******Harris FRAC Prep*******

A Rehabilitation Consultation was requested to determine this individual's current status and to develop an appropriate rehabilitation plan for consideration.

File Review

The information in the file review was obtained from the file provided by the referral source, as well as from client interview.

The referral for assessment in treatment services indicates the date of disability is October 21st, 2015. The primary diagnosis on the referral is indicated as Disc Disorder. Background information outlines the following. Mr. Harris is employed at the Heavy Equipment Operator (Grader) since October 2013. His date of disability October 21st, 2015. His diagnosis is Disc Disorder/Moderate Spinal Canal Stenosis with possible irritation/impingement (SI joint dysfunction). He has a history of radiating pain into the left hip, back and under the rib line. Previous SI joint injections have provided adequate relief. MRI requested by Dr. Spiess did not show significant changes. Mr. Harris was referred to Dr. Pally for second opinion, and a referral to a rheumatologist was recommended to explore other possible sources of pain before making a final decision regarding spinal surgery. The rheumatologist has, through of review Mr. Harris' medical history and physical examination, diagnosed pain amplification syndromes/central sensitization. The rheumatologist made recommendations for pain and sleep management and physiotherapy. A six week physiotherapy/rehabilitation program specific to central sensitization programming is available to Bourassa and Associates, after which readiness for more extensive programming will be determined. Of note, Mr. Harris underwent IME assessment with Dr. A. Woo, Spine Surgeon at Bourassa and Associates in 2016. At that time, Richard Bourassa had identified pictures of central sensitization.

Mr. Harris complains of constant pain that worsens with activity, awakens with pain at a level 5, and worsens during the day. His pain increases with activity, therefore he is unable to do much around the house or yard and unable to do activities related to work. He is unable to drive standard vehicles as no strength to manage the clutch. He is not able to do any work with heavy equipment, as he has pain with sitting for extended periods of time, with twisting and bending to use hand and foot controls. He is unable to sit for greater than 15 minutes. Job demands include walking, sitting for extended periods, moving, twisting, and manipulating the steering wheel and gear, manipulating pedals on equipment.

The return to work goal is own occupation. Mr. Harris does not have a job to return to with the pre-disability employer. He was working for Merit Contractors Association, as an equipment operator.

Medical Treatment

Mr. Harris was seen for an IME in April of 2016 by Dr. A. Woo, Orthopedic Surgeon, and Richard Bourassa, Orthopedic Manual Physical Therapist. Dr. Woo determined that Mr. Harris was not surgical. He felt that there are number of mechanical structures contributing to his symptoms, and rehabilitation is appropriate. There may be a need for EMG and neuroconduction studies if there is convincing evidence of neuropathic pain. He also recommended possible injection therapy for his hip abductor mechanism. The MRI imaging from December 2015 gives an impression of degenerative changes with moderate bilateral foraminal stenosis with possible irritation, mild impingement and moderate spinal canal stenosis at C6-7

without frank cord impingement. There is minor lumbar spine degenerative changes without significant associated foraminal stenosis or spinal canal stenosis. It should be noted that Mr. Harris has had significant prior thoracic compression fractures when a wall collapsed on him as well as flipping his motorcycle in motocross competition. He has quite significant bilateral cervical, bilateral upper extremity, lumbar and left buttock pain. His perceived disability instruments indicate high pain levels and high levels of perceived disability. On objective examination there were moderate tendencies toward non-organic or pain sensitized behavior. Alternatively, given his severe descriptions of nighttime pain and morning stiffness, if there is failure to a biopsychosocial model of rehabilitation, rheumatological workup should be considered for spondyloarthropathy. Overall, the conclusion is that this individual has biopsychosocial model of disability, with both physical and psychosocial aspects to his pain presentation. He has evidence of centrally sensitized behaviors that are amplifying his pain. Without psychological workup, it is difficult to differentiate between truly physiologically sensitized pain that is physiological within the nervous system or behavioral components that are creating downward influences. This opinion is reserved until psychology assessments are performed. A functional rehabilitation program of a biopsychosocial nature is recommended, 10 weeks in length. “I am anticipating difficulty with resolution of this problem sufficiently for the client to easily accept returning back to work. There are no organic findings present that would usually provide this level of disability at on and objective level he should be able to return back to his work. However, we expect the client to have ongoing levels of subjective descriptions of pain and disability and we are not certain that he will be fully cooperative with all aspects of care. At the very least, this program will indicate his level of involvement, his level of willingness to participate maximally, and assist with further insurance dedication.”

Mr. Harris was seen and review by Dr. M. Spiess on May 17th, 2018. This was in follow up after seeing Dr. Pally. Dr. Spiess have referred him there for second opinion regarding his suspected left Si joint pain. Dr. Pally reportedly recommended against surgery and recommended a rheumatology referral. Dr. Spiess is in agreement with this. Mr. Harris’ symptoms are quite diffuse, with normal imaging of his sacroiliac joints both on x-ray and MRI and it is hard to recommend proceeding with surgical fusion of a normal appearing joint.

Mr. Harris was seen in consultation by Dr. Reis, Rheumatologist, on June 19th, 2018. Mr. Harris indicated to her that he is in coping with chronic pain for 15 years, after the initial injury when a wall fell on him. He was able to ultimately return to work but in October 2015 a minor incident, twisting in bed, led to his disability. He has subsequently had three SI joint injections that provide about 12 days of relief. He was put on Lyrica in early 2016 but stopped due to side effects. He now spent a lot of his time sleeping during the day. He does not sleep well at night. He is chronically tired. He is unable to sit on his left buttock. His neck doesn’t move well and this causes headaches. He has an overactive bladder. Musculoskeletal examination reveals wide spreads off to shoe tenderness. Results of prior investigations include normal CRP. Investigations requested at the time of this assessment includes screening bloodwork and thoracic x-rays. Overall Mr. Harris presents with long standing, non-specific pain consistent with pain amplification syndromes/central sensitization. He has been reassured that he has no evidence to suggest to systemic inflammatory arthritis, nor a specific regional musculoskeletal problem. Medication recommendations are made, as well as physiotherapy, smoking cessation, and local therapy as needed including injections.

Rehabilitation

Diagnostics
MRI spine sacrum/coccyx without contrast, April 13th, 2018: Impression: Normal appearance of the SI joints.

Client's Current Symptoms

Objective Findings

Summary and Recommendations

Please refer to the attached quotation for recommended services.

Faye Georget and Richard Bourassa have reviewed and discussed these examination findings and recommendations.

This information is being circulated only to the insurer as per agreement. It is our understanding that the insurer will circulate to the circle of medical care. (Remove this comment if not going to GWL).

ELECTRONICALLY VERIFIED

From 2016 assessment: **File Review**

I have reviewed the report of Dr. Woo. In addition I comprehensively reviewed the file information that arrived from the insurer.

Mr. Harris is on disability insurance. He is usually employed as a heavy equipment operator for AECON construction.

The file indicates that Mr. Harris left work on October 21, 2015 with foot pain (query Achilles tendonitis). His was treated by a physical therapist 3 times per week for a month. The physical therapist determined that his back was the main problem area. He underwent MRI in December 2015 and was referred to Dr. Woo. He presents with ongoing pain throughout the back and neck.

The Attending Physician's Initial Statement, Disability Income Benefits, completed by Dr. H. Shah on October 28, 2015 gives a primary diagnosis of foot pain, with difficulty walking. Current physical ability level is sedentary. Physical therapy is recommended.

MRI of the cervical, thoracic, and lumbar spine, December 12, 2015, gives an impression of lower cervical spine degenerative changes resulting in moderate bilateral foraminal stenosis at C5-6 with possible exiting nerve root irritation or mild impingement and moderate spinal canal stenosis at C6-7 without frank cord impingement. Minor lumbar spine degenerative changes without significant associated foraminal stenosis or spinal canal stenosis.

An undated memo from Dr. Shah, faxed on February 19, 2016, indicates Mr. Harris has a longstanding history of low back pain. He was originally injured 14 years ago during a farm accident after which he was fine for some length of time before becoming very problematic now. Exam is grossly normal, with intermittent paresthesia to his great toe left foot and shooting pains through his legs, arms, ribs, elbows and hands. He is otherwise well. "He states the only thing that helps his pain is cannabis - which I refuse to prescribe. More recently he stated his father told him to use gabapentin, which I refused and prescribed a small doses of tegretol instead. The patient has asked for an undetermined amount of time off of work, which I also refused, and instead have given him a total of 2 months off now. I have ordered an MRI for this patient as he has new neurological findings. I see little that I can do on the care for him, I will be sending him to a chronic pain specialist and psychologist if he is not a surgical candidate."

Thoracic and lumbar spine x-ray report from August 1, 2003 indicates the degree of compression of T10, T11, and T12 vertebral bodies remains about the same as noted on January 7, 2003. The fractures appear to have healed in the interval. Minor compression of the superior endplate of T8 vertebral body is now identified. The rest of the spine is unremarkable.

Subjective Examination

The client was agitated and constantly moving during the subjective examination.

The above File Summary was reviewed with the client and there were no significant discrepancies from the client's recollection.

I asked about this specific history of onset. He indicates that it started in October 2015 with symptoms as described above. He was removed from work. Initially his pain started with foot pain and headaches. He describes the position of his cervical spine on the physical therapy table for the treatment of his foot pain to aggravate his cervical spine pain.

Relative to past history, the client indicates that a 12 foot x 20 foot wall that he was constructing with his father in 2003 collapsed and flipped over on to himself and his dad. This resulted in T8, T10 and 11 compression fractures. The client also indicates a motocross injury about 6 months after this episode, where he flipped on his motocross and landed upside down, traumatizing his head and neck area.

The client's only history of physical therapy treatment has been the brief course since October.

The client documented his location of symptoms on the following body chart:

I had the client complete a Brief Pain Inventory. The client was asked to rate pain from zero (no pain) and 10 (as bad as you can imagine). He indicated that his pain at its worst was 8 in the last week. His pain was 4 at the least in the last week. His pain was 7 on average. He rated his pain at 7 at the time of the assessment. The client completed questions related to how much the pain interfered with various aspects of his life. He rated the pain from zero (does not interfere) to 10 (completely interferes). He rated his pain interference as 7 with his general activity and as 8 with mood, as 7 with walking ability, as 8 with normal work including both work and home and household work, as 6 with relations with other people, as 6 with sleep, and as 6 related to enjoyment of life.

I had the client complete a Neck Disability Index Questionnaire. The client was told that the questionnaire was designed to enable us to understand how much neck pain affects his ability to manage his every day activities. He was asked to circle choices within a number of categories relating to pain intensity, personal care, lifting, reading, headaches, concentration, work, driving, sleeping, and recreation. The client scored 26/50, or 52%. The instrument suggests that this equates to a severe level of perceived disability on a range of no disability, mild, moderate, severe, and complete.

The client completed a Roland Morris Disability Questionnaire relative to his lumbar spine. Client was asked to check off statements that describe his back pain. The client scored 17/24, with 24 representing maximal disability.

As a result of the subjective examination, a few key points came forward. It was the physical therapist managing the client that had determined that this was unlikely Achilles and plantar fasciitis.

The client indicates that about two years ago his 'heart quit beating'. This seems to relate to a fall with his head onto a washing machine. When he was worked up medically, he was told that his electrolytes were 'off'. He does not recall having any specific head, or cervical problems prior to this, but did experience some stiffness of his cervical spine after this event.

The client's symptoms at this point in time are a sacral area of pain, right and left leg pain and neck pain.

Subjective questions were asked relative to the client's condition. At the present time the client indicates that his general health is without abnormality. He reports no specific illnesses at present. He gives a history of a septoplasty on February 29th, 2016 in Saskatoon performed by Dr. Frank. He feels he has recovered from this. He gives a past history of a hernia and varicocele. He also gives a history of undescended testicles. The client's weight is steady. He

indicates that he is at 150 pounds and has been the same since Grade IX. Medications include Lyrica and Advil for headaches. He uses non-medicinal marijuana as required. He indicates that if he is not on his Lyrica that he will scratch his legs until they bleed. The client is right handed. There is no dizziness experienced except when he has a bad headache. There are no frank drop attacks. Quick movements of his cervical spine cause severe pain. Sustained postures make him ‘very sore’. He does experience some increased symptoms with coughing. There is no quadrilateral tingling or numbness. There is no history of arthritic conditions. He did have steroid injections in 2005 and 2006 related to T10-11. He indicates that it helped for about three weeks. His coagulation is normal. Bowel and bladder function is normal. There is no saddle anesthesia.

Questions were asked relative to the behavior of his symptoms. He indicates that he has severe night time pain and severe morning stiffness. He classifies his pain as 7/10. When asked about his functional capacities in life he indicates that he has moderate functional disability. He cannot perform any significant material handling activities and he cannot work.

I asked some basic psychosocial screening questions. He is the single parent of a 9 year old boy, His mother has given up custody. He current girlfriend works at a front desk reception position.