MEDICAL RECORDS REVIEW

July 2, 2012

[redacted]

Attn: [redacted]

Claimant: [redacted]
Claim number: 4233326CAR

At the request of Liberty Mutual, I have reviewed the following medical records submitted:

Date	Document	Source
12/6/11	Work restriction letter	Dr. [redacted]
12/11	Statement of earnings	UC Davis
11/7/11	Work restriction letter	Dr. [redacted]
10/3/11	FP office note	Dr. [redacted]
9/20/11	Ophthalmology office note	Dr. Je[redacted]
9/19/11	Cardiology office note	Dr. [redacted] 25
8/30/11	FP office note	Dr. [redacted]
8/25/11	Dermatology office note	Dr. [redacted]
8/11/11	FP office note	Dr. [redacted]
8/10/11	GI office note	Dr. [redacted]
8/2/11	FP office note	Dr. [redacted]
7/14/11	Ophthalmology office note	Dr. [redacted]
7/14/11	Cardiology office note	Dr. [redacted] 61
7/5/11	Cardiac surgery office note	Dr. [redacted] 68
	Lab flow sheets	
8/25/11	Skin pathology report	UC Davis
6/24/11	MRSA culture—nasal swab	UC Davis
6/25/11	Lab flow sheets	UC Davis
8/11/11	Chest x-ray	UC Davis
7/14/11	Computerized ophthalmic imaging	UC Davis
7/5/11	Chest x-ray	UC Davis
7/1/11, 6/30/11, 6/29/11, 6/28/11, 6/27/11, 6/26/11, 6/25/11, 6/23/11	Chest x-ray	UC Davis
6/24/11	Carotid ultrasound	UC Davis
6/24/11	Vein mapping	UC Davis
7/1/11	Discharge summary	UC Davis
6/23/11	Cardiac cath report	UC Davis 128
6/29/11	Ophthalmology consultation	Dr. [redacted]
6/23/11	Cardiology H and P	Dr. [redacted]
6/27/11	Critical care consultation	Dr. [redacted]
6/25/11	CABG report	Dr. [redacted]

6/30/11	Work restriction letter	Dr [redacted] 141
8/5/11	AP statement	Dr. [redacted] 142
	Statement of earnings	UC [redacted]
11/3/11	Records release authorization	M [redacted]
6-8/11	Lab tests	UC [redacted]
8/11/11, 7/1/11	Chest x-ray	UC [redacted]
7/14/11	Computerized imaging ophthalmic nerve	UC Davis
6/23/11	CT angio chest abdomen and pelvis	UC Davis
6/24/11	LE vein mapping	UC Davis
6/23/11	Endocrine consult	Dr. [redacted]
9/19/11, 8/23/11, 7/14/11, 6/26/11 and others from hospitalization	ECG	UC Davis
8/31/11	Treadmill report	UC Davis 273
6/23/11	Echo report	UC Davis 290
11/7/11	FP office note	Dr. [redacted] 5
?11/16/11	Ophthalmology office note	UC Davis
12/6/11	FP office note	Dr. [redacted] 311
1/11/12	FP office note	Dr. [redacted] 312
1/20/12	Dermatology office note	Dr. [redacted]
2/2/12	Cardiology office note	Dr. [redacted] 317
3/7/12?	FP office note	Dr. [redacted] 320
3/14/12	Dermatology office note	UC Davis
?5/16/12	Ophthalmology office note	Dr. [redacted]
12/11	Lab results	UC Davis
11/10/11	MRI brain	UC Davis
1/10/12	Echocardiogram	UC Davis 355
1/10/12	Stress echo	UC Davis 357
12/28/11	Clinical Case Review	Dr. [redacted]

History/Case details

([redacted]5) is a 56 year old man admitted to the hospital in June, 2011, with a non ST-elevation MI. He underwent cardiac catheterization and was found to have 3 vessel coronary disease and on 6/25/11 underwent bypass surgery with LIMA to the LAD and separate SVG to OM1, OM3, diagonal, and acute marginal branch of a nondominant RCA. The hospital course was complicated by visual impairment characterized as ischemic optic neuritis, which has unfortunately proved to be progressive. From a cardiac standpoint, his recovery has been uncomplicated. Follow up with his cardiologist Dr. [redacted] on 7/14/11 led to a short course of a diuretic. On 8/31/11, Mr. [redacted] completed a pre-rehabilitation stress test where he exercised for 9 minutes on a Bruce protocol, achieving 10 METs, peak heart rate of 133, and stopped because of fatigue. On 9/19/11, Dr. [redacted] noted dizziness and stopped valsartan, and also commented that Mr. [redacted] had started cardiac rehabilitation. An echocardiogram on 1/10/12 showed normal LV function, and a stress echo on the same day showed a similar exercise tolerance of 9 minutes, 10 METs, no evidence of ischemia, and a

similar suboptimal heart rate of 127 bpm. On 2/2/12, Dr. [redacted] noted no abnormality in recovery, but did not comment on work status.

Mr. [redacted] is employed as a Clinical Engineer by the hospital. A job description is not provided. His return to work has been addressed by his PCP, Dr. [redacted]. On 8/2/11, Dr. [redacted] noted that Mr. [redacted] was to start rehab. On 8/30/11, he cleared Mr. [redacted] to return to work half days (4 hours) with a 25# lifting restriction. On 10/3/11, he noted that Mr. [redacted] had poor exercise tolerance. On 11/7/11, he advanced Mr. [redacted]'s work to 5 hours a day and a 40# lift restriction. He noted that Mr. [redacted] stopped cardiac rehab before its conclusion due to inconvenience and cost. He noted that Mr. [redacted] had no discomfort or shortness of breath with walking, but was experiencing fatigue, eye strain, and worsening visual acuity. On 12/6/11, he noted that there was "no apparent contraindication to increasing work schedule to 6 hours" with plans to go to 7 hours in a month. On 1/11/12, work was not commented upon. At the most recent office visit available, Dr. [redacted] noted that Mr. [redacted] has been unable to work more than 5 hours a day. On 12/28/11, in an independent cardiology review, Dr. [redacted] felt there was no cardiac basis for disability, and referred to conversation he had with Dr. [redacted] in which Dr. [redacted] agreed that cardiac problems were not a basis for disability.

Mr. [redacted] also has high cholesterol, possibly familial hypercholesterolemia with an untreated cholesterol level of 310. He has a history of melanoma and non-melanoma skin cancers, hepatitis C, sciatica, hypertension, and intolerance to ACE inhibitors due to cough. Mr. [redacted] was noted to have optic neuritis after surgery in addition to a partially characterized cognitive impairment.

Record of Treating Physician contact

On 7/2/12, 5PM ET, I called Dr. [redacted]'s office and was informed by [redacted] that he will be out until 7/5. On 7/5/12, I called at 5:30PM ET and spoke with Dr. [redacted]. He noted that Mr. [redacted] visual impairment is profound. Mr. [redacted] is seeing a low vision specialist. Mr. [redacted] complains of fatigue and has been unable to work more than 6 hours a day, but Dr. [redacted] feels that this limitation is not cardiac, but may be the result of impaired vision and eye strain or fatigue.

Record of co-reviewing contact

On 7/6/12 at 2PM ET, I spoke with Dr. [redacted]. He agrees that ischemic optic neuropathy is likely responsible for the visual impairment. Dr. [redacted] agrees that eye fatigue or strain is a diagnostic possibility.

Question/answer

1. *What diagnosis is supported by the medical evidence in the file?*
   Mr. [redacted]'s diagnosis is unstable coronary disease, and bypass surgery on 6/25/12.

2. *Please clarify which diagnosis is causing impairment.*
   There is no cardiac basis for impairment as of 8/31/11. Two stress tests on 8/31/11 and 1/10/12 both demonstrated an exercise capacity of 10 METs, which documents cardiac reserve for at least medium duty employment.

3. *Provide a description of the claimant's impairments, if any.*
   No cardiac impairment is identified. There is evidence, beyond the basis of a cardiology review, for visual impairment and possibly cognitive impairment.

4. *Outline how any impairment translates into restrictions and limitations. Please include the expected duration for any supported restrictions (please use quantifiable time periods or amounts when giving restrictions, excluding use of words such as prolonged or repetitive).*
   There is no basis for cardiac restrictions and limitations. As of 8/31/11, adequate exercise capacity is demonstrated for moderate work.

5. *When clarifying the supported restrictions, please be sure to address sustained capacity for part-time and full-time occupational demand.*
   The evidence indicated capacity for sustained full time employment at moderate duty as of 8/31/12. The basis for this capacity is the stress test of that date. There is not a cardiac basis for lifting restrictions as of 10/25/11. The basis for this capacity is a four month window generally accepted for sternal stability to accommodate lifting.
6. *Does the medical evidence support any side effects from the prescribed medications? If yes, please provide the supported impairments and outline how any impairment affects functional capacity.*
   The record notes a cough associated with an ACE inhibitor and dizziness possibly associated with valsartan. No other impairments are associated with medications.

7. *Comment on the restrictions and limitations provided by the attending physician. Are they supported by the medical evidence?*
   The 25# lifting restriction of 8/30/11 is reasonable and supported by standard of care. Subsequent lift restrictions are not supported for cardiac reasons alone. Hour-based restrictions are not supported for cardiac reasons alone. However, these restrictions may be appropriate based on cognitive and ophthalmological issues.

8. *Are they consistent with the medical information provided? Please indicate if the attending physician has not placed any specific restrictions to comment on.*
   Other than that noted above, the restrictions are not consistent with the cardiac data available.

9. *Please comment on the duration for any supported restrictions.*
   As of 8/31/11, there is not a cardiac basis for an hour restriction. As of 10/25/11, there is not a basis for a lifting restriction.

10. *What is the claimant's prognosis?*
    The prognosis from a cardiac standpoint is excellent.

11. *Has the claimant reached maximum medical improvement? If not, when would this be expected?*
    Maximal medical improvement is likely reached, though rehab was not completed.

Synopsis of treating physician contact (Dr. [redacted])
On 7/2/12, 5PM ET, I spoke with [redacted] in Dr. [redacted] office who noted that Dr. [redacted] will not be in the office until Thursday, July 5. I left a voice mail to contact me directly.

Synopsis of reviewing physician contact (Dr. [redacted])

0m 7/2/12, 6:50PM ET, I left a voice mail for Dr. [redacted] and requested a call back.

Summary:
Mr. [redacted] underwent CABG for unstable coronary artery disease on 6/25/11. His cardiac course was uncomplicated, but unfortunately, he experienced visual loss due to ischemic optic neuritis. The evidence suggests a cardiac capacity for return to work without restrictions or limitations, but his vision and possibly cognition may be mitigating his full recovery.

The review represents my analysis of the documents listed above. I have not seen or examined the claimant. I have no conflict of interest in this case. This concludes my review of this case. If I may be of further assistance, please do not hesitate to contact me.

Steven Borzak, MD
Licensed to practice medicine in the State of Florida