Fortunes Rocks Consultants MD

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Independent Medical Evaluation Report

Examinee: Tom Sample
File/Claim Number: 000123456

Date of Examination: September 18, 2004
Examining Physician: William F. Boucher, MD
Examination Location: Vermont

Date of Birth: January 1, 1964
Date of Injury: December 18, 1985

Client Organization: The Best Insurance Company
Referral Source: Miss Adjuster

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Introduction

This 40-year old, right-handed man was referred for an independent medical evaluation (IME) by the above client. The independent medical examination process was explained to the examinee, and he understands that no patient/treating physician relationship was established. Mr. Sample was advised that the information provided will not be confidential and a report will be sent to the requesting client. The client's questions were described to the examinee.

Mr. Sample was cooperative. History was provided by the examinee who was a good historian. The information he provided was consistent with the medical records provided. Accompanying Mr. Sample was his wife who waited outside.

A questionnaire and pain inventories were completed by the examinee. To ensure accuracy, the clinical history was dictated in his presence.

Mr. Sample reported no difficulties occurring during the examination.

The client provided the following clinical records: The Medical Center and One Memorial Hospital.

These records were carefully reviewed, and listed for the examinee. No records prior to December 18, 1985 or subsequent to June 14, 2004 were available to review. These records will be purged from this file. The report, questionnaires, pain inventories and other material specific to this evaluation will be retained. The following records were not available at the time of this evaluation: None.

History

Preexisting Status

Mr. Sample denies any previous problems or injuries, including any other work- or liability-related injuries. Mr. Sample also denies having any difficulties similar to those he is now experiencing prior to the date of injury.

Injury

Mr. Sample reports that on December 18, 1985, he fell on the ice landing on his left hip.

At that time the difficulties were fracture of the left hip.

Clinical History

The examinee was transported to the Hospital Emergency Department, then transported at his request to One Medical Center. Examination at that time revealed shortening and external rotation of the left lower extremity, pain with internal and external hip rotation. X-ray revealed a left intra trochanteric fracture. The examinee was seen by Dr. Kinko, who on December 19, 1985, performed open reduction and internal fixation of the fracture. The examinee did have postoperative complications including pulmonary edema, which resolved promptly with treatment.

The examinee was then discharged with gradually increasing weight bearing. By February 2, 2004, the examinee was ambulating with a cane. He was referred to physical therapy. Initial evaluation revealed mildly decreased left hip motion.

By mid March 2004, Dr. Kinko noted essentially normal gait with painless hip motion. Hip motion was not measured at that time. The examinee's left leg was noted to be one-half inch short and the patient was given a lift.

By mid June 2004, x-rays revealed healing of the fracture with some ongoing impaction. Gait was normal. The examinee was released from Dr. Kinko's care at that time. The examinee has required no further treatment for his left hip condition.

Diagnostic Studies:

Study	Date	Result
X-Ray Left Hip	6/18/03	Fixation hardware in good position; fracture healed with slight impaction

Current Status

The examinee's chief concern is whether it is a "permanent injury."

He reports difficulties with pain which is primarily located in the left hip. The pain is described as minimal. The pain is worsened by lying on the left side and prolonged walking. The pain is reported as intermittent.

On a scale from 0 (no pain) to 10 (excruciating pain), the examinee reports the pain now is a 2. During the past month the pain averaged 2, with a high of 4 and a low of 1.

Functional Status

Examinee states he is able to lift a gallon of milk; able to lift a heavy bag of groceries; able to lift a pail of water. Examinee states that he can sit for up to two hours, stand for up to two hours and walk for up to two miles.

Occupational History

At the time of the injury, he had been employed by The Fort at #4 and had been working there for two years. He was working full-time as a museum administrator. According to the description provided by the examinee, the job involved operation of a museum and staff. He has a college education.

In terms of current work status, he is currently not working. He last worked on January 12, 2004.

Social History

The examinee lives in Charleston, NH. The activities of a typical day include "seeking new job." He denies performing any other work activities or vigorous recreational pursuits.

The examinee does not smoke or drink.

Past Medical History

Medical:	Chron's disease
Surgery:	Bypass surgery
Medications:	See list
Allergies:	None known

Review Of Systems

Noncontributory

Family History

Noncontributory

PHYSICAL EXAMINATION

Observations

The examinee is a well-developed, well-nourished male. He appears healthy. Examination of the hands reveals mild callus. No assistive devices were used. Height was 5 feet, 7 inches and weight 160 pounds as reported by the examinee.

Behavioral Observations

The examinee was pleasant, cooperative and attentive. Affect was normal. During the visit, he appeared comfortable. He sat continuously for up to 20 minutes. There was no significant pain behavior. Non-physiologic findings were not present.

Structural Examination

In the standing neutral position, cervical, thoracic and lumbar curves were well-maintained. The shoulders were symmetric. The right PSIS was elevated (as the examinee was not wearing his heel lift). Gait was normal with no antalgia. There was no external rotation of the left foot.

Lower Extremity Examination

Inspection revealed a well-healed surgical scar over the lateral left hip. Hip motion as measured with a goniometer was symmetrically decreased in external rotation, but otherwise normal.

MOTION	NORMAL	LEFT	RIGHT
Forward flexion	100	120	120
Extension	0	0	0
Abduction	25	35	35
Adduction	15	30	30
Internal Rotation	20	35	35
External Rotation	30	15	15

The examinee had no pain with hip motion. Resisted hip abduction and external rotation was pain free. There was no tenderness of hip structures. There was no left thigh atrophy. However, leg length measured from the lateral pelvic rim to the lateral tibial plateau revealed a 2.5 cm deficit on the left.

PAIN STATUS INVENTORIES

Pain Drawing

The examinee completed a pain drawing (attached), using symbols to describe sensations. This drawing did reveal findings suggestive of symptom magnification.

Pain Disability Index

The Pain Disability Index uses rating scales to measure the extent of perceived disability in seven areas of life. The results are as follows:

Area	Perceived Disability
Family/home responsibilities	20%
Recreation	20%
Social Activity	0%
Occupation	10%
Sexual activity	40%
Self-care	0%
Life-support activities	0%

The total score is 9 out of a possible 70, for a total index of 13%. This indicates a mild degree of perceived disability.

CES-D

The Center for Epidemiologic Studies Depressed Mood Scale was administered. The examinee scored 10, which is not consistent with a depressed mood.

CONCLUSIONS

Diagnoses

1. Left hip fracture, intra trochanteric
   1.1 Status post open reduction and internal fixation
2. Status post fracture left ankle
3. Coronary Artery Disease
4. Diabetes
6. History depression

Discussion

The examinee's injury of December 18, 1985 was a left hip fracture which did not involve the hip joint. He underwent open reduction and internal fixation (without joint replacement) and has done very well. He does generally use a heel lift due to left leg shortening, but is currently walking two miles per day with no difficulty.

Causation

Based upon the available information, to a reasonable degree of medical certainty, there is a causal relationship between the examinee's current left hip complaints and the reported injury. The examinee's more diffuse low back symptoms are of uncertain origin, given the degree of symptom magnification present. More likely than not, these symptoms are due to pre-existent (mild) facet arthropathy, obesity and symptom magnification.

Work Capacity

This examinee has at least a sedentary work capacity as defined in the *Dictionary of Occupational Titles*, U.S. Department of Labor. At this time, the examinee can lift perhaps 10 pounds occasionally and five pounds frequently. He assumes that he is unable to sit, but I can find no objective reason why that should be the case. In truth, it is likely that he could sit and stand for reasonable periods of time, requiring frequent position changes. He could walk for perhaps 15 minutes per hour. He can bend and twist occasionally, but should involve spotting. He can kneel and crawl occasionally and climb stairs minimally. He should avoid ladders. He can push and pull with perhaps 20 pounds effort. He would have no other restrictions regarding upper extremity use. He should avoid driving a motor vehicle or operating machinery due to her multiple sedating medications.

Prior to his July 2004 hip surgery, he would have had essentially the same work restrictions, except that his duration for sitting, standing and walking may have been somewhat greater.

Appropriateness of Care

The client has asked that I specifically address the issue of appropriateness of medical care. Based on the specifics of this care, it is my professional opinion that care has not been entirely consistent with the usual standards of care for this problem. In particular, the use of Avinza is inappropriate given the lack of objective reason for the examinee's pain complaints and the ineffectiveness of the medication. Furthermore, use of Neurontin has been inappropriate given the lack of evidence of neuropathic pain. Finally, the failure to address the examinee's probable significant depression has been inappropriate.

Prognosis

The overall prognosis is good.

Maximum Medical Improvement

The examinee has achieved maximum medical improvement. MMI is defined as the date after which further recovery and restoration of function can no longer be anticipated, based upon a reasonable degree of medical probability.

Permanent Impairment Evaluation

Permanent impairment evaluation was performed in accordance with the AMA *Guides to the Evaluation of Permanent Impairment*, Fifth Edition. The examinee warrants impairment on the basis of a 2.5 cm limb length discrepancy. According to Table 17-4 (page 528), this imparts 7% lower extremity impairment, which converts to 3% whole person impairment.

Recommendations

Diagnostic/Consultation

No further diagnostic testing or consultation is indicated.

Therapeutic

The examinee will continue to require a heel lift of perhaps 1.5 cm. No other treatment will be necessary for his left hip condition.

Qualifications

I am a founding member of the American Board of Independent Medical Examiners, having served on the Selection Committee, and am certified by ABIME. I have performed over 2000 Independent Medical Examinations and Permanent Impairment Ratings in the past 13 years. I have spoken to national groups on work fitness and disability issues, and have built a national reputation for my expertise in these issues. I have been a contributor to publications regarding disability issues and permanent impairment. I am board certified in Occupational Medicine, and am a Fellow of the American College of Occupational and Environmental Medicine and the American College of Preventative Medicine. I am past Chairman and current secretary of ACOEM's Work Fitness and Disability Evaluation Section. I maintain a clinical practice as Medical Director of WorkWell at Southern Maine Medical Center.

The above analysis is based upon the available information at this time, including the history given by the examinee, the medical records and tests provided, the results of pain status inventories, and the physical findings. It is assumed that the information provided to me is correct. If more information becomes available at a later date, an additional report may be requested. Such information may or may not change the opinions rendered in this evaluation.

The examiner's opinions are based upon reasonable medical certainty and are impartial. Medicine is

both an art and a science, and although an individual may appear to be fit for work activity, there is no guarantee that the person will not be re-injured or suffer additional injury. If applicable, employers should follow the processes established in the Americans with Disabilities Act, Title I. The opinions on work capacity are to facilitate job placement, and do not necessarily reflect an in depth direct threat analysis. Comments on appropriateness of care are professional opinions based upon the specifics of the case, and should not be generalized, nor necessarily be considered supportive or critical of, the involved providers or disciplines.

Any medical recommendations offered are provided as guidance, and not as medical orders. The opinions expressed do not constitute a recommendation that specific claims, or administrative action be made or enforced.

Sincerely,

William Boucher, M.D., C.I.M.E.

WB/ls