Recommended Training for Treating Doctors

Recommended Outline of Procedures For an Effective Initial Office Visit:

NOTE: Every examination / office visit should be consistent with the 1997 E/M Guidelines for the requirements for an examination. These should be performed in more detail due to the current state of Texas Workers Compensation with issues of limited treatment, disputed conditions, delays with referrals for specialists and/or diagnostic testing and imaging.

1. **HISTORICAL ACCOUNT**: A **detailed account of the etiology** must be taken as part of the history must be taken and verified with the patient (read it back to the patient to verify the accuracy of the history). Be sure to list ***EACH AND EVERY BODY AREA*** that was involved, including scrapes (abrasion), contusions, lacerations. Take pictures of observable injuries to document any obvious injuries.

   NOTE: Take the time to get an accurate and correct history and read it back to the patient to verify that it accurately describes, in detail, what happened.

   Note: *Use questionnaires for head injuries (TBI, concussion) and monitor every 30 days for 2-3 months and if symptoms persist, request a Neuropsychological Evaluation and then refer to a Neurologist.*

   Here is example of a *DETAILED* history:

   "On 2/1/2019, Ms. Nurse reported that while working as a Patient Care Technician, she went into a patient's room to help a patient sit up in a hospital bed because the patient was unable to do so on their own. The patient weighed around 200 pounds, so Ms. Nurse had to help the patient up using a draw sheet with both hands, leaning over and twisting her lower back/torso to pull the draw sheet upwards to raise the patient up into a sitting position. While raising the patient up, she felt a sudden pain in her lower back with a pulling/popping sensation with some immediate radiating pain to both gluteal areas. Ms. Nurse finished raising the patient up and then she transferred the patient and then placed the patient back in her bed.

   She reported the incident to the charge nurse after that. She finished working that day and the pain was tolerable. Later that day, she completed the injury paperwork. She was provided instructions for self-care. She went home and returned to work only to do light workload. The following week, she did not seek medical care and the at-home care was not helping and the pain remained the same. About a week later, she lifted another patient with the help of the Charge Nurse, and the patient slipped and they had to lower the patient to the floor. She did not seek care for another week for the second incident but on 2/15/2019, she again, was transferring another patient and as a result, her lower back pain intensified and then she was sent home and sent to Med Springs for an evaluation and she was seen on 2/16/2019. She was evaluated and x-rays were taken."

2. **MECAHNISM OF THE INJURY (MOI)**: You must give an **accurate** and correct explanation of the mechanism of injury (MOI).

   NOTE: The mechanism of the injury connects the injury to the condition(s) and this is essential in properly identifying the areas and conditions involved.

   a. The doctor should get the version of the incident straight from the claimant and not second hand from prior medical records or other sources.

   b. The doctor must give an easily understandable explanation of how the MOI caused harm to the involved area(s) of the human body by explaining how the etiology is associated (causal relationship) with the MOI and how these adversely affected the involved body area(s). For example, this would include a description of the forces involved and explaining how these were ***SUBSTANTIAL CONTRIBUTING FACTORS*** that resulted in injuries of the involved area(s).

Here is an example of a description of the mechanism of injury for a patient who is a nurse who was lifting a patient up from a supine position who was on a hospital bed and using a draw sheet to do so:

"Ms. Nurse described the incident and the details of the injury involved her attempting to lift a patient who weighed around 200 pounds who was laying in a supine position and unable to help herself sit up in her hospital bed. So, Ms. Nurse had to lift her up without assistance from any co-workers. As Ms. Nurse began to pull the patient up using a draw sheet that was behind the patient and wrapped around the patient, she had to bend over slightly at the waist with her lower torso turned to the left as her left hand closer to her holding the drawer sheet and her right hand reaching across holding the other side of the drawer sheet. As she started to pull the patient up using the drawer sheet with both hands, she had to do so with a slight clockwise (to the right) twisting motion of her lower torso while simultaneously lifting the patient upwards. During this process of lifting the patient up, she felt a sudden pain in her lower back area with a pulling/popping sensation.

Based upon Ms. Nurse's description of the claimed incident during my interview with her during the evaluation, it is my opinion that the mechanisms of injury that occurred during his accident included fall causing shearing exceeding tensile strength limits of the structures of the lower back area due to adverse forces that resulted from excessive, injurious compression forces combined with increased rotation that produced adverse shearing forces. There was recorded evidence of twisting or torsion of the lower back area from the medical records. The mechanisms of the injury and forces the injured worker sustained during the claimed incident support and correlate with the causal relationships between the compensable sites of the lower back (lumbar, lumbo-sacral and sacroiliac joint areas) and the reported event. As a result of the work-related incident, it is my opinion that it is medically reasonable and probable that the disputed conditions did in fact result from the onset of the alleged work-related event."

c. Although details involving the incident are important in describing the mechanism of an injury, the doctor must give an easily understandable **medical** explanation of how the effects of the MOI can cause an injury to the human body. This helps to justify the working and differential diagnoses involved.

d. It is important to also include medical journal articles to support the doctor's opinion, as well as ODG references (causation).

3. **EXAMINATION**: The examination must include the following examinations in addition to other evaluations as required by the E/M 1997 Guidelines:

***NOTE**: An incomplete examination leads to an incomplete picture and oftentimes underdiagnosing as well as lead to future disputed conditions by the carrier.*

a. Ranges of Motion (if applicable) – perform ***active and passive ROMs*** stating what specific motions for ***all*** motions of a particular joint, are restricted, any increased pain with those motions, any adverse muscle motion patterns or pathologies associated such as muscle spasms, muscle guarding (as these are specific conditions for spinal impairment ratings) or muscle rigidity and what side these area present and with which motion, and any associated radicular-related complaints that may support nerve root involvement, ligament injury or abnormal motions due to losses of motion (Dysmetria). Be sure to state if pain was present or increased during each specific motion.

b. Orthopedic Testing: Perform 2-3 orthopedic tests, especially those that are referenced in the ODGs to help support the working and differential diagnosis. These should help to differentiate the grades of sprains and strains.

c. Inspection: Describe and observable body abnormalities such as scars, tatoos, abnormal curvatures (hypolordosis, hyperkyphosis, scoliosis, etc), disfigurements, gait, station and ambulation patterns, antalgic postures.

d. Palpation: discuss and reported tenderness of bony (osseous) or soft (muscular) tissues and specify what type of pathology(s) are present. Also determine if any joint or capsular instability may be present. Be sure to use language that correlates with the AMA's *Guidelines to the Evaluation of Permanent Impairment*, fourth edition, ***for spinal muscle pathologies including muscle spasms and/or muscle guarding***.

e. Neurological Testing:

i. **DTRs** (upper extremities; C5 – biceps, C6 – Brachioradialis, C7 – Triceps; lower extremities: L4 – Patellar, L5 – Hamstrings, S1 – Achilles; Abdominal reflexes: T10 – above umbilicus, T12 – below Umbilicus)

ii. **Dermatomes** DTRs (upper extremities: C5, C6, C7, C8, T1; lower extremities: L3, L4, L5, S1; Abdominal dermatomes: T10 and T12) and **2-point discrimination** for sensory loss of the fingers using an Aesthesiometer.

iii. **Manual Muscle Testing** (MMT) with Strength Grades and Ratings (using the Wexler Grading Scale) should be performed reflective of the area involved and/or neuro-anatomical relationships associated with specific muscles. Also determine if pain is present or worse with MMT. Grade based on the Wexler muscle strength testing scale, 5 to 0 for the grade and a description of the rating, strong weak, etc.

iv. Take **Circumferential Measurements** of the upper and/or lower extremities to determine if there is any evidence of early atrophy (that may correlate with spinal injuries at the level of the suspected injury) or joint swelling/edema.

4. **COMPLICATING / CONFOUNDING FACTORS**: The doctor should list any complicating / confounding factors and state how these may adversely affect and/or prolong their treatment, recovery, prognosis and impairment. The ODGs state the following as complicating / confounding factors:

NOTE: When you identify complicating / confounding factor(s), it takes away the cookie recipe of the ODGs and allows you to request more therapy as long as you can explain how the complicating / confounding factor(s) is adversely affecting their treatment and recovery.

- Obesity
- Smoking
- Diabetes
- Hypertension
- Depression or PTSD
- Substance Abuse / Opoid Use
- Psychological Disorders
- Surgery / Hospitalization
- Legal Representation

5. **DIAGNOSIS**: You must give **specific working and differential diagnoses of ALL body areas affected from the claimed incident**, because a general diagnosis will not work. Be sure to state the degree of Grade (1, 2 or 3) for strains/sprains and site the ODGs for this. When dealing with spinal injuries, identify the level(s) of the spine that are injured.

NOTE: Remember, when it comes to diagnosis, you can always remove codes because adding codes for workers comp cases in nearly impossible and creates problems for compensability and extent of injury.

a. You should also include a statement about future potential diagnostic tests and imaging that may be necessary to confirm any differential diagnoses and to determine other condition(s) that may not be obvious that could be related to the injury.

b. The doctor must always address the issue of a **pre-existing condition or prior injuries**, and the claimant's medical history. For example, diabetes, obesity, and the effects that pregnancy can have an adverse effect on Carpal Tunnel Syndrome, based on evidence-based medicine.

   i. Address these issues and whether or not they may or may not be a factor, instead of ignoring them.

   ii. If it is the doctor's opinion that there was no pre-existing injury, a discussion must be given. On the contrary, if the injury could possibly be perceived as a degenerative or pre-existing condition, the doctor must explain how this event ***aggravated*** the condition.

   iii. An ***aggravation*** of a pre-existing injury is a new injury under Texas workers' compensation law.

   iv. However, you must be able to medically identify and explain how the injury was worsened, accelerated, or enhanced by the MOI.

***NOTE**: Be sure to **NOT** use the term exacerbation, because this a term of art in workers' compensation law to simply mean an increase in pain with no additional damage and would not equate to an aggravation, which is an aggravation, worsening or enhancement of a pre-exsiting condition and would be considered and injury.*

6. **PHYSICAL PERFORMANCE TESTING** (PPTs) should be performed within 2 days of the initial examination and NOT the same day. This is consistent with the ODGs recommendations and will establish the basis for outcome assessments. These should be updated periodically, around every 30 days. These are billable services that help to demonstrate progress, regression or when the patient's conditions plateau. The findings from prior PPTs should be compare to the current findings with an explanation of the progress, stability or regression and the medical decisions that need to be made as a result of the comparative information.

7. **ORDERING ADVANCED DIAGNOSTIC IMAGING**: When you order an MRI or CT, this should be done as close to the date of the injury so that any signs of an acute injury can be visualized. Ordering an MRI 3-6 months after an injury may demonstrate injuries but it will by extremely difficult to relate those injuries to the claimed incident.

   it is CRITICAL to include instructions for the Radiologist of the purpose of the referral and provide a description of the history or the injury and mechanism(s) of the injury. It should be noted that your request should also include your opinion of any current or suspected condition(s) that may have resulted from the claimed incident (your working and differential diagnoses). For example,

   So, when you send your request to the facility, you need to provide instructions to the Radiologist that help to determine if there is an acute or recent injury to the involved area (which is why you are referring the patient there in the first place) and what findings support this. Oftentimes, Radiologists do not provide information in their reports that help the referring doctor establish injuries that are related to the claimed incident, they just report what they see and this turns out to be a HUGE disservice to the patient and the referring doctor. Many carrier disputes are based on an MRI report – verbatim.

   So, when you order an MRI or CT, you need to provide instructions with a purpose. You need to copy and paste the description of the injury along with the mechanism of the injury and then state your instructions.

   Here is an example of what instructions need to be stated in the order:

   Based upon the above description of the claimed work-related incident and mechanism of the injury associated with the incident, I am requesting an MRI of the lower back in order to confirm or rule out three things:

   1. Any abnormal findings or pathologies in the lower back region.
   2. Provide information and/or findings that would support or rule out an acute or recent injury.

3. Provide your medical opinion for which injuries may or may not be reasonably related to an acute or recent injury.

Note: If there are pre-existing conditions present determined to be present from imaging findings (like degenerative processes such as hypertrophy, spondylosis, facet arthropathy, degenerative joint or disc disease, etc.) and/or prior injuries or effects from those prior injuries (such as a prior surgery), would it be medically reasonable that the pre-existing conditions were **aggravated**, (an ***aggravation*** is defined as "*a claimed injury that causes additional damage or harm to the physical structure of the body and can include any naturally resulting disease or infection; and can include an enhancement, accelerative or worsening of an underlying condition."* The term aggravation should be used and not the words exacerbation or exacerbated, which is defined as a temporary increase in symptoms and not a permanent effect from the incident). A pre-existing condition can become **aggravated** and, therefore, be included as part of or a result from the claimed incident.

Based on the Appeals Panel Decisions [APD] in Texas, in order to prove an aggravation of a pre-existing condition there must be some enhancement, acceleration, or worsening of the underlying condition from the injury and not just a mere occurrence or recurrence of symptoms inherent in the etiology of the pre-existing condition. [*APD No. 94428, decided May 26, 1994*].

Please keep in mind that if there are pre-existing / degenerative conditions present as well as other conditions that may not be directly related to the pre-existing / degenerative conditions, these need to be differentiated as such.