ADVANCED CLNC®
Practice-Building Program

Insurance Companies and the CLNC® Consultant

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THE PIONEER OF LEGAL NURSE CONSULTING
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I. INTRODUCTION

A. Insurance Liability Defense Is a Growing Field for Certified Legal Nurse Consultants

   1. Whether in-house or as independents, CLNC® consultants work in many areas of insurance.
      a. Commercial liability.
      b. Personal liability.
      c. Workers’ compensation.
      d. Med/PIP.

B. The Insurance Liability Claims Process

   1. A homeowner, business owner or auto owner (first party) purchases liability insurance from an insurance company (the second party) for protection against third parties who may file claims against them.
      a. Some state laws vary regarding coverages (i.e. MED-PIP – no fault coverages).

   2. A third party (claimant) makes a claim alleging that the insurance policyholder is responsible for damages.
      a. The insurance company claims representative or adjuster then assesses the claim, verifies insurance coverage, investigates the claimant, the insured and the circumstances.
         (1) CLNC® consultants often assist in reviewing documents and medical records.
      b. The claims representative considers costs.
         (1) Special damages – claimant’s out-of-pocket expenses and lost wages.
         (2) General damages – compensation for pain and suffering (noneconomic damages).

   3. Once the investigation is completed, the claims representative will offer a fair settlement to the claimant up to the dollar limits of the policy.
a. Once the claimant and insurance company agree on the amount of loss, the company pays that amount less the deductible and less any Medicare or lien amounts or bills owed.
b. If no agreement, arbitration, mediation or a trial will follow.

II. COMMON INSURANCE LIABILITY DEFENSE CASES

A. Commercial and Personal Injury Allegations
   1. Slip and fall or trip and fall.
   2. Auto accident.
   3. Food poisoning.
   4. Foreign object or choking.
   6. Thermal burns – water or electrical.
   7. Myocardial infarction, stroke and death secondary to original injury claim.

B. Special Claims
   1. ADA (Americans with Disabilities Act).
   2. Products liability.
   4. Environmental or mold.

III. COMMON INJURIES IN COMMERCIAL AND PERSONAL LIABILITY

A. Orthopedic – Fractures of Feet, Ankles, Hips, Wrists, Skull; Torn Rotator Cuffs; Torn Meniscus
B. Spine – Disc Injuries, Whiplash, Radiculopathies

C. Neurological – Chronic Pain

D. Traumatic Brain Injury and Post-Concussion Syndrome

E. Psychological – Depression

F. Dental – Broken Teeth, Mouth Burns

G. Gastrointestinal – Gastroesophageal Reflux Disease (GERD), Choking, Food-Bourne Illness

H. Dermatological – Abrasions, Lacerations, Contusions, Burns, Scarring

I. Ophthalmological – Eye Injuries, Chemicals or Glue in the Eyes

J. Gynecological and Obstetrics – Fetal Deaths, Premature Births

IV. COMMON PLAINTIFF ALLEGATIONS FOR COMMERCIAL AND PERSONAL LIABILITY

A. Plaintiff alleges causes of action against defendant.
   1. Motor vehicle.
   2. General negligence.
   3. Premises liability.

B. Plaintiff Suffered
   1. Wage loss.
   2. Loss of property.
   3. Hospital and medical expenses.
4. General damage.
5. Property damage.

C. Complaint

1. Plaintiff alleges the acts of defendants were the legal proximate cause of damages to plaintiff. On (date) __________ plaintiff was injured on the following premises in the following fashion.
   a. Count one – negligence: The defendants who negligently owned, maintained, managed and operated the described premises were (names) __________.
      (1) Businesses or home owners associations – poor conditions leading to alleged injuries or damages, (e.g. flooring, stairwell, door handles, broken pipes).
   
   b. Count two – willful failure to warn: The defendant owners who willfully or maliciously failed to guard or warn against a dangerous condition, use, structure or activity were (names) __________. Plaintiff, a recreational user, was (an invited guest or a paying guest).
      (1) Wet floors recently mopped and not labeled in public places, faulty equipment, unsafe public areas.
   
   c. Count three – dangerous condition of public property: The defendants who owned the public property on which a dangerous condition existed were (names) __________.
      (1) Uneven public sidewalks, driveways, unsafe public areas.

D. Common Medical Component in Allegations

1. Pain so bad they will never work again.
2. Traumatic brain injury (TBI).
3. Chronic regional pain syndrome (CRPS).
4. Fractures.
5. Back injuries or surgeries.
   a. Can no longer participate in activities they did before the accident: walk, work, golf, play with kids, etc.

7. Degenerative v. acute conditions.
   a. The plaintiff states that the injury was first noticed after the loss (testifying that they had no pre-existing injury).

V. COMMON DEFENSES FOR INSURANCE LIABILITY CASES

A. Plaintiff's Injuries Were Present Prior to the Incident

B. The Mechanism of Injury Does Not Correlate with the Alleged Injuries

C. Plaintiff's Condition Is Degenerative, Not Acute or Traumatic

D. Plaintiff Delayed Seeking Medical Treatment After the Incident

E. The Treatment Is a Continuation of Prior Medical Care

F. Plaintiff Treated with Unnecessary Treatment for Stipulated Medical Condition

G. Plaintiff Sustained Additional Injuries After Incident Exacerbating the Alleged Injuries or Causing New Injuries

VI. THE ROLE OF THE CERTIFIED LEGAL NURSE CONSULTANT™ IN INSURANCE LIABILITY CASES

A. Interacts with Multiple Parties for Each Case (Claim)
   1. Claims representatives.
   2. Defense attorneys.
   3. Mediators (an attorney or judge) with defense attorney (on occasion the plaintiff attorney also at mediation).
4. Insurance company’s education division and other educators.

5. SIU (special investigations unit) for fraud or criminal investigations.

B. **Ensure an Educated Staff and a Successful Outcome**


2. Informal consultations.

3. Case (claim) analysis and report writing.
   a. The claims representative submits to the CLNC® consultant specific requests or concerns regarding the claim and the records to be reviewed.
      (1) Targeted review for a specific need, not screening for merit.
         (a) Causation.
         (b) Overutilization.
         (c) Gaps in treatment.
         (d) Pre-existing conditions.
   b. Records review.
      (1) Organize, review and analyze medical records.
         (a) Often electronic within specialized systems.
         (b) Usually do not include all records – only relevant ones.
      (2) Prepare a brief report or opine to facts, not to the merits of a case or claim.
      (3) Prepare a detailed chronology with case analysis and recommendations.
      (4) Prepare requests for production and interrogatories.
      (5) Review SIU records (criminal background checks).
      (6) Review police and accident reports.
      (7) Review photographs.
      (8) Review school and employment records.
      (9) Identify files for expert opinion.
      (10) Provide medical research on related medical issues.
      (11) Identify and obtain expert witnesses and medical reviewers.
      (12) Prepare deposition questions for peer review, claims representatives, defense attorneys, IMEs, expert witnesses.
      (13) Review and analyze expert witness reports and depositions.
(14) Review and audit medical billing.
   (a) Norms versus overutilization.
   (b) Billing fraud.

4. Roundtables.

5. Mediations.

C. Analyze Specific Conditions or Procedures

1. Pain.
   a. Interview witnesses.
   b. Attend IME to understand limitations.
   c. Obtain life care plan factoring in training for new job.
   d. Identify by examples the plaintiff’s lack of credibility.
   e. Identify inconsistencies in testimony.
   f. Prepare attorney to demonstrate plaintiff’s general truthfulness.

2. TBI.
   a. Observe plaintiff doing activities *sub rosa* inconsistent with disability.
   b. Obtain statements from employers and unbiased people about the condition.
   c. Obtain neuropsychologist evaluations.
   d. Locate testifying experts, e.g. biomechanical engineers.

3. Chronic regional pain syndrome (CRPS).
   a. IME to identify if it is CRPS or a similar pain syndrome.
      (1) If not legit, claims reps focus on the same as TBI to defend (IME, observing *sub rosa*, witness qualifications).

4. Fractures, back injuries or surgeries
   a. Evaluate to understand strengths and weaknesses of the injury case.
   b. Obtain neuroradiologist review of diagnostics.
   c. Attend IME.
   d. Interpret witness qualifications to help shape the strategy.

5. Limitations.
   a. Film the plaintiff *sub rosa* performing the very same tasks or similar tasks.
      (1) Extremely useful in proving to the jury that the plaintiff is not being truthful.
6. Degenerative v. acute conditions.
   a. Obtain all the plaintiff's medical records.
   b. Request the pharmacy records of all the pharmacies in the
      plaintiff's neighborhood.
   c. Have the medical records evaluated by a medical expert.
      (1) A radiologist can opine on whether the injury is
degenerative or acute.

VII. INTERROGATORIES AND REQUESTS FOR PRODUCTION

A. Interrogatories Directed to the Plaintiff

1. Please identify each physician who examined or treated plaintiff
   from (Date) __________ to (Date) __________.
   a. Name.
   b. Address.
   c. Specialty.
   d. The nature of each health problem and the date of each
      exam or treatment.

2. Identify each medical facility where you have been admitted or
   presented for treatment and/or examination in the (5) five years
   prior to the incident that is the basis for this litigation from (Date)
   __________ to (Date) __________.
   a. Name.
   b. Address.
   c. Phone number.
   d. The nature of each health problem and the date of each
      exam or treatment.

3. Please describe where and how you believe the incident happened,
giving all events in detail and in order in which they occurred.

4. Please describe all conversations at the accident scene, including
   conversations with any police officer.

5. List plaintiff's employment history from (Date) __________ to
   (Date) __________.

6. Itemize the specific medical bills and list any other damages for
   which plaintiff is seeking compensation.
7. Please list the following for any photographs or recordings taken at the accident scene:
   a. Number of photographs related to incident.
   b. Date on which such photographs and recordings were taken.
   c. Person who has custody and control of said photographs and recordings
   d. Persons who were present when said photographs and recordings were taken.

8. Please list lawsuits or workers' compensation claims plaintiff has been a party to.
   a. Name.
   b. County.
   c. Case number.

9. Please list the name and address of any and all pharmacies where plaintiff has filled prescriptions from (Date) __________ to (Date) __________.

10. Please identify any prior injuries (physical or mental) from which plaintiff suffered which are similar to the injuries claimed in this lawsuit or in the same location as the injuries claimed in the lawsuit or that affected the same areas or tissues.
    a. Surgeries.
    b. Diseases.
    c. Illnesses.
    d. Pre-existing genetic conditions.
       (1) Nature of the problem.
       (2) Where and when plaintiff first suffered it.
       (3) Whether plaintiff still suffers from it.
       (4) Full name and address of each physician or other healthcare provider who has treated plaintiff or who has assigned a disability rating to plaintiff.

11. Please list any intoxicating beverages or drugs plaintiff consumed from (Date) __________ to (Date) __________.

12. Describe plaintiff's educational history.
    a. Names and locations of schools of any type.
    b. Years of attendance at each.
    c. Diploma, certificate, degree and any scholastic honor obtained at each.
B. Requests for Production Directed to the Plaintiff

1. Please provide copies of any and all materials evidencing the condition of the plaintiff from (Date) __________ to (Date) __________.
   a. Narrative medical reports.
   b. Hospital records of treatment.
   d. Other records and/or reports.

2. Please provide copies of all costs incurred for treatment to the plaintiff from (Date) __________ to (Date) __________.
   a. Medical bills.
   b. Pharmacy bills.
   c. Hospital bills.
   d. Other bills and evident costs.

3. Please provide color copies of any and all photographs, movies or video recordings allegedly showing the condition of the plaintiff from (Date) __________ to (Date) __________.

4. Please provide color copies of all photographs, diagrams, video recordings, maps or sketches evidencing the scene or site of the accident on (Date) __________.

5. Please provide any and all color copies or negatives of any and all images of plaintiff’s vacations or travel taken after the date of incident that is subject of this lawsuit.
   a. Photographs.
   b. Slides.
   c. Film.
   d. Video recordings.
   e. Other recordings.

6. Please provide copies of all diagnostic films or scans depicting parts of plaintiff’s body claimed to have been injured as a result of the accident which is subject of this lawsuit. This request includes films taken both before and subsequent to said accident.
   a. MRIs.
   b. CT scans.
   c. X rays.
   d. Myelograms.
   e. Bone scans.
VIII. RECOMMENDED QUALIFICATIONS FOR AN IN-HOUSE CERTIFIED LEGAL NURSE CONSULTANT™ IN INSURANCE CASES

A. College Degree or Nursing Degree and Certification

B. Legal Nurse Consulting Experience (Three Years)

C. Claims Experience Strongly Preferred

D. Third Party Personal and Bodily Injury Experience

E. Medical and Nursing Knowledge

F. Managed Care Experience

G. Strong Clinical Background
   1. Orthopedic and emergency department.

H. Knowledge of Jurisdiction and Specific Medical Guidelines

I. Strong Knowledge of Medical Causation and Relatedness

J. Strong Knowledge of Medical Standards of Care

K. Strong Research and Analytical Skills

L. Effective Time Management and Organizational Skills

M. Computer Efficiency

N. Knowledge of Business and Technology

O. Adaptability and Ability to Work Independently
IX. EXHIBIT: SAMPLE REPORT

   A. Commercial and Personal Injury – Slip and Fall (Exhibit A)

X. RESOURCES

   A. Websites


      2. ClinicalKey® (formerly MD Consult). clinicalkey.com

      3. MDGuidelines®. mdguidelines.com
EXHIBIT A
Commercial and Personal Injury: Slip and Fall

Insurance Company Name / Logo
Confidential Work Product

Date: 03/06/2013
To: Awesome Claims Representative
Insured: Yummy Cafe
Claimant: Mr. Clumsy
Loss Date: 08/09/2010
Claim No. 00000000

Purpose of Review

- Alleged Injury: Right and left knee injury requiring knee replacement.
- Concerns and Issues: Knee replacement was two years post loss. With claimant being a runner and very active, this may have happened without the loss.

Analysis

The claimant (Mr. Clumsy) is a 71-year-old English speaking male. His height is 6’ and weight is 200 pounds, placing his body mass index (BMI) at 27.18. He is classified as overweight. He is a former smoker with a history of hypothyroidism, hypertension, GERD, heartburn and several drug allergies.

Per the deposition summary, the claimant was walking behind a hostess who was showing him to his seat in the insured’s restaurant, and slipped on the floor. His right foot went in front of him and left leg popped. He landed on his right buttocks and right elbow and was flat on his back. He was not carrying anything. He said his knees hurt a little. He remained at the restaurant 45 minutes, had breakfast and was able to drive home. He did not seek any emergency department or paramedic help. The date of loss, he claims he had pain in his back, elbow, bilateral knees and took Tylenol. The next day he felt pains all over his body and he took Tylenol. He went to see an orthopedic physician for bilateral knee pain, back pain and elbow pain.

Records Fall Descriptions

As described on 08/13/2010 at Dr. Bone’s office, the fall was four days ago when he slipped at a restaurant, lost his footing, went down and hyperflexed his right knee. He noticed low back discomfort, but did not think much of it. His knee became sore and achy that night; his back stiffened in a few days and he had pain with movement.
On 10/28/2010 Dr. Bone’s note indicates the claimant fell back on his outstretched hand. At physical therapy on 11/17/2010, the fall was described that he fell at a restaurant; landed on his right knee bent under him and then braced himself with his right arm extended behind him.

**Running Did Not Contribute to the Osteoarthritis, But There Were Other Risk Factors**

*Recreational running does not contribute to degenerative joint disease.* See “Running and Osteoarthritis” by Willick et al. in *Clinics in Sports Medicine*, Volume 29, Issue 3 (July 2010); *Wilderness Medicine, Sixth Edition*.; and Kelley’s *Textbook of Rheumatology, Eight Edition*. Also, Mr. Clumsy engaged in that activity prior to the date of loss.

He was diagnosed with osteoarthritis prior to this date of loss and had an increased risk and contributory factors for developing osteoarthritis including age, smoking, obesity and history of trauma or repetitive occupational trauma (activities that require frequent bending or carrying heavy loads). He worked as a plant manager for 44 years, participates in weightlifting in his workouts and past participation in high-impact sports such as football.

He did participate in jogging or running up through his first right knee arthroscopic surgery in 1998; and he appears to have started running or jogging again a few months postoperatively. He had a second right knee surgery in 2001 after which he continued to be actively “working out at the gym with a friend” including weight lifting and walking five to six miles a day when he could no longer run or jog.

**Left Knee**

Based upon the records, it seems unlikely that Mr. Clumsy required the 02/22/2012 left knee arthroscopy or 08/29/2012 left knee replacement due to the 08/9/2010 incident. Four primary factors lead to this conclusion:

First, on 08/13/2010 (five days after the fall), Dr. Bone’s exam revealed his left knee was nonirritable. Although Mr. Clumsy testified at deposition that he heard his left knee pop at the time of the fall, this was not reported to his physicians at any time.

Second, Mr. Clumsy did not complain of left knee pain until 11/15/2010, more than three months after the fall. Had Mr. Clumsy injured his left knee in the fall, one would have expected him to voice complaints earlier. Also, the recordation seems questionable, because the 11/15/2010 exam and diagnosis both focus on the right knee, not the left. It is not unusual for a physician to inadvertently note “left”, when they mean right.

Third, after 11/15/2010 no further complaints about the left knee were recorded, despite multiple physician office visits, until 06/02/2011.
Fourth, almost two years before the fall, Dr. Joint noted that left knee replacement might be required. The first documented left knee pain was on 03/12/2004. The X rays revealed marked medial joint space narrowing and advanced patellofemoral arthrosis.

On 06/13/2008 the claimant saw Dr. Joint for left knee pain. X rays revealed tricompartmental arthritis mostly involving patellofemoral joint. He recommended a steroid injection of the left knee, but the claimant declined because he was symptom free at the time.

On 9/26/2008 Dr. Joint had noted that Mr. Clumsy had severe degenerative joint disease of both knees, which might warrant knee replacement in the future.

On 01/08/2010 the claimant saw Dr. Bones for complaints of bilateral knee pain. Examination showed the left knee with prepatellar swelling and prepatellar and suprapatellar point tenderness. The impression was mild prepatellar bursitis.

**Right Knee**

When Mr. Clumsy eventually undergoes right knee replacement, it is unlikely that the need for the procedure will have arisen due to the 08/09/2010 fall. Right total knee replacement was recommended on 09/26/2008; almost two years before the event. However, like many patients, Mr. Clumsy declined to undergo the procedure at that time. After the fall, the acute findings appear to have resolved by 11/25/2010. Mr. Clumsy has continued to decline right knee replacement, although he has had recurrent symptoms and additional treatment since that time.

After the fall on 08/13/2010, Mr. Clumsy did complain of increased pain. A mild effusion was present, along with medial joint line tenderness. However, his range of motion remained 5-125 degrees, just like it had been at the last pre-fall visit on 01/8/2010. Dr. Bone diagnosed “Osteoarthritis of the knees; the right knee aggravated by the fall”. It is possible that a fall on a hyperflexed knee could have exacerbated his pre-existing arthritis.

By 08/24/2010 the effusion had resolved and by 11/25/2010, Dr. Bone noted no significant irritability. The aforementioned notes suggest that Mr. Clumsy may have sustained a temporary aggravation of his knee arthritis, which resolved by 11/25/2010.

Mr. Clumsy did return to Dr. Bone on 01/7/2011 with complaints about his right knee motion. However, the range of motion was unchanged from 01/08/2010, before the fall. The exam findings were unchanged at the 03/03/2011 visit, as well. Three Synvisc injections were administered between 03/23/2011 and 04/06/2011. Thereafter, additional complaints of right knee pain were recorded on 05/11 and 06/16/2011.

After a six-month gap, additional right knee complaints were recorded on 11/08/2011. Four and a half months later, 03/23/2012, right knee pain was again recorded. These
gaps in complaints seem typical of the waxing and waning progressive nature of the pre-existing degenerative osteoarthritis, rather than continuous exacerbation from the 08/09/2010 fall. However, Mr. Clumsy will probably contend that he was focused on treating his low back and his left knee at the time.

One must consider the impact of his medical history which includes two previous knee surgeries; multiple Orthovisc, Synvisc and steroidal injections, and two previous falls before this fall affecting the right knee. Each of these items affects the integrity and stability of the knee, and influences the production of arthritis.

The claimant’s right knee symptoms actually began at some point in the ‘80s. When the claimant began treating with The Ortho Group in 1999, he stated he injured his knee about 15 years before. He recalled having the knee aspirated. An MRI was done, and he was told he may have had some cartilage damage. Dr. Bone began treating him at that time and his initial impression was of right knee pain and effusion with possible internal derangement. A new MRI showed degenerative changes in the medial joint, but no frank meniscal tear. In August 1999, Dr. Bone noted he “will eventually need a total knee replacement arthroplasty.” He received steroidal injections.

In August 1999 he had a diagnostic arthroscopy, partial medial meniscectomy and synovectomy. During the procedure the findings included significant radial tear of the medial meniscus, degenerative changes in the medial compartment with an area of eburnated bone along the medial side of the medial femoral condyle and a large medial synovial plica.

He attempted to start jogging and running again in January 2000. His right knee pain persisted in 2001 and 2002 and extended to his right hip. He was given steroidal injections. On 05/07/2002 a right knee X ray revealed significant joint space narrowing medially which was really not much different than two years before.

On 05/22/2002 the claimant saw Dr. Bones because he injured his right foot the previous day while walking his dog on a slope. The slope gave way and he fell five feet sliding down the slope and jamming his right foot with his knee extended. He was having hip, back and leg discomfort. The impression was a soft tissue injury and nondisplaced stable-appearing fracture of the right foot along the fourth metatarsal.

On 07/26/2002 an MRI of the right knee revealed:

- Tricompartmental degenerative osteoarthritic joint disease with severe degree of medial joint compartment narrowing.
- Anterior cruciate ligamentous tear, probably intrasubstance type.
- Mild joint effusion.

Synvisc injections were given next. X rays on 12/21/2002 revealed narrowing of the medial compartment of the knee joint, degenerative changes of the patellofemoral joint;
mild joint effusion and osteophytic spur projecting posteriorly from the tibial plateau. The bone scan showed osteoarthritis.

On 12/27/2002 Dr. Bone performed an abrasion arthroplasty and debridement done arthroscopically of the right knee. Surgical findings included:

- Advanced arthrosis in the medial compartment with extensive eburnated bone throughout the medial femoral condyle.
- Eburnated bone on the medial aspect of the tibial surface with the patient being status post partial medial meniscectomy.
- Large anterior osteophyte
- Small osteochondral loose body.
- Some degenerative fraying of the meniscus.
- Patellofemoral joint had moderate degeneration with grade two and early grade three chondromalacia in the groove and medial patellar facet.

Right knee pain resumed in February 2003 and steroidal injection was given. In April 2003 Dr. Bone discussed the possibility of future surgical treatment options including a medial cobalt joint spacer.

On 03/12/2004, the X rays revealed minimal medial joint space narrowing, advanced patellofemoral arthrosis – worse than left knee. On 04/23/2004 a cardiology note states “Fell this morning walking dog; Clonopin for sore left hip and right knee.” The note from the orthopedic group states “Fell 2 days ago while walking his dog – slipped on some mud. Feet went out from under him and he landed on his left buttock.”

By 06/09/2004 Dr. Bone was recommending surgery. He discussed lengthening the iliotibial band, possibly the lateral hamstring and knee arthroscopy. He also was considering left knee injections. On 06/13/2008 he saw Dr. Joint for right knee pain. X rays revealed tricompartmental arthrosis mostly in the medial compartment. In 2008 he continued to workout with a friend in a gym. He did not attend to the recommended physical therapy on several occasions for his knees and back.

On 09/26/2008 Dr. Joint noted that Mr. Clumsy’s knees had severe degenerative arthritis, especially the right, which might warrant knee replacement in the future. Mr. Clumsy decided he wanted to pursue nonoperative treatment.

On 05/29/2009 the claimant saw Dr. Bone for complaints of increased difficulty with his right knee with exercise and walking the dog on uneven hills. When sedentary he had very little pain, and he wanted to be more active. A right knee X ray revealed advanced osteoarthritis with significant medial joint space narrowing and quite severe patellofemoral changes.

On 01/08/2010 the claimant saw Dr. Bone for complaint of bilateral knee pain when touched and walking for three months. He had maintained regular activity and gave up running. He was walking five to six miles a day. Examination showed the right knee with
chronic swelling, bony hypertrophy and thickening of the bone, especially medially, no tenderness, range of motion 5-125 degrees, stable. The impression was mild prepatellar bursitis.

**Low Back (Lumbar Spine)**

Based upon the medical records, it appears that Mr. Clumsy may have experienced a temporary aggravation of pre-existing lumbar degenerative disease, due to the fall. The claimant’s first medical care after the fall was on 08/13/2010 (five days after the fall), with his regular treating orthopedic physician, Dr. Bone. The exam revealed he had a twinge of back pain when he moves suddenly, twists or gets up from sitting. He had spine irritability with good overall motion, no spasm and no neurological deficit. He was diagnosed with a low back strain with some mechanical back pain probably due to the fall.

X rays on 08/24/2010 revealed a significant degenerative change in the disc spaces both above and below the sixth lumbar vertebrae and facet degeneration. A note on 09/25/2010 indicated he was doing occasional weight lifting. If he was already lifting weights a month after injury, he was likely feeling recovered and not experiencing pain. Lifting weights is not recommended for those with back pain or strains.

One might consider the claimant’s later complaints of low back pain in the context of his anatomy, and his pre-existing history of presenting back pain. A transitional vertebrae is a congenital abnormality that may be contribute to back pain. The presence of a transitional lumbosacral vertebrae refers to a total or partial fusion of the transverse process of the lowest lumbar vertebrae to the sacrum. Increased prevalence of disk protrusion or extrusion above the transitional vertebrae or altered biomechanics associated with asymmetric transitional vertebrae may account for the pain. Rubin DI “Epidemiology and Risk Factors for Spine Pain”, *Neuro Clin*. 25(2): May 01, 2007, 353-371.

Mr. Clumsy has an extensive history of low back pain and degenerative lumbar disease pre-dating the fall. On 05/30/2002 a chest X ray revealed prominent spurring in the lower half of the thoracic spine.

On 06/05/2002 the MRI of the lumbar spine revealed:
- Disc dehydration T12-L1.
- Schmorl’s node at the inferior endplate of T12.
- L3-L4 left lateral disc bulge – 4mm bulging into the inferior aspect of the left neural foramen obtunding the epineural fat. No significant extradural indentation is noted upon the thecal space.
- L4-L5 rather marked disc space narrowing with degenerative disc disease and disc dehydration.
- L5-S1 disc dehydration moderate degree. 2mm broad-based generalized disc annular bulge at this articulation not causing significant thecal sac indentation.
In 2007 he complained of right hip pain and was diagnosed with inflammatory and arthritic pain from the lumbar spine of the SI (sacroiliac) joint and not the hip, based on hip X rays.

On 06/13/2008 the claimant saw Dr. Joint for low back pain. Lumbar spine X rays revealed a transitional vertebrae between L5 and S1 junction, degenerative changes extending throughout the lumbar spine most prevalent from L4 to sacrum and facet arthropathy. His impression was lumbar degenerative disc disease and spondylosis.

**Neck (Cervical Spine)**

It is unlikely that Mr. Clumsy’s later complaints of neck pain are related to the fall. After the fall, the claimant complained for the first time since the fall (date of loss) of increased neck stiffness or tightness beginning on 10/28/2010 (12 weeks after the fall). There is a significant gap in time between the fall (date of loss), and claimant’s first reporting of neck pain. One might consider this pain as a reoccurrence of the arthritis pain he has experienced in the past.

The first documented cervical complaints in the records are cervical spine X rays done on 03/05/2001 which revealed:

- Intervertebral disc spaces C3-4, 5-6 and 6-7 moderately narrowed with associated hypertrophic changes anteriorly and posteriorly.
- Uncal spurs project mildly into the neural foramina C3-4, 5-6 and 6-7 bilaterally.
- Calcification in the anterior longitudinal ligament C4-5.
- Hypertrophy of the apophyseal joints C3-4.
- Cervical spondylosis with degenerative disc disease and neural forminal stenosis and described above.
- Osteoarthritis C3-4 level.

On 3/16/2002 the claimant saw Dr. Bone for neck pain radiating to his occipital, scalp and upper back areas. The X rays showed degenerative changes. Interim he had improved and was no longer having pain. The claimant stated he had several minor neck injuries over the years, especially playing football. The impression was cervical spondylosis aggravation.

On 09/26/2008 the claimant was seen by Dr. Joint for neck pain. The impression was cervicalgia with suspected degenerative disc disease. Physical therapy was ordered.

**Right Elbow**

*It is unlikely that Mr. Clumsy’s later complaints of right elbow pain are related to the fall.* The claimant’s first post-fall complaint of right elbow pain was on 10/28/2010 (12 weeks after the fall) to Dr. Bone. Had he injured his elbow in the fall, he probably would have reported it earlier. One might consider this pain as a reocurrence of the arthritis pain he has experienced in the past (2001 and 2007).

[Contents]
In November 2001 the claimant saw Dr. Bone for right elbow problems for the past year and a half. He stated he had numerous past traumas to his elbow. He played baseball and football growing up. An X ray of the right elbow revealed degenerative changes, primarily at the radiocapitellar joint, with severe narrowing and irregularity of the capitellum and osteophyte formation off the coronoid process. Dr. Bone’s impression was degenerative changes right elbow, likely an old capitellar osteochondritis which now developed into arthritis. He was given a steroidal injection.

On 06/01/2007 the claimant complained of right elbow pain to The Ortho Group, which he had for a month that was affecting his workout (bicep curls). Right elbow X rays revealed radial capitellar joint space narrowing and arthritis and a small osteophyte a medial epicondyle. The impression was medial epicondylitis, an osteoarthritis of the right elbow. He was given a steroidal injection.

Suggestions

To ensure you have all of the records related to this claim for evaluation and investigation, please request updated medical records including any photographs, tests, EMGS, and a complete set of films starting from six years prior to the date of injury (08/09/2010) to present including MRIs, CT scans, X rays or myleograms of the bilateral knees, lumbar spine and cervical spine from the following facilities and providers:

1. Total open MRI, (address).
   a. Dr. Visual (radiologist).

2. Open-ended MRI, (address).
   a. Dr. Radiation (radiologist).

3. School of Medicine, Department of Neurology, (address).
   a. Dr. Nerves (neurologist).

4. Internal Medical Group, (address).
   a. Dr. Days.
   b. Dr. Nights.
   c. Dr. Investigator.
   d. Dr. New.
   e. Dr. Pain.

5. Amazing Specialty Surgery Center, (address).
   a. Dr. Bones.

6. Community Orthopedic Medical Group, (address).
   a. Mr. Ortho, PA-C.
   b. Mr. Muscles, PA.
   c. Dr. Bones (orthopedic surgeon).
d. Dr. Joint.
e. Dr. Views (radiologist).

7. Super Hospital, (address).
   a. Dr. Gut (gastroenterologist).
   b. Dr. Internal.
   c. Dr. Emergency.

8. Mission Regional Imaging Center, (address).
   a. Dr. Flash (radiologist).
   b. Dr. Film (radiologist).

9. Beach Area Orthopedic Rehabilitation and Physical Therapy, (address).
   a. Mr. Happy, PT.
   b. Dr. Joint.

To assess causation, nature and age of alleged bilateral knees, lumbar spine and cervical injuries:
   1. Once medical records and films are retrieved (as noted above) consider:
      a. Neuroradiologist evaluation and film review.
      b. Orthopedic medical record and film review.

Request payout records from the claimant’s insurance providers starting from three years prior to the date of injury to present to identify all prior and current treating physicians involved in his care and treatments provided.
   • Blue Shield, Policy # XEA000000000, Group # 0000000000 (address).
   • Medicare Part A and B.
   • Health Plan, Policy # XOXOXOXO, Group #000000, c/o Super Administrators (address).

Treatment: NOTE: The following chronology does not identify every treatment note reviewed. Rather, it references only those notes most significant to the undersigned’s analysis of the claim.

Records Reviewed and Treatment *(List most relevant records in chronological order.)*

<table>
<thead>
<tr>
<th>Date</th>
<th>Location Provider</th>
<th>Description / Service</th>
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I hope you find this report helpful to your analysis of the claim. Please call me with questions.

Tina R. Aluzzi, RN, BSN, CLNC
Nurse Consultant
This is not intended to be a medical diagnosis or a determination of liability. It is a review by a healthcare professional to assist in claim evaluation. The review is based on the records and documents presented at the time of review. If additional records or documents are obtained, this review may be modified as necessary. This report is confidential and privileged as work product. This report should not be produced, in whole or in part, to any individual or entity, other than the claims representative assigned to the claim and defense counsel, without prior approval from Nursing Management.