



MEDICAL EXAMINATION

MANUAL

Ohio | Industrial Commission

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 **Ohio** | Industrial Commission

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The Ohio Workers' Compensation System has provided Injured Workers with medical care and financial compensation for work-related injuries, diseases, and deaths since 1913. The Bureau of Workers' Compensation (BWC) is the administrative branch of this system, managing claims, collecting employer premiums, and paying bills. The Industrial Commission of Ohio (Commission) is the adjudicatory branch of this system.

This Manual presents Commission policies for independent medical examinations and medical file reviews. The purpose of the independent medical examination (IME) is to determine the degree of impairment resulting from an allowed work injury. Most examinations are to assist the Commission in the consideration of Permanent Total Disability (PTD). The first section of the manual explains administrative and examination policies common to all Commission independent examinations and file reviews. The remaining six sections of the manual describe specific examination requirements for evaluating various body parts, regions, or organ systems affected by an industrial injury or disease, and some special considerations related to maximum medical improvement.

We encourage specialist examiners and other interested parties to share ideas they believe may improve the system. Call the Commission Medical Advisor at 614.466.4291 with any questions.

GENERAL CONSIDERATIONS

ADMINISTRATIVE POLICIES

Legal Status

Examiners are independent contractors. Referral for medical review or examination represents a single fee-for-service commitment for the Commission and the examiner. The Commission requires examiners maintain professional liability insurance with \$1 million per incident and \$1 million annual aggregate.

Examination Observers

Injured Workers may have a relative present at their examination if so desired.
Legal representatives may not be present at examinations.

Recording Examinations

Electronic recording equipment is not permitted in the examination room.

Interpreter

The Commission will provide interpreters on request when a hearing impairment or language barrier exists.

Chaperone

Examinations should be conducted with a chaperone present when appropriate.

Impartiality

Examinations are to be performed by physicians and psychologists with no bias or conflict of interest with respect to the Injured Worker, the employer, or the workers' compensation system.

Examiners are excluded from performing specialist examinations when they have examined the Injured Worker or reviewed the claim file for the employer, the Injured Worker, the Bureau of Workers' Compensation or the Industrial Commission within three years of the filing date of an application for permanent total disability. Physicians and psychologists are also excluded from performing specialist examinations when they have a contractual relationship with the Injured Worker, employer, or their representative, or have been the physician of record for the Injured Worker.

An examiner who does not meet the impartiality requirements will decline to examine the Injured Worker. The Injured Worker will then be rescheduled with an impartial examiner.

Commission examinations are independent examinations. No authorization for treatment of the Injured Worker is implied or given in the Commission's request for examinations.

Physicians or psychologists performing examinations for the Commission may not communicate with the Injured Worker other than during the examination and may not accept the examined Injured Worker into treatment. Additionally, they may not communicate with the employer, the Bureau of Workers' Compensation or representatives of the Injured Worker or employer.

Timeliness of Reporting

In consideration for all parties involved, reports are due within ten business days of the examination. Late reports may result in suspension or dismissal from the specialist examiners' panel.

Deposition Policy

Parties to the claim must request Commission approval to schedule a specialist examiner deposition on her/his Independent Medical Examination. The party requesting this administrative deposition must state the reason for the deposition and must pay all deposition costs, including a fee (see below) to the specialist examiner who is to be

deposed. The requesting party must also provide an estimate of the time period required for deposition.

Commission policy prohibits pre-deposition conference between the physician and any party to the claim.

The requesting party must pay \$700 to the specialist examiner one week prior to the deposition date. If the deposition is cancelled with two business days’ notice, the examiner will refund this fee. With less notice, the physician may keep this fee. Depositions requiring more than one hour may be billed by the specialist examiner at the rate of \$350 per hour, in fifteen minute increments.

An Industrial Commission Hearing Officer usually attends administrative depositions held in Ohio. This hearing officer controls the deposition by determining the appropriateness of questions and whether the physician must answer. However, this hearing officer does not represent the physician in the deposition.

When a claim is pending in court, administrative deposition rules no longer apply. In a court deposition, civil rules of procedure and of evidence apply. Physicians having questions regarding court depositions should contact the Workers’ Compensation Section of the Attorney General’s office at 614.466.6696.

Addenda

In circumstances where additional information becomes available after the time of an examination, the examining specialist may be requested to provide an addendum to the original report. Specialists may charge \$200 per hour prorated in fifteen minute increments up to a maximum of \$200 for time spent preparing these addenda.

Interrogatories

Interrogatories are written questions submitted to examiners by Injured Worker/employer legal representatives and must be answered. Interrogatories must be submitted to the Commission for approval. Specialists may charge \$200 per hour prorated in fifteen minute increments up to a maximum of \$600 for time spent preparing their response.

AMA Guide References by Specialty

The following table summarizes the appropriate references for Industrial Commission examinations by specialty:

Specialty Description	AMA Guides Edition
Internal Medicine	Fifth
Neurology	Fifth
Occupational Medicine	Fifth
Orthopedics	Fifth
Physical Medicine & Rehab	Fifth
Psychiatry/Psychology	Second and Fifth
Pulmonary Disease	Fifth
Neuropsychologist	Second and Fifth
Cardiovascular Disease	Fifth
Dental Surgery	AAOMS*
Dermatology	Fifth
Otorhinolaryngology	Fifth
Gastroenterology	Fifth

Specialty Description	AMA Guides Edition
Ophthalmology	Fourth
Rheumatology	Fifth
Urology	Fifth
Allergy	Fifth
Endocrinology	Fifth
Maxillofacial Surgery	AAOMS*
Oncology	Fifth
Vascular Surgery	Fifth
Anesthesiology	Fifth
Gynecology	Fifth
Plastic Surgery	Fifth
General Surgery	Fifth

* American Association of Oral and Maxillofacial Surgeons’ Guidelines to the Evaluation of Impairment of the Oral and Maxillofacial Region, 2002

DEFINITIONS AND SOME LEGAL CONSIDERATIONS

Injury

Ohio Workers' Compensation law states, for injuries occurring on or after August 25, 2006,

" 'Injury' includes any injury, whether caused by external accidental means or accidental in character and result, received in the course of, and arising out of, the injured employee's employment. 'Injury' does not include:

1. Psychiatric conditions except where the claimant's psychiatric conditions have arisen from an injury or occupational disease sustained by that claimant or where the claimant's psychiatric conditions have arisen from sexual conduct in which the claimant was forced by threat of physical harm to engage or participate.
2. Injury or disability caused primarily by the natural deterioration of tissue, an organ, or part of a body.
3. Injury or disability incurred in voluntary participation in an employer sponsored recreation or fitness activity if the employee signs a waiver of the employee's right to compensation or benefits under this chapter prior to engaging in the recreation or fitness activity.
4. A condition that pre-existed an injury unless that pre-existing condition is substantially aggravated by the injury. Such a substantial aggravation must be documented by objective diagnostic findings, objective clinical findings, or objective test results. Subjective complaints may be evidence of such a substantial aggravation. However, subjective complaints without objective diagnostic findings, objective clinical findings, or objective test results are insufficient to substantiate a substantial aggravation."

For injuries occurring prior to August 25, 2006,

" 'Injury' includes any injury, whether caused by external accidental means or accidental in character and result, received in the course of, and arising out of, the injured employee's employment. 'Injury' does not include:

1. Psychiatric conditions except where the conditions have arisen from an injury or an occupational disease.
2. Injury or disability caused primarily by the natural deterioration of tissue, an organ, or part of a body.
3. Injury or disability incurred in voluntary participation in an employer-sponsored recreation or fitness activity if the employee signs a waiver of the employee's right to compensation or benefits under this chapter prior to engaging in the recreational or fitness activity."

Allowed Condition(s)

Industrial injuries become allowed conditions in workers' compensation claims as follows: When an injury occurs, a first report of injury (FROI-1) is filed with the Bureau of Workers' Compensation (BWC). The Bureau of Workers' Compensation reviews accident reports from the Injured Worker and the Employer as well as the medical treatment information, and allows or denies the claim within 28 days. When approved, the allowed condition becomes the legal basis for the Injured Worker's claim for compensation.

There may be multiple allowed conditions in one claim and multiple claims for one worker.

Impairment

The Ohio Supreme Court defines impairment as, "the amount of the Injured Worker's anatomical and/or mental loss of function caused by the allowed condition." It is the responsibility of the examining specialist in Permanent Total Disability examinations to provide an estimated percentage of whole person impairment arising from the allowed conditions in the claim, and to provide a discussion setting forth the physical or mental limitations resulting from the allowed conditions.

Disability

The Ohio Supreme Court defines disability as "the effect the impairment has on the claimant's ability to work," based on the allowed conditions in the claim. The Commission considers impairment arising from the allowed conditions, and disability factors (age, education and work training/experience) in determining Permanent Total Disability (PTD). Disability factors are not to be considered by the examining specialist when formulating opinions regarding percentage of impairment or physical or mental limitations resulting from the allowed conditions. Considering disability factors or impairment resulting from non-allowed conditions will disqualify the report.

Maximum Medical Improvement

A treatment plateau (static or well stabilized) where no fundamental or physiological change can be expected within reasonable probability, in spite of continuing medical or rehabilitative procedures. An Injured Worker may require supportive treatment to maintain this level of function.

In some circumstances, at the time of the Independent Medical Examination, it has already been determined by Industrial Commission order that the Injured Worker has reached maximum medical improvement. For these cases, please refer to the section **Maximum Medical Improvement- Special Considerations** on page 99.

Acceptance of Allowed Condition(s)

Allowed condition(s) are the legal basis of each claim. It is essential to the legal integrity of an Independent Medical Examination that examiners accept the allowed condition(s) in the claim. That is, the examiner should not question the validity of the allowed condition(s). The purpose of the Independent Medical Examination is to evaluate whether the allowed condition(s) have reached a level of maximum medical improvement (a plateau), and determine if and how much impairment has resulted from that condition(s).

Base opinion(s) solely on impairment arising from the allowed condition(s) highlighted on the Industrial Commission - Medical Exam Worksheet for each specialist examiner. *If current examination findings fail to confirm the presence of an allowed condition(s), examiners should state there is no evidence of impairment from the allowed condition(s) at the time of this examination. Examiners may not state that there is no evidence of the allowed condition(s).* This constitutes a denial of an allowed condition(s) and may disqualify the examination as "some evidence" at hearing or in court.

Causation

Opinions implying or stating that the industrial accident or exposure did not or could not cause the allowed condition(s) will disqualify the report as evidence at hearing.

Clinical Findings

Reports must present the objective clinical findings to support the physician’s opinion. These findings “shall be of sufficient quantity that they will hold true in fifty-one percent or more of similar cases.”

Possibilities are not acceptable as clinical findings as they are true less than fifty percent of the time.

Review of Pertinent Medical Records

The examiner is required to review pertinent medical records such as treatment(s), diagnostic testing, and examinations 36 months prior to the Injured Worker’s application for Permanent Total Disability. In some cases this may not be adequate and additional records may be provided.

EXAMINATION SCHEDULING

Medical Services in the Columbus office schedules all initial medical examinations. Regional offices reschedule examinations in case of cancellations, etc. Please direct questions to the scheduling office identified in the referral letter. Consult the Information Directory of Commission Offices for office addresses, fax and telephone numbers.

The following information is sent to examiners prior to examination:

- Medical Examination Referral Letter– states the examination issue and Commission requirements.
- Industrial Commission - Medical Exam Worksheet – the allowed conditions in the claim to be addressed by the examiner are highlighted. In addition, all treating, examining, or reviewing physicians are listed, enabling the assigned examiner to determine whether impartiality conflicts exist.
- Material evidence submitted by the employer and the Injured Worker for consideration at hearing.
- Examinations performed within 36 months prior to the filing date for permanent total disability.
- Statement of Facts – This is a Commission document providing a comprehensive summary of data, including: allowed claims, disallowed claims, claim number(s), allowed conditions, testing, treatment, disability factors and other pertinent information.
- Injured Worker’s Application for Permanent Total Disability – may provide useful information to the examiner regarding the applicant’s current ADLs and medical history.

Examples of the Medical Examination Referral letter, Industrial Commission - Medical Worksheet, Statement of Facts, Permanent Total Disability Application, and appropriate forms: Physical Strength Rating, Occupational Activity Assessment, and Residual Function Assessment are shown on the following pages.

STATE OF OHIO
THE INDUSTRIAL COMMISSION OF OHIO

MEDICAL EXAMINATION REFERRAL

SAMPLE

Doctor:

Specialty:

Date & time of exam:

Injured Worker:

Claim number(s):

The above Injured Worker has been referred to you for an independent medical evaluation to assist the Industrial Commission in its consideration of the Injured Worker's application for a determination of Permanent Total Disability. Pertinent medical records are enclosed. Based solely on the allowed condition(s) within your specialty, which are highlighted on the enclosed Medical Examination Worksheet, provide opinions on the following issues:

1. **Maximum Medical Improvement.** Please refer to your specialty section of the Medical Manual for complete instructions.
2. **Percentage of Impairment.** Please refer to your specialty section of the Medical Manual for complete instructions.
3. **Complete the enclosed form (Physical Strength Rating, Occupational Activity Assessment, Residual Functional Assessment) specific to your specialty.** Please refer to your specialty section of the Medical Manual for complete instructions.

Information on allowed testing is reflected in the Medical Examination Manual. Examiners may not treat examinees, as this ends their independent examiner status. Industrial Commission Policy states that independent medical examiners may have no contact with any parties to the claim other than the Injured Worker during examination.

Within ten business days from the date of examination, forward your signed typewritten report, the appropriate form, and your fee bill to the address below. Use official letterhead or white paper and our pre-addressed envelope for mailing.

If the Injured Worker fails to keep the appointment, or if you have other questions, please call *(telephone number will be provided)*.

In this space will appear the name and address of the regional office for report mailing.

DATE MAILED:

STATE OF OHIO
THE INDUSTRIAL COMMISSION OF OHIO
MEDICAL EXAM WORKSHEET

Claim Number: 93-00000

Heard with: 87-00000

Injured Worker's Name:

Street Address:

City, State, Zip Code:

Employer's Name:

Date of Birth:

Sex:

SSN:

Date of Injury/Disease:

Date of Death:

Claim Allowance(s):

93-00000	12/23/93	CERVICAL; STRAIN/SPRAIN; C6-7 DISC HERNIATION; BULGING DISC C5-6.
87-00000	1/23/87	SECOND DEGREE BURNS TO LEFT HAND AND NUMBNESS LEFT HAND; POST TRAUMATIC STRESS DISORDER AND SOMATOFORM DISORDER.

PLEASE EXAMINE ON HIGHLIGHTED CONDITIONS ONLY

Previous Physician(s): G. Gallucci, A. Krudy, L. Boulware, D. Braun, E. Ross, R. Corn, T. Craig, D. Lyons, R. Anschuetz, M. Allen, E. White, M. Leeb, A. Prochaska, F. Zahrawi, S. Kaffen, R. Lebham, L. Shapiro, J. Kenny, J. Fierro, R. Katzman, L. Leone

Number of Examiner(s): 02

Type(s): OCCMD, PSYCH

Examination Issue: ME5 (Permanent Total Disability)

Other Questions: _____

STATE OF OHIO
THE INDUSTRIAL COMMISSION OF OHIO

STATEMENT OF FACTS

Injured Worker:

Claim Number(s):

Issue: Application for permanent and total disability, filed.

1) Claim Number:

Employer:

Allowed condition(s):

Disallowed condition(s):

Date of injury:

Occupation at time of injury:

Description of injury:

Diagnostic tests within three years of IC-2 filing:

1. (ECM document date:)

Surgeries:

1. (ECM document date:)

Paid: Total Indemnity:

Total Medical:

Last Date of Temporary Total Compensation:

% Permanent Partial Disability:

Injured Worker's Medical Evidence:

1. (ECM document date:)

Employer's Medical Evidence:

1. (ECM document date:)

BWC Medical Evidence:

1. (ECM document date:)

Medical Evidence Obtained by the Industrial Commission:

1. (ECM document date:)

Continued on Next Page

STATE OF OHIO
THE INDUSTRIAL COMMISSION OF OHIO
STATEMENT OF FACTS CONTINUED

DISABILITY FACTORS FROM SOURCES OTHER THAN THE IC-2:

- | | |
|---|-------------------|
| 1. Age: | Date Last Worked: |
| 2. Education: | |
| 3. Previous Occupations and Work Experience: | |
| 4. Special Training and/or Special Vocational Skills: | |
| 5. Other Relevant Factors: | |

REHABILITATION INVOLVEMENT:
(ECM document date:) Closure Report Dated:

Statement Prepared By: _____ Date: _____

All forms should be printed at legal size and can be found on the Industrial Commission Web site at www.ohioic.com/forms/ or call the Commission Medical Advisor at 614.466.4291 to request a hard copy.



APPLICATION FOR COMPENSATION FOR PERMANENT TOTAL DISABILITY

*Please type or print clearly and answer ALL questions to the best of your ability.
 *To ensure prompt processing, this application should be filed directly with:

The Industrial Commission of Ohio
 Medical Services
 30 W. Spring St. 1st floor
 Columbus, Ohio 43215-2233

Injured Worker's Name	Social Security Number	Date of Birth
Address		Telephone Number ()
City	State	Zip Code

List your worker's compensation claims below:

Claim Number _____ Date of Injury _____ Employer _____

Claim Number _____ Date of Injury _____ Employer _____

Claim Number _____ Date of Injury _____ Employer _____

Claim Number _____ Date of Injury _____ Employer _____

Medical examinations will be conducted for conditions allowed in active claims.

OTHER DISABILITY BENEFITS

Have you ever filed for Social Security Disability benefits? yes no

If you are now, or have ever, received Social Security Disability payments, complete the following section.

This does not apply to Social Security Retirement

STARTING DATE	TERMINATION DATE AND REASON FOR TERMINATION	RATE PER MONTH
---------------	---	----------------

Do you receive disability benefits other than Social Security? (i.e., VA, Fireman & Police Officer Disability, etc.)
 yes no

EDUCATION

What is the highest grade of school you completed? _____ When? _____

Where? _____

Did you graduate from high school? yes no

If no, did you receive a certificate for passing the General Educational Development test (GED)? yes no

Why did you end your schooling? _____

Have you gone to trade or vocational school or had any type of special training? yes no

Notice: IC USE ONLY

Upon receipt of this application, forward immediately to:
 The Industrial Commission of Ohio, Medical Services,
 at the address indicated above.

All forms should be printed at legal size and can be found on the Industrial Commission Web site at www.ohioic.com/forms/ or call the Commission Medical Advisor at 614.466.4291 to request a hard copy.

If yes, what type of trade school or special training have you received and when? _____

How has this schooling or training been used in any of the work you have done? _____

Can you read? yes not well no
Can you write? yes not well no
Can you do basic math? yes not well no

MEDICAL HISTORY

Doctor's Name _____ Address _____

Date first seen _____ Date last seen _____

Reason _____

Doctor's Name _____ Address _____

Date first seen _____ Date last seen _____

Reason _____

Doctor's Name _____ Address _____

Date first seen _____ Date last seen _____

Reason _____

List all operations and surgical procedures you have undergone, beginning with the most recent.

Date _____ Name of surgical procedure _____

Date _____ Name of surgical procedure _____

Date _____ Name of surgical procedure _____

Date _____ Name of surgical procedure _____

Date _____ Name of surgical procedure _____

Do you use a cane, brace, TENS unit, traction device, oxygen machine, or any other appliance or device on a regular basis? yes no

If yes, please specify. _____

What other medical conditions prevent you from working? _____

REHABILITATION HISTORY

Have you ever participated in rehabilitation services? yes no Please explain. _____

If you have not sought or participated in rehabilitation services, are you interested in rehabilitation services offered by the employer or the Bureau of Workers' Compensation and do you desire to undergo rehabilitation evaluation?

yes no

EXAMINATION SCHEDULING

All forms should be printed at legal size and can be found on the Industrial Commission Web site at www.ohioic.com/forms/ or call the Commission Medical Advisor at 614.466.4291 to request a hard copy.

DAILY ACTIVITIES	
Has your treating physician told you to cut back or limit your activities in any way? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give the name of the doctor and tell below what he told you about cutting back or limiting your activities. Can you drive a car? <input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____ _____ _____ _____	
Describe your daily activities in the following areas and how much you do of each and how often. Housekeeping Chores: (meal preparation, laundry, home repairs, etc.) _____ _____ _____ Recreational Activities and Hobbies: (bowling, hunting, etc.) _____ _____ _____ Describe other limitations or changes in your life style, if any, resulting from the allowed conditions in your claim. _____ _____ _____	

WORK HISTORY	
--------------	--

Part 1 INFORMATION ABOUT YOUR WORK HISTORY

List all the jobs you have had. Start with your most recent job and work backwards to the first job you ever held.
 List SELF-EMPLOYMENT as you would any other job.

1	Job Title (Be sure to begin with your most recent job.)	Type of Business or Industry (Example: auto, insurance, construction, etc.)	Dates Worked (Month and Year)		Days Per Week	Specify Rate of Pay (per hour, day, week, month or year)
			From	To		
2						
3						
4						
5						
6						
7						
8						

EXAMINATION SCHEDULING

All forms should be printed at legal size and can be found on the Industrial Commission Web site at www.ohioic.com/forms/ or call the Commission Medical Advisor at 614.466.4291 to request a hard copy.

When was the last date you worked anywhere? _____

Do you have military experience? yes no If yes, provide dates of service,
positions held and description of duties. _____

Job Title No. 1 (from Part 1) _____

A

Describe your basic duties - what you did and how you did it. Please provide as much detail as possible.

1. Your basic duties: _____

2. Machines, tools, equipment you used: _____

3. Exact operations you performed: _____

4. Technical knowledge and skills you used: _____

5. Reading / Writing you did: _____

All forms should be printed at legal size and can be found on the Industrial Commission Web site at www.ohioic.com/forms/ or call the Commission Medical Advisor at 614.466.4291 to request a hard copy.

6. Number of people you supervised: _____

B Describe the kind and amount of physical activity this job involved during a typical day in terms of:

Walking (circle the number of hours a day spent walking)	0	1	2	3	4	5	6	7	8
Standing (circle the number of hours a day spent standing)	0	1	2	3	4	5	6	7	8
Sitting (circle the number of hours a day spent sitting)	0	1	2	3	4	5	6	7	8
Bending (circle how often a day you had to bend)	Never - Occasionally - Frequently - Constantly								

Check below the heaviest weight lifted and weight frequently lifted and / or carried.

Heaviest weight lifted:		Weight frequently lifted / carried:	
<input type="checkbox"/> 10 lbs.	<input type="checkbox"/> 100 lbs.	<input type="checkbox"/> Up to 10 lbs.	<input type="checkbox"/> Up to 50 lbs.
<input type="checkbox"/> 20 lbs.	<input type="checkbox"/> Over 100 lbs.	<input type="checkbox"/> Up to 25 lbs.	<input type="checkbox"/> Over 50 lbs.
<input type="checkbox"/> 50 lbs.			

Job Title No. 2 (from Part 1) _____

A

Describe your basic duties - what you did and how you did it. Please provide as much detail as possible.

1. Your basic duties: _____

2. Machines, tools, equipment you used: _____

3. Exact operations you performed: _____

4. Technical knowledge and skills you used: _____

5. Reading / Writing you did: _____

6. Number of people you supervised: _____

All forms should be printed at legal size and can be found on the Industrial Commission Web site at www.ohioic.com/forms/ or call the Commission Medical Advisor at 614.466.4291 to request a hard copy.

B Describe the kind and amount of physical activity this job involved during a typical day in terms of:

Walking (circle the number of hours a day spent walking) 0 1 2 3 4 5 6 7 8
Standing (circle the number of hours a day spent standing) 0 1 2 3 4 5 6 7 8
Sitting (circle the number of hours a day spent sitting) 0 1 2 3 4 5 6 7 8
Bending (circle how often a day you had to bend) Never - Occasionally - Frequently - Constantly

Check below the heaviest weight lifted and weight frequently lifted and / or carried.

Heaviest weight lifted: Weight frequently lifted / carried:

10 lbs. 100 lbs. Up to 10 lbs. Up to 50 lbs.
 20 lbs. Over 100 lbs. Up to 25 lbs. Over 50 lbs.
 50 lbs.

Job Title No. 3 (from Part 1) _____

A Describe your basic duties - what you did and how you did it. Please provide as much detail as possible.

1. Your basic duties: _____

2. Machines, tools, equipment you used: _____

3. Exact operations you performed: _____

4. Technical knowledge and skills you used: _____

5. Reading / Writing you did: _____

6. Number of people you supervised: _____

B Describe the kind and amount of physical activity this job involved during a typical day in terms of:

Walking (circle the number of hours a day spent walking) 0 1 2 3 4 5 6 7 8
Standing (circle the number of hours a day spent standing) 0 1 2 3 4 5 6 7 8
Sitting (circle the number of hours a day spent sitting) 0 1 2 3 4 5 6 7 8
Bending (circle how often a day you had to bend) Never - Occasionally - Frequently - Constantly

All forms should be printed at legal size and can be found on the Industrial Commission Web site at www.ohioic.com/forms/ or call the Commission Medical Advisor at 614.466.4291 to request a hard copy.

Check below the heaviest weight lifted and weight frequently lifted and / or carried.

Heaviest weight lifted:		Weight frequently lifted / carried:	
<input type="checkbox"/> 10 lbs.	<input type="checkbox"/> 100 lbs.	<input type="checkbox"/> Up to 10 lbs.	<input type="checkbox"/> Up to 50 lbs.
<input type="checkbox"/> 20 lbs.	<input type="checkbox"/> Over 100 lbs.	<input type="checkbox"/> Up to 25 lbs.	<input type="checkbox"/> Over 50 lbs.
<input type="checkbox"/> 50 lbs.			

A Job Title No. 4 (from Part 1) _____

Describe your basic duties - what you did and how you did it. Please provide as much detail as possible.

1. Your basic duties: _____

2. Machines, tools, equipment you used: _____

3. Exact operations you performed: _____

4. Technical knowledge and skills you used: _____

5. Reading / Writing you did: _____

6. Number of people you supervised: _____

B Describe the kind and amount of physical activity this job involved during a typical day in terms of:

Walking (circle the number of hours a day spent walking)	0 1 2 3 4 5 6 7 8
Standing (circle the number of hours a day spent standing)	0 1 2 3 4 5 6 7 8
Sitting (circle the number of hours a day spent sitting)	0 1 2 3 4 5 6 7 8
Bending (circle how often a day you had to bend)	Never - Occasionally - Frequently - Constantly

Check below the heaviest weight lifted and weight frequently lifted and / or carried.

Heaviest weight lifted:		Weight frequently lifted / carried:	
<input type="checkbox"/> 10 lbs.	<input type="checkbox"/> 100 lbs.	<input type="checkbox"/> Up to 10 lbs.	<input type="checkbox"/> Up to 50 lbs.
<input type="checkbox"/> 20 lbs.	<input type="checkbox"/> Over 100 lbs.	<input type="checkbox"/> Up to 25 lbs.	<input type="checkbox"/> Over 50 lbs.
<input type="checkbox"/> 50 lbs.			

All forms should be printed at legal size and can be found on the Industrial Commission Web site at www.ohioic.com/forms/ or call the Commission Medical Advisor at 614.466.4291 to request a hard copy.

SPECIAL FACTORS

Please use this space for comments, explanations or special factors you wish to add to support your application. (social, economic, psychological)

I certify that the information on this page and the preceeding pages is true to the best of my knowledge. By signing this application, I expressly waive all provisions of law which forbid any person, persons or medical facility who has medically attended, treated, or examined me, or who may have medical information of any kind which may be used to render a decision in my claim, from disclosing such knowledge or information to the Industrial Commission or employer(s) in my claim(s).

I am permanently and totally disabled as the result of the injuries sustained in the forgoing claim(s) and request that the Industrial Commission grant compensation for such disability. I further state that Dr. _____ has certified that I have physical and/or mental impairments resulting from the allowed conditions in my claims that permanently preclude me from returning to my former position of employment. I have attached to this form a copy of the doctor's report.

Person Completing This Form

X _____
Injured Worker's Signature

X _____
Date

DO NOT submit this application without the following:

- * Supporting medical evidence signed by the physician
- * Your signature on this application (above)

ATTENTION

This application will be dismissed if medical evidence supporting the request for Permanent Total Disability is not attached.

To ensure prompt processing, this application should be filed directly with:

**The Industrial Commission of Ohio
Medical Services
30 W. Spring St. 1st floor
Columbus, Ohio 43215-2233**

**Help Us Help You!
Please take a minute to give us your correct address
in the space provided on the first page of this application.**

PHYSICAL STRENGTH RATING

Injured Worker:

Claim number(s):

Based solely on impairment due to the allowed condition(s) in the claim within my specialty and with no consideration of the Injured Worker's age, education, or work training:

- () This Injured Worker has no work limitations.
 () This Injured Worker is incapable of work.
 () This Injured Worker is capable of work as indicated below.

() "SEDENTARY WORK"

Sedentary work means exerting up to ten pounds of force occasionally (occasionally: activity or condition exists up to one-third of the time) and/or a negligible amount of force frequently (frequently: activity or condition exists from one-third to two-thirds of the time) to lift, carry, push, pull, or otherwise move objects. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time. Jobs are sedentary if walking and standing are required only occasionally and all other sedentary criteria are met.

Further limitations, if indicated: _____

() "LIGHT WORK"

Light work means exerting up to twenty pounds of force occasionally, and/or up to ten pounds of force frequently, and/or a negligible amount of force constantly (constantly: activity or condition exists two-thirds or more of the time) to move objects. Physical demand may be only a negligible amount, a job should be rated light work: (1) when it requires walking or standing to a significant degree; or (2) when it requires sitting most of the time but entails pushing and/or pulling, or arm or leg controls; and/or (3) when the job requires working at a production rate pace entailing the constant pushing and/or pulling of materials even though the weight of those materials is negligible.

Further limitations, if indicated: _____

() "MEDIUM WORK"

Medium work means exerting twenty to fifty pounds of force occasionally, and/or ten to twenty-five pounds of force frequently, and/or greater than negligible up to ten pounds of force constantly to move objects. Physical demand requirements are in excess of those for light work.

() "HEAVY WORK"

Heavy work means exerting fifty to one hundred pounds of force occasionally, and/or twenty to fifty pounds of force frequently, and/or ten to twenty pounds of force constantly to move objects. Physical demand requirements are in excess of those for medium work.

() "VERY HEAVY WORK"

Very heavy work means exerting in excess of one hundred pounds of force occasionally, and/or in excess of fifty pounds of force frequently, and/or in excess of twenty pounds of force constantly to move objects. Physical demand requirements are in excess of those for heavy work.

Physician's Signature: _____ Date: _____

Physician's Name (print): _____

OCCUPATIONAL ACTIVITY ASSESSMENT

Mental & Behavioral Examination

Injured Worker: _____

Claim Number(s): _____

Based solely on impairment resulting from the allowed mental and behavioral condition(s) in this claim within my specialty, and with no consideration of the Injured Worker's age, education, or work training:

- () This Injured Worker has no work limitations.
- () This Injured Worker is incapable of work.
- () This Injured Worker is capable of work with the limitation(s)/modification(s) noted below:

Physician's Signature: _____ Date: _____

Physician's Name (print): _____

RESIDUAL FUNCTION ASSESSMENT

Injured Worker: _____

Claim Number(s): _____

Based solely on impairment arising from the allowed condition(s) within my specialty, and with no consideration of the Injured Worker's age, education and work experience:

- () This Injured Worker has no work limitations.
- () This Injured Worker is incapable of work.
- () This Injured Worker is capable of work with the limitation(s)/modification(s) noted below:

Physician's Signature: _____ Date: _____

Physician's Name (print): _____

BILLING PROCEDURES

Fees

**Ohio Industrial Commission Fee Schedule for Permanent Total Disability
Independent Medical Evaluations**

Services	Fees
Evaluation, one body part or organ system	\$500
Evaluation, two or three body parts or organ systems	\$600
Evaluation, Mental and Behavioral Health	\$600
Evaluation, four or more body parts or organ systems	\$700

Evaluation fees include: examination, document review, and the report.

When an Injured Worker fails to keep an appointment scheduled in the examiner’s office, notify the referring office. A \$100 “no show” fee may be billed. A \$100 fee may also be billed if an Injured Worker cancels an appointment for an examination in a Commission office and no substitute examination is scheduled.

Allowed Diagnostic Testing

Industrial Commission Independent Medical Examinations are performed to determine degree of impairment and functional limitations due to allowed conditions- not to establish a diagnosis. Therefore, diagnostic testing requirements are minimal.

The *AMA Guides to the Evaluation of Permanent Impairment*, Fifth Edition; Fourth Edition, and; the *Guidelines to the Evaluation of Impairment of the Oral and Maxillofacial Region* (2002) clearly delineate necessary and appropriate testing for impairment rating for the various body parts and systems. These studies, when necessary for application of the Guides, are billable at the time of report submission, along with the usual fee for the examination:

CPT Code	Diagnostic Procedure
72040	Cervical spine x-ray, 2 or 3 views
72052	Cervical spine x-ray, complete with flexion and extension
72070	Thoracic spine x-ray, 2 views
72100	Lumbar spine x-ray, 2 or 3 views
72114	Lumbar spine x-ray, complete with bending views
72200	Sacroiliac joint x-ray, < 3 views
73100	Wrist x-ray, 2 views
73500	Hip, unilateral x-ray, 1 view

CPT Code	Diagnostic Procedure
73560	Knee x-ray, 1 or 2 views (AP +/- sunrise)
73600	Ankle x-ray, 2 views (include mortise)
73620	Foot x-ray, 2 views
70320	Teeth x-ray, complete, full mouth
70140	Facial Bones x-ray, < 3 views
70250	Skull x-ray, < 4 views
92557	Comprehensive Audiometry
94010	Spirometry
94060	Bronchodilation responsiveness (used with asthma and reactive airway disease only)
94720	CO diffusing capacity
NPT 1	1 hour neuropsychological testing
NPT 2	2 hours neuropsychological testing
NPT 3	3 hours neuropsychological testing
NPT 4	4 hours neuropsychological testing
80053	Comprehensive metabolic panel
81000	Urinalysis, non-automated with microscopic
81001	Urinalysis, automated with microscopic
85004	Blood count

Any other testing requires prior approval. If you feel that a specific diagnostic procedure is necessary to determine impairment or functional limitations due to the allowed conditions, please call Medical Services at 614.466.4291. You will be put in contact with the Chief Medical Advisor for a physician-to-physician discussion for consideration of authorization.

It will be required that you include in your fee bill the CPT code(s) for the diagnostic procedure(s) performed. Payment will be denied for any testing performed that is not preauthorized.

Reimbursement rates are according to the Bureau of Workers' Compensation (BWC) fee schedule. Neuropsychological testing will be reimbursed at a rate of one hundred dollars per hour, with a maximum of four hours.

Injured Workers are not required to submit to any diagnostic testing. If you feel additional testing is necessary for evaluation of impairment or functional limitations due to the allowed conditions, and the Injured Worker declines, note the refusal and base opinions on the available diagnostic information.

Billing

A Provider Fee Bill is included in each referral packet (copy of form on next page). A Bureau of Workers' Compensation provider number is required for billing. Contact Medical Services at 614.466.4291 for assistance in obtaining a provider number.

Update your office mailing address, sign and date the fee bill, verify your tax ID number, and send the fee bill with the examination report within 10 business days of the examination date.

If you have not received payment within three months from the date of service, contact Medical Services. Note that payment is withheld until addenda or supplemental reports have been provided.

"State fund" employee examination fees are paid by the Bureau of Workers' Compensation, and "Self-Insured" employee examination fees are paid by the employer. The billing process for examiners is the same.

If you encounter billing problems, contact Medical Services at 614.466.4291. Have your provider number, the Injured Worker's name, and claim number(s) available when making inquiries.

STATE OF OHIO
THE INDUSTRIAL COMMISSION OF OHIO

PROVIDER FEE BILL

Claim File Number(s):
Injured Worker's Name:
Provider of Service Number:
Pay to Provider Number:

<input checked="" type="checkbox"/>	Type of Service	Date of Service	Charges
	Exam by Ohio Provider		
	Exam by Out of State Provider		
	File Review by Ohio Provider		
	File Review by OOS* Provider		
	Employability Assessment Report		
	Employability Assessor Travel Expense		
	Language/Hearing Interpretation		
	Injured Worker "No Show" for Exam		
	Cancellation of Exam (IC approved)		
	Diagnostic Test Name/CPT Code(s) Required		
	*Out of State		Total:

I hereby certify that the information contained on this form is true and correct to the best of my knowledge and belief.

Provider Signature: _____ Date: _____

Provider Name (Use Stamp Below)
Address
City, State, Zip
Phone Number

For I.C. Use Only

I.C. Verification:
Initial here for SURPLUS payment _____ (Initials and Date) _____

EXAMINATION QUESTIONS

AKRON REGIONAL OFFICE

Akron Government Center
161 South High Street, Suite 301
Akron, OH 44308-1602
Telephone: 330.643.3550
Fax No.: 330.643.1468

CINCINNATI REGIONAL OFFICE

125 East Court Street, Suite 600
Cincinnati, OH 45202-1211
Telephone: 513.357.9750
Fax No.: 513.357.9761

CLEVELAND REGIONAL OFFICE

615 Superior Avenue, N.W., 7th Floor
Cleveland, OH 44113-1898
Telephone: 216.787.3001
Fax No.: 216.787.3483

COLUMBUS OFFICE

(MEDICAL SERVICES)

Medical Scheduling Section
30 West Spring Street, 1st Floor
Columbus, OH 43215-2233
Telephone: 614.466.4291
Toll Free: 1.800.574.6559
Fax No.: 614.466.1661

DAYTON DISTRICT OFFICE

3401 Park Center Drive, 3rd Floor
Dayton, OH 45414-2580
Telephone: 937.264.5116
Fax No.: 937.264.3760

TOLEDO REGIONAL OFFICE

One Government Center, Suite 1500
Toledo, OH 43604
Telephone: 419.245.2740
Fax No.: 419.245.2673

YOUNGSTOWN DISTRICT OFFICE

242 Federal Plaza West
Youngstown, OH 44503-1206
Telephone: 330.792.1063
Fax No.: 330.742.0088

BILLING & TESTING

AUTHORIZATION QUESTIONS:

MEDICAL SERVICES

30 West Spring Street, 1st Floor
Columbus, OH 43215-2233
Telephone: 614.466.4291
Fax No.: 614.466.1661
Toll Free: 1.800.574.6559

File Reviews – Legal Requirements

The Supreme Court of Ohio has held that “a physician who reviews the medical record, without conducting an examination of the Injured Worker, is required to expressly accept all the clinical findings of the examining physicians, but not necessarily the opinion drawn therefrom.” The Supreme Court also requires a reviewing physician to consider and note all medical reports on record that may be considered relevant to the review issue. For these reasons, reviewers must:

1. indicate all examination reports considered in their review.
2. expressly accept the findings reported by examiners.
3. review all available relevant examinations in the medical records.

Other Examinations

The Commission may require examinations on the following issues:

1. Original or additional allowance
2. Extent of disability
3. Amount of permanent partial disability due to amputation or loss of use as indicated in the referral letter
4. Determine permanent partial disability

Questions of cause of death and additional allowance requests sometimes require file reviews.

EXAMINATIONS BY BODY SYSTEMS

Musculoskeletal, Cardiovascular, Respiratory, Central and Peripheral Nervous System

THE EXAMINATION REPORTING FORMAT

Background Information:

Injured Worker name
 Claim number(s)
 Date of birth
 Date(s) of injury
 Claim allowance(s)
 Place of exam
 Date of exam
 Examiner name
 Purpose of exam

Medical History including CC, HPI, and Pertinent PMH for each allowed condition

Review of Pertinent Medical Records

Examination Findings, reporting all pertinent positive and negative findings

Discussion of the medical findings supporting the opinion

Opinion

Opinions must be based solely on impairment arising from the allowed condition(s) in the claim. Examiners may not consider disability factors (age, education, and work training) in their opinion. Opinions on the following three issues are required.

1. Has the Injured Worker's condition(s) reached Maximum Medical Improvement (MMI) with regard to each specified allowed condition? Briefly describe the rationale for your opinion. If 'yes' then please continue to items #2 and #3.

Maximum Medical Improvement is defined as a treatment plateau (static or well stabilized) where no fundamental or physiological change can be expected within reasonable probability, in spite of continuing medical or rehabilitative procedures. An Injured Worker may require supportive treatment to maintain this level of function.

Under AMA Guides, Fifth Edition, a condition must be Maximum Medical Improvement before permanent impairment can be estimated.

2. Based on AMA Guides, Fifth Edition, and with reference to the Industrial Commission Medical Examination Manual, provide the estimated percentage of whole person impairment from each of the allowed condition(s). Please list each condition and whole person impairment separately, and then provide a combined whole person impairment. If there is no impairment for an allowed condition, indicate zero percent.

Cite the AMA Guides source for your impairment opinion.

Combine multiple allowed condition impairments using the AMA Guides Combined Values Chart.

3. Complete the Physical Strength Rating form. In your narrative report provide a discussion setting forth physical limitations resulting from the allowed conditions.

Consider only impairment arising from the allowed condition(s) in your opinion of the Injured Worker's strength rating. Do not consider disability factors (age, education and work training/experience).

Musculoskeletal and nervous system impairment directly limits body function, while cardiovascular and respiratory system impairment indirectly limits function by reducing work capacity. Use the Physical Strength Rating form for allowed condition(s) in any of these body systems.

ALLOWED DIAGNOSTIC TESTING

Since Commission Independent Medical Examinations are performed to determine degree of impairment, and not to establish a diagnosis, testing requirements are minimal. Injured Workers are not required to submit to any diagnostic testing. If an examiner feels additional testing is necessary and the Injured Worker declines, note the refusal and base opinions on the available diagnostic information.

Musculoskeletal exams may require X-rays to grade joint cartilage intervals in arthritic allowances, and spinal flexion and extension X-rays in measuring loss of segmental integrity. These studies are billable without prior approval.

Evaluation of disorders of the respiratory system may require spirometry, bronchodilation responsiveness (used in asthma and reactive airway disease only), and carbon monoxide diffusing capacity, which are billable without prior approval.

Other testing must have prior approval of Medical Services at 614.466.4291. Bill for any approved additional testing on the Provider Fee Bill.

Examples of Musculoskeletal, Cardiac, and Respiratory Independent Medical Examinations follow.

Raymond Specialist, M.D.**Physical Medicine & Rehabilitation**

100 State Street • Columbus, Ohio 41111

(614)224-0000

SPECIALIST REPORT**Background Information:**

Injured Worker:	Robert Smith	Claim No.:	(1) 97-00000
Employer:	Monster Machine Co.		(2) 99-00000
Date of Birth:	01/01/1943	Date of Injury:	(1) 05/22/1997
			(2) 01/06/1999
Date of Examination:	03/22/2008	Date of Report:	03/22/2008
Claim Allowances:	(1) Low back pain; herniated disc at L5-S1		
	(2) Bilateral carpal tunnel syndrome		

Purpose of Examination: To assist the Industrial Commission in its consideration of the question of Permanent Total Disability.

Historian: Injured Worker

History of Present Illness:

The Injured Worker is a 65 year old male who describes an injury in 1997 as sliding out of the way of a fork-lift when he felt a "twinge in his low back area." He states that he recovered and returned to work. He sustained an exacerbation of his low back injury approximately a year later when he was lifting parts off a skid while building a press. A CT scan on 05/08/1998 was negative for disc herniation but an MRI was suggested. The MRI showed minimal posterior bulging at L5-S1. The Injured Worker underwent surgery with a right L5-S1 microdiscectomy on 05/28/1998. The excruciating back and right leg pain experienced prior to surgery was decreased. However, he noted recurring pain in his back and right leg over time. EMG on 11/05/1998 post-operatively revealed evidence of chronic right L5 radiculopathy.

The Injured Worker currently describes constant low back pain as an achy soreness. He describes radiating pain into his right leg to his foot. He describes diffuse numbness in his right leg that is worse with sitting, walking, and standing. He has difficulty pushing a vacuum cleaner and making beds. He feels better when laying flat on a carpet, and when he does water exercises at the YMCA. He tries to get some regular exercise and walks up to 15 minutes at a time. He states that he has not seen a surgeon for his low back problem for a while. There is no plan for further surgical intervention.

The Injured Worker had a second injury on 01/06/1999. He was working as machine tool builder and exposed to the use of hand tools, vibratory tools, drills, etc., when he noted numbness and tingling in both wrists and hands. An EMG on 01/16/1999 revealed moderately severe bilateral carpal tunnel syndrome with loss of axons both on the right and the left. There was no evidence of generalized peripheral polyneuropathy. The Injured Worker underwent right carpal tunnel release on 04/28/1999. He notes he felt "only a little bit better" post-operatively as he did not experience significant relief of the symptoms on the right. He never did proceed with surgery on the left. The Injured Worker states he still has ongoing numbness and tingling in his right hand more so than his left. He uses his left a little more frequently from a

functional standpoint. He describes numbness in his thumbs and index fingers and pain in the wrist. At times he drops objects on both sides. He uses a right carpal tunnel splint with some relief of his symptoms especially at night.

Current medication includes: Darvocet, Elavil, Celebrex, and Ultram. He notices no significant change over the last year to a year and a half.

In his activities of daily living, he is not doing any cooking, cleaning, or shopping. He lives with his wife at home. He doesn't have any recreational activities. He does try to fish when he can. He states, "I can't do much at home." He does "go to the garage" but doesn't work on his car. He still is driving, but has a friend help him with driving for more than one hour at a time.

Past Medical History:

Past Surgeries: Right carpal tunnel release, lumbar discectomy, nasal surgery.

Medical Illnesses: None

Social History:

He smokes 3½ packs a day. He states, "I drink a couple of shots of whiskey and a couple beers every day."

He is married. He graduated from high school. His last day worked as 05/05/1999.

Physical Examination:

The Injured Worker is able to walk easily and freely. He walks easily from the hallway. He uses a cane on the right, but is not bearing a great deal of weight through the cane. He is able to independently mount and unmount on the examination table and the scale. The Injured Worker is 5'10" tall and weighs 202 pounds. The Injured Worker is able to walk on his heels and walk on his toes with 5/5 strength.

Bilateral elbow, wrist, and hand range of motion is normal. There is no atrophy of the thenar or hypothenar musculature. He has a well-healed ventral wrist incision on the right. Tinel's sign is moderately positive on the right. Sensation is decreased to light touch to the right thumb and index finger bilaterally. He has a well-healed scar from the a laceration over the thumb at the medial border of the left thenar eminence and the border of the abductor pollicis brevis. The Injured Worker is able to form a full fist with both hands. Bilateral finger, wrist, and thumb range of motion is normal. Peripheral radial pulses are 1+. His strength in the abductor pollicis brevis bilaterally is 4/5. Finger flexors and extensors are 5/5.

In a seated position the Injured Worker has normal strength in the bilateral lower limbs. Strength is 5/5. Bilateral thigh circumference is 45 centimeters, right calf is 44 centimeters, left is 43. Deep tendon reflexes are 2+ and symmetrical in the biceps, triceps, brachioradialis, patella, and Achilles. There is no decrement in the right Achilles as has been seen on previous examinations. Sensation is decreased in the right leg in a nondermatomal type fashion. There is no focal weakness as manual muscle testing reveals 5/5 strength in both lower limbs.

Review of Medical Records:

Review of the past three years' medical records indicates no plans for further surgical intervention.

Discussion:

A 1999 EMG/NCS study was positive for median nerve dysfunction. He had surgical release on the right, and had some

decrease in his symptoms, but ongoing symptoms of bilateral wrist and hand pain persists. He has slight decrease in sensation and a significant loss of strength bilaterally on examination. He has undergone definitive surgical treatment in the right hand, and has elected not to pursue further treatment on the left. His condition is not expected to change. Therefore, he has reached maximum medical improvement. It would be expected that repetitive movements of the hands and wrists would be limited by this condition.

The Injured Worker has a history of right L5-S1 diskectomy. A post-opt EMG showed a chronic right L5 radiculopathy. He had a nonfocal physical examination finding today, but in the past he had a decreased right Achilles reflex. He has also undergone surgery for his low back injury. No further surgery or other treatment is planned at this time. His medications have remained the same over the last year. Therefore, he has reached maximum medical improvement. Considering the nature of this low back condition it is anticipated that he would be limited to sedentary activities.

Opinion:

The following opinions are based solely on the allowed conditions listed in 99-00000: Bilateral carpal tunnel syndrome and, 97-00000: Low back pain; herniated disc at L5-S1.

1. Has the Injured Worker reached maximum medical improvement with regard to each specified allowed condition? Briefly describe the rationale for your opinion. If “yes” then please continue to items #2 and #3.

Yes. Please refer to narrative discussion above for rationale.

2. Based on the AMA Guides, Fifth Edition, and with reference to the Industrial Commission Medical Examination Manual, provide the estimated percentage of whole person impairment arising from each allowed condition. Please list each condition and whole person impairment separately, and then provide a combined whole person impairment. If there is no impairment for an allowed condition indicate zero percent.

Allowed Condition	Table/Figure/Page Number	Comments	Whole Person Impairment %
Bilateral carpal tunnel syndrome	Tables 16-10 and 16-11, p. 482 and 484 Table 16-15, p. 492	Grade 4 motor and sensory loss, median nerve below forearm, 7% WPI each arm	14%
Low back pain		Superseded by allowed disc herniation	0%
Herniated disc L5-S1	Table 15-3, p. 384	DRE Cat. III	10%
Combined whole person impairment:			23%

It is my opinion that the combined whole person impairment for the allowed conditions in these claims is: 23%.

3. Complete the enclosed Physical Strength Rating form. In your narrative report provide a discussion setting forth physical limitations resulting from the allowed condition(s).

The Physical Strength Rating form is completed and enclosed. Please refer to narrative discussion above.

Respectively submitted,

Raymond Specialist

Raymond Specialist, M.D.

Physical Medicine & Rehabilitation

PHYSICAL STRENGTH RATING

Injured Worker: Robert Smith

CLAIM NUMBER(S): 97-00000
99-00000**Based solely on impairment due to the allowed conditions in the claim within my specialty and with no consideration of the Injured Worker's age, education, or work training:**

- () This Injured Worker has no work limitations.
 () This Injured Worker is incapable of work.
 (X) This Injured Worker is capable of work as indicated below.

(X) "SEDENTARY WORK"

Sedentary work means exerting up to ten pounds of force occasionally (occasionally: activity or condition exists up to one-third of the time) and/or a negligible amount of force frequently (frequently: activity or condition exists from one-third to two-thirds of the time) to lift, carry, push, pull, or otherwise move objects. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time. Jobs are sedentary if walking and standing are required only occasionally and all other sedentary criteria are met.

Further limitations, if indicated: Repetitive motion of the wrist and hand should be limited.

() "LIGHT WORK"

Light work means exerting up to twenty pounds of force occasionally, and/or up to ten pounds of force frequently, and/or a negligible amount of force constantly (constantly: activity or condition exists two-thirds or more of the time) to move objects. Physical demand may be only a negligible amount, a job should be rated light work: (1) when it requires walking or standing to a significant degree; or (2) when it requires sitting most of the time but entails pushing and/or pulling, or arm or leg controls; and/or (3) when the job requires working at a production rate pace entailing the constant pushing and/or pulling of materials even though the weight of those materials is negligible.

Further limitations, if indicated: _____

() "MEDIUM WORK"

Medium work means exerting twenty to fifty pounds of force occasionally, and/or ten to twenty-five pounds of force frequently, and/or greater than negligible up to ten pounds of force constantly to move objects. Physical demand requirements are in excess of those for light work.

() "HEAVY WORK"

Heavy work means exerting fifty to one hundred pounds of force occasionally, and/or twenty to fifty pounds of force frequently, and/or ten to twenty pounds of force constantly to move objects. Physical demand requirements are in excess of those for medium work.

() "VERY HEAVY WORK"

Very heavy work means exerting in excess of one hundred pounds of force occasionally, and/or in excess of fifty pounds of force frequently, and/or in excess of twenty pounds of force constantly to move objects. Physical demand requirements are in excess of those for heavy work.

Physician's Signature: Raymond Specialist Date: 3/22/2008Physician's Name (print): Raymond Specialist, M.D.

Ralph Lowell, M.D.

100 State Street • Columbus, Ohio 41111

(614)224-0000

SPECIALIST REPORT

SAMPLE

Background Information:

Injured Worker:	Ralph Roberts	Claim No.:	PEL11111
Date of Birth:	07/19/1945	Date of Injury:	12/06/1990
Date of Examination:	05/23/2008	Date of Report:	05/23/2008
Examiner Name:	Ralph Lowell, M.D.		

Historian: Ralph Roberts, the Injured Worker was uncertain about exact dates.

Purpose of Examination: Consideration of Permanent and Total Disability

Allowed Conditions: Aggravation of pre-existing coronary artery disease causing myocardial infarction; cardiomyopathy, ventricular tachycardia

History of Present Illness:

The IW was on duty, as a deputy sheriff in Fairfield County, when a male suspect became combative. After the Injured Worker took control of the situation and the suspect was in custody, the Injured Worker felt severe chest pain. Upon arrival at the detainment center the Injured Worker was taken to the hospital where he was transferred to OSU hospital and treated for acute inferior wall myocardial infarction, ventricular tachycardia, and cardiomyopathy. Treatment included PTCA with stent and implantation of a defibrillator. The Injured Worker states he has had 4 heart attacks since 1990. He states he still has pain in the lower neck and chest area. The pain may last several minutes and may begin without any aggravation. He relates that the pain definitely begins with any type of exertion. He states that the pain is relieved with relaxation and deep breaths or in severe cases, the use of nitroglycerin. The Injured Worker states he cannot walk long distances without shortness of breath and cannot do "normal activities" around the house because he tires easily.

Past Medical History:

The Injured Worker also had shoulder surgery in 2002 that did not pertain to this claim. The Injured Worker is also a non insulin dependent diabetic. The Injured Worker stated he is able to walk without difficulty, and he used a riding mower to cut the grass in what he called a small yard. He also stated he could lift 25 pounds of weight but if he carried it across the room he would have difficulty breathing.

Medications:

- Zoloft - 50 mg. once daily
- Aspirin- 325 mg. once daily
- Glucotrol XL - 10 mg. twice daily
- Glucophage - 600 mg. twice daily
- Coreg - 26 mg. twice daily
- Gemfibrozil - 600 mg. once daily
- Wellbutrin - 160 mg.
- Zestril - 10 mg. once daily
- Pepcid - PRN
- Lipitor - 20 mg. once daily
- Lopid - 600 mg.

Habits:

Injured Worker drinks very little alcohol, smokes 3 cigarettes a day, and denies any drug use other than his prescribed medications.

Family History:

Injured Worker states that his paternal uncles have a history of heart attacks and both maternal and paternal forefathers have a history of diabetes mellitus.

Physical Examination:

Weight: 214 Height: 6'2"
 Blood Pressure: 120/62 Pulse: 68 Regular Respiration: 15 Regular

The physical examination showed a well developed, well nourished white male in no acute distress.

HEENT: The extraocular muscles are intact and the pupils are round, equal, and react to light. The Injured Worker wears dentures. The neck is subtle without adenopathy. There is a soft left carotid bruit that is heard and there is a well-healed scar from a previous right carotid endarterectomy.

CHEST/CARDIAC: The chest was clear to percussion and auscultation. The cardiovascular exam showed regular sinus rhythm without murmurs. The PMI was just to the right of the mid-clavicular line. There is an implanted defibrillator in the left chest.

ABDOMEN: The abdomen showed no organomegaly. The liver, spleen, and kidney were non palpable. Bowel sounds were considered active and no CVA tenderness was elicited.

EXTREMITIES: No pitting edema was found. The patient has one to two plus peripheral pulses throughout and these are equal bilaterally. No abnormal neurological signs were noted although the accompanying records suggest this man had an acute infarct in the right front parietal region of the brain, as seen on a MRI scan in September 2001.

CHEST X-RAY: On May 23, 2008 a standard PA chest x-ray showed a cardiothoracic ratio of 15.5/36.5. The cardiac silhouette is not enlarged but does show left ventricular dominance. The apices and CP angles are clear without evidence of infiltration. There is an implanted defibrillator in the left chest. There are calcified nodules bilaterally but especially prominent on the left, which are compatible with inert histoplasmosis. No other primary pulmonary disease seen. Bone density appears normal.

IMPRESSION: Globular heart with left ventricular dominance and implanted defibrillator.

EKG: Abnormal showing a previous inferior infarction but no evidence of arrhythmia.

Discussion:

The Injured Worker was working in 1990 as a deputy sheriff in Fairfield County when in the course of doing his job he suffered chest pain and subsequently a myocardial infarction. According to the medical records, the Injured Worker had several more myocardial infarcts. He had a PTCA procedure done as well as a defibrillator implanted in his chest. Additional history shows that the Injured Worker had a right carotid endarterectomy for a stroke in 2001. His memory concerning his medical experiences is not good.

The Injured Worker has chronic ischemic heart disease. The original myocardial damage on EKG has stayed consistently the same through the present time without objective evidence of further left ventricular damage. One of the previous

examiners noted that ventricular tachycardia was seen only on electrophysiology testing. The Injured Worker did not describe any episodes of the implanted defibrillator activating. A Stress Thallium report done in 1991 disclosed no evidence of ischemia. Therefore, with regard to the allowed conditions in this claim, he has reached maximum medical improvement. Because of the impairments due to his allowed conditions, which are judged to be Class 2-3, it is expected that he would be capable of only sedentary activities.

On the date of examination, the high blood sugar indicates that his diabetes is not under control. Perhaps the poor memory of this Injured Worker derives from CVA, the diabetes and/or the diminished blood flow to that part of the brain.

Opinion:

The following opinion is based solely on the allowed conditions, aggravation of pre-existing coronary artery disease with inferior myocardial infarction, cardiomyopathy, and ventricular tachycardia.

1. Has the Injured Worker reached maximum medical improvement with regard to each specified allowed condition? Briefly describe the rationale for your opinion. If “yes” then please continue to items #2 and #3.

Yes. Please refer to narrative discussion above for rationale.

2. Based on the AMA Guides, Fifth Edition, and with reference to the Industrial Commission Medical Examination Manual, provide the estimated percentage of whole person impairment arising from each allowed condition. Please list each condition and whole person impairment separately, and then provide a combined whole person impairment. If there is no impairment for an allowed condition indicate zero percent.

Allowed Condition	Table/Figure/Page Number	Comments	Whole Person Impairment %
Aggravation of pre-existing coronary artery disease	Table 3-6a, p. 36	Class 2	10%
Cardiomyopathy	Table 3-9, p. 47	Class 3	30%
Ventricular tachycardia	Table 3-11, p. 56	Class 2	10%
Combined whole person impairment:			43%

It is my opinion that the combined whole person impairment for the allowed conditions in this claim is: 43%.

3. Complete the enclosed Physical Strength Rating form. In your narrative report, provide a discussion setting forth physical limitations resulting from the allowed conditions.

The physical strength rating form is completed and enclosed. Please refer to narrative discussion above.

Sincerely,

Ralph Lowell

Ralph Lowell, M.D.

PHYSICAL STRENGTH RATING

Injured Worker: Ralph Roberts

CLAIM NUMBER(S): PEL11111

Based solely on impairment due to the allowed conditions in the claim within my specialty and with no consideration of the Injured Worker's age, education, or work training:

- This Injured Worker has no work limitations.
- This Injured Worker is incapable of work.
- This Injured Worker is capable of work as indicated below.

"SEDENTARY WORK"

Sedentary work means exerting up to ten pounds of force occasionally (occasionally: activity or condition exists up to one-third of the time) and/or a negligible amount of force frequently (frequently: activity or condition exists from one-third to two-thirds of the time) to lift, carry, push, pull, or otherwise move objects. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time. Jobs are sedentary if walking and standing are required only occasionally and all other sedentary criteria are met.

Further limitations, if indicated: _____

"LIGHT WORK"

Light work means exerting up to twenty pounds of force occasionally, and/or up to ten pounds of force frequently, and/or a negligible amount of force constantly (constantly: activity or condition exists two-thirds or more of the time) to move objects. Physical demand may be only a negligible amount, a job should be rated light work: (1) when it requires walking or standing to a significant degree; or (2) when it requires sitting most of the time but entails pushing and/or pulling, or arm or leg controls; and/or (3) when the job requires working at a production rate pace entailing the constant pushing and/or pulling of materials even though the weight of those materials is negligible.

Further limitations, if indicated: _____

"MEDIUM WORK"

Medium work means exerting twenty to fifty pounds of force occasionally, and/or ten to twenty-five pounds of force frequently, and/or greater than negligible up to ten pounds of force constantly to move objects. Physical demand requirements are in excess of those for light work.

"HEAVY WORK"

Heavy work means exerting fifty to one hundred pounds of force occasionally, and/or twenty to fifty pounds of force frequently, and/or ten to twenty pounds of force constantly to move objects. Physical demand requirements are in excess of those for medium work.

"VERY HEAVY WORK"

Very heavy work means exerting in excess of one hundred pounds of force occasionally, and/or in excess of fifty pounds of force frequently, and/or in excess of twenty pounds of force constantly to move objects. Physical demand requirements are in excess of those for heavy work.

Physician's Signature: Ralph Lowell Date: 5/23/2008

Physician's Name (print): Ralph Lowell, M.D.

SAMPLE

SPECIALIST REPORT

Background Information:

Donald Smith
60 East Bluelick Road
New Bierman, OH 45801

Claim Number: OD1234-22

Jenkins Foundry
Out of Business
Address Unknown

Examination Conducted By: James R. Reynolds, M.D.

Place of Examination: 30 West Spring Street, 1-West
Columbus, OH 43266-589

Date of Birth: 11/04/1926

Date of Injury: 06/13/1988

Date of Report: 10/23/2008

Date of Examination: 10/18/2008

Claim Allowances: OD1234-22 06/13/1988 Asbestosis

This 82 year old individual was evaluated on 10/18/2008 at your request. The patient was informed by this physician at the beginning of the evaluation of the Independent Medical Examination nature and that a report would be submitted to you. The history that follows below was obtained from the patient on this date and is included in its entirety.

Purpose of Exam: Consideration of Permanent and Total Disability

This individual is currently not working and has not worked since 06/13/1988. His past medical history he states is unremarkable for serious illness. He denies drug allergies. He states he takes Arthrotec and Allegra as his only medications. He states he takes the Arthrotec primarily for chest wall pain, which will be discussed below. Surgeries in his lifetime include bilateral total knee replacements and a single low back surgery. His injuries in his lifetime include a fracture of the left arm, which did not require surgery. His social history reveals that he is married with no children at home. He does not smoke and has not smoked since 1950. He states that he smoked for only approximately four years prior to 1950. He denies alcohol consumption. He states he drives his own motor vehicle and is able to perform his own activities of daily living.

A brief occupational history was obtained from the Injured Worker and states that he graduated from high school in 1944 and then worked for the above employer in the manufacture of locomotives for approximately twenty years where he was required to perform various labor grade jobs including placing insulation in locomotives. He then worked in construction primarily in the form of industrial and commercial construction for the remainder of his work career. He states he did install some asbestos insulation during his construction activities. He states he worked while wearing a

respirator when needed for the last approximate one half of his employment history. He states he was diagnosed as having asbestosis in 1988. He describes chest discomfort for which he takes Arthrotec. He's lost no time for work in regards to this claim. He's had no hospitalization or surgery in regards to this claim.

At the present time, he complains of constant chest pain, which is mid anterior chest pain. He states that this pain is made worse by taking deep breaths or heavy breathing. He complains of a nonproductive cough on a daily basis. He does not complain of edema. He states that over the last approximate five years he has slept on two pillows instead of one. He does not provide a history of paroxysmal nocturnal dyspnea. He states that he is able to walk one flight of stair steps but not two. He complains of shortness of breath with exercise. He states he is unable to tolerate taking long walks at this time, and cannot tolerate performing construction activities because of his shortness of breath.

Examination:

Physical examination at this time reveals a 5'9", 210 lbs. individual whose head, eyes, ear, nose and throat examination is unremarkable except for his bilateral hearing aids, which were removed during the examination. His chest is clear. He has no rales or rhonchi, rubs or wheezes. He does not utilize the accessory muscles of respiration. He has no swelling or clubbing. He does not have any chest tenderness including over the sternum and the anterior chest where he complains of chest pains. He did not cough throughout the evaluation in either the history or physical examination portions. His blood pressure was 136/64, his respirations were 12, his pulse was 72. A pulmonary function test was obtained at my office in Columbus shortly after I evaluated the patient at 30 West Spring Street and a copy of this report is enclosed for review. This individual's FVC was 57% and his FEV1 was 58%.

Record Review:

The FROI-1, which describes his numerous CT scans of the chest beginning in 1988 are reviewed. The 05/17/2002 letter of Dr. Kilroy is also reviewed. The numerous CT scan reports of the chest and chest x-ray reports are reviewed. This individual's primary difficulties relate to pleural plaques as opposed to parenchymal disease. The review of this file by Dr. Redd dated 1994 is reviewed, as is the 10/21/1993 report by Dr. Rudolph, as are the numerous medical records from early in this claim including the 10/04/1989 report of Dr. Mann.

Discussion:

In my opinion the Injured Worker's condition with regard to the allowed condition has reached a plateau where no significant change can be expected despite further treatment. Therefore he has reached maximum medical improvement. Based on the degree of his respiratory disorder, which is considered to be Class 3 according to the AMA Guides, Fifth Edition, it is my opinion that he would be capable of light work.

Opinion:

1. Has the Injured Worker reached maximum medical improvement with regard to each specified allowed condition? Briefly describe the rationale for your opinion. If "yes" then please continue to items #2 and #3.

Yes. Please refer to narrative discussion above for rationale.

2. Based on the AMA Guides, Fifth Edition, and with reference to the Industrial Commission Medical Examination Manual, provide the estimated percentage of whole person impairment arising from each allowed condition. Please list each condition and whole person impairment separately, and then provide a combined whole person impairment. If there is no impairment for an allowed condition indicate zero percent.

Allowed Condition	Table/Figure/Page Number	Comments	Whole Person Impairment %
Asbestosis	Table 5-12, p. 107	Class 3	35%
Combined whole person impairment:			35%

It is my opinion that the combined whole person impairment for the allowed condition in this claim is: 35%.

3. Complete the enclosed Physical Strength Rating form. In your narrative report provide a discussion setting forth physical limitations resulting from the allowed condition(s).

The physical strength rating form is completed and enclosed. Please refer to narrative discussion above.

Respectfully Submitted,

James R. Reynolds

James R. Reynolds, M.D.

PHYSICAL STRENGTH RATING

Injured Worker: Donald Smith

CLAIM NUMBER(S): OD1234-22

Based solely on impairment due to the allowed conditions in the claim within my specialty and with no consideration of the Injured Worker's age, education, or work training:

- () This Injured Worker has no work limitations.
 () This Injured Worker is incapable of work.
 (X) This Injured Worker is capable of work as indicated below.

() "SEDENTARY WORK"

Sedentary work means exerting up to ten pounds of force occasionally (occasionally: activity or condition exists up to one-third of the time) and/or a negligible amount of force frequently (frequently: activity or condition exists from one-third to two-thirds of the time) to lift, carry, push, pull, or otherwise move objects. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time. Jobs are sedentary if walking and standing are required only occasionally and all other sedentary criteria are met.

Further limitations, if indicated: _____

(X) "LIGHT WORK"

Light work means exerting up to twenty pounds of force occasionally, and/or up to ten pounds of force frequently, and/or a negligible amount of force constantly (constantly: activity or condition exists two-thirds or more of the time) to move objects. Physical demand may be only a negligible amount, a job should be rated light work: (1) when it requires walking or standing to a significant degree; or (2) when it requires sitting most of the time but entails pushing and/or pulling, or arm or leg controls; and/or (3) when the job requires working at a production rate pace entailing the constant pushing and/or pulling of materials even though the weight of those materials is negligible.

Further limitations, if indicated: _____

() "MEDIUM WORK"

Medium work means exerting twenty to fifty pounds of force occasionally, and/or ten to twenty-five pounds of force frequently, and/or greater than negligible up to ten pounds of force constantly to move objects. Physical demand requirements are in excess of those for light work.

() "HEAVY WORK"

Heavy work means exerting fifty to one hundred pounds of force occasionally, and/or twenty to fifty pounds of force frequently, and/or ten to twenty pounds of force constantly to move objects. Physical demand requirements are in excess of those for medium work.

() "VERY HEAVY WORK"

Very heavy work means exerting in excess of one hundred pounds of force occasionally, and/or in excess of fifty pounds of force frequently, and/or in excess of twenty pounds of force constantly to move objects. Physical demand requirements are in excess of those for heavy work.

Physician's Signature: James R. Reynolds Date: 10/18/2008Physician's Name (print): James R. Reynolds

EXAMINATIONS BY BODY SYSTEMS

Oral and Maxillofacial

THE EXAMINATION REPORTING FORMAT

Background Information:

Injured Worker name
 Claim number(s)
 Date of birth
 Date(s) of injury
 Claim allowance(s)
 Place of exam
 Date of exam
 Examiner name
 Purpose of exam

Medical History including CC, HPI, and Pertinent PMH for each allowed condition

Review of Pertinent Medical Records

Examination Findings, reporting all pertinent positive and negative findings

Discussion of the medical findings supporting the opinion

Opinion

Examiners must use the Guidelines to the Evaluation of Impairment of the Oral and Maxillofacial Region published by the American Association of Oral and Maxillofacial Surgeons in their impairment examinations. A copy of these Guidelines is included in this manual following this section.

The Commission requires examiners to provide opinions in three areas for each examination. These opinions must be based solely on the allowed condition(s) listed for examination on the Medical Examination Worksheet.

1. Has the Injured Worker's condition reached Maximum Medical Improvement (MMI) with regard to each specified allowed condition? Briefly describe the rationale for your opinion. If 'yes' then please continue to items #2 and #3.

Maximum Medical Improvement is defined as a treatment plateau (static or well stabilized) where no fundamental or physiological change can be expected within reasonable probability, in spite of continuing medical or rehabilitative procedures. An Injured Worker may require supportive treatment to maintain this level of function.

Under AMA Guides, Fifth Edition, a condition must be Maximum Medical Improvement before permanent impairment can be estimated.

2. Based on the *Guidelines to the Evaluation of the Oral Maxillofacial Region* (AAOMS), and with reference to the Industrial Commission Medical Examination Manual provide the estimated percentage of whole person impairment arising from each of the allowed condition(s). Please list each condition and whole person impairment separately, and then provide a combined whole person impairment. If there is no impairment for an allowed condition, indicate zero percent.

Cite the AAOMS source for your impairment opinion.

3. Complete the Residual Function Assessment. In your narrative report provide a discussion setting forth physical limitations resulting from the allowed conditions.

In assuming function, examiners may not consider the Injured Worker's age, education and work experience or impairment arising from non-allowed medical or surgical disorders. Only the impairment resulting from the allowed Oral and Maxillofacial conditions may be considered.

ALLOWED DIAGNOSTIC TESTING

Teeth (full mouth), facial, and skull X-rays require no prior authorization and may be billed on the Provider Fee Bill as outlined in the Billing section of the manual.

Any other diagnostic testing must have prior approval of Medical Services at 614.466.4291.

Injured Workers may decline testing. If so, note the refusal and base opinions on the available information.

An example of an oral and maxillofacial region Independent Medical Examination follows.

Bernard S. Ryan, D.D.S.

SAMPLE

IMPAIRMENT EVALUATION

Background Information:

Injured Worker: William J. Smith
Date of Examination: 01/24/2008
Claim No.: 96-426250
Date of Injury: 02-17-1996

As requested in your letter dated January 4, 2008, I performed an independent medical examination for Mr. William Smith on January 24, 2008. Per my specialty of oral and maxillofacial surgery, the examination was limited to the head, neck, oral and maxillofacial areas with specific references regarding the claim allowances which were highlighted on the medical examination worksheet, fracture malar/maxillary closed, left. Special attention was also directed to the questions in your letter. Prior to seeing Mr. Smith, a number of documents that were provided to me were reviewed. A history was taken from the patient and from the documents provided to me, a clinical examination was performed and a Waters View and a Panoramic x-ray were taken.

History reveals that this 47 year old Injured Worker was a driver for Papa John's Pizza on February 17, 1996. While making a delivery, Mr. Smith was assaulted and beaten with a baseball bat. He was taken to a Marietta Hospital and then was life-flighted to Grant Hospital in Columbus. He had multiple injuries including skull fractures, fractures of the orbital area and left maxilla, and other multiple injuries which are a matter of record. He had an emergency craniotomy at Grant Hospital for an epidural hematoma and to repair the skull fractures. He also had maxillofacial reconstruction of the orbital bones and left maxilla and zygomatic bone while in Grant Hospital. Since this reconstructive surgery, he has been undergoing efforts at rehabilitation and lives at home. He says he has more or less continuous headaches but has no specific complaints regarding his maxillofacial conditions.

Clinical examination reveals that Mr. Smith has an edentulous maxilla and has worn a full maxillary denture since 1984. He told me that the maxillary denture is now broken so he was not wearing any denture at the time of our examination. He is missing a number of lower teeth and those remaining are in poor state of repair. He has poor dental hygiene. He has normal jaw function with no evidence of temporomandibular joint symptoms. There is a slight depression and flattening of the bony contour of the left orbit with slight prominence of the zygomatic bone. There is a small scar approximately 1 cm in length over the left eyebrow. There is some tenderness over the left infraorbital rim and some numbness of the left infraorbital and frontal bone areas. However, I would consider the functional and aesthetic result of his maxillofacial reconstructive surgery to be very good. There is no evidence of any seventh nerve involvement. The panoramic x-ray shows evidence of multiple infected mandibular teeth but no bony abnormalities except the dental abscesses.

The Waters View x-ray shows good healing of the bones involved in the maxillofacial trauma with indwelling wire fixation. There is no reaction evidence around the indwelling wire fracture supports. Orbit and sinus contours

appear relatively normal and certainly satisfactory.

Answers to the specific questions contained in your letter follows:

1. In regard to the conditions for which I examined, the Injured Worker has reached Maximum Medical Improvement. This is a remote injury which has now healed and no further treatment is necessary for the allowed condition.
2. My opinion regarding percentage of permanent impairment is based on the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition, and the AAOMS *Guidelines to the Evaluation of Impairment of the Oral and Maxillofacial Region*. It is my opinion that the facial abnormalities associated with the allowed condition represents a Class II facial abnormality. This classification includes depressed cheek, nasal or frontal bones. According to the references cited above, a Class II impairment represents a 5 to 10% impairment of the whole person. It is my opinion that the impairments of Mr. Smith represent an 8% impairment of the whole person.
3. The Residual Function Assessment has been completed. There is no impairment due to the allowed conditions which is work limiting.

Please feel free to contact me if elaboration or clarification is desired regarding any of the items contained in this report.

Respectfully submitted,

Bernard S. Ryan

Bernard S. Ryan, D.D.S.

RESIDUAL FUNCTION ASSESSMENT

Injured Worker: William J. Smith

Claim Number(s): 96-426250

Based solely on impairment resulting from the allowed condition(s) within my specialty, and with no consideration of the Injured Worker's age, education, or work training:

- (X) This Injured Worker has no work limitations.
- () This Injured Worker is incapable of work.
- () This Injured Worker is capable of work with the limitation(s)/modification(s) noted below:

Physician's Signature: Bernard S. Ryan Date: 1/24/2008

Physician's Name (print): Bernard S, Ryan, D.D.S.



**GUIDELINES TO THE EVALUATION OF IMPAIRMENT
OF THE ORAL AND MAXILLOFACIAL REGION**

American Association of Oral and Maxillofacial Surgeons- 2002

1

The American Association of Oral and Maxillofacial Surgeons has recognized the need for the establishment of a specific method of evaluating permanent impairments of the maxillofacial region. The committee on Health Care Programs of the American Association of Oral and Maxillofacial Surgeons was given the responsibility of establishing the methodology of measurement, and assigning values for permanent impairment of this area. Using the methods described in this document, and the AMA Guides to the Evaluation of Permanent Impairment, the practitioner will be able to assign an impairment value to the individual for the maxillofacial region.

OBJECTIVES

- ❑ Provide a permanent Impairment Rating for the Maxillofacial Region
- ❑ Definition of terms
- ❑ Recognize that there are different purposes for providing an impairment rating, i.e. Workman’s Compensation, Social Security Administration, Personal Injury Litigation and Medical Indemnity Insurance.
- ❑ Understand applicable state regulation for conducting such examinations.

ACKNOWLEDGEMENT

The Report of Medical Evaluation (Permanent Medical Impairment) on page 11, 12 & the combined injury ratings on page 3 are taken from the Guides to the Evaluation of Permanent Impairment, current edition 5th AMA Guides.

This document does not constitute endorsement by the American Medical Association of the methods and procedures described by the AAOMS in the Guidelines to the Evaluation of Impairment of the Oral and Maxillofacial Region.

I. HOW TO PERFORM AN IMPAIRMENT EXAMINATION

- 1- History, physical examination, and review of pertinent medical records.
- 2- Review special studies.
- 3- Identify objective findings and compare with criteria (Injury Model vs. Range of Motion Model)
- 4- Consider permanency of Impairment
N.B. If impairment is resolving, changing, unstable or expected to change significantly within 12 months, do not do a rating. If condition is not fixed and stable, or if one is making a recommendation for curative (not palliative) treatment, do not give a rating

If range of motion model is used then combine the impairment ratings for injury model ratings

With neurologic impairment	p. 330, Table13-11, Ed. 5 VII, p332, Table13-12
With disfigurement impairment	p. 255, p. 272, p256, Table 11-5, Ed. 5.
With dietary impairment	p. 262, Table 11-7, Ed. 5
With pain	p 569, p 571, Table18-1, p573

If speech, airway, olfaction, ocular, auditory function is impaired, use ratings for injury model.

II DEFINITIONS

Clarification of the following terms is important in distinguishing between different terminology associated with impairments.

IMPAIRMENT DISABILITY HANDICAP

Impairment: is an alteration of an individual's health status that is assessed by medical means. Loss of or use of a body part, system of function.

Disability: is an alteration of an individual's capacity to meet personal, social, or occupational demands or to meet statutory or regulatory requirement. It assumes a medical impairment exists.

For example: Impairment: Loss of index finger.

For a person who is a singer, this in fact would be impairment, but not a disability. For an individual who is a typist, this could represent significant disability in their work as a typist.

Handicap: The Federal Rehabilitation Act of 1973 identifies a “handicapped” individual as one who has an impairment that substantially limits one or more life activities including work, has a record of such impairment, and this impairment can be overcome only by compensation. i.e. artificial limb, etc.

III EVALUATION OF THE ORAL AND MAXILLOFACIAL REGION FOR PERMANENT IMPAIRMENT

Injury model or range of motion model can be used to assess impairment in the maxillofacial region

A. Masticatory Dysfunction:

Eating involves the function of the teeth, jaws, muscles of mastication, muscles of deglutition, and temporomandibular joint. In addition, it requires the ability of a person through lip, tongue and muscle function to be able to swallow food. Loss or change in the functional relationship of any of these anatomic-physiologic components of the system will result in a functional change for the individual.

Loss of teeth and / or dentoalveolar structure (underlying osseous or soft tissue structure) may be due to trauma, developmental condition, or associated disease e.g. extractions indicated for radiation therapy.

There is a distinct and measurable variation between forces generated by natural dentition versus patients with prostheses (full removable dentures). Maximal bite forces appear to be five to six times less for complete denture wearers. In addition, many prosthetic patients select foods that require reduced masticatory capability.

Patients may also develop adverse sequelae with tooth loss including speech difficulties and associated psychosocial problem secondary to cosmetic changes.

The following recommendations are made for determining the impairment rating of the individual loss based on the contribution of each component to the masticatory system. However, reconstruction with prosthesis after a Loss of Dentition.

Patient restricted to liquid foods = 40 – 60% impairment of whole person if feeding tube is necessary

Loss of dentition with ability to wear dentures= 5 – 19% impairment of whole person if restricted to semi-solid and soft food, p 262, AMA Guides Ed 5.

Speech should not be evaluated by an Oral and Maxillofacial Surgeon, suggest referral to speech pathologist.

Example of trauma or oral cancer patient:

Calculation of whole person impairment using the combined value chart with the following assignments:

- 1- 24% impairment of a person who is restricted to a liquid diet and
- 2- 10% for speech impairment (not rated by an Oral Surgeon) is a combined value equals 32% whole person impairment.

B. Temporomandibular Joint

Range of motion model used to assess impairment in the maxillofacial region involving the TMJ

The craniomandibular articulation is composed of the temporomandibular joints bilaterally and the masticatory musculature. These two joint function as a unit.

Total loss of motion or ankylosis renders the patient unable to chew or speak in a normal manner.

The following are not correlated to AMA Guide, but are suggestions of the Health Care Committee:

Summary of Steps in Evaluation Impairments of Craniomandibular Articulation

- 1- Identify the area of involvement.
- 2- Measure the voluntary, non-painful interincisal opening between maxillary and mandibular central incisors (Interincisal Range of Motion).
Measure the lateral excursive distance of the mandible, using the dental midlines from maximum dental intercuspation.
- 3- Add the impairment values for loss of interincisal opening and lateral excursive distance to obtain the craniomandibular articulation impairment value.

INTERINCISAL RANGE OF MOTION	% OF NORMAL WHOLE PERSON	% IMPAIRMENT WHOLE PERSON
Hypomobile 0-10 mm	20	10
Hypomobile 10-20 mm	40	8
Hypomobile 21-29 mm	50	5-7
Hypomobile 30-35 mm	70	3-4
Hypomobile 35- 39mm	95	3-5
Normal 40-50 mm	100	0

American Association of Oral and Maxillofacial Surgeons- 2002

*35 mm is an acceptable range of jaw opening in the AAOMS Par Path Document.

LATERAL EXCURSION RANGE OF MOTION		% OF NORMAL	% IMPARIMENT OF WHOLE PERSON
Hypomobile	0-4mm	60	4
Hypomobile	4-7 mm	70	3
Hypomobile	8-10 mm	90	1
Normal	12 mm	100	0

Hypermobility generally does not impair function and is not ratable. If it appears to cause impairment, it should be treated as a muscle weakness.

Example: A patient has a noted disc derangement with an incisal opening of 25 mm. And lateral excursive movements of 6 mm.

Ratable Criteria:

Interincisal opening 6% impairment

Lateral excursive movement 3% impairment

The two range of motion values are added together:

6% + 3% = 9% impairment of whole person (see combined values chart p 604-5 AMA Guides Ed 5).

Example: A Patient has an ankylosis of the temporomandibular joint with a maximum opening of 5 mm. And lateral excursive movements of 2 mm. Diet is restricted to liquid foods.

Ratable Criteria:

Interincisal opening 10% impairment

Lateral excursive movement 4% impairment

Diet restriction (p. 262 Table 11-7 AMA Guide Ed.5) 30% Impairment

First, add the range of motion values 10% + 4% +14%, then using the combined values chart (AMA Guides p604-5) add the 14% + 30% = 40% of the whole person.

Note impairments secondary to other derangement such as resection, implant arthroplasty, or musculoskeletal disorders are usually rated according to the above

criteria. It is left up to the individual examiner whether to consider these disorders separately. The evaluator must use judgment and avoid duplication of impairments.

C. Skeletal Facial Deformities & Facial Disfigurement

(p. 255-9 AMA Guide Ed5)

Skeletal-facial deformities of the maxilla and / or mandible can produce abnormal function and appearance. These deformities may arise from multiple genetic factors, environment influences, acquired defects, neoplastic processes, degenerative disease and trauma.

Documentation of a skeletal-facial deformity should include

- ❑ History to clearly indicate the source of the skeletal-facial deformity (congenital, developmental, or acquired);
- ❑ Imaging documentation when feasible of the deformity, e.g. post-traumatic defects and / or lateral skull and facial bone x-rays for cephalometric analysis;
- ❑ Clinical photographs and /or
- ❑ Facial moulage or dental models.

Impairment evaluation of an individual with a skeletal facial deformity should be based on a combined value score using AMA's combine value table based on the following ratable symptoms that are deviations from normal function.

The following conditions (impairments) should be separately rated. Then, using the combined value table, a whole person impairment can be calculated.

Masticatory Insufficiency: Premature loss of teeth not in functional occlusion as a result of the underlying skeletal deformity.

All teeth missing or not in functional occlusion could be assigned an impairment value of 5% of the dental system for molars and 3% of the dental system for incisors. If the whole person impairment value based on premature loss of teeth or teeth not in functional occlusion is less than that of a total restriction to liquid diet, the greater value of a whole person impairment assigning 20-30% loss of whole person impairment based on a liquid diet should be used.

A person missing 30 teeth with prosthesis is not usually on a liquid diet. Therefore, 0% - 8% for loss of teeth (injury model).

Abnormal Respiratory (Airway) Problem: (this usually would be rated by other examiners) – relating to the skeletal dental deformity which results in either obstruction, snoring, or sleep apnea. Needs referral for a laboratory sleep study.

Patient with facial skeletal deformities such as vertical maxillary excess and mandibular retrognathia may have upper airway impairment. A sequela of this deformity may be multiple episodes of cessation of breathing for at least 10 seconds during periods of sleep.

Some of the signs and symptoms of this syndrome are snoring, abnormal behavior during sleep and interrupted sleep patterns, and excessive daytime somnolence.

Facial Appearance (Disfigurement): Facial appearance is extremely important for identification and self image. Disturbances in facial appearance or function can also have major impact in social acceptance. Loss of structural integrity and soft tissue changes or injury can result in disfigurements that result not only in physical, but social and functional problems.

In those cases, where the skeletal facial defects, as a result of either congenital or developmental deformities, disease, trauma, or surgical intervention results in a permanent disfigurement, the following impairments may be assigned and used with the combined values scale in determining a total value for skeletal facial deformities.

The AMA Guides to the Evaluation of Permanent Impairment recommend the following classification s and rating of whole person impairment. P. 256 Table 11-5AMA Guide Ed5

- Class 1 Impairment of the Whole Person, 0-5%
A patient belongs in class 1 when the facial abnormality is limited to a disorder of the cutaneous structures, such as visible scars and abnormal pigmentation, or mild unilateral total facial paralysis, or nasal distortion that affects appearance

- Class 2 Impairment of the Whole Person, 6-10%
A patient belongs in class 2 when there is a loss of supporting structure of part of the face, with or without cutaneous disorder. Depressed cheek, nasal, or frontal bones.

- Class 3 Impairment of the Whole Person, 11-15%
A patient belongs in class 3 when there is an absence of a normal anatomical area of the face. Loss of an eye or loss of part of the nose with the resulting cosmetic deformity (if visual or respiratory loss, suggest other examiners), or severe unilateral total facial paralysis, or mild bilateral facial paralysis

- Class 4 Impairment of the Whole Person, 16-35%
A patient belongs in class 4 when facial disfigurement is so severe that it precludes social acceptance.
Massive distortion of normal facial anatomy, or severe bilateral total facial paralysis, or loss of major portion of nose

<u>Disfigurement</u>	<u>Impairment of Whole Person</u>
Unilateral Total Facial Paralysis	= 1-4% mild
	= 5-9% severe
Bilateral Total Facial Paralysis	= 5-18% mild

	=	20-45% severe
Loss of Deformity of Outer Ear	=	0-2% mild
Loss of the Entire Nose	=	25-50%
Nasal Distortions in Physical Appearance	=	0-5%

(p. 2332, Table 13-12 AMA Guide Ed.5)

Cleft Palate Deformity: Example: Cleft palate deformity is a congenital deformity that is amenable to surgical correction and improvement from the time of birth through adolescent and adult year. It is a congenital deformity requiring multiple surgical procedures of the cleft. The cleft palate patient can be evaluated for impairment value based on skeletal deformity values of:

- 1- Mastication dysfunction / malocclusion
- 2- Articulation
- 3- Temporomandibular joint problems
- 4- Facial appearance
- 5- Psychosocial and / or behavioral problems
- 6- Sleep disorder

Psychosocial: If indicated, impairment values can be assigned for behavioral or psychosocial problems that are the result of a facial deformity, but suggest rate by other examiners.

Pain: This section has been totally revised from AMA Guides Ed4. A qualitative value for the evaluation of chronic pain and pain behaviors is now included in Edition 5. Although migraine, cluster and tension headache are now eliminated, pain disorders, somatoform disorder, psychogenic pain and malingering are discussed. A method for integrating impairment rating for pain with other impairments is now available. (see p. 580, Table 18-5, p584, Tables 18-6, 18-7.

- 1- Headache: example, page 586.
- 2- Cranial Nerve Pain: example page 330, Table 13-11

a. *Trigeminal Nerve Pain*

Mild impairment due to uncontrolled Facial neuralgic pain	=	0-14% whole person
Moderate impairment	=	15-24%
Severe	=	25-35%

b. *Facial Nerve*

Complete loss of taste – anterior tongue	=	1-4% whole person impairment
Mild unilateral facial weakness	=	1-4%
Mild bilateral facial weakness	=	5-19%

or

Severe unilateral facial paralysis with 75% or greater facial involvement

Severe bilateral facial paralysis with inability to control eyelid closure =20-45%

c. *Impairment of Cranial Nerve IX, X and XII, p 334, Table 13-14.*

Mild dysarthria, choke on liquid or
semi-solid food

= 1-14% whole person
impairment

REPORT OF MEDICAL EVALUATION PERMANENT MEDICAL IMPAIRMENT

TO:

RE:

CASE #:

DATE OF LOSS:

- | | | |
|-----------|--|----------------------|
| 1. | PAST MEDICAL HISTORY | YES / NO |
| | A. MEDICAL OFFICE RECORDS | REVIEWED
ENCLOSED |
| | _____ | _____ |
| | B. HOSPITAL RECORD | REVIEWED
ENCLOSED |
| | _____ | _____ |
| | C. FROM PATIENT | _____ |
| | D. FROM OTHER SOURCES (DESCRIBE) | _____ |
|
 | | |
| 2. | CLINICAL EVALUATION | YES / NO |
| | A. PHYSICAL EXAMINATION | REPORT
ENCLOSED |
| | _____ | _____ |
| | B. LABORATORY TEST | REPORT
ENCLOSED |
| | _____ | _____ |
| | C. SPECIAL TESTS AND DIAGNOSTIC PROCEDURES | REPORT
ENCLOSED |
| | _____ | _____ |
| | D. SPECIALTY EVALUATIONS | REPORT
ENCLOSED |
| | _____ | _____ |
|
 | | |
| 3. | DIAGNOSES | |
| | A. _____ | |
| | B. _____ | |

C. _____
D. _____

4. STABILITY OF MEDICAL CONDITION

A. THE CLINICAL CONDITION IS STABILIZED AND NOT LIKELY TO IMPROVE WITH SURGICAL INTERVENTION OR ACTIVE MEDICAL TREATMENT MEDICAL MAINTENANCE CARE IS WARRANTED.
YES / NO

B. THE DEGREE OF IMPAIRMENT IS NOT LIKELY TO CHANGE BY MORE THAN 3% WITHIN THE NEXT YEAR
YES / NO

C. EMPLOYMENT IS NOT LIKELY TO IMPROVE WITH SURGICAL INTERVENTION OR ACTIVE MEDICAL TREATMENT.
YES / NO

D. THE PATIENT IS NOT LIKELY TO SUFFER SUDDEN OR SUBTLE INCAPACITATION
YES / NO

5. OTHER ANALYSES

A. EXPLAIN BRIEFLY THE IMPACT (S) OF THE MEDICAL CONDITION (S) ON THE PATIENT'S ACTIVITIES OF DAILY LIVING (SEE APPENDIX A. P. 243)

B. IS THERE A MEDICAL REASON TO BELIEVE THE PATIENT IS LIKELY TO SUFFER INJURY, HARM, OR FURTHER MEDICAL IMPAIRMENT BY ENGAGING IN USUAL ACTIVITIES OF DAILY LIVING OR OTHER ACTIVITIES NECESSARY TO MEET PERSONAL, SOCIAL, OR OCCUPATIONAL DEMANDS? EXPLAIN BRIEFLY.

YES / NO

C. IS THERE A MEDICAL REASON TO BELIEVE OTHER RESTRICTIONS OR ACCOMMODATIONS ARE NECESSARY TO HELP THE PATIENT CARRY OUT USUAL ACTIVITIES OR MEET PERSONAL, SOCIAL AND OCCUPATIONAL

DEMANDS? IF SO, BRIEFLY EXPLAIN THEIR THERAPEUTIC, RISK-AVOIDANCE, OR OTHER KIND OF VALUE?

YES / NO

6. IMPORTANT EVALUATION ACCORDING TO AMA GUIDES – ATTACH A COMPLETE REPORT OF FINDINGS AND NARRATIVE COMMENTS FOR EACH BODY PART OR SYSTEM.

BODY PART OR SYSTEM	CHAPTER #	TABLE
---------------------	-----------	-------

- A. _____
- B. _____
- C. _____
- D. _____

- THIS PATIENT HAS BEEN UNDER MY CARE FROM _____ TO _____
- I HAVE NOT PROVIDED CARE FOR THIS PATIENT. I HAVE SEEN THIS PATIENT _____ TIME (S) FOR THE PURPOSE OF EVALUATING MEDICAL IMPAIRMENT.

SIGNATURE

PLEASE PRINT NAME

REFERENCES

Parameters and Pathways: Clinical Practice Guidelines for Oral & Maxillofacial Surgery (AAOMS Par Path 01)

Fundamentals of Impairment and Disability Evaluations Handbook, American College of Occupational and Environmental Medicine 1995.

Guides to the Evaluation of Permanent Impairment Fifth Edition. American Medical Association.

Statements by the American Association of Oral and Maxillofacial Surgeons Concerning the Management of Selected Clinical Conditions and Associated Clinical Procedures Temporomandibular Disorders.

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American Association of Oral and Maxillofacial Surgeons- 2002

14

EXAMINATIONS BY BODY SYSTEMS

Mental and Behavioral

THE EXAMINATION REPORTING FORMAT:

Background Information:

- Injured Worker name
- Claim number(s)
- Date of birth
- Date(s) of injury
- Claim allowance(s)
- Place of exam
- Date of exam
- Examiner name
- Purpose of exam

Review of Pertinent Medical Records

A Mental Health History

The Mental Status Examination

A Multiaxial Diagnosis

Opinions

Opinions must be based solely on the allowed psychiatric/psychological conditions highlighted on the Industrial Commission Medical Exam Worksheet. Examiners must accept the allowed condition(s) in the claim. If examination findings fail to confirm the presence of the allowed condition(s) in the claim at the time of the examination, an acceptable opinion is, "I find no evidence of impairment resulting from the allowed condition at the time of this examination." Examiners may not state, "I find no evidence of the allowed condition at this examination." Denial of the allowed condition may disqualify the examination as "some evidence" at hearing or in court.

Allowed Condition for Mental and Behavioral Disorders

Psychiatric/psychological conditions become allowed conditions in the following manner: When an injury occurs, a first report of injury (FROI-1) is filed with the Bureau of Workers' Compensation (BWC). The Bureau of Workers' Compensation reviews the Injured Worker's and employer's report of the accident, the medical reports, and either allows or denies the claim within 28 days. When approved by the Bureau of Workers' Compensation, the allowed condition becomes legal basis for the Injured Worker's claim for compensation.

The Injured Worker later suffers a psychological condition resulting from the injury. A request for the additional allowance of the psychological condition is made, and is allowed. The psychological condition then becomes an additional allowance to the original claim. There may be multiple allowed conditions in one claim and multiple claims for one worker.

1. Maximum Medical Improvement (MMI)

Has the Injured Worker reached Maximum Medical Improvement with regard to each of the allowed condition(s)? Briefly describe the rationale for your opinion. If 'yes' then please continue to items #2 and #3.

Maximum Medical Improvement is defined as a treatment plateau (static or well-stabilized) where no fundamental or physiological change can be expected within reasonable probability, in spite of continuing medical or rehabilitative procedures. An Injured Worker may require supportive treatment to maintain this level of function.

Note that under AMA Guides, Fifth Edition, a condition must be Maximum Medical Improvement before permanent impairment can be estimated.

2. Impairment

Based on the AMA Guides Second and Fifth Editions, and with reference to the Industrial Commission Medical Examination Manual, provide the estimated percentage of whole person impairment arising from each psychological/psychiatric allowed condition. Please list each condition and whole person impairment separately, and then provide a combined whole person impairment. If there is no impairment for an allowed condition, indicate zero percent.

The AMA Guides, Fifth Edition, Chapter 14, (Mental and Behavior Disorders) discusses an approach to evaluate and classify mental and behavioral disorders. However, neither the Guides Fourth or Fifth Editions provide impairment percentages. The Industrial Commission of Ohio requires a percent impairment be given for each allowed condition.

Therefore, a table has been constructed for use by the examiners to assist them in classifying and estimating percent impairment, and in order to fulfill the Industrial Commission requirements. This table combines the principles for estimating percentage of impairment taken from the Guides Second Edition, Chapter 11, Table 1, and the classes of impairment taken from the Guides Fifth Edition, Chapter 14, Table 14.1. A checkpoint for consistency is also offered by the Global Assessment of Function (GAF), as this value is inversely related to whole person percentage impairment. This table is included in this section of the Industrial Commission Medical Examination Manual.

The Independent Medical Examination shall indicate the class of impairment in each functional area, and an estimated percent whole person impairment for each allowed condition. If there is no impairment, indicate zero percent. If there is more than one allowed psychological condition, combine the whole percentage for each condition by using the AMA Guides Fifth Edition's Combined Values Chart found on Page 604 to give the total percent impairment.

The table located on the following page is useful in summarizing impairment assessment of an Injured Worker.

Classes of Impairment	Class 1 No	Class 2 Mild	Class 3 Moderate	Class 4 Marked	Class 5 Extreme
Description of Impairment Severity	No Impairment is noted	Impairment levels are compatible with most useful functioning	Impairment levels are compatible with some, but not all, useful functioning	Impairment levels significantly impede useful functioning	Impairment levels preclude useful functioning
Area or Aspect of Functioning					
Activities of Daily Living					
Social Function					
Concentration					
Adaptation					
GAF Value	81-100	61-80	51-60	31-50	1-30
Whole Person Impairment % Guides 2nd Edition	0-5%	10-20%	25-50%	55-75%	>75%

3. Occupational Activity Assessment

Complete the Occupational Activity Assessment (OAA). In your narrative report provide a discussion setting forth mental limitations resulting from the allowed psychological conditions.

ALLOWED DIAGNOSTIC TESTING

MMPI and Bender-Gestaldt are considered part of a psychological examination and are not billable. Injured Workers may decline testing, and if this is the case, note the refusal and base opinions on the available data.

Neuropsychological testing, when appropriate, will be reimbursed at a rate of one hundred dollars per hour, with a maximum of four hours.

Any additional diagnostic testing must have prior approval of Medical Services at 614.466.4291. Bill for approved additional testing on the Provider Fee Bill.

Examples of Mental and Behavioral Health Independent Medical Examinations follow.

Joe Jones, M.D.

100 State Street • Columbus, Ohio 41111

(614)224-0000

PSYCHIATRIC EVALUATION

Background Information:

Injured Worker:	Sue Smith	Claim No.:	93-00000
Date of Birth:	01/01/1945	Date of Injury:	02/01/1993
Occupation:	Dietary Hostess	SSN:	000-00-0000
Date of Exam:	01/01/2008	Examiner:	Joe Jones, M.D.
Place of Exam:	100 State Street, Columbus, Ohio 41111		
Duration of Exam:	1 Hour, 20 Minutes		
Purpose of Exam:	PTD IME		

Claim Allowance: Sprain/strain lower back; aggravation of pre-existing degenerative arthritis, lumbar spine; aggravation of pre-existing herniated disc L5-S1, major depression, recurrent, severe, without psychotic features.

Ms. Smith’s responses were relevant and goal-directed. She was judged to be an adequate historian.

Review of Medical Records:

- 03/19/1998 - Psychological Report, Thomas Cooper, Ph.D.
- 02/04/1999 and 11/05/1997 - Psychological Reports, James Young, Ph.D.
- 11/19/1998 - Orthopedic Report, Charles Thomas, M.D.

Description of Applicant:

Ms. Smith arrived punctually for her appointment, although she then needed to take ten minutes to visit the rest room. She had been driven by a friend as she no longer owns a car. Ms. Smith is a very obese 63 year old woman of 5’7” in height and 292 lbs. in weight. She said her weight has decreased in the last several years from 350 lbs. She attributes her weight loss to the inability to afford more food to eat rather than a specific attempt to diet per se. Ms. Smith was casually dressed in shorts and a t-shirt. Her behavior was appropriate in all respects. She walked with the help of a cane, moving slowly and deliberately. Throughout the interview, she sat for almost 1½ hours in a chair without complaint or apparent discomfort. She made good eye contact at all times. Her affect was somewhat flat, and she appeared to be a little depressed. Her speech was deliberate but not pathologically abnormal in any way. There was nothing unusual about her behavior.

Chief Complaints:

Ms. Smith’s main complaints at this time revolve around her financial status secondary to being unemployed. Repeatedly she impressed on how tough things were for her financially and socially as a result of having to go on welfare and SSI in order to survive. Her savings are depleted, and she has no other source of income. She also complained of pain in her low back and hips as well as just about every joint in her body. She attributed this pain to a degenerative cartilaginous joint condition. On specific questioning, she denied any complaints related to her morbid

obesity and claimed that no doctor had addressed this issue. Ms. Smith also acknowledged feeling depressed as a result of her chronic pain and desperate financial situation.

History of Present Illness:

Ms. Smith described how, in February 1993, about 1½ years after she had begun working at Lakeview Hospital as a dietary hostess, she noticed increasingly severe pain in her lower back. She attributed this to the daily task of pushing heavy food trays to patient wards. One morning she apparently woke up in moderate discomfort, went to work and requested that her supervisor allow her to see the doctor. Her instructions were to go home, stay in bed for two weeks and return to the clinic. After this, x-rays were performed and she was diagnosed with a back injury such that “I could no longer work.” In fact, since that time, Ms. Smith has not worked. She saw an orthopedic doctor who recommended physical therapy, which gave no relief, and another doctor injected her back and hips with an anesthetic injection. Eventually, the diagnosis of degenerative joint disease and herniated discs was made. Over the years, Ms. Smith has been given a variety of analgesic, muscle relaxant and anti-inflammatory medication. She gets some relief from a combination of such medications. She currently takes Prilosec, 2 tablets/day; Ultram, 8 tablets/day; Celebrex, 2 tablets/day; Ditropan, 4 tablets/day for a bladder control problem. Additionally, Ms. Smith takes a combination of antidepressant and hypnotic medications including Zoloft, 50 mg. 3/day; Doxepin, 3 tablets at night; Remeron, ½ tablet at night. On a monthly basis Ms. Smith sees her local physician, Dr. Blank, who cares for her emotional and orthopedic conditions. She claimed a satisfactory relationship with Dr. Blank. Ms. Smith noted that some years ago Dr. Blank did request that she be referred to a chronic pain program, but this was apparently denied. Ms. Smith claimed not to have participated in any programs, including rehabilitation or work hardening. When asked why, she claimed that her caseworkers feel she can return to work without further assistance. She attributes this to the fact that they cannot “see” anything wrong with her to justify her inability to return to work. She responds that, before she was hurt at work she was fine, but now she has to live on medications and walk with a cane. Ms. Smith claimed that she cannot stand for longer than five minutes, cannot lift anything in her left hand with the cane in her right or she becomes unbalanced and in pain. She claimed she is unable to sit for long, and in order to sleep and relax she said she needs pills. She asked repeatedly, “Who would hire somebody in my condition?” Ms. Smith claimed that her whole life has changed since her injury. As an example, she described how she used to enjoy “dressing up and wearing high heel shoes.” Now she can’t afford to do any of this and has had to resort to wearing men’s shoes to fit her swollen feet.

Psychiatric History:

Ms. Smith acknowledged seeing a counselor with Catholic Charities, Mr. Day, around 1990 following her first divorce and prior to her second marriage. She claimed she saw him for about a year. At one stage, Mr. Day referred her for a psychiatric evaluation. She saw this person on a one-time basis and does not recall the name. When asked if she had been depressed in the past, Ms. Smith claimed, “Yes, but I did not know it until I was older. I think I’ve been depressed since I was a teenager.” Subsequently, except for the psychiatric evaluation requested by Workers’ Compensation, Ms. Smith denied any other psychiatric treatment.

Past Medical History:

Ms. Smith recites a long history with recurrent urinary tract infections resulting in urgency and frequency. For this she takes Ditropan. She also reported a right carpal tunnel syndrome that she’s had for five years, as well as multiple joint problems due to cartilage degeneration. She also has a long history of pelvic inflammatory disease that she attributes to the sexual promiscuity of her first husband.

Developmental History:

Ms. Smith was born in Cleveland, "I was a product of a fling between my mother and my father." She claimed to have never known her father, but was raised instead by her stepfather. She never knew of her origins until sometime in her 30's. She claimed her childhood was one of chronic abuse. She described various sadistic and cruel behaviors and beatings from each parent as well as being strapped and tied up so she would not have to be watched. In her adolescence, she was inappropriately treated sexually inasmuch as her stepfather's friends would come and visit and "they'd hit on me," kissing her inappropriately with her stepfather looking on and refusing to protect her. Eventually, at age 17, she left home to marry.

Ms. Smith was educated into 11th grade at which time she quit school to work as a waitress. She achieved her GED in 1977 and went on to Tri-C, where she earned an Associate Degree in Business Management and Hospitality Room Service.

Ms. Smith married in 1963 at age 17 and lived for a while in Norfolk, VA. Thereafter, she had four children: Mary, now 36, Megan, 35, Misty, 32, and Mindy, 28. During this time, she worked intermittently as a hostess. Her children have caused her some concern, particularly the youngest, whose 2-year old daughter she has raised for about 16 months, until November, 1999, following the mother's abandonment of the child. Ms. Smith divorced her first husband in 1990 because of his abuse of her and promiscuity. She remarried in 1993 but the marriage lasted only a year after she discovered she had married a man similar to her first husband. Currently, Ms. Smith has a gentleman friend she has known for about three years. She sees him every couple of weeks and enjoys his company. However, they both have very low incomes, and if they married, their incomes would become even lower. Her friend is disabled secondary to a motor vehicle accident.

Occupational History:

Ms. Smith worked intermittently while her children were little. During the late 1970s she worked part-time for the Ohio School Board as a lunch aide and intermittently in a factory. For periods of time she did not work. Then in the 1980s she worked full-time for the Ohio School Board as a cafeteria manager until her husband requested that she work no longer but stay at home. Following her divorce in 1992, she took the job at Lakeview Hospital where she remained for 1½ years until she was injured.

Social History:

Overall, Ms. Smith described satisfactory interpersonal relationships. She claimed she enjoyed interacting with people in the workplace, although she did acknowledge difficulty at times with authority, saying, "I knew how to stretch a point." She acknowledged being reprimanded at work, perhaps on a monthly basis, and, if provoked, often reached the stage of "I wouldn't care a sh**", somewhat like I feel now. When I can't do something, I don't care." At the moment, Ms. Smith described minimal social activities. She attributes this to not being able to afford to pay to go out or to have clothing to wear to feel nice. She said she stays at home much of the time except for the occasional outing to see a doctor or to go to the supermarket. She does not participate in any club, social or church activity. Except for her gentleman friend, she rarely has people visit her home nor she theirs. Ms. Smith denied military service or police record. She denied ever having been raped or assaulted. She has not smoked for the last three months. Prior to that she said she smoked 6 - 8 cigarettes a day. She denied ever having been a drinker.

A typical day for Ms. Smith consists of sleeping until 1:00 - 2:00 p.m., at which time she will get out of bed and have coffee and toast. For most of the day she will sit on her back porch, occasionally reading. Later in the day she will watch some TV. Sometimes she might watch the news but usually watches an old movie. She said she washes her dishes as

they come, but as for housework and laundry, although she does her own she does this on a weekly or every-other-week basis. She said she keeps shopping to a minimum saying she becomes overwhelmed when she goes into stores and is very much aware of that which she cannot buy. As well, the physical discomfort of walking the aisles causes her discomfort, and “kills my back, and I’m shot for days afterward.” The day ends about midnight or thereafter when she goes to bed. Usually she lies awake several hours before falling asleep.

Mental Status Examination:

Ms. Smith was alert and well-oriented. She presented as described earlier in this report. Her mood she described as, “I’m crappy and not happy. Sometimes I sit and cry. I feel as if I’m not accomplishing anything in life.” She claimed she had thought of suicide at times, particularly when she thinks of the things she previously enjoyed but cannot do now, mostly gardening, bending and lifting. However, she denied being suicidal currently. With respect to her memory, she claimed it is bad and getting worse. She is forgetful and must write things down in order to remember them. She was able to recall my name, the name of the President and Vice President. However, she had little interest in politics, foreign affairs or most activities in the world around her. She said she reads history and occasionally watches TV. She was able to remember the names of the last 2 - 3 movies she had seen. When specifically given three colored objects to recall, she initially confused the colors and the objects but was able to get them correct, but five minutes later repeated the same confusion of mixing up the colors and the objects. She was able to repeat up to five digits forward and backwards but could not recall six digits in either direction. She was able to subtract serial 3s from 20 with facility and subtract \$17.42 from \$20.00 correctly. She claimed she lives alone, pays her bills and attends to all her own responsibilities successfully. She was able to do simple chores around the house and work out whatever basic problems need to be solved. She was able to handle proverbs in a satisfactorily abstract manner. She was able to spell simple words forward and backward. Her judgment and insight appeared to be satisfactory. She denied any evidence of psychotic thinking, no delusions or compulsions. Her depression focused primarily on not being able to do things she used to enjoy, especially when her grandchildren come over. She gave as an example, “All I can offer them is water, I can’t afford anything else.” Her sleep is variable. She said she goes to bed around 1:00 - 2:00 a.m. and falls asleep a few hours later. She said she takes pills to facilitate sleep. She denied bad dreams or nightmares. She said she often awakens fatigued in the morning. Her appetite is satisfactory. She said she eats what she can, although, as noted, her intake is generally limited by her budget. Her sex drive is satisfactory, and she denied any problems in this respect.

ASSESSMENT OF SEVERITY IN TERMS OF FUNCTIONAL LIMITATIONS DUE TO HER ALLOWED

DEPRESSIVE CONDITION (According to AMA Guides, Fifth Edition,):

It is to be noted that many of Ms. Smith’s functional limitations are due to her orthopedic problems and obesity. I will address only those due to her allowed emotional condition of Major Depression.

1. **Activities of daily living**, include cleaning, shopping, cooking, paying bills, maintaining a residence, caring appropriately for her grooming and hygiene, using telephones and directories, etc. **Class 2, mild impairment**, i.e., sometimes neglected because of despondency.
2. **Social functioning**, her ability to get on with others, avoid altercations, fear of strangers, avoidance of interpersonal relationships and social isolation. **Class 2, mild impairment**. Avoids people in that she feels she can’t afford nice things to wear, sometimes despondent.
3. **Concentration, persistence, and pace** with respect to completing tasks in a timely manner and being able to concentrate and attend to that which she is doing. **Class 2, mild impairment**. This reflects a mild distraction, loss of concentration.

4. **Decompensation in work or work-like settings;** capacity to adapt to stressful circumstances including the ability to make decisions, attend to obligations, make schedules, complete tasks, interact with supervisors and peers. **Class 2, mild impairment.** Becomes less functional when demands are put on her, e.g., pressure to perform mental tasks causes a deterioration in performance.

Overall Impairment Rating: Mild

Impairment due to allowed condition, Major Depression, is also mild (10%). This impairment rating is made with the recognition that Ms. Smith is currently taking the psychotropic medications Zoloft, Doxepin and Remeron. This level of impairment is contingent upon the continued use of this medication as long as her supervising doctor, Dr. Blank, sees necessary.

Diagnosis:

- Axis 1: Major Depression, recurrent, severe, without psychosis (allowed condition)
- Axis 2: No diagnosis, depressive characterological features
- Axis 3: As noted in medical records
- Axis 4: Severe, secondary to unemployment, financial difficulties, chronic pain, family stresses
- Axis 5: GAF = 70; some mild symptoms of depressed mood and mild insomnia with some difficulty in social and occupational functioning.

Opinion:

1. Has Ms. Smith reached MMI? Yes. Ms. Smith does appear to have reached Maximum Medical Improvement inasmuch as she is at a treatment plateau relative to her depressive symptoms. She is considered to have reached a plateau as this has been her emotional state for the last several years and in large part reflects her characterological structure and long-time functioning. However, this state of Maximum Medical Improvement is contingent upon her continuing use of medication unless reviewed by a psychiatrist in the future, who may decide to gradually wean her while supervising her progress.
2. What is the percentage of permanent impairment arising from her allowed depression? Based on today's examination and review, and with reference to AMA Guides Second and Fifth Editions and the Industrial Commission Medical Examination manual, Ms. Smith is considered to be experiencing about 10% permanent impairment arising from her depressive symptoms at this time.
3. What is the Injured Worker's occupational activity assessment? Overall, Ms. Smith's occupational activity capacity is minimally influenced by her depressive state. A full review of her mild impairment rating (approximately 10%) is outlined previously in Assessment of Severity.

Sincerely,

Joe Jones

Joe Jones, M.D.

OCCUPATIONAL ACTIVITY ASSESSMENT

Mental & Behavioral Examination

Injured Worker: Sue Smith

Claim Number(s): 93-00000

Based solely on impairment resulting from the allowed mental and behavioral condition(s) in this claim within my specialty, and with no consideration of the Injured Worker's age, education, or work training:

- This Injured Worker has no work limitations.
- This Injured Worker is incapable of work.
- This Injured Worker is capable of work with the limitation(s)/modification(s) noted below:

Ms. Smith's occupational activity capacity is minimally influenced by her depressive state. Her decompensation in stressful situations would cause her to be limited to a position where she is not required to be involved in complex decision-making. Her social interaction is affected by her depression and she would not function well in a position which would require continuous interaction with the public. Her concentration is adequate for most useful functioning.

Physician's Signature: *Joe Jones* Date: 1/01/2008

Physician's Name (print): Joe Jones, M.D.

Bob Smith, Ph.D.

100 State Street • Columbus, Ohio 41111
(614)224-0000

PSYCHOLOGICAL ASSESSMENT

Background Information:

Injured Worker:	Joseph Lombardi	Claim No.:	92-00000
Date of Birth:	01/01/1931	Date of Injury:	11/07/1992
SSN:	000-00-0000		
Date of Exam:	01/01/2008	Examined By:	Bob Smith, Ph.D.
Referring Agency:	Industrial Commission	Specialty:	Psychology

Allowed Conditions:

Right rotator cuff syndrome; chronic impingement syndrome of the right shoulder; degenerated rotator cuff; degenerative joint disease at the acromioclavicular joint; adhesive capsulitis right shoulder; major depressive disorder recurrent, moderate.

Description of Injured Worker:

Joseph Lombardi is a 77 year old, married Caucasian man. He is a small, quiet man, unshaven today. He was casually though appropriately dressed, his personal hygiene was adequate. His wife drove him to this examination. He reports that he cannot read English; he is an immigrant from Italy. He showed no abnormalities of movement. His eye contact was good. He spoke English with a heavy accent but was readily understandable. He was cooperative and responsive.

Purpose of Claim:

Joseph Lombardi was referred by representatives of the Industrial Commission of Ohio. They wish to know whether, in regard to his allowed psychiatric condition (“Major Depressive Disorder Recurrent, Moderate”), he has reached a condition of maximum medical improvement. They also wish to know the percentage of permanent partial impairment arising from this condition as well as his current occupational activity capacities.

Test Administered:

Beck Depression Inventory - 2

Review of Records:

In addition, reports of some past examiners were available. Mr. Lombardi’s psychiatrist, Demetrios Long, M.D., in a letter dated 6/12/99 offered the diagnosis of Major Depression, Recurrent, Moderate. In a letter dated 8/1/99, Dr. Long gave the opinion that Mr. Lombardi had not reached a condition of maximum medical improvement. And in a letter dated 11/2/00, he gave the opinion that Mr. Lombardi is sixty seven percent impaired as a result of his allowed psychological condition. Also present is an examination done 7/3/00 by Stanley White, Ph.D. Dr. White had found Mr. Lombardi to have reached a condition of maximum medical improvement and to not be capable of sustained remunerative employment as a result of his psychiatric condition.

Chief Complaints:

He was asked to describe the physical symptoms, including pain, which he experiences as the result of his allowed claim injury. He reports that, "I can't do nothing in my condition." "Every move I make it hurts me." The pain resides in the top of his shoulder and down the side of his (right) shoulder.

He was asked about the emotional aspect of his injury. The effect on his life is "terrible." "I'm nervous going outside." "My wife keeps telling me what would be good for me." "I wish I could be dead sometimes." "It makes me so ... what's that word ... depressed." "My wife has to cut the grass," he says weeping. "What's wrong with me?"

History of Present Illness:

He was asked about the time of onset of his emotional symptoms. He feels that these depressive symptoms began, "when I got hurt." This refers to his one allowed claim injury, which occurred on 11/7/92, when he fell off a scaffold while working as a mason.

He was asked about any history of mental health care. He denies any such care prior to his injury. Currently he is in treatment with a local psychiatrist, a Dr. Long. He has been in treatment with him, "for a long time." He currently sees him monthly. He denies having been psychiatrically hospitalized, or having had drug or alcohol rehabilitation. (Records on hand indicate he has been under Dr. Long's care at least since 1999).

For a summary of his activities of daily living, please consult the social functioning section of this report.

Mr. Lombardi is currently not working anywhere. Injured in 1992, he reports that he attempted to return to work in 1993. "I tried to do my best." However, he was unable to continue beyond a period of three months. He has not worked anywhere since then.

His family doctor is Dr. Black. As noted, his psychiatrist is Dr. Long. His doctor "for my back," is Dr. Clark. He was asked about medications he currently takes, he was unable to describe these. "My wife has them in her purse." After consulting with Mrs. Lombardi, it was reported that he is currently taking the following medications: for symptoms of depression, he takes Paxil, 10 mgs. For anxiety, he takes Alprazolam, .25 mgs., one or two tablets daily. "For sleep," he takes Sonata, 5 mgs. He does not use a cane or brace.

Asked about the effectiveness of his psychiatric treatments, he says, "I think so, yes. (That is, that they are helpful). I'm too nervous around the house. I take pills, they calm me down," he says weeping.

Occupational History:

Mr. Lombardi was born in Italy in 1931. He attended school only through the second grade, noting, "I don't know why they didn't send me to school." (Elsewhere in the file it notes that he has told others that his school was destroyed by allied bombing during World War II). He is unable to read either English or Italian. He immigrated to the United States when he was "over twenty," he cannot remember for sure. Prior to that, he had worked in Italy on the farm owned by his father. Coming to America, he went to live initially with an uncle who lived in Toledo, Ohio. He worked with this uncle, a concrete contractor. He worked as a concrete worker in the employment of his uncle for "maybe twenty years. I don't know how long." When his uncle retired, Mr. Lombardi found work in the concrete trade elsewhere. He worked for ABC Concrete Company and then for Concrete Construction Company, where he was injured. This was in 1992. He briefly returned to work, for a period of about three months, in 1993, and has not worked anywhere since then.

Asked whether he liked his job, he reported, "Oh, yes. It was a good job. They used to love me, I did good work."

Materials received from the Industrial Commission document only one allowed claim injury. This is for the injury occurring on 11/7/92. At that time he was climbing an eight-foot scaffold, and fell, injuring his shoulder.

Past Medical History:

He denies having experienced any surgeries or hospitalizations at any time during his life, either before or after his industrial injury.

He denies being treated at this time for any illnesses unrelated to his allowed claim.

Family History:

Mr. Lombardi was born in 1931, in Italy; he says he cannot remember where. His parents, together during his childhood, are now deceased. His father had been a farmer, his mother was a homemaker. Asked about his siblings, he stated, "I remember six brothers, I think there were two sisters." He was "in the middle" of the sibling group. He denies any particular problems within the family, such as abuse, alcoholism, or mental illness. He immigrated to the United States sometime in his early twenties.

He is married to Pam Lombardi, age sixty-five. He weeps as he says that he cannot say how long they have been married. Likewise he does not know the ages of his three children, whose names in descending order of birth, are: Thomas, Debbra, and Barbara. He has grandchildren, "I don't know how many." His household presently consists of himself and his wife. Their income consists of Social Security payments to him, and Social Security payments to her.

Social History:

He was asked to describe what for him is a typical day. He rises about 9:00 a.m., has coffee, watches television, and goes outside. Then he comes back inside. "That's all I do." In the afternoon he "do nothing." He denies having any hobbies at this time; when he was younger, he enjoyed playing Boccie Ball. He reports having no friends. As far as family members are concerned, he reports that his children "come see me every once in a while, every five or six months." "They live out of town." Asked to describe his relationship with his wife, he states, "I love my wife. I make her mad too many times, but I cannot help it."

He denies drinking any alcoholic beverages. He used to drink occasionally, but "not much." He denies every having been convicted of a crime. He was asked about his involvement in activities of daily living. He does not help with the laundry, "years ago I did." He does not help clean the house. He does not pay the bills or keep the checking account. He is not literate in English. He does not go grocery shopping, he says he does not go shopping at all, nor does he cook. He is able to dress and groom himself. "I manage pretty good," but he sometimes has difficulty putting on his socks. He used to drive a car, but now does not. "I get confused with the signs and the lights."

Mental/Behavioral Examination:

Mr. Lombardi's demeanor was downcast, sad. He is a small, quiet man, unshaven, casually dressed. He reported his wife drove him to this examination. His English was rudimentary, but it was adequate to the requirements of this examination. He was able to respond adequately to the questions asked. No abnormalities of movement were noted. His speech was clear, coherent, and goal directed. It was unremarkable in its content, showing no evidence of hallucinations, delusions, loosening of associations, paranoia, obsessions, or compulsions. His affect was depressed, and was appropriate to the content of his speech. His mood was discouraged, resigned, grieving. His short-term memory was tenuous; he was able to remember only one of three objects after five minutes. His longer-term memory was also tenuous; he thought that the current president was Mr. Clinton and was able to cite only two other recent presidents. His concentration was adequate to the demands of this evaluation, but is likely to be inadequate in some other

circumstances. He acknowledges thoughts of self-harm, but denies any plan or intent to harm himself or anyone else. As noted, he is illiterate; therefore the items of Beck Depression Inventory-2 were read to him and his answers taken down by this writer. His summary score of forty-seven, places him in the “extremely, severely depressed” range of response on this instrument.

Depressive symptoms that he reports at this time include sadness, discouragement about the future, anhedonia, dislike of himself, frequent tearfulness, diminished appetite, loss of interest in sexual expression, irritability, agitation, diminished physical and intellectual energy.

Discussion:

Joseph Lombardi, after coming to this country at the age of perhaps twenty, or twenty-two (this is one of many dates about which he is unsure), worked as a cement worker for thirty-five to forty years prior to injuring himself in a fall on the job in 1992. At this time he shows signs of discouragement and despair; a strong sense of what he is no longer able to do. He feels, as is often the case with those who labor with their hands and do not have educational backgrounds upon which to fall back, without hope as a result of this injury. He has not established other sources of enjoyment and productivity in his life. His wife does most of the activities that would be required for day-to-day functioning. As he is dependent on her for many things, he acknowledges he is irritable and demanding with her. Having left his family to immigrate to this country, and his children having moved away, there are few family contacts for him at this point, and he denies having much contact with friends. He has adopted a very low-key and withdrawn lifestyle. While this undemanding lifestyle may serve to reduce stress in the short-term, in the longer-term it would tend to further erode social skills and make it more likely that he would focus more upon his losses, and his pain.

In terms of the DSM-IV, his current diagnostic formulation would be as follows:

- AXIS I: Major Depressive Disorder, Recurrent, Moderate
- AXIS II: No diagnosis
- AXIS III: Reported chronic shoulder pain
- AXIS IV: Loss of vocational and avocational pursuits, chronic pain
- AXIS V: Highest GAF, past year: 60
Current GAF: 60

Opinion:

Mr. Lombardi, having immigrated to this country as a young man, worked as a cement mason for thirty-five to forty years prior to injuring himself in a fall on the job in 1992. He has not worked anywhere since that time. Despite ongoing psychiatric care, he continues to show symptoms of depression.

Regarding the specific referral questions, the following information is offered:

1. In regard to the allowed psychiatric condition, has the Injured Worker reached a condition of Maximum Medical Improvement?

Yes, it is found here that in regard to his allowed psychiatric condition (“Major Depression Disorder, Recurrent, Moderate”), he has reached a condition of MMI. In spite of his psychiatric care over the past two or three years at least, he continues to show significant depressive symptoms. We would conclude that he has reached a plateau in his treatment, beyond which further improvement would not be expected.

2. What is the percentage of permanent impairment arising from the allowed psychiatric condition?

In making the following assessments of his day-to-day functioning and percentage of impairment, the *AMA Guides to the Evaluation of Permanent Impairment, Second and Fifth Editions* and the Industrial Commission Medical Examination Manual have been relied upon.

In regard to his Activities of Daily Living, we note that there is little that he does on a very regular basis. His wife rather than he is involved doing laundry, cleaning the house, paying the bills, shopping, and cooking. He is able to dress and groom himself without major difficulty. He does not drive a car anymore, because "I get confused." He is not involved in any hobbies or organizations that take him outside of the house. His lifestyle is low-key and home-based. His associations are primarily with family rather than with friends, and even those associations are infrequent due to separation. His functioning in this area then suggests a Class III, or moderate level of impairment.

In regard to his Social Functioning, as noted his children are far from him geographically. He reports that his relationship with his wife is acceptable, he is aware that he is irritable to live with. He has little if any contact with friends, he has few if any family members in this area, having immigrated here as a young man. His functioning in this area again suggests a moderate or Class III level of impairment.

In regard to his Concentration, Persistence, and Pace, here again impairment is significant. His persistence and pace are adequate to the demands of this assessment, though minimally. Likewise, he seems to engage in no activities that would challenge him in these areas. He has no associations or projects that would require him to expend energy in a persistent and concentrated way. His attention and short-term memory are quite tenuous. His functioning in this area suggests a Class IV, or marked level of impairment.

In regard to his Adaptation to Changing Life Circumstances, we note that he and his wife live a quiet and subdued style of life at the age of 77. This may be more congenial to him than it would have been at an earlier time in his life. He prefers to spend his time primarily at home rather than out with others. He has taken upon himself no activities that would take the place of work as a central focus in his life. His functioning in this area then would suggest a Class III or moderate level of impairment.

Considered together, his functioning in these areas indicates a Class III, or moderate level of impairment. This is consistent with a thirty percent (30%) impairment of the whole person, directly attributable to his allowed psychiatric condition, "Major Depressive Disorder, Recurrent, Moderate."

3. What is the Injured Worker's Occupational Activity Assessment?

In reference to this question, please see the enclosed Occupational Activity Assessment form.

Respectfully submitted,

Bob Smith

Bob Smith, Ph.D.
Psychologist

OCCUPATIONAL ACTIVITY ASSESSMENT

Mental & Behavioral Examination

Injured Worker: Joseph Lombardi

Claim Number(s): 92-00000

Based solely on impairment resulting from the allowed mental and behavioral condition(s) in this claim within my specialty, and with no consideration of the Injured Worker's age, education, or work training:

- This Injured Worker has no work limitations.
- This Injured Worker is incapable of work.
- This Injured Worker is capable of work with the limitation(s)/modification(s) noted below:

Mr. Lombardi's depressive symptoms, most particularly his diminished concentration, his social withdrawal, his diminished physical and intellectual energy, and his discouragement and hopelessness, would in and of themselves prevent him from succeeding in sustained, remunerative employment.

Physician's Signature: *Bob Smith* Date: 1/01/2008

Physician's Name (print): Bob Smith, M.D.

EXAMINATIONS BY BODY SYSTEMS

Visual System

THE EXAMINATION REPORTING FORMAT:

Background Information:

Injured Worker name
 Claim number(s)
 Date of birth
 Date(s) of injury
 Claim allowance(s)
 Place of exam
 Date of exam
 Examiner name
 Purpose of exam

Review of Pertinent Medical Records

Injury or Occupational Disease History

Examination Findings

Identify and describe any ocular or facial deformities due to the injury, report the corrected and uncorrected near and distant vision each eye, note visual field examination findings, by confrontation if normal or formal visual field determination if abnormal, and describe ocular motility (extraocular muscle examination). Include any other appropriate findings.

Please note that corrected vision should be used for rating impairment in the case of application for Permanent Total Disability, including if the correction is by surgical or other (e.g., contact lens or glasses) means.

However, in the rare case of evaluation for loss of use of an eye in the case of application for a scheduled loss award, then the specialist must use uncorrected vision, without consideration of correction to vision due to surgical or other (e.g., contact lens or glasses) means.

Discussion

Provide an analysis of the examination evidence supporting the opinion.

Opinion

Opinions must be based solely on the allowed conditions listed for examination in your specialty on the Medical Examination Worksheet. Opinions on the following three issues are required.

1. Has the Injured Worker reached Maximum Medical Improvement with regard to each specified allowed condition? Briefly describe the rationale for your opinion. If 'yes' then please continue to items #2 and #3.

Maximum Medical Improvement is defined as a treatment plateau (static or well-stabilized) where no fundamental or physiological change can be expected within reasonable probability, in spite of continuing medical or rehabilitative procedures. An Injured Worker may require supportive treatment to maintain this level of function.

Under AMA Guides, Fourth Edition, a condition must be Maximum Medical Improvement before permanent impairment can be estimated.

2. Based on the AMA Guides, Fourth Edition, and with reference to the Industrial Commission Medical Examination Manual, provide the estimated percentage of the whole person impairment arising from each of the allowed condition(s). Please list each condition and whole person impairment separately, and then provide a combined whole person impairment. If there is no impairment for an allowed condition, indicate zero percent.

The accepted methodology for this determination is described on the following page.

3. Complete the Residual Function Assessment. In your narrative report provide a discussion setting forth physical limitations resulting from the allowed conditions.

A Residual Function Assessment form is used to assess the affect of the Injured Worker's visual impairment on his or her overall functional capability. In assessing function, examiners may not consider the injured worker's age, education and work experience or impairment arising from non-allowed medical or surgical disorders. Only impairment resulting from the allowed eye disorder may be considered.

ALLOWED DIAGNOSTIC TESTING

Visual acuity and visual field studies are considered part of eye examinations and are not billable.

Any other additional testing must have prior approval of Medical Services at 614.466.4291.

Injured Workers may decline testing. If so, note the refusal and base opinions on the available information.

Bill for approved additional testing on the Provider Fee Bill.

Eye Examination

The following method for determining loss of vision meets the administrative and legal needs of the Industrial Commission of Ohio.

Methodology

The Commission will continue to use AMA Guides to the Evaluation of Permanent Impairment, Fourth Edition, in determining whole person percentage impairment, since AMA Guides, Fifth Edition, procedures do not meet Ohio's legal requirements.

Please note that corrected vision should be used for rating impairment in the case of application for Permanent Total Disability, including if the correction is by surgical or other (e.g., contact lens or glasses) means.

However, in the rare case of evaluation for loss of use of an eye in the case of application for a scheduled loss award, then the specialist must use uncorrected vision, without consideration of correction to vision due to surgical or other (e.g., contact lens or glasses) means.

AMA Guides, Fourth Edition, permanent impairment percentages consider near and far central visual acuity, visual field perception, abnormal ocular motility and binocular diplopia. Examiners may combine an additional five to ten percent impairment for ocular or adnexal conditions that interfere with visual function not reflected in the visual acuity, visual field, or ocular motility impairment. These conditions might include media opacities, corneal or lens opacities, and abnormalities that cause symptoms such as epiphora, photophobia, or metamorphopsia. Up to ten percent additional impairment may also be considered for scars or cosmetic defects.

Table 3 "Loss (in %) of Central Vision in a Single Eye" provides the percent loss of central vision in a single eye using the measured Snellen rating for distant and near vision. The table also provides values for each combination of near and distant vision with and without allowance for monocular aphakia and pseudophakia.

Table 5 "Loss of Monocular Visual Field" provides percent loss based on the number of degrees of visual field loss due to the allowed condition. Figure 3 "Percentage Loss of Ocular Motility of One Eye in Diplopia Fields" is used to determine the loss due to ocular motility when appropriate.

To determine visual loss for "an eye," loss of central and near vision, loss due to visual fields, and loss due to diplopia are combined using the AMA Guides Combined Values Chart (pages 322-324).

An example of an Ophthalmologic Independent Medical Examination follows.

Stephen E. Dark, M.D. (Ophthalmology)

100 Holiday Lane • Smithville, Ohio 43551

(614)224-0000

SPECIALIST REPORT

SAMPLE

Background Information:

Injured Worker:	Sirlister Stalone	Claim No.:	65-00000
Employer:	International Enterprises	Date of Injury:	05/08/1995
Date of Birth:	01/01/1945	Occupation:	Floor Supervisor
Sex:	Male	Date of Report:	03/30/2008
Date of Examination:	03/30/2008		

Claim Allowances:

Ocular penetration NOS, right. Ocular laceration; glaucoma associated with unspecified ocular disorder, traumatic cataract, unspecified.

Purpose of Examination:

I had the pleasure of examining Sirlister Stalone on March 30, 2008, for the purpose of doing an independent medical examination. I reviewed the medical records sent to me and accept the allowed conditions in this claim.

Chief Complaint:

Poor vision in his right eye. Chronic headaches and gritty feeling in both eyes.

History of Present Illness:

Mr. Stalone suffered an injury to his right eye on May 8, 1995, when he was pushing a clothes rack and a hanger came off the rack and caught his right eye. He was seen that same day by Dr. Gerald Steph who diagnosed him with a corneal laceration with uveal prolapse. He underwent immediate repair in the operating room. He was subsequently followed by Dr. Steph. Also from the injury he had a large hyphema and a dense vitreous hemorrhage. On May 24, 1995, he underwent a pars plana vitrectomy in his right eye with scleral buckling by Dr. Phil Mead. At the time of the vitrectomy, he was noted to have several retinal tears which were repaired at that time. Mr. Stalone subsequently developed a cataract in his right eye which was removed by Dr. Steph in April of 1997. Currently, Mr. Stalone feels that the vision in his right eye is quite poor including both his central vision and his side vision. He also complains of chronic headaches and a gritty feeling in both eyes.

Physical Examination:

On examination, the visual acuity in the right eye without correction was 20/100 at distance and Jaeger 11 at near. In the left eye, it was 20/60 without correction at distance and Jaeger 11 at near. With a refraction, the right eye at a -1.75+1.25 at 145 vision at distance was 20/50. With a reading aid he saw Jaeger 9, best corrected in the right eye. The left eye best corrected was 20/30 at distance.

Slit lamp examination of the right eye revealed a 3-4mm corneal scar on the inferior temporal quadrant of the cornea with several sutures still in place and iris to the wound. The pupil was fixed at approximately 4mm and there was a

posterior chamber lens. Slit lamp of the left eye was within normal limits.

Intraocular pressure was 20 in the right eye and 21 in the left.

On dilated funduscopy examination of the right eye, the cup to disc ratio was .5. The vessels and macula appeared to be normal. In the peripheral retina, there was dense scarring. The dilated funduscopy examination of the left eye was within normal limits.

Esterman visual field revealed an Esterman efficiency score of 36 in the right eye and 68 in the left.

Discussion:

Mr. Stalone suffered a significant ocular injury to his right eye from a clothes hanger injury on May 8, 1995, resulting in his allowed conditions of ocular penetration not otherwise specified in the right eye, ocular laceration right eye, glaucoma associated with unspecified ocular disorder, traumatic cataract, unspecified in the right eye. He has undergone the above-referenced surgical procedures. No further surgery is planned and it appears that he has reached a plateau where further treatment would not be expected to significantly change his condition.

Opinion:

It appears that he has reached maximum medical improvement in regard to these allowed conditions.

Using the AMA Guides, Fourth Edition, Chapter 8, the Visual System, he has a best corrected central visual loss in his right eye of 77% using Table 3, p. 212. He has a 64% loss of the visual field in the right eye according to the Esterman Visual Field Test. Combining these two values 77+64 using the Combined Values Chart on p. 324, you get a visual loss of 92% in the right eye. Using Table 7, p. 219 he has a 23% loss of the visual system. This gives a 22% whole person impairment, according to Table 6, p. 218.

The Residual Function Assessment is attached. Please see narrative comments.

Sincerely,

Stephen E. Dark

Stephen E. Dark, M.D.

RESIDUAL FUNCTION ASSESSMENT

Injured Worker: Sirlister Stalone

Claim Number(s): 95-00000

Based solely on impairment arising from the allowed condition(s) within my specialty, and with no consideration of the Injured Worker's age, education and work experience:

- This Injured Worker has no work limitations.
- This Injured Worker is incapable of work.
- This Injured Worker is capable of work with the limitation(s)/modification(s) noted below:

Limitations include inability to qualify for a commercial driver's license; no working with heavy equipment or machinery; no working at heights; and he would have difficulty doing tasks which require good depth perception.

Physician's Signature: *Stephen E. Dark* Date: 3/30/2008

Physician's Name (print): Stephen E. Dark, M.D.

EXAMINATIONS BY BODY SYSTEMS: OTHER BODY SYSTEMS

**Digestive • Ear, Nose and Throat • Endocrine
• Hematopoietic • Skin • Reproductive • Urinary**

THE EXAMINATION REPORTING FORMAT:**Background Information:**

Injured Worker name
 Claim number(s)
 Date of birth
 Date(s) of injury
 Claim allowance(s)
 Place of exam
 Date of exam
 Examiner name
 Purpose of exam

Medical History including CC, HPI, and Pertinent PMH for each allowed condition

Review of Pertinent Medical Records

Examination Findings, reporting all pertinent positive and negative findings

Discussion of the medical findings supporting the opinion

Opinion

Opinions on the following three issues are required. Opinions must be based solely on impairment arising from the allowed condition(s) in the claim. Disability factors (age, education, and work training) may not be considered in the opinion. Opinions on the following three issues are required.

1. Has the Injured Worker's condition(s) reached Maximum Medical Improvement (MMI) with regard to each specified allowed condition? Briefly describe the rationale for your opinion. If 'yes' then please continue to items #2 and #3.

Maximum Medical Improvement is defined as a treatment plateau (static or well-stabilized) where no fundamental or physiological change can be expected within reasonable probability, in spite of continuing medical or rehabilitative procedures. An Injured Worker may require supportive treatment to maintain this level of function.

Under AMA Guides, Fifth Edition, a condition must be Maximum Medical Improvement before permanent impairment can be estimated.

2. Based on AMA Guides, Fifth Edition, and with reference to the Industrial Commission Medical Examination Manual, provide the estimated percentage of the whole person impairment arising from each of the allowed condition(s). Please list each condition and whole person impairment separately, and then provide a combined whole person impairment. If there is no impairment for an allowed condition, indicate zero percent.

Cite the AMA Guides source for your impairment opinion.

Combine multiple allowed condition(s) impairments using the AMA Guides Combined Values Chart and indicate the total whole person impairment from all allowed conditions in the claim.

3. Complete the Residual Function Assessment. In your narrative report provide a discussion setting forth physical limitations resulting from the allowed conditions.

Consider only impairment arising from the allowed condition(s) in completing the Residual Function Assessment. Do not consider disability factors (age, education and work training or work experience).

Please note that you may be examining the body systems described in this section along with Musculoskeletal, Cardiac, Respiratory and/or Nervous Systems in a single examination. In such cases, the Physical Strength Rating form would be appropriate.

Methodology for Rating Hearing Impairment

As stated in *AMA Guides*, Fifth Edition, hearing should be measured and reported with and without the injured worker's assistive device, if applicable. Impairment rating is to be determined without the assistive device. Assisted hearing is to be considered when determining limitations due to the allowed conditions when the Injured Worker has an assistive device.

ALLOWED DIAGNOSTIC TESTING

Since Commission Independent Medical Examinations are performed to determine degree of impairment and functional capacity rather than to establish a diagnosis, diagnostic testing requirements are minimal. Further, Injured Workers are not required to submit to any testing. If an examiner feels additional testing is necessary, and the Injured Worker declines, note the refusal, and base opinions on the available diagnostic information.

If an examiner finds testing is necessary for an IME in any of the above body systems, comprehensive audiometry (92557) testing, CBC, urinalysis, and comprehensive metabolic profile laboratory test panels, when appropriate, may be ordered and billed without prior approval from the Commission.

Other testing must have prior approval of Medical Services at 614.466.4291. Bill for any approved additional testing on the Provider Fee Bill.

Examples of Urologic and ENT Independent Medical Examinations follow.

James Richards, M.D.
Richards Urological Clinic
Jonesville, Ohio

Background Information:

Injured Worker: Paul Peterson
Claim Number: 91-642306
Date of Birth: 10/20/1956
Date of Injury: 09/29/1993
Date of Exam: 07/16/2008
Purpose of Exam: Review of Permanent Total Disability
Claim Allowance: Chronic prostatitis, organic impotence

History:

Mr. Peterson is a 52 year old male who is evaluated for organic impotence and chronic prostatitis. The patient is on multiple medications for pain. His medications include Oxycontin, Relafen, Prozac, Lithium, Wellbutrin, Valium, Klonopin, and Zomig. He also takes Viagra and Trazadone. He has no allergies to medications and smokes about one pack of cigarettes per day. The patient injured his back at work. An anterior discectomy, L5-S1 and anterior interbody arthrodesis, L5-S1 was performed on 4/9/1999. His back was initially injured in 1993. He was doing well erection-wise until after his 1999 back surgery but since then he claims he only has occasional partial erections and states he needs Viagra for intercourse. He does have orgasm but does not have ejaculation. He also notes some discomfort at the time of orgasm. Mr. Peterson has been using Viagra 100 mg. with no side effects.

Exam:

Physical exam revealed the abdomen to be soft and non tender. There was no scarring noted in the penis. His testes feel normal. The prostate was smooth and there was good rectal tone noted. His urine was clear microscopically.

The nocturnal penile tumescence (NPT) reveals normal erections at nighttime. His urine is clear. However, the patient can still have prostatitis on this basis. However, at this time I do not think any further treatment needs to be done for the prostatitis.

Conclusion:

In regard to the allowed conditions, organic impotence and chronic prostatitis and using the AMA Guides, Fifth Edition to the Evaluation of Permanent Impairment,

1. These conditions have reached maximum medical improvement. Further treatment is not anticipated to significantly change his condition
2. Urological impairment is 0% for each allowed condition.
3. The Residual Function Assessment is enclosed.

Sincerely,

James Richards

James Richards, M.D.

RESIDUAL FUNCTION ASSESSMENT

Injured Worker: Paul Peterson

Claim Number(s): 91-642306

Based solely on impairment arising from the allowed condition(s) within my specialty, and with no consideration of the Injured Worker's age, education and work experience:

- This Injured Worker has no work limitations.
- This Injured Worker is incapable of work.
- This Injured Worker is capable of work with the limitation(s)/modification(s) noted below:

There is no residual impairment from the allowed conditions.

Physician's Signature: *James Richards* Date: 7/16/2008

Physician's Name (print): James Richards, M.D.

Ear, Nose and Throat Specialists

100 East Main St.
Anderson, OH 44004

SAMPLE

22.Mar.2011

The Industrial Commission of Ohio

Medical Services, Level 1 West
PO Box 15218
Columbus, OH 43215

RE: David Wilson
DOB: 29.Apr.1950
Claim #: 89-000000
DOI: 04.Dec.1989
Allowed Conditions: hearing loss, left ear; tinnitus

To Whom It May Concern:

I consulted with Mr. Wilson on 22.Mar.2011. He is referred by IC for Independent Medical Evaluation for the allowed conditions of hearing loss, left ear and tinnitus. The following is a summary of my findings and opinions.

I reviewed all records provided to me by the Industrial Commission.

CHIEF COMPLAINT:

Hearing loss and ringing in left ear.

HISTORY:

Location: Left ear.

Quality: Significant trouble hearing from left ear. Some noises are painful. Hears ringing.

Severity: He does well except when there is background noise. Patient has problems understanding conversation in large groups, partly because of the ringing. The hearing loss is unchanged since onset.

Timing: This has been a problem for more than 20 years. It developed almost instantly. He had a skull fracture on the left side in 1989. There is no specific time when it is worse. This is not a recurrent problem. There has been only this one episode of occurrence. Persistent since 1989.

Setting in which it first occurred: After trauma to the head 1989.

Aggravating factors: None identified.

Relieving factors: None identified.

Associated manifestations: Recruitment of loudness.

Pertinent negatives: Delayed speech development, dizziness, family history of hearing loss, fever, frequent nasal congestion, history of exposure to noise, history of recurrent cerumen impactions, otalgia, otorrhea, pressure sensation in the ear associated with hearing loss, social problems caused by hearing loss, tinnitus.

Previous tests/evaluations: Prior audiometry, March 1990, reported moderate hearing loss left ear.

Previous treatment: Hearing aide, left ear.

22.Mar.2011, Page 2

RE: David Wilson

DOB: 29.Apr.1950

Claim #: 89-000000

OBJECTIVE:**HEAD, FACE, SALIVARY GLANDS AND TMJ:****Inspection of the Head and Face:** Face and head symmetry and contour normal. No skin lesions noted.**Percussion and palpation of the Face:** No tenderness to percussion or pressure.**Palpation of Parotid and Submaxillary glands:** Right parotid normal. Left parotid normal. Right submaxillary gland normal. Left submaxillary gland normal.**Facial Mobility:** Normal.**Temporaomandibular Joints:** Normal**EAR, NOSE MOUTH AND THROAT:****Pinnas and External Nose:** Normal.**Otoscopic exam:**

Right ear – External canal – normal size, skin normal; cerumen absent. Tympanic membrane translucent, normal light reflex; normal mobility to pneumatic otoscopy.

Left ear – Same as the right. External auditory canal normal. Tympanic membrane translucent, normal light reflex, normal mobility to pneumatic otoscopy.

Hearing: Abnormal to conversational and whispered speech and to tuning fork tests, left ear.**Nasal Interior:** Normal nasal septum.**Turbinates and middle meatus:**

Right – inferior turbinate normal.

Left – inferior turbinate normal.

Normal mucosa with no swelling, polyps, active bleeding or evidence of bleeding.

Lips, Teeth and Gums: Lips normal. Teeth in good repair. Gums normal.**Oral Cavity and Oropharynx:** Tonsils and soft palate normal. Posterior pharynx normal. Oral mucosa with normal color and moisture. No oral or oropharyngeal mucosal lesions. Anterior 2/3rds of tongue normal. Hard palate normal. Base of tongue, Pharyngeal walls, Valleculla and Pyriform Sinuses: The hypopharyngeal walls normal. Pyriform sinuses normal.**Larynx:** Epiglottis – normal. False vocal cords – normal. True vocal cords – normal mobility, no lesions. Voice quality – normal.**Nasopharynx examination:** Could not visualize with the mirror due to gag. Nasopharyngeal mucosa normal. Adenoids normal. Posterior choanae normal. Eustachian tubes orifices normal.**NECK AND THYROID:****Neck:** Normal symmetry; trachea midline; normal laryngeal crepitation; no adenopathy; no neck masses.**Thyroid:** Normal size; no masses or tenderness**LYMPH NODES: Neck Nodes:** normal

22.Mar.2011, Page 3

RE: David Wilson

DOB: 29.Apr.1950

Claim #: 89-000000

AUDIOMETRY:**92557 Comprehensive Audiometry**

Date: 22.Mar.2011

Tympanograms: Type Ad for the right ear, Type A for the left ear. Acoustic Immitance revealed normal external auditory canal volumes for both ears. Speech discrimination scores: R: 100%, L: 69%. Pure tone audiometry testing indicated hearing WNL from 250-4000 Hz sloping to a mild hearing loss at 8kHz in the right ear, and a moderately-severe SHNL for the left ear. The impairment calculated from this audiogram is based on the DSHL. The DSHL for the right ear is 30 (5+5+5+15) and the DSHL for the left ear is 280 (65+70+75+70). Monaural impairment percentage = 67.5% in the left ear, 0% for the right. With hearing aide, speech discrimination is increased to 92% for the left ear and DSHL is 40 (5+10+10+15). Linda Jackson, Au.D.

ASSESSMENT:

Hearing loss left ear; tinnitus.

OPINIONS:

It is my opinion that Mr. Wilson has reached maximum medical improvement in regard to the allowed ENT conditions. He has had these for many years and there are no surgical, medical, or rehabilitation treatments that would result in any significant improvement in his condition.

According to the AMA guides, Fifth Edition, page 248 table 11-2, Mr. Wilson has a 68% loss of hearing in his left ear and as per page 247 table 11-1 and 249 table 11-3, this results in a 4% whole person impairment for hearing loss. For the allowed condition of tinnitus, 2% is added, according to page 246, section 11.2a. The combined whole person impairment is 6%.

The Residual Function Assessment is enclosed. Limitations due to his hearing loss left ear and tinnitus would only include work that would require immediate sound localization, without his hearing aide. With the hearing aide, there are no significant limitations.

Sincerely,

Jennifer Taylor M.D.

Jennifer Taylor, MD

RESIDUAL FUNCTION ASSESSMENT

Injured Worker: David Wilson

Claim Number(s): 89 - 00000

Based solely on impairment arising from the allowed condition(s) within my specialty, and with no consideration of the Injured Worker's age, education and work experience:

- () This Injured Worker has no work limitations.
- () This Injured Worker is incapable of work.
- (X) This Injured Worker is capable of work with the limitation(s)/modification(s) noted below:

See narrative report.

Physician's Signature: Jennifer Taylor M.D. Date: 3/22/2011

Physician's Name (print): Jennifer Taylor, M.D.

MAXIMUM MEDICAL IMPROVEMENT

Special Considerations

MAXIMUM MEDICAL IMPROVEMENT – SPECIAL CONSIDERATIONS

In the event that it has been determined by Industrial Commission order that an Injured Worker has reached maximum medical improvement (MMI), then the Permanent Total Disability examination referral questions will read as follows:

“It has been determined by Industrial Commission order that this Injured Worker has reached maximum medical improvement (MMI).

Answer questions 1 and 2, if you believe the Injured Worker is still at MMI. Only answer question 3, if you do not believe the Injured Worker is still at MMI.

1. If you believe the Injured Worker is still at MMI, based on the *AMA Guides*, Fifth Edition, and with reference to the Industrial Commission *Medical Examination Manual*, provide the estimated percentage of whole person impairment arising from each allowed condition. Please list each condition and whole person impairment arising from each allowed condition separately, and then provide a combined whole person impairment. If there is no impairment for an allowed condition indicate zero (0) percent.
2. If you believe the Injured Worker is still at MMI, complete the enclosed Physical Strength Rating. In your narrative report provide a discussion setting forth physical limitations resulting from the allowed condition(s).

or

3. If you do not believe the Injured Worker is still at MMI, note the following and answer accordingly:

In order for an Injured Worker to be found no longer MMI, there must be a worsening of the allowed condition since the determination of MMI accompanied by the prognosis that the worsening is temporary. The mere prospect of improvement in the allowed condition beyond a level previously declared MMI with a proposed treatment will not justify change in the MMI determination.

What is the rationale for your opinion that the Injured Worker is no longer at MMI?”

Examples of musculoskeletal and mental and behavioral health independent medical examinations in which the injured worker has been determined by Industrial Commission order to have reached maximum medical improvement follow.

JONES ORTHOPEDICS

100 MAIN ST.

MILLERS VILLAGE, OH

**THE INDUSTRIAL COMMISSION OF OHIO
SPECIALIST REPORT****IW NAME:** John Smith**DATE OF BIRTH:** 04-06-59**CLAIM NUMBER(S):** 00-000000**DATE(S) OF INJURY:** 01-01-00**CLAIM ALLOWANCE(S):** Right knee strain; lumbar disc herniation, L4-5; major depression.**PLACE OF EXAMINATION:** Jones Orthopedics, Millers Village, OH**DATE OF EXAMINATION:** 03-09-2011**EXAMINER NAME:** Michael Jones, M.D.

PURPOSE OF EXAMINATION: To assist the Industrial Commission in its consideration of the Injured Worker's application for a determination of Permanent Total Disability.

The purpose of the examination was discussed with the injured worker. I explained that this would be a one-time evaluation at the request of the Industrial Commission in response to his application for permanent total disability, that I would be providing a written report to the Industrial Commission, and that the results of this examination are not confidential. I explained that I would not be providing him with any type of treatment or advice.

HISTORIAN: John Smith**ALSO PRESENT DURING EXAMINATION:** wife

OCCUPATIONAL HISTORY: Mr. Smith was working as a bouncer on weekends at Lakeview Bar and Grill at the time of his injury, which he had done for three years. He was also self-employed in boat repair for 30 years.

HISTORY OF THE PRESENT CONDITION: While working as a bouncer, Mr. Smith attempted to break up a fight. One of the patrons fell onto his right knee and caused him to strike his low back on a table. He was seen in the emergency department where X-rays of the back and knee were negative. He followed up with Dr. Patel, an orthopedic surgeon. He was treated with physical therapy and pain medication and experienced persistent back and knee pain. MRI of the back showed disk herniation at L4-5 to the right. MRI of the right knee showed an effusion, otherwise negative. He

underwent lumbar epidural steroid injection for his back without relief. He underwent cortisone injection and arthroscopic surgery for his knee. He was referred to Dr. Alam for low back surgery. He underwent laminectomy and discectomy by Dr. Alam in December of 2000. He reports that he experienced some relief of his back and leg. He underwent

additional physical therapy and injections without relief. He's been maintained on pain medicine for the last ten years and has not returned to work.

IW NAME: John Smith

DATE OF BIRTH: 04-06-59

CLAIM NUMBER(S): 00-000000

03-09-11

Mr. Smith reports that two months ago he experienced a severe increase in his pain. Follow-up MRI of the low back on 02-10-11 demonstrated a recurrent disk herniation at L4-5 to the right. He has had to increase his medication and is awaiting consultation with Dr. Alam.

CURRENT SYMPTOMS: He reports 4/10 right knee pain that he tells me has been constant. His knee swells occasionally and is worse in rainy weather. No locking or buckling. He reports that his low back generally has been 6/10, but over the last two months has increased to 10/10. It radiates to the anterolateral calf. He describes it as burning. He is unable to sit.

IMPACT ON ACTIVITIES: Before two months ago, Mr. Smith reports that he was independent with self care and mobility. However he was only able to walk about one block without stopping. He was unable to lift more than ten pounds. He did no yard work or house maintenance. He did the dishes and some light cooking occasionally. Now he reports his wife has to help with bathing, and dressing. He sleeps in a recliner.

PAST MEDICAL HISTORY: Hypertension, high cholesterol.

PAST SURGICAL HISTORY: As noted above. He has also had appendectomy, and inguinal hernia repair.

CURRENT MEDICATIONS: Oxycontin 40 mg. every four hours; Neurontin 800 mg. four times a day. Percocet 10mg. every four hours as needed for pain. He also takes Lipitor, Celexa, Buspar, and Altace.

ALLERGIES: Penicillin

SOCIAL HISTORY: He is married and lives with his wife.

HEALTH HABITS: He does not drink alcohol. He smokes one pack of cigarettes a day. No illegal drugs. He does not exercise.

REVIEW OF MEDICAL RECORDS: I reviewed all of the medical records and documents provided by the Industrial Commission.

PHYSICAL EXAMINATION: Height: 5' 9" Weight: 190 lbs.

This is a well-developed, well-nourished mid-aged male who appears in some distress. He is unable to sit during the interview. He walks with a list. He is unable to demonstrate consistent lumbar range of motion secondary to reported pain. Straight leg raising aggravates his leg pain in the seated position. Reflexes in the legs are 2+ at the knees and 1+ at the ankles. Motor strength is intact except for 4/5 right ankle dorsiflexion weakness. Palpation of the back reveals muscle guarding with no focal tenderness. He is able to walk on his toes briefly but is unable to get up on his right heel. Examination of his knee is difficult secondary to his reported back and leg discomfort. In the supine position, he is able to demonstrate active range of motion including minus 10 degrees of extension and 130 degrees of flexion. There is no effusion. He reports medial joint line tenderness. The knee ligaments appear stable with no clear meniscal signs.

IW NAME: John Smith

DATE OF BIRTH: 04-06-59

CLAIM NUMBER(S): 00-000000

03-09-11

DISCUSSION/OPINION: The following questions were asked to be addressed by the Industrial Commission:

It has been determined by Industrial Commission order that this Injured Worker has reached maximum medical improvement (MMI).

Answer questions 1 and 2, if you believe the Injured Worker is still at MMI. Only answer question 3, if you do not believe the Injured Worker is still at MMI.

1. If you believe the Injured Worker is still at MMI, based on the *AMA Guides*, Fifth Edition, and with reference to the Industrial Commission Medical Examination Manual, provide the estimated percentage of whole person impairment arising from each allowed condition. Please list each condition and whole person impairment arising from each allowed condition separately, and then provide a combined whole person impairment. If there is no impairment for an allowed condition indicate zero (0) percent.
2. If you believe the Injured Worker is still at MMI, complete the enclosed Physical Strength Rating. In your narrative report provide a discussion setting forth physical limitations resulting from the allowed condition(s).

OR

3. If you do not believe the Injured Worker is still at MMI, note the following and answer accordingly:

In order for an Injured Worker to be found no longer MMI, there must be a worsening of the allowed condition since the determination of MMI accompanied by the prognosis that the worsening is temporary. The mere prospect of improvement in the allowed condition beyond a level previously declared MMI with a proposed treatment will not justify change in the MMI determination.

What is the rationale for your opinion that the Injured Worker is no longer at MMI?

It is my understanding that it has been determined by Industrial Commission order that Mr. Smith has reached maximum medical improvement (MMI). However, it is my opinion that he is no longer at MMI. Two months ago, he experienced a sudden increase and recurrence of low back and right leg pain. Recent MRI demonstrated a recurrent disc herniation on the same side and at the same level as his previous herniation, which is an allowed condition in this claim. His history and physical examination today is consistent with his MRI findings. He is awaiting further evaluation and treatment. This represents a worsening of the allowed condition of lumbar disk herniation. This worsening is likely temporary and likely to improve.

Respectively submitted,

Michael Jones, M.D. 03/09/11

Michael Jones, M.D.

GARCIA PSYCHIATRIC CARE

100 HIGH ST.

JOHNSON STATION, OH

THE INDUSTRIAL COMMISSION OF OHIO**SPECIALIST REPORT****IW NAME:** John Smith**DATE OF BIRTH:** 04-06-59**CLAIM NUMBER(S):** 00-000000**DATE(S) OF INJURY:** 01-01-00**CLAIM ALLOWANCE(S):** Right knee strain; lumbar disc herniation, L4-5; major depression.**PLACE OF EXAMINATION:** Garcia Psychiatric Care, Johnson Station, OH**DATE OF EXAMINATION:** 07-11-2011**EXAMINER NAME:** Maria Garcia, PhD.

PURPOSE OF EXAMINATION: To assist the Industrial Commission in its consideration of the Injured Worker's application for a determination of Permanent Total Disability.

The purpose of the examination was discussed with the injured worker. I explained that this would be a one-time evaluation at the request of the Industrial Commission in response to his application for permanent total disability, that I would be providing a written report to the Industrial Commission, and that the results of this examination are not confidential. I explained that I would not be providing him with any type of treatment or advice.

HISTORIAN: John Smith**ALSO PRESENT DURING EXAMINATION:** wife Mary Smith

DESCRIPTION OF INJURED WORKER: Mr. Smith and his wife arrived on time for his appointment. He was dressed in a sweat suit and tee shirt. Hygiene appeared adequate, though he was unshaven with a rough beard. He appeared anxious and moved frequently from the seated to standing position during the interview.

HISTORY:

CHIEF COMPLAINT: Low back and right leg pain. Depression and despair.

HISTORY OF PRESENT CONDITION: Mr. Smith reports an injury to his low back and right knee while working part-time in a bar on New Year's Eve in 1999. He states "Some yahoos got drunk and got in a fight. It was my job to break it up. One of them fell on me and my back and leg have not been the same since. I'm in constant pain and I've lost my life." He underwent surgery for both that same year and reports some improvement after the procedures, though still required medication and was never able to return to work. He had also worked most of his adult

life self-employed in a boat repair shop, and was unable to keep that up. He says "I lost my shop and now I'm about to lose my house." He reports that after his back surgery late in 2000 he began to get depressed. "It relieved some of my pain, but it was still so bad that I couldn't do much." He indicates he went through physical therapy and other treatments for his back and knee, but was unable to return to work. He continued to treat with pain medication. He

IW NAME: John Smith

DATE OF BIRTH: 04-06-59

CLAIM NUMBER(S): 00-000000

07-11-11

reports after he was forced to close his boat repair shop he began to withdraw. He felt worthless. He had crying spells. He was started on medication and counseling and reports that these were helpful.

In January of 2011, he experienced sudden worsening and recurrence of his low back and right leg pain. He was found to have a new disk herniation in his low back and had a second surgery last month. He reports complications of the surgery including infection and possible medication reactions. "I don't remember anything for a week in the hospital." His wife reports that he was delirious, did not know where he was and didn't recognize his family. He was having visual hallucinations, thinking little kids were running around his room. He thought some teenagers were out driving his car. She reports that they took him off all of his medicines in the hospital for a week, because of his mental changes, and placed him on Risperidol. He tells me his pain is better than it was before surgery, but reports increased symptoms of despair. "I wouldn't care if I would have died. I'm tired of this crap. I'm done. I don't want to do anything." He denies suicidal thoughts.

REVIEW OF PAST TREATMENT: He has had surgery on his knee, injections, and physical therapy. He has had two back surgeries, the first by Dr. Alam and the second by Dr. Williams. He has had counseling once or twice a month with Dr. Harris for about ten years. He has had various antidepressant medications prescribed by his family doctor, Dr. Martinez.

REVIEW OF RECORDS: I reviewed all of the medical records and documents provided by the Industrial Commission.

CURRENT TREATMENT: He continues with psychological counseling with Dr. Harris. He was placed back on his regular pain medication antidepressant about two weeks ago by Dr. Martinez.

MEDICATIONS: Oxycontin, Neurontin, Percocet, Lipitor, Celexa, Buspar, and Altace.

MENTAL HEALTH HISTORY: He denies any symptoms or treatment for depression prior to his work injury. He reports no other psychiatric care.

PAST MEDICAL HISTORY: High blood pressure and high cholesterol.

FAMILY OF ORIGIN AND PROCREATION: He was born in Johnson Station. His parents were married 35 years before the death of his father from lung cancer about 12 years ago. He has one older sister with whom he keeps in touch with. His mother is living and resides about a mile away. His father worked as a construction laborer. He denies any abuse or neglect as a child.

SOCIAL HISTORY: He is married, and lives with his wife Mary of 25 years. They have three children ages 19, 22, and 24, all out of the house. Until his recent worsening and surgery, he and his wife would go to church weekly, out to eat once every week or so, and played Euchre with another couple once a month. He would go to McDonalds once or twice a week and have coffee.

EDUCATION: He completed three years of high school and then when he was 26 completed his GED.

IW NAME: John Smith

DATE OF BIRTH: 04-06-59

CLAIM NUMBER(S): 00-000000

07-11-11

WORK HISTORY: He worked at a local boat shop for about ten years, and then opened his own shop. He worked various part-time jobs at convenient stores and then worked about three years as a bouncer at a local bar on weekends (where he was injured).

LEGAL HISTORY: He reports one DUI arrest just after high school.

MILITARY HISTORY: None.

SUBSTANCE USE AND ABUSE: He quit drinking ten years ago. He reports no treatment for drug or alcohol abuse. He denies illegal drugs. He smokes one pack of cigarettes a day.

MENTAL STATUS EXAMINATION:

APPEARANCE: Middle-aged Caucasian male. Hygiene good. Poorly shaven. Casually dressed. Appears anxious and in some physical distress. He walked slowly and guardedly with some facial grimacing.

ATTITUDE: He was cooperative with the interview; however had his wife answer many questions. Eye contact was poor.

BEHAVIOR: He shifted in his seat and stood frequently during the interview.

MOOD AND AFFECT: He appeared sad with blunted affect.

SPEECH: Intelligible with multiple pauses and brief answers.

PERCEPTUAL DISTURBANCES: None apparent.

THOUGHT PROCESS (QUANTITY, TEMPO, AND FORM): He perseverated on his pain and despair. "I just want to get rid of this pain and get my life back."

THOUGHT CONTENT (DELUSIONS, HALLUCINATIONS, OBSESSIONS, AND PHOBIAS): No psychotic features. Denies suicidal thoughts or ideation.

COGNITION (ALERTNESS, ORIENTATION, ATTENTION, MEMORY, LANGUAGE, AND EXECUTIVE FUNCTION): He was alert and oriented in all spheres. He appeared distractible and tangential at times but was easily redirected. He remembered two of three items at one minute, and one of three at five minutes. He stated the president as "Obama" and named the previous three presidents. He followed the three step command "hold up one finger, tap your foot, and nod your head." He counted backward by seven from 100 to 65, with multiple errors. He was able to name eyeglasses and a wrist watch and what they are used for when presented. When asked how a tree and grass are the same he stated "They're both green."

INSIGHT: He verbalized understanding of his situation. "My back problem has made me depressed. I don't want to do anything anymore. I don't have any money and I'm afraid they're going to take my house."

IW NAME: John Smith

DATE OF BIRTH: 04-06-59

CLAIM NUMBER(S): 00-000000

07-11-11

JUDGMENT: When asked if he found a sealed, stamped, addressed envelope on the ground, he indicated he would mail it.

REVIEW OF FOUR FUNCTIONAL AREAS:

ADL/TYPICAL DAY: Since home from the hospital, he has only left the house for doctors' appointments. His wife says she has to force him to get dressed. He either stays in bed or in his chair. He doesn't read the paper or watch TV. He shaves only after several days of "nagging". His appetite has been poor. ("He won't eat anything.") He does no chores. **Class 4- Marked Impairment.**

SOCIAL FUNCTIONING: He will not answer the phone or answer the door. He has avoided talking to his mother and sister on the phone. He is short with his sons when they visit and makes poor eye contact. **Class 4- Marked Impairment.**

CONCENTRATION, PERSISTENCE, AND PACE: He demonstrated psychomotor retardation. He was slow, distractible, and tangential. He was unable to complete serial sevens and short-term memory was poor. **Class 4- Marked Impairment.**

ADAPTATION: He appears to have little mental ability to adapt to his change in circumstance at this time. **Class 4- Marked Impairment.**

MULTIAXIAL DIAGNOSIS: Axis I: Major depression

Axis II: none

Axis III: deferred to medical evaluation

Axis IV: none

Axis V: GAF VALUE: 40

DISCUSSION/OPINION: I have been asked to address the following questions by the Industrial Commission:

It has been determined by Industrial Commission order that this Injured Worker has reached maximum medical improvement (MMI).

Answer questions 1 and 2, if you believe the Injured Worker is still at MMI. Only answer question 3, if you do not believe the Injured Worker is still at MMI.

1. If you believe the Injured Worker is still at MMI, based on the *AMA Guides*, Second and Fifth Editions, and with reference to the Industrial Commission Medical Examination Manual, provide the estimated percentage of whole person impairment arising from each allowed condition. Please list each condition and whole person impairment arising from each allowed condition separately, and then provide a combined whole person impairment. If there is no impairment for an allowed condition indicate zero (0) percent.

IW NAME: John Smith

DATE OF BIRTH: 04-06-59

CLAIM NUMBER(S): 00-000000

07-11-11

2. If you believe the Injured Worker is still at MMI, complete the enclosed Occupational Activity Assessment. In your narrative report provide a discussion setting forth mental limitations resulting from the allowed condition(s).

OR

3. If you do not believe the Injured Worker is still at MMI, note the following and answer accordingly:

In order for an Injured Worker to be found no longer MMI, there must be a worsening of the allowed condition since the determination of MMI accompanied by the prognosis that the worsening is temporary. The mere prospect of improvement in the allowed condition beyond a level previously declared MMI with a proposed treatment will not justify change in the MMI determination.

What is the rationale for your opinion that the Injured Worker is no longer at MMI?

It is my understanding that it has been determined by Industrial Commission order that Mr. Smith has reached maximum medical improvement (MMI). However, it is my opinion that he is no longer at MMI. By history, his psychological allowance of major depression was stable, and he was on maintenance treatment. He then required surgery for his allowed back condition, and his post operative course was complicated by a change in mental status. His medication for depression was interrupted, and only recently restarted. Though he reports some improvement in his pain since surgery, his depression and sense of despair has clearly deepened. His functional status from a psychological standpoint has severely declined. His examination demonstrates worsening signs and symptoms of major depression. It is my opinion that this worsening is temporary, and will likely improve.

Respectfully Submitted,

Maria Garcia, Ph.D. 07/11/11

Maria Garcia, PhD.

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