INDEPENDENT MEDICAL EVALUATION

Claimant:
Requested by:
Date of Injury: February 3, 2003
Date of Examination: April 22, 2008
Claim #:

All information contained herein is from medical records provided to me by the claimant, as well as a history ascertained from the patient himself. Medical records reviewed included the following:

- Associates in Orthopedic and Sports Medicine.
- Hamilton Medical Center.
- Advanced Pain Care.
- North Georgia Neurological Institute.
- Open MRI of Dalton.
- Neurosurgical Group of Chattanooga at Dalton.
- Miscellaneous other records.

The records reveal that the claimant was injured on February 3, 2003 in a motor vehicle accident while driving a company truck. The claimant reports that he was a restrained driver, operating a pickup truck when he was involved in a head on collision with the other driver attempting to pass on the side of the road. He was seen at the emergency room at Hamilton Medical Center where x-rays were obtained of the lumbar and cervical spine as well as the knee. The claimant reports that he sustained trauma to the left knee and ankle when his knee hit the dashboard. He also had complaints of pain in his back and neck. X-rays of the knee revealed a small effusion, and cervical and lumbar x-rays were both unremarkable.

On February 12, 2003, the claimant was seen by J. Mitch Frix, M.D. at Associates in Orthopedic and Sports Medicine in Dalton, Georgia. Dr. Frix obtained x-rays of the ankle, which were unremarkable, and his diagnosis was ankle strain with a cervical and lumbar strain.

The claimant followed up with Dr. Frix again on April 30, 2003 with continued pain in the ankle, left knee, and low back. Dr. Frix noticed paresthesias down the left leg with increasing back pain, and ordered an MRI scan to evaluate the lumbar region. The MRI was performed at Open MRI of Dalton on May 5, 2003, and revealed mild degenerative changes at L5-S1 without evidence of a disc herniation. There were also small benign hemangiomas in the T11-T12 vertebral bodies without any focal abnormalities. The claimant was then seen again by Dr. Frix on May 8, 2003 and the MRI was reviewed. At that point, Dr. Frix began him on a Medrol Dosepak, and ordered EMG / Nerve Conduction Studies to rule out a neuropathy or other localized nerve lesion. Dr. Frix also gave the claimant lifting restrictions of 5 pounds at the time.

An EMG was performed on May 13, 2003 at the Hamilton Medical Center Neurodiagnostics by Dr. Kimberly Smith. The EMG showed no definite electrophysiologic evidence of acute lumbosacral radiculopathy. The claimant followed up with Dr. Frix on May 19, 2003, at which point the tentative diagnosis of a lateral femoral cutaneous nerve injury was made, and he was then referred for a neurologic evaluation. A CT scan was also performed of the abdomen and pelvis and was read as normal.

On June 10, 2003, the claimant was seen at the North Georgia Neurological Institute and a posttraumatic reference to cutaneous nerve injury of the thigh was considered. He was referred for a trial of local injections with anesthetic over the thigh and given a prescription for Celebrex.

On June 24, 2003, the claimant began seeing Dr. Michael Najjar at Advanced Pain Care in Chattanooga, Tennessee. At that point, he began a series of multiple injections into the lateral femoral cutaneous nerve both for diagnostic and therapeutic benefits. The claimant reports that he has undergone between 14 and 15 injections since his injury. The records reveal that he underwent lateral femoral cutaneous nerve injections with fluoroscopy on the following dates: June 30, 2003, July 22, 2003, and October 10, 2003. He was getting limited relief from the lateral cutaneous nerve blocks and was seen for follow up again on November 3, 2003, where Dr. Najjar opted to refer him for an orthopedic evaluation to consider lumbar epidural steroid injections. He was also released back to work by Dr. Frix on November 12, 2003 without limitations.

The claimant then began undergoing a series of lumbar epidural steroid injections, which he initially received on November 21, 2003. He reports that he had up to 6 epidurals done over an extended period of time.

The claimant was then seen on December 17, 2003, by Dr. Robert Peterson at North Georgia Neurological Institute, and recommendations for a spinal cord stimulator were made. On January 28, 2004 the notes revealed that the claimant continued to have pain in his back which did not improve with the cutaneous nerve injection or the epidural steroid injections. He was continued on Celebrex and Neurontin and ultimately was referred back to Dr. Najjar for consideration of a spinal cord stimulator. After viewing the video and after seeing Dr. Najjar, he reportedly decided not to undergo the spinal cord stimulator. On July 14, 2004, he was again seen by Dr. Peterson and since he did not want to pursue the spinal cord stimulation, Dr. Peterson noted that he should continue treatment with his chiropractor and there was nothing else that he could do.

Additional epidural steroid injections were then performed on December 2, 2004. A follow up MRI on December 3, 2004 revealed degenerative disk disease at L5-S1 without a focal disc herniation and without significant change from the prior study of May 5, 2003. The epidural injections gave him only limited relief, but he underwent additional

selective foraminal lumbar epidurals on April 1, 2005. He was also given a trial of Cymbalta by Dr. Peterson after undergoing the 3 epidural steroid injections which gave him transient relief of pain. The Cymbalta was given as his numbness in the left thigh had gotten worse and the MRI scan did not reveal surgical pathology per Dr. Peterson's note.

An Independent Medical Evaluation was then performed on January 13, 2006 at the Neurosurgical Group of Chattanooga at Dalton. The IME was performed by Michel C. Pare, M.D. and a disability of 10% of the whole body, 2% for the peripheral nerve, and 8% for the mechanical back pain was given at that time. The claimant continued to undergo epidural steroid injections after his IME and continued to remain out of work.

On September 28, 2006, an MRI was performed at Open MRI of Dalton and revealed a left intraforaminal disc herniation at L5-S1. He was again seen by Dr. Pare at the Neurosurgical Group of Chattanooga at Dalton on October 2, 2006, and at that time he was scheduled for PLIF instrumentation at L5-S1.

An operative report from October 19, 2006 revealed that the claimant underwent a L5-S1 posterolateral interbody fusion and instrumentation with the Globus system for interbody filled auto graft and immunologic bone matrix. Surgery was performed on August 18, 2006 and he was discharged from the hospital on August 23, 2006. Postoperative evaluation on December 18, 2006 revealed increasing pain, which was worse since his surgery. He was then seen approximately every three months and an x-ray of the lumbar spine (flexion/extension views) showed the L5-S1 level with good alignment status post fusion. On January 29, 2007, Dr. Pare referred him to physical therapy for three weeks in duration at a frequency of three times a week. He began his physical therapy evaluation on February 6, 2007 at the Hamilton Medical Center. He was also given a TENS unit and instructed to return to modified work restrictions to include two to three days a week, 8 hours a day with no lifting over 30 pounds. He was given a favorable postoperative evaluation and the last note in the records is dated November 26, 2007 where the claimant was seen by Dr. Najjar and given the medications Bextra and Flomax.

Today, the claimant complains of pain into his low back, predominantly left-sided. He has leg pain down to the ankle, with numbness and tingling in his thigh all the way down into his foot. He states that he worked up to the date of his surgery, but subsequent to the surgery he has not worked.

REVIEW OF SYSTEMS: The claimant complains of the following: Weakness, night sweats, weight gain, joint swelling, joint pain, joint stiffness, pain in his leg, pain in his arms, neck pain, low back pain, headaches, numbness and tingling, difficulty falling asleep, difficulty walking, difficulty urinating, up at night to urinate, feeling very tired, high level of stress, depression, difficulty staying asleep, anxiety, heartburn, and ringing in his ears.

CURRENT MEDICATIONS: Darvocet daily.

PAST MEDICAL HISTORY: He denies any medical conditions or illnesses.

ALLERGIES TO MEDICATIONS: Codeine causes nausea.

PRIOR SURGICAL HISTORY: Cholecystectomy in 2005 and lumbar spine surgery in November 2006.

SOCIAL HISTORY: He is married with children. He is currently on disability. He has not worked since his surgery. He does not smoke. He denies regular alcohol consumption, but does drink socially. He denies recreational drug use. He is currently is self-reportedly disabled.

FAMILY HISTORY: His mother and father are deceased. His siblings and children are alive.

FUNCTIONAL STATUS: He reports that he is independent in his activities of daily living.

PHYSICAL EXAMINATION:

General Exam: This is a 61-year-old gentleman, pleasant in nature; in no acute distress.

Vitals: Height is 5 feet 9 inch, weight is 194 pounds, respirations 15, pulse 90, and blood pressure is 190/100.

HEENT: Normocephalic and atraumatic. Extraocular muscles are intact.

Cervical Spine: Range of motion of the cervical spine is normal and nontender. Spurling and Lhermitte's tests are negative.

Thoracic Spine: No tenderness throughout the thoracic spine with normal thoracic excursion.

Lumbar spine: He has diminished active range of motion in all directions. He is diminished by about 40%, self-limited. Straight leg raise test is negative both sitting and supine. He has a well-healed scar over the lower lumbar spine.

Extremities: Upper extremities reveal full range of motion. Strength and sensation is normal. No clubbing, cyanosis, or edema. Lower Extremities reveal full range of motion without clubbing, cyanosis, or edema. Tenderness to palpation over the left SI and PSIS. Fabere's test is positive on the left. He has tight hamstrings bilaterally. There is atrophy in the left leg in the area of the calf.

Abdomen: Normal abdominal exam.

Pulses: Distal pulses are intact.

Skin: No signs of infections, lesion, or rashes. There is a surgical scar that is well-healed over the lower lumbar spine.

Neurologic: He is alert and oriented x3. Cranial nerves II through XII are grossly intact. Affect is normal. Sensory is decreased in the left leg along the L3-L5 and S1 dermatomes. Reflexes are 2+ and symmetric in bilateral upper and lower extremities, with the exception of the left ankle reflex, which is diminished to 1-. Strength is 5/5 bilaterally in the upper and lower extremities.

IMPRESSION: The claimant is a 61-year-old gentleman who sustained a soft tissue injury to his low back after being involved in a motor vehicle accident on February 3, 2003. Multiple MRIs revealed preexisting degenerative changes in his lumbar spine without any evidence of herniated discs. He underwent conservative treatment including medications, lateral femoral cutaneous nerve injections, and lumbar epidural steroid injections. He ultimately underwent a lower lumbar interbody fusion with postoperative physical therapy. He continues to have pain postoperatively and his symptoms are basically unchanged from prior to his surgery. His main complaints today are that of the lower lumbar spine with radiation into the left leg with significant numbness and tingling down into the area of the left foot.

I have been given a list of questions to address and the corresponding responses are noted below.

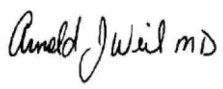
1. **What is/are the injuries or conditions diagnosed and documented in the clinical records?** Based upon review of the clinical records, the claimant had preexisting degenerative disc disease of the lumbar spine. His injuries sustained from his motor vehicle accident were soft tissue in nature, predominantly a cervical muscular strain, lower lumbar strain, and ankle and knee soft tissue injuries.
2. **Is the treatment consistent with the injury or conditions diagnosed and documented in the clinical records?** The treatment received by the claimant for his lower extremity and lumbar injuries included medications, multiple injections, and ultimately surgery. Based upon my exam, as well as my review of the records, the following treatments were consistent with the injuries diagnosed and documented in the clinical records: Medication management, lateral femoral cutaneous nerve injections, lumbar epidural steroid injections, and physical therapy. Without having the chance to evaluate and examine the claimant prior to his surgery, I cannot comment on the medical necessity of the surgical intervention.
3. **What is the etiology of the diagnosed injuries or conditions?** The etiology of his condition is consistent with his motor vehicle accident on February 3, 2003.
4. **How does the diagnosed injury typically occur?** The injury sustained by the claimant, including that of the ankle, knee, neck and low back, can occur from a motor vehicle accident like the one described.

5. **Based upon the examination of the patient, review of the medical records, clinical experience, and the applicable research, was the patient's condition caused by the accident?** Based upon my review of all the above, his condition was caused by the motor vehicle accident. He did have preexisting degenerative disc disease, however, which in no way was a result of the motor vehicle accident.
6. **Are there any preexisting or concurrent medical or psychological conditions?** The claimant did have preexisting lumbar degenerative disc disease. The motor vehicle accident may have aggravated his symptoms, but did not have any effect upon his degenerative lumbar condition. The radiographic changes in his spine appear to have been a normal progression of a preexisting condition and his employment activities were not affected by these preexisting degenerative changes.
7. **Are the type, intensity, frequency and duration of the provided treatment / services consistent with the severity of the documented injuries and conditions?** The type, intensity, frequency, and duration of the provided treatments are within the standard of care.
8. **Were there clinical findings noted on radiological films? Did these findings support the diagnoses according to the patient's clinical record?** The MRI films revealed degenerative changes in the lower lumbar spine. There is limited correlation between degenerative changes and his actual symptoms and findings on exam. The MRI findings do support the diagnosis of lumbar degenerative disc disease, but the degenerative changes do not correlate with his diagnoses of lumbar strain, cervical strain, and ankle and knee strains.
9. **Were the provided treatments, including services and products, necessary for the patient to achieve maximum medical improvement for the documented injuries or conditions?** Yes.
10. **What is / are your diagnoses of the patient's injury, disease, or disorder?** My diagnoses of the claimant include the following:
    1. Status post lumbar interbody fusion.
    2. Chronic low back pain with sciatica.
    3. Neuropathic pain in the left lower extremity with numbness and tingling.
11. **What is the patient's prognosis at his point?** The patient is essentially at MMI and his prognosis is fair.
12. **Did the patient sustain any permanent or temporary impairment as result of the injury sustained in the February 3, 2003 accident? What are the nature and extent of the impairment and what are the dates during which the patient was impaired?** Based upon my review of the records, the claimant did sustain a permanent impairment as a result of his motor vehicle accident on February 3, 2003. His impairment is permanent and would be effective from his surgery forward. Impairment would be on the order of 10% of the lumbar spine.

13. **Is the patient is able to return to pre-loss activity levels including the occupational duties of land surveyor? What, if any, are the patient's restrictions?** It would be beneficial to actually have a job description of a land surveyor. Based on my exam, and my review of my records, the claimant is able to return to the pre-loss activity levels and should be able to return back to employment. After reviewing the job description, I would be able to better quantify his ability to perform as a land surveyor.
14. **Has the patient reached maximum medical improvement related to the injuries or condition sustained on February 3, 2003 accident?** The claimant does not want to pursue his spinal cord stimulation. At this time, he is at maximum medical improvement.
15. **Is/are the current and recommended future treatment plans appropriate for and consistent with the severity of the injuries or conditions?** The records do not reveal any further recommended treatment or plans outside of spinal cord stimulation or medication management. Both of these are appropriate and consistent with severity of his injuries and conditions.
16. **Are there any preexisting or concurrent medical or psychological conditions affecting the patient's recovery for the injury sustained on February 3, 2003 accident**. There does not appear to be any preexisting or concurrent medical conditions which would affect his recovery and have any effect on his condition at this time.

All questions have been answered to the best of my ability, and all information obtained is based upon a degree of medical probability. If there are any additional questions that I can address, I would be pleased to do so.

Respectfully submitted,



Arnold J. Weil, M.D.
Board Certified, American Board of Physical Medicine & Rehabilitation

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