California Orthopaedic Association

Sample Medical Legal Report

This document is presented as an example of the form and general content of an orthopaedic QME/AME report. The specific diagnoses, conclusions, and opinions expressed herein are those of the author and not necessarily those of the California Orthopaedic Association or every California Orthopedist.

(Put on QME's Letterhead)

(Date of Evaluation)

Department of Industrial Relations
Division of Worker's Compensation
Disability Evaluation Unit
(Address)

Re: Peter Patient
SSN: (Social Security Number)
D/I: (Date of Injury)
C/N: (Ins. Co. Claim #)
WCAB: (WCAB Claim #)
Emp: (Name of Employer)
D/Exam: (Date of Exam)
D/Dict: (Date Report Dictated)

Qualified Medical Evaluation – Orthopaedic Surgery

The above-captioned patient was seen in this office on January 10, 2007 for an orthopaedic Qualified Medical Examination.

This was a Comprehensive Medical/Legal Evaluation involving extraordinary circumstances. Voluminous files of records including a one and three quarter hour deposition transcript were submitted for review requiring six hours of time by the physician to review all of the material with additional face to face time, counting as three complexity factors. This patient has had three injuries to his spine. He was in an automobile accident, there is a reference to a fall at work in 2005, and he is currently claiming that his spine is also involved as a result of the current injury. This counts as an additional complexity factor. Additionally there is a causation issue regarding which body parts are involved in his current injury since his spinal complaints and other areas are not originally mentioned in the medical reports. He also has an underlying disease of multiple sclerosis.

The patient is a 59-year-old, left-handed white male who works in craft services for (Company Name). He indicates he would work on a daily basis for many different studios doing the same type of work. In his work he lifts up to 175 pounds, he climbs ladders, and he also has to climb hillsides and stairs, etc. He has been doing this for 35 years.

The patient gives the following history. (It is very difficult to get a good history directly from the patient.)

The patient reports that on March 8, 2006 a forklift turned, struck his right side and caught his left foot. He says he fell and the load consisting of set walls, fell on top of him. He was not unconscious. The forklift was elevated and he got out by himself. He reported pain in his right shoulder, his back, and left foot. He was able to stand and walk. He says this happened at the end of the work shift and he went home. The following day he went to work. He requested a statement from the driver of the forklift. He worked the day after his injury.

On March 10, 2006, he was sent to a medical group where x-rays were taken of the left foot and he was told he had a “bunch of fractures.” He was given crutches and a boot and sent home. He was put on temporary disability.

He was sent a few times to the same medical group for follow-up evaluation but did not have any physical therapy. He says a few weeks later he was sent to Dr. B, an Orthopaedist. He was put in a different kind of boot. He then was not seen again for about ten weeks as he says there were some problems with his Workers’ Compensation claim.

He was subsequently followed by Dr. B and had physical therapy, but he says it was only directed toward the left foot. His last visit with Dr. B was in August, 2006.

He was subsequently seen by Dr. H upon referral of his attorney. He was first seen by this doctor in late October, 2006, and started on physical therapy for the right shoulder and elbow and low and upper back. The treatment consisted of roller massage, ultrasound, and body massage. His foot is not being treated by this doctor. He is still getting physical therapy once a week.

He has also been seen by a neurologist for a consultation. He was recently seen by Dr. M for an examination only. He has had no other treatment.

He has not worked since March 9, 2006. He is getting physical therapy once a week.

The patient states that he has retired and has no plans to ever return to work.

Present Complaints

(Please note: the patient gives a very elaborate description of the symptoms all over.)

He states that his problems are equally symptomatic in the entire spine, both feet and the right shoulder.

With reference to his spine, he states he has neck stiffness “60 percent” of the time. This neck pain and stiffness is aggravated by twisting or neck extension. The neck pain does not radiate and the pain in the arm is “independent.”

He says the entire spine, including the thoracic and lumbar areas, hurt all the time. This pain is aggravated by elevating the legs or by lifting. He says his back “snaps,” and that he cannot sit up very long.

He has pain that radiates into both legs to the feet equally on the left and right side and the leg pain is of the same intensity as the back pain. He has difficulty getting out of bed in the morning because of his spinal complaints. He says there is constant numbness and tingling in both lower extremities. Coughing and sneezing produce back pain.

The patient states his left foot is weak and painful. There is pain in the mid foot and the lateral foot and the lateral ankle. He says that both feet are “still black and blue.” (Please note: only one foot was injured.)

He says he cannot run and he can barely use a Nordic Track apparatus that he uses for heart conditioning.

He says both feet swell after “working out.” The left swells more than the right.

He also has complaints referable to the right shoulder where there is constant pain. The shoulder pain is aggravated by any lifting or by lying on the right side and by movement of his shoulder.

He says the right elbow pops and makes his forearm numb. He says both hands are numb and tired. He says he falls easily and because of this he uses a cane in his right hand.

Previous Injury History

The patient reports that in the past he has had fractures of the fifth fingers of both hands and he has had lots of cuts on his hands. He has had hernias for which he was off work for two weeks when he had surgery.

He was involved in an automobile accident in May 2004 or 2005 that involved his neck and left side of his head. When he was in that auto accident, he was taken by ambulance to Hospital A and seen in the emergency room.

Subsequently an attorney sent him to a chiropractor and he had seven months of chiropractic care while he continued to work when work was available.

He initially states he cannot recall any other work injuries that required treatment or loss of work time other than for the hernias.

He subsequently recalls a work injury in 2002 when something dropped on his right foot and he had a fracture and was off work for a few months. He was treated with casting and received a settlement for that right foot injury.

Personal History

The patient is married with two children. Tobacco: None. Alcohol: None. Medications: The patient takes medications for multiple sclerosis including Avenox, Amitriptyline and Provigil. He also takes Lipitor.

He does not take pain medications. Allergies: None known.

Past Medical History

The patient has had usual childhood diseases. Serious Illnesses: the patient has multiple sclerosis which was first diagnosed six to seven years ago. It was diagnosed because he started having symptoms of lack of energy and he would “freeze up.” The evaluation and diagnoses for the multiple sclerosis was done at a hospital.

His surgical history includes bilateral inguinal hernia repairs. His hospitalization was only for respiratory problems in 1997.

Physical Examination

The patient is a well-developed, well-nourished, white male. He comes to the evaluation utilizing a cane in his right hand, but it was not used during the course of the examination.

He gets on and off the examination table with some difficulty. He walks limping on the left side. He walks on his toes poorly. He can walk on his heels. He does have a normal stance and habitus.

Vital Signs: Blood Pressure 120/96; pulse 80. Height 6 feet 3 inches. Weight 200 pounds. Left handed.

Examination of the Cervical and Dorsal Spine:

Inspection: The patient stands with the right shoulder ½ inch higher than the left. The spine straight. There is no gross deformity.

Palpation: There is diffuse, very light touch tenderness throughout the cervical spine. (That is, anywhere he is touched about the cervical area he complains of tenderness to very light touch.) The thoracic spine has no tenderness. There is no muscle spasm.

Motions (R/L): The patient flexes his neck 80 degrees. Extension is 65 degrees. Neck rotation is 45/45 degrees. Neck lateral bending is 35/25 degrees. (He complains of upper trapezius pain with all movements of the neck.) Foraminal closure testing also produces upper trapezius pain. Cervical compression, cervical traction and shoulder depression all elicit complaints of pain.

Motor Testing: Motor function in both upper extremities is intact.

Sensory Testing: Sensation in both upper extremities is intact, although with palpation he complains of diffuse tingling. Tinel's sign over the carpal tunnel on the right produces tingling that extends proximally into the forearm, and Tinel's test over the carpal tunnel on the left produces tingling that extends into the hand but not specifically in the median nerve distribution. The Phalen's test for carpal tunnel syndrome is negative bilaterally.

Reflexes (R/L): The biceps, triceps and brachioradialis reflexes are present and symmetrical.

Measurements (R/L = inches):

Circumference of upper arm	12-1/4	12-1/4
Circumference of forearm	11-1/4	11-1/2

Examination of Both Shoulders: There is no atrophy. There is prominence of the acromioclavicular joint area bilaterally. There are no scars. There is diffuse tenderness about both shoulders. (Anywhere he is palpated about either shoulder irrespective of anatomical structures produce a complaint of tenderness.) There is no palpable increase in warmth. The patient has smooth scapulothoracic motion. Passive circumduction does not produce any crepitus, but there is some slight relative diminution of glenohumeral movement of the right shoulder.

Range of Motion of Shoulders (R/L): Flexion 135/135 degrees; extension 60/50 degrees; abduction 135/140 degrees; adduction 75/75 degrees; external rotation 90/90 degrees; internal rotation 90/70 degrees. There is good strength with all movement about the shoulders.

Examination of Elbows: The carrying angles are 5 degrees bilaterally and there is no gross deformity of either elbow. There is no soft tissue swelling, no instability, and there is no increase in local warmth. Palpation of the ulnar nerve at the cubital tunnel on the right side produces a complaint of tenderness, but does not produce radiating paresthesais.

Range of Motion of Elbows (R/L): Flexion 135/135 degrees; extension 0/0 degrees; pronation 80/80 degrees; supination 90/90 degrees.

Jamar Dynamometer Grip Strength Testing (R/L): 45/85, 60/70, 65/70.

Examination of the Lumbosacral Spine:

Inspection: The pelvis is level. The spine is straight. No deformity is evident.

Palpation: As was noted in the cervical area, there is a diffuse tenderness to very light touch anywhere he is palpated about the lower back. This is not related to any specific anatomical structure.

Motions (R/L): The patient flexes his lumbar spine 90 degrees (1 inch from the floor). There is normal reversal of the lumbar curve. Extension is 50 degrees. Lateral bending is 35/35 degrees. Trunk rotation is 60/60 degrees.

(The patient complains of pain with all movement of the lower back.)

Supine leg raising is 85/80 degrees. With elevation of the right leg, there is a complaint of pain in both the lower back and the foot. With elevation of the left leg, there is a hamstring stretching feeling.

Fabere test is negative. Fajersztajn test and the reverse Fajersztajn test are negative on the right side. On the left side, Fajersztajn test and the reverse Fajersztajn test both produce a complaint of foot pain. The flip test is negative. The Cram test is negative. The patella shift test is negative.

Motor Testing: Motor function in both lower extremities is intact.

Sensory Testing: Sensation in both lower extremities is intact.

Reflexes (R/L): Knee jerks 2+/2+; ankle jerks 2+/2+. There is no ankle clonus.

Measurements (R/L = Inches):

Leg length	39	39
Circumference of thigh	18-1/2	18-1/2
Circumference of calf	15-1/4	15-1/2
Circumference of ankle	12	11-3/4
Circumference of foot	10-1/4	10-1/4

Examination of the Ankles and Feet: The shoes the patient is wearing demonstrate a trace of diminished wear of the left toes and the left medial heel when compared to the right.

In addition to having a slight limp with walking, favoring the left lower extremity, and walking poorly on the toes but walking without problems on the heels, he indicates he cannot walk on the inner borders of either foot. He does walk on the outer borders of both feet, but with some difficulty.

His feet have symmetrical skin temperature, texture, moisture, color, and hair formation.

There is tenderness to percussion over the left lateral malleolus and there is diffuse tenderness over the mid foot and forefoot on the left side. There is free ankle, subtalar and mid tarsal motion.

Ankle Range of Motion (R/L): Extension 10/10; flexion 15/15 degrees; inversion 5/5 degrees; eversion 0/0 degrees.

There is no ligamentous instability about the ankle. Bilaterally he does have a slight hallux valgus. He has a moderate too-many-toes sign on the right side. There is no heel cord fullness. He can do a single leg toe raise bilaterally, but there is weakness when attempting this. There is no evidence of instability about the toes. There is diffuse tenderness of the toes.

X-Ray Report

X-rays of the cervical, thoracic and lumbosacral spine, pelvis, right shoulder, left ankle, and foot were obtained in this office January 10, 2007 by Certified Radiology Technician C (Certificate #), and interpreted by the undersigned.

Cervical Spine (7 Views): There is moderate narrowing of the C5-6 and C6-7 disc spaces with anterior vertebral body spurring at those levels. There are posterior spurs extending into the neural foramina bilaterally at C6-7 level. There is no evidence of fracture, dislocation, or other bony injury.

Thoracic Spine (3 Views): There is an upper thoracic short curve toward the right. There are generalized slight degenerative changes throughout the thoracic spine and moderate dorsal kyphosis. There is no evidence of fracture, dislocation, or other bony injury.

Lumbosacral Spine (5 Views): There is no evidence of fracture, dislocation, or other bony injury. Disc and joints spaces are well maintained. There is no arthritic spurring. There is no spondylolysis. There is no spondylolisthesis.

Pelvis (1 View): There is no bony abnormality of the pelvis. The hip and sacroiliac joints are well maintained.

Right shoulder (2 Views): There are two small benign cystic changes in the humeral head. There is no evidence of any trauma residual. The joint spaces are well maintained. There is no arthritic spurring.

Left ankle and Foot (5 Views): There is a residual of a tiny avulsion of the superior aspect of the navicular in the left foot. There is a suspicion of healed fractures of the proximal phalanges of the fourth and fifth toes in good alignment. There is no evidence of any residual fracture in the ankle area and the ankle mortise is within normal limits.

Review of Records

As noted at the beginning of this report, numerous records have been submitted for review. In addition to the records which I will summarize that refer to his orthopaedic conditions, there are a number of records regarding his hernia surgery which is outside of the scope of his current claim and an orthopaedic evaluation.

The first group of records that I will review and summarize refers to his right foot injury that occurred on June 4, 2002. There is a DWC Form-1 that was filed on June 24, 2002 that is very poorly duplicated, but it indicates that his date of injury was June 4, 2002. An Application for Adjudication of Claim dated July 31, 2002 lists June 4, 2002 as the date of injury when his employer was (employer) when a heavy structure dropped on his right ankle and foot.

The earliest available medical report regarding that incident is a Doctor's First Report of Work Injury prepared by Dr. S who saw the patient on August 7, 2002 for the injury of June 4, 2002 when a section of heavy floor dropped on his right foot and ankle. His complaints were that he had right ankle and foot swelling. The handwritten First Report is hard to read but apparently there was swelling laterally and a healed abrasion on the dorsum of the foot. There were some areas of tenderness but I could not read this clearly. There was decreased motion. An attached report is referred to.

There is a narrative report prepared by orthopaedic surgeon Dr. S who saw the patient on August 7, 2002. It was noted he was having right ankle and foot pain with swelling. The history of something accidentally dropping on his right foot and ankle is noted and it was stated he had immediate pain. He was seen at a Kaiser Hospital, was examined, had x-rays and was told he had a fracture in the right ankle and was put in a boot cast and taken off work. The boot cast was removed on July 19, 2002 and he had two sessions of physical therapy that did not provide relief. He was released to return to work on August *5*, 2002 and had been doing regular duties with increasing symptoms. He was currently seen by Dr. S after requesting a change in doctors.

His work history states he had worked for (employer) for approximately 31 years. (Please note: He worked for various studios on a day to day basis.)

His job duties are described. It was noted that he had been diagnosed as having multiple sclerosis in 2001. Other trauma, accidents and fractures were denied. There were no records available for review. Examination revealed a well-healed abrasion scar on the dorsum of the right foot and there was slight swelling of the lateral and medial malleolus. There was tenderness over the lateral greater than medial ligaments of the ankle and there was tenderness over the lateral malleolus. There was no laxity but inversion and eversion stress testing increased ankle pain. There was no crepitus. There was limited motion of the ankle in all directions. Sensation was intact and motor function testing was normal and reflexes were symmetrical. He was limping, favoring the right lower extremity. X-rays of the right foot and ankle showed a healing transverse fracture of the distal lateral malleolus. There was also a small bony spur at the medial malleolus and a heel spur. The diagnosis was that he was post right ankle and foot sprain with fracture of the lateral malleolus. The discussion summarizes the history of this injury and treatment and it was recommended he start a therapy program and medication. He was also to use a home electrical stimulation

unit. It was felt his condition was due to the work injury of June 4, 2002. He desired to continue at work at his regular duties despite symptoms and he could self modify his work duties.

There is a PR-2 report from the office of Dr. S where he was seen by a chiropractor on September 4, 2002 and it was stated that symptoms in the ankle and foot were decreasing with therapy and he was continued on therapy and home exercises.

He was seen again on October 4, 2002 in that office by Dr. P. A PR-2 report of that visit states that there was a slight increase in his ankle and foot pain and especially with prolonged walking or going down stairs. It was stated that the ankle was giving out on him, causing him to fall. Therapy seemed to help. (Please note: His symptoms are very similar to those that he currently complains of in the left ankle.)

Because of increasing symptoms he was to have an MRI of the right ankle and he was to continue physical therapy and he was to have acupuncture added to his treatment program. This report states he was to stay off work for four to six weeks. (Please note: Prior to this he was working at his regular job.)

There is a report of an MRI of the right ankle of October 5, 2002. It was stated the findings were consistent with a fibrous union of a previous fracture across the lateral malleolus and there was also evidence of a previous fracture at the attachment of the posterior talofibular ligament in the talus. There was no evidence of a tendon tear. The talofibular and calcaneofibular ligaments were poorly demonstrated and might reflect a previous sprain. There was also a moderate effusion of the flexor hallucis longus and tibiotalar fluid was minimal consistent with tenosynovitis.

The patient was apparently referred to Dr. N on October 15, 2002 for a defense QME. It was noted his right lower extremity claim had been denied. He was claiming an injury when a heavy structure dropped on his right ankle and foot and it was noted there were many different versions of the incident including one that potentially happened at home. It was noted he had been seeing Dr. S.

There is a narrative report of a Qualified Medical Evaluation prepared by orthopaedic surgeon Dr. N.

This report states he worked for (employer) starting in April 2002 and his last day of work was in September 2002. His job duties are described. It was noted he previously worked as a self contracted worker for 31 years. The history given by the patient was that on June 4, 2002 a plywood board weighing about 90 pounds dropped on his right foot, striking him on the ankle, and there was acute onset of pain. He notified the employer but was not referred for medical care and continued working the rest of the shift. It was noted that was the last day of the production. He then rested for five days and on June 10, 2002 was seen at Kaiser and it was stated x-rays showed a fracture and his subsequent treatment with a boot cast is noted and it was noted he then started seeing Dr. S and in mid September was taken off work and MRI studies were ordered. The findings on the MRI are reported. It was noted he was currently not working and had not worked since September. It was noted he did have a history of multiple sclerosis. Other injuries described were an injury to the left hand in 1993 and bilateral inguinal hernias in 1997. His current complaints were of continuous pain in the right ankle that would radiate to the foot and toes and was on the outer and inner aspect of the ankle. There was also swelling and “dislocation” of the ankle. Pain increased with prolonged standing and walking and there was a feeling of instability with popping and grinding. It was stated his gait was uneven but he was not using a cane or walker.

On physical examination he did have a normal gait. There was tenderness over the distal fibula but full range of motion of the ankle. Varus stress was slightly painful. Lower extremity measurements revealed some slight relative diminution of the right thigh and calf. X-rays of the ankle showed a fracture line of the distal fibula consistent with an incompletely healed fractured distal fibula with a fibrous union. There was also some irregularity of the lateral border of the distal tibia. The diagnosis was a possible fibrous union versus nonunion of the right lateral malleolus.

Dr. N planned to get a CT scan of the ankle to confirm union of the fracture but felt he should be allowed to return to work on a trial basis and he was not yet permanent and stationary.

On November 13, 2002 a PR-2 report from the office of Dr. S is handwritten and very hard to read but apparently the symptoms were being helped by acupuncture. The MRI studies were reviewed with the patient and he was to be switched to pool therapy and stop the land therapy. He was still kept off work.

On December 11, 2002 Dr. S reports he was improving with pool therapy and he was to return to work at modified duty with activity as tolerated. He was to do no very heavy lifting and he was to be allowed to sit and stand as needed.

He was seen again by Dr. N on April 11, 2003. It was noted he was last seen by Dr. N on November 12 when it was felt he should have a CT scan but the patient refused to have the study "for reasons that perhaps only he knows." It was felt he had a possible fibrous union versus nonunion of the right lateral malleolar fracture. It was noted that when he was last seen Dr. N felt he should be allowed to return to work because there were no significant findings on physical examination and he had full motion. It was felt that the opportunity to have future medical care should be left open which would include CT scanning and treatment based on the results. Absent additional evaluation which the patient refused Dr. N considered his condition to have become permanent and stationary. Subjective disability was rated as constant minimal pain, frequently becoming minimal to slight and reaching slight to slight to moderate with very prolonged standing and walking and with repetitive running, jumping and climbing. Objectively there was tenderness laterally and x-ray evidence of a nonunion or possible fibrous union. It was felt he did not require formal work restrictions and vocational rehabilitation was not indicated. There was no apportionment and his condition was due to the injury of June 4, 2002.

In carefully reading this report of Dr. N it does not appear that the patient was examined again but rather this permanent and stationary report was based upon the previous evaluation performed by Dr. N.

In sequence there are some imaging studies that have been ordered by Dr. N and were performed on July 15, 2003. Scout x-rays of the distal tibia and fibula showed no fractures. There was some mild ossification of the interosseous ligament. Spiral CT scan of the distal tibia and fibula showed no fractures, no focal lytic or blastic lesions, no bone tumors, and there was mild ossification of the distal interosseous ligament. The ankle joint appeared unremarkable and the remaining joints of the ankle and hind foot were normal. The only finding in summary on this CT study was the partial ossification of the distal tibial aspect of the distal interosseous ligament.

The patient then was seen again by Dr. N on August 5, 2003. It is noted that in November 2002 he returned to work and did his usual and customary work until April 2003 when he was laid off. Ever since he was last seen (November 2002) he had not seen any other physicians. He had been using a TENS unit and wearing an ankle brace. He was currently not working and had not worked since April when he was laid off. He was complaining of continuous pain in the ankle with swelling and "dislocation" of the ankle and symptoms were aggravated by weight bearing activities and there was a feeling of instability. It was stated he gave a history of walking with an uneven gait but was not using any assistive device.
On examination although it was stated that he gave a history of walking with an uneven gait, the doctor observed a normal gait. There was no swelling, there was no tenderness and there was full range of motion. Measurements now showed only a 1/4 inch discrepancy in the thigh and calf measurements. Some of the reports from Dr. S office were reviewed. Dr. N did review the CT studies and felt the diagnosis now was a history of a right lateral malleolar fracture. It was noted initially the doctor was concerned he might have a fibrous union of the lateral malleolus but the CT study that was obtained showed that the previously suspected fibrous union has "gone on to fuse." Records were provided and there was nothing that would change his prior opinions. It was felt that his prior permanent and stationary report accurately reflects his current condition with no revisions indicated. (One revision would be that the fracture was now solidly healed.)

On October 14, 2003 a supplemental report from Dr. N reviews the deposition of Mr. Patient of May 22, 2003. (Please see my own review of this deposition which follows the review of the medical records regarding this specific injury.) Dr. N briefly summarizes entries in the deposition and notes that the

testimony was consistent with the information that was given to Dr. N and there was no reason to modify his previous opinions.

There is an orthopaedic permanent and stationary evaluation prepared by Dr. S reflecting an examination of January *5*, 2004.

The history of injury and subsequent treatment are reviewed and it is noted he was reevaluated on December 11, 2002 in that office and released to return to work on December 12, 2002 with some restrictions. He did not again return to that office until the current re-evaluation of January *5*, 2004. (He went one full year without being seen.) It was noted that after returning to work in mid December 2002 he worked a few days and then was at a location in Alabama for several months and after returning to California in approximately April 2003 he had worked on and off for different companies. (Please note: When seen in August Dr. N reported he had not worked at all since April.)

The patient indicated there had been some slight improvement but little change in the last few months. He had frequent pain in the right ankle and foot that increased related to his weight bearing activities. It was noted that in February 2003, working for the same employer, he was lifting a heavy cart and developed inguinal pain which had not yet been evaluated. He had had no treatment since he was seen in December 2002.

The ankle and foot were evaluated and it was stated there was mild swelling but no deformity. There was tenderness of the lateral ligamentous complex with lesser tenderness of the distal fibula. The medial side of the ankle was not tender. There was increased lateral ankle pain with inversion stress but no laxity. There was only 5 degree limitation of motion. Neurovascular testing was intact. It was stated he had a mild limp favoring the right lower extremity. (Please note: The examination findings reported by Dr. N and by Dr. S are quite different. Dr. N reports no swelling, no tenderness, full motion and a normal gait, yet Dr. S reports that all of these aspects of the examination had some abnormalities.)

In the discussion, Dr. S briefly reviews his findings and indicates that it was now believed he had reached maximum medical improvement and that he was permanent and stationary. Objective disability was restricted motion, tenderness, swelling, pain with inversion and stress and x-rays that showed a nondisplaced healed fracture of the right ankle distal fibula. Subjectively there was frequent slight pain at rest increasing to moderate with very prolonged weight bearing and very repetitive walking over uneven ground and very repetitive squatting and climbing.

It was noted the patient wanted to continue his usual work and was currently looking for work. Restrictions were not indicated but it was felt he had lost a percentage of his preinjury capacity to perform various activities. It was felt he had lost about 25% of his preinjury capacity for right ankle activities and 15% of his preinjury capacity for weight bearing. It was felt his right ankle condition was due to the work injury of June 4, 2002 without apportionment. It was felt future care may be necessary for exacerbations and he was given a replacement right ankle brace because his previous one was worn out. It was recommended the home stimulator unit be purchased for him. It was stated he should also have access to surgery if it was warranted in the future. (There was absolutely no evidence of any condition in the ankle that would lead to a consideration for surgery at the current time or in the future.)

It was noted he did not require specific work restrictions and was not eligible for vocational rehabilitation.

In addition to the medical records regarding his evaluations and treatment for that right ankle injury of June 2002 there is also a transcript of a deposition of Mr. Patient that was taken on May 22, 2003. He was asked if he was currently working and it was noted he had been working in January, February, March and April for (employer) but he had not worked in May. It was noted he worked as a craft services person (the same occupation he had at the time of his current injury).

It is noted he was having some difficulties with Workers' Compensation benefits. His job duties in the various shows he worked on are reviewed. The injury when something fell on his right ankle and foot is described. It was noted he initially went to Kaiser on his own and it was noted that subsequently his claim was being denied because of various stories as to how the injury had happened. It is noted he had been released to return to work by Kaiser and then started seeing Dr. S. It was noted he had last seen Dr. S in December 2002 and he was released to restricted work. It was noted he had been scheduled to see Dr. N. His current complaints of continual pain in the right ankle were described. There was some discussion about his hernia condition and previous finger injuries. There is nothing else in this deposition that would be pertinent to his current orthopaedic evaluation.

Finally, regarding that injury of June 4, 2002, there is documentation from the WCAB of a Compromise and Release that was dated April 12, 2004 indicating the patient was given an award for the right lower extremity, ankle and foot of $8,400.

This concludes the records that specifically refer to the injury of June 4, 2002 that involved the right ankle and foot.

The next group of records available refer to an automobile accident that took place on May 20, 2005. (Within this file of records about an auto accident of May 2005 there is mention of a work injury involving the neck and lower back of March 11, 2005, but I do not have any specific records regarding that work injury of March 2005 to the same bodily areas he is currently complaining of.)

The earliest report comes from the emergency room of the Hospital where he was seen on May 20, 2005 after being in a car accident. He was a seatbelted driver in an accident and was complaining of soreness in the neck and back. There was also some slight soreness in his right elbow. It was noted that about three years ago he was diagnosed with multiple sclerosis. It was stated he was currently on disability "secondary to this fall and injury with some discomfort to his back." It was noted he had a past history of "some recent disability secondary to a fall." It was also noted that he did not give much history regarding whether he had disability from his multiple sclerosis. It was stated, "His recent problem has been that from a fall and injury." It was noted currently the soreness was more to the neck and back area. There was only minimal soreness of the elbow. On examination he was wearing a cervical collar and had mild soreness to palpation. There was minimal soreness of the right elbow, and the ankle, knees and hips had normal passive motion. There were no focal neurological findings. X-rays were taken but the findings were not listed. The diagnosis was a muscular neck and back injury and a contusion of the elbow. He was given ice packs and Motrin and was to see his primary physician for follow-up. There are some reports from the radiology department of the hospital of x-rays taken on May 20, 2005 when he was seen in the emergency room. X-rays of the pelvis were normal. X-rays of the cervical spine showed some straightening of the spine laterally and "degenerative changes of the lower cervical spine." There was narrowing of the C5-6 and C6-7 disc spaces with degenerative spurring. (Please note: The same findings that I identified on x-rays currently in 2007 were already present in May 2005 at the time of an automobile accident.)

Lumbar x-rays showed slight narrowing at L4-5 with no other abnormality. It was stated elbow x-rays showed some degenerative change but no acute fractures.

Next regarding that accident there is a summary report from Chiropractor M that describes treatment through November 15, 2005 in the clinic of Chiropractor L. It was noted he was initially seen in the clinic of Chiropractor L on May 28, 2005 as a result of the traffic accident of May 20, 2005. It was noted his car was struck on the driver's side and he was "semi-conscious" after the accident. He was seen at the emergency room and had x-rays. Currently he had complaints of pain in the neck, the lower back, the upper back, the right shoulder, the right elbow, the right knee, the right ankle, the right upper chest and the left wrist and headaches. There was also dizziness, nausea, numbness and tingling in both arms and multiple cuts on both the right and left tibia. It was noted that he did have a work injury on March 11, 2005, injuring his neck and low back and was off work until May 26, 2005 but had returned to work. (Please note: He was off work more than two months after a work injury and was still off work at the time of the auto accident.)

There is a discussion of his original examination and it was noted there was pain and tenderness of the neck and tightness and spasms of the upper trapezius muscles. There was tenderness to deep palpation of the cervical spine and limited motion of the neck in all directions. There was a positive foramen compression test. The thoracic spine had tenderness and spasm. The lumbosacral area had tenderness with radiating tenderness. Lumbar motion was limited in all directions. Lasegue's test was negative bilaterally. The right shoulder also had wide-ranging tenderness with limited motion in all directions. The right elbow had pain, swelling and crepitus and limited motion but there was no instability. The left wrist had limited motion and there was numbness with Phalen's test, and Finkelstein's test was positive for tenosynovitis. The right knee also had tenderness and limited motion and pain with testing for stability but no instability is described. The right ankle had pain medially and laterally and limited motion. The neurological examination described revealed diminished sensation in the left C5-C7 and the right L4-S1 dermatomes. The previous hospital reports regarding the x-rays of the elbow are described. The diagnoses were sprains of the entire spine, right shoulder, right elbow, right knee, right ankle and left wrist. Also diagnosed were a chest contusion, headaches, post-traumatic vertigo, paresthesias of the upper extremities and abrasions of both legs. The patient was treated with physical therapy with modalities as well as spinal manipulation and exercises. After several months of care it was stated he had favorable resolution of symptoms. Re-examinations are described through November 15, 2005. He was 40 to 50 percent better overall but still had the same complaints, and after working long hours, symptoms would recur and he was having ongoing neck, upper back and lower back pain. He also had persistent pain in the right shoulder, right elbow, right knee and right ankle and occasional chest pain and other symptoms. He had restricted motion of the cervical and lumbar spine and right shoulder. A statement is made that I do not understand. It was said, "Due to the patient's pre-existing injuries and health condition, the symptoms experienced by the patient remained current." It was stated treatment had helped him about 50% at times. Although there were previous injuries, his conditions were worsened and weakened by the auto accident. He had reached maximum benefit and was to continue with exercise. The prognosis was moderately guarded.

Billing information from the office of chiropractor Leung indicates that his total charges for the evaluation and treatment of the patient were $4,520.

There are no other records regarding the May 20, 2005 auto accident but it is significant that he was still having symptoms from a March 11, 2005 work injury and was still on disability at the time of this auto accident, and when he was discharged from care on November 15, 2005 he was still having symptoms that involved his spine and right shoulder which are some of the areas of his current complaints.

The next group of records is prepared with reference to his current industrial injury of March 2006. (This is just four months after being discharged with persistent symptoms.)

The earliest available record is a Doctor's First Report of Work Injury that is dated March 17, 2006 prepared by Dr. T. The dates on this First Report are very confusing since it states that his date of injury was December 8, 2005, that he last worked on March 10, 2006, and was being first seen on March 10, 2006. The patient stated he injured his left foot when his foot got caught under a dolly full of wall sections. It was stated there was a left foot injury. It was stated there was no edema, no erythema or ecchymosis and he had a normal gait. There was tenderness of the first distal metatarsal and moderately at the scaphoid. (Please note: The scaphoid is a bone in the wrist that is also known as the navicular. In the ankle it is only known as the navicular.)

X-rays of the foot showed a questionable "scaphoid" fracture. The diagnosis was contusion of the foot, rule out fracture. He was given a posterior splint and orthopaedic shoe and crutches and some medication. He was to be at modified work. He was to be seen in follow-up on March 13, 2006.

From the Medical Group where he was seen by Dr. T there is a follow-up visit of March 13, 2006 stating he was to go back to modified work at a sit- down job and he was to use crutches. It was stated he was improving but still had pain and there was still edema, and, if I am reading this handwritten note correctly, there was tenderness laterally and at the dorsum of the foot. It was stated there was a questionable chip fracture and he had a slight limp. (Unfortunately, I do not have a radiologist's report.)

On March 16, 2006 he was again seen in follow-up and now the diagnosis is fracture left navicular and he was to be referred to an orthopaedist. It was noted there was left foot tenderness dorsally and he was limping. There is a First Report of Work Injury prepared by Dr. H who first saw the patient on March 27, 2006 for a date of injury of March 8, 2006. In the First Report there is no history of injury but the subjective complaints were of pain in the left ankle and foot and there was tenderness of the lateral malleolus and the left foot and x-rays showed an avulsion fracture of the left navicular with some displacement and a fracture of the lateral malleolus and the left toes. It was felt he needed outpatient surgery with an open reduction and internal fixation of the left navicular fracture. It was stated he was unable to work but could be at modified work with a sit-down job only.

There is a narrative report from Dr. H that is dated March 27, 2006. It was noted his complaint was of left foot pain. It was noted a forklift pushed a dolly loaded with scenery into his left foot and he had pain and swelling since. He had been seen in an emergency room, had ice, splinting and x-rays and then was referred to Dr. H. He denied prior similar injuries to the left foot. It was noted the right foot had a Workers' Compensation injury one or two years ago with a similar injury which was a strain and did not require surgery and resolved after several months. Under his medical history there is no mention of the fact that he has multiple sclerosis.

On physical examination it was noted there were no sensory abnormalities and sensation was intact in both lower extremities. Motor strength evaluation of the lower extremities was completely normal and reflexes were symmetrical. There was no tenderness of the ankle and foot but there was swelling of the foot and in spite of stating there was no tenderness of the ankle it was stated there was tenderness of the lateral malleolus and tenderness over the foot with tenderness over the left fifth toe. The alignment of the toe was good but there was moderate swelling. There was no instability of the ankle. There was dorsiflexion of 5 degrees and plantar flexion of 15 degrees. Apparently the limitation was due to pain. It was stated x-rays showed a nondisplaced lateral malleolar fracture and a minimally displaced left fifth toe proximal phalanx fracture in good alignment and an avulsion fracture of the left dorsal navicular. It was felt that the lateral malleolar and toe fractures could be treated closed with just ice, elevation and a splint and should heal in six weeks. The avulsion of the navicular was a fairly large fragment and it was felt it might not reattach because of displacement of more than a millimeter and it was recommended he have an open reduction and an internal fixation of the fragment which could be done as an outpatient and then would heal in six weeks. It was stated work contributed to the injury and he should currently do only sit-down work.

A surgical authorization request prepared by Dr. H notes that they were requesting authorization for open reduction and internal fixation of the fracture of the left navicular.

On April 25, 2006 utilization review notes that the surgery certification was recommended.

On May 3, 2006 a handwritten progress note from Dr. H says he could not fully weight bear on the foot and there was mild tenderness. It is stated however, "Due to minimum symptoms now would not recommend surgery at this time." The diagnoses were fractures of the fifth and fourth proximal toes that were healed, the avulsion fracture of the navicular with fibrous union, and the lateral malleolus fracture which was healed. It was recommended he have physical therapy to rehabilitate the foot and he was to stop using a fracture walker and was to use a regular shoe. He could go back to modified work at a sit-down job. Another handwritten form of May 25, 2006 notes he had started therapy and was having less pain. He was still using one crutch to walk. There was still some swelling of the foot with diffuse tenderness. It was noted the fractures of the fourth and fifth toes were healed, the fracture of the lateral malleolus was healed, and there was an avulsion fracture of the talus. He was to continue physical therapy.

On June 22, 2006 he was still complaining of foot pain and using a crutch and had mild tenderness. Range of motion apparently was improving and the diagnoses now were a foot strain and an avulsion fracture and he was to continue with therapy. He was to go to work with fewer restrictions which involved limited weight bearing-type activities.

On July 20, 2006 he was improving and had only minimum tenderness but there was slight swelling of the dorsal mid foot. The diagnoses were the same and physical therapy was to be stopped.

There is a narrative report from Dr. H which is a permanent and stationary report indicating the patient was seen on August 17, 2006. Again the history of the injury was that a forklift pushed a dolly loaded with scenery into his left foot and there had been pain and swelling since. He was currently complaining of no improvement and constant pain in the foot and he stated he could not stand on it for more than 30 minutes at a time and he was walking with a cane. There had been no previous similar injuries to the foot. The examination revealed no sensory abnormalities and sensation was intact in all dermatomes of the lower extremities. All muscles tested in both lower extremities were normal, reflexes were symmetrical and measurements of the lower extremities were symmetrical. Examination of the ankle and foot revealed no tenderness, although there was mild swelling of the mid dorsum and forefoot. There was some minimal tenderness of the dorsum of the foot in the area of the navicular and cuneiforms. (Please note: Within one paragraph it was stated there was no tenderness and then there is an area of minimal tenderness described.)

There was no instability, the toes moved well and inversion and eversion of the foot were normal. He was walking with a cane slowly but had only a minimal antalgic limp. X-rays did show the avulsion of the dorsum of the distal navicular. The diagnosis was a soft tissue injury of the foot and an avulsion fracture of the dorsum of the navicular. The causation was that work did contribute to the injury and apportionment was not applicable. Work restrictions recommended were that he avoids standing and walking 30 minutes at a time with a 30 minute break in between for sitting. He was to not do more than three to four hours a day of standing and walking and no more than 30 minutes at a time. Lifting would be limited to no more than 10 pounds frequently and occasionally 15 to 20 pounds. Future care would be anti-inflammatory medication and elevation but no other type of treatment was contemplated. Job duties were reviewed and it was felt lifting requirements may be excessive for the type of employment he had.

Dr. H did an AMA Impairment evaluation and indicated that the numbers would rate to a 3 % whole person impairment which he believed was more than indicated for the avulsion fracture and he would give him a 2% whole person impairment. (Please see my own rating of impairment in the discussion which follows.)

This concludes the permanent and stationary report prepared by Dr. H. (Please note: Through the time when he was considered permanent and stationary by his original treating orthopaedist in August 2006, more than five months after the injury, there is no mention of any part of the body being involved other than the ankle or foot.)

Records then skip to a report dated October 20, 2006 indicating the patient was seen on that date by orthopaedic surgeon Dr. E. This report states that he was being seen for the injury of March 8, 2006 in which he suffered injuries to “his left foot, neck and lower back.” (There is no prior mention of the neck or lower back in any available report.) It was noted the source of facts was the patient’s stated history, past history and the doctor’s physical examination. (There is no indication that Dr. E ever reviewed any previous medical records.)

It was noted his last day of work was March 10, 2006. The history of injury of March 8, 2006 was noted when a co-worker driving a forklift pushed him to the ground and he fell on his back and his left foot got caught under the dolly board. This report indicates the patient stated he was, “dragged for about 25 feet on the pavement.” (Please note: There is absolutely no history of any type of similar mechanism of injury of being caught and dragged in any earlier report and this would be a significant history that would not be omitted in the earlier records.) It was noted the co-worker driving the forklift helped him up. (Please note: The patient told the undersigned that the forklift was lifted off his foot and he was able to get up by himself.)

It was noted the driver refused to write a letter stating what happened. His boss was immediately informed and the patient was taken off work. He was sent to a company doctor and had x-rays only of the foot, “even

though he had neck and back pain." (Please note: There is no mention by any doctor that he had neck or back pain.)

It was noted that he was given a temporary boot and then told to come back a few days later and was told there would be an investigation. About a month later he was sent to see Dr. H who took x-rays and gave him pain medication but "ignored his neck and back pain." (Please note: There would be no reason for Dr. H to ignore complaints and there is no mention in the report of Dr. H that those other areas were mentioned.) It was noted that in April 2006 he returned to see Dr. H, was examined and the foot had not improved and he kept on using a boot. It was stated he complained of back pain and the doctor told him he did not have authorization from the insurance company to treat his back. (Please note: This is the patient's statement to Dr. E that is not substantiated by the records.) It was noted that Dr. H told the patient he would only treat his foot and the doctor stated he needed surgery on the foot and the foot was "out of alignment." (Please note: There was a displaced avulsion fracture, not a lack of alignment of the foot.) It was noted in May 2006 he started therapy to his right (sic) foot and had about 12 sessions. It was again stated that even though he complained of back pain he was not treated. It was stated the last therapy he received was in August 2006 when he was released from care as far as his foot was concerned and he had seen no other doctors since August 2006. He had not been treated at all for his back symptoms since the injury. (Please note: Throughout this history, although back symptoms are described along with foot symptoms, there is no ongoing discussion of other parts of the body being involved.) Under current complaints, however, it was stated he had neck pain and stiffness, constant back pain radiating to the legs aggravated by bending and weight bearing activities and he could not walk without a cane. He had strength and energy loss in his legs and arms. There was occasional dizziness and mental fatigue and constant right headedness (sic). There was also constant left foot pain with swelling and inability to bear weight on the left leg. (Please note: It sounds like he was completely unable to bear weight, yet he was walking.)

It was noted he did have a history of multiple sclerosis. It was stated he denied any other prior medical problems other than the multiple sclerosis and hernia surgery. It was stated he was in a prior auto accident in May 2005, injuring the neck, back and right shoulder, elbow and head. (There is no mention about whether or not he was treated or recovered from that accident of May 2005, less than one year before the current industrial injury.)

Under industrial injuries it was stated he had a fracture of the right pinky and left hand 10 years ago. (Please note: Similar to the history he gave the undersigned there is an omission of the history of the injury of March 11, 2005 that was a work injury involving the neck and back for which he was still on disability at the time of the auto accident in May 2005.)

This report also says he denied any prior non-industrial injuries on the same page where it was mentioned that he had an auto accident involving the neck, back and shoulder, elbow and head.

Physical examination revealed normal posture of the neck. There was tenderness of the paraspinal muscles and a positive cervical compression test. There was some slight limitation of motion of the neck in all directions. Upper extremity reflexes were normal and sensation was normal. The thoracic examination revealed tenderness and spasm. The lumbar examination revealed normal posture but there was paralumbar tenderness and muscle spasms. There was limited motion of the lower back in all directions. Leg raising was reportedly positive both seated and supine. (How far the leg could be elevated is not stated and whether or not the pain radiated into the lower extremity distal to the knee is not stated.)

It was stated that Fabere test was positive, a Valsalva and sciatic test were all positive but a number of other stretch tests were negative including Lasegue's sign. It was stated he was walking with a cane and heel and toe test produced pain but he was able to fully squat. (Please note: Squatting puts a great deal of stress on the ankle and foot, yet the patient could do it and there is no mention that it was painful to perform this maneuver.) It was noted reflexes were normal, sensation was intact in the lower extremities, and the vascular examination was normal. The ankle and foot revealed no swelling, deformity ó ecchymosis. There was tenderness of the foot but the location of the tenderness is not stated. There was no crepitus. There was

limited motion of the left ankle and foot in all directions. The diagnoses were a cervical, thoracic and lumbar sprain and strain and ankle and foot contusion and multiple sclerosis.

Authorization for medication and therapy was requested. It was felt that he did have an industrial injury and started to develop symptoms that require reasonable and necessary treatment. The patient was referred for therapy once a week for six weeks and it was recommended he have a neurological evaluation. It was felt he was temporarily totally disabled until the next evaluation.

A PR-2 report from the office where he was seen by Dr. E but produced by Dr. G indicates the patient was seen in that office on December 1, 2006. It was stated the foot and ankle had numbness and tingling and there was low back pain and neck pain and he was taking medication. There are some abbreviations I do not understand in the report but it was stated he had diminished ankle plantar flexion and there was tenderness of the cervical and lumbar muscles and limited neck flexion. The diagnoses were the same of a cervical and lumbar sprain and strain, a left ankle and foot contusion and multiple sclerosis. It was suggested he follow up with neurology at Kaiser and he was to continue getting therapy for his neck, back and left ankle. (He specifically told me that Dr. E was not providing him with any treatment for the ankle for foot.) He was kept on disability.

The next and most recent available report comes from neurologist Dr. M examined the patient on January 8, 2007. It was stated the patient was a fair historian. (Please note: There are a number of discrepancies in the various histories reported by this patient.)

The history of injury is different than that previously reported and says that on March 8, 2006 he was hit by an “A-frame.” Record review indicates he was injured when his left foot got caught under a heavy dolly. It was noted that in the original First Report of Work Injury there was no reference to any injury to the head, neck, shoulder or back. It was noted that at the Group where he was first seen he was only treated for the left foot. A good deal of the history comes from the records and it was noted he was subsequently seen by Dr. H whose diagnosis of a navicular avulsion and nondisplaced fracture of the lateral malleolus was noted. It was noted in October 2006 when he was seen by Dr. E he had neck pain and stiffness and back pain going down the legs and other symptoms such as loss of strength in the arms, dizziness and mental fatigue.

Dr. M noted the patient did have prior work-related injuries and in June 2002 injured the right lower extremity and there is a discussion about the evaluation by Dr. S and the Compromise and Release award for that right foot injury. It was also noted he was in a motor vehicle accident in May 2005 and had x-rays that showed degenerative changes.

Dr. M noted the report from Dr. W of November 2005. It was also noted that six or seven years ago the patient stated he had been told he had multiple sclerosis and his initial complaints were of diffuse weakness, impaired energy and impaired coordination. After an MRI, MS was diagnosed. He was currently seeing a doctor every six months at Kaiser and being treated with medication.

His current complaints were of left foot pain and the foot may swell and pain was increased with walking. There was also a complaint of neck and low back pain, lack of balance and dizziness at times. He was using the cane since March 2006 because of impaired balance and foot pain. Referable to the MS he was feeling tired and had intermittent numbness in the hands and legs and some lightheadedness with over- exertion, and memory problems at times.

Under past history it was noted he had a history of a broken right foot in 2002, a hernia in 2004 and bilateral hand injuries. He had had bilateral hernia surgery and bilateral hand surgery. He had the history of multiple sclerosis and was taking a number of medications. The auto accident of May 20, 2005 is noted and he had back and right ankle and foot injuries with residual back symptoms.

A number of records were reviewed which are the same records that were seen by the undersigned.

His mental status was intact and general neurological examination was normal. It was stated he did have a minimally widened base gait, some decreased ability to tandem walk and some difficulty walking on heels and toes because of poor balance. (There is no mention of any type of limp because of pain.) It was noted his strength was normal in the upper and lower extremities. He did report impaired sensation over the soles of his feet. Reflexes were all normal. It was felt there was no evidence of a work-related neurological injury.

In the discussion the doctor indicates as best as he could determine there was an injury when a dolly rolled over his left foot and he had a navicular fracture. It was noted there was no reference to any head injury or any injury involving the neck, low back, shoulder or elbow between March 2006 and October 2006. It appeared his first complaints of those symptoms were in October 2006. It was also noted in May 2005 he was in a motor vehicle accident with neck and low back injury and subsequent dizziness that were ongoing as of November 2005.

Dr. M clearly felt that except for symptoms related to the left foot the other symptoms he now complains of such as neck pain, low back pain, dizziness and elbow pain were present and pre-existent prior to the time of the work injury of March 2006. It was noted records documented the exact same complaints that were claimed at the time of a May 2005 accident. Additionally the patient had a history MS with symptoms related to that. It was stated there was no mechanism of injury that could have led to neurological damage as a result of the injury of March 2006. It was also noted he had a six to seven year history of multiple sclerosis which in no way was affected by what occurred at work in March 2006. In summary, it was felt that his foot was run over by a dolly and he had a navicular fracture and the only area injured in March 2006 was the left foot. He was treated from March to August for the left foot with no other complaints noted in the records. Two months after discharge by Dr. H he saw Dr. E and then complained of neck pain, back pain and other radicular complaints. Dr: E did not explain how this could be related to the foot injury of March 2006. Dr. M clearly states, “I find no evidence whatsoever of a work-related neurological injury that led to the development of any of the symptomatology other than that related to his left foot.” He felt there was no need for temporary partial or temporary total disability from a neurological standpoint or need for further diagnostic testing or treatment from a neurological standpoint. His only need for treatment or disability connected with the March 8, 2006 injury was from an orthopaedic standpoint for the left foot only.

Dr. M also states, “100% of any alleged disability in the other body parts are apportioned to residuals of his prior auto accident and MS.” He did not require vocational rehabilitation from a neurological standpoint. Future care and limitations for his left navicular fracture should be addressed by an orthopaedist.

This concludes the review of the submitted medical records. Additionally I have received a detailed job analysis from (employer) for the job title of Laborer. The job functions are described. Physical demands involved constant walking with a maximum at one time of four hours. There would be the occasional to frequent walking on uneven terrain lasting for seconds at a time and there would be occasional standing for up to one hour at a time. Squatting would be frequent to continuous for one minute. There would be occasional balancing above ground for 10 minutes. There would be constant lifting in the 26 to 50 pound category from waist to above shoulder level and occasional lifting of up to 100 pounds to waist level. There would be constant carrying of 26 to 50 pounds for up to 100 feet and occasional carrying of up to 100 pounds for distances of 10 feet. The other physical activities of the job would not involve his foot. (Please note: I would suggest that Dr. M discuss the non-industrial appropriateness of this patient’s ability to balance above ground level with reference to his multiple sclerosis, although this is completely unrelated to his industrial injury. It is also somewhat academic since the patient has fully retired.)

This concludes the review of records submitted about this patient.

Comment

After a review of the history as obtained directly from the patient and voluminous records that have been submitted, my physical examination and the x-rays available, it is my opinion that the above-captioned patient has the following orthopaedic conditions:

1. History of multiple minor fractures left foot (industrially related).
2. History of chronic cervical degenerative disc disease (non-industrial).
3. History of a chronic thoracolumbar sprain and strain (non-industrial).
4. History of chronic strain right shoulder and right elbow (non-industrial).
5. Multiple sclerosis (non-industrial).
6. History of prior right foot fractures (prior industrial injury).

This patient has reached maximum medical improvement and has been permanent and stationary for quite some time.

I believe that on the basis of the records submitted, this patient's left foot condition, which is the only area that was injured March 2006, has been permanent and stationary and has reached maximum medical improvement as of August 17, 2006 when he was considered permanent and stationary by Dr. B.

The injury in question of March 2006 will be evaluated by the AMA Impairment Guidelines, which are the appropriate rating methods considering the date of injury.

I concur with the assessment of Dr. B that because of this patient's left foot condition; he does have a 2% whole person impairment. It is noted that utilizing Page 547- Table 17-33 which refers to an intraarticular fracture with displacement of the talonavicular joint would be a 10% foot impairment; a 7% lower extremity impairment, and a 3% whole person impairment.

I concur with Dr. B that a lesser whole person impairment is indicated since this patient's fracture was not actually an intraarticular fracture, but rather an avulsion fracture from the dorsum of the bone where there is a capsular attachment. This was not an intraarticular fracture itself. I therefore believe that a slightly lesser impairment rating is appropriate.

This patient's other areas of injuries were all pre-existing and there is no indication that any of these pre-existing problems were actually aggravated by the injury of March 2006. I would concur with the reasoning of Dr. M that there was well-established difficulty long before the injury of March 2006. It was not until he saw Dr. H in October 2006, seven months after the injury in question, that there is any mention of symptoms in any part of the body other than the ankle and foot, related to the current injury.

With reference to the spinal complaints, it is noted that although there are no records available, they are referred to by Dr. T, indicating he had prior work-related injury on March 11, 2005 when he fell and had an injury involving his neck and back. The emergency room note on May 20, 2005, the day of the car accident and the reporting of Dr. T, indicates he was actually still on Workers' Compensation disability on May 20, 2005 because of his neck and back that were injured at work in March 2005. The accident of May 20, 2005 involved his neck, back, and right upper extremity and he was still having symptoms when he was discharged from care on November 15, 2005, less than six months before the current industrial injury.

All of his symptoms of weakness, dizziness, and lightheadedness are more appropriately attributed to his multiple sclerosis rather than to having a specific injury when his left foot was run over.

Further evidence that all of these conditions, other than his left foot condition, are pre-existing and are included in the report of x-rays of May 20, 2005 that showed that the degenerative changes in the cervical spine are the same as the degenerative changes currently noted.

It is therefore my opinion that all of his left foot and ankle conditions should be considered of industrial causation and related to the specific injury of March 8, 2006 without apportionment.

All of his other orthopaedic complaints including his neck, back, upper extremities, and right foot are completely unrelated to the injury when his left foot was run over and were pre-existing. All of his conditions other than for the left foot should be apportioned to non-industrial causation as it relates to the specific industrial injury of March 2006. There may have been industrial aggravation of his neck and back condition from the time when he fell previously as well as from the non-industrial automobile accident that occurred in 2005. The right foot condition is the result of an industrial injury and his claim for that right foot condition has been previously settled by Compromise and Release.

With reference to the treatment this patient has had in the past, I believe the treatment rendered by Dr. B was appropriate. It is noted that as a result of the treatment by Dr. B, he has had complete resolution and healing of the fractures of the lateral malleolus and of the proximal phalanges of the fourth and fifth toes. These fractures have healed uneventfully without residuals.

He still does have some slight displacement of the avulsion fracture of the dorsal navicular but although initially surgery was suggested for this condition, when the symptoms resolved sufficiently, it was felt that surgery was not necessary and I would concur that no further treatment is required for the avulsion fracture of his foot.

From a musculoskeletal standpoint I believe that the patient is fully capable of performing his usual and customary work as described in the submitted job analysis. He was doing this type of work when he was injured in March 2006 after all of his conditions other than for the left foot were fully established. I do not believe he has lost any of his pre-injury work capacity because of the injury to his left ankle and foot. I believe a period of temporary total disability for a few weeks after that injury in March 2006 was indicated and subsequently, I believe he would have been capable of returning to modified work by May of 2006. By August 17, 2006 when he was discharged from care by Dr. B, I believe he was physically capable of returning to his usual and customary work.

Whether or not he should be considered restricted from performing his usual and customary work that required balancing above ground level should be determined by the neurologist with reference to his multiple sclerosis, but would not be affected by his musculoskeletal complaints.

This may be academic since he has fully retired from gainful employment and does not intend to ever return to work.

In overall summary, from an orthopaedic standpoint with reference to his injury of March 2006, it is noted that the only part of the body that was injured was his left foot and ankle. He had multiple fractures. The fractures in the proximal phalanges of the fourth and fifth toes and the lateral malleolus have completely healed uneventfully. He does have some residual displacement of the fracture of the dorsal navicular which is tiny and does not cause any disability, although it does produce slight whole person impairment according to the AMA Impairment Guidelines. His past treatment by Dr. B through August 2006 was appropriate, but no treatment was required after that date. Although Dr. H states that the foot was being treated, the patient says that the foot was not being treated by Dr. H.

His foot condition is fully apportionable to the specific injury of March 2006. His other musculoskeletal conditions are completely unrelated to that injury. At the current time with reference to the foot injury, he could return to his usual and customary work but it is noted that he has retired from the open labor force.

The patient was seen at this time for orthopaedic evaluation purposes only. If there are any questions regarding these opinions, please do not hesitate to call upon me.

Please note, obtaining a history directly from the patient (with the assistance of an interpreter, if needed), reviewing and summarizing all records (if any), performing the entire physical examination and all measurements, reviewing x-rays (if any), and the preparation and dictation of this entire report were entirely and solely performed personally by the undersigned. The only exceptions were the measuring of vital signs and transcription of my personally dictated findings onto an office work sheet which were done

by (office manager), who has been my office manager and back office assistant for 20 years and has been instructed and monitored in these activities by me.

The time spent in connection with this evaluation was in compliance with any available guidelines.

Face to Face Time with Patient (History and Physical Examination)	= (List Time Spent)
Record Reviewing Time (Sorting, Reading, Summarizing)	= (List Time Spent)
Report Preparation Time (Dictation and Proof Reading)	= (List Time Spent)
Total Hours	Total = (Total Hours Spent)

I declare under penalty of perjury that there has not been a violation of Labor Code Section 139.3, that the contents of the report are true and correct to the best of my knowledge, and any statements concerning any bill for services are true and correct to the best of my knowledge.

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

Date_____ in the County of_____

Sincerely yours,

Joe QME
Diplomat of the American Board of Orthopaedic Surgery

CC: Adjustor
Referring Attorney