

DR. X MEDICAL GROUP

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June 29, 2013

Ally McBeal, Esquire
10000 Hollywood Blvd, Suite 100
Hollywood, California 91601.

Forever insurance
Post Office Box 100000
Oklahoma City, OK 72000

RE: DOE, John
DATE OF INJURY: September 13, 2010
EMPLOYER: Metropolis Construction
INSURANCE CARRIER: Forever Insurance
CLAIM NUMBER: WCXXXXXXXX
WCAB NUMBER: ADJ XXXXXXXX
DATE OF EVALUATION: June 29, 2013

PANEL QUALIFIED MEDICAL EVALUATION AND REPORT

Dear Sir/Madame:

This report is being submitted as an ML-104 for the following reasons:

- 1) Multiplicity of the issues was addressed.
 - 2) Causation AOE/COE was addressed.
 - 3) Apportionment was addressed.
 - 4) History and physical examination: 2.25 hours
Record review time: 2.50 hours
Medical research: 3.00 hours
Report preparation, including editing: 3.50 hours
- Total time spent: 11.25 hours

The following information was obtained from the patient.

IDENTIFYING INFORMATION:

Mr. John Doe was evaluated by me on June 29, 2013 at my office located at 11111 Brookshire Avenue, Suite 111 Downey, CA 90241.

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JOB DESCRIPTION:

Mr. Doe stated that he began his employment for Metropolis Construction as a window installer approximately in 2001. His last day of work was December 16, 2010. He stated that he worked 11 hours per day, 55 hours per week. His job responsibilities included installing windows, painting, cutting wood and drywall/stucco work. He was also responsible for installation of doors and cutting doors. He would also drive a truck, collect trash, load and unload materials, doors, windows and tools. He was also doing installation of sliding doors.

The patient's normal activities during a workday included constantly walking and standing. His job required him to frequently bend and twist at the neck and waist level. He would occasionally sit, squat, climb and kneel. His job did not require him to crawl.

The patient was constantly required to do simple grasping using both hands. He would frequently perform power grasping, pushing and pulling as well as reaching activities below the shoulder level. He would occasionally perform fine manipulation with either hand as well as reaching activities above the shoulder level.

The patient's job did require him to drive a truck. His job also required him to work at heights. He did not use any visual or auditory protective equipment. His job required him to work around equipment and machinery. His job did require the operation of foot controls and repetitive foot movement. He was required to walk on uneven ground. He was exposed to excessive noise as well as extremes in temperature, humidity and wetness. He was also exposed to dust, gas and fumes. He did not work with bio-hazardous materials.

The activities required in the performance of the patient's job included constantly lifting and carrying up to 10 lbs. He would also frequently lift up to 25 lbs. He would occasionally lift and carry up to 100 lbs. The heaviest items he was required to carry were doors weighing up to 100 lbs for a distance of 50-75 feet.

HISTORY OF WORK-RELATED INJURY AND TREATMENT:

The patient stated that on the day of the accident, December 16, 2010, while performing his normal and customary duties and during the course of his employment, he was working in the City of Burbank with two coworkers. His job consisted of installing windows. He was cutting the "flush" of a vinyl window with a skill saw. The window was positioned on top of a stand. While he was cutting the window with a skill saw, the extension cord got stuck on the stand the window was on. The window started slipping. He reached for the window and the saw got his left hand. He ran toward his coworkers and he told them that he cut his hand and they called an ambulance. The patient was taken to St. Joseph's Hospital in Burbank. At the emergency room, the hand was cleaned and a gauze bandage was applied. Dr. House examined the patient and prescribed pain medication. X-rays were taken. The patient stated that he was taken to surgery by Dr. House on December 17, 2010. Two weeks after the surgery, he was started on physical therapy. The patient stated that he had about 20-30 physical therapy treatments.

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In June 2010, the patient retained an attorney and was sent for evaluation and treatment to Dr. Derek Shepard who evaluated the patient and prescribed medication. Mr. Doe stated that he did not want to continue treating with Dr. Shepard since he was a spine specialist. He returned to Dr. House.

On September 1, 2011, Dr. House performed a revision surgery on his left hand. After the surgery, the patient continued with physical therapy treatments two times per week until he was discharged by Dr. House on January 30, 2012.

The patient was evaluated by Dr. Shepard on October 17, 2012, at which time, he was provided with oral medication and medicated patches.

The patient was reevaluated by Dr. Shepard in December 2012, at which time Dr. Shepard referred the patient to upper extremity specialist, Dr. Benjamin Spock.

Mr. Doe was evaluated by Dr. Spock on January 30, 2013. Dr. Spock recommended additional MRI studies of the cervical spine, left shoulder, and left hand/wrist as well as new electrodiagnostic studies of bilateral upper extremities. Mr. Doe stated that he saw Dr. Spock two times, after which, he was not given more appointments.

The patient continued to see Dr. Shepard on a monthly basis. He continued to receive medications from Dr. Shepard.

The patient stated that he saw Dr. Shepard last week.

The patient presented to this office today for a Panel Qualified Medical Evaluation.

CURRENT WORK STATUS:

The patient is currently employed. His last day of work was December 16, 2010.

RELEVANT MEDICAL HISTORY:

Medical History/Major Illnesses: Including constitutional symptoms, eyes, ears, nose, mouth, throat, cardiovascular, respiratory, gastrointestinal, genitourinary, integumentary, neurological, psychiatric, endocrine, hematologic/lymphatic, and allergic/immunologic: The patient stated that he has had constipation for about 1 year.

Previous/Subsequent Injuries: The patient denied history of prior work-related injuries. He denied any car accidents in the past. He denied slip and fall accidents. He denied sports-related injuries.

Surgical History: Significant for two hand surgeries on December 17, 2010 and September 1, 2011.

Current Medications: Tramadol two to three tablets per day, Gabapentin two times a day, Docusate sodium one to two tablets per day and Medrox patches at bedtime.

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Allergies: There is no history of any allergies.

Social History: The patient is married. He has one son who is 4 years old. He denied smoking, he had never smoked. He drinks alcohol socially. He denied using any drugs. He denied ever being treated for drug or alcohol abuse.

Family History: The patient stated that his parents are alive and healthy. He has two sisters and three brothers, all of them are healthy.

CHIEF COMPLAINTS:

Left Wrist/Hand: The patient complained of left wrist/hand pain present 75% of the time with radiating pain to the shoulder, neck and left side of the upper back when he flexes his digits. He reports numbness in the left 3rd, 4th and 5th digits and weakness in the left hand. On a scale from 1 to 10, (1 being no pain at all, 10 being the most severe pain), the patient rated the pain as being 6-7/10 with activities of daily living, increased to 8-9/10 while trying to make a fist, with grasping and gripping with the left hand. Rest, medications and medicated patches partially relieve his symptoms.

Right Wrist/Hand: The patient stated that he does not have symptoms in the right wrist/hand with activities of daily living. He experiences pain in the right wrist and hand with grasping something with force. On a scale from 1 to 10, (1 being no pain at all, 10 being the most severe pain), the patient rated the pain as being 5-6/10 when he experiences it with forceful activities. Rest and hot compresses relieve his symptoms.

ACTIVITIES OF DAILY LIVING:

The patient was specifically questioned regarding his activities of daily living, and the effects of his injuries on his normal activities of daily living, and he has provided the following responses.

1. Regarding the ability to perform personal self-care activities including washing, dressing, using the bathroom, the patient indicated that it is uncomfortable to look after himself but he is slow and careful.
2. Regarding the ability to lift and carry objects, the patient indicated that he can lift and carry light to medium objects if they are conveniently positioned.
3. Regarding the ability to walk, the patient indicated that he is able to walk the same distance he could before his injury.
4. Regarding the most strenuous level of activity that he could do for at least two minutes, the patient indicated that he can do light activity.

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5. Regarding the ability to climb one flight of stairs, the patient indicated that he does not experience difficulty and he can easily perform the activity.
6. Regarding the ability to sit for 30 minutes to an hour, the patient indicated he does not experience difficulty and he can easily perform the activity.
7. Regarding the ability to sit for two hours, the patient indicated that he does not experience difficulty and he can easily perform the activity.
8. Regarding the ability to stand or walk for 30 minutes to an hour, the patient indicated that he does not experience difficulty and he can easily perform the activity.
9. Regarding the ability to stand or walk for two hours, the patient indicated that he does not experience difficulty and he can easily perform the activity.
10. Regarding the ability to reach and grasp something off a shelf at eye level, the patient indicated that he has a lot of difficulty but he can still do the activity.
11. Regarding the ability to reach or grasp something off a shelf overhead, the patient indicated that he has a lot of difficulty but he can still do the activity.
12. Regarding any difficulty with pushing and pulling activities, the patient indicated that he is unable to perform this activity unless someone helps him with it.
13. Regarding any difficulty with gripping, grasping, and holding and manipulating objects with the hands, the patient indicated that he has a lot of difficulty but he can still do the activity.
14. Regarding any difficulty with repetitive motions such as typing on a computer, the patient indicated that he is unable to perform this activity unless someone helps him with it.
15. Regarding any difficulty with forceful activities with his arms and hands, the patient indicated the patient indicated that he is unable to perform this activity unless someone helps him with it.
16. Regarding any difficulty with kneeling, bending or squatting, the patient indicated that he has no difficulty and he can easily perform the activity.
17. Regarding any difficulty with sleeping, the patient indicated that his sleep is moderately disturbed (2-3 hours of sleeplessness) since his injury.
18. Regarding sexual activity since and because of his injury, the patient indicated that it is a little less frequent because of his injury.
19. Regarding his pain at the moment, the patient indicated it is moderate at the moment.

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20. Regarding his pain most of the time, the patient indicated that his pain is moderate most of the time.
21. Regarding how much the injury and/or pain interfered with his ability to travel, the patient indicated that it interferes some or a little of the time.
22. Regarding how much the injury and/or pain interfered with his ability to engage in recreational activities, the patient indicated that it interferes all of the time and he cannot engage in recreational activities.
23. Regarding how much the injury and/or pain interfered with his ability to engage in social activities, the patient indicated that it interferes a lot or most of the time.
24. Regarding how much the injury and/or pain interfered with concentrating and thinking, the patient indicated that it interferes all of the time and he cannot concentrate or think very clearly.
25. Regarding how much the injury and/or pain caused emotional distress with depression or anxiety, the patient indicated all of the time (severe depression or anxiety from the injury or discomfort).

PHYSICAL EXAMINATION:

The patient was a well-developed, well-nourished 36-year-old right hand-dominant male in good apparent general health, weighing 140 pounds, height of 5 feet and 2 inches.

Neck and Cervical Spine: On examination of the neck and cervical spine, there was no suboccipital, scalenus, trapezius, paracervical or sternocleidomastoid muscle spasm or tenderness, bilaterally. There was no limitation of movement of the cervical spine. The range of motion of the cervical spine was as follows:

RANGE OF MOTION	RIGHT	CENTER	LEFT	NORMAL
Forward Flexion	N/A	50	N/A	50
Extension	N/A	60	N/A	60
Lateral Rotation	80	N/A	80	80
Lateral Bending	45	N/A	45	45

ORTHOPAEDIC SIGNS & TESTS:

Cervical Compression	RIGHT Negative	LEFT Negative
Cervical Distraction	Negative	Negative
Soto Hall	Negative	
Spurling Maneuver	Negative	Negative
Wright's Test	Negative	Negative

Thoracic Spine: The thoracic spine was unremarkable. There were no deformities of the thoracic spine present. There was no muscle spasm and no tenderness of the thoracic spinous processes. There was no paraspinal muscle tenderness. The range of motion of the thoracic spine was within normal limits.

RANGE OF MOTION	RIGHT	CENTER	LEFT	NORMAL
Forward Flexion	N/A	50	N/A	50
Rotation	30	N/A	30	30

Upper Extremities: Examination of the upper extremities was significant for the *left wrist and hand*. There was no tenderness or spasm noted on palpation along the trapezius, deltoids, acromioclavicular joint or rotator cuff muscles, bilaterally. There was no limitation of movement of the shoulders. There was no tenderness or spasm along the biceps or triceps, bilaterally. No tenderness was elicited along the medial or lateral epicondyles, bilaterally. There was no limitation of movement of both elbows. There was no tenderness over the flexor or extensor muscles as well as the brachioradialis muscles, bilaterally. There was ulnar claw noted in the left hand. There was a 3-cm vertical scar noted along the ulnar aspect of the left wrist. Additionally, there was also a 3.5-cm curved scar noted in the ulnar aspect of the left wrist. There was muscle atrophy noted to the 1st dorsal interosseous and hypothenar eminence of the left hand. Tenderness was noted in the palmar aspect of the left wrist. There was no tenderness or swelling along the dorsal, ulnar or radial aspect of both wrists. There was no tenderness or swelling on palpation of the radial and ulnar styloid as well as the distal radioulnar joint of both wrists. No tenderness or swelling was elicited on palpation of the ulnar or radial collateral ligaments bilaterally. The patient was unable to abduct and adduct the 2nd, 3rd and 4th digits of the left hand. He was also unable to make a full “pinch” with the index and the thumb of the left hand. The rest of the examination of the upper extremities was within normal limits.

SHOULDER RANGE OF MOTION	RIGHT	LEFT	NORMAL
Flexion	180	180	180
Extension	50	50	50
Abduction	180	180	180
Adduction	50	50	50
External Rotation	90	90	90
Internal Rotation	90	90	90

Orthopaedic Tests (shoulders):

	<u>Right</u>	<u>Left</u>
Neer Impingement Sign	Negative	Negative
Hawkins Test	Negative	Negative
Jobe Test	Negative	Negative
Drop Arm Test	Negative	Negative
Hornblower Sign	Negative	Negative
Rubber Band Sign	Negative	Negative
Lift-Off Test	Negative	Negative
Belly-Push Test	Negative	Negative

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Apprehension Test	Negative	Negative
Relocation Test	Negative	Negative
Jerk Test	Negative	Negative
Sulcus Sign	Negative	Negative
Active Comprehension Test	Negative	Negative
Speed Test	Negative	Negative
Yergason Test	Negative	Negative

ELBOW RANGE OF MOTION	RIGHT	LEFT	NORMAL
Flexion	150	150	150
Extension	0	0	0

ORTHOPAEDIC SIGNS & TESTS:	RIGHT	LEFT
Cozen Test	Negative	Negative
Mill's Test	Negative	Negative

FOREARM RANGE OF MOTION	RIGHT	LEFT	NORMAL
Supination	80	80	80
Pronation	80	80	80

ORTHOPAEDIC SIGNS & TESTS:	RIGHT	LEFT
Tinel's Sign	Negative	Negative
Phalen's Test	Negative	Negative
Finkelstein's Test	Negative	Negative
Median Nerve Compression Test	Negative	Negative

WRIST RANGE OF MOTION	RIGHT	LEFT	NORMAL
Extension	60	30	60
Flexion	60	60	60
Ulnar Deviation	30	22	30
Radial Deviation	20	14	20

RIGHT HAND/FINGERS

Finger	MP		PIP		DIP		
	Action	Normal	Actual	Normal	Actual	Normal	Actual
Thumb	(Ext)	+40°	+40°	****		+30°	+30°
	(Flx)	60°	60°	****		80°	80°
Index	(Ext)	0°	0°	0°	0°	0°	0°
	(Flx)	90°	90°	100°	100°	70°	70°
Middle	(Ext)	0°	0°	0°	0°	0°	0°
	(Flx)	90°	90°	100°	100°	70°	70°
Ring	(Ext)	0°	0°	0°	0°	0°	0°
	(Flx)	90°	90°	100°	100°	70°	70°
Little	(Ext)	0°	0°	0°	0°	0°	0°
	(Flx)	90°	90°	100°	100°	70°	70°

Thumb Radial Abduction 50 (0-50°) (hand flat, abduct thumb)

Thumb Adduction 1 cm (from flexion crease of IP joint to distal palmar crease over the level of the MP joint of the little finger) (0-1 cm of abduction normal range).

Thumb Opposition 8 cm (Normal 8 cm) (distance between the flexion crease of the thumb PI joint to the distal palmar crease directly over 3rd MP joint).

LEFT HAND/FINGERS

Finger	MP		PIP		DIP		
	Action	Normal	Actual	Normal	Actual	Normal	Actual
Thumb	(Ext)	+40°	+40°	****		+30°	+30°
	(Flx)	60°	60°	****		80°	80°
Index	(Ext)	0°	-10°	0°	-5°	0°	-5°
	(Flx)	90°	70°	100°	85°	70°	40°
Middle	(Ext)	0°	-50°	0°	0°	0°	0°

	(Flx)	90°	60°	100°	20° of flexion contracture	70°	40° of flexion contracture
Ring	(Ext)	0°	0°	0°	-50°	0°	0°
	(Flx)	90°	14°	100°	60°	70°	30° of flexion contracture
Little	(Ext)	0°	+30°	0°	0°	0°	0°
	(Flx)	90°	0°	100°	90° of flexion contracture	70°	30° of flexion contracture

Thumb Radial Abduction 50 (0-50°) (hand flat, abduct thumb)

Thumb Adduction 3 cm (from flexion crease of IP joint to distal palmar crease over the level of the MP joint of the little finger) (0-1 cm of abduction normal range).

Thumb Opposition 6 cm (Normal 8 cm) (distance between the flexion crease of the thumb PI joint to the distal palmar crease directly over 3rd MP joint).

NEUROLOGIC EVALUATION: (UPPER EXTREMITIES)

Sensory Examination: On examination of the left hand, sensation was absent to light touch and pinprick testing along the 4th and 5th digit as well as the ulnar side of the 3rd digit. The 1st digit of the left hand showed absent sensation to Semmes-Weinstein and two-point discrimination testing. The 2nd digit of the left hand demonstrated a Semmes-Weinstein score of 4.56 and two-point discrimination of 13-14 mm. The 2nd digit and thumb had normal sensation. The 3rd digit of the left hand showed decreased sensitivity along the radial side. There was minimal sensation along the dorsum of the hand to the ulnar border of the 3rd digit. The 4th digit of the left hand demonstrated absent sensation along the ulnar side of the palm of the hand to the ulnar border of the 3rd digit but there was normal sensation from the ulnar border to the thumb. The 5th digit of the left hand demonstrated Semmes-Weinstein score of 6.65 and absent two-point discrimination testing.

<u>Muscle Strength:</u>	<u>Right</u>	<u>Left</u>	<u>Normal</u>
Deltoids (C5)	5/5	5/5	5/5
Biceps (C5)	5/5	5/5 5/5	
Triceps (C7)	5/5	5/5 5/5	
Wrist Extension (C6)	5/5	5/5 5/5	

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Wrist Flexion (C7)	5/5	5/5	5/5
Finger Extension (C7)	5/5	5/5	5/5
Interossei (T1)	0/5	0/5	5/5

<u>Reflexes:</u>	<u>Right</u>	<u>Left</u>	<u>Normal</u>
Biceps	2+	2+	2+
Triceps	2+	2+	2+
Brachioradialis	2+	2+	2+

GRIP STRENGTH (Kilogram Force):	RIGHT	LEFT
JAMAR (1 st Attempt)	48	6
JAMAR (2 nd Attempt)	46	6
JAMAR (3 rd Attempt)	48	6

The patient is right hand dominant.

MEASUREMENTS (cm):	RIGHT	LEFT
Biceps (3" Above elbow):	26.0	24.5
Forearms (3" Below elbow):	24.5	23.5

DIAGNOSTIC STUDIES:

8/6/12 – Electrodiagnostic Consultation and Report

Impression:

- 1) Abnormal NCS.
- 2) Normal EMG.

7/25/12 – Left Wrist Arthrogram

Impression:

There is non-displaced fracture involving the dorsal aspect of the lunate with surrounding acute trabecular bone injury within the lunate bone. There is no acute displaced fracture or dislocation. The lunate demonstrates a normal orientation and the scapholunate and lunotriquetral ligaments are grossly intact.

7/25/12 – Magnetic Resonance Imaging of the Cervical Spine

Impression:

1. There is loss of lordosis with slight superior rightward tilt.
2. C5-6: There is a 2-mm bulge. There is mild left neuroforaminal stenosis with mild control

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- stenosis.
3. C6-7: There is a 2- to 3-mm broad rightward bulge or protrusion with moderate right greater than left neuroforaminal stenosis. There is mild-to-moderate central stenosis.

7/24/12 – Magnetic Resonance Imaging of the Left Shoulder

Impression:

There is moderate reduction of the subacromial space. There is no evidence of rotator cuff tear or retraction.

This concludes the review of the diagnostic studies.

REVIEW OF RECORDS:

The following medical records were reviewed:

2/17/10 - X-rays of the Left Wrist

Impression (as of 7:04:27): Radial ulnar subluxation was present. Avulsion of the lateral margin of the distal ulna was present.

Impression (as of 11:06:11):

- 1) There was no evidence of a metal hypodermic needle seen within the soft tissues of the forearm or hand and wrist.
- 2) A metal safety pin was seen overlying the midportion of the forearm on its palmar surface. A safety pin lies external to the soft tissues of the forearm.

12/17/10 - Operative Record, Northridge Hospital Medical Center, Gregory House, M.D.

Preoperative diagnosis: Complex saw injury, ulnar border left wrist.

The patient underwent surgical repair of the saw injury. The artery and nerve were done using the operating microscope, a microneurorrhaphy and micro arteriorrhaphy.

Postoperative diagnoses:

- 1) Complex saw injury, ulnar border left wrist.
- 2) Partial fracture of the ulna.
- 3) Complex division of the ulnar nerve, the ulnar artery, the flexor carpi ulnaris, the profundus tendons to the ring finger and profundus tendon to the little finger.

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9/1/11 - Operative Report, Valley Hand Surgery Center, Gregory House, M.D.

Preoperative and postoperative diagnosis: Flexion contractures, left ring and little fingers, due to scarring in the distal wrist.

The patient underwent extensor tenolysis of the left long, ring and little fingers.

This completes the review of submitted medical records.

DIAGNOSTIC IMPRESSIONS:

1. Status post severe laceration of the left wrist with laceration of the flexor tendon of the left little finger, ulnar nerve and ulnar artery, with residuals.
2. Ulnar claw hand as a result of the ulnar nerve laceration at the left wrist.
3. Non-displaced fracture involving the dorsal aspect of the lunate, left wrist, confirmed by an MRI.
4. Neuralgia of the left upper extremity.
5. Complaints of right wrist/hand pain with negative physical examination findings.

SUMMARY/CAUSATION:

Based on the history provided by the patient, the review of all available medical records, my physical examination findings, the review of the diagnostic studies, and the review of the patient's deposition transcript, there is consistency noted between the objective findings, the patient's subjective complaints and the mechanism of injury as described. It is fair to state with reasonable medical probability, based on all the information available to me that Mr. John Doe had sustained a specific orthopedic injury to his left wrist and hand as a result of the work-related accident on December 16, 2010, while employed as a window installer for Metropolis Construction. It is my opinion that there is no medical evidence to support the patient's claim that he sustained alleged injuries to the whole left upper extremity, neck, back, right upper extremity, hand and wrist. In my opinion, the symptoms that the patient has been experiencing in his left elbow, shoulder, left side of the neck and the left side of the upper back are due to the radiating pain from the left wrist and hand. This can be stated with reasonable medical probability. Moreover, physical examination of the left elbow, left shoulder, cervical spine and thoracic spine revealed no abnormalities. With regard to his right upper extremity, the patient has been experiencing intermittent symptoms in the right upper extremity with forceful strength activities. Since the time of the injury, he was using predominantly his right hand for all of his activities of daily living and his intermittent symptoms could be due to the overcompensating with his right upper extremity. However, physical examination findings revealed no abnormalities with regard to the right upper extremity. Therefore, it cannot be stated with reasonable medical probability that the patient had sustained a compensable consequence injury to the right upper extremity.

DISABILITY STATUS:

It is my opinion that the patient reached maximum medical improvement on or about January 30, 2012, when he was found to be permanent and stationary by his primary treating physician, Dr. Gregory House.

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The patient's condition with regard to his left wrist and hand has remained essentially unchanged since the time he was discharged by Dr. House. There has not been any worsening or improvement of his left wrist/hand condition since the time of his discharge.

OBJECTIVE FACTORS OF DISABILITY:

1. Physical examination findings on June 29, 2013.
2. Results of the diagnostic studies as described above.

IMPAIRMENT RATING:

The patient's impairment is determined in accordance with the American Medical Association Guides to the Evaluation of Permanent Impairment Fifth Edition.

Left Wrist

For the **left wrist**, Figures 16-28 and 16-31 on pages 467 and 469 are used. The patient is given 5% upper extremity impairment (UEI) due to limited extension at 30 degrees, 1% UEI for abnormal radial deviation at 14 degrees, and 2% UEI due to limited ulnar deviation at 22 degrees. This gives the patient 8% *upper extremity impairment*.

Left hand

The left hand impairment is determined based on loss of motion in the five digits and digital ulnar sensory loss from the third to fifth digits and partial digital radial sensory loss in the third digit.

Left Thumb

For the **left thumb**, Tables 16-8b and 16-9 on pages 459, and 460 are used. He is given 3% digit impairment (DI) for limited adduction at 3 cm and 3% DI for limited opposition for a total of 6% digit impairment or 1% *hand impairment of the left thumb*, per Table 16-1 on page 438..

Left Index Finger

For the **left index finger**, Figures 16-21, 16-23, and 16-25 on pages 461, 463, and 464 are used. At the DIP joint, the patient incurred 1% DI for limited extension at -5 degrees, and 15% DI for limited flexion at 40 degrees, for a total of 16% digital impairment. At the PIP joint, he has 1% DI for limited extension at -5 degrees and 9% DI due to limited flexion at 85 degrees, for a total of 10% digit impairment. At the MP joint, he incurred 7% DI for limited extension at -10 degrees and 11% DI for limited flexion at 70 degrees for a total of 18% DI. These will yield a total of 44% digit impairment or 9% *hand impairment for the left index finger*, per Table 16-1 on page 438.

The patient's laceration has affected his ulnar nerve and has resulted in a claw hand deformity. He has sustained flexion contractures and sensory deficits in the third to the fifth digit.

Left Middle Finger

For the **left middle finger**, Figures 16-21, 16-23, and 16-25 on pages 461, 463, and 464 are used. At the DIP joint, the patient has a flexion contracture at 40 degrees, which is equivalent to 35% DI. He also has a flexion contracture at 20 degrees in the PIP joint, which corresponds to 55% DI. At the MP joint, he incurred 41% DI for limited extension at -50 degrees and 17% DI for limited flexion at 60 degrees for a total of 58% DI. These are combined to per the Combined Values Chart on page 604, yielding 88% digit impairment.

On sensory examination, the applicant has partial sensory loss in the radial sensory nerve based on Semmes-Weinstein monofilament testing, which corresponds to 15% DI, per Table 16-7 on page 448. He also has total sensory loss in the digital ulnar nerve, which is equivalent to 20% DI, for a total of 35% DI.

Combining the two impairments, and cross-referencing to Table 16-1 on page 438, he incurred 92% DI or *18% hand impairment for the left middle finger.*

Left Ring Finger

For the **left ring finger**, Figures 16-21, 16-23, and 16-25 on pages 461, 463, and 464 are used. At the DIP joint, the patient is given 33% DI for flexion contracture at 30 degrees. At the PIP joint, he has 25% DI for limited extension at -50 degrees and 24% DI for limited flexion at 60 degrees for a total of 49% DI. At the MP joint, he incurred 5% DI for limited extension at 0 degrees and 46% DI for limited flexion at 14 degrees for a total of 51% DI. These are combined to per the Combined Values Chart on page 604, yielding 83% digit impairment.

On sensory examination, the patient has total sensory loss in the digital ulnar nerve on Semmes-Weinstein monofilament testing, which is equivalent to 20% DI, per Table 16-7 on page 448.

Combining the two impairments, and cross-referencing to Table 16-1 on page 438, he incurred 86% DI or *17% hand impairment for the left ring finger.*

Left Little Finger

For the **left little finger**, Figures 16-21, 16-23, and 16-25 on pages 461, 463, and 464 are used. At the DIP joint, the patient incurred 33% DI for flexion contracture at 30 degrees. At the PIP joint, he has 75% DI for flexion contracture at 90 degrees. At the MP joint, he incurred 49% DI for limited flexion at 0 degrees. These are combined to per the Combined Values Chart on page 604, yielding 91% digit impairment

On sensory examination, the patient has total sensory loss in the digital ulnar nerve on Semmes-Weinstein monofilament testing, which is equivalent to 30% DI per Table 16-6 on page 448.

Combining the two impairments, and cross-referencing to Table 16-1 on page 438, he incurred 94% DI or *19% hand impairment for the left little finger.*

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The hand impairments are combined using the Combined Values Chart to yield 51% hand impairment. Cross-referencing on Table 16-2 on page 389, this is equivalent to 46% *upper extremity impairment for the left hand*.

Additional impairment rating is determined based on grip strength loss in the left minor hand. He demonstrated decreased grip strength on the left as evidenced by the Jamar testing. Mr. Doe has an average strength of 6kg/force on the left. He has an average strength of 47.33kg/force on the right major hand. Using the formula on page 509, the patient has 87% strength loss. Referencing Table 16-34, he has 30% upper extremity impairment (UEI) due to loss of grip strength in the left hand.

The upper extremity impairment for the left wrist left hand, and grip strength loss are then combined and with a total of 65% upper extremity impairment or **39% whole person impairment for the left upper extremity**.

As the result of the persistent pain following the industrial injury as described above, the patient has a well-established pain syndrome that is normally not associated with measurable organ dysfunction, *but that does impact the patient's activities of daily living* (ADL). It has been decided by this examiner that the pain-related impairment makes the patient's burden of illness slightly greater than the conventional rating indicates. As a result, per the AMA Guides to the Evaluation of Permanent Impairment (Fifth Edition), I have assigned a Discretionary PRI allowance of **3% Impairment of the Whole Person** resulting from the patient's pain following this industrial injury.

The 3% is added to the left hand impairment.

The Total Whole Person Impairment was calculated by adding the 39% Whole Person Impairment for the left upper extremity with the 3% Whole Person Impairment due to the ongoing chronic pain symptoms with resultant **42% Whole Person Impairment**.

APPORTIONMENT:

Apportionment was addressed in accordance with Labor Code Section 4663 and 4664. With regard to the patient's left wrist and hand, there appears to be no indication for apportionment regarding this case. This patient had no prior history of impairment, disability or any medical or surgical conditions, or any other conditions, work-related or not work-related, for which there is a need for apportionment. Therefore, 100% of the patient's residual disability with regard to his left wrist and hand is apportioned to the industrial accident on December 16, 2010. This can be stated with reasonable medical probability.

APPROPRIATENESS OF TREATMENT PROVIDED:

During the course of management of the patient's condition, he underwent several diagnostic studies, x-rays, MRI scans and electrodiagnostic studies to better evaluate his injuries. The patient had two surgeries on his left upper extremity. He was treated with postoperative physical therapy. He was treated with oral and topical medications. These diagnostic and treatment modalities are considered to be reasonable and

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necessary in the management of the patient's medical condition caused by the industrial injuries as referenced above.

Appropriateness of the treatment provided on a non-orthopedic level should be discussed by the appropriate specialist in those fields.

FUTURE MEDICAL CARE:

Although, there are tendon tests and operations to correct the ulnar claw hand deformity, it is my opinion that 2-½ years after the initial injury, all tendon transfer operation would not improve the function of the left hand. The patient may choose, however, to improve the appearance of his deformed left hand and this operation would involve some tendon releases and joint fusions. If the patient decides to have this done, this surgery should be provided to him on an industrial basis. The patient should be provided with refills of analgesic medications.

WORK RESTRICTIONS:

With regard to the patient's left wrist and hand, he has disability resulting of the left hand being a helping hand only.

VOCATIONAL REHABILITATION:

The patient cannot return to his pre-injury occupation as a window installer. Therefore, he is a qualified injured worker.

RATIONALE FOR CONCLUSIONS:

- 1) Review of all submitted records.
2. Physical examination findings on 06/29/2013.
- 3) Correlation of the patient's oral history compared to records.
- 4) Credibility of the patient.
- 5) My clinical experience in treating patients with similar injuries over the past 21 years.

I reserve the right to alter my opinion in the light of any additional submitted medical information that may be presented subsequent to this evaluation and report.

If I may be of further assistance to you, please do not hesitate to contact me. This examiner appreciates the confidence of all parties involved in this case in allowing me to examine this patient in the capacity of a Panel Qualified Medical Examiner.

LABOR CODE §§4663, 4664:

I have discussed apportionment in the body of this report. If I have assigned impairment to factors other than the industrial injury, that percentage constitutes the apportionment. The ratio of non-industrial impairment, if any, to total impairment represents my

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best medical judgment of the approximate percentage of impairment or disability caused by the industrial injury and that caused by other factors, as defined in *Labor Code §§4663 and 4664*.

DISCLOSURE:

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I reserve the right to change my opinion based on additional medical evidence.

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 for information that I received from others. As for that information, I declare under penalty of perjury that the report accurately describes the information provided to me and, except as noted herein, that I believe it to be true.

Pursuant to Sections LC 5703 and 5307 (a) (1), I declare under penalty of perjury that I have not violated Labor Code Section 139.3 and that I have not offered, delivered, received, or accepted any rebate, refund, commission, preference, patronage, dividend, discount, or other consideration, whether in the form of money or otherwise as compensation or inducement for any referred examination or evaluation.

Signed on _____, in the County of Los Angeles, California.

Sincerely yours,

Hannibal Lecter, M.D., QME
Diplomate American Board of Orthopaedic Surgery
Qualified Medical Examiner #: XXXXXX
California License #: GXXXXXX



February 24, 2014

SAMPLE

RE: DOE, John
DATE OF INJURY: September 13, 2010
EMPLOYER: Metropolis Construction
INSURANCE CARRIER: Forever Insurance
CLAIM NUMBER: WCXXXXXXXX
WCAB NUMBER: ADJ XXXXXXXX
DATE OF EVALUATION: June 29, 2013

IMPAIRMENT RATING ANALYSIS

This feedback report concerns industrial injuries claimed by John Doe on September 13, 2010 while employed as a window installer with Metropolis Construction. A copy of a panel qualified medical evaluation report by Dr. Hannibal Lecter, dated June 29, 2013, has been provided for reference.

DISCUSSION

Dr. Lecter diagnosed the applicant with (1) status post severe laceration of the left wrist with laceration of the flexor tendon of the left little finger, ulnar nerve and ulnar artery, with residuals; (2) ulnar claw hand as a result of the ulnar nerve laceration at the left wrist; (3) non-displaced fracture involving the dorsal aspect of the lunate, left wrist, confirmed by an MRI; (4) neuralgia of the left upper extremity; and (5) complaints of right wrist/hand pain with negative physical examination findings.

Left wrist impairment was derived secondary to abnormal range of motion. This is calculated accurately.

The left hand impairment is calculated secondary to loss of motion for the thumb and index finger. The impairment for the left middle, ring, and little fingers are determined based on loss of motion and sensory deficit for each digit. The following errors were noted:

For the left thumb, per table 16-1 on page 438, the 6% digit impairment is equivalent to 2% hand impairment and not 1%.

For the index finger, the reviewer noted that Dr. Lecter added the digit impairments (DI) derived secondary to abnormal range of motion. This is incorrect. Per page 465 of the *AMA Guides 5th Edition*, "combine the finger impairments derived for each joint to obtain the total finger impairment due to loss of motion. According to Dr. Lecter's report, the applicant incurred 16% DI at the DIP joint, 10% DI at the PIP joint, and 18% DI at the MP joint of the left index finger. These are combined per the Combined Values Chart on page 604, yielding 38% digit impairment or 8% hand impairment for the left index finger, per Table 16-1 on page 438.

For the left middle finger, the range of motion and sensory deficit impairments are derived correctly.

For the left ring and little finger, the calculation of the digit impairment are correct; however, the conversion of the digit impairment to hand impairment is inaccurate. Per table 16-1 on page 438, the 86% DI of the left ring finger is equivalent to 9% hand impairment while the 94% DI of the left little finger should correspond to 9% hand impairment.

The applicant should have incurred the following hand impairments:

Left thumb:	2% hand impairment
Left index finger:	8% hand impairment
Left middle finger:	18% hand impairment
Left ring finger:	9% hand impairment
Left little finger:	9% hand impairment

Dr. Lecter combined the hand impairments for each digit. However, the Guides indicated on page 436 that to get the total hand impairment, add the hand impairment of the thumb, index, middle, ring, and little finger. Using the correct hand impairments listed above, the applicant sustained 46% hand impairment, which is equivalent to 41% upper extremity impairment for the left hand.

Dr. Lecter also determined impairment due to grip strength loss in the minor left hand. Grip strength should not be included as part of impairment since the patient has left hand deformity, which impedes his ability to have an adequate grip strength measurement. According to page 508 of the Guides, "decreased strength cannot be rated in the presence of decreased motion, painful conditions, deformities, or absence of parts that prevent effective application of maximal force in the region being evaluated.

The pain related impairment (3% WPI) provided in the report is deemed to be reasonable in relation to the applicant's difficulty with activities of daily living.

The upper extremity impairment for the left wrist and left hand had a combined value of 46% upper extremity impairment or **28% whole person impairment for the left upper extremity. Adding the 3% whole person impairment due to ongoing pain will yield 31% total whole person impairment.**

BODY PARTS	CORRECTED IMPAIRMENT RATING
Left upper extremity	41% UEI c 8% UEI = 46% UEI (28% WPI)
Total whole person impairment:	28% WPI + 3% WPI (Pain) = 31% total WPI

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