

## Chapter 8 Physical Examination

### 8.1 Executive Summary

A detailed, well-documented physical examination is an essential part of the IME report. All of the tests performed and all findings should be clearly documented. Further advice regarding documenting the physical examination follows.

- Although commonly used to support EM (Evaluation and Management) coding, self-serving descriptions of the physical examination as “comprehensive” or “complete” should be avoided. If the tests and measurements performed are documented in the report, the “completeness” of the examination will speak for itself.
- The physical examination section of the report should be broken up into subsections dealing with the various components of the examination (such as “Observation,” “Structural Examination,” “Range of Motion,” “Neurological Examination,” etc.). This will make the report easier to read.
- The precise (not rounded off) starting and ending times of the physical examination should be documented.
- The behavioral assessment should be objectively documented.
- IME reports are most believable when the “normal” results received are not universally “textbook perfect” figures.
- Test results and measurements should be formatted in an easy-to-read manner.
- The specific tests performed for nonphysiological findings should be carefully documented. Examiners should expect close questioning during cross-examination regarding any nonphysiological findings.
- Adding digital photos to an IME report is of great benefit to the client and will make the IME report stand out.
- The most commonly used pain inventories are:
  - Medical Outcome Studies (MOS)
  - SF-36 Health Survey
  - Pain Drawing
  - Pain Disability Index
  - McGill Pain Questionnaire
  - West Haven-Yale Multidimensional Pain Inventory, Short Form - 36 Questions (SF-36)
  - Mensana Clinic Pain Validity Test
  - Center for Epidemiologic Studies - Depressed Mood Scale
  - Beck Depression Inventory

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- The examiner should only use pain inventories that she sufficiently understands and can defend during cross-examination.
- The *current status* should be elicited in detail and thoroughly documented.
- The location, intensity, frequency, pattern, and nature of the pain, as well as aggravating and relieving factors, need to be documented.
- Functional status should be thoroughly elicited and documented in detail.
- Examiners should not spy on examinees while they arrive at and leave the examination.

### **8.2 Physical Examination**

A detailed physical examination is essential. All of the tests performed and findings should be clearly documented. Appropriate normal examination findings should also be recorded and, when possible, a comparison to the opposite extremity should be made. If the tests performed are not documented, counsel may try to imply on cross-examination that the tests were not done. Self-serving descriptions of the physical examination as “comprehensive” or “complete” should be avoided. Such descriptions will needlessly open up the examiner to cross-examination. If the numerous tests and measurements are documented in the report, the “completeness” of the examination will speak for itself.

The physical examination section of the report should be broken up into subsections dealing with the various components of the examination (such as “Observation,” “Structural Examination,” “Range of Motion,” and “Neurological Examination”). This will make the report easier to read.

It is good practice to note the starting and ending times of the physical examination and to make sure that the examination is not rushed or hurried. A common line of questioning used against independent medical examiners is to try to show that the examination was too brief. Times should be noted precisely to the minute and not rounded off. (See Example 11.104.)

#### **Behavior assessment**

Some examiners also perform a behavioral assessment as a supplement to the physical examination. This commences when the examinee is greeted. Pain behavior and inconsistencies are documented as part of this behavioral assessment. All findings should be documented in an objective, professional, and nonjudgmental manner. The examiner’s behavioral assessment is likely to be an area of close questioning because this assessment is subjective and may be outside of the examiner’s true area of expertise.

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### Musculoskeletal conditions

If the problem is musculoskeletal in nature, posture and structural examinations are made. The general observations include factors such as level of cooperation, appearance, presence or absence of multiple tattoos, use of assistive appliances (noting whether they appear used), affect, vital signs, height, and weight. The examiner should also document observed tolerances (e.g., for sitting) and any pain behaviors, such as guarding, rubbing, sighing, grimacing, or rigidity. Any inconsistencies should be objectively documented.

### Regional examinations

Regional examinations will help ensure reliability in the evaluation process. The examiner should document all positive, negative, and nonphysiologic findings. For example, in an examinee with low back pain, the examination should include a detailed assessment of gait, observation of the back (lordotic curves, pelvic symmetry, surgical scars), palpatory findings (localized tenderness, spasm, trigger points), and range of motion.

### Neurologic examinations

A neurologic examination includes, among other evaluations, sensory assessment, motor evaluation (strength and atrophy), and straight-leg raising in both sitting and supine positions. Specific maneuvers also should be performed to determine the presence of suspected problems, such as sacroiliac problems, piriformis syndrome, somatic dysfunction syndrome, and problems that may masquerade as low back pain.

### Range of motion

Range of motion of the spine should be determined using an inclinometer, measuring true cervical, thoracic, and lumbosacral angles. All measurements obtained, such as range of motion measurements, grip strength measurements, and girth measurements, should be documented. IME reports are most believable when the “normal” results received are not universally “textbook perfect” figures. (Please see Example 11.105.) Test results and measurements should be formatted in an easy-to-read manner. (Please see Example 8.24.)

### Pain

Complaints of pain during the examination should be noted. The absence of pain complaints should also be documented. Use of a pain drawing and pain scales are helpful.

### Nonphysiologic findings

The examination should also include tests for nonphysiologic findings or symptom magnification. The specific tests performed should be carefully

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documented. Examiners should expect close questioning during cross-examination regarding any nonphysiologic findings.

### Photos

Some examiners supplement the physical examination section of their report with digital photos of the affected area or tracings of the hand. For example, if the injury in question is to a finger, a digital photograph of this finger is taken and inserted into the report. (Please see Example 5.21 and the hand tracing at end of the book.) Adding digital photos to an IME report is of great benefit to the client and will make the IME report stand out.

### **Example 8.21: “The examinee appeared healthy”**

#### *Report States:*

The examinee appeared healthy and had no callus on the hands. He was overweight, with a protuberant abdomen. He reported his weight as 204 lbs. and his height at 5 ft., 9 in. His resting pulse rate was 72, and it remained at 72 when reporting pain.

#### Behavioral Examination

The examinee was cooperative and attentive, although somewhat irritable. Affect was normal and he maintained eye contact. He appeared comfortable during the interview, sitting continuously for 45 minutes, but uncomfortable during the exam, displaying guarding, bracing, and grimacing. There was more pain behavior during the exam than at other times. Nonphysiologic findings were present and are detailed in the exam.

#### Structural Examination

In the standing neutral position, cervical and thoracic curves were well-maintained. There was no loss of lower cervical lordosis or exaggeration of upper thoracic kyphosis, but lumbar hypolordosis was present. There was no scoliosis or protraction of the shoulders. The upper and lower extremities appeared grossly normal. The pelvis appeared symmetric.

Gait was normal, with no antalgia. There was normal gluteal participation in weight-bearing and leg-clearing phases. There was no tendency to asymmetric external rotation at the hips. Heel and toe walking were intact.

#### Low Back Examination

There were surgical scars. There was generalized tenderness over the low back, but no paraspinal muscle

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tenderness or spasm. There were no vertebral, sciatic, sacroiliac, or coccygeal tenderness. Active trigger points were identified in the right gluteus medius.

<u>Lumbar Motion</u>	<u>True Lumbar Angle</u> (degrees)	<u>Sacral Angle</u> (degrees)
Flexion forward	6-17	0-5
Extension backward	7-18	0-5
Left lateral flexion	13-25	5
Right lateral flexion	5-29	5

Range of motion measurements were made with an inclinometer and were not reproducible. The sacral components were inconsistent with straight-leg raising as noted. Specific individual results are shown on Fig. 79, Lumbar Range of Motion, attached. Sacroiliac tests were negative for pain bilaterally.

### Lower Extremity Neurologic Examination

Patellar reflexes were +1/4 L, +1/4 R; Achilles were +1/4 L, +1/4 R.

There was normal strength symmetrically of hip flexion, knee flexion and extension, ankle dorsi- and plantar flexion, and great toe plantar flexion. There was mild weakness of great toe extension on the right. There was no muscle atrophy. Mid-thigh circumferences 15 cm above the patella were 51 cm L and 51 cm R. Mid-calf circumferences in extension were 32 cm L and 32 cm R.

Sensation was diminished to light touch and pinprick on the right, in a distribution consistent with the L5 dermatome. Straight-leg raising sitting was negative bilaterally, limited to 80° L and 80° R by hamstring tautness. Straight-leg raising supine, however, was positive for back pain at 40° L and 30° R.

### Nonphysiologic Findings

Numerous nonphysiologic findings were present: light pressure on the skull caused complaints of increased back pain, rotation of the trunk as a unit resulted in complaints of increased pain, superficial touch resulted in severe pain, superficial pressure resulted in radicular pain complaints, range of motion measurements were

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inconsistent, range of motion was inconsistent with straight-leg raising, and SLR supine measurements were inconsistent with SLR sitting.

### *Resulting Cross-examination:*

- Q.** Doctor, the examinee was cooperative, correct?  
**A.** Yes, he was.
- Q.** When you say he “appeared healthy,” you don’t mean to say you can tell what is wrong with an examinee just by looking at him, do you?  
**A.** That’s not what I meant.
- Q.** Did you weigh him, Doctor?  
**A.** No.
- Q.** So you don’t know what he actually weighed?  
**A.** Only what he told me.
- Q.** He was cooperative but exhibited pain behavior?  
**A.** Yes, he did.
- Q.** Could the pain behavior he exhibited be due to his pain?  
**A.** It’s possible.
- Q.** His nonphysiologic findings made you suspect pain behavior or symptom magnification?  
**A.** Yes, they did.
- Q.** Did you test for nonphysiologic findings using Waddell tests?  
**A.** No.
- Q.** Did you have the examinee fill out a pain drawing?  
**A.** No.
- Q.** Did you perform the Patric test?  
**A.** No.
- Q.** The Gaensler test?  
**A.** No.
- Q.** The Milgram test?  
**A.** No.
- Q.** Did you have the examinee complete one or more of the pain status inventories?  
**A.** No.
- Q.** So, just like he “appeared healthy,” he appeared to you to have nonphysiologic findings?

**Comment:** Examiners who are faced with nonphysiologic findings and suspect symptom magnification or malingering should carefully document their findings. The more specific and detailed the findings, the better position the examiner will be in to defend his report.

Mr. Johnson’s examination today is significant for the absence of objective signs of neurologic impairment and is significant for the absence of objective signs of musculoskeletal impairment. Mr. Johnson’s examination specifically revealed no muscle spasm, no muscle atrophy, no loss of relevant reflexes, no atrophy of one arm or leg in comparison with the opposite arm or leg, no non-verifiable radicular complaints, no radicular complaints and no nonuniform loss of range of motion.

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Mr. Johnson's examination today, including marked pain behavior and the presence of 5 of 5 Waddell's nonorganic signs, is consistent with symptom exaggeration and inappropriate illness behavior.

**Defending the Report As Written:** Examiners should expect opposing counsel to directly attack findings of pain behavior, symptom magnification, or malingering. The successful examiner can defend himself during these attacks.

**Q.** His nonphysiologic findings made you suspect pain behavior or symptom magnification?

**A.** It was not just the nonphysiologic findings, but also the exaggerated grimacing, limping, and grabbing his back. It was also not just one nonphysiologic finding. As I said in my report:

“Numerous nonphysiologic findings were present: light pressure on the skull caused complaints of increased back pain, rotation of the trunk as a unit resulted in complaints of increased pain, superficial touch resulted in severe pain, superficial pressure resulted in radicular pain complaints, range of motion measurements were inconsistent, range of motion was inconsistent with straight-leg raising (SLR), and SLR supine measurements were inconsistent with SLR sitting.”

Taking all this into consideration, I concluded that both pain behavior and symptom magnification were present.

### **Example 8.22: The “complete, detailed, and lengthy physical examination”**

*Report States:*

A complete, detailed, and lengthy physical examination was performed.

*Resulting Cross-examination:*

**Q.** Your IME report indicates that you performed a complete, detailed, and lengthy physical examination, correct?

**A.** Yes, it does.

**Q.** Are you familiar with the saying in medicine that “If it's not documented, it's not done,” Doctor?

**A.** I have heard it.

**Q.** What does that mean?

**A.** If the physician doesn't properly document the medical record, it will be presumed that the procedure was not done.

**Q.** Doctor, where in your ½-page IME report do you document the complete, detailed, and lengthy physical examination that you allegedly performed?

**Comment:** Examiners who do not adequately document their reports are particularly vulnerable to cross-examination. It will be difficult to defend an undocumented report.

**Defending the Report As Written:** Even a poorly documented IME report can be defended. The examiner will have to focus on what he did do as opposed to what he failed to do.

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**Q.** Doctor, where in your ½-page IME report do you document the complete, detailed, and lengthy physical examination that you allegedly performed?

**A.** I was asked to answer one simple question in my report, which I have done. I am sure the judge would prefer that we concentrate on my findings and opinions than engage in personal attacks. Would you like me to discuss my medical findings and opinion, Counselor?

### **Example 8.23: “Personally” examined**

*Report States:*

I personally examined the claimant.

*Resulting Cross-examination:*

**Q.** Doctor, you personally examined the claimant in this case?

**A.** Yes, I did.

**Q.** Is there any difference between examining and personally examining a claimant?

**A.** Not really.

**Q.** Why did you state in your IME report, then, that you personally examined the claimant?

**Comment:** Examiners are best served by not characterizing their examinations or review of records as “personal,” “thorough,” “careful,” etc. This leads to avoidable cross-examinations about why sometimes the examiner is thorough and sometimes she is not.

**Defending the Report As Written:** When confronted with her own characterization, the examiner needs to be able to explain what she meant.

**Q.** Why did you state in your IME report, then, that you personally examined the claimant?

**A.** I did the exam myself, as opposed to one of the other four physicians in my group. That’s what I meant by “personally examined.”

### **Example 8.24: Well-formatted and documented physical examination—second example**

*Report States:*

#### **Physical Examination**

##### **Vital Signs**

Temperature - 97.4

Pulse - 70

Blood Pressure - 130/74

##### **Observations**

Mr. Babitsky is a well-developed male who was in obvious pain and distress.



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### Behavioral Observations

Mr. Babitsky was pleasant and cooperative during the examination. He demonstrated a normal affect. During the visit he appeared comfortable and demonstrated pain behaviors that were appropriate and confirm clinical findings of the lower back and right leg. The pain behavior that was observed was mild limping right leg.

He scored a +1 in pain behavior assessment. This indicates that the pain behaviors are appropriate and tend to confirm the clinical findings of the lumbar spine and lower extremities (legs).

### Structural Examination:

His observed gait was mild limp right leg. There was no antalgic posture noted. There was significant loss of lumbar lordosis and deconditioning of the lumbosacral muscles. There was a surgical scar of 10 cm.

### Range of Motion

Range of motion was tested using dual inclinometers and the results of the maximal ROM in each plane follows. The ROMs indicated below in Table 1 meet the validity criteria as delineated in the AMA's *Guides to the Evaluation of Permanent Impairment*, 5<sup>th</sup> edition, in all ranges.

Lumbar ROM		
Flexion	20	33% of Normal (60°)
Extension	12	50% of Normal (25°)
Left Lateral Bend	8	33% of Normal (25°)
Right Lateral Bend	8	33% of Normal (25°)

### ORTHOPEDIC EXAMINATION:

#### Lumbar Spine:

#### **Lumbar palpation examination:**

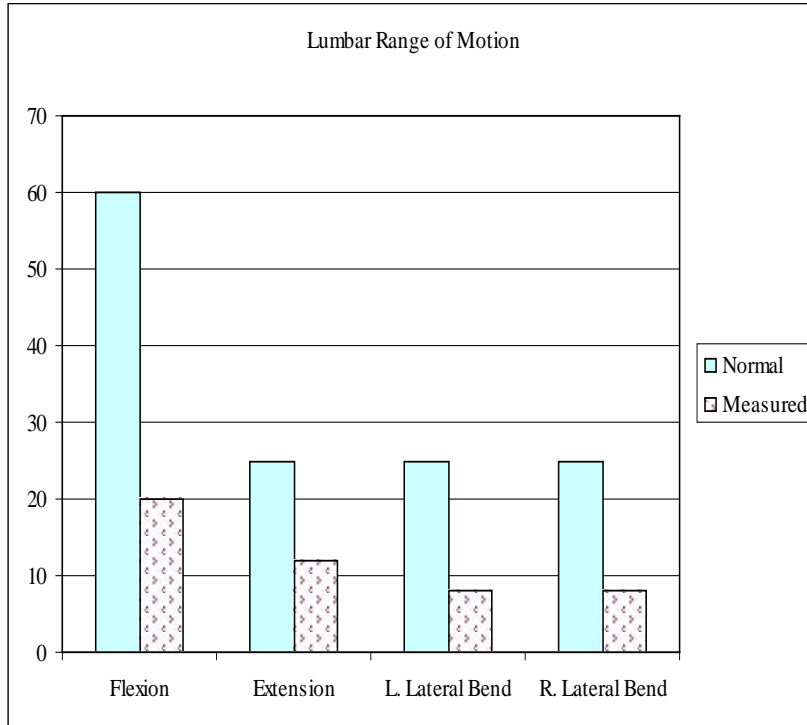
Muscle spasms and tenderness detected to palpation in the lumbar paraspinal musculature on range of motion with pain.

Muscle spasms and tenderness detected in the gluteus musculature on range of motion with pain.

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Tenderness to palpation detected in the lumbar spinous processes of L2, L3, L4, and L5.

Tenderness detected in the lumbar facets of L2, L3, L4, and L5 bilaterally.



	<b>Flexion</b>	<b>Extension</b>	<b>L. Lateral Bend</b>	<b>R. Lateral Bend</b>
<b>Normal</b>	60	25	25	25
<b>Measured</b>	20	12	8	8

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Lumbar joint pain and tenderness, joint asymmetry, range of motion joint abnormality, connective tissue tone, texture, and temperature abnormality was detected.

Deconditioning to the lumbar spine, loss of lumbar lordosis and loss of muscle tone.

SI joint pain and tenderness, joint asymmetry, range of motion joint abnormality, connective tissue tone, texture, and temperature abnormality was detected bilaterally.

Limited mobility of the SI joint with pain noted bilaterally.

### Lower Extremity Right Lower Thigh and Calf

The patient exhibited a mild limp on toe off and heel off.

Circumferential mensuration was as follows:

	Left	Right
<b>leg: 10 cm above superior pole of patella:</b>	<b>51 cm</b>	<b>47 cm</b>
<b>10 cm below inferior pole of patella:</b>	<b>44½ cm</b>	<b>42 cm</b>

There are 4 cm of atrophy noted in the right thigh.

There are 2½ cm of atrophy noted in the right lower calf.

There is a 60% 3/5 right muscle strength deficit and sensory loss.

Supraspinatus tendonitis test	NEGATIVE
Codman arm drop	NEGATIVE
Apprehension test	NEGATIVE
Yergason's test	NEGATIVE
Apley's test	NEGATIVE
Drawer test	NEGATIVE
McMurray's test	NEGATIVE

### RELIABILITY TESTS:

Libman's	NEGATIVE
Mannkopf's	NEGATIVE
Burn's Bench	NEGATIVE
Waddel's	NEGATIVE

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### **NEUROLOGICAL TESTING:**

Neurological testing consisted of 1) muscle testing, 2) reflex testing and 3) sensation testing.

### **SENSORY DERMATOME LEVELS:**

A hypoesthesia was noted along the L5 right nerve distribution.

Upper extremities along the sensory dermatome distribution, sensory dermatome level testing was within normal diagnostic perimeters for upper appendages.

### **DEEP TENDON REFLEXES:**

The Deep Tendon Reflexes tested as follows:

Patellar Reflexes 1+/3 right	2+/3 left
Achilles Reflexes 0+/3 right	2+/3 left

### **MUSCLE TESTING:**

C5, C6, C7, C8 and T1 upper extremity strengths of the muscles involved were tested and found to be symmetrical and equal.

L4, L5, S1 lower extremities strengths of the muscles involved were tested and found to be weaker on the right leg and unequal compared to the left leg.

### **ORTHOPEDIC TESTING**

Valsalva's test was positive L2, L3, L4, and L5.

Kemp's was positive L2, L3, L4, and L5.

Straight leg raise was painful at greater than 60 degrees, positive on the right.

Confirmatory straight leg raise test was positive on the right.

Soto-Hall's test was positive in the lumbar spine.

### **VASCULAR TESTING:**

The following tests were done to determine any abnormalities of the lower extremities:

There were no abnormal clinical signs of the arteries of the lower extremities.

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### Jamar Dynamometer

Mr. Babitsky was tested for grip strength using the Jamar Dynamometer. Mr. Babitsky is right-hand dominant. His best performance was obtained at position 4 and the data are presented in Table 1.

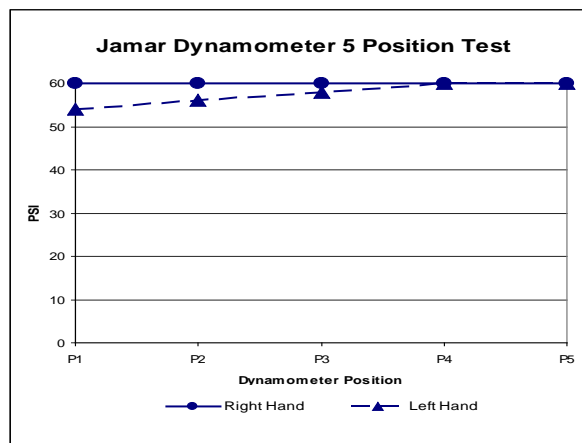
**Table 1**  
**Grip Strengths of Right and Left Upper Extremities**

		Mean Value Left Hand		Right Hand (Dominant)	Mean Value Right Hand
<b>1</b>	54 lbs			60 lbs	
<b>2</b>	56 lbs	58 lbs		60 lbs	60 lbs
<b>3</b>	58 lbs			60 lbs	
<b>4</b>	60 lbs			60 lbs	
<b>5</b>	60 lbs			60 lbs	

Mr. Babitsky made a concentrated and maximal effort to comply with this test protocol. This is evidenced by the minimal variance between trials for each hand. His grip strength fell well within the average ranges for males in his age group.

Mr. Babitsky's performance on the five-position Jamar Dynamometry tests produced curves that demonstrate symmetry between the efforts of the right and left hands, Figure 1. These curves represent the expected research trends and indicate a maximal attempt at the task and the ability to use repeated grip mechanics. I concluded that Mr. Babitsky gave maximum effort to provide grip strength data.

**Figure 1**



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### Pain Status Inventories

Mr. Babitsky completed the following self-report questionnaires:

#### Pain Drawing

Mr. Babitsky completed a Pain Drawing. Using the scoring mechanisms for this diagram, he scored a 2 which suggests good psychometrics. Scores of less than “2” are considered indicative of normal psychometrics.

#### CES-D

The CES-D is a psychometric instrument designed to screen for depression and an affective overlay that may result in symptom magnification. Scores of greater than “16” suggests depression and may suggest a need for additional investigation. The examinee scored a 22.

**Comment:** This is another example of a well-documented, clearly written, and easy-to-read section.

### 8.3 Pain Status Inventories

Pain and functional status inventories may supplement the evaluation. This is especially true of someone with pain complaints. Pain status inventories include instruments to assess behavioral and psychological factors. The most commonly used inventories are as follows.

- Medical Outcome Studies (MOS)
- SF-36 Health Survey
- Pain Drawing
- Pain Disability Index
- McGill Pain Questionnaire
- West Haven-Yale Multidimensional Pain Inventory, Short Form - 36 Questions (SF-36)
- Mensana Clinic Pain Validity Test
- Center for Epidemiologic Studies - Depressed Mood Scale
- Beck Depression Inventory

The examiner should choose a battery of pain inventories consistent with the needs of the assessment. These inventories provide information on the perceived level of function and disability and offer information concerning behavioral overlay and psychological problems. When selecting an inventory, the examiner should consider its intended use, appropriateness to the examinee, validity, and reliability. The examiner should only use pain

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inventories that he sufficiently understands and can defend during cross-examination.

The report should briefly explain the findings and significance of the inventories in an objective, supportable manner. If the examinee refuses to complete the inventories, this should be documented in the report.

### **Example 8.31: Pain inventories confirm non-organic cause of pain**

*Report States:*

The patient was provided a battery of pain inventories. These confirm my suspicion of the non-organic cause of the so-called pain.

*Resulting Cross-examination:*

**Q.** Your report indicates that the “patient was provided a battery of pain inventories. These confirm my suspicion of the non-organic cause of the so-called pain,” correct?

**A.** Yes, that’s what it says.

**Q.** You interpreted the MMPI-2 yourself?

**A.** Yes, I did.

**Q.** What did the L-Scale show, Doctor?

**A.** I am not sure.

**Q.** Do you know what the L-Scale tests for?

**A.** Not specifically.

**Q.** What about the F-Scale?

**A.** I don’t know.

**Q.** Can you explain how the F Minus K-Scale measures “faking bad” and “faking good”?

**A.** I cannot.

**Q.** What did the meta-analysis of the research reports show that an F-K score less than or equal to -8 is a strong indicator of?

**A.** I don’t know.

**Q.** The only thing that you really do know is that the pain inventories which you do not understand confirm your suspicion of a non-organic cause of the examinee’s so-called pain?

**Comment:** Examiners who use pain inventories in their IME reports should understand the inventories, how and what they test, how the numbers are arrived at, and what they mean. Examiners who do this will be in the best position to defend their IME reports. For example:

The most commonly used pain inventories are: Pain Disability Index, Oswestry Low Back Pain Disability Questionnaire, Short Form McGill Pain Questionnaire, and the West Haven-Yale Multidimensional Pain Inventory.

#### *Pain Disability Index*

The Pain Disability Index was developed by Tait et al and focuses on pain-related disability. The index uses 0 (no disability) to 10 (total disability) ratings of disability in seven areas of activity. These areas are family/home responsibilities, recreation, social activity, occupation, sexual activity, self-care, and life-support activities. They are scored by identifying the

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percentage of perceived disability for each category and the overall level of perceived disability. An individual who reported being totally disabled in all areas would have a score of 70 (10 x 7). Levels of reported disability disproportionate to impairment and clinical assessment suggest behavioral overlay. According to Tait, high scores relate to “time spent in bed, psychosomatic symptoms, stopping activities because of pain, work status, pain duration, usual pain intensity, quality of life, pain extent, and education.” The Pain Disability Index appears to possess both test-retest reliability and validity for pain-based disability.<sup>1</sup>

### Oswestry Low Back Pain Disability Questionnaire

The Oswestry Low Back Pain Disability Questionnaire includes ten six-point scales. The first section rates the intensity of pain and the remaining nine cover the disabling effect of pain on typical daily activities. The examinee marks the statement in each section that most accurately describes the effect of his or her pain. The sum of the total scores is expressed as a percentage of the maximal score. If the examinee fails to complete a section, the percentage is adjusted. Scores from 0 to 20% represent minimal disability, 20 to 40% represent moderate disability, 40 to 60% represent severe disability, while scores of 60% or more indicate that the examinee reports being severely disabled in several areas of life.<sup>2</sup>

### Short-Form McGill Pain Questionnaire

The McGill Pain Questionnaire (MPQ) was designed to provide a quantitative profile of pain. It is the leading instrument for describing the diverse dimensions of pain. This instrument is available in long and short forms. The short-form MPQ includes 15 descriptive words, 11 of which are sensory and four of which are affective. Sensory descriptors describe the sensory qualities of the experience in terms of temporal, spatial, pressure, thermal, and other properties. In the short-form MPQ each word or phrase is rated on a four-point intensity scale. The MPQ is scored by determining if sensory descriptors are predominately used, suggesting less emotional overlay, or whether affective descriptors are used, suggesting behavioral overlay. The process of scoring the MPQ is detailed in the *Handbook of Pain Assessment* by Turk and Melzack.<sup>3</sup>

### West Haven-Yale Multidimensional Pain Inventory

The (West Haven-Yale) Multidimensional Pain Inventory focuses on the pain’s impact on the individual’s life, the responses of others to the individual’s communication of pain, and the extent to which the individual participates in common daily activities. It groups individuals into categories of adaptive cooperative, dysfunctional, or interpersonally distressed. This instrument and the software to score the inventory are available at minimal cost through the University of Pittsburgh.<sup>4</sup>

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<sup>1</sup> *The Comprehensive IME System*, SEAK, Inc. p. 52 (1997).

<sup>2</sup> *Ibid.* at 52.

<sup>3</sup> *Ibid.* at 53.

<sup>4</sup> *Ibid.*



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**Defending the Report As Written:** Examiners who are not intimately familiar with pain inventories but who insist on using them can still defend their reports.

**Q.** So you interpreted the MMPI-2 yourself?

**A.** No. I have a forensic psychologist who I use to interpret and score psychological tests. I reviewed her scoring.

### **Example 8.32: Pain inventories clearly documented**

*Report States:*

#### Pain Drawing

The examinee completed a pain drawing (enclosed), using symbols to describe sensations. This drawing received a score of 8, suggesting poor psychometrics.

#### Pain Disability Index

The Pain Disability Index uses rating scales to measure the extent of perceived disability in seven areas of life. The results are as follows:

<u>Area</u>	<u>Perceived Disability</u>
Family/home responsibilities	90%
Recreation	90%
Social activity	90%
Occupation	100%
Sexual activity	80%
Self-care	60%
Life-support activities	70%

The overall score is 58 out of 70, for a high level of perceived disability (83%), with the highest level of reported disability being for occupation.

#### McGill Pain Questionnaire

The patient completed the McGill Pain Questionnaire (Short Form), rating 15 pain descriptors on a scale from 0 (none) to 3 (severe). The sum of 11 sensory descriptors was 25, averaging 2.3. The sum of 4 affective descriptors was 11, averaging 2.75. The total of all descriptors was 36 (an elevated score). The descriptors were primarily affective, suggesting exaggerated pain. The descriptors rated as severe were stabbing, hot-burning, aching, tender, splitting, tiring-exhausting, sickening, and punishing-cruel. The overall pain intensity was rated at 4 (horrible) on a scale of 0-5.

#### Multidimensional Pain Inventory

The results of the University of Pittsburgh School of Medicine Multidimensional Pain Inventory are attached. The examinee rated the impact of the pain in several areas on a 0-6 scale. The first page reports the scores and statistical analysis, and the second page

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gives a graphic representation of the results compared with a control group.

This profile is that of a dysfunctional individual. Compared with the control group, these individuals report a higher severity of pain, greater interference with their lives, a higher degree of psychological distress, a lower perceived ability to control their lives, and lower activity levels. They are labeled dysfunctional because the pain has affected a broad range of their functioning.

### CES-D

The Center for Epidemiologic Studies Depressed Mood Scale was administered. The examinee scored 34, suggestive of a depressed mood.

### Oswestry Function Test

His score on the Oswestry Function Test was 27 out of a possible 50 (54th percentile), indicating a perception of severe disability.

### *Resulting Cross-examination:*

- Q.** Doctor, you scored the examinee's pain drawing as an 8 in your IME report?
- A.** Yes, I did.
- Q.** That's because he made too many Xs and went outside the line?
- A.** It's not that simple, Counsel.
- Q.** Had the examinee not "colored outside the lines," would you have scored him as an 8?
- A.** Well, no.
- Q.** Did anyone explain to this examinee, with his third-grade education, that he should stay within the lines?
- A.** No. That's part of the test.
- Q.** The pain indexes utilized do have their shortcomings, don't they, Doctor?
- A.** Well, no test is perfect.
- Q.** Are you familiar with the critique of the Pain Disability Index done by Hebben?
- A.** What are you referring to, Counsel?
- Q.** Hebben, N., *Toward the Assessment of Clinical Pain in Adults*, in Aronoff G.M., (ED) *Evaluation of Chronic Pain*, William and Wilkins, 1992, p. 384-393?
- A.** No, I am not.
- Q.** Would you like to see this before you continue to use this index?
- A.** Yes.
- Q.** Are you familiar with the problems using the McGill Pain Questionnaire?
- A.** No.
- Q.** There is significant disagreement over the accuracy of the test and its ability to discriminate diagnostic groups of patients, correct?
- A.** I have not heard of that criticism and I doubt it exists.
- Q.** Doctor, I am showing you the chapter by Hinnant, D.W., "Psychological Evaluation and Testing," from *Tollison Handbook of Pain Management*, 2<sup>nd</sup>

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edition, 1994, pp. 18-35. Would you like some time to review it before we proceed?

**Comment:** Examiners who make extensive use of pain inventories should study the inventories and understand their strengths and weaknesses. Only then will they be in the best position to defend their opinions and reports.

**Defending the Report As Written:** Physicians who are ready to respond excel at defending their opinions and reports.

**Q.** Are you familiar with the critique of the pain disability index done by Hebben?

**A.** Hebben found that the Pain Disability Index possessed both test-retest reliability and validity with regard to pain-based disability.

### **8.4 Current Status**

The current status should be elicited in detail and thoroughly documented. This process usually commences with identification of the examinee's primary concern. Most often the complaint is pain. The location, intensity, frequency, pattern, and nature of the pain, as well as aggravating and relieving factors, need to be documented. Associated symptoms, such as numbness, tingling, weakness, morning stiffness, and other physiologic difficulties, should be assessed and documented. It is important to identify not only positive attributes but negative attributes as well. Anxiety, discouragement, depression, and sleep disturbance should be referenced. Any inconsistencies should be documented.

#### **Example 8.41: Current complaints documented**

*Report States:*

The examinee's major concern is that his "back hurts and I can't lift." He reports that since the injury he has remained the same.

The pain is located primarily in the right low back, and is described as nagging. It radiates down the right leg posterior to the knee.

Aggravating Factors: Significantly worsened by forceful use, movement, lifting, cold or damp weather, and sitting; somewhat by exercise, coughing, or sneezing, standing, walking, and "driving my car."

Relieving Factors: The pain is improved somewhat with rest. On a scale from 0 (no pain) to 10 (excruciating pain), initially it was a 10. During the past month it averaged a 7, with a low of 4 and a high of 10. Today the pain is a 7.

He has numbness on the outside of the right leg to the knee, and rare tingling. He reports weakness of his back and right leg, and morning stiffness lasting an hour or so. He admits feeling

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discouraged at times and depressed, although he denies suicidal thoughts. His sleep is disturbed, with primary and secondary insomnia due to pain. He mentions as another problem that “my neck is occasionally stiff.”

*Resulting Cross-examination:*

- Q.** Doctor, do you believe the examinee when he reports that his back hurts and he can't lift?
- A.** I have no reason not to believe him.
- Q.** Depending on the intensity and frequency, pain can be disabling?
- A.** In some cases.
- Q.** Did you ask him about the frequency of his pain?
- A.** No, I did not.
- Q.** Do you know if his pain is intermittent, occasional, frequent, or constant?
- A.** I do not.
- Q.** You would agree that the frequency of his pain is of significance, would you not?

**Comment:** Examiners who comment on pain should do so in a detailed manner. Both the intensity and frequency of the pain should be documented.

**Defending the Report As Written:** Examiners can expect to be questioned about the nature, extent, and impact of the pain reported by the examinee. The examiner needs to be able to defend his comments on pain and its impact on the examinee. When given an “opening,” some examiners capitalize on it.

- Q.** Depending on the intensity and frequency, pain can be disabling?
- A.** In my experience, the motivation and not the pain is what is crucial. I have seen workers who lost a finger return to work in two hours and others who complain of pain from a simple laceration be out of work for months. This is not a pain issue. It is a question of motivation.

### **8.5 Functional Status**

Functional status should be thoroughly elicited and documented in detail. This is particularly true for those functions that are most problematic. The physician should have the examinee express her capacity to perform various activities of daily living, such as exercising, sitting, standing, household chores, driving, etc. This is helpful in understanding the difficulties perceived or reported by the examinee and may be useful in assessing work ability. If the examinee is quoted in the report, the physician should be careful not to misquote her.

The functional status may also be considered in terms of whether it fits with the diagnoses in question and is consistent with other observations. The person's reported tolerances for sitting, standing, walking, lifting, and carrying are noted. Also noted is the ability to carry out a variety of tasks associated with activities of daily living. In a credible examinee, these representations may be accurate. In an examinee with symptom magnification behavior, the representations may be inconsistent with

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observations during the visit, surveillance material, and the medical condition.

Some examiners include observations of the claimant arriving at and leaving the examiner's office. This is not recommended because it will likely result in close questioning on cross-examination in an attempt to show that the examiner was spying or looking for anything to help the insurance company.

All findings should be objectively and carefully documented in the report. Ideally, functional status is addressed in a separate section of the report that is identified with a topic heading. Please consider the following examples.

### **Example 8.51: Functional status**

*Report States:*

#### **FUNCTIONAL STATUS**

He feels he can sit for half an hour, stand for one hour, walk for half an hour, and lift up to 10 lbs. occasionally. He reports being unable to lift heavy weights, and has major difficulty lifting a heavy bag of groceries, bending, lifting from floor to waist or waist to shoulder, lifting above shoulder level, climbing stairs, or driving. He indicates minor problems lifting a light bag of groceries, reaching above shoulder level, pulling, pushing, sweeping or vacuuming, and moving his neck. He is unsure of his ability to climb ladders. His most difficult task is "driving my car over bumpy roads."

*Resulting Cross-examination:*

**Q.** Doctor, the functional status portion of your IME report is just what the examinee told you, correct?

**A.** Well, yes.

**Q.** You didn't perform a functional capacity evaluation to determine if the examinee has the ability to return to work?

**A.** No, I did not.

**Q.** Thank you.

**Comment:** The examiner can obtain significant information from the examinee by asking him about his limitations. These self-reported limitations are another part of the IME puzzle.

**Defending the Report As Written:** Examiners need not apologize for the fact that the functional status is the examinee's perception of his ability and limitations.

**Q.** Doctor, the functional status portion of your IME report is just what the examinee told you, correct?

**A.** The examinee's perceived functional status expressed in his own words is very important in clarifying work capacity and potential behavioral issues.

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### Example 8.52: “He cannot articulate”

*Report States:*

#### **Functional Status**

He states he cannot be as active as he would like when performing activities such as hunting, riding horses, riding in the mountains, jogging, swimming, or fishing secondary to the pain. He denies any problems with household or yard work or preparing meals, but states he has problems pulling on his shoes and socks and picking things up once he has dropped them. Most of his yard work and household work is done by his relatives. He is able to sit for only 20 minutes. He cannot articulate how long he could stand, drive, or walk.

*Resulting Cross-examination:*

**Q.** Doctor, you said in your IME report that the examinee could not articulate how long he could stand, drive, or walk, correct?

**A.** Yes.

**Q.** When you asked him how long he could stand, he didn’t say, “I cannot articulate,” did he?

**A.** No.

**Q.** He said he wasn’t sure, didn’t he?

**A.** Something like that or words to that effect.

**Q.** You didn’t put in his answer but your characterization of what he said, correct?

**Comment:** Examiners are better served by using the examinee’s verbatim response or non-response to questions regarding his functional status.

When asked how far he could drive, the examinee replied, “I don’t know. I haven’t driven in two years.”

**Defending the Report As Written:** Examiners need not take criticism for the failure of the examinee to reply to simple, direct questions.

**Q.** When you asked him how long he could stand, he didn’t say, “I cannot articulate,” did he?

**A.** No, Counsel. He said, “I couldn’t say.”

### Example 8.53: Observation in parking lot

*Report States:*

Mrs. Buckner was observed entering a blue Toyota Camry, which includes bending and turning, including her neck, without difficulty or limitations. She operates it without any identifiable problems.

*Resulting Cross-examination:*

**Q.** Doctor, you observed the claimant in your parking lot?

**A.** Yes.

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- Q. Do you normally observe claimants get into their cars as part of your IME exam?
- A. Sometimes I do.
- Q. Is this intentional or by accident?
- A. Mostly by accident.
- Q. How far away were you from the claimant when you observed her?
- A. About 75-100 feet.
- Q. Which part of the car was closest to you?
- A. The rear.
- Q. When she got into the car, you were looking at the back of her head, correct?
- A. Yes.
- Q. If she grimaced in pain you could not see that, correct?
- A. She seemed to be OK.
- Q. Could you see if her back went into spasms after she sat down?
- A. I didn't see anything like that.
- Q. You couldn't see it because her back was against the seat, correct?
- A. Her back was against the seat.
- Q. You observed her operate her vehicle "without any identifiable" problems. Is that what you wrote in your independent medical report?
- A. Yes.
- Q. You observed her as she pulled out of the parking lot?
- A. Yes.
- Q. How long did that take, Doctor?
- A. 20-30 seconds.
- Q. You didn't follow her...or did you?
- A. No, I did not and I do not appreciate your sarcasm, Counselor.
- Q. Based on those 20-30 seconds, you formed an opinion about her ability to operate a motor vehicle without problems?
- A. I reported what I saw.
- Q. You did not observe her for the rest of her 45-minute drive?
- A. That's correct.
- Q. Do you normally observe patients you treat getting in and out of their cars?
- A. Once in a while.
- Q. Do you report your observations in their medical records, Doctor?
- A. No.
- Q. That's because in those cases you are not working for an insurance company and trying to build a case that there is nothing wrong with the patient, correct?
- A. I call them as I see them, Counselor.
- Q. It's just the IME examinees that you "accidentally" see getting in and out of their cars and driving out of the parking lot so you can report your observations in your independent medical report?

**Comment:** When examiners stretch to find items that will help them show that the examinee is "normal," they run the risk of being perceived as an advocate. The reporting of objective medical test results is much more effective and does not smack of partiality. When, as in the above example, the examiner tries to argue that in a brief observation he can determine the examinee's true health

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status, he undermines his credibility and even the appearance of his impartiality. The examiner would have been better served by either omitting the sentence completely or at least reporting the observations without drawing opinions directly from his observation.

The examinee entered her Toyota Camry, twisted her neck, and backed out of the driveway without apparent difficulty.

**Defending the Report As Written:** The IME physician, when faced with questions on his observations, should give the simple facts that he observed without embellishment or characterization.

**Q.** Doctor, you observed the claimant in your parking lot?

**A.** I saw her enter her Toyota Camry, turn her neck around to back up, and drive out of the lot without apparent difficulty.