



Spine Institute of Waukegan
PERSONAL INJURY and WORKERS COMPENSATION SPECIALISTS
ACCIDENT and INJURY form PIFR-3
PRIMARY TREATING PHYSICIAN'S FINAL REPORT (PIFR-3)
FINAL IMPAIRMENT RATING PERSONAL INJURY REPORT
OFFICIAL OFFICE FORM

Last:	First:	MI:	Sex:	D.O.B:
Address: .		City:	State:	Zip:
Occupation:	SS#:	Phone:		

Claims Administrator:		DOI:		
Adjuster Name:		Claim Number:		
Address:		City:	State:	Zip:
Phone:		Fax:		

Attorney Information: (If applicable)				
Name:		Claim Number:		
Address:		City:	State:	Zip:
Phone:		Fax:		

FINAL VALUES for IMPAIRMENT RATING

CASE HISTORY BRIEF and CURRENT STATUS:

As you will remember, this patient was involved in a motor vehicular accident at or around 8:00am on September 29th at the intersection of Martin Luther King Ave. and Green Bay Road. Patient was stopped at a red light turning right on Green bay road. It was daylight, the road condition was dry, and the visibility was good. Patient was looking left for oncoming traffic when suddenly he was rear-ended by a 2002' Dodge Stratus. Patient was the only person in his 2005' Buick Century car. The accident was a complete surprise. At moment of impact, his foot was on the brake pedal but believes that it was knocked off by the impact. He was using his shoulder-lap restraint belt, his headrests were in the low position, and the air bags did not deploy. As a result, his body was rotated left, he is not sure how his body was thrown possibly forward/backward, his neck was rotated to the left, and his neck was pitched forward/backward. Patient's head struck the headrest; he is not sure of what other body parts he struck. Patient then called the police. At the time of the accident, patient had no immediate pain. Pain started about an hour after the accident. Patient drove himself to the VA Hospital in North Chicago. X-rays were taken and at first they thought he had a compressed C6, but radiologist later said it may be a normal phenomenon for him and to monitor his condition for the next several weeks however, the patients' neck pain was severe at this point. Patient was given pain medications and was told to follow up with a Specialist. Patient went to Dr. Olsen at the Naval Hospital. Dr. Olsen told patient he had a whiplash injury and was given more pain medications. He presented to our facility on 10/18/06 for further evaluation and treatment, approximately 3 weeks after the incident, due to the ongoing pain in his neck, back and extremity numbness. He was thoroughly evaluated and then placed on a treatment regimen for 10-14 weeks ending on 02/12/07 when he was released as permanent and stationery.

SUMMARY OF CARE:

Short and Long Term Treatment Goals:

Short Term Goals: Passive intervention is to promote anatomical rest, to diminish muscular spasm, to reduce inflammation and alleviate pain overall. The initial plan of care was to begin the patient on passive modalities to reduce swelling and inflammation with pain as well as other items of mention previous.

The patient received Interferential treatment or muscle stim to the areas of complaint, mainly the cervical, thoracic and lumbar paravertebral muscles. This was performed to assist in diminishing muscular spasm, reduce pain and enhance local metabolism, for 10-15 minutes at 1-150Hz's (Multifunction setting). MilliAmperes will vary depending upon patient tolerance level.

The application of Moist Heat at same areas as above for 10 minutes or more was to improve local metabolism and enhance vasodilation of tissues.

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This is also utilized as a precursor to the CMT procedure and assists in reducing or diminishing secondary muscle spasm from the CMT procedure.

The patient received Ultrasonic Therapy to assist in subcutaneous and basilar layer of derma, increased metabolism and further deeper enhanced vasodilation and normalcy of cellular oscillation at or nearest to 70uV's.

CMT procedures or Chiropractic Manipulative Therapy technique for separation of the Cervical, Thoracic and Lumbar fixated facet joints/ articulations noted above utilizing low force, high velocity Diversified and Gonstead Techniques to increase the range of pain free motion and to minimize deconditioning. CMT procedures or adjustments were applied to mainly the lower spine and cervical region to restore the loss of the biomechanical curves changed from the intrinsic muscles of the spine causing the curves to reverse due to the whiplash and belt injuries.

Isokinetic Resistance was utilized to assist in facilitating correct skeletal biomechanical movement and translation of joints one among another, that have been misaligned as well as to strengthen extrinsic and intrinsic muscles of the spine and body that are consistent with the injuries at hand. Protocol consists of reps and sets with averages of 12-15 reps per set and up to 3-5 sets per exercise. The patient was involved with up to 5 strengthening machines, cables and elastic theraband and floor exercises.

Manual Therapy was also provided where the patient received deep Neuromuscular Massage work to different areas of the spinal paravertebral musculature to assist in increasing the overall range of motion of the spine and to break up deeper tissue adhesions causing limitations thereof and producing chronic myofascial pain syndromes.

Lifestyle adaptations of home recommendations of rest, meditation, improved nutrition and light stretching to the lower spine, mid and upper as well as the cervical spine was promoted to further diminish anxiety and to mitigate the cost of recovery.

Patient was placed on a 3-4 times per week Physical Therapy program that initially consisted of the CMT procedures along with the passive modalities. On November 1, 2006, the patient slowly began the rehabilitation and further extensive Physical Therapy. The active role the patient played in his treatment and overall care assisted in his recovery. On 11/21/06, the patient was dropped to 2-3x's per week after his first re-examination. Patient was to continue with treatment 2-3 times per week until his next re-exam. He was then re-examined yet again on 12/18/06 and was found to be continuing with discomfort but on a minimal level. He still was experiencing headaches with spine pain. The headache he was experiencing was due to the shift in the cervical curve and that it still was not completely corrected and was still in a hypolordotic curve. The patient was given home exercises for this and they were updated at this point with discussion as to how to perform these at home with everyday household items so that he could get relief at home. The patient was asked or recommended to continue care 1x/wk for four weeks when he returned in our office for a re-evaluation on 01/11/07. He was examined and his home exercises were updated and asked to return one last time in 30 days but to not receive therapy during this time. He returned on 02/12/07 and was found to be maximally medically improved from the treatment prescribed and was released with recommendations to return at least once a month for the next 24 months due to the cervical spine curve loss that we could continue to attempt to restore this and to not lose what was gained from the treatment.

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He was also recommended to continue the home exercises and stretches and specific exercises for his cervical spine. Lastly, to come in more frequent for care if indeed his condition should flare-up or reexacerbate as we suspect it will once or twice a year, mainly with his neck but could also with his lower back due to the x-ray findings noted and the abnormal curves noted secondary to the muscle spasm/ injury.

Long Term Goals: These were to return Mr. John Conrad to as close to pre-injury status and diminish potential deconditioning of injured tissue to prevent chronic pain syndrome(s). Treatment type, duration of treatment and frequency of care was within normal limits due to the severity of his injuries. Range of deficits and ligament instability were stabilized through a controlled functional recovery program.

Diagnostic Testing:

During the course of this patient's treatment, it was necessary to refer the patient out for further testing of his lower extremity paresthesia and numbness with pain. The patient had been experiencing this since the accident and prior to seeing us, that was directly related to his injuries sustained in the 09/26/06 accident. The patient qualified for this procedure since it was beyond a reasonable time period having the symptoms and the initial accident being at least 20 or more days, in this case over 1 month, prior. He was referred and received a lower extremity NCV/SSEP on 10/25/06 which showed left Tibial and right Peroneal SSEP delays consistent with possible Spinal Stenosis and nerve root compression, possibly secondary to the accident.

Further, it would appear that the patient also shows sign of an S1 radiculopathy on the right side and a left Peroneal f-wave comparison delay. Findings suggest that there is injury to the spinal column neurologically. Since this is the side of the referred pain and numbness, it would stand to reason that the patient, from all findings noted in the study, exhibits a discal injury to the L5/S1 region and most likely has a disc bulge on this side that is posterolateral to the right compressing on the right nerve root. The bony misalignment is also contributing to this that is noted within the x-ray findings as depicted from the radiologist.

The patient's treatment was altered and appeared to assist the patient with the residual symptomatology in that regard by diminishing the paresthesia and tingling. An MRI might have been the best situation to look at the anatomical structures in the lower spine and to officially rule out disc bulges or herniations since there are findings both with the SSEP and the H-Reflex exhibiting radiculopathy at S1, however, since his condition began to diminish from the treatment prescribed, we held off to mitigate expenses.

X-rays were performed at our facility and referred out with radiologist read. 5 view lumbar spine, 2 view thoracic spine, and Davis Series X-rays taken. Lumbar spine shows femoral head length unleveling. Thoracic spine shows a mild flattening of the thoracic kyphosis. Cervical spine shows loss of cervical lordosis with misalignments throughout along with motion integrity compromise and reduced range of motion. There were dextro and levoscoliosis's or spinal curves found throughout the spine in all three areas consistent with injury or secondary muscle spasm in the spine.

Medical Specials: \$9,077.10 *(Include all medicals from our office and the EDX lab)
Property Damage: Unknown
Income Loss: Unknown

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Injuries:

Neck and Back Injuries
Extremity numbness

ICD9 Injury Codes: E813.0, 722.10, 782.0, 784.0, 847.0, 847.1, 847.2, 739.1, 739.2, 739.3, 728.87, 308.0, 839.20, 839.08, 724.4, 737.9. *****COMPLICATING FACTORS:** *(737.39, 721.1, 721.2, 721.3)

CPT Treatment Codes: 97140, 97014, 97010, 97035, 98942, 98940, 72070, 72052, 72110, 99204, L0120, 99212-25, 98941, 97110, 97032, 97039, 99082, 99199, 99214-25, 95900, 95903, 95904, 95926, 95934, 95999, 93760, 96004, 99090, 99213-25, 99080.

Neck and Back Injuries

<u>Provider Name</u>	<u># of Treatments</u>	<u>Last Treatment Date</u>	<u>Prognosis</u>
ER Physician (VA HOSPITAL)	1	09/26/06	Complaints/Treatment
Dr. Olsen, MD (NAVAL HOSPITAL)	1	UNKNOWN	Complaints/ Treatment
Kelly G. Worth, DC	23 (scheduled)	02/12/07	Complaints/Treatment

<u>Hospitalization; # of times:</u>	<u>Dates:</u>	<u>Days:</u>	<u>ICU:</u>
2	09/26/06, UK	1	No

History of Complaints:

<u>Symptom</u>	<u>Physician</u>	<u>Date Noted</u>	<u>Duration</u>
Range of Motion	Dr. Kelly G. Worth, DACAN	10/18/06	02/12/07
Spasm	Dr. Kelly G. Worth, DACAN	10/18/06	02/12/07
Difficulty Sleeping	Dr. Kelly G. Worth, DACAN	10/18/06	02/12/07
Radiating Pain	Dr. Kelly G. Worth, DACAN	10/18/06	02/12/07
Headaches	Dr. Kelly G. Worth, DACAN	10/18/06	02/12/07
Numbness	Dr. Kelly G. Worth, DACAN	10/18/06	02/12/07

History Treatments:

<u>Treatment:</u>	<u>Duration</u>	<u>Provider</u>	<u>Times per week</u>	<u>Last Date Noted</u>
Chiropractic	Prolonged Regular	Dr. Kelly G. Worth	3	02/12/07
Physical Therapy	Prolonged Regular	Dr. Marcello Leao	3-4	02/12/07
Rehabilitation	Prolonged Regular	Dr. Marcello Leao	3	02/12/07
Self Exercise	Short Regular	Dr. Kelly G. Worth	Daily	02/12/07
Medication	Regular Prolonged	ER Physician, MD Dr. Olsen, MD	As Prescribed	09/26/06 Unknown
Duties under Duress	12 Weeks/ Ongoing	Dr. Kelly G. Worth		02/12/07
Loss of Enjoyment	12 Weeks	Dr. Kelly G. Worth		02/12/07

IMPAIRMENT CONSIDERATIONS:

This patient qualifies for a DRE CATEGORY II **5%** Impairment of the WHOLE PERSON for the Cervical Spine.

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Mr. Conrad also qualifies for a CATEGORY II **7%** Impairment of the WHOLE PERSON for the Lumbar Spine. These figures were derived from the AMA Guides to the *Evaluation of Permanent Impairment, 5th Edition*; (Page 384, Chapter 15, Section 15.4, Table 15-3 - Criteria for Rating Impairment Due to Lumbar Spine Injury). Also; (page 392, Chapter 15, Section 15.6, Table 15-5 - Criteria for Rating Impairment Due to Cervical Disorders).

Page 604 of the COMBINED VALUE CHART issues the tables that allow combination of two or more WHOLE PERSON VALUES as in this patient’s case. Patient’s combined values exhibit a total from the combined chart table of **12%** TOTAL IMPAIRMENT. Total values were considered by objective and subjective information that followed the protocols consistent with the AMA guidelines noted in the patient’s exam findings. The 12% Impairment is a combined value of all injuries ratable at the time of the patient’s release but mainly his cervical and lumbar spine. 2% additional % was placed on the Lumbar spine due to the increase in difficulties with ADL’s and the Lower lumbar spine as apposed to the Cervical spine. Patient’s impairment rating in our professional opinion will not change either way within 1% for the next year or more. This patient’s condition is stable and static.

Further, the patients’ x-rays were sent out for viewing and digitizing by a third party company called National Injury Diagnostics whereby they digitized the x-rays for impairment reasons and for further viewing of possible evidence of permanent ligamentous damage. The patient does not qualify for a 25% impairment for his cervical spine secondary to x-ray translations, however; X-rays were digitized of the cervical spine and exhibit motion segment integrity with signs of ligamentous instability at C2 and C3 but is not beyond the ratable findings noted and necessary for the impairment rating of the spine via x-ray digitization following the AMA Guidelines of the Impairment Rating Guide, 5th edition.

CURRENT MEDICAL EXPENSES: (These are actual costs of necessary medicals and medicals already given directly related with our office and referrals and based on the patients’ current exam findings and history of injuries and other notes and records. This does not include all probable future medical expenses upon static and stable condition and release with impairment. This does not include visits to the VA Hospital and/or other personal Medical Physicians’ the patient has seen)

<u>Amount: \$</u>	<u>Type:</u>	<u>Physician:</u>	<u>Chart Date-Initial Visit</u>
\$1,788.87	Chiropractic	Dr. Kelly G. Worth, DACAN	10/18/06
\$1,642.42	Rehabilitation	Dr. Marcello Leao	10/18/06
\$2,102.93	Physical Therapy	Dr. Marcello Leao	10/18/06
\$3,192.88	Lab	Shaku Chhabria, MD	10/25/06
\$350.00	Misc: (Travel Assist, Report, Record Retrieval, etc.)		10/18/06
TOTAL EXPENSES			\$9,077.10

FUTURE MEDICAL EXPENSES:

<u>Future Treatment</u>	<u>Future Cost</u>	<u>Physician</u>	<u>Chart Date</u>
Chiropractic Manipulative Therapy	\$2,947.20	Dr. Kelly G. Worth	02/12/07
Physical Therapy	\$8,478.72	Dr. Kelly G. Worth	02/12/07
Rehabilitation	\$0	Dr. Kelly G. Worth	02/12/07

*(Rehab has changed to Home Exercise)

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Future Medical Expenses Discussed:

Mr. John Conrad suffered injuries to his Cervical, Thoracic and Lumbar region with further injuries to his upper and lower extremities as a result of the motor vehicle collision that occurred on or about 09/26/06. Currently, Mr. Conrad's condition is stable and static. As such, his current prognosis for future treatment is probable. Due to the probability of returning symptomatology from increased levels of structural and muscular stress at home and as a full time naval officer and recruit trainer putting in 20 hour days, he will fail to sustain maximum therapeutic benefits and his condition will progressively deteriorate due to the withdrawal of active and/or passive care. His position with the government is high and his days are long and the physical demands on his body are such that he needs to be in top shape. With residuals lingering in his spine from the accident, it is most definite that he will continue to struggle with pain in his spine, loss of range of motion in his neck and back and loss of enjoyment with duties under duress ongoing.

Since John was seen at the Naval Hospital the same day and reported pain immediately in multiple areas of his neck, head and back, etc... right after the accident and further, had several follow-up visits, according to the scientific literature, patients that report immediate symptoms are at higher risk of long term pain from whiplash and motor vehicular spinal trauma, (Radonov, BP et al., Long Term Outcome after Whiplash Injury...Medicine 1995: 74(5): 281-476). In addition, John did not receive care from our facility until 3 weeks after the incident. This was due to his multiple visits and treatment he was receiving from the Naval Hospital or the VA. He continued to take prescribed medication but his condition did not let up or subside. He tried to perform active treatment on his own at home while taking the medication but it did not help him. This is when he felt it necessary to see a specialist and presented himself to our facility.

It is well understood in the medical literature that severe ligament sprains of the Spine and Cervical spine are the result of traumatic tears of the anatomical structures uniting the vertebrae; disruption allows the vertebrae to be displaced beyond the physiologically normal range. The whiplash and spinal trauma sustained by Mr. Conrad from the accident/ injury collision caused a significant ligamentous injury and instability pattern as noted by our x-ray findings and objective exam specific for the anterior and posterior longitudinal ligament. The cervical injury sustained from this motor vehicular collision caused a rupture of stabilizing soft tissue resulting in a biomechanical instability which may lead to future neurological impairment.

The whiplash and spinal trauma, sustained by the patient from the accident injury collision, caused a significant ligamentous injury that continues to compromise function of normal daily activities as duly noted in final patient record dated 02/12/07. In regards to permanent impairment assessment, it was performed in accordance with the AMA Guides to the *Evaluation of Permanent Impairment, Fifth Edition*. Impairment is considered permanent when it has reached maximum medical improvement, meaning it is well stabilized and unlikely to change substantially in the next year with or without medical treatment.

As such, for this patient, final exam findings exhibit loss of range of motion in both the cervical and lumbar region with residual myofascitis or chronic muscle spasm that continues to give pain to the patient on a lesser scale.

I believe that he will need additional follow-up care up to 2 years (24 visits over the next 24 months) at \$238.04 per visit which includes Physical Therapy Modalities and CMT procedure to the entire spine.

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Because of his intense duties with the government and further, his recruit training responsibilities, he will ultimately at least once a year for a minimum of two years, need more than just one visit a month and will need to carry out a 4-6 week schedule of care at 2-3x's per week due to flare-up or re-exacerbation. This equates to, in addition to the 24 visits or once a month for two years, approximately 24 additional visits making it a total of approximately 48 visits over a two year period he will need. John will continue to perform duties under duress and loss of enjoyment will be ongoing at work and at home. This will affect his mental and physical health. He will attempt to treat himself at home with self-exercise as we have discussed with him, improved nutrition and light stretching to diminish anxiety and again, mitigate cost of recovery. We have counseled John that he becomes more physically active with regard to exercising the upper and lower body in general with weight training mainly. Excellent exercises also include swimming and walking but have really stressed the weights.

Lastly, it should be pointed out that if the patient does continue to experience pain in his cervical spine, because of what was noted in the exam and x-rays, the patient should obtain a Cervical MRI. Further, if indeed his symptomatology returns with his lower back and because of the history of events that took place and the symptomatology that he experienced with the right radicular pain and finally, the EDX exam which showed S1 Radiculopathy as well as other multiple signs of disc herniation, that the patient should as well, carry out a lumbar spine MRI to distinguish how many bulges there might be and the size. If his symptoms return, it will be necessary to be referred to an Orthopedist MD for further evaluation and possibly a pain management specialist for epidural injections. Cost on all of this could be closer to ten thousand dollars for MD evals, MRI's and so forth but again, will only be necessary if indeed the patients' condition gets worse.

Medical Expense Summary:

Current Physician Expenses (Chiro., P/T, Rehab, Exams, X-rays, Records, Reports, etc.)	\$5,884.22
Future Medical (As it relates to Chiropractic/ P/T only.)	\$11,425.92
Future Income Loss	Unknown

TOTAL MEDICAL EXPENSES \$17,310.14

*(Future Medical is only an estimate and only relates to our Specialty. It does not relate to MRI studies and other necessary medicals that may or are needed.)

BASIS of OPINION:

The basis of our opinion is duly noted from our objective findings from our examinations and the patient's symptomatology ongoing and the history of events that took place. The findings were consistent with the injury of question. The patient shows no history of injuries that are in need of apportionment. Further, the patient shows no past history of injuries or health conditions that would warrant suspicion of the current injuries also being apportioned. That these injuries were solely and 100% from the auto accident of issue. Residual findings of the examination were noted and all examination and diagnostic findings were utilized for final impairment rating purposes.

TREATMENT GUIDELINES USED:

This patient received treatment in the form of Physical Therapy and CMT procedures daily for one to two weeks followed by then 3x's per week with a gradual reduction of weekly visits until such time the patient was released as stable and static. *(CAD Croft Guidelines are utilized in our facility specific for Motor Vehicular injuries, particularly where the Cervical Spine is injured.

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These Guidelines are based on specific criteria of initial rating of patient's condition. The Grades of Severity of Pain would be from Grade I-IV, Minimal, Slight, Moderate and Severe. Guidelines for Frequency and Duration of Care also Grade and are I-V ranging from 21 total visits or less for a Grade I up to 76 visits or less for a Grade III. Above this level would relate to surgical and even more severe injuries where over 100 visits would be warranted over a 56(+)wk period.) This patient is categorized as a GRADE II to GRADE III and would follow the Grade II Category of Guideline Treatment of the Croft Guidelines for CAD Motor Vehicular Injuries. As you can see from our treatment given, we are largely under the standard acceptable range for treatment both in visits and time length. This is due to our sophisticated rehab center and maturity of the Physicians on staff with experience in injuries. Our goal is to also mitigate costs and expenses as quickly as possible by providing the patient with multiple exercises and other necessary home programs that essentially cut the treatment time down a third to one half.

The patient does have ligamentous instabilities in his cervical spine, but it is not operable and does not require surgery since there is no neurological component involved at this time. All treatment prescribed and carried out as well as recommended

VALIDATION of IMPAIRMENT RATING:

Impairment ratings were reviewed with Physician's below with final findings and noted as being true Impairment rating scores directly from the *AMA GUIDES to Impairment rating, 5th Edition*. Dr. Kelly G. Worth is a "***Certified Disability Analyst***" with Diplomate status and qualifies for rating persons for Impairment residuals.

Thank you for you cooperation and appreciate final processing of this patient's chart.

Respectfully,

Dr. Kelly G. Worth, DC, ND, CMUA, FAFICC, FIACN, DACAN, DABCI
Fellow of the American Forensic Industrial Chiropractic Consultants
Fellow of the International Academy of Clinical Neurology
Diplomate American Chiropractic Academy of Neurology
Board Certified Chiropractic Neurologist
Diplomate American Board of Chiropractic Internists
Board Certified Chiropractic Internists
Certified Manipulation under Anesthesia
Board Certified Naturopathic Physician
Diplomate American Board of Pain Management
Diplomate American Board of Disability Analysts
Qualified Medical Examiner, CA 1991-1994, 1998-2006
Clinic Director and Primary Treating Physician

CA Lic#: 19653
WI Lic#: 4264-012
IL Lic#: 038-010349

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Respectfully,

Dr. Marcello Leao
Assisting Treating CMT Physician
Rehabilitation and Physical Therapy Coordinator