% whole person or 5% lower extremity impairment is given.”
- Remember, the AMA Guides do NOT consider a CT injury because only 9 states do.
- There is now a push in CA to have “evidence-based causation” as a standard of proof.

EXAMPLE #6

10 LE COMBINED 10LE
= 19LE COMBINED 5LE
= 23% LE = 9% WPI

RE:
DOI: 06/14/2017
Examined: 09/20/2018

permanent and stationary.

IMPAIRMENT RATING:

Impairment Rating: 4% WPI.

Based on the AMA Guidelines for Evaluation of Permanent Impairment, Chapter 17, the patient qualifies under impairment estimates for diagnosis 17-33. Whole person impairment of partial medial and lateral meniscectomy, 4% whole person and 10% lower extremity impairment. The patient has a functioning ACL without evidence of laxity and, therefore, he qualifies for a 4% whole person impairment, 10% lower extremity impairment.

SUBJECTIVE FINDINGS OF DISABILITY:

The patient reports some occasional popping and crepitus in the knee.

OBJECTIVE FACTORS OF DISABILITY:

There is some crepitus with range of motion. He does have a stable knee and full range of motion with full strength.

WORK STATUS:

The patient is being returned to work with no limitations or restrictions.

VOCATIONAL REHABILITATION:

The patient is not an injured worker. Therefore, there is no need for vocational rehabilitation.

APPORTIONMENT:

There is no basis for apportionment in this case.

FUTURE MEDICAL TREATMENT:

This patient should be allowed visits to an orthopedic surgeon should his crepitus continue to impair him and if he desires, proceed with any arthroscopic debridement. The patient may also require future physical therapy as needed.

He stepped into a
hole + twisted his
Knee

EXAMPLE #7

What happens when an MD
fails to review op report
(shld surg)

JULY 19, 2018 -

derangement and necessitating arthroscopic surgery.

DISCUSSION:

At this time, I think the patient can be rated MMI, despite the fact that I recommended post-operative physical therapy to the left shoulder which was not done. However, the patient has been doing home exercises. He has had some improvement in his shoulder motion.

I still have not been sent the operative report to verify what was done at the time of surgery. However, clearly as he has not had any care in the last five months, he is at Maximum Medical Improvement.

FUTURE MEDICAL CARE:

The patient is entitled to future medical care for the left shoulder consisting of physical therapy two times per week for four weeks, twice a year. An allowance for a trigger point injection for a flare-up in the shoulder would be reasonable. For a flare-up he should also be provided nonsteroidal anti-inflammatory medications on a p.r.n. basis; i.e. Motrin or Naprosyn.

STATUS:

He is at Maximum Medical Improvement.

AMA IMPAIRMENT:

Using the AMA Guides, 5th Edition, he is rated on the decreased motion of the shoulder. In the absence of the operative report, there is no other impairment beyond the decreased motion. Using figure 16-43 on page 477, abduction to 90 degrees equals 4% upper extremity impairment. Using figure 16-40 on page 476, flexion to 160 degrees is a 1% upper extremity impairment. This gives him a total of 5% upper extremity impairment. Using Table 16-3 on page 439, a 5% upper extremity impairment converts to a 3% whole person impairment.

Correct
The total whole person impairment is 3%.

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EXAMPLE #8

- Commercial kitchen worker sustains crush injury to fifth digit on left hand (his pinky)
- Has reconstruction surgery to finger including debridement and amputation to PIP joint (Proximal Interphalangeal Joint – the one just north of the knuckle)
- 75-80% of grip strength is from the function of the thumb, 4th, and 5th digits.

EXAMPLE #8

on 12/26/2018 10:07:10 AM [Pacific Standard Time] on server VLTTELFFPAX2 from.

Examination of the Right Elbow

There is no tenderness to palpation. There is no swelling or erythema. There is no evidence of elbow instability.

Range of Motion

Range of motion of the right elbow is as follows:

Flexion	140°
Extension	0°
Pronation	80°
Supination	80°

Grip Strength Testing (Jamar Dynamometer)

Grip strength testing in three successive trials is:

<u>Right Hand</u>	<u>Left Hand</u>
30-28-28 kilograms	14-16-12 kilograms

DIAGNOSTIC TESTING

X-rays, three views, left small finger, August 3, 2018, in Santa Fe Springs California, and previously reviewed by this physician, showed a disarticulation of the small finger through the PIP joint with sufficient padding.

IMPRESSION

1. Left small finger amputation with subsequent necrosis.
2. Status post left small finger crush injury, July 24, 2018.
3. Status post irrigation, debridement, and disarticulation of the left small finger, July 24, 2018.

CAUSATION

The patient sustained a specific injury at work as per his history. The patient denied any prior industrial or nonindustrial medical conditions or injuries related to the left small finger, and therefore it is medically reasonable to state that his conditions are industrial in nature.

EXAMPLE

#8

on 12/26/2018 10:07:30 AM [Pacific Standard Time] on server VLTELRFPAAX2 from.

DISABILITY STATUS

The patient sustained the above injury for which he was treated operatively. Postoperatively he went on to heal uneventfully and has resumed his full duties. He has reached maximum medical improvement and is now permanent and stationary.

OBJECTIVE FACTORS OF PERMANENT DISABILITY

1. The patient has an amputation of his left small finger through the PIP joint level.
2. The patient has a relative loss of grip strength on the left. Given the grip strengths on the right, it would be anticipated that the grip strengths on the left would range between 25 and 27.

AMA IMPAIRMENT ANALYSIS AND RATING

The patient has no swelling and his grip strengths are not ratable. His amputation through the PIP joint level rates an 80% small finger impairment (Figure 16-5, Page 443). An 80% small finger impairment corresponds to an 8% hand impairment (Table 16-1, Page 438). An 8% hand impairment corresponds to a 7% upper extremity impairment. His residual pain based on Table 18-1 and Section 18-3(D) of the AMA Guides rates an additional 2% impairment, for a total upper extremity impairment of 9%. A 9% upper extremity impairment corresponds to a 5% whole person impairment (Table 16-3, Page 439).

APPORTIONMENT

The patient sustained a specific injury at work as per his history. The patient denied any prior industrial or nonindustrial medical conditions or injuries related to the left small finger, and therefore it is medically reasonable to state that his conditions are industrial in nature. His factors of permanent disability are therefore 100% apportionable to his employment with the Paloma Mexican Foods Corporation.

FUNCTIONAL CAPACITY ASSESSMENT

The patient may continue at his full duties.

FUTURE MEDICAL CARE

It is anticipated that over the next three to six months the patient's pain will diminish and his strength will improve. Should they fail to do so, he should be permitted to return for further evaluation and treatment. Should he need a refill of his medication, he should be permitted to return for that purpose as well.

EXAMPLE #8

STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION

Case No.: ADJ12.

**ORDER SUSPENDING ACTION
ON STIPULATIONS WITH REQUEST
FOR AWARD**

Applicant,

vs.

**DON JOSE CHICHARRONES, STATE
COMPENSATION INSURANCE FUND,**

Defendants.

The above document is on file herein. Approval thereof will be stayed and will be considered again only after the additional information requested below has been filed or the required action taken. In the absence of response from the parties within twenty (20) days from the date hereof, this matter will be: Set for Conference by separate notice of hearing.

THIS MATTER IS SET FOR HEARING AS FOLLOWS: _____
before Workers' Compensation Administrative law Judge, Robert G. Rassp, at 320 West 4th Street, 9th
Floor, Los Angeles, CA 90013. Action has been suspended for the following reason(s):

The MMI report from the treating physician Paul _____ MD fails to provide an accurate WPI rating. This is a PIP joint amputation of the little left finger with sensory and motor deficits. The physician incorrectly provides a pain add-on using upper extremity ratings and not WPI ratings. In addition, the anatomic loss does not account for the significant grip strength loss which should be separately rated and combined with the partial amputation of the finger. The physician incorrectly states that "grip strengths are not ratable." Under the Guides and case law, rating of the amputation can be combined with the grip loss since anatomic loss can be combined with functional loss.

The Applicant is encouraged to have an examination by a Qualified Medical Examiner with a specialty in hand surgery.

Dated: May 17, 2019



ROBERT G. RASSP

WORKERS' COMPENSATION APPEALS BOARD JUDGE

Filed and Served by mail on all parties on the Official Address Record.

ATTENTION: SERVICE UPON ALL INTERESTED PARTIES AND FILING OF PROOF OF SERVICE WITHIN
TEN DAYS IS DELEGATED TO: SCIF INSURED BAKERSFIELD

California Orthopedic Association

The Spine

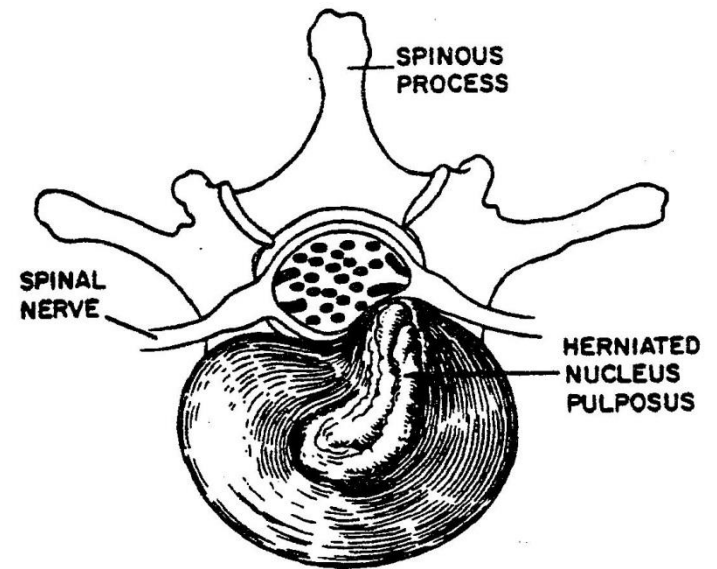
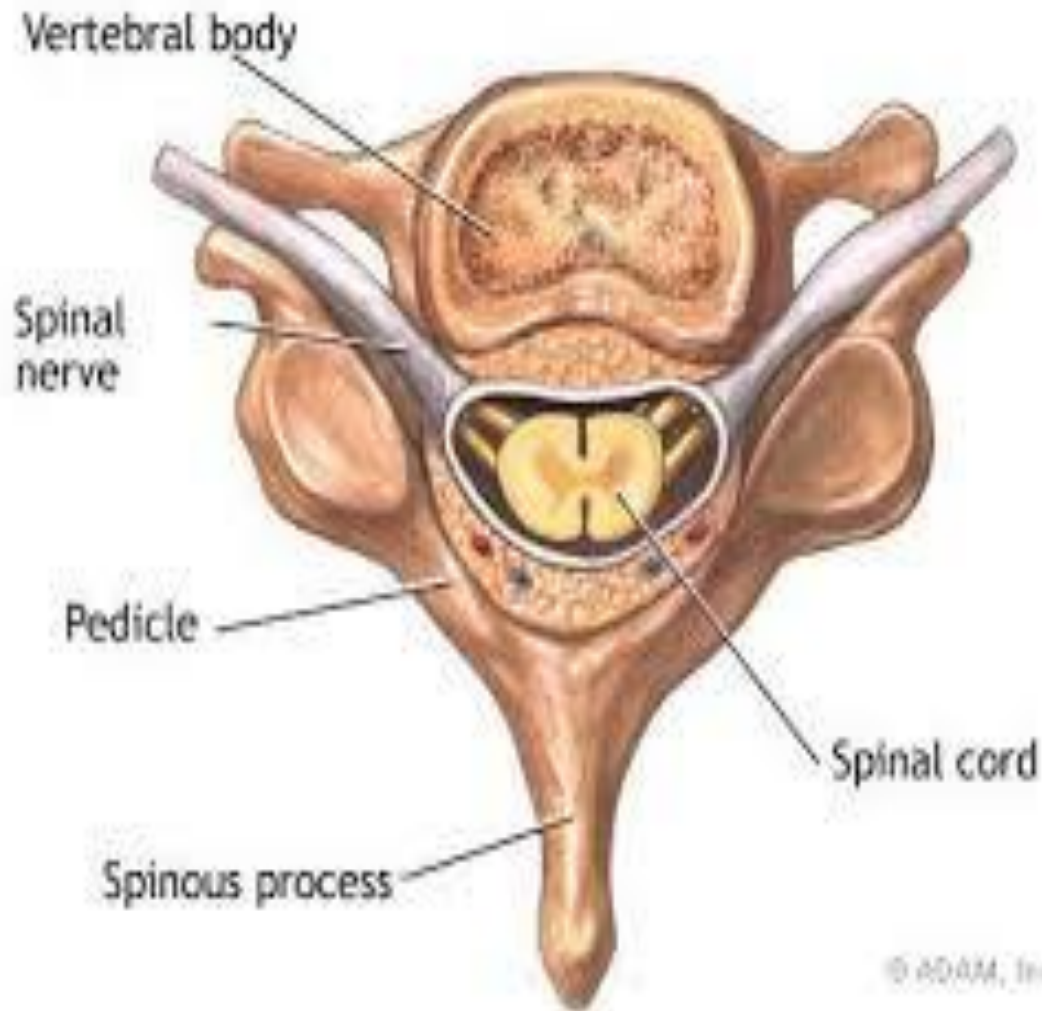
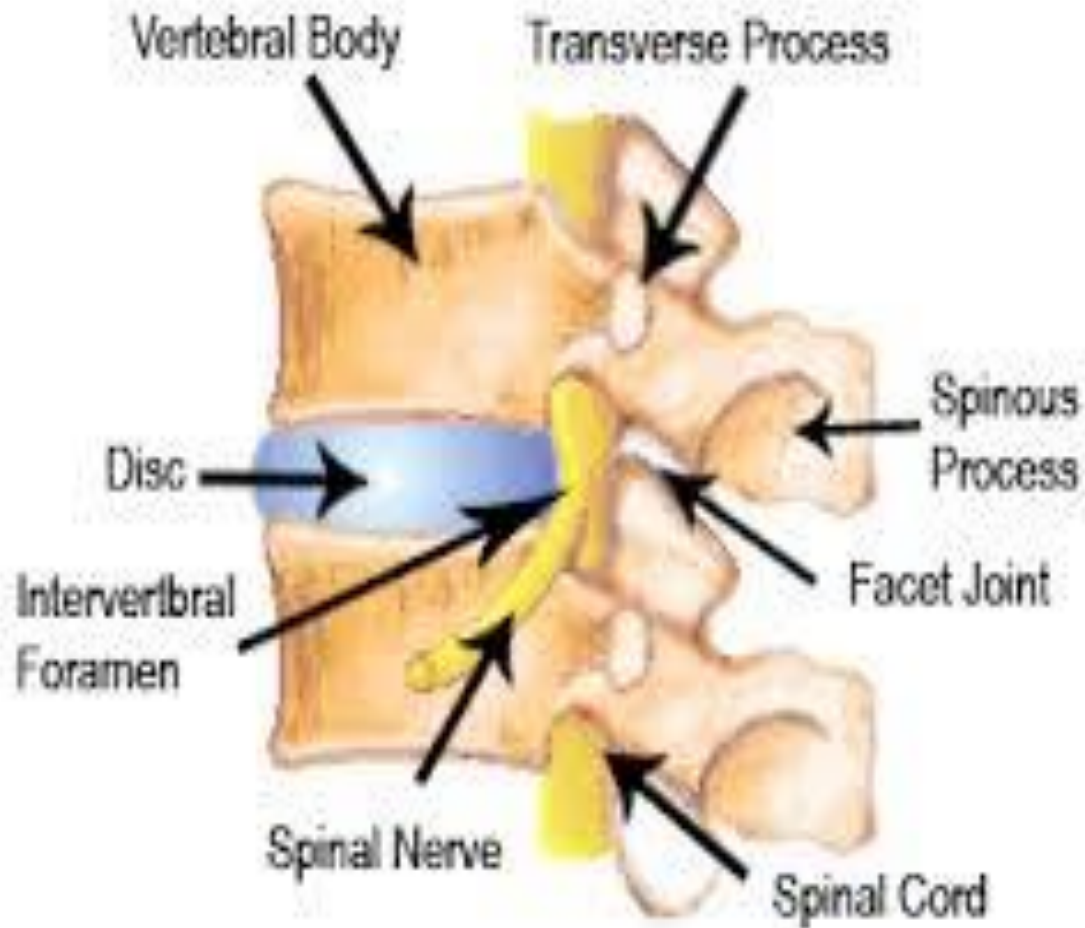


Fig. 9-10

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- Spinal canal or neural foramina stenosis
 - “Stenosis” means narrowing
 - Lumbar spinal canal is >13 mm diameter
 - Stenosis is <12 mm
 - Cervical spine canal is 13-15 mm diameter
 - Stenosis is <10 mm
- Neural Foramina stenosis
 - A 2 mm disc bulge can cause it if the bulge is para-central 4:00 or 8:00 on the image previous slide

California Orthopedic Association



California Orthopedic Association

The Spine

- DRE vs. ROM (Pages 379-381)
 - Spondylosis
 - Spondylolysis
 - Spondylolisthesis
 - Herniated nucleus pulposus
 - Spinal canal or neural foramina stenosis
 - Zygoapophyseal pain (aka Facet Joint Syndrome)
 - Annular tears

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The Spine

- DRE vs. ROM (Pages 379-381)
 - Conflict in Guides regarding use of ROM “only if there is radiculopathy”
 - But see Table 15-7, section II(C)
 - The *Guides* do NOT contemplate a cumulative trauma injury to the spine

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Table 15-7 enlarged

II. Intervertebral disk or other soft-tissue lesion			
Diagnosis must be based on clinical symptoms and signs and imaging information.			
A. Unoperated on, with no residual signs or symptoms.	0	0	0
B. Unoperated on, with medically documented injury, pain, and rigidity* associated with none to minimal degenerative changes on structural tests.†	4	2	5
C. Unoperated on, stable, with medically documented injury, pain, and rigidity* associated with moderate to severe degenerative changes on structural tests;† includes herniated nucleus pulposus with or without radiculopathy.	6	3	7
D. Surgically treated disk lesion without residual signs or symptoms; includes disk injection.	7	4	8
E. Surgically treated disk lesion with residual, medically documented pain and rigidity.	9	5	10
F. Multiple levels, with or without operations and with or without residual signs or symptoms.	Add 1% per level		
G. Multiple operations <i>with</i> or without residual signs or symptoms	Add 2%		
1. Second operation	Add 1% per operation		
2. Third or subsequent operation			
III. Spondylolysis and spondylolisthesis, not operated on			
A. Spondylolysis or grade I (1%-25% slippage) or grade II (26%-50% slippage) spondylolisthesis, accompanied by medically documented injury that is stable, and medically documented pain and rigidity with or without muscle spasm.	6	3	7
B. Grade III (51%-75% slippage) or grade IV (76%-100% slippage) spondylolisthesis, accompanied by medically documented injury that is stable, and medically documented pain and rigidity with or without muscle spasm.	8	4	9

Table 15-3 Criteria for Rating Impairment Due to Lumbar Spine Injury

DRE Lumbar Category I 0% Impairment of the Whole Person	DRE Lumbar Category II 5%- 8% Impairment of the Whole Person	DRE Lumbar Category III 10%-13% Impairment of the Whole Person	DRE Lumbar Category IV 20%-23% Impairment of the Whole Person	DRE Lumbar Category V 25%-28% Impairment of the Whole Person
<p>No significant clinical findings, no observed muscle guarding or spasm, no documentable neurologic impairment, no documented alteration in structural integrity, and no other indication of impairment related to injury or illness; no fractures</p>	<p>Clinical history and examination findings are compatible with a specific injury; findings may include significant muscle guarding or spasm observed at the time of the examination, asymmetric loss of range of motion, or nonverifiable radicular complaints, defined as complaints of radicular pain without objective findings; no alteration of the structural integrity and no significant radiculopathy</p> <p>or</p> <p>individual had a clinically significant radiculopathy and has an imaging study that demonstrates a herniated disk at the level and on the side that would be expected based on the previous radiculopathy, but no longer has the radiculopathy following conservative treatment</p> <p>or</p> <p>fractures: (1) less than 25% compression of one vertebral body; (2) posterior element fracture without dislocation (not developmental spondylolysis) that has healed without alteration of motion segment integrity; (3) a spinous or transverse process fracture with displacement without a vertebral body fracture, which does not disrupt the spinal canal</p>	<p>Significant signs of radiculopathy, such as dermatomal pain and/or in a dermatomal distribution, sensory loss, loss of relevant reflex(es), loss of muscle strength or measured unilateral atrophy above or below the knee compared to measurements on the contralateral side at the same location; impairment may be verified by electrodiagnostic findings</p> <p>or</p> <p>history of a herniated disk at the level and on the side that would be expected from objective clinical findings, associated with radiculopathy, or individuals who had surgery for radiculopathy but are now asymptomatic</p> <p>or</p> <p>fractures: (1) 25% to 50% compression of one vertebral body; (2) posterior element fracture with displacement disrupting the spinal canal; in both cases, the fracture has healed without alteration of structural integrity</p>	<p>Loss of motion segment integrity defined from flexion and extension radiographs as at least 4.5 mm of translation of one vertebra on another or angular motion greater than 15° at L1-2, L2-3, and L3-4, greater than 20° at L4-5, and greater than 25° at L5-S1 (Figure 15-3); may have complete or near complete loss of motion of a motion segment due to developmental fusion, or successful or unsuccessful attempt at surgical arthrodesis</p> <p>or</p> <p>fractures: (1) greater than 50% compression of one vertebral body without residual neurologic compromise</p>	<p>Meets the criteria of DRE lumbosacral categories III and IV; that is, both radiculopathy and alteration of motion segment integrity are present; significant lower extremity impairment is present as indicated by atrophy or loss of reflex(es), pain, and/or sensory changes within an anatomic distribution (dermatomal), or electromyographic findings as stated in lumbosacral category III and alteration of spine motion segment integrity as defined in lumbosacral category IV</p> <p>or</p> <p>fractures: (1) greater than 50% compression of one vertebral body with unilateral neurologic compromise</p>

Muscle Spasm

Muscle spasm is a sudden, involuntary contraction of a muscle or group of muscles. Paravertebral muscle spasm is common after acute spinal injury but is rare in chronic back pain. It is occasionally visible as a contracted paraspinal muscle but is more often diagnosed by palpation (a hard muscle). To differentiate true muscle spasm from voluntary muscle contraction, the individual should not be able to relax the contractions. The spasm should be present standing as well as in the supine position and frequently causes a scoliosis. The physician can sometimes differentiate spasm from voluntary contraction by asking the individual to place all his or her weight first on one foot and then the other while the physician gently palpates the paraspinal muscles. With this maneuver, the individual normally relaxes the paraspinal muscles on the weight-bearing side. If the examiner witnesses this relaxation, it usually means that true muscle spasm is not present.

Muscle Guarding

Guarding is a contraction of muscle to minimize motion or agitation of the injured or diseased tissue. It is not true muscle spasm because the contraction can be relaxed. In the lumbar spine, the contraction frequently results in loss of the normal lumbar lordosis, and it may be associated with reproducible loss of spinal motion.

Asymmetry of Spinal Motion

Asymmetric motion of the spine in one of the three principal planes is sometimes caused by muscle spasm or guarding. That is, if an individual attempts to flex the spine, he or she is unable to do so moving symmetrically; rather, the head or trunk leans to one side. To qualify as true asymmetric motion, the finding must be reproducible and consistent and the examiner must be convinced that the individual is cooperative and giving full effort.

Nonverifiable Radicular Root Pain

Nonverifiable pain is pain that is in the distribution of a nerve root but has no identifiable origin; ie, there are no objective physical, imaging, or electromyographic findings. For dermatomal distributions, see Figures 15-1 and 15-2.

Reflexes

Reflexes may be normal, increased, reduced, or absent. For reflex abnormalities to be considered valid, the involved and normal limb(s) should show marked asymmetry between arms or legs on repeated testing. Once lost because of previous radiculopathy, a reflex rarely returns. Abnormal reflexes such as Babinski signs or clonus may be signs of corticospinal tract involvement.

Weakness and Loss of Sensation

To be valid, the sensory findings must be in a strict anatomic distribution, ie, follow dermatomal patterns (see Figures 15-1 and 15-2). Motor findings should also be consistent with the affected nerve structure(s). Significant, long-standing weakness is usually accompanied by atrophy.

Atrophy

Atrophy is measured with a tape measure at identical levels on both limbs. For reasons of reproducibility, the difference in circumference should be 2 cm or greater in the thigh and 1 cm or greater in the arm, forearm, or leg. The evaluator can address asymmetry due to extremity dominance in the report.

Radiculopathy

Radiculopathy for the purposes of the *Guides* is defined as significant alteration in the function of a nerve root or nerve roots and is usually caused by pressure on one or several nerve roots. The diagnosis requires a dermatomal distribution of pain, numbness, and/or paresthesias in a dermatomal distribution. A root tension sign is usually positive. The diagnosis of herniated disk must be substantiated by an appropriate finding on an imaging study. The presence of findings on an imaging study in and of itself does not make the diagnosis of radiculopathy. There must also be clinical evidence as described above.

Electrodiagnostic Verification of Radiculopathy

Unequivocal electrodiagnostic evidence of acute nerve root pathology includes the presence of multiple positive sharp waves or fibrillation potentials in muscles innervated by one nerve root. However, the quality of the person performing and interpreting the study is critical. Electromyography should

USE THIS
TABLE TO
DETERMINE
WHICH DRE
CATEGORY
APPLIES

California Orthopedic Association

be performed only by a licensed physician qualified by reason of education, training, and experience in these procedures. Electromyography does not detect all compressive radiculopathies and cannot determine the cause of the nerve root pathology. On the other hand, electromyography can detect noncompressive radiculopathies, which are not identified by imaging studies.

Alteration of Motion Segment Integrity

Motion segment alteration can be either loss of motion segment integrity (increased translational or angular motion) or decreased motion secondary to developmental fusion, fracture healing, healed infection, or surgical arthrodesis. An attempt at arthrodesis may not necessarily result in a solid fusion but may significantly limit motion at a motion segment. Motion of the individual spine segments cannot be determined by a physical examination but is evaluated with flexion and

extension roentgenograms. The loss of motion segment integrity is defined in Section 15.1b.

Cauda Equina Syndrome

Cauda equina syndrome is manifested by bowel or bladder dysfunction, saddle anesthesia, and variable loss of motor and sensory function in the lower extremities. Individuals with cauda equina syndrome usually have loss of sphincter tone on rectal examination and diminished or absent bladder, bowel, and lower limb reflexes.

Urodynamic Tests

Cystometrograms are useful in individuals where a cauda equina syndrome is possible but not certain. A normal cystometrogram makes the presence of a nerve-related bladder dysfunction unlikely. Occasionally, more extensive urodynamic testing is necessary.

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Example 9

DRE v. ROM

- 27-year-old dishwasher at restaurant lifts heavy bin of dishes and has acute onset of low back pain.
- Within one week, seeks treatment with a chiropractor
- Here is his MMI report

Example 9

Re: ~~John Doe~~
DOI: 11/14/2013
Ins: Employers Comp

Exam Date: 7/24/15

Page 4 of 12

OBJECTIVE FINDINGS:

Height: 5'11"
Weight: 266 lbs
B.P.: 129/96
Pulse: 87 bpm
Right-hand dominant

Muscle Girth Circumference:

	Left:	Right:
Thigh:	51.0 cm	52.0 cm
Calf:	46.0 cm	46.0 cm

→ Mr. ~~Doe~~ has normal gait. He uses a back brace.

Sensation is decreased in the right lower extremity over the L4-S1 dermatomes.

Motor strength is decreased in the left quadriceps, hamstrings, tibialis anterior, peroneus longus, and extensor hallucis muscles (L4-S1 dermatomes).

Motor strength is decreased in the right peroneus longus and extensor hallucis muscles (L5-S1 dermatomes).

Knee Jerk and Achilles reflexes are decreased bilaterally.

All measurements were obtained through the use of instrumentation, and were obtained in accordance with the instructions within the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition.

Lumbar Exam:

There is no bruising, swelling or atrophy noted.

There is tenderness and spasm over the lumbar paravertebral muscles and bilateral SI joints.

Orthopedic Tests:

→ Left Straight Leg Raise ranges to 10 degrees with pain radiating to the buttock.
Right Straight Leg Raise ranges to 12 degrees with pain radiating to the buttock.
Kemp's causes radiating low back pain bilaterally.

Lumbar Range of Motion:

Muscle guarding is present.

→

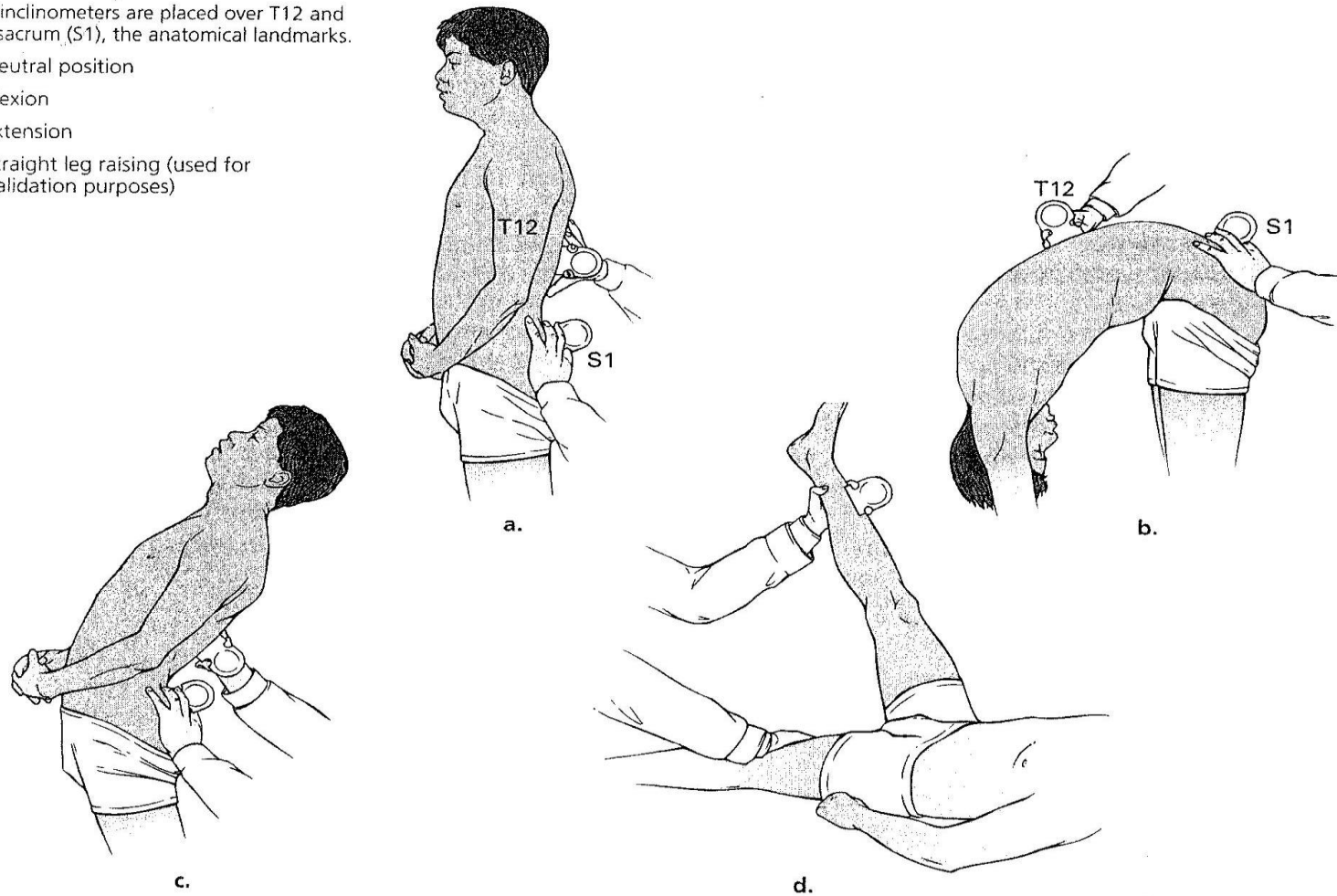
Movement	Description	Range		
Lumbar flexion (60)	T12 ROM	13	12	14
	Sacral ROM	1	3	2
	True lumbar flexion angle	12	9	12

California Orthopedic Association

Figure 15-8 Two-Inclinometer Technique for Measuring Lumbar Flexion and Extension

The inclinometers are placed over T12 and the sacrum (S1), the anatomical landmarks.

- a. neutral position
- b. flexion
- c. extension
- d. straight leg raising (used for validation purposes)



Example 9

Re: ~~XXXXXX~~
DOI: 11/14/2013
Ins: Employers Comp

Exam Date: 7/24/15

Page 5 of 12

	$\pm 10^\circ$ or 5°	Yes	No	
	Maximum true lumbar flexion angle	12		8% WPI
Lumbar extension (25)	T12 ROM	9	10	10
	Sacral ROM	2	1	2
	True lumbar extension angle	7	9	8
	$\pm 10^\circ$ or 5°	Yes	No	
	Maximum true lumbar extension angle	9		5% WPI
Straight leg raising (SLR), left	Left SLR	9	10	8
	$\pm 10^\circ$ or 5°	Yes	No	
	Tightest SLR Left	8		
Straight leg raising (SLR), right	Right SLR	10	12	12
	$\pm 10^\circ$ or 5°	Yes	No	
	Tightest SLR Right	10		
Lumbar left lateral bending (25)	True lumbar left lateral bending angle	12	9	11
	$\pm 10^\circ$ or 5°	Yes	No	
	Maximum lumbar left lateral bending angle	12		3% WPI
Lumbar right lateral bending (25)	True lumbar right lateral bending angle	14	14	15
	$\pm 10^\circ$ or 5°	Yes	No	
	Maximum lumbar right lateral bending angle	15		2% WPI
References	Table 15-8, page 407 Table 15-9, page 409	18% WPI due to lumbar loss of motion		

DIAGNOSTIC STUDIES:

1/12/2014 MRI of the lumbar spine – Saad Naseer M.D.:

1. Disc desiccation at L4-L5 and L5-S1.
2. Straightening of the lumbar lordotic curvature.
3. L3-L4: Broad-based disc protrusion which causes stenosis of the spinal canal. Disc measurements: NEUTRAL: 5.4 mm; FLEXION: 2.7 mm; EXTENSION: 2.7 mm.
4. L4-L5: Broad-based disc protrusion which causes stenosis of the spinal canal. There is associated stenosis of the bilateral lateral recess with deviation of the visualized bilateral L5 transiting nerve roots. Disc measurements: NEUTRAL: 4.0 mm; FLEXION: 5.4 mm; EXTENSION: 5.4 mm.
5. L4-L5: Broad-based disc protrusion which causes stenosis of the spinal canal. There is associated stenosis of the bilateral lateral recess with deviation of the visualized bilateral S1 transiting nerve roots. Disc measurements: NEUTRAL: 4.0 mm; FLEXION: 5.4 mm; EXTENSION: 5.4 mm.

L5-S1

2/5/2014 X-ray of the lumbar spine – Stuart Strausberg, D.O.:

1. Normal lumbar spine examination with no subluxation on flexion and extension.
2. Incidentally noted are multiple sutures in the right upper quadrant compatible with a previous cholecystectomy.

Example 9

Re: ~~XXXXXX~~
DOI: 11/14/2013
Ins: Employers Comp

Exam Date: 7/24/15

Page 6 of 12

3/10/2014 X-ray and CT of the lumbar spine – Sean Johnston, M.D.:

1. Schmorl's node formation is seen within the superior endplate of L4 and superior endplate of S1.
2. L3-4: 1-2 mm posterior disc bulge without evidence of canal stenosis or neural foraminal narrowing.
3. L4-5: 2-3 mm posterior disc bulge resulting in mild left neural foraminal narrowing. Vacuum phenomenon is seen with the left facet joint.
- 4. L5-S1: 3-4 mm posterior disc bulge resulting in mild right and mild to moderate left neural foraminal narrowing. Mild canal stenosis is seen.

4/4/2014 EMG/NCV of the bilateral lower extremities – Javier Torres, M.D.:

- 1. Normal EMG studies of the lower extremities with no acute or chronic denervation potentials.
2. Normal NCV studies of the lower extremities did not reveal any electrophysiological evidence of Peripheral Nerve Entrapment.

HISTORY OF TREATMENT:

Mr. ~~XXXXXX~~ was referred to my office on November 21, 2013. He has received conservative care in the form of chiropractic therapy, physiotherapy, aquatic therapy, and acupuncture. I ordered a back brace and a cane. He was placed on temporary total disability.

He was initially seen by Archie Mays, M.D., for orthopedic consultation on February 4, 2014. He was evaluated and referred for diagnostic studies. He was provided with analgesic, anti-inflammatory, antispasmodic and antigastritis medications, as well as Ambien for sleep. Dr. Mays continued to follow up with him every four to six weeks.

He was seen by Arlen Green, D.O., for pain management consultation. Dr. Green recommended lumbar epidural steroid injection.

He was initially seen by Justin Paquette, M.D., for neurosurgical consultation on February 17, 2014. He was evaluated and referred for lumbar epidural steroid injection, which he underwent in October 2014. Dr. Paquette then recommended L4-S1 posterior fusion and decompression. The surgery has not been performed due to lack of authorization.

Mr. ~~XXXXXX~~ was initially seen by Nathan Ford, M.D., on May 5, 2015. He was prescribed medications for pain and inflammation, including Norco, Neurontin, Prilosec, and Naproxen.

DIAGNOSTIC IMPRESSIONS:

Lumbar disc protrusions L4-5 and L5-S1 with stenosis, per MRI [722.10, 724.02]
Lumbar muscle spasm [728.85]
Lumbar radiculopathy, clinical [724.4]
Status post LESI [V45.89]
Loss of sleep [780.5]
Psych component

Example 9

Re: [REDACTED]
DOI: 11/14/2013
Ins: Employers Comp

Exam Date: 7/24/15

Page 7 of 12

DISCUSSION/DISABILITY STATUS:

Mr. [REDACTED] was working as a dishwasher at the time of the subject injury. He initially presented to my office on November 21, 2013 for evaluation and treatment of his work-related injuries. He has been provided with appropriate treatment, and has reported improvement; however, he remains with residuals to the original areas of complaint. Mr. [REDACTED] has reached maximal medical improvement, from a chiropractic standpoint, as of July 24, 2015.

Please note that, per the AMA Guides Training CD-ROM, published by the AMA in 2005, the average length of time to reach MMI (maximal medical improvement) is 1 year post-injury or surgical procedure. The length of time between injury and MMI may be longer or shorter depending on the type of injury and other factors.

It is in my professional opinion based on the work injury history as presented, patient history, and examination findings that Mr. [REDACTED] condition is a direct result of the injury of issue.

Mr. [REDACTED] residual complaints, as stated above, at the present time do preclude and limit some of his work duties. The pain as described by Mr. [REDACTED] may increase in the future if he returns to his normal job duties without any work modification.

AMA IMPAIRMENT RATING:

This impairment rating evaluation was performed in accordance with the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition. All measurements taken during the examination were made with instrumentation, and in accordance with instructions provided in the AMA Guides.

DRE → In regard to the lumbar spine, clinical history and examination findings are compatible with a specific injury. Findings include muscle spasm, muscle guarding, decreased sensation in a dermatomal distribution, and decreased motor strength in a dermatomal distribution. Mr. [REDACTED] falls within DRE Lumbar Category III of Table 15-3 on page 384, with 13% whole person impairment based on effects on his activities of daily living.

However, as there is evidence of multiple-level injury in a single spinal level, the ROM method may also be used, according to Figure 15-4 on page 380. Mr. [REDACTED] has disc herniations at two levels with degenerative changes and radiculopathy, for which I will include 7% + 2% whole person impairment, according to Sections II.C and II.F of Table 15-7 on page 404.

ROM → He has 18% whole person impairment due to loss of motion of the lumbar spine, according to Tables 15-8 and 15-9 on pages 407 and 409.

He also has radiculopathy in both lower extremities at multiple levels. The sensory/motor deficits are rated according to Tables 15-15, 15-16 and 15-18 on page 424 below:

Left Lower Extremity:

L4: 25% motor deficit x 34% maximum lower extremity impairment
= 8.5% lower extremity impairment

- L5: 25% motor deficit x 37% maximum lower extremity impairment
= 9.25% lower extremity impairment
S1: 25% motor deficit x 20% maximum lower extremity impairment
= 5% lower extremity impairment

The 21% combined lower extremity impairment is converted to 8% whole person impairment, using Table 17-3 on page 527.

Right Lower Extremity:

- L4: 25% sensory deficit x 5% maximum lower extremity impairment
= 1.25% lower extremity impairment
L5: 25% sensory deficit x 5% maximum lower extremity impairment
= 1.25% lower extremity impairment
25% motor deficit x 37% maximum lower extremity impairment
= 9.25% lower extremity impairment
S1: 25% sensory deficit x 5% maximum lower extremity impairment
= 1.25% lower extremity impairment
25% motor deficit x 20% maximum lower extremity impairment
= 5% lower extremity impairment

The 17% combined lower extremity impairment is converted to 7% whole person impairment, using Table 17-3 on page 527.

According to the instructions on page 380, if an individual can be rated using both the DRE and the ROM methods, the individual is evaluated using both methods and the higher of the two ratings is given. In this case, the rating using the ROM method is higher.

Pain Assessment:

Mr. ~~XXXX~~ was asked to complete Table 18-4 of the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition, located on pages 576 and 577. Following the instructions provided in Table 18-6 on page 584, his scores are as follows:

Table 18-4 Ratings Determining Impairment Associated with Pain		Score	Max
Section I	Pain, Self Report of Severity 7; 10; 10; 10; 10	19.25	20
Section II	Activity Limitation or Interference 7; 7.5; 8; 8.5; 10; 10; 10; 9.5; 9; 8; 8; 5; 2; 4; 4; 7	21.9	30
Section III	Individual's Report of Effect of Pain on Mood 9; 10; 10; 10; 10	9.8	10

Observed pain behaviors from Table 18-5 include: facial grimacing; moving in a guarded or protective fashion; moaning.

Example 9

Example 9

Table 18-6 Worksheet for Calculating Total Pain-Related Impairment Score	
1. Sum the scores for Section I of Table 18-4, items A-D, and divide by 4; add response to item E. Range is from 0 to 20.	19.25
2. Total scores for Section II of Table 18-4, items A-P, divide by 16, and multiply by 3. Range is from 0 to 30.	21.9
3. Sum scores for Section III of Table 18-4, items A-E, and divide by 5. Range is from 0 to 10.	9.8
4. Global pain behavior rating from Table 18-5 (rating should be any number between -10 and +10).	+0
Subtotal steps 1 through 4 (maximum = 70)	50.95
5. Physician adjustment based on clinical judgment of patient's credibility. Add or subtract 0 to 10.	+10
6. Total pain-related impairment score = total of steps 1 through 5.	60.95

Per Table 18-7, page 584, a cumulative score of 61 indicates severe impairment.

With reasonable medical probability, there is excess pain in the context of medical conditions that cause pain. The pain is considered ratable under Chapter 18 of the AMA Guides. Therefore, I will include an additional 3% whole person impairment due to pain.

Consideration of Almaraz-Guzman II:

Considering the impact on his activities of daily living, it is my opinion that the above impairment rating does not accurately reflect Mr. Rojo's impairment.

Mr. ~~Rojo~~ reports limitation of daily social and interpersonal functioning. He experiences anxiety, depression, and irritability due to his injury, which causes him to avoid others. He feels that others avoid him because of his moods. I find an accurate description of this condition in Class 1 of Table 13-8 on page 325 (Emotional and Behavioral Disorders), which gives a range of 0-14% whole person impairment. I will provide 8% whole person impairment in this regard.

Mr. ~~Rojo~~ also reports difficulty sleeping and disturbance of sleep due to pain, which results in excessive daytime sleepiness, as indicated by his Epworth Sleepiness Score of 19/24. I find an accurate description of this condition in Class 1 of Table 13-4 on page 317, which provides a range of impairment from 0-9%. I will include 5% whole person impairment in this regard.

SUMMARY OF IMPAIRMENTS:

Lumbar disc herniations at L4-5 and L5-S1 with degenerative changes	9%
Lumbar spine loss of motion	18%
Left lumbar radiculopathy (decreased motor strength)	8%
Right lumbar radiculopathy (decreased motor strength and decreased sensation)	7%
Limitation of daily social and interpersonal functioning	8%
Sleep impairment	5%
Pain-related impairment	3%†
Total Whole Person Impairment	47%

California Orthopedic Association

Example 9

DRE v. ROM

- 27-year-old dishwasher at restaurant lifts heavy bin of dishes and has acute onset of low back pain.
- Ortho PQME rated DRE Category II 5% WPI

California Orthopedic Association

Example 10

From 0% PD to 22% PD

- 55-year-old packer for glass manufacturer had a 3400-pound steel frame loaded with glass panels run over his left foot resulting in a dislocated great toe.
- In one year he returned to work, wears an orthotic post surgery
- A walk-through Stipulations With Request for Award was submitted for WCJ approval

Example 10

2. The injury (ies) caused temporary disability for the period 03/09/2017 through 01/02/2018 for which indemnity has been paid at \$ 336.79 per week.
MM/DD/YYYY Indemnity Paid

2(a). The injury(ies) caused additional temporary disability for the period N/A through N/A at the rate of \$ N/A in the amount of \$ N/A.
MM/DD/YYYY Rate Indemnity Paid

3. The injury(ies) caused permanent disability of 0 % for which indemnity has been paid at \$ N/A per week beginning N/A in the sum of \$ N/A, less credit for such payments previously made. ☐ And a life pension of \$ N/A per week thereafter.
MM/DD/YYYY Life Pension

An informal rating ☐ has / ☒ has not (Select one) been previously issued in case no(s) _____

4. There ☒ is ☐ is Not a need for medical treatment to cure or relieve from the effects of said injury (ies).

5. Medical-legal expenses and/or liens are payable by defendant as follows:

N/A

6. Applicant's attorney requests a fee of \$ N/A

☐ Fees to be commuted as follows:

N/A

7. Liens Against compensation are payable as follows:

N/A

Example 10

STATE OF CALIFORNIA WORKERS' COMPENSATION APPEALS BOARD

abel

Applicant,

vs.

glassworks LP

Defendant(s).

WALK THROUGH APPEARANCE SHEET

Case No(s). ADJ. _____

Enter: ☐ Yes ☐ No

Case set for hearing: ☐ Yes ☐ No

Walk through document:

- ☐ C & R ☒ Stipulations with Request for Award
☐ 5710 Deposition Attorney's Fees
☐ Petition to Compel Attendance at Medical Eval/Depo
☐ Petition for Stay Order (PJ ONLY)

APPEARANCES:

Applicant ☐ PRESENT ☒ NOT PRESENT

Applicant Represented By: _____ ☐ ATTORNEY ☐ HEARING REP.

Defendant Represented By: SHW ☐ ATTORNEY ☐ HEARING REP.

Others Appearing: _____ ☐ ATTORNEY ☐ HEARING REP.

Interpreter: _____ Certification No. _____

DISPOSITION: ☐ OTOC ☒ Order Suspending Action on C&R/Stips ☐ C&R/Stips Approved

ORDER(s)/COMMENT(s): MHC report does not provide evaluation for joint impairment per table 17-5 or any other alternative noting the dislocated great toe on L foot. Also earnings dispute resulting in STD rate issue. 4906(g) not signed by E/I or claims admin.

☐ PETITION APPROVED: ☐ 5710 Fees ☐ Petition to Compel Attendance at Medical Eval/Depo

☐ Petition for Stay Order

☐ PETITION DISAPPROVED: ☐ 30 Days to Submit Requested Docs ☒ Set for Status Conference

DATE: 2-13-19 TIME: 1:30 JUDGE: RASSP LOCATION: LAO

Date: NOV 21 2018

Robert G. Rassp

ROBERT G. RASSP

WORKERS' COMPENSATION JUDGE

NOTICE TO: SHW TO SERVE ALL PARTIES ON THE OFFICIAL ADDRESS RECORD _____

FOR WCAB USE ONLY:
JUDGE ASSIGNED: _____

Example 10

WCJ ordered CA to
obtain a QME panel in
podiatry

CONTINUATION: QUIRARTE, ABEL
APRIL 9, 2019

PAGE 7.

coincide with an arthritic joint causing pain to the 1st IPJ necessitating a fusion. But it is reasonable why he would be having pain at the 1st MPJ due to hallux limitus and jamming of the MPJ with dorsiflexion of the joint. It also makes sense why he has a steppage gait and avoids a normal heel to toe gait, therefore avoiding dorsiflexion of the 1st MPJ. His left foot is supinated and inverted because he is avoiding pressure to the medial forefoot. Therefore, he may have a nerve compression injury to the dorsal digital (superficial dorsal cutaneous) and plantar digital (medial plantar) nerves. His gait is altered secondarily because of muscle weakness, limited range of motion to the 1st MPJ, no motion to the 1st IPJ, and possible nerve pain. CRPS is low on the differential diagnosis because he doesn't present with the dermatological, vascular, and neurological signs and symptoms.

Muscle testing was variable and unreliable. Patient did not have motor control and was uncoordinated in actively moving his muscles. The test was very subjective. Therefore, I was unable to determine accurately his full muscle strength to give a rating.

FACTORS OF DISABILITY:

Subjective Factors: Constant pain to the left 1st MPJ to distal great toe.

→ Objective Factors: Ankylosis and arthritis 1st IPJ, hallux limitus 1st MPJ, muscle weakness, atrophy calf, and derangement gait.

IMPAIRMENT RATING: According to the AMA Guides to the Evaluation of Permanent Impairment, fifth Edition, utilizing the range of motion, ankylosis, and atrophy, I determined his impairment from pages 530-552. I used tables 17-14, 17-30, 17-6 and 17-37.

Pages 533-538 and table 17-14, range of motion toe impairment. The left 1st MPJ has (mild) limited range of motion rated at 1% whole body, and the 1st IPJ (moderate to severe) no range of motion rated at 2% whole body.

Pages 538-543 and table 17-30, joint ankylosis toe. The 1st MPJ and IPJ have ankylosis with rating of 4% whole body.

Pages 530-531 and table 17-6, muscle atrophy as measured to the calf with the right larger by 1 cm. Rated at 1% whole body.

Pages 550-551 and table 17-37, peripheral nerve injury. The medial plantar nerve to the great toe with rating 2% whole body.

Therefore the total impairment rating is summed to (1+2+4+1+2) 10% total body. I utilized the objective findings from my examination to determine the impairment.

FUTURE MEDICAL TREATMENT:

Future medical treatment would include further diagnostic test to determine the source of his pain. This would include a neurological consultation with nerve conduction and EMG testing. Treatment with a qualified physical therapist to help strengthen his muscles, pain management,

Example 10

Disability Evaluation Unit
Division of Workers' Compensation
320 W. 4TH ST. #970
LOS ANGELES, CA 90013
(213)5767426

State of California
Gavin Newsom, Governor

CONSULTATIVE RATING DETERMINATION

Page 1

Employee: ~~ABE QUINARTE~~

DEU Case ~~DEU1009034~~

No:

Occupation: OPERATOR

Age at date of injury: 55

Claim No: CALK

Date of Injury (DOI):

03-09-2017

Treating Physician

Edward S. Chin, DPM

04-09-2019

Rating per 2013 PDRS

Rating per AMA Guides

L Greater Toe - Ankylosis: 10 LE = 4 WP

17.09.02.00 - 4 - [1.4]6 - 460F - 6 - 7 PD (A)

L Medial Plantar Nerve - Peripheral Nerve: 5 LE = 2 WP

17.01.04.00 - 2 - [1.4]3 - 460H - 5 - 6 PD (A)

(A) 7 C 6 = 13 Final PD

Lower extremity combining Table 17-2 applied.

Alternative Rating provided by physician

L Greater Toe ROM / Ankylosis: 10 C 5 C 2 = 17 LE = 7 WP

17.09.07.00 - 7 - [1.4]10 - 460H - 13 - 16 PD (A)

L Calf Atrophy: 3 LE = 1 WP

17.09.01.00 - 1 - [1.4]1 - 460F - 1 - 1 PD (A)

L Medial Plantar Nerve - Peripheral Nerve: 5 LE = 2 WP

17.01.04.00 - 2 - [1.4]3 - 460H - 5 - 6 PD (A)

(A) 16 C 6 C 1 = 22 Final PD

SHAW-LA
MAY 20 2019
RECEIVED

Example 10

What
triggered the
OSA?

...The PTP
MMI report

Isys Medical Management: from October 16, 2017 to June 6, 2018.

September 19, 2017 - Dr. Shun evaluated big toe which remains pretty stiff. Patient cannot return to his previous job duties at this juncture. Dr. Shun does feel the toe may not ever feel quite the same as there is some arthritis in the joint.

October 16, 17, 2017 - no pain at rest and 5/10 prolonged weight bearing. Return to modified work if available with sedentary work restrictions.

November 13, 14, 2017 - no pain at rest. 3-4/10 pain with weight bearing. Pending modified work but continue TTD.

December 20, 2018 - 2/10 pain weight bearing. Release to working 4 hours maximum.

December 23, 2018 - the big toe remains pretty stiff. There is visible antalgia during ambulation. He is to continue with Ibuprofen, ice, and elevation. Release to modified sedentary work only until January 1, 2018. Released to full duties for a 4 hour work day.

January 11, 2018 - Dr. Shun evaluated the big toe which has increased tenderness and swelling. There is decreased range of motion with 5/10 pain. Dr. Shun injected cortisone into the big toe joint.

January 28, 2018 - 5/10 pain prolong work shifts. Orthotics will not fit in work boots. Finished physical therapy and taking no pain meds. Cortisone injection was given and rx for 800mg Ibuprofen. Working full duties and modified duty not applicable. MMI targeted in 6 weeks.

March 20, 2018 - patient reach maximal medical improvement. Return to full work duties.

May 3, 2018 - patient Permanent and Stationary January 25, 2018 and released from care. Pending Permanent and Stationary Report.

June 6, 2018 - reached Permanent and Stationary status. Released to full work duties. To sedentary work only no restrictions. Dr. Shun deemed MMI on January 25, 2018. NCM educated Dr. Shun PR-4 framework to complete PR-4 report. 0% impairment, no restrictions established. Future medical on as needed basis to include evaluation, diagnostics, injections, and therapy.

Impressions: Ankylosis of the first metatarsophalangeal joint with hallux limitus, ankylosis of the first interphalangeal joint with ankylosis and arthritis, possible compression nerve injury, muscle weakness due to lack of use and compensation, and pain.

Discussion/recommendations/future medical treatment plan:

Mr. ~~Quirarte~~ had sustained a traumatic injury in March 9, 2017 where a 3400 pound metal rack rolled over his left forefoot. The crushing injury dislocated his left first interphalangeal joint developing fracture blisters and skin slough due to trauma. He underwent surgical repair a week later with open reduction and internal fixation. The extensor hallucis longus tendon and capsule was interposed within the joint. Dr. Shun cut the tendon and removed the capsular interposition to allow the joint to position back into anatomical position. He placed a "K" wire across the first interphalangeal joint for immobilization and was kept non weight bearing for many months. After approximately 5 to 6 months the pin was removed. On December 14, 2017, Mr. Quirarte was then returned to work with no disability and declared permanent stationary.

My clinical examination revealed paresthesia to the dorsal and plantar aspect of the left foot.

OK, ARE YOU READY TO WRITE A BULLET PROOF REPORT?



Armaque, July 2002-
March 2016. We miss
you.