Welcome to the WOEMA WINDOW. This e-newsletter is sent to members by email on a monthly basis. The e-newsletter provides links to this page. Below are the items that appeared in the August 2019 issue.

State of California
Department of Industrial Relations

STANDARDS BOARD ADOPTS EMERGENCY REGULATION TO PROTECT OUTDOOR WORKERS FROM WILDFIRE SMOKE

The California Department of Industrial Relations' (DIR) Occupational Safety and Health Standards has adopted an emergency regulation to protect workers from hazards associated with wildfire smoke, effective Aug. 1.

The emergency regulation is effective for only one year although a permanent rule is expected soon. It applies to workplaces where the current Air Quality Index (AQI) for airborne particulate matter (PM) is 151 or greater and where employers should reasonably anticipate that employees could be exposed to wildfire smoke. This will affect many employers who have a substantial number of outdoor workers such as in construction, agriculture, and transportation industries, to name a few. As mentioned, this is an emergency regulation and knowledge of its adoption make not yet be widespread..

The new regulation requires employers to take the following steps to protect workers who may be exposed to wildfire smoke:

1. Identify harmful exposure to airborne particulate matter from wildfire smoke before each shift and periodically thereafter by checking the AQI for PM 2.5 in regions where workers are located.
2. Reduce harmful exposure to wildfire smoke if feasible, for example, by relocating work to an enclosed building with filtered air or to an outdoor location where the AQI for PM 2.5 is 150 or lower.
3. If employers cannot reduce workers' harmful exposure to wildfire smoke so that the AQI for PM 2.5 is 150 or lower, they must provide respirators such as N95 masks to all employees for voluntary use.
4. Employers must provide training on the new regulation, the health effects of wildfire smoke, and the safe use and maintenance of respirators.

Click here to read the full document

The full text, including all requirements, exemptions and exceptions, will appear in the new Title 8 section 5141.1 of the California Code of Regulations.

On Aug. 27, the Cal/OSHA Standards Board will consider making the rule permanent at their meeting in Oakland.

FREE CME WEBINAR

THURSDAY, AUGUST 29 • 12:00 PM PDT

WEBINAR TOPIC: HOW TO BE CHOSEN AS A QME/AME

Speaker: Steven Feinberg, MD, MPH

This Webinar will address how to be chosen/selected as a QME and how to reach AME status. Issues discussed will include quality, timeliness, combining versus adding (The Kite case), and how to address complex issues of causation, apportionment and providing the most accurate impairment rating (Almaraz Guzman analysis).

Learning Objectives – After this webinar, participants will be able to:

- Understand how to get selected as the QME or being chosen as the AME
- Address complex issues of causation and apportionment
- Provide the most accurate impairment rating

Dr. Steven Feinberg is a physiatrist and pain medicine specialist practicing in Palo Alto. He is an Adjunct Clinical Professor and teaches at the Stanford University Pain Service. Dr. Feinberg is a past president (1996) of the American Academy of Pain Medicine (AAPM). He is lead author of the 2019 American Chronic Pain Association Resource Guide to Chronic Pain Treatment. Dr. Feinberg served as the ACOEM Chronic Pain Guideline Panel Chair. He is a member of the DWC Pharmacy and Therapeutics Committee.

[REGISTER NOW]

THE IME HANDBOOK – PART 3

PART 3 IN A NEW SERIES BY DR. STEVEN FEINBERG

Dear fellow WOEMA members, some of you may be interested in performing independent medical legal evaluations (referred to as an IME) in addition to evaluations done within the workers' compensation system. WOEMA presented a symposium at the WOHC 2017 Maui annual meeting in which Dr. Christopher Brigham and I provided a copy of our book, The IME Handbook. This is installment part 3 from that book. As always, I am personally available to you via email to answer any questions (stevenfeinberg@hotmail.com). This 3rd installment will cover the IME history and physical examination report writing.

Dr. Brigham has a web site devoted to IME education. While you will have access through the WOEMA Newsletter to the full IME Handbook in installments, the full IME Handbook PDF is available on his web site as well. There is a cost associated with Dr. Brigham's materials.

IME REPORT WRITING

Introduction

Physicians are aware of the usual details covered in a standard history and physical examination. The IME report goes into much greater detail in certain areas, as compared to a medical consultation; other factors contribute to the issues of perceived pain and disability.

The examinee's preinjury status is carefully detailed. It is very important to determine if there was any condition, impairment or disability predating the injury. The history of the injury, subsequent events and medical care up to the present time are carefully ascertained.

Any inconsistency between the individual's report and information found in the medical record is noted. It is important to remember that individuals often have selective memories and, sometimes, what they remember is not accurate. The premise that examinee reports are accurate has repeatedly failed scientific testing.[1] Studies have demonstrated that in addition to exaggerating preexisting health status, claimants tend to minimize their current health status, i.e., they tend to report they were better than they were prior to an injury and after the injury over report symptoms and functional difficulties.

Sadly, some examinees are "coached" prior to their evaluation by their attorney. The IME physician should be aware of this potential symptom bias when taking the examinee's history. Careful preparation with the medical records beforehand can be invaluable in detecting this bias.

The medical record is of critical importance; however, it is possible that the health care professional left something out or misunderstood the examinee. Therefore, just because something is not reported in the medical record does not mean that it did not happen. An evaluator considers all these factors. The IME physician is neither a magician nor fortune teller but must assess all the information available and provide a medically reasonable explanation, to a reasonable degree of medical probability (more likely than not).

Identifying Information

The report starts with identifying information of the name of examinee, claim or identifying numbers, date of injury, date of the evaluation and/or report, and the name of the examinee. For workers' compensation cases, the employer's name is often listed.

Any other parties present for the examination should be listed (attorney or the representative, interpreter or other participant).

Purpose of the Examination

The report is addressed directly to the referral source. The first report paragraph typically notes the purpose of the exam and any other specific questions asked or reasons for the evaluation. You may add a paragraph noting that the report is based upon the personal interview and examination of the examinee, combined with review of available medical records and radiographs and other submitted information. A list of all records reviewed is either listed in the body of the report or attached as an addendum. Typically, a summary of the content of each document is provided.

You may choose to ask to see examinee's picture identification such as a driver's license. You should identify if the examinee was accompanied by an interpreter or any other person (significant other, friend, relative, lawyer, nurse, court reporter, videographer, etc.) and whether the examinee tape recorded the examination. Document that the examinee was informed the purposes of the examination and that there was no doctor-patient relationship and that the examinee should not perform any maneuvers that the individual would consider harmful or injurious. Some IME physicians ask for a baseline pain level before the exam and then ask what the pain level is at the termination of the exam; mainly to document that that the IME did not cause any injury during the exam. This information also helps if the examinee alleges that symptoms were worse the next day due to the exam.

Examinee Introduction

The next paragraph lists the examinee's age, handedness, and marital status. In the workers' compensation arena, the employer, years on the job, and current work status can be listed.

Pertinent History

For most evaluations, there is a point in time when problems surfaced, either due to a specific injury or illness or on an alleged cumulative trauma basis; this date should be identified. The reported mechanism of injury and associated problems and care must be thoroughly documented.

Document pre-existing status, i.e. whether prior to some identified point in time the examinee described being in good health without ongoing disability or the examinee had a pre-injury (or illness) history of pertinence. Also describe any relevant prior history of injuries or illness (this might include auto accidents, illnesses, prior work or other injuries, surgeries, etc.).

The clinical course is described in detail, including subsequent symptoms, health care provider visits, diagnostic testing and treatment (including medications prescribed and surgeries). You should assess whether the history is consistent with the records; if it is not, you should attempt to clarify inconsistencies with the examinee and document them.

Current Symptoms

Current symptoms are carefully documented. The examinee is given the opportunity to detail all symptoms and complaints, including any interference with activities of daily living or perceptions of loss of pre-injury capacity. Document body parts involved including location and radiation of symptoms and referral patterns along with spatial characteristics, duration periodicity, and intensity/severity.

Pain complaints are commonly associated with disability and the character of the pain (i.e., continuous, non-fluctuating; continuous fluctuating; episodic; paroxysmal, etc.). A description of the quality of the pain (e.g., burning; freezing; sharp; pins and needles; aching; dull; hot; cold; numbing; and electrical.) A Pain Drawing or other questionnaires (Pain Disability Index, Oswestry Function Test, McGill Pain Questionnaire, Etc.) can be useful.

Additional descriptors should be listed (tingling; numbness; weakness; swelling; color change; temperature change; sweating; skin or hair growth changes. etc.).

Provocative or aggravating factors that worsen the pain and palliative factors that alleviate the symptoms should be detailed.

- Provocative or aggravating factors can include sitting; rising from sitting; standing; walking; stair climbing; lying on side, back or stomach; kneeling, bending or squatting; lifting and carrying; reaching, grasping, gripping, holding and manipulation; pushing or pulling; driving, coughing or sneezing; running; sleeping; sexual activity; Valsalva-type maneuvers; physical activity including exercise; and other activities of daily living.
- Palliative or alleviating factors or treatments can include rest; passive modalities (heat, ice, TENS, acupuncture, massage, manipulation, trigger point injections, etc.); medications; procedures and other treatments; active activities (physical therapy, yoga, tai chi, stretching and exercise, etc.); and mind–body treatments (biofeedback, cognitive behavioral therapy, meditation, etc.).

The current intensity of the pain is described on a 10-point scale, where “0” represents no pain and “10” represents the worst pain imaginable. Stanford Five[2]:

1. **Cause:** What tissue abnormalities the examinee believes to be the cause of the current problem.
2. **Meaning:** The presence of any sinister beliefs related to the pain, in terms of tissue damage, that precludes activity.
3. **Impact:** What impact does the primary problem have on the examinee’s life including interferences with vocational, social, recreational activities and in general, the quality of life.
4. **Goals:** What the examinee expects to achieve with further treatment.
5. **Treatment:** What the examinee believes needs to be done now and in the future to help resolve the problem.

Scientific knowledge clearly indicates that psychological and social factors commonly play a more significant role than the direct/primary physical effects of the condition in the development of chronic pain; therefore, the evaluator must consider these factors. Subjective complaints are reinforced by the context of litigation and scientific findings

have indicated that eligibility for compensation is a factor for chronic pain claims.[3] Adverse childhood experiences (ACEs)[4] and personality disorders have also been identified as a significant risk factor.[5] [6] [7] [8] In addition to the prominence that has been scientifically established for personality disorders as risk factors for the development of chronic pain, other forms of mental illness have also been established as risk factors.[9]

The presence of any examinee reported emotional (anxiety, depression, etc.) or cognitive dysfunction (memory, concentration, etc.) should be noted. Additional relevant information may be obtained from significant others.

Functional History

Obtain information regarding activities of daily living (ADLs – feeding, grooming, bathing, dressing, and toileting) and instrumental ADLs (IADLs – complex skills needed to function independently, i.e., using the telephone, doing laundry, preparing meals, care of others, managing finances, shopping, taking medication, managing transportation, etc.). IADLs overlap with questions concerning any changes in cognition, concentration and memory.

If work capacity is an issue, it is also important to assess more complex issues such as pacing (speed of activity); Repetition (repetitive activities); time (prolonged activity); and positioning (static or awkward posturing).

Also obtain a description of the examinee's daily routine (exercise, outdoor activities, recreation, household chores, etc.) and changes from pre-injury status.

Any use of adaptive equipment such as braces, canes, wheelchairs, etc., should be noted.

Current & Past Medications

Obtain a list of past and current medications. It is useful to request that the examinee bring all current medications to the examination. The examiner should assess medication effectiveness, side-effects and any evidence of misuse or abuse.

Review of Systems

Consider constitutional, head and neck, cardiovascular, respiratory, genitourinary, gastrointestinal, neurological, psychiatric and musculoskeletal symptoms in the review.

Past Medical and Surgical History

Note relevant injuries and illnesses including accidents (auto and other) and include a review of all past significant or similar medical diagnoses, treatments, allergies, previous hospitalizations, and surgical procedures plus any history of psychiatric disorders / treatments / hospitalizations. Note potentially significant other medical problems such as diabetes, cardiovascular or pulmonary disease, hypertension, arthritis, gout, etc.

Family History

Document relevant family history issues especially any alcoholism, substance abuse, major injuries, disability, pain, etc. Disability, illness or death in the family may affect how the individual responds to his or her own medical problems. A family history of certain diseases may explain symptoms in the examinee that have not previously been well explained.

Personal History

Information in this section can be of critical importance and areas of concern include the following.

- Childhood, i.e., was the examinee's childhood normal, dysfunctional, or abusive (sexual/verbal/physical/neglect)?
- Education, i.e., years of formal education; military service and any legal history (litigation or incarceration).
- Significant other and/or spouse, i.e., does the examinee have a significant other or has he or she ever been married, how many times and for how long? Was there any associated abuse history? Is this significant other and/or spouse working or disabled?
- Children, i.e., if there are children, what ages and how many?
- Current living situation, i.e., who is the examinee living with? Is there an apartment or house? Is it accessible (number of steps, adaptive equipment, etc.)?
- Illicit substance use or abuse? If positive, provide previous and current usage level.
- Tobacco, caffeine and alcohol usage.
- Current income source, if any (family members, workers' compensation, pension, Long Term Disability, State disability, Social Security, etc.)
- Work history: The occupational history should include not only the names of previous employers, job titles, types and physical intensity of previous jobs, but also continuity and length of previous positions. Attitudes about work (work "ethic" and work attitude) can be of considerable importance.

Records Reviewed

A listing of all materials and records reviewed should be listed and relevant information summarized. For imaging studies, it should be noted whether the actual studies were reviewed or just the reports.

Physical Examination

The physical examination is similar to a medical consultation; but it is important to document negative, positive and non-organic findings.

If you are performing an AMA *Guides* impairment evaluation, perform the assessment according to specific examination requirements in the relevant edition and section of the AMA *Guides to the Evaluation of Permanent Impairment.*

When giving testimony, an opposing attorney can make the IME physician feel quite uncomfortable when parts of the examination are not documented. A template or checklist of anticipated examinations or parts of examinations used during the examination can be helpful to minimize this issue.

The examination integrates information obtained from physical findings to support or refute diagnoses suggested during the history taking. The examination may uncover physical findings not readily apparent from the history or even known to the examinee.

The physical examination is not limited to, but is directed to the concerned body parts and when a change or abnormality is identified, the appropriate regional examination is expanded. The examination includes documentation of:

- General observation of the examinee.
    - Appearance and constitutional can include body habitus (nutrition: over-, under- or average-weight), grooming (appropriateness of dress and general cleanliness), odor (tobacco, alcohol, body odor, etc.), body markings (tattoos, piercing, etc.) and other observances (i.e. dirt stained and calloused hands, etc.).
    - Adaptive aids are noted such as braces/splints, walking aids/wheelchair and including whether such are appropriate or inappropriate to the diagnosis and whether they're utilized appropriately or are more suggestive of pain behavior.
    - Behavior includes such issues as cooperation and attentiveness, along with any pain behaviors or unusual activities. The individual's sitting and standing tolerance are noted and all measurements recorded. Non-physiologic findings (Waddell's signs, symptom magnification, chronic pain behavior such as moaning, groaning and misuse of assistive devices, etc.) are also noted.

- Initial functional observations that include observation of functional maneuvers such rising from seated position, using hands/arms to complete forms, head turning, gait, quality of handshake, interactions with office staff. These observations are used to cross reference the functional history and either invalidate or verify findings when similar maneuvers are used during the exam.

- Patient descriptors, i.e., whether the examinee is a good, poor or fair historian and, when appropriate, descriptions, e.g., pleasant and cooperative (versus unpleasant and uncooperative), angry or hostile and/or garrulous or loquacious.
- Pain behavior, i.e., verbal (sighing, moaning, groaning) and non-verbal (grimacing, guarding, splinting, clutching, bizarre gait).

Other physical examination findings, dependent on the context of the evaluation, may include:

- Head, eyes, and ears – General appearance, deformities, assistive devices (e.g., hearing aids, glasses), and visual/auditory acuity.
- Mouth, throat, and nose – General appearance, general dental condition, and patency of airway.
- Neck – General appearance, vascular distension, auscultation for bruits, and active range of motion (AROM) and passive range of motion (PROM), lymph nodes.
- Cardiovascular – Auscultation of the heart, examination of peripheral pulses, inspection of vascular refilling, varicosities, swelling, and edema.

- Respiratory & Chest – General appearance of the chest, breasts for masses or tenderness, auscultation of lungs and upper airways, observation of breathing pattern, and examination for peripheral clubbing or cyanosis.
- Gastrointestinal/genitourinary – Inspection of abdomen and pelvis, auscultation of bowels, palpation of abdominal organs, and rectal examination.
- Genitourinary – directed as appropriate.
- Integumentary – Inspection and palpation of skin and subcutaneous tissues for color, mottling, sweating, temperature changes, atrophy, tattoos, lesions, scars, rashes, ulcers, and surgical incisions.
- Musculoskeletal – Inspection, percussion and palpation of joints, bones, and muscles/tendons noting any deformity, effusion, misalignment, laxity, crepitation, masses or tenderness; assessment of AROM and PROM and stability of joints; inspection of muscle mass; spinal alignment and symmetry; and assessment of muscle strength and tone.
- Provocative tests – Maneuvers for thoracic outlet syndrome, Phalen's and Tinel's for carpal tunnel, foraminal compression for cervical radiculopathy, straight leg raising for sciatica, etc.
- Neurologic – Assessment of level of consciousness (alert, lethargic, stuporous, comatose) and mental status (e.g., orientation, memory, attention and concentration, thought processes and content, speech and communication /language and naming, fund of knowledge, insights into current condition), and assessment of cranial nerves. The neurologic examination also includes assessment of (1) sensation to pinprick, two point discrimination (in selected cases) sensibility (light touch), vibration, and proprioception, (2) assessment of sphincter tone and superficial reflexes (e.g., bulbocavernosus, abdominal, cremasteric, etc., as appropriate), (3) assessment of deep tendon reflexes (DTR) in the upper and lower extremities, including pathologic reflexes (e.g., Babinski, Hoffman, palmomental, etc.), (4) assessment of coordination (e.g., finger/nose, heel/shin, rapid alternating movements, fine finger dexterity), and tandem gait, and (5) functional mobility including gait and station.
- Non-physiologic behaviors are assessed such as Waddell signs (e.g., superficial skin tenderness, stimulation of back pain by axial loading or trunk rotation, differences in straight leg raising response between supine and sitting positions, regional non-anatomic weakness or numbness, and overreaction/disproportionate pain responses).

The next installment (part 4) in the upcoming WOEMA Newsletter will cover IME assessment, case summary, clinical impression & analysis, causation and apportionment, prognosis, maximal medical improvement, impairment, work ability, appropriateness of medical care, recommendations and disclosures.

[1] Barth RJ. Examinee-Reported History is Not a Credible Basis for Clinical or Administrative Decision Making. Guides Newsletter. September / October 2009.

[2] https://en.wikipedia.org/wiki/Stanford_Five

[3] Barth RJ. Chronic Pain: Fundamental Scientific Considerations, Specifically for Legal Claims. Guides Newsletter. January – February 2013.

[4] https://www.cdc.gov/violenceprevention/acestudy/index.html

[5] Dersh J. Prevalence of psychiatric disorders in patients with chronic disabling occupational spinal disorders. Spine. 2006 May 1;31(10):1156-62.

[6] Monti DA, Herring CL, Schwartzman RJ, Marchese M: Personality assessment of patients with complex regional pain syndrome type I. The Clin J of Pain. 1998;14:295-302.

[7] Fishbain DA, Goldberg M, Meagher BR, Steele R, Rosomoff H. Male and female chronic pain patients categorized by DSM-III psychiatric diagnostic criteria. Pain. 1986 Aug;26(2):181-97.

[8] Gatchel RJ, Garofalo JP, Ellis E, Holt C. Major psychological disorders in acute and chronic TMD: an initial examination. J Am Dent Assoc. 1996 Sep;127(9):1365-70, 1372, 1374.

[9] Barth RJ. Non-injury-related Psychological Issues as the Cause of Medical-Legal Claims. In: Melhorn JM and Barr J. 11th Annual American Academy of Orthopaedic Surgeons Occupational Orthopaedics and Workers Compensation: A Multidisciplinary Perspective. 2009. American Academy of Orthopaedic Surgeons.

[READ PART 1]

[READ PART 2]

ONE-DAY OCCUPATIONAL MEDICINE BOARD EXAM PREPARATION COURSE – SEPT. 11, SAN DIEGO

New this year at WOHC, there is a condensed eight-hour refresher course to prepare graduating and current residents to take the ABPM Occupational Medicine Board Examination, as well a for established Occupational Medicine physicians to update their knowledge ahead of the recertification exam. John Meyer, MD and Nimisha Kalia, MD will provide a teaching session and review on clinical, administrative and programmatic aspects of occupational medicine that appear on the ABPM examination, and offer you the chance to assess your familiarity with the major areas of occupational medicine practice. Whether you are taking the exam for the first time, or are updating for your ten-year re-certification, this course can provide you with the right material to enable you to feel confident in your OEM expertise.

Wednesday, September 11, 2019 – 8:00 am – 5:30 pm

COURSE SCHEDULE:

7:30 am – 8:00 am – Registration / Check-in

8:00 am – 10:00 am – Course begins

10:00 am – 10:15 am – Break

10:15 am – 12:00 am – Course Curriculum

12:00 am – 1:00 am – Lunch on your own

1:00 am – 3:00 am – Course Curriculum

3:00 am – 3:15 am – Break

3:15 am – 5:00 am – Course Curriculum

5:00 am – 5:30 am – Q&A / Course ends

REGISTRATION FEES: Fees cover course materials, breaks, and CME/MOC credits. ACOEM Member: $495; Non-Member: $695; Resident or Student Member: $295

This course will be held at the Sheraton Hotel & Marina Bay Tower in San Diego, CA.

[Details]

[REGISTER]

FIESTA BY THE BAY SIGNATURE DINNER AT WOHC 2019 IN SAN DIEGO

Friday, September 13, 2019 • 7:00 PM

Overlooking the San Diego Bay at sunset, this outdoor evening will be full of fun and enjoyment with colleagues and friends. Our Mexicana theme will compliment the culture that has made San Diego so desirable, including food, music, and dancing. Guests are welcome. Tickets $95 each available when registering to attend WOHC

[REGISTER]

Exhibitors to Meet at WOHC

WOEMA is pleased to announce the following companies will be displaying their products and services on September 12-14 at WOHC 2019 at the Sheraton Hotel & Marina, Bay Tower, San Diego: Concentra, Premise Health, Kaiser Permanente, TSI, Inc., Agility, Corporate Health Resources (CHR), Novo Nordisk, Institutes of Health, Dynavax, MEDI, Medlock Consulting, Quantgene, Reliant Urgent Care, RateFast, Enterprise Health, Healthesystems

REGISTER FOR WOHC 2019

WOEMA is a regional component of the American College of Occupational and Environmental Medicine (ACOEM) and is dedicated to high-quality medical care and ethical principles governing the practice of occupational medicine.

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