M.D. Pain Specialists

James B. Shaw, M.D.

April 23, 2011

McKenzie Dawson, Claims Administrator
AIMS
P.O. Box 269120
Sacramento, CA 95826

RE:	**TIFFANY ANDERSON**
DOB:	**August 22, 1970**
DOI:	**June 19, 2008**
CLAIM #:	**VE0700184**
SSN:	**549-23-5133**
EMPLOYER:	**San Joaquin County Mosquito and Vector Control District**
DOE:	**April 23, 2011**

PAIN MANAGEMENT CONSULTATION REPORT

Dear Claims Adjuster,

Thank you for your kind referral of Tiffany Anderson who was seen at my Stockton office on April 23, 2011, for a Pain Management Consultation. This report is based upon personal interview and examination of the patient, combined with review of the available medical records and other submitted information.

CURRENT COMPLAINTS:

Right Knee Pain

HISTORY OF INJURY:

The patient was being seen today for a pain specialty consultation exercising their rights under Labor Code 4600 for selecting their Primary Treating Physician. Tiffany Anderson is a 40-year-old, right-handed female with an industrial knee injury. Prior to the work injury the patient denies any ongoing musculoskeletal or neurological complaints.

In regards to the work injury the patient reports injuring her knee while walking through

eroded pasture land, climbing over fences, and walking in heavy mud that made her feet stick as she walked. She complained to her supervisor, but continued to work her shift. She subsequently was referred to the company clinic, and then an Orthopedic Surgeon. The patient has improved somewhat from treatment, but her progress has reached a plateau. She initially was treated by Dr. Murata on June 19, 2008, and he recommended surgery with arthroscopic lateral meniscectomy. Dr. Murata performed surgery for a tear of the anterior horn of the lateral meniscus, and it was found to have complex radial and lateral tears. there was also chondromalacia of the medial femoral condyle which was trimmed. At the time of that surgery he resect ed 30% of the meniscus down to a stable base.

The patient had a second MRI that showed a horizontal cleavage tear which was nearly circumferential, and there was an old Baker Cysts 6x7 cm of the posterolateral aspect of the knee. The patient continued to experience lateral knee, patellofemoral, and lateral joint line pain that continues. The patient has continued to have significant pain despite two surgeries the last by Dr. Murata, March 9, 2010. She was found to have garde IV chondromalacia of the medial femoral condyle, and a recurrent lateral meniscus tear, and had a microfracture of the condyle, and a partial menisectomy.

She was seen June 8, 2010 for a Qualified Medical Evaluation, and there was felt a need for continued medical care for analgesics, and antiinflammatories.

JOB HISTORY/JOB DUTIES:

I have been provided an RU-91 on this patient. The patient is a mosquito control technician, and worked in this capacity with the employer with the San Joaquin County District. Her physical demands were reviewed.

CURRENT SYMPTOMS:

The patient has drawn her symptoms on a diagram outlining the human body. The body parts reported are knee.

The patient was asked to describe his pain based on the McGill Pain Questionnaire short form. The character of the pain is described as ache.

The patient's present pain intensity on a numeric rating scale (NMRS) is 5/10.

From the patient's perspective the cause of pain is from the original injury. Aggravating factors include general activities and normal work. Palliative measures include rest.

Current ADL limitations per Table 1-2:

Self-care, Personal Hygiene	None
Communication	None
Physical Activity	Mild- moderate

Sensory Function	None
Non specialized Hand Activities	None
Travel	None
Sexual Function	N/A
Sleep	Moderate -Severe

Physical: Reports sitting intolerance between 30- 60 minutes, walking intolerances between 30-60 minutes. Slight loss in pushing very heavy objects. Difficulty with kneeling, bending, and squatting.

Reports moderate pain most of the time in the knee affecting her back at times.

Psychological Symptoms Questionnaire:

The patient endorses the following psychological indicators of psychosocial distress. The following were reported: 1) tension 2) sleeplessness 3) depression 4) fatigue 5) feelings of helplessness 6) nervousness 7) worry about career 8) confused thoughts 9) poor concentration 10) anger 11) exhaustion 12) poor self esteem 13) irritability 14) feelings of discrimination 15) self doubt 16) frustration 17) harassment at work.

EPWORTH SLEEPINESS SCALE:
Epworth scores > 10 associated with sleep disorders.

Score: 11.0.

Screener Opioid Assessment Profile (S.O.A. P.):
The SOAP Questionnaire is a 14 question instrument used to identify patient's that may have problems with opioids.

YELLOW:
Score greater than 7 indicates higher risk of difficulties.

The patient scored a 7.0 with 2/4 mood swings, family problems with alcohol and drugs 4/4, and 1/4 with friends with problems with alcohol, and drugs. Also, the patient reports that she does not crave opioid medications, but is utilizing 8 Norco 10-325 a day.

The patient would fit best in a cautious category for opioids, and her regiment from an occupational status would be sub-optimal. Additionally the medications are prescribed for chronic headaches (non industrial).

CURRENT MEDICATIONS:

1 Norco 10-325 Tablet Mg (Other MD) SIG: take 1-2 tablets every 4-6 hours/ 8/day
2 Xanax 0.5 Mg Tablet (Other MD) SIG: takes 1 tablet every 12 hours

ALLERGIES: No Known Drug Allergies

MEDICAL HISTORY:

1) No History of Motor Vehicle Accidents
2) Complicated History of Exposures/ Work Injuries- reported June 19, 2009, March 26, 2009, and July 2, 2009.

I have not been provided a complete set of records, and, therefore am limited in a comprehensive discussion of he issues.
3) History of depression
4) History of severe migraine headaches, and has participated in the chronic pain program at Kaiser.
5) History of musculoskeletal injuries.

FAMILY HISTORY:

Family history is non-contributory for this condition.

Reported substance alcohol/medications issues in family 1/4. She does not reside with her mother or father her are reportedly divorced.

SOCIAL HISTORY:

She denies smoking cigarettes. She denies alcohol use. The patient denies taking any illicit drugs. The patient has 2 children.

REVIEW OF SYSTEMS:

Constitutional:
Patient denies fever, chills, fatigue, previous chronic illness or injury, change in appetite, weight gain, weight loss without dieting, night sweats or other constitutional complaint.

Head:
Patient denies closed head injury, concussion, loss of consciousness, tumors, seizures, dizziness, vertigo, or other complaints. The patient reports chronic headaches, and has been seen at Kaiser. She also was seen in the pain program at Kaiser.

Neck:
Patient denies pain with movement, increased muscle tone, palpable mass, dysphagia.

Respiratory:
Patient denies cough, sputum, wheeze, dyspnea, hemoptysis or pleuritic pain.

Cardiovascular:
Patient denies chest pain, dizziness, orthopnoea, palpitations, pedal edema.

Gastrointestinal:
Patient denies nausea, vomiting, diarrhea, constipation, abdominal pain, heart burn, dysphagia, hematemesis and melena.

Genitourinary:
Patient denies known occupational conditions of the genitourinary system.

Neurological:
Patient denies dizziness, paresthesia, seizures, weakness.

Endocrine:
Patient denies chronic fatigue, heat/cold intolerance, polyuria, polydipsia, polyphagia, unexplained weight loss or gain, or changes in skin pigmentation.

Psychiatric:
Patient reports significant affective distress including anxiety, depression, sleep disturbance. Patient has reported previous psychiatric treatment, with medication, but her current work injury, and circumstances surrounding her employment reportedly have made everything much worse.

PHYSICAL EXAMINATION:

Weight:	**145 lbs**
Height:	**5' 4"**
BMI:	**24.89**
Pulse:	**80**
Respiration:	**20**

GENERAL APPEARANCE:
The patient is well developed, well-nourished, and in no distress. The patient is alert, and oriented x3.

HEENT:
Normocephalic, atraumatic. Palpatory examination normal. Pupils are equal, round, and reactive to light. Extraocular muscles are intact. Sclerae are non-icteric. Conjunctiva are pink, non icteric.

NECK:
There is no significant lymphadenopathy or mass. Trachea is mid-line. The thyroid is without enlargement or palpable nodule. There is no evidence of jugular vein distention.

CARDIOVASCULAR:
The heart has a regular rate and rhythm. Pulses are normal.

RESPIRATORY:
Lungs are clear.

LUMBAR SPINE:
Gait is normal.
Normal Lumbar flexion.
Straight leg raise is negative.
Spasm and guarding is noted lumbar spine mild soreness/ no spasm/ guarding.

FABER TEST Negative.

Patrick Test Negative.

Gaenslen's Test Negative.

MUSCULOSKELETAL:
Right knee has palpatory tenderness over the joint line, and Gerdy's tubercle. No fluid today. No erythema. ROM- extension 0 degrees, flexion 130 degrees. There is no evidence of bony tenderness, joint effusion, enlargement or abnormal motion. No muscle fasciculations, atrophy, muscle weakness, asymmetry or reduced range of motion is noted.

NEUROLOGIC:
Cranial nerves II-XII grossly intact. Strength 5/5 in all muscle groups. Sensation intact to light touch and pinprick. Reflexes are equal and symmetric bilaterally in the upper- 2+/2+ and lower extremities- 2+/2+. Babinski is negative. Cerebellar function grossly intact. Finger-to-nose testing within normal limits. Gait normal.

MEDICAL RECORDS, DIAGNOSTICS AND IMAGING REVIEW:

The medical records were reviewed. This is a separately reimbursable report in addition to the Evaluation and Management Code. After examination of the patient and prior to preparing this report, I spent 30 minutes reviewing the medical records of the initial treating physician, including the initial report, patient questionnaire, and follow-up treatments and any x-rays and/ or other diagnostic testing performed. These reports have been used in the assistance of formulating the patient's scope of previous treatment as well as current diagnosis and the anticipated course of treatment and prognosis.

September 7, 2010 QME Supplemental Report

June 8, 2010 QME Dr. Khosrow Tabaddor, M.D., Orthopedic Surgeon

September 17, 2008 Alpine Orthopedics, Dr. Murata, M.D. progress note.

DIAGNOSTIC IMPRESSION:

1. 717.9 Internal Derangement of Knee NOS
2. 716.96 Arthropathy NOS - L/Leg

3. 729.1 Myalgia and Myositis NOS

DISCUSSION:

The patient has an accepted injury from her August 19, 2008 right knee injury, and has a provision for future medical care. She was seen by Khosrow Thabaddor, M.D., Orthopedic Surgeon, and he outline future medical care to include anti-inflammatory therapy and analgesics, PT x6 per year, and occasional intra-articular injection of Dep-Medrol been recognized as active or inactive consequences of the patient's industrial injury.

The chronic pain patient represents the largest group of outcome failures and the most difficult treatment groups. The patient reported injuring her knee, and has had a poor outcome. Review of her operative reports revealed she has grade IV chondromalacia, and her long term prognosis would suggest more pain.

The patient has found that self directed care at a local health club is the best treatment. She has brought with her billing statements from her file, and is requesting that the insurance carrier cover all, or part of her month gym membership fees. I have shared with her the challenges that can frequently be encountered in getting these memberships certified. Her request does not seem unreasonable given the fact she appears to be using her membership for primarily her knee rehabilitation. She additionally has utilized therapist associated with the gym.

I would encourage that the therapist write our exactly what he is doing, frequency, duration, goals, and have him place the specific request on what is being requested. She is a complicated patient to manage as well since she has pain in other areas that are not accepted body parts. It would appear to this observer there are many issues that may need to be addressed as well.

In the meantime, I have agreed to ask the carrier for authorization of some, or part of her monthly gym membership. I formally request authorization for gym membership.

The patient was not interested in medication therapy options at this time.

The Qualified Medical Evaluator reports that he has brought closure of the patient's injury claim. The patient still manifests a mechanical and myofascial disorder of the lumbar spine with degenerative changes. She is complaining of left knee pain as well. The patient was informed that her back and left knee are not part of her work claim that we are addressing.

TREATMENT/CARE PLAN:

The conceptual model of pain and its management requires the formulation of treatment plans, and careful dynamic assessment of the patient and outcomes based on appropriate goals.

The patient is a candidate for pain medications supported by ACOEM/MTUS Guidelines.The justification for medication therapy is based on a dynamic assessment for risk/benefit analysis in conjunction wit a functional assessment.

The patient has benefited immensely from the an educational focus that imparts information for the patient to be more in control of their care. The benefits that accompany a patient centered model of care are becoming abundantly clear. Increasing evidence demonstrates that self care decreases hospitalizations, emergency room visits, overall health costs, improved outcomes, and increased patient satisfaction with treatment and outcome.

Work Restrictions:

Modified work is recommended.

The patient is precluded from jumping and running as per QME Supplemental Report.

AFFIDAVIT OF COMPLIANCE:

"I declare under penalty of perjury that I personally performed the evaluation of the patient on April 23, 2011 at my Stockton office and that, except as otherwise stated herein, the evaluation was performed and the time spent performing the evaluation was in compliance with the guidelines, if any, established by the Industrial Medical Council or the administrative director pursuant to paragraph (5) of subdivision (j) of §139.2 or §5307.6 of the California Labor Code."

"I further declare under penalty of perjury that I have not violated the provisions of California Labor Code §4628, §5703 and §139.3 with regard to the evaluation of this patient to the preparation of this report and that the contents of this report are true and correct to the best of my knowledge."
"The examination was conducted by me. The conclusion and opinions expressed in this report are mine, based on my personal evaluation of the patient and any records available to me."
"I verify under penalty of perjury that the total time I spent on the following activities is true and correct:

a.	Reviewing the Records	.50 Hours
b.	Face-to-face time with the patient	1.25 Hours
c.	Preparation of the report	1.0 Hours
d.	Any other relevant activities detailed in the report	_____ Hours

"I declare under penalty of perjury that this bill for my services is true and correct to the best of my knowledge."

If there are any questions at all regarding this patient, please do not hesitate to call me directly.

Executed this [illegible] day of [illegible], 2011, in Vista, California.

Sincerely,

James B. Shaw, M.D.
Board Certified Pain Medicine and Anesthesiology
Qualified Medical Examiner

Cc: McKenzie Dawson, Claims Administrator
AIMS
P.O. Box 269120
Sacramento, CA 95826