1 Patient Information

1 PATIENT DETAILS

Name:	Derek A. Simmons	**Date of Report:**	04/22/2026
DOB / Age:	09/05/1981 / 44 years	**Provider:**	Dr. Paul R. Hensley, MD, MPH — Occupational Medicine
MRN:	OCC-2026-044917	**Report type / purpose:**	Independent Medical Examination (IME) — Workers Compensation; evaluation of causation, diagnosis, and work capacity for lumbar injury claim filed with Ohio Bureau of Workers Compensation (Claim #BWC-2026-0044917)

2 Reason for Report

2 PURPOSE

This report is prepared at the request of Ohio Bureau of Workers Compensation to provide an independent medical evaluation of Mr. Derek A. Simmons (DOB 09/05/1981), a 44-year-old male warehouse distribution supervisor, regarding a workplace lumbar injury claim. The purpose is to: (1) establish diagnosis and causation, (2) determine degree of functional impairment, (3) assess maximum medical improvement (MMI) status, and (4) provide work capacity recommendations and restrictions. All medical records provided by BWC were reviewed prior to and during this evaluation.

3 Clinical History

3a RELEVANT MEDICAL BACKGROUND

Lumbar disc disease, L4-L5 (pre-existing, diagnosed 2019 — prior MRI showed mild L4-L5 disc bulge without neural compression). Essential hypertension — controlled on lisinopril 10 mg daily. BMI 31.4 kg/m² (obesity Class I). No prior lumbar surgeries or epidural steroid injections. No prior workers compensation claims. No history of rheumatologic disease, malignancy, or neuropathy. Prior occupational exposure: 18 years of heavy manual labor including frequent lifting 50-75 lbs.

3b PRESENTING COMPLAINT

Mr. Simmons sustained a work-related injury on 02/14/2026 while lifting a 65 lb pallet of automotive parts at Ohio Distribution Partners (employer, Columbus, OH). He reports feeling a sudden "pop" in his lower back at the moment of lift, followed by immediate severe low back pain radiating down the right leg to the lateral calf and dorsum of right foot. Incident was witnessed by a coworker (statement on file with BWC). Patient reported to occupational health on-site that day and was subsequently seen in the ED (Grant Medical Center, 02/14/2026). Ongoing right leg pain, weakness, and paresthesias since that date.

4 Examination Findings

4a PHYSICAL EXAMINATION

Vital Signs: BP 138/86, HR 74, RR 16, Height 5'11", Weight 225 lbs, BMI 31.4.
Gait: Antalgic — favors left lower extremity; slow cadence with decreased right stance phase.
Lumbar Spine: Reduced range of motion in all planes — flexion 40° (norm 60°), extension 10° (norm 25°), right lateral flexion 15° (norm 25°); tenderness to palpation at L4-L5 and L5-S1 paravertebral musculature bilaterally, right > left.
Neurological: Right great toe extension strength 3/5 (L5 myotome); right ankle dorsiflexion 4/5; right ankle reflex absent (S1); sensation decreased to pinprick in right L5 distribution (lateral calf and dorsal foot). Left side intact throughout.
Provocative testing: Positive straight leg raise (SLR) right at 35° with concordant radicular pain to right lateral foot; negative left. Femoral stretch test negative bilaterally. Waddell signs: 0/5.

4b DIAGNOSTIC FINDINGS

Relevant diagnostic results reviewed — lab values, imaging interpretations, ECG findings, or specialist reports referenced in this report...

5 Investigations

5 TESTS PERFORMED OR REVIEWED

MRI Lumbar Spine without contrast (02/15/2026, Grant Radiology, Dr. Kim): Large right paracentral disc herniation at L4-L5 with right-sided subarticular recess stenosis and moderate right L5 nerve root compression; moderate L4-L5 disc height loss. L5-S1 shows mild disc bulge without neural compression. No fracture, infection, or malignancy.
EMG/NCS (03/18/2026, Dr. Vasquez, Neurology): Right L5 radiculopathy confirmed — reduced recruitment, fibrillations at R tibialis anterior and R peroneus longus; right sural SNAP preserved; H-reflex absent on right (consistent with S1 involvement). Left side normal throughout.
Lumbar X-rays (02/14/2026, Grant ED): No acute fracture; mild L4-L5 disc space narrowing consistent with chronic degenerative change.

A Assessment

6a DIAGNOSIS / CLINICAL IMPRESSION

PRIMARY DIAGNOSIS: Acute-on-chronic right L4-L5 disc herniation with right L5 radiculopathy (M51.16 / G54.4), causally related to workplace lifting injury of 02/14/2026 at Ohio Distribution Partners.
CAUSATION OPINION: It is my opinion, within a reasonable degree of medical certainty, that the work injury of 02/14/2026 is the direct cause of the acute disc herniation and resultant radiculopathy documented on MRI and EMG. The pre-existing L4-L5 disc bulge (2019 MRI) represents a significant aggravation by the work incident — the degree of herniation, acute onset, and neurological findings are temporally and mechanistically consistent with the reported injury mechanism (heavy lift with acute onset of symptoms).

6b SEVERITY & PROGNOSIS

SEVERITY: Moderate-to-severe. Patient has significant right L5 motor deficit (great toe extension 3/5, dorsiflexion 4/5), absent S1 reflex, and persistent radicular pain 6/10 on NRS. EMG-confirmed radiculopathy has not resolved with conservative care. MMI STATUS: Patient has NOT reached maximum medical improvement (MMI). Active treatment ongoing.
PROGNOSIS: Guarded for full recovery of right L5 motor function. Patients with EMG-confirmed radiculopathy and L5 motor deficit who fail conservative care and ESI have approximately 60-70% likelihood of improvement with surgical decompression. Without intervention, progressive neurological deficit is possible. Recommend neurosurgical consultation within 30 days.

R Recommendations

7a TREATMENT PLAN

IMMEDIATE: Neurosurgical consultation (right L4-L5 microdiscectomy likely indicated given EMG-confirmed radiculopathy, L5 motor deficit, and failure of 10 weeks of conservative care including PT and ESI). Continue gabapentin 300 mg TID for neuropathic pain. Consider pain psychology referral for chronic pain coping strategy development.
MEDICATION: Gabapentin continue; consider duloxetine 30 mg daily for neuropathic pain augmentation (discuss with treating physician). Cyclobenzaprine taper after 30 days.
REHABILITATION: Resume PT post-surgically if microdiscectomy performed — lumbar stabilization protocol. Functional capacity evaluation (FCE) recommended 12 weeks post-operatively to objectively determine return-to-work capacity.

7b WORK & ACTIVITY RESTRICTIONS

CURRENT WORK RESTRICTIONS (effective immediately):
- No lifting >10 lbs
- No bending, twisting, or stooping
- Sit/stand as tolerated with position changes every 20-30 minutes
- No driving while on cyclobenzaprine or gabapentin
- No climbing ladders or working at heights
- Modified/sedentary duty only; current warehouse distribution supervisor role IS NOT compatible with restrictions at this time

ESTIMATED TIME TO FULL DUTY: Cannot be determined until post-surgical assessment and FCE. Estimated minimum 4-6 months from date of surgery if microdiscectomy performed.

Provider name & credentials:	Dr. Paul R. Hensley, MD, MPH — Occupational & Environmental Medicine	**Date of Report:**	04/22/2026
Signature:	Paul R. Hensley, MD, MPH	**Facility / Practice:**	OhioHealth Occupational Medicine, 700 Ackerman Road, Suite 500, Columbus, OH 43202
License / NPI:	Ohio Medical License #56-047821 / NPI: 1639204857	**Report recipient:**	Ohio Bureau of Workers Compensation, Claims Unit, Claim #BWC-2026-0044917