PAST MEDICAL CONDITION:, None.,ALLERGIES:, None.,CURRENT MEDICATION:, Zyrtec and hydrocodone 7.5 mg one every 4 to 6 hours p.r.n. for pain.,CHIEF COMPLAINT: , Back injury with RLE radicular symptoms.,HISTORY OF PRESENT ILLNESS:, The patient is a 52-year-old male who is here for independent medical evaluation. The patient states that he works for ABC ABC as a temporary worker. He worked for ABCD too. The patient's main job was loading and unloading furniture and appliances for the home. The patient was approximately there for about two and a half weeks. Date of injury occurred back in October. The patient stating that he had history of previous back problems ongoing; however, he states that on this particular day back in October, he was unloading an 18-wheeler at ABC and he was bending down picking up boxes to unload and load. Unfortunately at this particular event, the patient had sharp pain in his lower back. Soon afterwards, he had radiating symptoms down his right buttock all the way down to the lateral part of his leg crossing his knee. This became progressively worse. He also states that some of his radiating pain went down to his left leg as well. He noticed increase in buttock spasm and also noticed spasm in his buttocks. He initially saw Dr. Z and was provided with some muscle relaxer and was given some pain patches or Lidoderm patch, I believe. The patient states that after this treatment, his symptoms still persisted. At this point, the patient later on was referred to Dr. XYZ through the workmen's comp and he was initially evaluated back in April. After the evaluation, the

patient was sent for MRI, was provided with pain medications such as short-acting opioids. He was put on restricted duty. The MRI essentially came back negative, but the patient continued to have radiating symptoms down to his lower extremity and subsequently the patient was essentially released by Dr. XYZ in June with maximum medical improvement.,Unfortunately, the patient continued to have persistence of back pain and radiating symptoms down to his leg and went back to see Dr. XYZ again, and at this point, the patient was provided with further medication management and sent for Pain Clinic referral. The patient also was recommended for nerve block at this point and the patient received epidural steroid injection by Dr. ABC without any significant relief. The patient also was sent for EMG and nerve conduction study, which was performed by Dr. ABCD and the MRI, EMG, and nerve conduction study came back essentially negative for radiculopathy, which was performed by Dr. ABCD. The patient states that he continues to have pain with extended sitting, he has radiating symptoms down to his lower extremity on the right side of his leg, increase in pain with stooping. He has difficulty sleeping at nighttime because of increase in pain. Ultimately, the patient was returned back to work in June, and deemed with maximum medical improvement back in June. The patient unfortunately still has significant degree of back pain with activities such as stooping and radicular symptoms down his right leg, worse than the left side. The patient also went to see Dr. X who is a chiropractic specialist and received eight or nine visits of chiropractic care

without long-term relief in his overall radicular symptoms.,PHYSICAL EXAMINATION:, The patient was examined with the gown on. Lumbar flexion was moderately decreased. Extension was normal. Side bending to the right was decreased. Side bending to the left was within normal limits. Rotation and extension to the right side was causing increasing pain. Extension and side bending to the left was within normal limits without significant pain on the left side. While seated, straight leg was negative on the LLE at 90° and also negative on the RLE at 90°. There was no true root tension sign or radicular symptoms upon straight leg raising in the seated position. In supine position, straight leg was negative in the LLE and also negative on the RLE. Sensory exam shows there was a decrease in sensation to the S1 dermatomal distribution on the right side to light touch and at all other dermatomal distribution was within normal limits. Deep tendon reflex at the patella was 2+/4 bilaterally, but there was a decrease in reflex in the Achilles tendon 1+/4 on the right side and essentially 2+/4 on the left side. Medial hamstring reflex was 2+/4 on both hamstrings as well. On prone position, there was tightness in the paraspinals and erector spinae muscle as well as tightness on the right side of the quadratus lumborum area, right side was worse than the left side. Increase in pain at deep palpatory examination in midline of the L5 and S1 level.,MEDICAL RECORD REVIEW:, I had the opportunity to review Dr. XYZ's medical records. Also reviewed Dr. ABC procedural note, which was the epidural steroid injection block that was performed in

December. Also, reviewed Dr. X's medical record notes and an EMG and nerve study that was performed by Dr. ABCD, which was essentially normal. The MRI of the lumbar spine that was performed back in April, which showed no evidence of herniated disc.,DIAGNOSIS: , Residual from low back injury with right lumbar radicular symptomatology.,EVALUATION/RECOMMENDATION:, The patient has an impairment based on AMA Guides Fifth Edition and it is permanent. The patient appears to have re-aggravation of the low back injury back in October related to his work at ABC when he was working unloading and loading an 18-wheel truck. Essentially, there was a clear aggravation of his symptoms with ongoing radicular symptom down to his lower extremity mainly on the right side more so than the left. The patient also has increase in back pain with lumbar flexion and rotational movement to the right side. With these ongoing symptoms, the patient has also decrease in activities of daily living such as mobility as well as decrease in sleep pattern and general decrease in overall function. Therefore, the patient is assigned 8% impairment of the whole person. We are able to assign this utilizing the Fifth Edition on spine section on the AMA guide. Using page 384, table 15-3, the patient does fall under DRE Lumbar Category II under criteria for rating impairment due to lumbar spine injury. In this particular section, it states that the patient's clinical history and examination findings are compatible with specific injury; and finding may include significant muscle guarding or spasm observed at the time of examination, a symmetric loss of

range of motion, or non-verifiable radicular complaints define his complaints of radicular pain without objective findings; no alteration of the structural integrity and no significant radiculopathy. The patient also has decrease in activities of daily living; therefore, the patient is assigned at the higher impairment rating of 8% WPI. In the future, the patient should avoid prolonged walking, standing, stooping, squatting, hip bending, climbing, excessive flexion, extension, and rotation of his back. His one time weight limit should be determined by work trial, although the patient should continue to be closely monitored and managed for his pain control by the specific specialist for management of his overall pain. The patient although has a clear low back pain with certain movements such as stooping and extended sitting and does have a clear radicular symptomatology, the patient also should be monitored closely for specific dependency to short-acting opioids in the near future by specialist who could monitor and closely follow his overall pain management. The patient also should be treated with appropriate modalities and appropriate rehabilitation in the near future.,