[Date of Evaluation]

Chinweike Izeogu, M.D.
Anesthesiology & Pain Management
IME Office Location

[Carrier]

RE: CLAIMANT
DATE OF BIRTH: [DOB]
CLAIM NUMBER: [Claim Number]
DATE OF INJURY: [Date of Injury]
DATE OF EVALUATION: [Date of Evaluation]

To Whom It May Concern:

Ms. CLAIMANT was seen at your request for an Independent Pain Management Medical Evaluation on the date of evaluation, in the New Jersey office. Prior to initiating the evaluation, I explained to the claimant that our meeting was for evaluation purposes only and that I would not be rendering any treatment. In that regard, she understood that a doctor/patient relationship was not established.

HISTORY & TREATMENT:

Ms. CLAIMANT is a right-handed 58-year-old female who stated that she was injured on the date of injury. She stated that she was a restrained driver who was involved in a front-end motor vehicle accident. She states that she was stopped on the street when a school bus in front of her reversed and struck her vehicle. Airbags did not deploy and she did not lose consciousness. Police were called to the scene and she was transported to the emergency department by her husband on the day of the accident.

Ms. CLAIMANT stated that she sustained injuries to the cervical spine, lumbar spine, and left shoulder as a result of this accident. She states that she has had diagnostic testing including MRI of the cervical and lumbar spine and plain X-rays. She states that she received chiropractic therapy consisting of approximately 16 sessions. She was evaluated by an orthopedic surgeon for her left shoulder and was referred for physical therapy for the left shoulder. She was also evaluated by a pain management physician who reviewed her imaging studies and ordered a lumbar epidural steroid injection. She reports that she is no longer in active treatment.

CURRENT SYMPTOMS:

The claimant's current complaints began on the date of injury and include pain in her neck, lower back, and left shoulder. Her primary complaint is lower back pain that is constant, sharp and stabbing in character, rated at 9 to 10 out of 10 at its worst and 5 out of 10 at its best on a numeric

pain scale of 0 to 10 where 0 is no pain and 10 is the worst pain imaginable. She reports bilateral leg radiation, worse on the left, that is exacerbated by sitting, lying down, walking, and driving. She states the pain radiates down the left leg at night and wakes her from sleep. She denies headaches and dizziness. She reports sleep disturbance as an associated symptom.

ALLERGIES:

Penicillin and Betadine

MEDICATIONS:

Tylenol 600 mg as needed

PAST MEDICAL/SURGICAL HISTORY:

Hypertension, pre-diabetes. The claimant reports a prior motor vehicle accident approximately 20 years ago in which she sustained cervical and lumbar spine injuries. She denies any prior spine surgery. Prior left shoulder arthroscopy and prior left knee surgery.

SOCIAL HISTORY:

She denies a history of smoking. She reports occasional use of alcoholic beverages. She denies recreational drug use.

EMPLOYMENT HISTORY:

Ms. CLAIMANT is employed and has continued working full duty without restrictions since the motor vehicle accident.

PHYSICAL EXAMINATION:

A photo ID was used for identification purposes.

The examination demonstrated a female who was alert and well oriented to time and place. She ambulated with an antalgic gait favoring the left lower extremity. She presented as cooperative and pleasant and was in mild distress. No assistive devices were used.

The cervical spine exam demonstrated restricted range of motion with flexion to 35 degrees (normal 45 degrees), extension to 30 degrees (normal 45 degrees), left lateral flexion to 25 degrees (normal 45 degrees), right lateral flexion to 30 degrees (normal 45 degrees), left rotation to 50 degrees (normal 60 degrees), and right rotation to 40 degrees (normal 60 degrees). All motions were guarded and painful at end range. There was mild midline tenderness and left-sided paraspinal tenderness to palpation at the C3 through C6 levels. Left-sided trapezius and SCM spasm was noted. There were no spasms on the right. There was no cervical step-off or deformity. Spurling's test was negative bilaterally. Hoffman's sign was negative bilaterally.

Upper extremity exam showed normal motor strength in the C5/deltoids, C6/biceps, C6/wrist extension, C7/wrist flexion, C7/elbow extension, C8/finger flexion, T1/finger abduction, and

T1/interossei, all normal at 5/5 bilaterally. The neurological exam of the cervical spine showed deep tendon reflexes at the C5/biceps, C6/brachioradialis, and C7/triceps levels 2+ and symmetric bilaterally. Sensation to light touch was grossly intact in all four extremities. The joint examination of the bilateral shoulders, elbows, and wrists was normal with full range of motion and no crepitus noted. Bilateral shoulder range of motion was full and symmetric with flexion to 180 degrees, extension to 60 degrees, abduction to 180 degrees, internal rotation to 70 degrees, and external rotation to 90 degrees. Shoulder strength was 5/5 bilaterally for the deltoids, supraspinatus, external rotators, and internal rotators.

The thoracolumbar spine exam demonstrated restricted range of motion with flexion to 40 degrees (normal 60 degrees), extension to 10 degrees (normal 25 degrees), left lateral flexion to 15 degrees (normal 25 degrees), right lateral flexion to 20 degrees (normal 25 degrees), left rotation to 15 degrees (normal 30 degrees), and right rotation to 20 degrees (normal 30 degrees). All motions were guarded and painful at end range. There was no midline tenderness. There was moderate left-sided paraspinal tenderness to palpation at the L4-L5 level. There were no palpable spasms on the right. Lumbar lordosis was preserved. Heel and toe walking was antalgic. Straight-leg-raises were positive bilaterally at 45 degrees. Facet loading was negative. Crossed straight-leg-raise was positive, femoral stretch, and FABER tests were negative bilaterally. Valsalva maneuver was negative for the lumbar spine. Waddell's signs were absent.

The lower extremity neurological exam showed L2/hip flexion, L3/knee extension, L4/ankle dorsiflexion, L5/EHL dorsiflexion, and S1/plantar flexion all normal at 5/5 bilaterally. The L3/L4 patellar reflexes were 2+ and symmetric. The S1/Achilles reflexes were 1+ bilaterally and symmetric. Sensation to light touch was grossly intact in all four extremities. The joint examination of the bilateral hips, knees, and ankles was normal with full range of motion and no crepitus noted.

MEDICAL RECORD REVIEW:

1. Application for Benefits (NF-2) – [Date]
2. Police Report – [Date]
3. Vehicle photographs
4. JOHN DOE, MD – Emergency Department Progress Notes – [Date]
5. JOHN DOE, DC – Chiropractic Initial Evaluation – [Date]
6. JOHN DOE, DC – Chiropractic Progress Notes – [Multiple Dates]
7. JOHN DOE, PA-C / JOHN DOE, MD – Orthopedic Office Visit – [Date]
8. JOHN DOE, MD – Pain Management Office Visit – [Date]
9. MRI Lumbar Spine – [Date] (Radiology Facility, read by JOHN DOE, MD)
10. MRI Cervical Spine – [Date] (Radiology Facility, read by JOHN DOE, MD)

IMPRESSION:

Cervical strain resolved
Left shoulder contusion resolved

Degenerative lumbar spine disease
Chronic lumbar spine pain, aggravation of pre-existing condition

DISCUSSION:

Based on my examination and review of the submitted medical records, Ms. CLAIMANT sustained causally related cervical and left shoulder injuries as a result of the motor vehicle accident. Both of these diagnoses have been resolved. Her predominant ongoing complaint of lumbar spine pain with bilateral lower extremity radiation represents chronic degenerative lumbar spine disease that predates the accident and is supported by the imaging findings described below. She has reached maximum medical improvement from an interventional pain management perspective for the cervical spine and left shoulder.

The vehicle photographs submitted for review documented minimal visible damage to the claimant's vehicle, consisting of a minor dent to the license plate area. The officer on scene documented no visible damage to either vehicle. This low-energy mechanism is inconsistent with the breadth and severity of the lumbar complaints and bilateral radicular symptoms described by the claimant.

The emergency department records from the date of the accident are clinically significant. The examination performed at the treating emergency department documented a normal cervical spine with full range of motion and no paraspinal tenderness. The claimant denied radiculopathy, numbness, tingling, bowel or bladder dysfunction on that date. The lumbar spine X-ray obtained on the day of the accident demonstrated pre-existing disc space narrowing and degenerative changes at L3 through S1. These findings confirm that significant degenerative pathology was present at the lumbar spine prior to this accident.

The cervical spine MRI demonstrated multilevel disc herniations from C2-3 through C5-6 with associated annular tears, mild to severe central canal stenosis, and moderate to severe bilateral neural foraminal stenosis most pronounced at C3-4 and C4-5, with disc material abutting the ventral aspect of the cervical spinal cord without definite cord compression. The multilevel disc desiccation noted by the radiologist was characterized as appropriate for age. In the absence of prior cervical MRI for comparison and given the degree of multilevel degenerative changes documented by the radiologist as age-appropriate, these findings are consistent with pre-existing cervical spondylosis and are not causally attributable to the low-energy mechanism of this accident. Notably, my cervical neurological examination demonstrated full 5/5 motor strength at all myotomal levels bilaterally, intact sensation, and symmetric deep tendon reflexes at 2+, which is inconsistent with clinically significant radiculopathy from the described cervical disc pathology. Spurling's test and Hoffman's sign were both negative.

The lumbar spine MRI demonstrated disc herniations at L3-4, L4-5, and L5-S1 with associated annular tears, moderate central canal stenosis at L3-4, and severe bilateral neural foraminal stenosis at L3-4 and L5-S1, with impingement of the exiting left L3 nerve root at L4-5. The

radiologist's use of "chronic" in the clinical history and the presence of multilevel spondylotic changes are consistent with pre-existing degenerative disease rather than acute traumatic injury. The claimant's history of a prior lumbar epidural steroid injection at L4-5 with relief approximately ten years prior to the index accident, as reported to the treating pain management physician, further corroborates long-standing lumbar degenerative pathology at the same level currently under treatment. The current accident may have temporarily aggravated the claimant's pre-existing lumbar condition; however, the underlying degenerative disease is constitutional and not causally related to the motor vehicle accident.

My lumbar neurological examination demonstrated intact motor strength at 5/5 at all lumbosacral myotomal levels bilaterally. Sensation was intact. The L3/L4 patellar reflexes were 2+ bilaterally. The S1/Achilles reflexes were 1+ bilaterally, which is within acceptable limits and symmetric. Straight-leg-raises were positive bilaterally at 45 degrees, which at this angle is a nonspecific finding. FABER, crossed straight-leg-raise, and femoral stretch tests were negative. Waddell's non-organic signs were absent. These findings do not demonstrate objective evidence of active lumbar radiculopathy.

There is no evidence of radiculopathy on my physical examination of either the cervical or lumbar spine. All motor strength testing was 5/5 bilaterally at all myotomal levels. There are no objective signs of myelopathy on examination.

The chiropractic records document 16 sessions over approximately five weeks following the accident. The claimant reported gradual improvement in cervical and lumbar range of motion over the course of treatment. The chiropractic treatment rendered during the acute phase was medically necessary and consistent with evidence-based clinical guidelines. The claimant has reached maximum medical improvement for the cervical spine and left shoulder and does not require further chiropractic treatment for these diagnoses.

The orthopedic evaluation documented a left shoulder contusion with a positive impingement sign and restricted left shoulder range of motion. It is noted that the claimant has a documented history of prior left shoulder arthroscopy, which is directly relevant to any left shoulder causation analysis. On my examination today, left shoulder range of motion was full and symmetric bilaterally with normal strength at 5/5, consistent with resolution of the acute left shoulder contusion. No further treatment for the left shoulder is medically necessary or causally related to this motor vehicle accident.

The pain management evaluation documented cervical facet tenderness at approximately C4/5/6 with negative Spurling's and Hoffman's tests, intact bilateral upper extremity motor strength at 5/5, restricted lumbar range of motion, and positive bilateral lumbar facet loading. An L4-5 lumbar epidural steroid injection was ordered. Given that the lumbar MRI findings are consistent with pre-existing degenerative disease and that my neurological examination does not demonstrate objective radiculopathy, lumbar epidural steroid injections are not medically necessary or causally

related to this motor vehicle accident. Similarly, cervical facet joint injections, percutaneous neuromodulation therapy, and trigger point injections are not medically necessary or causally related to this motor vehicle accident.

The diagnostic studies performed in the course of treatment, including the lumbar and cervical spine MRIs, were medically necessary and consistent with evidence-based clinical guidelines given the persistence of symptoms. No additional MRI studies, CT scans, discograms, or radiographic testing are medically necessary at this time. Electrodiagnostic testing is not medically necessary.

Physical therapy is recommended for the lumbar spine, three times per week for six weeks, followed by re-evaluation by pain management. This represents the only treatment that is medically necessary and causally related to the temporary aggravation of the claimant's pre-existing lumbar condition. Further chiropractic intervention, acupuncture, percutaneous neuromodulation therapy, and TENS are not medically necessary or causally related to this motor vehicle accident for the cervical spine.

Ms. CLAIMANT continues to work full duty without restrictions. She does not require assistance with activities of daily living.

DME supplies, including braces, splints, and TENS units, are not medically necessary or causally related to this motor vehicle accident. Household help and special transportation are not medically necessary or causally related to this motor vehicle accident.

The claimant left the room in the same condition in which she arrived with no complaints or apparent signs of dissatisfaction regarding this examination.

The above opinions are based on my experience as an actively practicing Pain Management and Anesthesiology physician in combination with the history provided by the claimant, any medical records reviewed, physical exam performed and are consistent with standards of care as documented by guidelines published by the American Society of Interventional Pain Physicians.

All these questions have been answered to a reasonable degree of medical certainty.

Chinweike Izeogu

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