Alan, MD

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, CA 94538

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Impairment Rating Report

Patient: Thomas **File #:** 6129826

Referral Source

Company Name:

Address: 18625 Sutter Boulevard, Suite #500, Morgan Hill, CA 95037
Phone/Fax: Phone: (408) 782-1074 Fax: (951) 683-3539

Case Identifiers

Patient Name: Thomas Sample
Patient Address: Middlefield Avenue, Fremont, CA 94539
Social Security #:
Date of Birth: 07/05/1958
File #: 6129826
Claim #: 022
Date of Injury/Illness: 10/24/2006
Evaluation Date: 09/19/2007
Dominant Side: Left Side
Employer: City of Milpitas
Employer Address: 455 East Calaveras Boulevard, Milpitas, CA 95035

Thomas Sample reached Maximum Medical Improvement on 09/19/2007**.**

Total Whole Person Impairment: 11% WP

Medical History

Narrative History

Please note that nurse case manager Gillian, RN, JD, was present during this permanent and stationary evaluation.

DESCRIPTION OF INJURY:
Thomas Sample is a 49 year-old right-handed male police lieutenant for the city of Milpitas who, at work on 10/24/06, injured his left shoulder while using it to ram open a shut door. The patient felt sudden pain in his left shoulder and was unable to move his left arm for about 30 minutes. He experienced radiation of the pain down the lateral aspect of his left upper arm and up towards his left trapezius muscle. At first the patient tried Motrin, icing and heat, which only helped minimally. As his symptoms persisted, he sought medical attention by seeing

Dr. Sample on 11/2/06 at the Kaiser Fremont occupational medicine clinic.

CURRENT SYMPTOMS:
The patient has has 2/10 pain at his left shoulder with end range of motion movements. The patient also has discomfort at his left shoulder with prolonged shoulder flexion movements (i.e., long drives).

PAST MEDICAL HISTORY:
The patient denies any prior history of significant left shoulder injuries.

Medical Record Review

TREATMENT COURSE:
Upon initial evaluation Dr. Sample 's assessment was that the patient had a left shoulder and trapezius strain and instituted conservative medical management which included modified work, NSAIDs (Motrin) with Vicodin for breakthrough pain, Salonpas patches, and Flexeril for muscle spasms. Dr. Sample also ordered x-rays of the left shoulder, which took place that day and were within normal limits.

Unfortunately, these measures did not help significantly; the patient's left shoulder pain worsened and he also began experiencing numbness and tingling at the ulnar two fingers of his left hand and at the lateral aspect of his dorsal left forearm, with episodic sudden weakness in his left hand grip.

With regard to the patient's left shoulder, Dr. Sample suspected that the patient had a rotator cuff tear and ordered a left shoulder MRI, which took place on 11/13/06 and was positive for a focal full-thickness tear in the distal anterior supraspinatus tendon as well as fluid in the subscapularis bursa. Dr. Sample referred the patient to orthopedic surgery for operative intervention.

With regard to the patient's symptoms of nerve irritation, Dr. Sample 's assessment was that it could be due to cervical radiculopathy and/or brachial plexus injury and/or ulnar nerve entrapment at the cubital tunnel. He ordered a NCS/EMG of the patient's bilateral upper extremities, which was performed by outside physician Dr. Rhee on 12/5/06 and demonstrated electrodiagnostic evidence to support a bilateral ulnar neuropathy at the elbows, consistent with mild cubital tunnel syndrome as well as electrodiagnostic evidence to support a left median sensorimotor neuropathy and right median motor neuropathy at the wrist without axonopathy, consistent with moderate carpal tunnel syndrome. Although the patient's bilateral upper extremity NCS/EMG was consistent with cubital tunnel and carpal tunnel syndrome, Dr. Sample observed no signs of such syndromes with provocative physical exam tests. It should be noted that Dr. Sample also ordered x-rays of the patient's cervical spine, which took place on 11/9/06 and demonstrated moderately severe degenerative joint disease at the lower cervical spine; which pointed toward the possibility of cervical radiculopathy. This, coupled with inconsistency of cubital tunnel and carpal tunnel syndrome with the patient's mechanism of injury, led Dr. Sample to refer the
patient to a spine specialist for clarification of pathology.

As there was some time before the patient could be scheduled to see an orthopedic surgeon and a spine specialist, and as the patient's left shoulder pain was worsening, Dr. Sample increased the patient's pain medications from Vicodin to Norco and finally to Endocet, which was helpful. Physical therapy was also taking place, which was initially beneficial.

On 12/29/06 the patient saw orthopedic surgeon Dr. Cain, who recommended operative intervention, and on 1/18/07 the patient had an arthroscopic rotator cuff repair, subacromial decompression and bursectomy performed by Dr. Cain (in conjunction with orthopedic surgeon Dr. K).

On 1/17/07 the patient saw spine specialist Dr. Chen whose assessment was that the patient's intermittent left ulnar hand parasthesias were more likely due to cervical radiculopathy and less likely due to focal ulnar nerve entrapment at the elbow, especially given his mechanism of injury. Dr. Chen recommended a MRI of the cervical spine for clarification, which Dr. Sample agreed with; it took place on 2/15/07 and demonstrated marked narrowing at the C6-7 disc space with uncinate spurring that encroached on the foramina bilaterally as well as posteriolateral disc protrusion on the left. Dr. Sample recommended referral to neurosurgery, and on 4/5/07 the patient saw Dr. Erasmus, who evaluated the studies and whose assessment was that no surgical intervention was indicated; the patient's neck stiffness and pain with intermittent left ulnar hand parasthesias and weakness was consistent with a left brachial plexus injury, which should improve with time.

The patient's left shoulder pain improved significantly after the arthroscopic surgery, and he soon no longer required opioids for pain. Post-operative physical therapy began on 2/12/07 and the patient rehabilitated very well; his range of motion and strength returned close to pre-injury levels and by 5/14/07 he returned to regular work duties, which he has since tolerated.

The patient's neck stiffness and pain with intermittent left ulnar hand parasthesias and weakness also resolved toward baseline levels, which was facilitated by acupuncture treatments. Furthermore, NCM Gillian Hames recommended a workstation evaluation to prevent future flare-ups from his neck injury, which, especially as the patient's job involves spending 90-95% of the time behind a desk, Dr. Sample agreed with. The workstation evaluation took place and the recommended changes were implemented, which was helpful.

As the patient's left shoulder pain, strength and range of motion improved to close to pre-injury levels and his neck stiffness and pain with intermittent left ulnar hand parasthesias and weakness resolved toward baseline, it became apparent to Dr. Sample that the patient was approaching maximal medical improvement and therefore a permanent and stationary evaluation was scheduled.

JOB DESCRIPTION:
As a police lieutenant for the city of Milpitas, the patient's job duties include managing the traffic enforcement unit, which predominantly involves desk work. The patient does on occasion go onto the field for law enforcement duties. In summary, these job duties require frequent (3-6 hours per 10 hour workday) static neck posturing and repetitive use of either upper extremity; some (<1 hour per 10 hour workday) gripping/grasping with either hand, forceful use with either upper extremity, pushing/pulling with either arm, reaching at/above shoulder level, and lifting/carrying (which, on occasions such as arrests and rescues, can be upwards of 250 pounds).

MEDICATIONS:
The patient occasionally takes OTC Motrin for his left shoulder pain.

Clinical Evaluation

Physical Examination

The patient is in no acute distress. With regard to his neck, inspection reveals no gross abnormalities; there is no tenderness to palpation at the paracervical or trapezius muscles; range of motion is within normal limits; sensation to light touch is within normal limits; and the Spurling test is negative bilaterally. With regard to his left shoulder, inspection reveals scars from his arthroscopic surgery; there is no significant tenderness to palpation; range of motion is very close to baseline (forward flexion is to 150 degrees whereas with right shoulder it is to 160 degrees, abduction is to 145 degrees whereas with right shoulder it is to 150 degrees; please refer to "Impairment Rating and Rationale" section of this report for more details); supraspinatus, infraspinatus and subscapularis are at 5/5 strength; sensation to light touch is within normal limits; and the Hawkins, cross-body adduction test and Yergason's are all negative. Please note that the slight limitations in the patient's left shoulder range of motion were not due to pain or fear of pain.

Diagnostic Studies

11/2/06 x-rays of the left shoulder: The soft tissues are within normal limits. Joint spaces are preserved. No significant bony abnormalities are seen. There is no evidence of fracture or subluxation. Impression: normal examination.

11/9/06 x-rays of the cervical spine: There is partial fusion of the C3-C4 vertebrae consistent with a congenital anomaly. There is moderately severe narrowing of the C5 through C7 disc spaces with associated mild vertebral body spurring. There is mild narrowing of the neural foramina in the lower cervical spine due to osteophytic spurring. Mild narrowing of the right C3 and C4 foramina is likely positional and lies at the level of the fusion anomaly. Impression: 1) Moderately severe DJD lower cervical spine.

11/13/06 MRI of the left shoulder: Impression: 1) Focal full-thickness tear in the distal anterior supraspinatus tendon without significant atrophy or retraction. 2) Fluid in subscapularis bursa may represent bursitis.

12/5/06 bilateral upper extremity NCS/EMG (outside physician Dr. Rhee): Impression: 1) There is electrodiagnostic evidence to support a bilateral ulnar neuropathy at the elbows, consistent with mild cubital tunnel syndrome; please correlate clinically; 2) There is electrodiagnostic evidence to support a left median sensorimotor neuropathy and right median motor neuropathy at the wrist without axonopathy, consistent with moderate carpal tunnel syndrome; please correlate clinically.

Final read on 2/15/07 MRI (Fremont Imaging Center) of the neck: Impression: 1) Congenital fusion of C2 and C3 with essentially obliteration of this disc space. 2) Broad-based mildly bulging disc at C4-5 causing mild impression on the anterior aspect of the subarachnoid space. 3) Moderate narrowing at the C5-6 disc space with a moderate impression on the anterior aspect of the subarachnoid space by mild disc protrusion/osteophyte complex. This abuts the anterior aspect of the cord, however, does not compress the cord. 4) Marked narrowing at the C6-7 disc space with a moderate posterolateral protrusion of disc on the left, probably associated with endplate hypertrophic changes as well. This causes a moderate impression on the subarachnoid space and abuts and appears to mildly compress the cervical cord on the left. No abnormal signal intensity in the underlying cord. There appears to be moderate encroachment on the intervertebral foramina bilaterally at C6-7 by uncinate spurs, and there is some contribution to the encroachment on the left by the posterolateral disc protrusion.

Diagnosis

719.51 - jt stiffness nec-shlder
V45.89 - postsurgical states nec
354.0 - carpal tunnel syndrome
722.10 - lumbar disc displacement

Impairment Rating and Rationale

Shoulder: Range of Motion	Ch 16, pp 450-454 and 474-479 (Figures 16:38-16:46)	L: 0% UE / R: 0% UE
Hand: Amputation	Ch 16, pp 440-444 (Table 16:4, Figures 16:2-16:5)	L: 20% Hand / R: 0% Hand

After the values from each region/body system are expressed in %WP, they are combined to produce the Total Whole Person Impairment.

Whole Person Impairment: 11%

Amputation

Digits

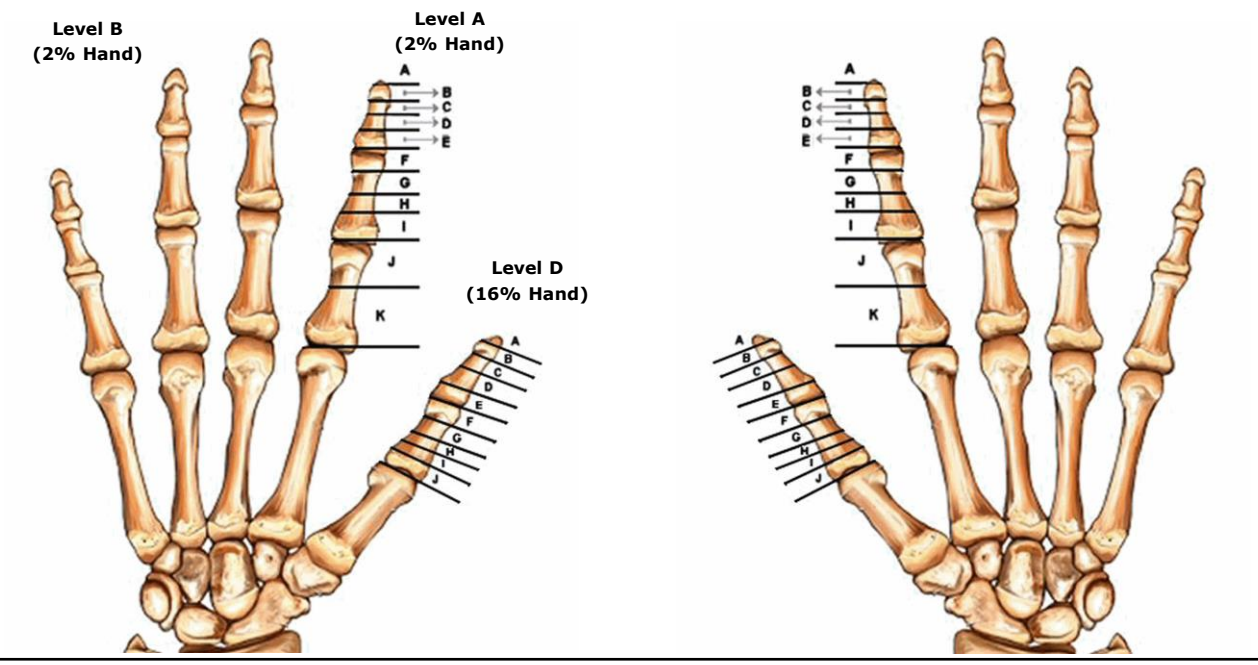
This portion of the evaluation was conducted by Alan Sample , MD on 6/21/2012.

Impairment Rating Report

Patient: Thomas Sample **File #:** 6129826

Involved Side: Left **Previous Injury:** No

(Left Hand Posterior View) (Right Hand Posterior View)



Impairment Calculation/Discussion

Refer to AMA Guides, 5th Edition, Chapter 16, pp 440-444 (Table 16:4, Figures 16:2-16:5)

Calculated Impairment		Assigned Impairment	
Left: 20% Hand	Right: 0% Hand	Left: 20% Hand	Right: 0% Hand
Left: 18% UE	Right: 0% UE	Left: 0% UE	Right: 0% UE

Range of Motion/Ankylosis

Shoulder Range of Motion/Ankylosis

This portion of the evaluation was conducted by Alan Sample , MD on 9/19/2007.

Involved Side: Left **Previous Injury:** No

Impairment Rating Report

Patient: Thomas Sample **File #:** 6129826

Left Side

	Flex	Ext	Ank
Angle	145	50	
Impairment	2%	0%	
	Abd	**Add**	**Ank**
Angle	150	40	
Impairment	1%	0%	
	Int Rot	**Ext Rot**	**Ank**
Angle	80	90	
Impairment	0%	0%	

Right Side

	Flex	Ext	Ank
Angle	150	50	
Impairment	2%	0%	
	Abd	**Add**	**Ank**
Angle	160	40	
Impairment	1%	0%	
	Int Rot	**Ext Rot**	**Ank**
Angle	80	90	
Impairment	0%	0%	

Impairment Calculation/Discussion

Refer to AMA Guides, 5th Edition, Chapter 16, pp 450-454 and 474-479 (Figures 16:38-16:46)

All range of motion impairment values are added.

Impairment

Left: 0% UE Right: 0% UE

Total Left Upper Extremity Impairment

18% UE (or 11% WP)

Total Right Upper Extremity Impairment

0% UE (or 0% WP)

Activities of Daily Living

1. With regard to performing personal self care including washing, dressing, using the bathroom, etc., the patient can look after himself normally but has extra discomfort.
2. The patient has some difficulty (but can still perform the activity well enough) with reaching and grasping something off a shelf overhead.
3. The patient has some difficulty (but can still perform the activity well enough) with pushing and pulling activities.
4. The patient has some difficulty (but can still perform the activity well enough) with repetitive activities such as typing or keyboarding.
5. The patient has some difficulty (but can still perform the activity well enough) with forceful activities with his arms and hands.
6. The patient's pain is mild at the moment.
7. The patient's pain interferes with his ability to travel (driving for long distances causes discomfort at his left shoulder).
8. The patient's pain interferes with his ability to engage in recreational activities such as weight lifting, basketball and other throwing sports.
9. The patient's pain interferes with his concentrating and thinking some or a little of the time.

Patient expressed having difficulty with Communication in the following activities;

Typing

Patient expressed having difficulty with Physical Activity in the following activities;

Standing

Patient expressed having difficulty with Self Care, Personal Hygiene in the following activities;

Urinating

Discussion

IMPRESSION:
1. Mild residual left shoulder stiffness following 1/18/07 arthroscopic left rotator cuff repair, subacromial decompression and bursectomy performed for treatment of work-related left rotator cuff tear.
2. Intermittent left ulnar hand parasthesias and weakness due to work-related left brachial plexus injury, resolved.

Recommendations

FUTURE MEDICAL TREATMENT:
If the patient has a flare-up of his work-related left shoulder pain in the future, he may need to see a physician and/or a physical therapist. In the future, he may elect to use presription analgesic medications on an as-needed basis. From a clinical standpoint, no repeat surgical intervention at the left shoulder is indicated at this time; however, should his work-related left rotator cuff repair fail in the future, he should be evaluated by an orthopedic surgeon.

Work Ability/Restrictions

At this time, the patient is tolerating his usual and customary work duties.

Causation and Apportionment

Based on Labor Codes 4663 and 4664, it is my professional medical opinion that there is no apportionment to causation or any other factors relating to the present industrial injury that I have been asked to evaluate. This injury, which is either acute or cumulative in nature and subsequent impairment is 100% attributable to the industrial injury that occurred on 10/24/2006.

Disclosure Statement

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

I further declare under penalty of perjury, that I personally performed the evaluation of the patient and that, except as otherwise stated herein, the evaluation was performed and the time spent performing the evaluation was in compliance with the guidelines, if any, established by the Industrial Medical Council or the administrative director pursuant to paragraph (5) of subdivision (j) of Section 139.2 or Section 5307.6 of the California Labor Code.

I further declare under penalty of perjury, that I have not violated the provisions of California Labor Code Section 139.3 with regard to the evaluation of this patient or the preparation of this report. I have not offered, delivered, received, or accepted any rebate, refund, commission, preference, patronage, dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for any referred examination or evaluation.

I further declare under penalty of perjury, that no one has performed any services in connection with the report, including diagnostic studies, other than clerical preparation. I further declare under penalty of perjury, that I devote annually greater than 1/3 of my time to medical treatment. I have not violated Labor Code 139.3, and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under the penalty of perjury.

The opinions rendered in this report are based on the information available to me at the time of this evaluation. If further information is required to be reviewed, I reserve the right to change my opinion.

Alan Sample ,