ExamWorks

Carl F. Mercurio, M.D.
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Roseland, NJ 07068

EXAMINEE INFORMATION

DATE OF EXAMINATION: April 24, 2017

EXAMINEE IDENTIFICATION INFORMATION:

Examinee Name:	[redacted]
Address:	
Home Phone:	
Date of Birth:	
SS#:	
Age:	31
Sex:	Male

CLIENT INFORMATION:

Attention:	Sonia Gittens
Firm:	Am Trust North America
Address:	PO Box 99405 Cleveland, OH 44101
Telephone:	888-239-3909
Claim No.:	2278805-1
CP No.:	2016-29001
D/I:	4/28/2016

EMPLOYER INFORMATION:

Company:	Hendricks Appliance
Address:	21 Bridge Street Stockton, NJ 08859

IMPORTANT MESSAGE

INTRODUCTION:

[redacted] was referred for an independent medical evaluation (IME) at the request of the above client. A medical assistant was present during the examination. The IME process was explained to the examinee and he understood that no patient/doctor relationship exists and that a report would be sent to the requesting client. The examinee verbalized his understanding of the process and agreed to proceed with the evaluation. This history was provided by the examinee, who was a cooperative and fair historian. He was uncertain of some of the names of some of the treating physicians and sequence of events. He arrived on time for his appointment. He reported no difficulties associated with this examination.

Date of claim is 4/28/16. He is 31-years-old. He is right handed.

HISTORY OF PRESENT ILLNESS (per examinee):

[redacted] **related the following history.** He indicates that on 4/28/16, he was doing his usual and regular duties as an appliance installer. He had been working for that company for 5 years. That particular day, he was lifting a subzero, when he developed immediate back pain. He stopped what he was doing. He reported it and he went to see his primary care physician.

He was seen and treated by Cindy Barter in Lambertville, New Jersey (5/20/16). He complained of back pain. He indicated to me that this was several days after the accident. He was kept out of work and given medications and started on a physiotherapy program. He does not remember having an MRI done at that time.

Eventually, his workers comp kicked in and he was seen and treated by an orthopedic surgeon (medical records indicate James Dwyer on 8/5/16). He underwent an examination. His physiotherapy was continued over the next several months.

He was kept out of work. He was eventually sent for an MRI of his back (8/12/16). Injections were discussed, but not done. (Medical records indicate a functional capacity evaluation on 11/9/16 and demonstrated submaximal effort).

He went back to the same orthopedic doctor and was discharged back to regular duty (medical records indicate MMI on 12/5/16).

He never returned back to work. He is not working at the present time.

Past history indicates no previous injuries to his back. He has had no new injuries to his back. Orthopedically, he had a work related car accident in 2009, in which he injured his left shoulder and required surgical intervention. He denies any major medical problems. He took no pain medication before today's examination.

CURRENT STATUS:

Regarding his lower back, he continues to have pain and discomfort. He has more bad days than good days. It wakes her up at nighttime depending on the position he sleeps in. It is affected by the weather and changes in weather. It goes down both legs on the right side it goes down to his foot with occasional numbness, pins, and needles. He is able to drive. He drove here today. In regards to activities of daily living, he does not do any lifting or running and he indicates that it affects just about everything that he does on a daily basis. Once again, he has not returned back to work.

The medical records provided to me were reviewed: On 5/20/16, [redacted] was seen by Dr. Cindy Barter regarding back and shoulder pain. Patient stated that back pain was severe, it fluctuated and occurred persistently. The onset of back pain was three weeks ago and the onset of shoulder pain was six months prior. Pain was located in the middle and lower back, and radiated to the left and right thigh. He described pain as deep and shooting. Patient stated changing positions, rolling over in bed, standing and walking aggravated symptoms. Symptoms were relieved by trigger point injection. Patient also complained of worsening right shoulder pain. Pain was dull and was aggravated by lifting. Symptoms included joint tenderness and nocturnal pain. He was a smoker and allergic to Gabapentin, Sulfanilamide and Penicillin. Patient was assessed with back and shoulder pain. A magnetic resonance imaging (MRI) of thoracic spine was ordered and considerations of injections for shoulder were discussed.

On 8/5/16, patient was seen by Dr. James Dwyer and complained of thoracolumbar pain that radiated into the right lower extremity. His symptoms were secondary to work related injury. Patient stated that while at work on 4/28/16, he was lifting a subzero refrigerator and felt as if there was an "explosion" in his back and he was gasping for 20 to 30 minutes, took some tramadol and worked; the next day was not better. By Monday, he was unable to move. He did see his primary care physician who did x-rays. He had been attending physical therapy. The pain radiated to his right lower extremity. He also complained of neck pain to his right shoulder. He experienced pain at night. Coughing and sneezing increased the pain in his thoracic and lumbar region. He felt he improved slightly and he was not stiff as he had been when it first occurred. His medications included Advair, Ventolin and Trazodone. His past surgical history included hernia repair, shoulder repair and cataract surgery. **X-rays** were performed and revealed thoracic spine were in normal limits. He was diagnosed with annular tear of the lumbar and thoracic spine and probable herniated nucleus pulposus. Patient was prescribed Naprosyn and MRI of the lumbar and thoracic spine was ordered. Physical therapy was ordered.

On 8/12/16, a thoracic spine **MRI report** revealed degenerative changes most pronounced at T3-4 and T5-6, cord compression or edema was not present. There was a mild focal cord deformity secondary to a right-sided osteophytic ridge at T3-4 without cord edema.

On 8/12/16, a lumbar spine **MRI report** revealed mild left L5-S1 foraminal stenosis due to loss of foraminal height, endplate osteophyte and disc bulge. There was no significant central canal stenosis. There was moderate L5-S1 disc degeneration and mild L4-5 facet arthropathy.

On 8/22/16, Mr. Eastwood followed up with Dr. Dwyer regarding lumbar pain radiating to his right lower extremity. He complained of numbness over the lateral border of his right thigh and calf and had been out of work since time of injury. He stated physical therapy had not helped improve his symptoms. He was diagnosed with an annular tear in lumbar spine. Epidural injections were discussed.

A **functional capacity evaluation (FCE)** on 11/9/16 showed he demonstrated sub-maximum effort and was capable of medium category work.

On 12/5/16, patient followed up with Dr. Dwyer and continued to complain of lumbar and thoracic pain. Pain was unchanged and it occasionally radiated to right lower extremity. Pain had not worsened or improved. He attended physical therapy and medications which did not help as well, occasionally Advil gave him relief. He was diagnosed with annular tear of the lumbar spine, degenerative disc disease of the lumbar spine, traumatic lumbar spine and herniated nucleus pulposus of the thoracic spine. Patient was capable to perform medium duty at work but not capable of heavy duty work. He was placed on light duty. Patient had reached maximum medical improvement (MMI).

JOB DESCRIPTION:

[redacted] installed appliances for six years at Hendricks Appliance. He is no longer employed. He does not have a side job. He graduated high school.

PAST MEDICAL HISTORY:

No pain medicine was taken today. He is allergic to penicillin. He has a history of asthma and uses an inhaler. He had shoulder surgery, a herniorrhaphy and another surgery. He had fractures of the fingers and toes. He had an ankle sprain. He had another work related injury to the shoulder. He has not seen a chiropractor. Dr. Barber has been his **family doctor** for 10 years.

SOCIAL HISTORY:

He quit smoking in 2016. He continues to go walking. He can no longer go fishing, hunting or jogging. He has trouble dressing and using the toilet. At home, he continues to mow the lawn, do yard work, take out the trash, cook, do laundry, grocery shop, clean, vacuum and wash dishes. He can no longer wash the car, repair cars or do household painting.

[redacted] was examined on April 24, 2017 in the Bedminster office.

PHYSICAL EXAMINATION:

All range of motion measurements were made without forcing the examinee beyond the point where pain is reported.

Lumbar Spine Range of Motion (in degrees):

	Flexion	Extension	Left Side Bending	Right Side Bending	Right Rotation	Left Rotation
Examinee	60	25	25	25	30	30
Normal	**60**	**25**	**25**	**25**	**30**	**30**

The normal values are from the AMA Guides to the Evaluation of Permanent Impairment, 4th ed. and The Clinical Measurement of Joint Motion, American Academy of Orthopedic Surgeons, 1994. There can be considerable normal variation due to age, gender and body mass. It is best to compare normal and affected sides.

Hip Range of Motion (in degrees):

	Flexion	Extension	Abduction	Adduction	External Rotation	Internal Rotation
Right Side	100	30	40	20	50	40
Left Side	100	30	40	20	50	40
Normal	**100**	**30**	**40**	**20**	**50**	**40**

The normal values are from the AMA Guides to the Evaluation of Permanent Impairment, 4th ed. and The Clinical Measurement of Joint Motion, American Academy of Orthopedic Surgeons, 1994. There can be considerable normal variation due to age, gender and body mass. It is best to compare normal and affected sides.

Knee Range of Motion (in degrees):

	Flexion To	Extension To
Right Side	110	0
Left Side	110	0
Normal	**110**	**0**

The normal values are from the AMA Guides to the Evaluation of Permanent Impairment, 4th ed. and The Clinical Measurement of Joint Motion, American Academy of Orthopedic Surgeons, 1994. There can be considerable normal variation due to age, gender and body mass. It is best to compare normal and affected sides.

Ankle Range of Motion (in degrees):

	Dorsiflexion To	Plantar Flexion To	Inversion	Eversion
Right Side	20	40	20	10
Left Side	20	40	20	10
Normal	**20**	**40**	**20**	**10**

The normal values are from the AMA Guides to the Evaluation of Permanent Impairment, 4th ed. and The Clinical Measurement of Joint Motion, American Academy of Orthopedic Surgeons, 1994. There can be considerable normal variation due to age, gender and body mass. It is best to compare normal and affected sides.

Manual Muscle Testing:

	Right Side	Left Side
Psoas	+5	+5
Gluteus	+5	+5
Hip Abductors	+5	+5
Hip Adductors	+5	+5
Quadriceps	+5	+5
Hamstrings	+5	+5
Tibialis Anterior	+5	+5
Tibialis Posterior	+5	+5
Extensor Hallucis Longus	+5	+5
Flexor Hallucis Longus	+5	+5
Flexor Digitorum Longus	+5	+5
Extensor Digitorum Longus	+5	+5
Intrinsic Toe Flexors	+5	+5
Peronei	+5	+5
Gastrocsoleus	+5	+5

British Muscle Testing System +5=Normal, +4=Weak, +3=Able to move the joint against gravity, +2=Able to move joint if gravity eliminated, +1=Trace contraction, 0=No contraction

Reflexes:

	Knee-Patellar	Ankle-Achilles
Left Side	+2	+2
Right Side	+2	+2

Straight Leg Raising Test:

	Sitting	Lying
Left	Negative	Negative
Right	Negative	Negative

Pulses

	Right	Left
Dorsalis Pedis	Positive	Positive
Posterior Tibial	Positive	Positive

The examinee had no pain on palpation over the upper spinous processes, lower spinous processes, right sacroiliac joint, left sacroiliac joint, right paraspinal muscles, left paraspinal muscles, right buttock and left buttock. There was pain on flexion in the knees bilaterally. The examinee was able to sit normally. Ankle inversion and eversion were unrestricted. Babinski's test was negative bilaterally and clonus was absent bilaterally. Gait was normal. The examinee was able to heel walk. The examinee was able to go up on tiptoes.

Pinwheel sensation was diminished in the left lower extremity.

There was no anterior groin, posterior hip and trochanteric pain on palpation bilaterally. There was no spasm with log rolling of the hip bilaterally.

There was no Trendelenburg gait involving the hip bilaterally. There was a negative Trendelenburg sign involving the hip bilaterally. There was a negative Patrick's sign involving the hip bilaterally.

The pelvis was level. There was no pain with anteroposterior and lateral pelvic compression.

There was no tenderness over the medial femoral condyle, lateral femoral condyle, tibia, patella, medial joint line and lateral joint line bilaterally. There was no effusion and synovitis in the knee bilaterally. The medial and lateral collateral ligaments in the knee were intact to stress testing bilaterally. There was no crepitus with motion in the knee bilaterally. There was no pain with patellar compression in the knee bilaterally. The patellar apprehension test was negative bilaterally. Lachman's test, the anterior drawer's test, posterior drawer's test, McMurray's test, Apley's test, pivot shift test, Apley's compression, Apley's distraction test were negative in the knee bilaterally.

His thigh circumference was 16-1/2 inches bilaterally. His calf circumference was 14-1/2 inches bilaterally. His ankle circumference was 9 inches bilaterally. The examinee was able to squat fully.

The examinee had no anterior, anterolateral, inferolateral, posterolateral, anteromedial, inferomedial, and posteromedial ankle pain bilaterally to palpation. The examinee had no bunion involving the foot bilaterally. The examinee had no heel tenderness at the Achilles tendon insertion and plantar heel tenderness involving the foot bilaterally. The examinee had no ankle instability on examination and a negative drawer's sign in the ankle bilaterally. Both feet had a normal longitudinal arch.

There was no overlapping of toes in the foot bilaterally.

[redacted] was 71 inches tall and weighed 200 pounds.

OBSERVATION:

Mr. Eastwood sat comfortably during the interview. He showed no unusual posturing. There were no assistive devices visible in the room.

Inspection of the lower extremities revealed normal skin color, normal skin temperature, normal hair growth, and normal capillary refilling. Unrelated tattoo of the left lower extremity was noted.

Gait within the examining room was normal walking forwards and backwards. He was able to mount and dismount the examining table without any difficulty. He did not use any external means of support. He was able to turn from the supine to the prone position without any complaints. He was able to fully squat without any complaints. He was able to get up on his heels and toes without any complaints.

In the standing position, compression of the head and shoulder produced low back pain. Passive range of motion of the shoulders and pelvis produced low back pain.

During the majority of the examination, there was generalized grunting and groaning, but no specific complaints of pain.

He was asked to take his socks off and he sat in the examining chair, leaned forward and took off his socks without any complaints of back pain.

In the prone position, flexion of both knees produced low back pain. The same maneuver in the sitting position produced no such complaints. I found this inconsistent and signs of illness behavior.

IMPRESSION:

Thoracolumbar pain.

OTHER DIAGNOSES:

1. Work related injury to the left shoulder 2009.
2. Symptom magnification.

CONCLUSIONS:

The above individual had the above diagnosis.

Diagnostic reports only were reviewed for this claim. There were no actual films/cd's available to view at the time of the examination except where noted:

- X-ray reports were performed and revealed thoracic spine were in normal limits on 8/5/16.

- On 8/12/16, a thoracic spine MRI report revealed degenerative changes most pronounced at T3-4 and T5-6, cord compression or edema was not present. There was a mild focal cord deformity secondary to a right-sided osteophytic ridge at T3-4 without cord edema.
- On 8/12/16, a lumbar spine MRI report revealed mild left L5-S1 foraminal stenosis due to loss of foraminal height, endplate osteophyte and disc bulge. There was no significant central canal stenosis. There was moderate L5-S1 disc degeneration and mild L4-5 facet arthropathy.
- A functional capacity evaluation (FCE) on 11/9/16 showed he demonstrated sub-maximum effort and was capable of medium category work.

It is my opinion, based upon review of the medical records and my objective physical examination, the above examinee has reached medical plateau orthopedically, and no further treatment is necessary. He can return back to her normal daily activities including work

Opinions about work restrictions should be justified on the level of evidence they have available about the job demands and work functioning. In other words objective measures (physical exam and diagnostic test findings), to validate the opinion and not only on what the work thinks they can do.

You need job information based on the worker and/or general description written by the employer or a survey of job demands.

Based upon available information and within a reasonable degree of medical probability, I find causal relationship between the claim of 4/28/16 and the above impression. It was reported in a timely fashion. The mechanism of injury was consistent. He denies any new injuries or accidents.

LUMBOSACRAL SPINE

I find 0 % permanent partial disability of the lumbosacral spine due to the diagnosis low back pain. I base this upon the following:

- Reports of diagnostic studies (x-rays of 8/5/16, MRI of 8/12/16).
- My objective physical examination, in which I find a full painless range of motion of the lumbosacral spine. There was no sign of physiological nerve irritation in the lower extremity. The findings were of whole extremity, therefore non-physiological and non-anatomical in nature. Reflexes at the knees and ankles were symmetrical. Manual muscle testing was normal. There were no signs of muscle atrophy. Straight leg raise in the sitting and supine produced neither leg pain nor back pain. He was able to get upon on his heels and toes without any complaints. He has minor subjective limitations with activities of daily living. For unknown reasons, he has not returned back to work.

The above statements have been made within a reasonable degree of medical certainty or probability. The opinions rendered in this case are mine alone. Recommendations regarding treatment, work and impairment ratings are given totally independent from the requesting agent.

Opinions do not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.

This evaluation is based upon the history given by the examinee, the objective medical findings noted during the examination, and information obtained from a review of the prior medical records presented with the assumption that this material is true and correct. If additional information is provided to me in the future, an additional service/report/reconsideration may be requested. Such information may or may not change the opinions rendered in this evaluation.

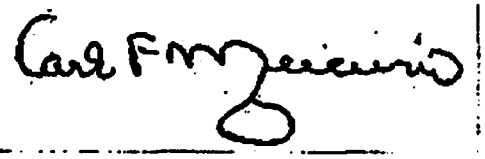
Medicine is both an art and science, and although an examinee may appear to be fit to return to duty (work), there is no guarantee that he will not be injured or sustain an additional injury once he returns to work.

Surgery does not result in an additional add-on value or added impairment percentage.

Impairment ratings are based on the examinee's condition and objective findings at the time of the examination.

The examinee's ID was requested and if available was checked prior to the examination. I did not engage in any doctor-patient relationship with the examinee, and the examinee is aware of this fact.

If further information is required, please contact the office.



Carl F. Mercurio, M.D.
CFM:as/jns/et/sc/ba/ks

IN PREPARATION FOR THIS REPORT, THE FOLLOWING RECORDS WERE REVIEWED:

1. Notes from Dr. Cindy Barter dated 5/20/16
2. Notes from Dr. James Dwyer dated 8/5/16, 8/22/16 and 12/5/16.
3. MRI Reports dated 8/12/16 from Dr. James Dwyer.
4. FCE report dated 11/9/16.