

April 19, 2005

Claim No.:

Claimant:

Insured:

Date of Loss: 10/14/04

Dear Ms. _____:

At your request, I performed an Independent Chiropractic Evaluation of _____ on April 19, 2005. This took place in Miller, South Dakota from approximately 2:00 to 4:00 p.m.

Included as part of this examination was a review of records submitted by _____. These records include the following:

- Letter dated April 7, 2005 from _____/_____ requesting this IME.
- Chiropractic records from Dr. _____ of _____ Chiropractic Clinic dated October 17, 2004 through March 24, 2005.
- Medical report from Dr. _____ dated 10/26/04 and 11/20/04.
- MRI Report and Lumbar X-ray Report (5 views) from _____ dated 11/2/04.

The following is a report of my interview and examination, my paper review of _____'s medical records made available, and my opinions concerning his condition as it relates to his October 14, 2004 Work Comp injury.

In performing a paper review, I utilize acceptable guidelines adopted by the South Dakota Board of Chiropractic Examiners and by the State of South Dakota. These include Guidelines for Chiropractic Quality Assurance and Practice Parameters, Proceedings of the Mercy Center Consensus Conference; Procedural/Utilization Facts, Chiropractic/Physical Therapy Treatment Standards, Fifth Edition by Richard E. Olson, DC; and the current State regulations in Worker's Compensation.

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HISTORY: Mr. _____ states he injured his low back on October 14, 2004 while at work pulling on a flat piece of steel approximately 6 inches wide by 20 feet long and weighing approximately 200 lbs. He was trying to place it on a stand when the stand lost its balance and the flat piece started to fall. He caught one end of the piece of steel and the other end hit the floor causing it to vibrate and injure his low back.

He initially thought it felt like he just strained the low back but the next morning it started to get severe. In fact, he had to leave work on Friday, October 15, 2004 before his work was finished due to the pain. That night he had severe pain and could not sleep. The next morning on Saturday, October 16, 2004, his wife and father had to help him get out of bed. He called several Chiropractic Physicians and was not able to get a hold of anyone for an emergency call. He therefore called a Physicians Assistant, Ms. _____, and was given some pain medication which seemed to help. On October 17, 2004 he did get an appointment with Dr. _____, Chiropractic Physician, for evaluation and care.

Mr. _____ states that initially the only thing that relieved his pain was lying on the floor with his feet elevated. He did receive care from Dr. _____ which included spinal manipulation (activator method), electrical stimulation, massage, and intersegmental traction. This helped initially for the first 6 to 8 weeks. He stated that Dr. _____ held him off of work for the first month. Mr. _____ requested to go back to work after this period and was allowed to but advised to do light activity.

Mr. _____ stated that the care seemed to help him for the first 6 to 8 weeks especially when he was off of work, but when he returned to work the treatments did not seem to help as much. He stated that certain movements and activities would cause flare-ups at work. In later December of 2004 he stated he had a big project to do and it really flared up his back. Since December he states he has had constant pain and aggravation. He has tried hard to do light activity but with his line of work – dealing with steel and welding – he has to bend, twist, and lift routinely.

On November 2, 2004, Dr. _____ did refer Mr. _____ to _____ for an MRI of the lumbar spine which revealed no extruded disc herniations but did reveal mild multi-level disc degeneration without spinal stenosis.

CURRENT COMPLAINTS: Mr. _____ complains of constant sharp, shooting, burning pain in the midline lumbosacral area with intermittent leg pain that is reproduced on certain movement as well as with sitting and bending forward at work. He states the pain is midline and primarily to the left but also on the right side through the lumbosacral region. He states it will radiate down the leg from the buttock to the mid thigh (left side worse, but sometimes on the right side). He states on a VAS scale of 0 to 10 – 10 being unbearable – he rates his pain at a level of 8. He states this pain has not changed over the last several months. He states that chiropractic care only gives him short-term relief.

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He does state that he will get tension in the neck and between shoulders, but this is something that is not associated to this Work Comp injury and will not be addressed in this report.

PAST MEDICAL HISTORY: Mr. _____ did state that he was a prior patient of Dr. _____'s. He states that he saw him approximately 2 to 3 weeks prior to his Work Comp injury of October 14, 2004 primarily for rib pain and neck pain due to routine twisting, bending, and lifting at work. He states he had no low back pain or leg pain prior to this injury. The low back was asymptomatic prior to the Work Comp injury of October 14, 2004. Prior to this Work Comp injury he was able to do normal activities without difficulty and had had no health problems whatsoever. He did state that when he was a teenager he was involved in 2 car accidents resulting in neck pain, but no lower back pain. He is only taking Tylenol at this time for medication. He has had no previous surgeries.

SOCIAL HISTORY: Mr. _____ is married with four children. He is currently employed as a welder/shop employee for _____, _____. He is a full-time employee. He states he has missed approximately 1 month of work from October 14, 2004 through November 15, 2004 due to this injury. He states that it is difficult for him to miss work due to the financial burden it causes him and his family. Therefore, he has not been able to take the time off of work that he feels, and Dr. _____ feels, is necessary for him to recover from this condition. He states that he is not able to perform all work duties and has been assisted in heavy lifting. Due to his type of workload he is required to do a lot of bending, lifting, and stooping for long periods of time.

Mr. _____ states that he is restricted from recreational and social activities and has continual pain on a daily basis. His Back Index taken by me on April 19, 2004 reveals a 70% score. This score reveals an elevated level of back disability.

MEDICAL HISTORY: Mr. _____ is a non-smoker. He does not drink alcohol. He drinks 2 pops or coffee per day mainly in the a.m. He does not use illicit drugs. He is not at this time taking any medication other than Tylenol. He has had no previous surgeries or other procedures performed. He reports 2 motor vehicle accidents as a teenager primarily involving the cervical spine without residuals.

FAMILY HISTORY: His family history is non-contributory and is unremarkable except for a sister who has colon cancer of approximately a two-year duration.

PHYSICAL EXAMINATION: Mr. _____ is a pleasant and cooperative 44-year-old male Caucasian. He appeared to be in acute discomfort and had difficulty sitting. He therefore would stand up and pace and then sit again during our interview. He stands 5'11" tall and weighs 204 lbs. Blood pressure was 126/84 in the left arm in a seated position. Temperature was 98.1 degrees. Pulse was 76 bpm. Respirations were 14 per minute. Heart S1, S2 sounds were

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essentially normal. Lungs were clear with good expansion. Carotid artery auscultation revealed no bruits. Eyes accommodation and light reflexes were essentially normal. Fundoscopic exam was essentially normal. His right ear revealed external canal infection. He indicated he is currently seeing a physician for the ear infection.

Observation: He stands with a slight increase in the lumbar lordosis with +3 tenderness to palpation over the midline lumbosacral up to L3. He has +3 tenderness in the left low back from L3 to S1 and +2 tenderness on the right. There is +3 hypertonicity in the lumbar paraspinal musculature primarily on the left. He has no gluteal pain. Piriformis tenderness is noted on the left with +3 hypertonicity. He does have some suboccipital hypertonicity bilaterally at +2 in the upper cervical spine. He has a left high shoulder but the hips appear level.

Range of Motion/Lumbar Spine: Flexion is 45 degrees (normal 90 degrees). Extension is 5 degrees (normal 30 degrees). Left lateral flexion is 5 degrees (normal 20 degrees). Right lateral flexion is 10 degrees (normal 20 degrees). Left rotation is 15 degrees (normal 30 degrees). Right rotation is 15 degrees (normal 30 degrees). At all end ranges of motion, pain was elicited in the midline lumbosacral and to the left. Left lateral flexion and extension caused significant pain in the left low back with radiation down to the buttock and mid hamstring.

Orthopedic Tests/Lumbar Spine: Adam's forward bending test was positive causing midline lumbosacral pain. (This test indicates lumbar strain/sprain.) Kemp's test was positive on both the left and right. On the left it elicited left low back pain with shooting pain down to the mid thigh. On the right it caused pain mainly midline lumbosacral and to the right. (Positive Kemp's test with radiation reveals nerve root impingement, sciatic neuralgia, and possible disc involvement.) Lasegue's Straight Leg Raise was positive on the left at 45 degrees eliciting left leg pain to the mid thigh and left low back pain. Right Straight Leg Raise was positive at 90 degrees eliciting pain in the midline lumbosacral region. (Straight Leg Raise positive with leg pain reveals sciatic neuralgia, nerve root impingement, and possible disc involvement. Straight Leg Raise positive at 90 degrees without leg pain reveals lumbosacral strain/sprain involvement.) Braggard's was positive on the left revealing increased left leg pain. (Positive Braggard's reveals sciatic neuralgia, possible disc involvement, and nerve root impingement.) Double Leg Raise was positive at 60 degrees causing midline lumbosacral pain. (Positive Double Leg Raise reveals lumbosacral strain/sprain.) Patrick Fabere, right and left leg, was negative. Hoover's malingering test was negative. Kernig's test was negative on the left and right. Sitting Bechterew's was positive on the left and negative on the right revealing left low back pain and posterior buttock to thigh pain. (Positive Bechterew's reveals nerve root impingement, sciatic neuralgia, and possible disc involvement.) Lindner's test was positive causing midline low back pain and some left leg to mid thigh pain posterolateral. (Positive Lindner's reveals low back nerve root compression.) Dejerine's Triad was negative. Minor's sign was positive. (Positive Minor's sign is characteristic for patients with sciatic neuralgia or nerve root impingement.)

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Hibb's test was negative. Yeoman's test did cause pain in the lumbosacral spine but no sacroiliac pain was noted and therefore is a negative test.

Lower Extremity Muscle Testing: Mr. _____'s lower extremity major muscle testing revealed bilateral 5/5 strength with no atrophy noted. Even though he had normal muscle strength, Mr. _____ did have breakaway pain when testing the quadriceps muscle on the left as this reproduced low back pain and radiating pain to the mid thigh posterolateral.

Neurologic Evaluation: This revealed an increased sensation over the L4 dermatome from the medial tibia down to the great toe – on the left only – otherwise normal. Reflexes including biceps, triceps, brachioradialis, Achilles, and patellar were all normal at 2+ and brisk. No clonus noted. Babinski's pathological reflex was negative. Patient could heel/toe walk but both elicited pain in the lumbosacral region as well as the buttock to hamstring on the left.

MEDICAL RECORDS REVIEW: Chiropractic records from Dr. _____ of _____, South Dakota, revealed that Mr. _____ was initially evaluated on October 17, 2004. This was 3 days after his initial Work Comp injury of October 14, 2004. His initial documentation did not encompass a full examination to correctly evaluate this patient's acute condition. His documentation showed only minimal objective findings. In fact, the entire records submitted for review by Dr. _____ from October 17, 2004 through March 24, 2005 were generic in nature. The objective findings, treatment, and assessment were almost exactly the same on every visit. The records failed to tell the patient's story of his condition and his response to treatment.

Dr. _____ did document this patient's VAS pain scale (Visual Analog Scale) on each visit and it appears that this patient initially started with a VAS scale of 10. On the third visit of October 20, 2004, Mr. _____ was down to a VAS scale of 7 which is where it remained throughout his care through March 24, 2005. Dr. _____'s records failed to tell this patient's story. In fact, the only way I could really get a basis for this patient's condition was through my own interview and examination performed on April 19, 2005. Mr. _____ clearly stated that he felt he was improving with care until he had a re-aggravation of his Work Comp injury in mid to late December which caused him to hit a plateau. I was able to decipher from the December 18, 2004 notes that it seemed Mr. _____ had gone back to work and re-aggravated his condition at approximately that date. Therefore, it appears that care beyond December 18, 2004 did not seem to improve this patient's condition on a long-term basis.

Dr. _____ diagnosed Mr. _____ initially with 839.20, lumbar subluxation; 847.2, lumbar strain/sprain; and 724.2, low back pain. This diagnosis was never upgraded throughout care even though this patient did present with some radicular type pain.

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Dr. _____ has treated Mr. _____ 33 times from October 17, 2004 to March 24, 2005. I did not receive a service utilization report to tell exactly what was done each time, but it appears that he did spinal manipulation via activator technique to the lumbar spine. He did at times massage therapy which seemed to assist this patient with his discomfort, electrical stimulation, intermittent traction with a roller-type table, and had the patient use a TENS unit at home. The patient conveyed to me again that the treatments seemed to help until approximately December 18, 2004 when re-aggravation occurred. Since that time he has seen no significant long-term improvement. The patient utilizes a TENS unit at home which gives him great relief. He states he goes home after work and uses the TENS unit at night and it helps him cope with the pain and helps him get a better nights sleep. The massage therapy was only done once or twice but did assist in improvement. The frequency and duration of the care rendered by Dr. _____ is not excessive, but it appears that it only assisted this patient from October 17, 2004 through December 18, 2004. Since December 18, 2004 Dr. _____'s care has been supportive in nature and has not appeared to provide this patient with long-term improvement.

The MRI report revealed degenerative changes of the lumbar spine to a mild degree with no disc herniation or stenosis. X-rays taken on November 2, 2004 also revealed early degenerative changes of the lumbar spine.

DISCUSSIONS/CONCLUSIONS: The following opinions are provided with a reasonable degree of chiropractic certainty based on my interview and examination of Mr. _____, my review of the provided records, and my 24 years as a licensed Chiropractic Physician practicing in the State of South Dakota.

1. According to my interview and examination performed on April 19, 2005, Mr. _____ was asymptomatic with the lumbar spine prior to the October 14, 2004 Work Comp injury.
2. According to the documentation submitted for review, Dr. _____'s diagnosis of lumbar strain/sprain/subluxation and low back pain is supported, but there were not sufficient objective findings to substantiate his diagnosis. It is only by this patient's information gathered today, April 19, 2005, that I am able to substantiate the diagnosis. I also feel that upgrading this diagnosis is warranted and would therefore include lumbar disc syndrome with sciatic neuralgia. Dr. _____'s objective findings failed to support the diagnosis, but he had sufficient subjective findings to support the mechanism of injury and that this patient injured his lower back on October 14, 2004. In the body of this report I have substantiated my additional diagnosis with the orthopedic tests, neurologic tests, range of motion, and palpatory findings to justify upgrading the lumbar disc syndrome with sciatic neuralgia diagnosis accompanied by the lumbar strain/sprain/subluxation complex with low back pain.
3. Please refer to #2 above.

4. In the body of my report I have described positive orthopedic tests revealing nerve root impingement and sciatic neuralgia, limitations in range of motion, hypertonicity of the paraspinal musculature, and palpatory findings eliciting pain in the left low back and leg region. I feel these objective findings substantiate the diagnosis given in #2 above.
5. I feel that the MRI report of November 2, 2004 revealing mild multi-level disc degeneration without canal stenosis and extruded disc herniations are not a result of this injury suffered on October 14, 2004. I feel that this patient had prior mild early degenerate changes of the lumbar spine which are consistent with this patient's age and the type of work load he does on a daily basis.
6. I do not feel that the employee's pre-existing degenerative spinal condition is responsible for any of the ongoing symptoms. I feel his lumbar condition is solely due to the injury which occurred on October 14, 2004.
7. I feel that the frequency and duration of care is supported up until December 18, 2004. After this period, I feel supportive care had been performed and it provided this patient no long-term relief. I feel this patient should have been referred to either another Chiropractic Physician for services that were not performed by Dr. _____ or referred to an Orthopedic/Neurologic Specialist as this patient's symptoms continued to occur at the same level of intensity and severity from December 18, 2004 to present.
8. I feel that future care is needed. This patient is still suffering from a debilitating low back condition with sciatic neuralgia. I feel that further diagnostic procedures may be warranted as well as a referral to an Orthopedic/Neurologic Specialist. I also feel chiropractic care accompanied by rehabilitation may be beneficial to this patient pending the diagnostic and orthopedic/neurologic results. At this time I cannot be specific as to the type, length, or duration of treatment still necessary until further evaluation and studies are performed on this patient. Because this condition has not progressed since December 18, 2004 further evaluation is necessary to be able to specifically outline a treatment plan that would give this patient the most benefit for his ongoing Work Comp injury.
9. I feel a referral to an Orthopedic or Neurologic Specialist is warranted as this patient does have an ongoing low back condition with reproducible sciatic neuralgia.
10. I do not feel this patient has reached MMI. I do feel improvement of this condition can occur if further diagnostic procedures and a referral for evaluation and care from the proper specialists are performed.
11. I do not feel Mr. _____ has reached MMI. Therefore, it is too early to determine any permanent/partial disability rating at this time.

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12. I feel this patient does need work restrictions. He has reproducible pain with long-term sitting beyond 2 to 3 hours, standing beyond 2 to 3 hours at a time, and repetitive bending, lifting, and stooping. I feel this patient should not lift above 20 to 25 lbs. He should not be on his feet past 2 to 3 hours at a time nor sitting for more than 2 to 3 hours at a time. I feel restricting him to a shorter work day of 5 to 6 hours would be warranted. Repetitive pulling, tugging, and twisting motions should be restricted. At this time I feel these would only be temporary restrictions and they should be supervised by a referral to either another Chiropractic Specialty and/or Orthopedic/Neurosurgeon.

Thank you for allowing me to participate in Mr. _____'s independent medical evaluation.

If you have any further questions, please feel free to contact me.

Respectfully yours,

John S. Carr, DC

JSC/lb

Seen: 4/19/05

Transcribed: 4/20/05