

Health Point Occupational Rehabilitation Functional Capacity Examination

Section 1: Data and History

Client Name:	L M	Secondary Diagnosis:	s/p cervical fusion x 2
Date of Birth:	1/1/54	Physician:	Dr. Ortho
Social Security:	XXXXXXXX	Employer:	Ship Building Co.
Date of Injury:	6/1/01	Employment Status:	Unemployed
Diagnosis:	S/p Laminectomy	Work Status:	OOW
Job Title:	Rigger	Date of Evaluation:	5/30/08
Claim #:	XXXXXXXX	Insurance:	Ship Building Co.
Adjuster:	Ms. Adjuster	Therapist	Adam Iannazzo, MPT

Verbal Job Description By Client: NA not a RTW FCE

Past Medical History:

High Blood Pressure:	Y			Kidney Disease:		N
Nervous Disorder:		N		Heart Disease:		N
Pregnancy (at this time):		NA		Diabetes:		N
Balance Disorder:	??			Seizures:		N
Tuberculosis:		N		Headaches:	Y	
Other: Permanent nerve damage left over right. Clavicle Fracture						

History of Current Injury: On the DOI I was going up a ladder 12 feet up and I fell hitting the steel deck hitting a steel column fracturing the tailbone. I also hit my head on the ladder. Dx: fractured tailbone, ?? fractured vertebrae and concussion. Released after a few days and started PT after a few weeks for the neck but it didn't help and the MRI was ordered and it was about 4 months after the injury. After the fracture was found, they set up the surgery but the day of my surgery, my appendix ruptured and I had that surgery which put me down for about 6 weeks and I almost died. Then they did the neck surgery (C5, 6 fusion) with the halo and all. I had C6-7 fusion four years later. In regards to the back, I have had 6 injections, 3 before the foramotomy and 3 after. The surgery caused me to lose feeling in my foot and toes on the right. I have had EMG's showing damaged nerves. I have done a lot of PT for the neck and the back. The doctor has now P&S'd me and am here now.

Resting Heart Rate: 68

Blood Pressure: 135/98

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Section 2: Musculoskeletal Evaluation

Cervical AROM	Degrees
Flexion (80)	40
Extension (70)	28
RSB (45)	28
LSB (45)	28
R Rot (70-90)	50
L Rot (70-90)	34

Myotomes	Left	Right
C4 Shoulder elevation	5	5
C5 Shoulder abduction	5	5
C6 Elbow flex/wrist ext	4	5
C7 Elbow ext/ wrist flex	4	5
C8 Thumb extension	4	5
T1 Intrinsic (finger abd)	5	5

Shoulder AROM	R	L
Abduction	160	155*
Flexion	145	145*
ER	30	24
Apley's IR	32	32
Ext	65	44
IR at 90 of Abd	75	55*
ER at 90 of Abd	72	72

Shoulder Strength	R	L
Abduction	5	4
Flexion	5	4
ER	5	4*
Apley's IR	5	4*
Ext	5	5
IR at 90 of Abd	5	4+*
ER at 90 of Abd	5	4+*

*shoulder pain

Lumbar AROM	Degrees
Flexion (40-60)	15 **
Extension (20-35)	5**
RSB (15-20)	0**
LSB (15-20)	0**
R Rot (3-18)	3**
L Rot (3-18)	0**

Myotomes	Left	Right
L2 Hip flex	4+	5
L3 Knee Ext	4	5
L4 Ankle DF	4-	5
L5 Halux Ext	4	5
S1 Ankle PF	3	4
S2 Knee flex	4	5

** Left LBP

Hip AROM	R	L
Flexion (115)	65	65
Extension (15)	NT	NT
Int. Rot (40)	25	25
Ext. Rot (50)	25	22
Abduction (45)	NT	NT
Adduction (30)	NT	NT

Hip Strength	R	L
Flexion	UA to test	
Extension	UA to test	
Int. Rot	5	4
Ext. Rot	5	4
Abduction	5	5
Adduction	5	5

Elbow Strength	R	L

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Flexion	5	5
Extension	5	5

Elbow AROM	R	L
Flexion	145	145
Extension	0	0

Wrist Strength	R	L
Flexion	5	5
Extension	5	4
RD	5	5
UD	5	4
Pronation	5	5
Supination	5	5

Wrist AROM	R	L
Flexion	WNL	WNL
Extension	WNL	WNL
RD	WNL	WNL
UD	WNL	WNL
Pronation	WNL	WNL
Supination	WNL	WNL

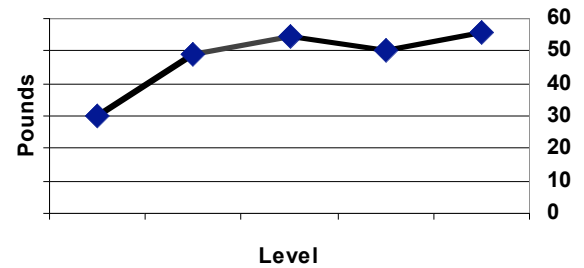
Waddell's

Test	Positive	Negative	Comments
Simulated Trunk Rotation	To the right		At left low back
Distracted Straight Leg Raise	R L X	R X L	Left at 25 degrees while supine
Superficial Palpation	X		Left low back.
Axial Compression	X		

Right

Grip (pounds)	Trial 1	Trial 2	Trial 3	Mean
Level one	26.0	32.6	32.4	30.3
Level two	49.8	47.6	49.0	48.8
Level three	51.4	56.2	55.2	54.3
Level four	47.9	49.3	52.9	50.0
Level five	63.1	55.5	47.9	55.5

Right Grip Strength



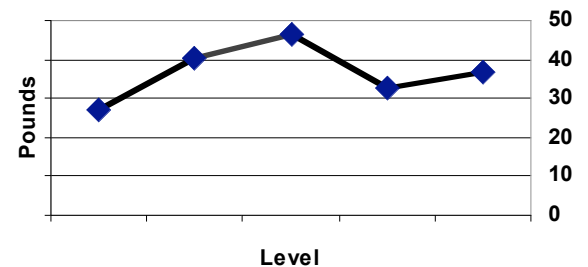
Pinch (pounds)	Trial 1	Trial 2	Trial 3	Mean
3 Jaw Chuck	10.7	13.2	17.1	13.7
Key Pinch	23.7	24.7	26.9	25.1

Sitting for levels 4 and 5.

Left

Grip (pounds)	Trial 1	Trial 2	Trial 3	Mean
Level one	20.2	25.5	35.5	27.1
Level two	41.2	43.8	36.4	40.5
Level three	57.4	46.0	35.2	46.2
Level four	38.3	36.9	32.6	32.6
Level five	36.9	41.0	32.4	36.7

Left Grip Strength



Pinch (pounds)	Trial 1	Trial 2	Trial 3	Mean
3 Jaw Chuck	10.7	13.2	17.1	13.7
Key Pinch	23.7	24.7	26.9	25.1

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3 Jaw Chuck	9.0	10.1	11.5	10.2
Key Pinch	14.3	13.8	13.2	13.8

GRIP STRENGTH TEST NORMS

Age	15-19		20-29		30-39		40-49		50-59		60-69	
Gender	M	F	M	F	M	F	M	F	M	F	M	F
Above Average	103-112	64-70	113-123	65-70	113-122	66-72	110-118	65-72	102-109	59-64	98-101	54-59
Average	95-102	59-63	106-112	61-64	105-112	61-65	102-109	59-64	96-101	55-58	86-92	51-53
Below Average	84-94	54-58	97-105	55-60	97-104	55-60	94-101	55-58	87-95	51-54	79-85	48-50
Poor	≤83	≤53	≤96	≤54	≤96	≤55	≤93	≤54	≤86	≤50	≤78	≤47

Section 3: Lifting Capacity

10 Rep Max

Task: Two-handed	Trial 1	Trial 2	Trial 3	Comments
Floor to knuckle Heart Rate	NT	NT	NT	Not tested secondary to safety issues with squatting.
Knuckle to shoulder Heart Rate	16.3	13.3	13.3	I can't do much more. Pt having involuntary spasm of left hand
Shoulder to Overhead Heart Rate	10.7	13.4	17.8	I'm done, I can't do any more.
Pushing Heart Rate	NT	NT	NT	Pt unable to complete this portion of the testing due to intense pain and fatigue
Pulling Heart Rate	NT	NT	NT	Pt unable to complete this portion of the testing due to intense pain and fatigue

Task: Right hand	Trial 1	Trial 2	Trial 3	Comments
Floor to knuckle Heart Rate	NT	NT	NT	Pt unable to complete this portion of the testing due to intense pain and fatigue
Knuckle to shoulder Heart Rate	NT	NT	NT	Pt unable to complete this portion of the testing due to intense pain and fatigue
Shoulder to Overhead Heart Rate	NT	NT	NT	Pt unable to complete this portion of the testing due to intense pain and fatigue
Pushing Heart Rate	NT	NT	NT	Pt unable to complete this portion of the testing due to intense pain and fatigue
Pulling Heart Rate	NT	NT	NT	Pt unable to complete this portion of the testing due to intense pain and fatigue

Task: Left hand	Trial 1	Trial 2	Trial 3	Comments
Floor to knuckle Heart Rate	NT	NT	NT	Pt unable to complete this portion of the testing due to intense pain and fatigue
Knuckle to shoulder Heart Rate	NT	NT	NT	Pt unable to complete this portion of the testing due to intense pain and fatigue
Shoulder to Overhead Heart Rate	NT	NT	NT	Pt unable to complete this portion of the testing due to intense pain and fatigue
Pushing Heart Rate	NT	NT	NT	Pt unable to complete this portion of the testing due to intense pain and fatigue
Pulling Heart Rate	NT	NT	NT	Pt unable to complete this portion of the testing due to intense pain and fatigue

(All numbers in pounds)	Sedentary	Light	Medium	Heavy	Very Heavy
Occasional = 1-33% of day	0-10	11-20	21-50	51-100	Over 100
Frequent = 33-66% of day	0-5	6-10	11-25	26-50	Over 50
Constant = 66-100% of day	0-2	3-5	6-13	14-25	Over 25

Section 4: Summary

Mr. L M is a 54 year old right handed male that worked as a rigger at Nassco full time and has been progressively getting increased back pain with disability due to an injury that occurred seven years ago secondary to a fall and then continued work with subsequent surgeries to the neck and back. Mr. M arrived on time for the examination and he was co-operative throughout the testing.

An upper body musculoskeletal examination was performed in the usual way for active range of motion and strength as described by Kendall. Muscle strength was graded on a 0-5 scale. Zero is no contraction, 1 is palpable contraction, 2 is less than 50% of the active range in a gravity eliminated position, 3 is full active range of motion against gravity, 4 is moderate resistance and 5/5 is maximal resistance against the extremity by the examiner. The musculoskeletal examination was the first portion of this examination and there were multiple findings to discuss. Firstly, it is explained to the participant that pain will not be the focus of the examination and only when it is reported will it be documented. If there is no complaint offered, it is assumed by the evaluator that there is no increase in pain or issue with the test performed. The cervical spine was limited in all planes but no pain or increased radiculopathy was reported. Myotomes for the cervical spine on the right were strong while left C6-8 were slightly limited. Both shoulders had functional range of motion with only abduction, flexion and internal rotation eliciting pain which was subjectively attributed to the clavicular fracture. The right shoulder was strong without pain while the left had weakness throughout with pain during internal rotation while abducted and external rotation at the side and at ninety degrees of abduction. Lumbar motion was extremely limited in flexion and extension while there was no ability to sidebend or rotate at any segment due to pain. Myotomes were strong on the right except for plantar flexion which was slightly limited. However, the left lower extremity had global weakness with plantarflexion being the weakest. It is of note that when manually testing the left dorsiflexors, the grade of 4 means the tester could "break" the resistance provided but when asked to walk on his heels; Mr. M was able bilaterally which is inconsistent. Both hips had functional range of motion during flexion and rotations. All other hip motions were not tested due to positional pain. Hip strength was strong on the right with some weakness only detected during rotations on the left. Mr. M had normal elbow motion and now had 5/5 strength which is inconsistent with myotomal testing just a few minutes earlier where weakness was present. A similar occurrence is noted during wrist strength testing during flexion on the left which was now strong as compared to myotomal testing earlier. Mr. M ambulates with and without a single

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point cane but is very unsteady and unsure on his feet and hunches significantly. During the entirety of the examination, every 15-20 minutes the client had to sit and rest due to increased low back pain. The rests usually lasted for no more than a few minutes and the examination lasted approximately 2.5 hours. The above MSK evaluation is consistent with a deconditioned man that has permanent disability due to years of inactivity and injury.

Waddell testing is done to assist in ruling in or ruling out non-physiological pain responses. This testing is performed as described by Waddell. Axial compression is a sustained pressure on the top of the head while the patient is in a standing position and should not elicit pain. Superficial palpation is a pinching of the skin and subcutaneous fat that should not result in increased complaints of pain. The distracted straight leg raise is done in two parts. First is the standard leg raising with no verbal cues by therapist about pain in back, just questioning about any general increase or decrease in pain. This is followed by a length of time where other parts are tested and then during deep tendon reflex testing, the Pt is sitting upright and one at a time the knees are extended to test the Achilles DTR. If Pt has consistent pain complaints in back during the straightening of the leg, the test is negative. However, if the Pt complains during the standard leg raise but not during DTR testing in sitting, the result is positive. Finally, simulated trunk rotation is performed in standing and the therapist turns the Pt at the hips and asks about pain. This should not elicit pain in back since the hips are moving. Mr. M had four out of five positive results showing signs of non-physiological pain responses or fabrication of symptoms with testing to show disability.

Grip strength is tested with the BTE Primus in the five level fashion for consistency of effort. The graph should represent a bell curve with the greatest strength in the second to third positions and then falling steady after that secondary to muscle length and the fact that muscles are strongest in the mid range of the arc of motion. Both graphs are not consistent due to the fact that level five increased in strength. Also, during level one, the number 26 is bolded because of the variability in the trials which also shows inconsistent effort. Another issue with pinch and grip testing is that Mr. M had very strong right sided key pinch testing which was stronger than level one grip testing which shows obvious inconsistent effort. When comparing Mr. M to men in a similar age group for grip, he falls into the poor class for men and in the below average class for women. Key pinch on the right for Mr. M falls within one standard deviation of the norm for men in a similar age group while the left is 3 standard deviations from the norm and is comparable to women aged 70-74. 3 jaw chuck had similar results where Mr. M was as strong as a 70-74 year old woman bilaterally. While there is obvious weakness due to documented neuropathy, the grip testing does not support Mr. M's claims of weakness due to the inconsistent nature of the results.

L M's lifting capacity was tested using the BTE Primus and he was blind to the amount of force he created isometrically during both tests. The Primus calculates a coefficient of variance (CV) to judge how consistent the effort is that the patient is demonstrating where a CV of 15% or greater shows an inconsistent effort with the lift. Only seated isometric lifting at the shoulder and overhead height was tested due to the client's reports of intense pain and the need to finish the examination and go home. The CV's of both tests were well above the 15% cut off but this could be due to the neuropathy and the client's inability to create a consistent force. Mr. M created only 10-18 pounds of force and this is consistent with a sedentary light classification as described by the DOL. Floor lifting was not tested for the safety of the client.

Pain was rated on a 10cm visual analog scale pre-FCE, post-FCE and was asked to fax, or call a 24 hour post report. Initially, Mr. M had difficulty understanding the VAS and was being coached by his wife. I asked her to allow Mr. M only to fill out the form and she left the room. Mr. M was obviously confused about the scale when he rated his low back pain at just 1.9 cm and the left leg at only 0.7 cm. When subjectively asked to rate

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on a 0-10 scale, he rated it at a seven. After the FCE was completed, Mr. M appeared to understand the VAS and rated his pain at 7.5 cm for the arm and neck and 8.5 for the low back. The left leg was not rated this time. After 24 hours, pain was rated at 4.1 for the arm and a 5 was written next to the words. The low back and leg were now rated at 9.8 with the number 9 written close to the line. I do believe this client has accurately portrayed his pain and is not exaggerating.

Section 5: Recommendations

While there are some inconsistencies noted above, it is obvious that there is a significant permanent disability since the injury and subsequent surgeries and I would place him in the sedentary lifting category and limit him to sustained sitting/standing for no more than 15 minutes. Any future employment would be limited to 2-3 hours at a time less than 3 days/week and would need to include the ability to change position and take breaks frequently. Since tolerance to activity can always improve, this client would also benefit from a home exercise program and the ability to try pool therapy in the future if requested.

Position/ Activity	Never	Rare 1-8% of an 8 hour day	Occasional 9-32% of an 8 hour day	Frequent 33-66% of an 8 hour day	Constant 67-100% of an 8 hour day
Standing		X			
Sitting		X			
Kneeling	X				
Squatting	X				
Lifting Floor to 33"	X				
Lifting 33" to 55"		10-16			
Overhead Lifting		10-18			
Pushing		X			
Pulling	X				
Carrying	X				

Adam Iannazzo, MPT

Date

I agree with the findings and Recommendations made by this FCE

Dr. Ortho

Date

I do not agree with the Recommendations made by this FCE and will propose my own.

Dr. Ortho

Date

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Addendum: 7/8/08

Client Name:	L M	Secondary Diagnosis:	s/p cervical fusion x 2
Date of Birth:	2/7/54	Physician:	Dr. Van Dam
Social Security:	552-94-3909	Employer:	Nassco
Date of Injury:	6/1/01	Employment Status:	Unemployed
Diagnosis:	S/p Laminectomy	Work Status:	OOW
Job Title:	Rigger	Date of Evaluation:	5/30/08
Claim #:	2001135	Insurance:	Nassco
Adjuster:	Jessica Yandall	Therapist	Adam Iannazzo, MPT

After reviewing the videos of 5/23/08, 5/29/08 and 6/9/08 of Mr. M it is clear that the functional capacity evaluation and the subjective data collected along with the objective findings are not at all indicative of what this client is capable and he was fabricating a disability and magnifying his pain during the entirety of the examination of 5/30/08. During the evaluation, Mr. M had trouble ambulating without a cane, standing for more than 5-10 minutes without need for rest and he was not able to sit cross legged comfortably or move his back more than a few degrees in any plane of motion or lift any substantial weight due to reports of intense pain and shaking/"tremors" of the hands due to the reported nerve damage.

All of the above objective findings were shown to be fabricated due to the fact that Mr. M was able to walk without a cane without antalgia on 5/23/08 at 7:27 am. He was able to bend into the trunk of a car at 7:03 am on 5/29/08 to greater than ninety degrees and sustain this position for over a minute without signs of discomfort or pain upon standing straight. On 5/29/08 at 7:28 am, he again reached into the back seat of his car and achieved well over 100 degrees of lumbar and hip motion with a forward reach. I feel that the most damaging evidence to Mr. M's reports made during the 5/30/08 examination is on 6/9/08 where he sat for over ten minutes with his leg crossed on the left and the right while at a local Starbucks for over an hour in the same position without rising which is in direct contrast to his reports that he is unable to sit for more than 15 minutes. Then on the same day, Mr. M was kneeling, quadruped and pulling when he was actually gardening which if the information attained during the FCE was actually the capacity of the client, would be absolutely impossible without terrible pain. Finally, no "tremor" of the hands was noted during any of the video.

While Mr. M may not be suited for his old position as a Rigger, he is obviously able to attain work at a job with sustained positions of sitting, standing and even pulling/pushing and lifting without fear of injury. Subjective reports of pain should no longer be taken as valid and only gold standard objective findings along with current standards of recovery for future employment as a competitive worker in an appropriate field based on the diagnosis and subsequent treatments rendered should be used for this client.

Adam Iannazzo, MPT

Date

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