

The Independent Medical Evaluation Report: A Step-by-Step Guide with Models

THE INDEPENDENT
MEDICAL EVALUATION REPORT

A Step-by-Step Guide with Models

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Table 3-1

<i>Issue</i>	Workers' Compensation	Personal Injury	Disability
<i>Diagnosis</i>	◆◆◆◆	◆◆◆◆	◆◆◆◆
<i>Causal Relationship</i>	◆◆◆◆	◆◆◆◆	◆◆◆◆
<i>Prognosis</i>	◆◆	◆◆	◆◆◆
<i>Maximum Medical Improvement (MMI)</i>	◆◆◆	◆◆◆	◆◆◆
<i>Impairment Rating</i>	◆◆◆	◆◆◆	◆
<i>Work Capability</i>	◆◆◆◆	◆◆◆	◆◆◆◆
<i>Appropriateness of Care</i>	◆◆◆◆	◆◆◆	◆
<i>Recommendations</i>	◆◆	◆◆	◆
<i>Functional Capacity</i>	◆◆◆	◆◆◆	◆◆◆

Key:

[◆◆◆◆Very Important] [◆◆◆Important] [◆◆Some Importance] [◆ Not Important]

Table 3-1 shows the relative importance of common issues to workers' compensation, disability, and personal injury claims. As can be seen, the importance of these issues varies depending upon the type of claim involved. Note that in many particular instances not all issues are of concern to the client. For example, in a certain workers' compensation case causation may already be agreed upon, and the only remaining issue may be evaluation of impairment. In another workers' compensation case impairment evaluation may not have any specific relevance, the relevant issues may be confined to areas such as work capacity and appropriateness of care.

16.5 Multiple Injuries

- *The Case: Examinee was a passenger in a motor vehicle involved in an accident.*
- *At Issue: Causation, management, maximum medical improvement, and work capacity*

This case involves another common source of workers' compensation claims -- a motor vehicle accident. The examinee presents with numerous complaints. Through a detailed evaluation and reporting process the physician is able to recommend to the client the steps to be taken to appropriately manage this complex case.

This examination and evaluation were performed by J. R. McCarthy, MD, in conjunction with Karen McCarthy, RN, Clinical Nurse Specialist.

IDENTIFYING DATA:

Mrs. Yolanda Grahams is a 43-year-old ambidextrous female who presents with a chief complaint of total body pain sparing the right upper extremity times two years including problems with vision, hearing, balance, and memory. The patient is represented by Sally McPlaintiff with the firm of Dewey, Cheatum, and Howe. Her worker's compensation insurance carrier is CMIA, claim No. K9248537, attention: Christine Matal. At the time of her work-related injury the patient was employed as a truck driver with Acme Shippers Service. The patient has had multiple treating practitioners including Dr. Young, MD, Dr. Rossie, PhD, and Dr. Hughes, DC.

PRE-EXISTING INJURIES, ACCIDENTS, OR DISEASES:

The patient notes rheumatic fever during childhood with consequent mitral valve prolapse. She notes no prior work-related injury and no prior involvement in motor vehicle accidents. She denies any prior chiropractic care and specifically denies any prior body aching, visual or hearing disturbance, or difficulty with memory.

HISTORY OF PRESENT ILLNESS:

Mrs. Yolanda Grahams is a 43-year-old ambidextrous female with date of birth being 12/8/50. The patient states that she was involved in a work-related motor vehicle accident on 11/14/92. At that time the patient was employed as a team truck driver with her husband and had been doing this type of work for approximately four years. On the date of the above-noted work-related accident the patient and her husband were driving their truck in Nebraska. The patient indicates that she had just finished her "shift" of driving and was asleep in the sleeper compartment of the truck cab. Her husband was driving and in an attempt to avoid hitting a herd of deer he swerved off the road into the woods. The patient indicates that they apparently traveled several miles into the woods. She was awakened and thrown around in the sleeper. The patient denies loss of consciousness but states that she was "tossed around like a rag." The patient apparently found her husband unconscious and radioed for help. The patient and her husband were taken to County Regional Medical Center in Omaha, Nebraska where they were evaluated in the

PAST MEDICAL HISTORY:

ALLERGIES: The patient notes multiple allergies -- sensitivities including Elavil, Penicillins, anti-inflammatories, lotions, detergents, molds, Prednisone, aspirins, Cortisones, perfumes, dust, heat, plants, and sun.

PAST SURGICAL HISTORY:

None.

PRIOR HOSPITALIZATIONS NOT INVOLVING SURGERY:

None.

PAST ACCIDENTS, INJURIES OR DISEASES:

As noted above in pre-existing.

MEDICATIONS:

The patient is currently on Buspar daily and Tylenol approximately two times per day.

REVIEW OF SYSTEMS:

The patient denies a history of hypertension, diabetes, cancer, or lung problems. She notes a history of rheumatic fever as a child with a "leaky valve murmur." The patient notes occasional stomach upset related to medications. She states that she has some liver problems from use of Naprosyn.

The patient describes sweats, chills, and loss of appetite secondary to pain. She has gained weight over the last two years. She notes frequent sleep disruption. She notes problems with sexual function secondary to pain. She describes feelings of chronic tiredness. She notes poor circulation. She notes occasional discomfort in her chest primarily since osteopathic manipulation. She notes occasional swelling in her ankles.

The patient notes episodes of dizziness, falling, problems with balance, and fainting which she relates to her "head injury." She admits to feelings of depression and anxiety.

The patient notes multiple problems with her bowel and bladder indicating occasional incontinence up to two to three times per week. The patient notes the occurrence of bowel and bladder dysfunction up to two to three times per week. She has had no specific work-up for these complaints. She feels that these bowel and bladder problems occur "when my pelvis is out of alignment."

The patient notes problems with her vision and hearing. She also notes spasms in her jaw.

The patient lastly notes that she had extensive dental work and ultimately had to get dentures.

SOCIAL HISTORY:

The patient smokes one pack of cigarettes per day and has done so for 21 years. She denies alcohol intake. She does have daily caffeine intake.

FAMILY HISTORY:

The patient has been married for 5 years. This is her fourth marriage. She indicates that she has one adopted daughter and 2 stepsons who are on their own. The patient notes that her husband continues to do poorly following his problems related to their work-related motor vehicle accident. The patient also notes that her mother-in-law died the night of their motor vehicle accident and there was another death in their family 2 weeks prior to their accident.

OCCUPATIONAL HISTORY:

As noted above, the patient was employed as a team truck driver with her husband for approximately 4 years. She indicates that she loved this work and wishes she could return to it. The patient is currently receiving wage compensation and there is an attorney involved in her case.

LEVEL OF EDUCATION:

The patient states that she completed high school and does have a college degree.

RECREATIONAL ACTIVITIES:

The patient notes that she enjoys fishing, truck driving, car driving, walking and hiking, cooking, reading, sewing, and painting. Primarily due to her visual problems, "blackouts," and dizziness, she is no longer able to enjoy these activities.

FUNCTIONAL HISTORY:

The patient states that she can sit for 15 minutes (40 minutes observed), stand for 30 minutes, drive for one hour and 20 minutes, and walk for 5 minutes (before getting busy).

ACTIVITIES OF DAILY LIVING:

The patient notes that she has difficulty with all aspects of daily living including dressing, performing personal hygiene, doing house and yard work, and preparing meals.

The patient states that she frequently stretches. She also goes to the Bally Health Club approximately 1 to 2 times per week, but this is limited by her husband's health.

GOALS:

The patient notes on her questionnaire that her goals are to "be normal (my above average) again and to be safely able to do everything to perfection as I did prior to the accident on 11/14/92."

PHYSICAL EXAMINATION:

GENERAL APPEARANCE: The patient presented as a pleasant and cooperative female appearing slightly older than her stated age of 43 years. She was mildly obese. She exhibited moderate pain behaviors. Affect was appropriate although the patient presented as fairly comfortable despite her multiple pain complaints.

POSTURE: Round shouldered anteriorly. Functionally kyphotic. Slight forward cervical tilt.

VITAL SIGNS: Height 5'5-1/2" and weight of 159 pounds.

CERVICAL RANGE OF MOTION: The patient is quite guarded with all range of motion. Flexion to 75 degrees and extension full. Left lateral bending to 25 degrees and right lateral bending to 20 degrees. Left rotation to 65 degrees and right rotation to 70 degrees. Range of motion quite above this when not under direct observation.

UPPER EXTREMITY SHOULDER RANGE OF MOTION: Within functional limits for flexion, extension, internal rotation, and external rotation.

CRANIAL NERVE EXAMINATION: Cranial nerves II through XII were grossly intact.

TEMPOROMANDIBULAR JOINT EXAM: Negative with no paracranial tenderness.

UPPER EXTREMITY NEUROLOGICAL EXAMINATION: Strength was 5/5 bilaterally. Inconsistent non-dermatomal complaints of hypesthesia in the bilateral upper extremities - most likely normal sensory examination. Deep tendon reflexes +1 in the bilateral biceps and pronators and +2 in the bilateral triceps. Hoffmann's absent bilaterally. No wrist clonus.

LUMBOSACRAL RANGE OF MOTION: Flexion to 40 degrees and extension to 15 degrees. Left lateral bending to 25 degrees and right lateral bending full. Again, range of motion improved when not under direct observation.

PELVIC EXAMINATION: Symmetrical sacroiliac motion. Hemi-pelvis symmetrical.

LOWER EXTREMITY NEUROLOGICAL EXAM: Strength was 5/5 bilaterally. Sensation was intact to light touch bilaterally. Deep tendon reflexes were +2 bilaterally of the Achilles tendons and of the patellar tendons. Babinski's absent bilaterally. No ankle clonus. No gastroc weakness was noted. The patient was able to engage in alternate heel and toe walking without difficulty. Bilateral genu varus noted.

MANEUVERS: 5/5 Waddell's signs noted. Right straight-leg raise to 85 degrees and left straight leg raise to 80 degrees. Bilateral Gaenslen's maneuvers refers pain to the neck and lumbosacral spine but not

to the sacroiliac joints.

MEASUREMENTS: No leg length discrepancy was noted. Girth of the thigh on the right was 44/15 cm and on the left 45/15 cm. Girth of the calves was 34/12 cm bilaterally.

RIGHT KNEE EXAMINATION: No asymmetrical effusion. Negative drawer sign. Good end point. Negative Lachman's. No medial lateral instability. Click noted superiorly and laterally on McMurray's maneuver. The patient was diffusely tender over the right knee.

PALPATORY EXAMINATION: Fibromyalgia screen noted 15 out of 18 tender points. The patient also was noted to be tender over the forehead but not over the jaw or nose. The patient was also tender over the bilateral sacroiliac joints. No active trigger points were elicited. Negative Romberg.

DATA:

Cervical MRI dated 12/4/92 shows: (1) Mild C5-6 central spur and protrusion without impingement of thecal sac slightly eccentric to the left with slight narrowing of C5-6 foramen. This finding could be asymptomatic and normal for age although high intensity zone within the protrusion is more suggestive of acute annular tear - clinical correlation recommended.

IMPRESSIONS:

1. Cervical spondylosis pre-existing-to but aggravated-by work-related motor vehicle accident of 11/14/92 with mild C5-6 protrusion.
2. Chronic cervical, thoracic, and lumbosacral strain secondary to work-related motor vehicle accident of 11/14/92.
3. Positive fibromyalgia screen, rule-out somatoform equivalent.
4. Complaints of intermittent visual dysfunction —rule-out ophthalmic migraine, rule-out mild decompensated esotropia secondary to work-related motor vehicle accident of 11/14/92.
5. Probable mixed-tension and vascular headaches secondary to work-related motor vehicle accident of 11/14/92.
6. Complains of intermittent bowel and bladder incontinence of unknown etiology —rule-out neurogenic involvement as a result of work-related motor vehicle accident of 11/14/92.
7. Complaints of post-traumatic vertigo with normal neuro-otologic testing to date —rule-out somatoform equivalent.
8. Probable somatoform pain disorder.
9. Rule-out personality disorder with passive dependent features.
10. Rule-out anxiety disorder.

RECOMMENDATIONS AND TREATMENT PLAN:

1. Recommend referral to Dr. Judy Lunney, MD, for complaints of intermittent headaches and "blindness."
2. Referral to Dr. Tom Pulitzer, OD, for evaluation and treatment regarding complaints of "intermittent blindness and blackouts."
3. Referral to Dr. David Copas, MD, and to Dr. Phil Hand, MD, for evaluation and treatment regarding intermittent bowel and bladder incontinence.

4. The patient is recommended to finish testing recommended by Dr. Sims, MD.
5. The patient is to continue weaning of chiropractic treatment from 2 times per month to 1 time per month over the next 2 to 3 months.
6. The patient should continue follow-up psychological counseling with Dr. Rossie and Dr. Sting on an every-2 week basis.
7. The patient will follow-up with the nurse clinician in 2 weeks and Dr. McCarthy in approximately 1 month.

It will most likely take approximately 6 to 8 weeks to complete the above evaluations and depending on the results will then formulate a treatment plan or consider referral to a pain rehabilitation program. Over the next 2 to 6 months the patient's care should be coming to closure. The patient was advised of the above diagnoses and treatment plan. Additionally, she is instructed to either pull off the road or not drive at all when she is experiencing visual complications.

DISCUSSION:

This patient has had a myriad of extensive treatment and physician intervention over the last 2 years but unfortunately, coordination of these interventions was difficult to achieve. Her physical presentation and history overwhelmingly suggest a somatoform pain disorder but we must emphasize that such a diagnosis is a diagnosis of exclusion and before her clinicians can proceed appropriately toward case closure, the patient's trouble complaints of intermittent "blindness" as well as bowel and bladder dysfunction must be specifically clarified. Hence, the above referrals to Dr. Pulitzer and Dr. Lunny relative to complaints of headaches and visual disturbances and to Dr. Copas and Dr. Hand for complaints of bowel and bladder dysfunction.

Once these physicians' recommendations have been optimally considered, we can then determine whether participation in a multidisciplinary pain program, either with Dr. Bass or Dr. Ento/Dr. Rothman will be appropriate. I believe it is incumbent upon us to clarify these issues as the discussion above and also doubt that the patient will accept any kind of case closure without a thorough and coordinated approach to these complaints.

With the above in mind, I anticipate maximum medical improvement can be attained within 2 to 6 months depending on these consultants' recommendations. The patient admits that she is not that much better than at the time of treatment initiation some 2 years ago and seems agreeable to the weaning of chiropractic care described above.

With respect to questions queried in the 7/22/94 correspondence by Laurel Slotnick, questions 1, 2, 3, 4, and 8 are addressed above. I would require a physical capacity evaluation or feedback from a pain program team to determine accurately this patient's work restrictions and I think it is premature to speculate empirically as to these issues at this time. The patient will probably have a mild permanent physical impairment at the time of MMI whose calculations will be deferred until that time.

With respect to question No. 7, although it appears that the vast majority of care to date was reasonable and necessary, it unfortunately was coordinated rather poorly resulting in some unfortunate duplication of effort. To the degree that the Division of Worker's Compensation's low back pain guidelines generally limit manual medicine interventions to less than 50 total visits over a one year period, the overall quantity of chiropractic interventions appears excessive particularly in light of minimal long-term physical or functional benefit.