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INDEPENDENT MEDICAL EVALUATION

PATIENT NAME:
DATE OF BIRTH:
DATE OF IME: October 17, 2022
DATE OF INJURY:
EXAMINING PHYSICIAN: Peter J. Buecker, M.D., Ph.D.
CLINIC LOCATION: 9900 Corporate Campus Dr., #2400, Louisville, KY 40223
ATTORNEY:

INTRODUCTION: The purpose of today's visit is the completion of an Independent Medical Examination to determine whether or not a permanent impairment exists related to the injury that occurred on November 3, 2021, while the patient was under the employment of Spectrum Cable performing duties as a second-level field tech.

HISTORY OF PRESENT ILLNESS: is a now 41-year-old man, who was performing his normal work-related duties in the employment of Spectrum Cable as a second-level field tech, which required him to do rigorous physical activity including all aspects of cable, phone, and internet service from the "pole into the home." This also involved carrying ladders, which weighed 68 pounds by patient report, and wire spools weighing up to 115 pounds, also by patient report. These duties include climbing, crawling, climbing ladders, bending, occasionally getting in crawl spaces, going up and down steps, etc.

On November 3, 2021, the patient was performing his normal duties when he had gone on a "trouble call" to a customer's home. In doing his initial evaluation of where the lines existed to determine the point of difficulty, the customer led . onto the customer's deck. The customer then re-entered the home and closed the door. As was walking on the deck, one of the boards underneath his feet gave way causing his left leg to breach the deck, leaving his right lower extremity up on the walking surface causing a significant twisting injury to his right leg resulting in a dislocated right hip and a badly fractured right lower tibia and fibula. He states the second that this happened, he knew that his leg was broken and called his supervisor.

He then called EMS for medical assistance. His first line and building supervisors both came to the scene and were there, by patient report, when EMS arrived. EMS did arrive, he said, within 7 to 10 minutes and he had requested to be taken to University of Louisville Hospital, where he had received care for a non-work-related injury in 2015.

Upon arrival at University Hospital, he was assessed. He was noted to have the above-mentioned dislocated hip, which was reduced acutely, and a significantly comminuted right distal tibial pilon fracture with an accompanying distal fibular fracture. He was admitted to Dr. Seligson's service and was taken the next day, November 3, 2021, for external fixation of his distal tibial and fibular injury. He was subsequently discharged from the hospital and brought back on November 8, 2021, for removal of the fixator, reduction, and fixation of the fractures including screw fixation and a cephalomedullary intramedullary nail placed into the tibia and crossing the ankle joint.

He remained non-weight bearing for four months until March of 2022, at which time he was prescribed physical therapy, which he performed at Frazier Rehab in Clarksville for about six weeks, at which time he says he was making progress with his gait and weight bearing. There were some concerns by Dr. Seligson with some of the activities that were happening and so Dr. Seligson stopped the physical therapy, by patient report. At that time, the patient ultimately transferred his care to Dr. Stacie Grossfeld mainly due to some frustrations with the U of L hospital clinic and not with Dr. Seligson particularly. Dr. Grossfeld did resume physical therapy at ProRehab, also in Clarksville, which he completed over a period of about 2-1/2 to 3 months.

Ultimately, the patient was terminated from Spectrum Cable effective October 4, 2022.

CHIEF COMPLAINT: As the patient sits here today, he states the major issues he is having are swelling and discoloration of the right leg, ankle, and foot, particularly after periods of activity. He has pain in both hips including his low back, his right knee, and of course, his right ankle. He does bear weight fully. He does require use of a Double-Up below-knee brace, as well as a single-tip cane that he uses p.r.n. for longer periods of walking and when his back and right hip are hurting. He uses compression garments to assist with the swelling. He states that sitting is painful and he develops a "needles: type of sensation in his right hip and buttock primarily with longer periods of sitting, at which time he has to move to help alleviate these symptoms.

EDUCATION: The patient states his highest degree of completed education is a technical certificate in heating and cooling from Ivy Tech. He has a GED. Additionally, he served in the Armed Forces from 2000 until 2004 in a unit that he refers to as 52 Delta, which was involved with power generator service and repair with technical education commensurate to those duties.

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HOUSING: He lives in his own house with his wife. They have not made any accommodations to the house as a result of this injury, although he states that he minimizes his access to the second floor due to the steep nature and number of the stairs going up to the second floor. He states he does this about two times per week with difficulty, for instance holding onto the rail and the wall and going one step at a time. Going up steps, he also leans forward to put his hands on the steps above to help stabilize himself as he ascends.

ACTIVITY TOLERANCE BY SELF-REPORT: The patient states he can walk about 300 feet before he has to sit down. He can lift about 20 pounds, which he relates as two cartons of milk. He does not crawl. He can kneel on one leg only keeping his left knee on the ground, but he cannot tolerate kneeling on his right. He has to get up after a couple of minutes in this and needs assistance typically. If he sits on the ground or gets on the ground, he needs assistance getting up. He can do stairs as described above.

ACTIVITIES OF DAILY LIVING: The patient can shower without assistance. He can use the commode without assistance. If he is sitting in a tub soaking, he does need help getting out. He states that this injury has affected his sexual function and relations with his wife mainly due to pain and overall effects on libido.

ALLERGIES: He is allergic to morphine, which causes significant itching.

MEDICATIONS: He takes no prescription medications at this time.

PAST MEDICAL HISTORY: No other significant past medical history other than a motorcycle accident in 2015, which was not work-related, which did require surgery on his left wrist, which was also performed by Dr. Seligson. He did not have any injury to his leg, knee, hip, or back as a result of that accident.

OTHER PRIOR ACCIDENTS, INJURIES, OR LEGAL CLAIMS: The patient has no other prior accidents, no other work-related injuries, or work-related or legal claims related to injury.

FAMILY HISTORY: The patient's family history is reviewed with the patient and is found to be noncontributory for the current complaints.

SOCIAL HISTORY: The patient had a 20-minute commute to the exam today. He drove himself in a vehicle with automatic transmission. He and his wife have three teenage children, all girls, ages 18, 17, and 15. They also have custody of a niece and nephew.

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SUBSTANCE HISTORY: Regarding substances, the patient states that he does use a vaping device, which has a 5 mL tank and he uses 3 tanks containing 3 mg of nicotine each per day. He does not use alcohol or other illicit substances.

REVIEW OF SYSTEMS: Negative for any significant symptoms related to his head or neck, chest, breathing, cardiovascular system, gastrointestinal system, endocrine system, or other musculoskeletal and neurologic complaints other than those related above.

RECORDS REVIEWED: The records reviewed for this examination include the following:

1. Intake form provided by the patient at the time of the visit.
2. EMS report from November 3, 2021, stating that this was indeed the date of injury. This is the Run Report and describes the injury and the transport to the hospital.
3. Discharge Summary from U of L Hospital on November 4, 2021, containing details consistent with those provided in the history of present illness.
4. X-ray report from University Hospital dated November 4, 2021, confirming that the injury is a comminuted intraarticular fracture of the distal right tibia with some fragments demonstrating anterior and medial displacement, as well as a comminuted fracture of the distal fibula and lateral malleolus with impaction of the ankle mortise
5. X-ray from November 5, 2021, from University Hospital, which is the post-surgical x-ray showing the external fixation in place with fracture fragments in satisfactory alignment.
6. Operative note from November 8, 2021, from University Hospital, which is for the removal of external fixation, as well as internal fixation of the fracture including screws and an intramedullary nail.
7. Post-surgical x-rays of November 8, 2021, are reviewed.
8. Note from Frazier Rehab Institute in Southern Indiana dated December 28, 2021, which appears to be more of an intake-type form.
9. Follow-up care including an x-ray from January 31, 2022, at University Hospital.
10. Clinic visit on March 18, 2022, with Dr. Seligson, which showed that he did require the use of a bone stimulator, had been limited weight bearing, review of x-rays, as well as an intent to start physical therapy in earnest at this time, as well as documenting his fixed ankle brace and the fact that he was not able to return to work and had not, at that time, reached maximum medical improvement.
11. Note from May 9, 2022, which also shows that the patient is not at MMI, cannot return to crawling and use of ladders as required for his job at Spectrum. The patient was continuing with physical therapy and was to return in three months.
12. At that time, the patient had transferred his care to Dr. Grossfeld for further followup and saw her on July 25, 2022. She ordered a CT scan to evaluate for nonunion or delayed union of the fracture. She wanted to continue physical therapy and prescribed meloxicam.

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RECORDS REVIEWED (cont.):

13. CT scan from August 5, 2022, which showed extensive hardware with some arthritis of the tibiotalar joint and osteopenia, which would be commensurate with the injury, but no sign of delayed or nonunion.
14. The final note we have from Dr. Grossfeld is dated August 24, 2022, at which time she documents the results of the CT scan and states in her plan under item #2 that she felt that he was at MMI as of the date of that visit. She recommended p.r.n. followup.
15. Functional Capacity Evaluation from Results Physiotherapy dated August 18, 2022, performed by Kevin Mooney, P.T., D.P.T., C.O.M.T. This test was reported to have a good consistency and validity, particularly with good effort on the requested tasks. The report does state the patient "demonstrated a full and consistent effort on this FCE." He was found to demonstrate the ability to work in the medium DOT Category, which involves occasional lifting of up to 50 pounds, frequent lifting of up to 25 pounds, and constant lifting of up to 10 pounds. This also included the fact that he could sit constantly, stand frequently, climb stairs occasionally, bend frequently, and was unable to assess his ability to kneel and crawl. Full results are in the legal and medical record.

PHYSICAL EXAMINATION: The patient was observed ambulating from the waiting area into the exam room today. He is noted to walk with a significant limp favoring the right side. He is wearing a brace. He is not using a cane today.

On examination in the exam room, the patient is asked to disrobe from the waist down other than his underwear to fully evaluate the bilateral lower extremities. His skin is noted to be intact and normal appearing with appropriate scarring related to the procedure that he had as described above. All incisions appear well-healed. There are no signs of post-surgical complication to include any infection, undue swelling, or any significant swelling for that matter. No skin discoloration is appreciated at this time. Palpation of the bony elements does not reveal any significant palpable deformity, no significant prominent hardware, or other palpable abnormality.

Examination of the right hip reveals full range of motion without sensation of instability or impending dislocation. No sign of residual instability of the hip is noted and no pain with range of motion is elicited. The same goes for the right knee. There is full range of motion from 0 degrees of extension with 130 degrees of flexion. No ligamentous instability is identified. There is no tenderness along the axis of the tibia or fibula with some mild tenderness down around the area of the fracture and known injury and incisions for the placement of the distal hardware. This is felt to be in line with the procedure and not felt to be a complication of sign of a new impending problem. He is noted to have atrophy of the musculature of the calf and measurement with a tape measure at the thickest aspect of circumference of the calf musculature would reveal a 2cm atrophy on the right side compared with the left.

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Examination of the right ankle does reveal well-healed incisions. There is no significant edema and certainly no pitting edema. No significant joint swelling or joint effusion is appreciated. The most significant finding here is that his range of motion is limited, particularly in dorsiflexion, where he is measured with three separate goniometric measurements confirming that he has 0 degrees of dorsiflexion, 40 degrees of plantar flexion, less than 10 degrees of subtalar eversion, and 15 degrees of subtalar inversion. Again, these are the greatest motions observed over three separate goniometric measurements of the tibiotalar and subtalar joints.

No neurologic impairment or significant loss of sensation is appreciated at the time of this exam. Vascular examination appears normal with brisk capillary refill and palpable pulses in the dorsalis pedis and posterior tibial pulses.

INTERROGATORIES: No specific interrogatories have been provided. Therefore, I will use a standard set of interrogatories to complete the Independent Medical Examination findings and recommendations.

1. **Are the diagnoses and symptoms consistent with the history of known injury?**

   Yes. All findings including the diagnosis of a comminuted tibial pilon fracture, the patient's current symptoms, and physical exam findings are consistent with the history of the injury documented on November 3, 2021.

2. **Did the patient sustain harmful change to his organism due to the stated injury? If so, what change and how does it relate?**

   Yes, the patient did sustain a harmful change to his organism as related to the injury of November 3, 2021. He had a significant fracture of his right lower extremity, the nature of which is notoriously difficult to overcome long-term. He continues to have pain. Most notably, he has restricted range of motion in the ankle and a significant limp with gait despite the use of a brace and p.r.n. use of a cane. He is unable to kneel or crawl. He is unable to climb ladders and has a great deal of difficulty with stairs, none of which were a problem prior to the injury.

3. **What is the permanent whole person impairment rating related to the stated injury?**

   At this time, it is my assessment that Mr. Drumm has a 5% whole person impairment according to the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 5th Edition.

INTERROGATORIES (cont.):

This is calculated as follows: The patient has 0 degrees of ankle extension, which according to Table 17-11 on Page 537, confers a 3% whole person and a 7% lower extremity impairment.

Additionally, he has less than 10 degrees of eversion and 15 degrees of inversion, which according to Table 17-12 on Page 537, confers a 1% whole person impairment for inversion and 1% whole person impairment for eversion, each of which are an additional 2% of lower extremity impairment.

Adding these values confers a 5% whole person impairment.

Though the patient does have obvious gait derangement and muscle atrophy noted on exam, Table 17-2 on Page 526 clearly indicates that these are not able to be utilized for calculation of whole person impairment since the range of motion measurement does confer the highest degree of noted impairment.

4. **Did the patient have a pre-existing active or dormant condition prior to the above-mentioned injury?**

   The patient had no pre-existing condition of the right lower extremity including the hip, knee, or ankle prior to the injury of November 3, 2021. All findings are felt due to a new injury consistent with that on the date of noted injury.

5. **On what date did the patient reach maximum medical improvement?**

   Dr. Grossfeld, in her note of August 24, 2022, under her plan, item #2, states that he is at MMI today. Given the findings, given the nature of the injury sustained, the procedure, etc., I do concur with this date and I do believe that the patient was at maximum medical improvement as of August 24, 2022.

6. **Are there any further treatments recommended?**

   At this time, I do not believe there are any further treatments that are going to improve Mr. Drumm's overall situation. It is possible at some point that he may require removal of hardware due to prominence, irritation, migration, etc. This is uncertain and at this time, is not felt necessary, but does remain a possibility for the long-term. I do not feel that any further physical therapy or local treatments are going to improve his situation at this time.

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INTERROGATORIES (cont.):

7. **Does the patient, at this time, have any permanent restrictions related to the injury?**

   I do concur with the findings of the Functional Capacity Evaluation. I do believe he should not be regularly lifting any more than 20 pounds. I do not believe it is appropriate for him to be crawling, climbing ladders, navigating steps, or kneeling for prolonged periods of time, all of which would be required for his job duties that he was performing at the time of the injury.

8. **Does the patient retain physical capacity to return to the same work activities that he was performing at the time of injury?**

   No. There are numerous duties which he would no longer be able to perform that he was performing just fine prior to his injury. These include crawling, kneeling for periods of time, navigating steps, climbing ladders, and carrying a ladder that weighed 68 pounds by his own report. He can do none of these activities at this time and therefore, would not be able to perform job duties as were specified, which he was performing just fine at the time of the injury of November 3, 2021, while employed at Spectrum Cable.

9. **Will the patient require ongoing care for the injury? If so, what?**

   It is not felt at this time that ongoing care is going to make a difference one way or another for him. He may, at some point, require replacement of his Double-Up below-knee brace and of course, as mentioned above, may require removal of hardware at some point for pain, prominence, or migration. It is not clear that this will be necessary, but it does remain an ongoing possibility. He has been released to p.r.n. followup by Dr. Grossfeld and I do feel that is appropriate.

   Though I feel that unlikely, it is possible the patient could develop osteonecrosis of the right hip, having suffered an acute traumatic dislocation, though there is no indication of this or any symptomatology related to this at this time.

10. **Are all opinions in this report based on a reasonable degree of medical probability?**

    Yes, all opinions rendered here are based on a reasonable degree of medical probability.

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ATTORNEY: [REDACTED]

Thank you for the opportunity to provide this Independent Medical Examination of [REDACTED] If any additional questions arise or any additional information is required, please do not hesitate to reach out.

Sincerely,

Peter J. Buecker, M.D.
Diplomate, American Board of Orthopedic Surgery
Kentucky License #35801
Kentucky Worker's Claim Physician Index Number 4822

PJB/tmh