

# Ohio DDD Internal Medicine

## Consultative Examination Guidelines

### Part IV: Musculoskeletal Consultative Examination Guidelines

#### General Examination/Report Requirements

##### Introduction and Required Components

Make sure the report - through its thoroughness and the presentation and interpretation of evidence - demonstrates that a genuine effort has been made to identify all diagnoses and probable diagnoses, as well as formulate a carefully thought-out assessment of current functional status ("Medical Source Statement").

Make sure that the report documents the positive elements of the medical history and physical examination, as well as the negative elements. This is crucial because DDD cannot accept that an element of the history or physical examination was negative or normal unless it was explicitly stated to be negative or normal.

Make sure that all of the following requirements are met and documented in the report narrative using appropriate headings:

- A. Identify the Claimant
- B. List All Chief Complaints
- C. Elaborate on Each Complaint in the History of Present Illness
- D. Document All Elements of Medical History
- E. Describe Claimant's Usual Daily Activities and Ability to Perform Activities of Daily Living
- F. List All Medications
- G. Document the Family History
- H. Document the Social History
- I. List Results of the Review of Systems
- J. Measure Vital Signs
- K. Describe Claimant's General Appearance and Presentation
- L. Observe and Examine the Back and Spine
- M. Examine Extremities and Measure Ranges of Motion
- N. Perform a Neurological Examination
- O. Examine the Skin
- P. Review Medical Records from DDD
- Q. Review Results of X-Rays or Other Tests Performed in Your Office
- R. List All of Your Diagnostic Impressions
- S. Provide a Functional Statement ("Medical Source Statement")
- T. Enter the Manual Muscle Test Results in the Neuromuscular Data Sheet
- U. Enter the Range of Motion Test Results in the Neuromuscular Data Sheet
- V. 1151 Form

W. Proofread

X. Signature

##### What If a Report is Inadequate?

If a report contains errors, DDD will need you to prepare an addendum that contains corrections or clarifying information. *Note: You are not paid for drafting addenda.*

If a report is missing important historical information or elements of the physical examination, DDD will need you to prepare an addendum and, in some cases, will require you to reexamine the claimant in your office at your own expense.

DDD understands that in some cases a claimant may be uncooperative. Document this in your report.

##### Thoroughness and Time Spent During the History and Physical

DDD does not want you to rush through these important examinations, which are distinct from your regular examinations in the course of medical practice. Sometimes a consultative examination is the only medical evidence DDD will receive, making it vital to the determination process.

You need not create a therapeutic relationship during a consultative examination, but do allow enough time so that some degree of rapport can be developed between examiner and examinee. Allow ample time for the claimant to state all of his or her complaints and symptoms and to answer all of the questions with minimal interruptions from the examiner. This may take about an hour, but SSA requires that the history and physical (not including the writing and dictating of the report) must take 30 minutes or more.

Avoid excessively brief examinations. Important elements of the history or physical could be omitted during a cursory history and physical, which could result in the consultant having to complete a request for a clarifying addendum or even reexamine the claimant at the consultant's own expense. SSA requires that all claimant complaints be investigated, and one of the most common complaints is that an examination was too brief.

## Who Is Permitted to Perform Various Parts of the Examination?

DDD realizes that a physician is not needed to weigh, measure height, take blood pressure and pulse, or even measure visual acuity; however, SSA has published criteria that specify who can and who cannot do various aspects of the history, physical examination and ancillary testing.

The Green Book states: "The medical source chosen may use support staff to help perform the consultative examination. Any such support staff (e.g., X-ray technician, nurse, etc.) must meet appropriate licensing or certification requirements of the State."

DDD has no problem with some elements of the examination or testing being performed by appropriate support staff, which would include licensed and certified physician extenders like physician assistants and nurse practitioners. Similarly, a licensed and certified physical therapist or occupational therapist could measure ranges of motion and a licensed and certified respiratory therapist could conduct spirometry or other pulmonary function testing. Except for these substitutions, DDD expects that the physician personally perform all of the following:

- Take the history
- Examine the claimant
- Conduct ancillary testing

Some physicians use patient-completed questionnaires. If you use one or more of these forms, you must still go through the claimant's chief complaints, history of present illness, past medical history, family history, social history, and review of systems using spoken questions that elicit spoken responses (unless the claimant cannot speak). DDD cannot assume that all claimants can read or comprehend the printed questions on a questionnaire. The entire, or vast majority of the consultative examination must use face-to-face verbal interaction.

## Professionalism and Complaints

DDD follows a formal procedure when a complaint is received. Common complaints in the past, in addition to allegations of an excessively brief examination encounter, have included that the consultant:

- Was rude
- Asked questions too quickly
- Did not give the claimant enough time to answer the questions
- Was rough when testing range of motion
- Had a poor bedside manner
- Told the claimant he/she was not disabled
- Told the claimant to go get a job

If any complaint is received, DDD will write you, request a written response to the claimant's allegations and evaluate your response.

If a consultant receives multiple complaints, DDD will investigate and may cease to do business with that consultant.

You must be sincere and professional in all of your encounters with claimants.

## Routine Review of Consultative Examination Quality

A statistical sample of reports is reviewed weekly by DDD's Chief Medical Consultant. When a report is found to be unsatisfactory, a letter is sent to the consultant, who must then submit a clarifying addendum. DDD monitors reports that deviate from SSA and DDD standards; however, most consultants regularly meet or exceed examination/report standards. When DDD does find poor quality reports, with no improvement in response to constructive criticism, the agency may cease to do business with a consultant.

## Definite and Probable Diagnoses: Dealing with Uncertainty

The primary reason DDD needs your services through a consultative examination is that the agency has received little or no medical evidence from a claimant's treating sources. This is usually because the treating sources have not responded to medical records requests or the claimant does not have a treating source. As a result, when you see a claimant, you may not have other medical data that would assist you in definitively diagnosing any impairments or conditions that he or she may have.

Because of the lack of medical testing and other data, you may not have enough information to make one or more definitive diagnoses on the basis of a one-time history and physical examination. It is acceptable to mention probable diagnoses. For example, in a claimant with a long history of knee pain who, upon examination has an antalgic gait plus a swollen, tender knee with decreased range of motion, it is recommended that you list "probable osteoarthritis of the knee" in your list of diagnoses even though you do not have X-ray or MRI confirmation.

## Voucher Information

Read all of the voucher information so that you are aware of and can complete all that is requested. On some occasions, there are special instructions about specific elements of the history or physical upon which DDD would like you to focus and comment. Common special instructions and questions include:

- Can the claimant hear conversational speech?
- Does the claimant have brawny edema and if so, how far up the leg does it extend?
- Has the claimant's foot ulcer healed?

## Conducting Tests that Have Not Been Ordered

In the past, some consultants - on their own - have decided that an unorderd test would be helpful and have gone on to perform the test. **This must not be done.** Payment will not be rendered for testing that is not pre-approved and ordered on the voucher.

## How to Add a Test

If you think it would be beneficial to add a test, such as a weight-bearing joint X-ray or spirometry, call DDD to discuss the suggestion. Sometimes, the agency will approve the added test. You will be paid for the test **only** if you follow proper procedures and get approval in advance.

## Non-English-Speaking Claimants

For non-English speaking claimants, the history must be obtained from family members present during the exam or from an interpreter contracted by the DDD. Report communication difficulties whether due to:

- Language barrier
- Difficulty hearing
- Difficulty speaking
- Difficulty seeing
- Cognitive impairment
- Mental illness
- Other

## Specific Examination/Report Requirements

### Identify the Claimant

Compare the claimant's countenance with a valid photo identification card.

### List All Chief Complaints

- Give claimant ample time to name complaints.
- Instead of asking, "Why can't you work?" be general and ask, "What sorts of physical problems and symptoms do you have?"
- Report from whom you obtained the medical history.

- Record whether you believe the claimant or other informant was reliable in presenting the history.

## Elaborate on Each Complaint in the History of Present Illness

- Elaborate fully on each symptom and specific illness stated as a chief complaint. Elaboration is not required on any psychological, emotional or mental allegations.
- Record when each major symptom and each specific illness began.
- Explain how each specific illness was diagnosed.
- Describe the severity of each symptom and specific illness at onset and how the severity has changed or progressed.
- Document the treatments or surgeries or procedures that have been done and how successful they have been.
- Report symptoms or specific illnesses associated with pain in a special way:

- » Describe where the pain is located (describe all areas if multiple sites).
- » State whether there is a known (or probable) underlying disease or disorder to which pain can be attributed.
- » Describe the character of the pain.
- » Record when the pain first occurred and how it has changed or progressed.
- » List what makes the pain worse.
- » List what makes the pain better.
- » Describe the treatments, surgeries or procedures that have been done and how successful they have been.

- For examples of specific questions for two common chief complaints (back pain and knee pain), see *Examples of Key Questions for Two Common Chief Complaints (Part IV - Appendix A)*.

## Document All Elements of Medical History

- List significant traumas
- List surgeries and significant procedures
- List recent transfusions
- List hospitalizations
- List all medical diagnoses

## Describe Claimant's Usual Daily Activities and Ability to Perform Activities of Daily Living

### List All Medications

## Document Family History

If present, list family histories of:

- Osteoarthritis, especially of the spine, hips and knees
- Systemic lupus erythematosus
- Rheumatoid arthritis or any other joint, autoimmune, connective tissue disorder and other rheumatological disorders
- Total joint replacements
- Premature osteoporosis
- Bone diseases such as osteogenesis imperfecta, achondroplasia or kyphoscoliosis
- Fibromyalgia
- Neurological or neuromuscular disorders
- Other familial or genetic disease with musculoskeletal manifestations

## Document Social History

List whether the following have been used and the extent of use (i.e., pack years, etc.):

- Tobacco (smoking)
- Tobacco (smokeless)
- Alcohol
- Illicit drugs

## List Results of the Review of Systems (Focus on Musculoskeletal and Nervous Systems)

- Record the positive results.
- Record the negative results. This is essential because DDD cannot assume a symptom was absent if not explicitly stated.

## Measure Vital Signs

Report each of the following:

- Measured height without shoes
- Measured weight without shoes
- Sitting blood pressure
- Sitting pulse
- Sitting respiratory rate
- Oral temperature if you believe the claimant is febrile
- If severe kyphoscoliosis is present, report measured arm span (finger tips to finger tips)

It is helpful, but not required, that you calculate and record body mass index (BMI). (Note: morbid obesity (BMI 40+) is a medically-determinable impairment per SSA.)

## Describe Claimant's General Appearance and Presentation

- Describe the salient features of your first impression of the claimant in detail.
- Especially important are observations of:
  - » Mobility
  - » Dexterity
  - » Acute illness
  - » Chronic illness
  - » Morbid obesity
  - » Malnutrition
  - » Ability to walk (see also *Examine the Extremities and Measure Ranges of Motion*)
  - » Ability to dress and undress
  - » Ability to climb on to and off of the examination table
  - » Ability to squat and get up from a chair

## Examine the Back and Spine

- Record any of the following findings, if present:
  - » Kyphosis
  - » Scoliosis
  - » Paraspinal muscle spasm
  - » Paraspinal tenderness
  - » Sacroiliac joint tenderness
  - » Vertebral tenderness
  - » Listing of the lower back that makes one hip appear higher than the other
  - » Surgical scars
- If myofascial pain or fibromyalgia is alleged, palpate the tender point locations as specified by the American College of Rheumatology. Also, test for allodynia.
- Measure spine ranges of motion and record the measurement on the *Range of Motion section of the Neuromuscular Data Sheet (Part II - Appendix B)*.
- Perform the straight leg raising test in the sitting and supine positions, recording whether there is:
  - » No pain
  - » Pain in the back
  - » Pain that radiated down the leg to the foot
  - » Pain in the back plus pain that radiated down the leg to the foot

## Examine Extremities and Measure Ranges of Motion

Focus the extremity exam on eight major areas:

### 1. Measure the active and passive ranges of motion of all major joints as listed on the *Range of Motion section of the Neuromuscular Data Sheet (Part II - Appendix B)*.

- » Preferably use a goniometer for these measurements.
- » Record these measurements on the *Range of Motion section of the Neuromuscular Data Sheet (Part II - Appendix B)*.
- » Do not detail all these measurement in the narrative.

### 2. Observe and palpate painful joints, joints with decreased range of motion and joints that appear grossly abnormal.

- » Record any of these joint findings, if present:
  - *Bony enlargement*
  - *Swelling or effusion*
  - *Synovial thickening*
  - *Warmth*
  - *Erythema*
  - *Tenderness*
  - *Pain with range of motion maneuvers*
  - *Deformities, such as ulnar deviation, or varus or valgus deformities of the knee*
  - *Contractures*
  - *Ligamentous laxity*
  - *Crepitus*

### 3. Observe gait in detail.

- » A detailed gait description is needed if the claimant:
  - *Has a visible limp or other abnormality of gait*
  - *Alleges trouble walking or maintaining balance*
  - *Has had a stroke or has another neuromuscular condition*
  - *Has pain, or decreased range of motion, or an abnormality on examination of the:*
    - » *Foot/ankle*
    - » *Knee*
    - » *Hip*
    - » *Spine*
- » A detailed gait description includes all of the following:
  - *Describe exactly what you observe when the claimant walks or attempts to walk (see Part II - Appendix C for select abnormalities of gait.)*

- *If the claimant uses a hand-held assistive device, if safe to do so, observe the claimant attempting to walk without the assistive device.*
- *If the claimant uses a hand-held assistive device, decide whether it is necessary (obligatory) to allow ambulation in each of these circumstances:*

- Short distances on level surfaces
- Long distances on level surfaces
- Short distances on uneven surfaces
- Long distances on uneven surfaces

- *Is the claimant a fall risk?*
- *Attempt to estimate how many total hours (per eight-hour workday) the claimant can be in the upright position ("on his or her feet") either standing or walking (combined).*

### 4. Observe hand function in detail.

- » Using the *Range of Motion section of Neuromuscular Data Sheet (Part II - Appendix B)*, record whether the claimant can:
  - *Open a door*
  - *Open a jar*
  - *Pick up keys*
  - *Pick up a coin*
  - *Write*
  - *Button*
  - *Unbutton*
  - *Zip*
  - *Unzip*
- » Using the *Manual Muscle Testing section of the Neuromuscular Data Sheet (Part II - Appendix B)*, describe claimant's ability to:
  - *Grasp (grabbing, as in a hand shake)*
  - *Manipulate (handle)*
  - *Pinch (between the thumb and index finger)*
  - *Finely manipulate (rely on finger functioning as in typing)*

### 5. Observe limb bulk and symmetry for atrophy or differences in the sizes of the opposite extremities.

- » Using the *Range of Motion section of the Neuromuscular Data Sheet (Part II - Appendix B)*, record measurements of the circumference of the forearms, arms, thighs and legs if there is suspicion of atrophy or asymmetry due to swelling/edema.

6. Observe feet and ankles without socks and shoes.

» Record any of these findings, if present:

- *Edema (graded trace through 4+)*
- *Lymphedema (usually the foot is swollen in addition to the ankle)*
- *Brawny edema (if present, remark how high up each leg it extends)*
- *Foot or ankle or leg ulcers (if present, remark location, depth, diameter, and appearance)*

7. Palpate peripheral pulses and look for signs of arterial insufficiency.

» Grade pulses “not palpable” through 4+.

» Remark if there is:

- *Dependent rubor*
- *Blanching on elevation of the leg*
- *Skin atrophy*
- *Loss of hair growth*

8. In amputations, observe the status of the stump.

» If a claimant has a prosthesis, observe ambulation with it in place.

» If a claimant does not have a prosthesis, observe and describe ambulation (if this can be safely done).

### Perform a Neurological Examination

Perform a comprehensive neurological examination that must include each of the following eight elements, though some elements have been described in other sections:

1. Describe general appearance and presentation (*see Describe Claimant’s General Appearance and Presentation*)

2. Observe gait in detail (*see Examine the Extremities and Ranges of Motion*)

3. Describe hand function in detail (*see Examine the Extremities and Ranges of Motion*)

4. Examine motor strength in all major muscle groups graded as 0 through 5, where 5 is normal. Record this on the *Manual Muscle Testing section of the Neuromuscular Data Sheet (Part II - Appendix B)*, which in addition, describes the five muscle strength grades.

» Attempt to elicit Babinski’s sign

» Conduct motor strength proxy tests including:

- *Ability to rise from the seated position without using hands*
- *Ability to mount the examination table*
- *Ability to dismount the examination table*
- *Toe-walking*
- *Heel-walking*
- *Hopping*
- *Pronator drift*

» Record any of these findings, if present:

- *Clonus*
- *Increased muscle tone*
- *Muscle hypertrophy*
- *Decreased muscle tone*
- *Spasticity*
- *Flaccidity*
- *“Cog-wheeling” rigidity*
- *“Lead-pipe” rigidity*
- *Lack of arm swing with walking*
- *Slowness of movement (bradykinesia)*

5. Observe any muscular atrophy, measure the circumference of the forearms, arms, thighs, and legs if there is any suspicion of it (*see Examine the Extremities and Ranges of Motion*) and record the data on the *Manual Muscle Testing section of the Neuromuscular Data Sheet (Part II - Appendix B)*.

6. Elicit deep tendon reflexes (see below) and record results for each reflex on each side:

- » Brachioradialis
- » Biceps
- » Triceps
- » Knee
- » Ankle

7. Test each of these sensory modalities:

- » Light touch
- » Pain sensation (pin prick)
- » Proprioception (great toe positioning)
- » Vibratory sensation

## 8. Test cerebellar function by:

- » Assessing gait for ataxia or unsteadiness
- » Finger-to-nose test
- » Heel-to-shin test
- » Rapid alternating movements
- » Romberg Test with eyes open and with eyes closed

## Examine the Skin

Describe in detail any of the following findings, if present:

- Surgical wounds that are not completely healed
- Open wounds of any kind
- Amputee stump abnormalities
- Rashes
- Abnormal skin findings such as sclerodactyly of scleroderma
- Finger tip ulcers as in scleroderma or lupus
- Cutaneous findings of Raynaud's phenomenon
- Gangrenous portions of the feet or elsewhere
- Healed surgical scars

## Review Medical Records from DDD

- If DDD has medical records on the claimant, the agency will send you some of the most pertinent records.
- Document key findings such as abnormal MRI findings in your report and incorporate these results in your clinical assessment, diagnostic impressions (*see List All of Your Diagnostic Impressions*) and functional statement (*see Provide a Functional Statement ("Medical Source Statement")*).

## Review Results of X-Rays or Other Tests Performed in Your Office

- If you have preformed X-rays or pulmonary function tests, for example, document the main results briefly in your narrative report.
- Incorporate these results in your clinical assessment, diagnostic impressions (*see List All of Your Diagnostic Impressions*), and functional statement (*see Provide a Functional Statement ("Medical Source Statement")*).

## List All of Your Diagnostic Impressions

- This is a key element of the consultative examination and report.

- Include confirmed diagnoses and "probable" diagnoses.

- » For example: Someone with a long history of knee pain and obesity who has an antalgic gait, bony enlargement of the knee, and a varus or valgus deformity probably has osteoarthritis of the knee even though you may not have an X-ray available to review at the time of your examination (*see also Examine the Extremities and Measure Ranges of Motion*).

## Provide a Functional Statement ("Medical Source Statement")

- This is an "educated estimate" of ability to physically function in the workplace for eight hours per day, five days per week.
- DDD realizes that you do not have the availability of every useful test to help you; that is why it is described as an "educated estimate."
- Use all of the data you have, including the history, examination results, any X-rays or other tests done in your office (if applicable), and any medical records sent to you by us.
- What is most important is that you do a reasonable and realistic assessment of function based on everything you know or have discovered about the claimant's medical illnesses and functional status.
- Include the effects of symptoms if there are plausible underlying medical conditions that could cause them.
- Some functional capacities that are important are educated estimates of how many hours during an eight hour workday a claimant can be on his or her feet (that is, stand and/or walk). Another important functional assessment is how much weight a claimant can lift and carry for more than two hours per day ("occasionally," indicates up to a third of an eight-hour day and "frequently" indicates from a third to two-thirds of an eight-hour day).

## Enter Manual Muscle Testing Results in Neuromuscular Data Sheet

- Do not delegate this to anyone else other than a licensed physical or occupational therapist, physician assistant, or nurse-practitioner.
- This form must be completed in its entirety, signed and returned to DDD for every claimant. Testing details are given within the *Manual Muscle Testing section of the Neuromuscular Data Sheet (Part II - Appendix B)*.

## Enter Range of Motion Test Results in Neuromuscular Data Sheet

- Do not delegate this to anyone else other than a licensed physical or occupational therapist, physician assistant, or nurse-practitioner.
- This form must be completed in its entirety, signed and returned to DDD for every claimant. Testing details are given within the *Manual Muscle Testing section of the Neuromuscular Data Sheet (Part II - Appendix B)*.

## 1151 Form

- In some cases that have been appealed, an administrative law judge will request an *1151 Form (Part II - Appendix D)*, which is included in your packet. If it is requested on your voucher but not in the packet, *contact DDD*.
- An extra fee is paid for completion of a requested *1151 Form (Part II - Appendix D)*. The form is self-explanatory.
- The same principles stated in *Provide a Functional Statement ("Medical Source Statement")* should be used in completing the 1151 Form. A copy of an *1151 Form* can be found in Part II - Appendix D.

## Proofread

## Signature

Sign the report personally. Stamps, electronic signatures or signatures by persons other than the consultative physician are not permitted.

## Part IV Appendices

### A. Examples of Key Questions for Two Common Chief Complaints

#### Part IV - Appendix A: Examples of Key Questions for Two Common Chief Complaints

##### *Back pain*

- Where is the pain?
- Does it stay in the back or extend to the legs? If so how far down the leg or legs?
- When did you first start having back pain?
- Does anything make the pain better?
- Does anything make the pain worse?
- Has anyone ever evaluated your back pain? If so, what was found? What were the results of any back X-rays or MRIs?
- Has back surgery ever been recommended?
- Have you ever had back surgery? Do you know specifically what was done? When did you have surgery?
- Do you ever lose control of your bowels or bladder?
- If back pain occurs with walking, how far can you walk without having to stop due to back pain?

*Note: if, in your opinion, a definite or probable spine disease is present, list this in your impressions or diagnoses near the end of your report.*

##### *Knee pain*

- Where is the pain?
- When did the pain start?
- Was there an injury prior to the onset of the knee pain? If so, what?
- Does anything make the pain better?
- Does anything make the pain worse?
- Has anyone ever evaluated your knee pain? If so, what was found? What were the results of any knee X-rays or MRIs?
- Has knee surgery ever been recommended?
- Have you ever had knee surgery or arthroscopy? Do you know what was found and/or what was done? When did you have surgery or arthroscopy?
- Does your knee pain affect walking? Affect stair climbing?
- How far can you walk without stopping?
- Do you use an ambulatory aid? What aid? Do you use it outdoors? Indoors? How long have you been using it? Who prescribed it? When?

*Note: if, in your opinion, a definite or probable knee or other joint disease (such as osteoarthritis) is present, list this in your impressions or diagnoses near the end of your report.*