Case 2
Re: Alfred W
Date of Injury: 7/8/07

Mr W was injured when he fell about eight or nine feet onto concrete. He hit his left buttock and left elbow. He was evaluated in the ER the day after the fall. His back was tender to palpation, his left elbow had superficial abrasions with good range of motion. The plain films of his back and elbow were normal.

He was re-evaluated 4 days post injury and had healing elbow abrasions, mildly diminished left elbow range of motion, and decreased back range of motion. His assessment was lumbar sprain, left elbow sprain.

He is re-evaluated on 7/27/07 and 8/9/07. He continues to have low back, left elbow and left shoulder pain. On 8/16/07, he was seen in urgent care, with no new injury, for back pain by Dr E. His exam was inconsistent. He was refused narcotics and the patient "left angry". He was then evaluated by Dr S, covering for his PCP on 8/16/07. He had persisting back pain, numbness into his right foot. No objective deficits were found on exam, and Dr S believed he had a low back strain.

He is revaluated on 8/30/07, with his lumbar strain nearly resolved and his left shoulder strain and left elbow contusion resolved.

He returned for evaluation on 9/13/07, with his back and left shoulder nearly back to normal. He had left "tennis elbow symptoms", without weakness in his left elbow. Dr E evaluated him on 10/2/07. The worker had extreme tenderness to the lateral left elbow; numbness and tingling. He was given a steroid injection. Dr E sets his work restrictions to no lifting greater than 5 pounds with his left hand. He diagnosed post traumatic left elbow epicondylitis and recommended additional conservative treatment prior to considering surgery.

What are three "red flags" in this worker's history?

Surveillance video of Mr W is provided for 4/11/08, 4/12/08, 5/16/08, 5/17/08, and 5/18/08. Mr W is seen at his unfinished home carrying multiple heavy objects with both hands, tossing heavy items into the debris bin, cutting tile on a tile cutter for several hours, and enjoying pleasure boating.

He presents again on 6/2/08. Dr E reports a failure of conservative treatment and opines he is a candidate for operative intervention.

When is surveillance video appropriate?

As en employer, how can you facilitate?

As an adjuster, how can you facilitate?

As a medical provider, how can you facilitate?

Dr E meets with the insurance adjustor later that month and views video; he notes that the worker has been violating his work restrictions.

He is re-evaluated by Dr E on 7/1/08. He had tenderness to palpation to the left lateral epicondyle. He opined the next course would be operative intervention, but he was unable to schedule until the workman's compensation claim was finalized.

On 7/3/08, he is seen for a second injury, which occurred the day prior on 7/2/08. This too was a fall, injuring his left shoulder, left elbow, and his left little finger. His left elbow range of motion was intact. His motor strength was intact. His PCP diagnosed left lateral epicondylitis, exacerbated, left shoulder strain, mild, and left pink strain, mild. He was re-evaluated on 7/7/08, with normal range of motion, normal strength but continued pain along the left elbow epicondyle.

He is re-evaluated on 7/8/08 by his PCP. He continues to have left elbow pain. He had normal range of motion of his left elbow. He had extreme tenderness to palpation of the left epicondyle. His assessment was left epicondylitis, unchanged.

He had an IME by Dr K on 8/5/08. Dr K. On exam, Mr W had some tenderness in the left lateral epicondylar region, some give way weakness on the left wrist. His assessment was: resolved contusion of the left elbow, resolved left shoulder strain, resolved lumbar strain, history of mild lateral epicondylitis that was unrelated to the work injury of 7/8/07, and history of contusion to the left fifth finger, resolved.

His PCP and Dr E concurred with the IME findings.

He is seen for an arbiter exam in January 2009.

With respect to his left elbow, Mr W reports that he has significant pain. The pain radiates into his middle fingers and occurs with full elbow extension and repetitive movement. He is on a lifting restriction of five pounds. He states he meets the lifting restriction by keeping his hand in his pocket or holding a pop can. With respect to his lumbar strain and left shoulder, Mr. W states he is doing a lot better. Currently he uses oxycodone and ambien for his left elbow pain.

On exam, on inspection of the left elbow, he has no scars, inflammation, or ecchymosis. On palpation, he has pain with light palpation at the lateral epicondyle.

The strength of his left elbow (flexion, extension) was 5-/5 with give way, and 5/5 on the right. The extension strength of his left wrist was 4/5 with give way and 5/5 on the right.

His range of motion of his left elbow was mildly decreased in flexion, pronation and supination as compared to the right.

At the end of the arbiter exam, while repositioning his shirt neckline with his left hand, his movement of his left upper extremity appeared more fluid than seen with formal range of motion testing.

What are the additional “red flags” for this patient?

What could have been done differently to help the worker?

Claims adjuster?

Doctor?

Employer?