



IMEs • File Reviews • Pharmacy Reviews

October 8, 2012

Adjuster  
Amerisafe  
c/o Adjusters' Choice  
5040 Greenwood Circle  
Minneapolis, MN 55331

Re: Daniel Kelly  
Claim Number: 200224319MN  
Date of Loss: 12/23/2001

Dear Adjuster;

I was asked to conduct an independent pharmacy review, based on information submitted to be, for a work related injury of 12/23/2001 sustained by Mr. Daniel Kelly. Following are my findings.

#### MEDICAL RECORDS REVIEWED

84 pages of medical records were submitted for this review, this includes:

1. No date, case notes.
2. No date, medication history.
3. 05/23/2012 - Clinical notes, John Bostwick Sweet, MD.
4. 02/28/2012 - Clinical notes, John Bostwick Sweet, MD.
5. 11/16/2010 - Clinical notes, John Bostwick Sweet, MD.
6. 10/14/2009 - Clinical notes, John Bostwick Sweet, MD.
7. 10/14/2009 - Spirometry report, no stated provider, Fairview Lakes.
8. 09/02/2008 - Clinical notes, Carlton Erickson.
9. 10/27/2007 - Clinical notes, Carlton R. Erickson, MD.
10. 10/25/2006 - Clinical notes, Carlton R. Erickson, MD.
11. 03/22/2006 - Correspondence with findings of order and commission, Heacox, Hartman, Koshmrl, Cosgriff, and Johnson, (attorney).
12. 01/18/2006 - Correspondence with bill for deposition, Ronald R. Vessey, MD.
13. 10/27/2005 - Clinical notes, Carlton R. Erickson, MD.
14. 02/24/2005 - Clinical notes, Carlton R. Erickson, MD.
15. 01/19/2004 - Clinical notes, Carlton Erickson.

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16. 12/17/2003 - Emergency department note, Francisco J. Torres, MD.
17. 12/08/2003 - Clinical notes, Carlton R. Erickson, MD,
18. 07/28/2003 - Clinical notes, Carlton Erickson.
19. 11/05/2002 - Closure report, Janet Darrow, Darrow Rehabilitation Services.
20. 10/21/2002 - Clinical notes, Carlton Erickson, MD.
21. 09/12/2002 - Clinical note, David W. Bonham, MD.
22. 08/19/2012 - Correspondence, Ronald R. Vessey, MD.
23. 08/01/2002 - Clinical notes, Carlton Erickson.
24. 07/29/2002 - Clinical notes, Carlton Erickson.
25. 07/18/2002 - Clinical notes, Carlton Erickson.
26. 07/15/2002 - Clinical notes, Carlton Erickson.
27. 06/20/2002 - Clinical notes, Carlton Erickson.
28. 06/03/2002 - Clinical notes, Carlton Erickson.
29. 04/25/2002 - Clinical notes, Carlton Erickson, MD.
30. 03/29/2002 - Correspondence, Ronald R. Vessey, MD.
31. 03/27/2002 - Pulmonary function report, Michael Bowen, MD.
32. 03/15/2002 - Clinical note, Carlton Erickson, MD.
33. 03/08/2002 - Pulmonary function test interpretation, Carlton Erickson, MD.
34. 03/08/2002 - Arterial blood gas laboratory analysis, no stated provider.
35. 03/06/2002 - Pulmonary function report, Bill Capla, CPFT.
36. 02/28/2002 - Clinical notes, Carlton Erickson.
37. 02/21/2002 - Clinical notes, Carlton Erickson.
38. 02/20/2002 - First Report of Injury.
39. 02/19/2002 - Emergency department records, Barbara G. Bonkoski, MD.
40. 02/19/2002 - Radiology report, Phyllis J. Noss, MD.
41. 01/31/2002 - Clinical note, William C. Piotrowski, MD.
42. 01/12/2002 - Clinical note, Michael R. Schmidt.
43. 01/05/2002 - Clinical note, Thomas A. Leaf, MD and Jason Devries, MS3.

## SUMMARY

The employee is a 53-year-old male with a reported date of injury of 12/23/2001. On 01/05/2002 employee was seen in clinic by Thomas A. Leaf, MD. He presented with a cough for 1 to 2 weeks and explained that he worked for the State and was grinding shower stalls, which contained moldy mildew and paint resins, such as epoxy. As a result of that there was a lot of dust in the air and he began doing this around Thanksgiving. A couple of weeks after that he began to cough.

He stated his coughing has gotten progressively worse despite the use of a respirator at work for the last 2 weeks. His cough is dry and occurs in bouts. He coughed to the point of gagging but he is not throwing up or vomiting. He states his cough is worse at night and seems to prevent him from sleeping. He states he has a history of taking albuterol inhaler medications secondary to smoking and upper respiratory infections. He has a familial history of severe asthma.

Respiratory examination revealed expiratory wheezing bilaterally. Assessment was cough, likely due to a reactive airway process, secondary to environmental exposures with the possibility of pneumonia being considered. There are no other infections or symptoms present. Albuterol inhaler 2 puffs 4 times a day were prescribed as well as prednisone 20 mg by mouth twice daily times 6 days and 1 times 3 days. Dictation for that exam was performed by Jason Devries, MS3.

On 01/12/2002, he was seen in clinic with evaluation by Michael R. Schmidt, MD. He had complaints of respiratory symptoms with a persistent cough which had been present for approximately 2 weeks prior to this exam. He thought he had a cough that came on primarily since he had been working at a job, grinding epoxy paint from walls and showers and applying fiberglass with epoxy glue. He thought he had a lot of mold exposure with this work. He stated he had been using a dust mask initially but was using a respirator at this time period. He reported that his cough is almost continuous at times and he does wheeze. He states that in the past he was given inhalers for several weeks for wheezing which was associated with a respiratory illness but he had not previously required inhalers for this most recent episode. He stated he was seen over the weekend for evaluation of his wheezing and was started on albuterol inhaler every 4 hours as needed, prednisone 40 mg daily for 6 weeks and then 20 mg daily. He was also using his girlfriend's nebulizer at that time and reported shortness of breath and wheezing that did improve for a short time after albuterol.

He has a family history of asthma with a brother having this disease. He has no other ongoing medical issues and reported that he did smoke until 01/2001 and has not smoked for almost a year. On exam his ear, canals are clear, TMs are normal, and nose is mildly congested. His throat is clear and his neck is supple. He has scattered rhonchi on lung examination. There are diffuse wheezes on forced expiration. Breath sounds are actually thought to be pretty good, and a chest x-ray shows hyperinflated lung fields. There is suspicion either for asthma, emphysema or likely a combination. Assessment was chronic obstructive pulmonary disease with bronchospastic component.

He was placed on Combivent inhaler 2 whiffs 4 times daily. He was also given an Advair Diskus 100/50 1 dose twice daily. He also has to take prednisone 60 mg daily for 3 days and then 20 mg daily for another 3 days and then stop the prednisone. He is advised to use albuterol as needed in between doses of the Combivent.

On 01/21/2002, employee was seen in clinic by William C. Piotrowski, MD. He indicated he had some problems over the last month with breathing and had been prescribed prednisone and was on Advair Diskus. He stated this had helped him. He stated he felt short of breath at times and worked in a plant where they used epoxy mix. He stated he started having problems when he began working with that type of epoxy previously and stated that he had a rash on his hand and still gets rashes on his hand.

Examination revealed peak flow was 500 with a pulse oximetry at 97%. He did not exhibit shortness of breath. His pharynx was clear and his neck was supple and lungs were clear with good air movement. There was some cracking on examination of his hands but this was on both hands and on his forearms. Assessment was suspicion for asthma secondary to industrial inhalation and contact dermatitis.

On 2/19/2002, this employee was seen in the emergency room. He had difficulty breathing at that time. He again stated he had started working with epoxy and initially just had difficulty with a skin rash consistent with contact dermatitis and then went on to develop respiratory distress, wheezing and coughing. He stated he had been placed on inhalants and continued to have some cough and wheezing. He was working on 02/19/2002 and developed significant shortness of breath, wheezing, coughing and respiratory distress despite using a respirator. He stated this was while grinding paint off the walls, which, again, had an epoxy base.

On exam, he had regular S1 and S2 heart sounds without murmur, gallop or rub and no edema was noted. Peak flow prior to albuterol was 290 and he was given an albuterol neb treatment after which his peak flow went up to 360. Chest x-ray revealed normal cardiac silhouette and clear lung fields were noted with mildly increased markings. Assessment was asthma with apparent hyper-sensitivity to epoxy.

He was instructed to stay away from work until he was released by his physician and he was placed on a prednisone taper and was given 100 mg of Solu-Medrol in the ER through an IV. Exam was performed by Barbara G. Bonkoski, MD and chest x-ray was read by Phyllis G. Noss, MD.

On 02/20/2002, the Employer's First Report of Injury or Illness was filed indicating that he was grinding walls to prep them for special coatings and had an allergic reaction to chemicals in the dust created by the sanding process and employee was using a respirator but still experienced shortness of breath.

On 02/21/2002, employee was seen in clinic by Carlton Erickson, MD. He was having coughing spells and auscultation of his chest at that time showed musical rhonchi heard rather throughout. He had been using a metered dose inhaler with poor technique and was getting none into his lungs. Assessment was probably environmentally caused reactive airway disease but there was some indication that he had a generalized reaction to stinging insects and this might be related in some way. He was taught to properly use a metered dose inhaler and it was indicated that his symptoms may have been exacerbated when he went to a fish store where there were many tanks and he had shortness of breath there as well.

He returned to Dr. Erickson on 02/28/2002 and was on a prednisone taper at that time. He had run out of his metered dose albuterol and was using Advair and was much better. He had musical rales throughout his lungs but he was not as dyspneic as before. He was to continue on

the tapered dose of prednisone and avoid epoxy and any other chemicals associated with it. Pulmonary function test was to be performed as well.

On 03/06/2002, pulmonary function test was performed. This was a pre and post-bronchodilator spirometry and the interpretation was basically normal lung functions with minimal change with a bronchodilator. Mid-flow variation was not uniformly accepted as diagnostic of any particular pulmonary function. That exam was read by Carlton Erickson, MD.

He was seen back in clinic by Dr. Erickson on 03/15/2002 to discuss pulmonary function tests. He had a diminished diffusion of 82% but the precision of that measurement was in dispute. His employer requested him to work in an area which was not associated with epoxy. The provider indicated that he was not at all confident that any exposure to epoxy dust to the employee or any other employees was going to be avoided. He had a severe asthmatic attack treated at the hospital in the past. Second was epoxy exposure bronchospasms. He was cautioned to avoid exposure.

He had a repeat pulmonary function test on 03/27/2002 and spirometry and lung volumes and diffusion were read as normal by Michael Bowen, MD.

On 03/29/2002, correspondence by Ronald Vessey, MD stated that he should be re-evaluated in 6 months and a pulmonary function study should be attained. It is indicated that his medical care and therapy had been reasonable and appropriate and he should continue with inhaled bronchodilator/steroid medication until he was instructed to stop. He was seen back in clinic on

04/25/2002 for continued care. His peak flow was 590. It was indicated that he could not continue to work at any place where it involved chemicals. Forms were filled out indicating that he had reached maximum medical improvement but was not able to work in any place where it involved chemicals for the foreseeable future. Family history indicates he has a brother who has asthma and he drives around delivering epoxy chemicals and wheezes terribly. He has to use a mask and yet he continues with the job because of the pay. Auscultation of the chest at that time was entirely clear and his peak flow was 590 and within normal limits. His girlfriend was going to monitor his peak flow meter over the next few days.

He returned to clinic with further evaluation by Dr. Erickson on 06/03/2002 and he had found that he could not tolerate inhaled chemicals much at all. He stated he got exacerbations when he was at different stores from various vapors such as pesticides and fertilizers. He was instructed to monitor his peak flow.

He returned on 06/20/2002 with further evaluation by Dr. Erickson. He also developed a topical reaction to latex gloves and it was questioned whether this might be contributing to his problems as since this was a contact dermatitis and he had no signs of any inhalant reaction to the latex it was indicated that no testing would be of value in defining this.

Pharmacy Review  
Re: Daniel Kelly  
Page 6

He returned to Dr. Erickson on 07/15/2002 for further evaluation. He was tested for reactions to trees, weeds and grasses, and with appropriate positive negative controls he showed no sensitivity to any of those plants. A negative test was also demonstrated to allergens of the plant families and latex was applied to his skin and this was to be inspected at 24 and 48 hours.

He returned on 07/18/2002 for latex testing and there was negative contact patch testing for latex products at that time. There was no reaction at all.

On 07/29/2002, he returned for inhalant testing for dust epithelials and molds and he showed no conclusive reactions to any of those by intradermal method with positive and negative controls.

He was seen in clinic on 08/01/2002 by Dr. Erickson and it was determined that his maximum medical improvement was difficult to ascertain as his pre-exposure was without known asthma. His post-exposure was with asthma and inhalant allergens showed no indication for desensitization and contact testing for latex showed no evidence of erythema, vesiculation or other indications of a type IV reaction.

On 08/19/2002, Dr. Vessey submitted correspondence indicating that the employee was able to return at just about any job that did not require him to be exposed to wet or dry epoxy resin fumes.

On 08/19/2002, a letter was submitted by Dr. Vessey indicating that his sole work limitation was that he should avoid either wet or dry epoxy compounds and there is no evidence in any of the information received that had to do with any other work restrictions placed prior to his returning to fulltime employment. It was indicated he should be able to return to work at his previously held custodial job at the school district as long as he is able to avoid epoxy fumes.

On 09/12/2002, employee was seen in clinic by David W. Bonham, MD. Reason for referral was respiratory problems. Assessment was occupational asthma associated with epoxy inhalation with ongoing symptoms to the present time requiring ongoing treatment with bronchodilators and modification of work environment. He is recommended for inhaled inflammatory and bronchodilator medication such as Advair that he is currently on and an albuterol metered dose inhaler 2 puffs on an as needed basis.

On 10/21/2002, employee returned to Dr. Erikson. He stated he was working in a sewer pipe, which was totally concrete. There was no adhesive or rubberized or other chemical treatments and they use good air movement so he was not exposed to fumes and was enjoying his work. It was indicated he was at maximum medical improvement at that time and he was recommended to have annual pulmonary function tests at least for 3 years after no deterioration was noted these would be spaced out further.

On 11/05/2002, a closure report from Darrow Rehabilitation Services indicated that he was employed since 08/06/2002 and all parties had been advised that closure was taking place with agreement period.

On 07/28/2003, he was seen in clinic by Dr. Erickson. He was in good health and stated that his breathing was the best as it has ever been. TMs and canals were normal and nasopharynx and oropharynx were normal. His lungs were clear to auscultation with a peak flow of 530. Medications were removed for a year and he was advised to follow-up on an as needed basis.

On 12/08/2003, employee was seen in clinic by Dr. Erickson and his lungs were clear and peak flow was 530, considered normal. He had used albuterol twice a day but felt that he was short of breath. He was advised that they would try pre and post bronchodilator peak flow to see if it was peak flow diminished or if it could be improved. He was to be scheduled for a pulmonary function test.

On 12/17/2003, he was seen in the emergency room complaining of 10/10 pain and decreased range of motion after a fall on the ice falling onto his right knee. He said he could not bear weight on it but denied numbness or any other trauma. His right knee was swollen with a joint effusion and it was tender to palpation along the medial aspect. The patella seemed to be fine. There was no tenderness over the patella area. Anterior and posterior drawer test and Lachman's test were normal. He had decreased range of motion, especially in flexion, with flexion around 40 degrees. There was no sensory loss and good pulses. X-rays failed to show fractures. Assessment was right knee sprain with a joint effusion and he was treated first with Toradol 60 mg IM for pain and then was given Tylenol with codeine No. 3 and instructed to follow-up. Exam was performed by Francisco G. Torres, MD.

On 01/19/2004, employee returned to Dr. Erickson for further evaluation. He had developed an upper-respiratory infection and was having coughing combined with his asthma. He felt like he was short of breath. He had used his albuterol the night before and was better as a result of that.

Exam showed the TMs and canals to be normal but he felt very stuffed in his head. The lung examination revealed mucous-like rales, particularly anteriorly. They changed with cough and peak flow was 550. Impression was upper respiratory infection with asthma.

His albuterol was refilled and he was to start on guaifenesin on a twice a day basis to assist in the coughing. Postural drainage was recommended as well. His pulmonary function test was discussed showing no deterioration.

On 02/24/2005, he was seen back in clinic by Dr. Erickson. Clinical note is absent for that visit.

On 10/27/2005, he was seen in clinic by Dr. Erickson. A court-observed agreement was noted to pay for his medications for the remainder of his life, but this had been discontinued. He was informed that he no longer needed the Advair as this had been adjudicated in a court sanctioned

hearing. He was using albuterol 2 to 3 times a day and had not observed any changes in pre or post albuterol use in respiratory function by utilizing his peak flow meter.

On 09/02/2008, he was seen back in clinic by Dr. Erickson. Peak flow was 460, within normal limits. He was to continue albuterol. His Advair was incremented from 250/50 to 500/50. Medications were renewed at that time.

On 10/14/2009, he underwent pulmonary function test, which revealed that his FEV-1 actual was 65, predicted was 78.

On 11/16/2010, he was seen in clinic by John Bostwick Sweet, MD. His respiratory function test demonstrated FCV to be normal, FEV-1 to be normal and FEV-1/FVC to be normal. There was evidence of mild obstruction and he made a good effort. He was to resume Advair 500 twice a day, albuterol on an as needed basis, and start fluticasone nasal spray 1 spray each nostril twice a day. He was to return to check in 1 year or as needed.

On 02/28/2012, he was seen in clinic by Dr. Bostwick. He stated that he took all his medications as prescribed but reported a cough during his sleep at least once a night and several times each day when at work. He described no severe exacerbations over the past year requiring prednisone or emergency department visits. He noted that there were several cats, dog and birds at home; previous allergen testing found no allergic sensitivity.

He had a normal pulmonary effort and breath sounds without wheezes or rales. His FVC was 6.44, 117% of predicted, FEV-1 was 4.16 or 99% of predicted and his FEV-1/FVC was 65 or 85% of predicted. His asthma was not well controlled and there was suspicion for allergen exposure. He was to undergo allergen skin testing and his Advair discus was refilled and he was to start Singulair daily.

On 05/23/2012, he returned to Dr. Sweet for repeat allergen testing. He had a strong sensitivity to molds and dander and moderate sensitivity to pollens, dust. He had severe, persistent asthma. Plan at that time was to review how allergens could exacerbate asthma symptoms and allergen avoidance to reduce asthma symptoms and the need for inhaled steroids and bronchodilators were reinforced. He was to review seasonal allergen abatement, and he was to start allergy immunotherapy in 2 weeks.

## QUESTIONS

### 1. Please list the injured worker's current/active medications.

The clinical note of 05/23/2012 is reviewed and medication list included Advair Diskus 500/50 mcg per dose, Flonase 50 mcg/ACT nasal spray, prednisone 20 mg tablets, albuterol or Ventolin HFA 2 puffs into lungs every 4 hours as needed and Singulair 1 tablet by mouth at bedtime.

**2. Is the employee's use of each of his ongoing medications reasonable, necessary, and related to his admitted injury?**

This employee sustained an exposure to epoxy allergens on 12/23/2001. However, he has a familial history of asthma and a personal history with asthma and now has documented allergen sensitivity to molds and dander and to pollens and dust. He appears to be well controlled with these medications during most of the time.

However, these medications may be reasonable and necessary but are not related to his admitted injury of 12/23/2001 as he has a pre-existing condition of asthma and now has documented allergen sensitivity which is an ordinary disease of life and not related to the 12/23/2001 incident. Therefore, the continued use of these medications, although reasonable and necessary are not related to his admitted injury.

**3. If so, for what length of time should he be expected to continue use of the medications?**

As stated previously, the medications although reasonable and necessary, are not related to the work injury. As such, these medications may be continued but they should be continued as a non-compensable medication.

**4. If not, what is the suggested method and timeline for discontinuing the medications?**

There is no specific weaning process for any of these medications. However, as a sudden withdrawal may cause sudden respiratory distress if he was exposed to certain allergens the employee should be advised prior to discontinuation of these medications and instructed to obtain these medications through another source. After that the medications can be discontinued without a weaning process.

**5. For any reasonable, necessary, and related medications are there any suggestions for substitutions and/or changes in dosages?**

N/A.

**6. For any brand name prescriptions deemed reasonable, necessary, please indicate when their patent expires. Comment also if you have knowledge regarding projected arrival of a generic alternative.**

N/A.

**CONCLUSION**

Pharmacy Review  
Re: Daniel Kelly  
Page 10

The employee is a 53-year-old male with a reported date of injury of 12/23/2001. At that time he reported being exposed to epoxy resins and this caused respiratory distress. He was treated conservatively with medications and then was found to have not only asthma but allergen sensitivity. Current medications may be reasonable but are not related to the 12/23/2001 incident.

#### REFERENCES

Official Disability Guidelines, Medication Chapter.

I certify that I hold appropriate credentials to conduct this review. I received my medical degree from the University of the State of New York. I completed an internal medicine residency at the State University of New York at Buffalo and fellowships in critical care at Wayne State University and pulmonary diseases at the University of Rochester. I have experience producing Peer Reviews supported by evidence-based medicine and have experience with worker's compensation claims. I am Board Certified in Internal Medicine by the American Board of Internal Medicine and Board Certified in Pulmonary Diseases by the American Board of Internal Medicine.



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