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**Objective Medical Assessments Corporation**
401 Second Avenue South, Suite 110, Seattle, WA 98104

**To:**

**Medical Examination of**

**Employer:**
**Claim Number:**
**Date of Exam:**
**Date of Birth:**
**Date of Injury:**

**Location of Exam:**
**Examining Physician: Joseph R. Lynch, MD**
**Dictated by: Dr. Lynch**

## INTRODUCTION

Thank you for requesting OMAC to schedule an independent medical examination on ______. The following is a report of an examination performed by Dr. Lynch.

This report is intended to provide you with a fair and objective review of the medical facts relating to the examinee's circumstance, including those particular issues presented for our consideration.

The opinions expressed in the Diagnoses and Recommendations and Discussion sections are solely those of the physician performing the examination.

A reminder letter was sent to the examinee that included an explanation of the purpose and procedures of the examination. The letter also informed the examinee that a written report will be sent to the agency requesting the examination. The examinee should contact that agency for information regarding the report.

The dictated report is as follows:

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## ORTHOPEDIC EVALUATION

This is an independent medical evaluation performed by myself, Dr. Lynch, on claimant ______. Prior to beginning, I met the claimant to discuss the IME process, how there is no doctor/patient relationship implied or established, and that I am not a treating physician. In addition, I discussed how the examination will be limited to the condition in question which is outlined by the letter from ______, and stated to be her low back. This is in no way meant to be a general physical examination. We discussed how the claimant is to have self-imposed limitation in motion during the examination process. I also instructed the claimant to let me know if anything bothers her or is uncomfortable, even minimally, during the examination process, as well as during the history, and I will stop that portion immediately. Additionally, as the claimant is a female, I will have an OMAC employee present during the entire physical examination as an observer. The claimant verbalized understanding and agreement with all these points of discussion and requested that I proceed.

## CHIEF COMPLAINTS

Low back pain, left greater than right.

## HISTORY OF PRESENT ILLNESS

The date of injury, in the claimant’s own words, was said to occur on ______, 2006. It was at the end of the night. She was feeling rushed. She had to get racks of drinking glasses, which she states weighed approximately 45 to 50 pounds each; and that she had to serve two seven-person tables. She went to the kitchen and attempted to take two racks of drinking glasses to the tables, lifting them with both hands. She noted no pain or trouble while lifting these, nor did she notice any difficulty finishing her work activities that evening. However, when she got home she noticed excruciating pain localized to the low back without any radiation, weakness, or numbness. She did not seek medical attention that evening. The next morning, she stayed in bed and went back to work the next afternoon after being in bed all day. She states that when she went back to work, they told her that she was not fit for work because of her pain and instructed her to see a medical doctor.

She was then sent to a walk-in clinic at ______ by a provider whose name she does not remember, but is presumed to be Dr. ______. She saw this provider, who recommended symptomatic treatment, and then she had followup with her regular doctor, who at the time was Dr. ______. Dr. ______ and his associates saw the claimant in followup and diagnosed the patient with lumbosacral strain,

and treated her with narcotic medication, muscle relaxants, and forms of physical therapy. The claimant states that she went through approximately 10 physical therapy appointments, but they did not improve her symptoms. She states that she was unable to get to any additional sessions as she had car trouble that precluded travel.

She then developed a situation approximately three weeks after her injury where she states she had acute exacerbation of her pain, unrelated to any type of injury or insult, and saw an on-call physician from Dr. ______ group, who, in her words, accused her of seeking pain medication. She then left the examination with this physician, as she was not satisfied with the care he was providing.

She then sought her own care by Dr. ______, who was recommended by a friend. She underwent care with Dr.______ at his own clinic and was prescribed more physical therapy, aquatherapy, Percocet, oxycodone, and ultimately recommended an epidural steroid injection. She states that the aquatherapy helped, as well as the pain medication. She did not feel that she was back to her level of comfort prior to the injury. She then had an MRI obtained, which showed mild degenerative changes in the low lumbar spine. Dr. ______ had recommended an epidural steroid injection, which she had performed, and she states it provided her two weeks of relief. She then returned to her baseline of pain which was present after the date of injury.

She states that she returned to work at light duty, rolling silverware and then subsequently hosting, approximately three weeks after the injury occurred. She said that she had no difficulties with those jobs with the exception that while she was hostessing, occasionally while walking she would get radiating pains down her leg where her whole leg would experience shooting pains starting in the back of her leg. She also states that at night her leg would go entirely numb on the right, sometimes to the level of her toes, but more recently just to the level of the calf. She has not had these symptoms on the left side, nor did she have any of these symptoms in or around the original date of injury. She feels as though these symptoms are worse while she is at home and while she is sleeping and states that there was nothing to her knowledge from her work environment that provoked the new symptoms.

Approximately three weeks ago, she returned to her job of injury as a server. She states that she has difficulties with all the activities and any kind of significant lifting activity at work.

## CURRENT COMPLAINTS

The pain diagram indicates burning pain and aching pain localized to the left low back and pins-and-needles, as well as stabbing pain going down both legs in the front and the back. The front of the legs only bother her at nighttime. The location of her pain, she states, is localized to the low back. The duration is on a daily basis and constant in nature. She describes it as a burning sensation. She states it radiates more so on the right than the left. She denies any weakness of her arms or legs, but has numbness at night only.

She states that aquatherapy and the medications in the form of narcotic and muscle relaxants make her symptoms better, but that any type of strenuous activity and work makes them worse. She is currently using a back brace at work. Current treatment and medications include Zanaflex, Naprosyn, and oxycodone. She rates her pain at the time of injury as a 9/10, currently today she rates it as a 6.5/10. When she takes her medication, she says that she can get her pain down to a 4/10.

Of note, the patient started crying during the history portion of the examination, stating that she has a lot of outside social stressors currently going on in her life. At the time that she started crying, I offered her some tissue and asked her if she would prefer that I stop the examination. She said no and she asked me to continue with the examination process. She stated that she did not feel uncomfortable, nor did she want me to discontinue the independent medical evaluation, but that she was just stressed concerning social issues at home.

## CHART REVIEW

This is meant to be a summary of the provided medical record as it relates to the musculoskeletal issues described above and is in no way meant to substitute for the entire medical record. Should any questions arise regarding this review or IME in general, I would request that the entire medical record be available for further review.

Date — The first document is dated ______, 2006, in a Self Insurer Accident Report filled out by ______ for the ______. The description of the injury is in quotes and handwritten. “When I went to work on ______,2006 my back was fine. When I left work late last night about 12:10 a.m., I got home about 12:20. I went to get undressed and my back was hurting really bad.” The remainder of the description is illegible and handwritten, but it says something to the effect that she was lifting heavy drinking glasses.

Date — The next document dated ______, 2006, is a Physician’s Initial Report. Diagnosis is lumbar sprain and left sacroiliitis. There were

no objective findings to support the diagnosis other than soft tissue pain.

Date The next document is handwritten notes dated ______, 2006, from the ______ clinic. Diagnosis is left sacroiliitis and lumbar sprain. Discharge instructions indicate return to clinic as needed. The claimant was prescribed Naprosyn, Darvocet, and Flexeril.

Date The next documentation is dated ______, 2006, listed as a Physician's Initial Report, handwritten. Diagnosis is lumbosacral strain. The objective findings are listed as reproduced tenderness to palpation in the left lumbosacral region. Treatment recommendations were muscle relaxants, analgesics, and physical therapy. This is signed by ______, DO.

Date The next document is an x-ray report from ______ Imaging, **two to three views, lumbar spine**. Impression is question spondylosis, L5. Interpreting provider is ______, MD.

Date The next document is an imaging report from ______, **x-ray of sacroiliac joints, bilateral**. Impression is mild sclerosis, right sacroiliac joint. Interpreting provider is ______ MD.

Date The next document is a progress note provided by ______, DO. Date of service is ______, 2006. This document states that while lifting glasses, dishes, trays in a twisting fashion she began noticing some tightness to the left low back. There was tenderness to palpation on the left lumbosacral paraspinal region, as well as left buttock region. Straight leg raise was negative. Neurologic examination was normal. Impression was left lumbosacral strain. Plan was to stop Flexeril and Darvocet and begin trial of methocarbamol for pain relief, as well as a trial of Vicodin and a trial of physical therapy. He stated do not have the claimant do any work requiring prolonged walking, standing, and no lifting more than 10 pounds or up to three hours of repetitive work.

Date The next document is a handwritten physical therapy prescription form dated ______, 2006, signed by Dr. ______, for a diagnosis of lumbosacral strain.

Date The next document is a progress note by ______, MD. Date of service is ______, 2006. She was still having quite a bit of pain. The pain medicine with Vicodin, piroxicam, and methocarbamol

was "not really cutting it." On examination, she had a slightly positive Patrick test on the left. Assessment was low back pain and lumbosacral strain. The plan was a Medrol Dosepak.

Date — The next document is a handwritten physical therapy note emphasizing manual therapy, flexibility, teaching in postural education, and strengthening exercises.

Date — The next documentation is dated ______, 2006, and is the emergency physician record, ______, and is handwritten. Chief complaint was low back pain. Illegible portions of this note state that the patient has had back pain for four weeks, followed by primary care doctor. Taking Percocet, which is not helping, and has to take 20 pills in one and a half days, which is a large dose of narcotics. The remainder of the note is illegible.

Date — Next is a typewritten note from ______, 2006, which is an emergency room progress note from ______. Diagnosis was ______-year-old female with a headache and low back pain, which is presumed secondary to lumbar strain. She apparently had a **CT of the head**, which was negative. The patient refused a lumbar puncture.

Date — The next document is a handwritten Physician's Initial Report dated ______, 2006. Diagnosis is left wrist sprain. Objective findings were tenderness and mild swelling of the dorsum of the left wrist. No treatment recommendations are given.

Date — The next document is dated ______, 2006, and is handwritten. It states that claimant ______ went to the emergency department secondary to headaches due to prednisone. The remainder of the note is illegible.

Date — The next document is from ______, 2006, which is a physical therapy report, suggesting to continue traction and initiate standing extension.

Date — The next document, dated ______, 2006, is a release to return to work with modified duty, signed by Dr. ______.

Date — The next document is a physical therapy report dated ______, 2006.

Date The next document is dated ______, 2006. The provider is______, MD, from ______. Apparently, this was a Saturday. She had come in and had already called her provider, Dr. ______, saying that she had taken all of her Percocet and that she needed additional Percocet. It is also documented that she called Dr. ______ office on ______ for additional Percocet, for which she picked up her prescription of 30. She was not offered any further Percocet because of the recent prescription, but was offered a shot of Toradol. The patient apparently became rather agitated and declined the shot. She refused the Toradol injection and refused an MRI for further diagnostics, and apparently stormed out of the room and called Dr. ______ back.

Date The next document is a handwritten note from the Walk-In Clinic with the diagnosis of back pain, stating that the patient declined to have MRI. The remainder of the note is illegible.

Date The next document is dated ______, 2007, with the title of "Formedic." It is a handwritten note which is illegible.

Date The next documentation is a job analysis sent by ______. This was approved by Dr. ______ on ______, 2006. The job title is rolling silverware, preparing salads, and hosting.

Date The next document is a physical therapy report from ______, 2006, stating continue plan of care.

Date The next document is dated ______, 2006, with the diagnosis of lumbosacral strain and muscle spasm, with the plan of considering an MRI.

Date The next document is a physical therapy report from ______, 2006, suggesting to continue plan of care.

Date The next document is a handwritten progress note dated ______, 2006, with a diagnosis of lumbosacral strain and muscle spasm. The plan is handwritten and written as, "Goal: Lowest possible dose."

Date The next document is dated ______, 2006, a handwritten progress note, again with low back pain and strain and muscle spasms. The plan, handwritten, is "TPI " The remainder of the plan is illegible and is signed by a DO physician whose name is illegible.

Date — The next documentation is dated ______, 2006, with a lumbosacral sprain as the diagnosis. The plan is moist heat and consider MRI, again signed by a DO physician whose name is illegible.

Date — The next document is dated ______, 2006, signed by the same physician, who is a DO. Same diagnosis. The plan is moist heat.

Date — The next documentation is a release to return to work dated ______, 2006, signed by Dr. ______. The patient was released for modified duty with the plan to release to full duty on ______, 2007.

Date — The next documentation is a job analysis with the job title of rolling silverware, preparing salads, and hosting. This job was approved by Dr. ______ on ______, 2006.

Date — The next document is a handwritten progress note dated ______, 2006, presumed signed by Dr. ______, based on the similarity of the signature, but is illegible. There is no diagnosis. The plan is MR lumbar spine with traction.

Date — The next document is a handwritten progress note from ______, 2006, signed by the same illegible signature, with the diagnosis of lumbosacral sprain and muscle spasm. The plan was traction and heat, and to continue home exercises.

Date — The next documentation is from ______, dated ______, 2006, which is an **MRI report of the lumbar spine**, with an impression of (1) Minimal disk bulge at L4-5 with very subtle left lateral annular tear near the opening to the left neural foramen; (2) Mild facet arthropathy bilaterally at L4-5 and L5-S1. Interpreting provider was ______, MD.

The next documentation is a handwritten progress note with a diagnosis of low back pain. The plan is illegible. The date is illegible as well.

Date — The next document is dated ______, 2006, handwritten progress note. Diagnosis is low back pain. Plan is moist heat and traction with consideration of epidural steroid injection.

The next document is a Return-To-Work/Functional Capacities form for ______. It states that she ______ return to work on ______, 2006, with a diagnosis of lumbar strain or sprain with muscle spasm; that the patient can lift or carry up to 20 or 30 pounds.

Date The next document is a **lab report** dated______, 2007, which is positive for codeine as well as morphine.

Date The next note is a handwritten progress note dated ______, 2007. The diagnosis is lumbosacral sprain. Plan again includes moist heat. Discussed the MRI scan, with a trial of full duty at work. This is signed with an illegible signature, but presumed to be Dr. ______.

Date The next document is a job analysis form with the job title of server. The employer is ______. The physician's review states that it is not approved, signed by Dr. ______, dated ______, 2007.

Date The next document is dated ______, 2007. Lumbosacral sprain is the diagnosis. Plan is moist heat and review job analysis. He recommended a neuro consult and consider physical therapy, stating that the claimant is unable to lift 30 pounds or carry with one hand.

Date The next document is a job analysis with the job title of server. It states, by the physician's review, that this job is approved, dated ______, 2007. There are no objective neurologic impairments to preclude work. Signature of this physician is illegible, but presumed to be either ______, MD, or ______, MD, from the independent medical evaluation provided on the same date.

Date The next document is an **independent medical evaluation** provided ______, 2007. The diagnosis is lumbar strain, related to work place activities on ______, 2006. There were no objective findings or findings from imaging studies that would preclude gainful employment. Further recommended treatment was a home therapy program for core stabilization and tapering of opiate use. These physicians also felt, if elected by the patient or provider, that an epidural steroid injection ______ promote resolution of the symptoms, but this ______ not be considered a curative treatment. They felt that there was no curative treatment or permanent partial disability resulting from the injury of ______, 2006; and that home

therapy and consideration of an epidural steroid injection would appear reasonable. The claimant was rated as a Category 1 lumbosacral spine impairment.

Date The next document is a handwritten progress note from ______, 2007, by Dr. ______. Diagnosis is lumbosacral sprain. Plan was refer for physical therapy and stretching.

Date The next documentation is from ______, 2007. Diagnosis is lumbosacral strain. Plan was moist heat and start physical therapy.

Date The next document is a physical therapy report from ______ , 2007.

Date The next document is a certificate of disability dated ______ , 2007, for ______, stating that she is unable to work due to disability arising from the industrial injury or occupational disease (signed ______, ______, 2007). The physician's stated diagnosis is lumbar strain. The objective medical findings were muscle tightness (and something which is illegible). The remarks or comments is that she is still in physical therapy. This is signed by Dr. ______ on ______ 20, 2007.

Date The next document is from ______ , 2007. Diagnosis is low back pain. The plan is moist heat and continue physical therapy.

Date The next document is a physical therapy referral, signed by Dr. ______, dated ______ , 2007.

Date The next document is a physical therapy report from ______ , 2007, and ______ , 2007.

Date Next is a letter from ______ to Dr. ______, asking whether or not Dr. ______ agrees with the ______ IME provided by Dr. ______ and Dr. ______. He signed that he concurs as of ______ , 2007.

Date The next document is a physical therapy report from ______ , 2007, and another from ______ , 2007, and ______ , 2007.

Date Next is a handwritten progress note dated ______ , 2007. Diagnosis is lumbosacral sprain. Plan is moist heat. Patient refused

to change medication to methadone for four to six weeks. Additional prescriptions were oxycodone 15 milligrams.

Date The next document is dated ______ , 2007. It is a formal physical therapy report. Additional therapy report on ______ , 2007.

Date Next is a job analysis for ______. Job title is ______ modified, selected as modified duty. The position was approved. Effective date was ______ , 2007, signed by Dr. ______.

Date The next document is a handwritten progress note dated ______ , 2007. Diagnosis is lumbosacral sprain. Plan is epidural steroid injection, home exercise program, and increased oxycodone.

Date The next document is from ______. Interpreting physician is ______, MD. Exam is **lumbar epidural steroid injection**. The impression is technically successful lumbar epidural steroid injection.

Date The next document is a physical therapy report from ______ , 2007.

Date The next document is a handwritten progress report dated ______ , 2007, with a diagnosis of low back pain. Plan was moist heat and continued care for employer, as well as osteopathic manipulative therapy, lumbar spine.

Date The next document is a physical therapy report from ______ , 2007, and ______ , 2007.

Date The next document is a handwritten progress note dated ______ , 2007. Diagnosis is lumbosacral sprain. Plan is osteopathic manipulative therapy, lumbar spine.

Date The next documents are multiple physical therapy reports between ______ , 2007, and ______ , 2007.

Date The next document is an **independent medical evaluation** dated ______ , 2007, performed by ______, MD, orthopedic surgeon. Diagnoses were (1) Status post lumbar strain nine months ago with continuing low back pain without evidence of radiculopathy; (2) Mild evidence of symptom magnification with large discrepancy between

sitting and supine straight leg raising, and nonanatomic distribution of sharp sensation in the left lower extremity; (3) Probable narcotic addiction with history of at least six months of taking oxycodone; (4) Probable chronic pain syndrome. His opinion was that the acute lumbar sprain had evolved into a mild chronic low back pain syndrome, which is mild. He felt that the acute lumbar sprain had resolved and that there was no objective evidence on the examination that would preclude her from return to full duties as a server. There was no permanent partial disability as a result of the injury sustained ______ , 2006, rating this claimant as a Category 1, according to the State of Washington Categories of lumbar and lumbosacral impairment.

Date Next is a job analysis form from ______. Job title is server. Physician's review is the job is approved, signed ______ , 2007.

The next document is a physical therapy report, which is undated.

## PAST MEDICAL HISTORY

### Injuries:

She reports no prior injuries and no prior hospitalizations or treatment with regard to her back or any other part of her body, for that matter.

### Past/Recent illnesses:

She has no current active illnesses of which she is aware.

### Surgeries:

She reports operations to be appendix, gallbladder, nose, tonsils, and tubal ligation. She has had hospitalizations only as related to these surgeries.

### Allergies:

Allergies are reported to pollens, trees, grass, fresh fruits and vegetables, and codeine.

### Medications:

Current medications include Naprosyn 500 milligrams once a day, Zanaflex two at bedtime in the form of 4 milligrams, and oxycodone one to two every six hours, and this is 15 milligrams.

## REVIEW OF SYSTEMS

*The review of systems is historical, based upon the medical documentation provided and an interview with the examinee.*

### HEENT:
Positive for glasses or contacts, sinus or nasal passage problems.

### Dermatologic:
Tattoos.

### Musculoskeletal:
Back pain, of which she states she had no history until the injury. She has not had any fractured or broken bones.

## SOCIAL AND FAMILY HISTORY

*Information in the Social and Family History section of this report was obtained from a form completed by the examinee and an interview with the examiner.*

### Education level:
Her highest level of education is three years of college.

### Habits:
She denies smoking tobacco. She denies drinking alcohol. She denies any illicit drug use.

### Hobbies and activities:
Her hobbies include hanging out with friends, going to movies, and hanging out with kids and grandkids.

### Exercise:
Exercise includes home exercises once a day and waitressing.

### Military history:
She has no prior military service.

### Personal history:
She is single. She has four dependents.

### Familial history:
Family history is positive for thyroid cancer in her mother, but nothing is listed for her father.

## Work history:
Employer at the time of injury was ______. She is currently working.

## Benefits:
Medical.

# PHYSICAL EXAMINATION

| | |
|---|---|
| **Height:** | 5 feet, 3 inches |
| **Weight:** | 182 pounds |
| **Dominant hand:** | Right |

Again, Ms. ______ was asked not to engage in any physical maneuvers beyond which she could tolerate comfortably. A female OMAC employee was present as an observer.

Her height is 5 feet, 3 inches, weight is 182 pounds. She is right hand dominant.

Her general appearance is that she appears somewhat distressed. As stated previously, she was crying during the history portion of the examination process, and she relates this to current stresses in her life, but unrelated to the current exam, and she requested that I proceed.

# ORTHOPEDIC EXAMINATION

With gait examination, she moves about the examining room very smoothly without hesitation or limp.

Her posture reveals a normal thoracic kyphosis and a normal cervical and lumbar lordosis with no signs of scoliosis. The shoulders and pelvis are level.

With requests of toe walking and heel walking, she refuses, saying that these exacerbate her pain.

She is able to forward flex to 35 degrees and extend to 20 degrees to her level of comfort. She can laterally bend to 30 degrees to the right and 30 degrees to the left. She can rotate her thorax to 45 degrees to the right and 45 degrees to the left without discomfort.

Inspection demonstrates no signs of skin ulceration, redness, spasm or abnormality. She has no paraspinal rigidity and no tenderness along the spine

itself in the thoracic or lumbar spine with the exception of some tenderness to deep palpation in the lower lumbosacral region. This is noted on the left side. There is no tenderness on the right. There is no spasm or rigidity associated with this deep palpation. She has nontender greater trochanters and nontender superior iliac spines, as well as posterior iliac spines.

Sensory testing to light touch demonstrates intact sensation in all dermatomes with no abnormality.

Strength testing demonstrates 5/5 strength for extensor hallucis longus, plantar flexors of the ankle, dorsiflexors of the ankle, and hip extensors bilaterally. She demonstrates cogwheeling against resistance with knee flexion bilaterally, alternating between 5/5 and 4/5, as well as cogwheeling with knee extension on the right, alternating between 5/5 and 4/5 strength. She is able to perform a seated straight leg raise to 90 degrees bilaterally without discomfort or reproduction of symptoms. She does state, however, that when she plantar flexes on the left that this causes a reproduction of her symptoms in her back. In moving her legs from a seated position to 90 degrees of flexion, she tolerates this comfortably with no signs of discomfort.

Standing examination reveals she has a normal lower extremity alignment. Her anterior iliac crests are level. The lower extremities do not exhibit any signs of atrophy or deformity.

Reflexes at the patellae are 2+ bilaterally and 1+ at the Achilles. She has one beat of clonus bilaterally.

Supine testing demonstrates hip flexion to 110 degrees bilaterally with the contralateral hip flat on the examining table. She has no exacerbation of her pain with these movements. Knee flexion is from 140 degrees of flexion to full extension without discomfort or disability. Patrick test is negative bilaterally. On the right side, when she abducts her lower extremity, she does say that she feels as though she gets tenderness over the right side of her back. Hip abduction is to 40 degrees bilaterally.

She has no tenderness with axial compression of her spine. She has no superficial tenderness.

She is able to perform a full squat without difficulty, though she does exhibit some pain behavior while doing this. She is also able to do a single-leg stance with no drooping of the pelvis and a negative Trendelenburg sign.

## IMAGING STUDIES

There are no available studies for review.

## DIAGNOSES

As it pertains to the low back with claim number ______:

1. Lumbosacral strain, related to the industrial injury on a more-probable-than-not basis, resolved.

2. Degenerative disk disease, lower lumbar spine, preexisting disease and not related to the industrial injury with the date of ______ , 2006, on a more-probable-than-not basis.

## RECOMMENDATIONS AND DISCUSSION

The cover letter asks a series of questions to be answered as follows:

1. **What is your diagnosis of the condition(s) found and your opinion of the relationship of those conditions to the occupational injury, on a more probable than not basis?**

   Please see the Diagnoses section.

2. **Is the present condition due in whole or in part to the occupational injury? If due only in part, please explain.**

   The condition of the lumbar strain is due in whole to the occupational injury and is now resolved. Diagnosis 2, mild degenerative disk disease and spondylosis of the lumbar spine, is a preexisting disease and not related to the industrial injury on a more-probable-than-not basis.

3. **Is the worker able to work full duty as a server? See enclosed job analysis. If not, what restrictions would you place on Ms. ______?**

   In my opinion, the worker is able to work full duty as a server, as she has been doing for the past three weeks, without limitations. There is nothing in the current job analysis listed as a server for the ______ restaurant that she should not be able to perform based on the objective findings demonstrated on today's examination and history, in my opinion.

4. **Is the worker's condition more probably than not the result of a non-**

**industrial condition or a preexisting disease, which has not been permanently affected by the claimed injury? If so, please explain.**

In my opinion, the claimant sustained a lumbar strain related to the industrial injury on a more probable than not basis. However the worker's condition of mild degenerative disk disease and spondylosis as evident by the MRI, which showed a minimal disk bulge at L4-5 with a subtle left lateral annular tear and mild facet arthropathy at L4-5 and L5-S1 are chronic and pre-existing changes and are not related to the industrial injury on a more probable than not basis. In my opinion the claimant's pre-existing mild degenerative disk disease has not been permanently affected by the claimed injury.

5. **Has the worker's condition reached maximum medical improvement?**

It is my opinion that the diagnosis related to the industrial injury, the lumbar strain, has reached maximum medical improvement on a more probable than not basis.

6. **If the worker's condition has not reached maximum medical improvement, what specific treatment measures are indicated and what is the anticipated duration of that treatment? Please segregate proposed treatment, indicating whether it is related to the occupational incident ______2006, or rather to a preexisting disease, condition or injury.**

In my opinion, the lumbar strain has reached maximum medical improvement and no further curative treatment is indicated.

7. **If the worker's condition has reached maximum medical improvement, and no further treatment measures are indicated, please provide your opinion as to whether any permanent partial disability has resulted from the reported injury of ______2006.**

In my opinion, there is no permanent partial disability that has resulted from the reported injury of ______ 8, 2006.

8. **Please rate any disability found in accordance with the guidelines of the State of Washington and segregate this from any disability caused by preexisting disease, condition or injury.**

I would rate her disability in accordance with the guidelines for

Washington State Workers' Compensation as Category 1.

OMAC/cs