



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 IMPAIRMENT 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:** (Describe pertinent details as to the accident or injury that has occurred.)

On May 1, 2006, this patient was traveling in a 1993 Toyota Corolla at approximately 6:45p.m. Her husband was driving and she was the passenger in the vehicle. They were at the corner of Atkinson and Washington in the city of Grayslake. They were at a stop light when suddenly they were hit from behind by another vehicle. Patient stated that there were two cars behind their vehicle and that a third vehicle crashed into the second car behind them, which caused their vehicle to get hit as well. Due to the shock of the impact, the patient's head was jerked forward causing her to put her left hand on the dash board and resulted in immediate pain in her neck and shoulder. Patient called the police and once they arrived she was asked if she was in need of an ambulance. Patient said no because she was still in shock. After her hand had landed on the dash board she felt pain but she felt it was not severe enough to go to the hospital until later.

Later that night at about 10:00 p.m. she began to feel pain on the left shoulder get much worse. The pain radiated down her shoulder towards her arm and mid back giving her weakness. Patient stated that she was feeling more pain when she used her arm. Patient then decided to go to Victory Hospital where they took X-rays and she was told by the doctor that she may have pulled a muscle or torn a rotator cuff muscle in her shoulder and also sprained her neck. She was given Motrin for the pain and was told to follow up in two days. Patient could not go because she didn't want to miss work for fear of losing her job. Patient went home, took medicine, and went to work the following day. She stated that she was unable to work at her full capacity due to the pain. She was not seen by any other doctors. She thought that the medication was going to take the pain away but she soon ran out and was taking OTC meds. She applied herself into an active treatment protocol whereby she would try and do stretching and other forms of activity but only seemed to hurt her more. It finally got to the point where it was necessary for her to take time off work and see a Physician. Patient's symptoms were progressively getting worse and presented to our facility for further evaluation and treatment on or around 06/21/06. She was given a complete examination and evaluation of her injuries and was placed on a strict regimen of Physical Therapy and CMT procedures whereby she engaged in on a regular basis or as much as she could due to her work responsibilities and schedule. Recommendations were given for her to come 3x's per week but the patient was only able to come 2-3 times per week for the first month followed by 1-2 times per week thereafter. She complied to the home exercises that we prescribed to her however her compliance with the protocol at the office was not consistent because of transportation issues and work schedule. She however, was consistent making it in weekly at least once or twice because of her pain levels and did so through the month of June and July into August whereby her visits were dropped to 2x's per week which she was able to follow. September she was dropped to once a week however, she only made it in twice and then followed up monthly through October, November and December when she was finally released.

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Social and Past History:

Patient is married with three children. She does not smoke or drink. She has had no other surgery, injuries, or accidents in the past.

Disability Status:

Patient was released to return to work on 06/27/06 without restrictions. Patient was to wear her arm brace at all times. Due to the injuries sustained to her left shoulder while involved in an auto accident on May 01, 2006, she was to continue wearing her brace while working or at home until such time she was able to function without it.

Subjective Complaints:

1. Dull ongoing constant pain in her left shoulder but not as severe as initially. Patient has difficulty using her left upper extremity.
2. Dull pain in left arm that radiates from the shoulder. Pain radiates down biceps, forearm, and wrist.
3. Sharp pain on left side of middle back. Difficulties performing job duties due to the pain.
4. Moderate pain throughout her cervical spine, particularly on the left side, with pain that travels down her left arm with periodic numbness and tingling. The pain is not as severe as before but still remarkable. She experiences headaches and sleeplessness due to the pain. She has also been experiencing anxiety and stress due to the situation at hand with trying to make the office visits, schedule at work, missed work, her ongoing pain, etc...

Objective Exam Findings:

PHYSICAL EXAM: Height 155cm, Weight 127lbs, T 98.6F, BP 120/70, Pulse 54, Respirations 17. Patient is right handed. Alert, awake, and oriented x 3.

CERVICAL SPINE: Range of motion in flexion is 55° with pain, extension 40° with pain, R. Lateral flexion 40° with pain, L. Lateral flexion 40° with pain, R. Rotation 75° with pain, and L. Rotation 75° with pain. **INSPECTION:** Normal skin appearance. No deformity noted. There is no swelling. There is no discoloration. Mild kyphosis present. **PALPATION:** No crepitation present. Trigger points noted throughout paraspinal muscles bilaterally. Tenderness and spasms throughout paraspinal muscles bilaterally particularly the left side. Tender cervical spinous process at C4-C7. No effusion. No mass noted. **SPECIAL TESTS:** Cervical compression (+), Cervical distraction (-), Shoulder depression (+) left and right side (-), Soto-hall (-) bilaterally. Grip strength 10, 10, and 15 for Left and 55, 40, and 40 for right.

THORACOLUMBAR: Range of motion in flexion 70° with little pain, extension 30° with little pain, R. Lateral flexion 30° with little pain, L. Lateral flexion 30° with little pain, R. Rotation 45° with no pain, and L. Rotation 45° with no pain. **INSPECTION:** No ecchymosis. No erythema. No deformity or swelling noted. **PALPATION:** The paravertebral musculature was within normal limits. There was minor pain at the upper levels of the spine upon pressure, T2-T7 with some trigger point areas in the left shoulder blade as well as the left trapezium. **SPECIAL TESTS:** (-) SLR bilaterally, (-) Nachlas bilaterally, (-) Ely's bilaterally, (+) Compression of the Thoracic spine at the levels indicated above.

SHOULDER EXAM: The range of motion of the left shoulder was limited 25-33% in all directions. Flexion was approximately 90 degrees, Extension was 45 degrees, Internal and External rotation was approximately 45 degrees, adduction was 45 degrees and finally, abduction was approximately 80 degrees.

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INSPECTION: There is no ecchymosis, no erythema or deformity. There is no apparent swelling.

PALPATION: The shoulder itself exhibits pain and tenderness at the anterior deltoid region where the biceps tendon and other tendons attach. There is also tenderness in the trapezium superiorly from the same area where there are trigger points noted chronic, mainly the left side. These areas are moderately tender to the patient when palpated. Movement is inhibited by the muscle spasm and pain, otherwise, the patient is able to move freely in all directions. **SPECIAL TESTS:** (+) Apley's Left, (+) Supraspinatus Test.

*(Patient has suspected Rotator Cuff Tear with secondary Brachial Plexus injury on the left.)

NEURO: Reflexes for upper and lower extremities 2+ bilaterally and symmetrical. Patient is able to walk on her heels and toes.

MUSCLE STRENGTH: Cervical flexion 4/5, Cervical extension 5/5, Cervical Lat Flexion 4/5 for L and 4/5 for R., Shoulder abduction 4/5 for L with pain and 5/5 for R, Shoulder Ext. Rotation 5/5 for L and 5/5 for R, Shoulder Int. Rotation 5/5 for L and 5/5 for R, Shoulder Flexion 4/5 for L with pain and 5/5 for right, Shoulder Extension 5/5 for L and 5/5 for R. No other remarkable findings as noted.

CIRCUMFERENTIAL MEASUREMENTS: Biceps 24.5cm on left and 24cm on right, Elbow 22cm on left and 22.5cm on right, Forearm 22.5cm on left and 24 cm on right, Wrist 15cm on left and 15cm on right.

Past Medical History: None

Past Surgical History: Unremarkable

Allergies: None

Medications: None

Social History: Denies tobacco, alcohol and IV drug abuse.

Family History: Negative

Review of Systems: Unremarkable. Patient denies bowel or bladder changes.

sEMG and Thermo Readings; 06/21/06: (Brief overview of what's noted on initial scans or graphs.)

Thermoscan reading exhibits positive autonomic neurophysiology in the Cervical, Thoracic and Lumbar areas consistent with the patient's objective exam findings and further, the patient's symptomatology. Findings are positive for bony misalignments that are or could be causing disruption in the normal patterns of the physiology in those areas. Findings also suggest lateralization of the spine with a transaxial rotation. These findings would qualify the patient for CMT procedures.

Surface EMG study was performed and exhibits positive neuromuscular activity readings that are consistent with acute muscle spasm in the areas surrounding the Cervical and Thoracic spine. This also is consistent with the patient's injuries and is consistent with the symptomatology and validates the medical necessity for physical therapy and rehabilitation which was given.

Prognosis: (What is professional opinion of patient's future outcome at this point; If unknown, state unknown at this time.)

Complaint / Treatment Recommended

SUMMARY OF CARE: (*Give a summary of all treatment administered and type, MD referrals, MRI/ NCV referrals, etc...)

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.

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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 paravertebral muscles and left arm and shoulder. 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.

This was also medically necessary to use for a precursor to the CMT procedures and was necessary to warm the region up to adjust.

The patient also 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 other 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. These were important or restoration of the lost Cervical curve or the hypolordosis and further, assisting the loss of range of motion that seemed to get worse as she progressed through care due to the severity of injury to her cervical spine and the deep intrinsic musculature of the cervical spine changing her skeletal biomechanics.

Isokinetic Resistance/ Therapeutic Exercise 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. This was necessary for the rehabilitation of her left shoulder and cervical spine.

Manual Therapy was also provided where the patient received deep Neuromuscular Massage work to different areas of the spinal paravertebral musculature and shoulder as well as her left arm where there was much swelling and pain with paresthesia. This to assist in increasing the overall range of motion of the spine and shoulder 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 upper spine, mid and left shoulder 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 times per week Physical Therapy program that initially consisted of the CMT procedures along with the passive modalities. This was only for the first and second week. She was then reduced to two-three times per week thereafter gradually reducing her weekly visits until she was released on or around December 08, 2006 as permanent and stationery.

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She was given mini re-exams along the way with more formal re-exams performed on August 04 and November 06, 2006, that allowed us to chart her progress on a regular basis. On August 04, 2006, it was noted that the patient should begin formal rehabilitation and on August 09, 2006, the patient slowly began the rehabilitation and further extensive Physical Therapy. The active role the patient played in her treatment and overall care assisted in her recovery even though she was unable to make it more often than she did. She performed well with the exercises and treatment.

Long Term Goals: These were to return Ms Amador 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 her 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 her upper extremity paresthesia and numbness with pain. The patient had been experiencing this for some time prior to the test and it appeared that it was not going away. The patient qualified for this procedure since it was beyond a reasonable time period having the symptoms and the initial accident being 8 weeks prior with no improvement on the extremity paresthesia. She was referred and received an upper extremity NCV/SSEP which showed multiple sensory neuropathies consistent with possible median nerve entrapments and/or brachial plexus involvement.

She also received X-rays the day of her exam which were sent out and read by the Radiologist. A complete left shoulder series was performed along with a 2v T-sp and 7v Cervical spine. The most severe read was the Cervical spine which indicated translation of vertebrae and probable ligamentous disruption secondary to the whiplash injury at levels C5/C6 and C6/C7. The shoulder and thoracic spine showed minimal findings and can be read more thoroughly on the report enclosed.

Due to the x-ray findings in the cervical spine, the patient's x-rays were referred out to National Injury Diagnostics to be processed and digitized for measurement. Upon Dr. Cronks' extensive evaluation, it was noted that this patient has angular motion segment integrity change at C2, C3, C4 and C5 meaning that due to the forces of the trauma of the injury, the anterior and posterior longitudinal ligaments were disrupted along with others, causing the vertebrae to be altered from their prospective skeletal biomechanical norm. They in other words have shifted from their normal position permanently due to the disruption of the ligamentous structures surrounding the area. George's lines have been altered mainly at C4/C5 region and indicate sub failure. Although there are findings noted within these regions that are measurable, they are not ratable according to AMA guides.

Medical Specials: \$10,717.88 *(Include all medicals from our office and the EDX lab)

Property Damage: Unknown

Income Loss: Unknown

Injuries:

Neck, Back Injuries, Upper Extremity, Anxiety, Difficulty Sleeping

ICD9 Injury Codes: E815.0, 722.0, 723.4, 782.0, 847.1, 847.0, 728.87, 728.85, 784.0, 716.95, 780.50, 308.0, 723.1, 840.4, 729.1, 840.8, 739.1, 739.2, 839.08, 839.21, 737.9, 728.4. ******COMPLICATING FACTORS:** *(737.39, 721.1, 721.2)

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CPT Treatment Codes: 97140, 97014, 97010, 97035, 98942, 98940, 72070, 72052, 73030, 99204, L0120, 99212-25, 98941, 97110, 97032, 97039, 99082, 99199, 99214-25, 95900, 95903, 95904, 95925, 95999, 93760, 96004, 99090, 99213-25, 99080.

Dx-DIAGNOSIS and ICD-9 Injury Codes:

1. CERVICAL DISC INJURY/ SYNDROME	ICD-9 722.0
2. UNS THORACIC/CERV NEURITIS/RADICUL	ICD-9 723.4 - Intermittent
3. PARESTHESIA, Upper Extremity Left	ICD-9 782.0 - Intermittent
4. THORACIC SPRAIN and STRAIN-Upper	ICD-9 847.1 - Resolving
5. NECK SPRAIN and STRAIN	ICD-9 847.0 - Resolving
6. MUSCLE WEAKNESS	ICD-9 728.87 - Resolving
7. SPASM OF MUSCLE	ICD-9 728.85 - Intermittent
8. HEADACHE	ICD-9 784.0 - Intermittent
9. INFLAMMATION and SWELLING	ICD-9 716.95 - RESOLVED
10. INSOMNIA / SLEEPLESSNESS	ICD-9 780.50 - Intermittent
11. ACUTE ANXIETY and STRESS	ICD-9 308.0 - Resolving
12. CERVICALGIA	ICD-9 723.1
13. ROTATOR CUFF INJURY/ SYNDROME	ICD-9 840.4
14. MYOFASCIAL/ MUSCLE PAIN	ICD-9 729.1
15. SHOULDER SP/ST- Left	ICD-9 840.8 - RESOLVED
16. SEGMENTAL DYSFUNCTION – Cervical Spine	ICD-9 739.1
17. SEGMENTAL DYSFUNCTION – Thoracic Spine	ICD-9 739.2
18. MULTIPLE VERTEBRAE DISPLACED-C/SP	ICD-9 839.08 - Resolving
19. MULTIPLE VERTEBRAE DISPLACED-T/SP	ICD-9 839.21 - Resolving
20. CERVICAL HYPOLORDOSIS, Slight	ICD-9 737.9 - PERMANENT
21. LAXITY of LIGAMENT, C-SP	ICD-9 728.4 - PERMANENT
22. MOTOR VEHICLE COLLISION w/ ANOTHER VEHICLE	ICD-9 E815.0

History of Treatment:

Neck and Back Injuries

<u>Provider Name</u>	<u># of Treatments</u>	<u>Last Treatment Date</u>	<u>Prognosis</u>
ER Physician (Victory Memorial Hospital)	1	05/01/06	Complaints/Treatment
ER LAB (Victory Memorial Hospital)	1	05/01/06	Complaints/Treatment
Dr. Kelly G. Worth, DACAN	24 (scheduled)	12/08/06	Complaints/Treatment

<u>Hospitalization; # of times:</u>	<u>Dates:</u>	<u>Days:</u>	<u>ICU:</u>
1	05/01/06	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	06/21/06	12/08/06
Spasm	Dr. Kelly G. Worth, DACAN	06/21/06	12/08/06
Anxiety	Dr. Kelly G. Worth, DACAN	06/21/06	12/08/06
Difficulty Sleeping	Dr. Kelly G. Worth, DACAN	06/21/06	12/08/06
Radiating Pain	Dr. Kelly G. Worth, DACAN	06/21/06	12/08/06
Headaches	Dr. Kelly G. Worth, DACAN	06/21/06	12/08/06

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History Treatments:

<u>Treatment:</u>	<u>Duration</u>	<u>Provider</u>	<u>Times per week</u>	<u>Last Date Noted</u>
Physical Therapy	Prolonged Regular	Dr. Marcello Leao	3	12/08/06
Rehabilitation	Prolonged Regular	Dr. Marcello Leao	3	12/08/06
Self Exercise	Short Regular	Dr. Kelly G. Worth	Daily	12/08/06
Chiropractic	Prolonged Regular	Dr. Kelly G. Worth	3	12/08/06
Medication	Prolonged Regular	ER, MD	As Prescribed	05/01/06
X-Ray/CT-Scan	Short Regular	ER, MD	As Prescribed	05/01/06
Duties under Duress	6 Months (+)	Dr. Kelly G. Worth		12/08/06
Loss of Enjoyment	6 Months (+)	Dr. Kelly G. Worth		12/08/06

IMPAIRMENT CONSIDERATIONS:

This patient qualifies for a DRE CATEGORY II **8%** Impairment of the WHOLE PERSON for the Cervical Spine. These figures were derived from the AMA Guides to the *Evaluation of Permanent Impairment, 5th Edition*; (page 392, Chapter 15, Section 15.6, Table 15-5 - Criteria for Rating Impairment Due to Cervical Disorders). Impairment loss is due to objective factors relating specifically to her limited range of motion for both areas consistent with impairment rating AMA guidelines as well as her loss of enjoyment and duties under duress.

In the shoulder of the left side, the patient showed a consistent 27-33% loss or limitation of movement in all directions. This was applied to the charts noted in Chapter 16 for the upper extremity AMA Impairment Rating, 5th edition whereby Flexion and Extension were a total of 5%, Abduction and Adduction were a total of 3% and External and Internal Rotation were 3% for a grand total of 11%. This was converted to whole person from the table on pages 438, Table 16-3 where it converts the 11% to **7%** whole Body Impairment.

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 **14% 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 14% Impairment is a combined value of all injuries ratable at the time of the patient’s release but mainly her cervical spine and left shoulder. 3% additional % was placed on the Cervical spine due to the increase in difficulties with ADL’s and the Cervical spine along with the left shoulder and upper extremity.

The 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.

CURRENT MEDICAL EXPENSES: (These are actual costs of necessary medicals and medicals already given 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.)

<u>Amount: \$</u>	<u>Type:</u>	<u>Physician:</u>	<u>Chart Date-FINAL Visit</u>
\$2,338.69	Chiropractic	Dr. Kelly G. Worth, ND, DACAN	12/08/06
\$1,770.23	Rehabilitation	Dr. Marcello Leao	12/08/06
\$3,097.76	Physical Therapy	Dr. Marcello Leao	12/08/06

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\$3,117.32	Lab	Shaku Chhabria, MD	07/05/06
\$375.00	Misc: (Travel Assist, Report, Record Retrieval, etc.)		05/08/07

TOTAL EXPENSES			\$10,699.00
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FUTURE MEDICAL EXPENSES:

<u>Future Treatment</u>	<u>Future Cost</u>	<u>Physician</u>	<u>Chart Date</u>
Chiropractic Manipulative Therapy	\$1,473.60	Dr. Kelly Worth, ND	12/08/06
Physical Therapy	\$4,239.36	Dr. Kelly Worth, ND	12/08/06
Rehabilitation	\$0	Dr. Kelly Worth, ND	12/08/06

*(Rehab has changed to Home Exercise but will need follow-up each month for 24 months. 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.)

Future Medical Expenses Discussed:

Mrs. Marta Amador suffered injuries to her Cervical and Thoracic region with further injuries to her Upper Extremity/ Left Shoulder as a result of the motor vehicle collision that occurred on or about 05/01/06. Currently, the patient's condition is stable and static. As such, her 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 worker, she will fail to sustain maximum therapeutic benefits and her condition will progressively deteriorate due to the withdrawal of active and/or passive care.

Since Mrs. Amador was seen at the Hospital the same day and reported pain immediately in multiple areas of her neck, head and back and extremities right after the accident, 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).

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 this patient 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 by Mrs. Amador, our patient; from this motor vehicular collision caused a rupture of stabilizing soft tissue resulting in a biomechanical instability which may lead to future neurological impairment. This is due to the already present radicular pain and EDX findings noted in the nerve study and the ongoing intermittent paresthesia noted. It is felt that the brachial plexus on the left was stressed causing the secondary symptomatology she experiences.

The whiplash and spinal trauma, also sustained by the patient from the accident injury collision, caused a significant ligamentous injury to her neck that continues to compromise function of normal daily activities as duly noted in final patient record dated. In regards to permanent impairment assessment, it was performed in accordance with the AMA Guides to the *Evaluation of Permanent Impairment, Fifth Edition*.

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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 left shoulder region with residual myofascitis or chronic muscle spasm that continues to give pain to the patient. She is thought to have a rotator cuff tear of the left shoulder as well as the cervical spine having a disc protrusion or bulge. Further MRI studies of both these areas would be medically acceptable and would allow us the disc bulge size of the cervical spine and also, if the supraspinatous tendon is torn partially or all the way.

I believe that she will need additional follow-up care either way, up to 2 years (24 visits over the next 24 months) at \$209.71 per visit which includes Physical Therapy Modalities and CMT procedure to the upper spine and neck. She will also be in need of the rehabilitation portion of this therapy, a minimum of 2-4 units or 30-60 minutes at \$170.04 for 3 units of time or \$56.68 per unit of 15 minute measure. Normally this is given to the patient to do at home, but because of her condition with her left shoulder, she will be in need of focused care on this area more than just the passive care. She will continue as such to perform the in home exercises and is recommended to return once per month on average or when she is to have a flare-up or re-exacerbation. The amount of visits or 24 noted is an average of one a month however, in all likeliness the patient will utilize the treatment stratagem when she has a flare-up condition and will have to come in 2-3 visits a week for 3-6 weeks at a time. This is expected to happen a minimum of once in the two year period.

Mrs. Amador will continue to perform duties under duress and loss of enjoyment will be ongoing at home. This will affect her mental and physical health. She will attempt to treat herself at home with self-exercise, improved nutrition and light stretching to diminish anxiety and again, mitigate cost of recovery. We have counseled this patient that she becomes more physically active with regard to exercising the upper and lower body in general. Excellent exercises include weight training, swimming and walking and have advised the patient accordingly and to continue to come in to our facility a minimum of once a month for her condition. She has also been advised that if her condition does not get any better, she is to be referred for the recommended MRI's and then be evaluated by our Orthopedic MD for second opinion.

Medical Expense Summary:

Current Physician Expenses (Chiro., P/T, Rehab, Exams, X-rays, Records, Reports, etc.)	\$7,600.56
Future Medical (As it relates to Chiropractic/ P/T)	\$5,033.04
Future Medical (As it relates to Rehabilitation)	\$4,080.96
Future Income Loss	Unknown

TOTAL MEDICAL EXPENSES \$16,714.56

*(Future Medical is only an estimate and only relates to our Specialty)

BASIS of OPINION:

The basis of our opinion is duly noted from our objective findings from our examinations and the patient's symptomatology ongoing. 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.

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TREATMENT GUIDELINES USED:

This patient received treatment in the form of Physical Therapy and CMT procedures 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. 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 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 with experience in injuries who assist in co-management of the patients. 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 serious ligamentous instabilities in her cervical spine and shoulder, but it is not operable and does not require surgery at this time since there is no permanent neurological component involved and we do not have MRI films.

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