MEDICAL CHRONOLOGY - INSTRUCTIONS TO FOLLOW

General Instructions:

I and II: Accident report and EMS report: *These will be left blank if the records are not available/ applicable.*

III. Injury report: *This comprises of an abstract of the patient's related damages, surgical details, disability, etc – This table will be filled only if there is one date of loss available.*

IV: Brief Summary/Flow of Events: *This will include only the related prior conditions, injuries due to the subject incident, significant surgical procedures, therapy outcome, any complication due to hospitalization and status as per the last available record. Events will be presented date wise with provider details – this will be filled only if there are more than one date of loss or if requested as a standing order.*

V: Missing medical record: *This table comprises of all the missing records, inclusive of interim, probable and confirmatory missing records.*

VI. Patient History: *Details related to the patient's past history (medical, surgical, social, occupational, family history and allergy details.) are captured from the medical records.*

Verbatim Detailed Medical Chronology: *Information is captured "as it is" from the medical records without alteration of the meaning. Type of information capture (all details/zoom-out model and relevant details/zoom-in model) is as per the requirement of the case which will be elaborated under the 'Specific Instructions'*

Reviewer's Comments: *Comments on contradictory information and misinterpretations in the medical records, illegible handwritten notes, missing records, clarifications needed etc. are given in italics and red font color and will appear as * Reviewer's Comment*

Illegible Dates: *Illegible and missing dates are presented as "00/00/0000"(MM/DD/YYYY format)*

Illegible Notes: *Illegible handwritten notes are left as a blank space "_____" with a note as "Illegible Notes" in the heading of the particular medical record.*

Specific Instructions:

- *Medical chronology focuses on the Work Place Injury on MM/DD/2018, the resulting injuries (Low back, neck and bilateral knee) and their treatment*
- ***In many visits, the date of injury was incorrect hence we have corrected to MM/DD/2018 as mentioned and presented in italics***
- ***Therapy records:*** *Initial and final physical therapy visits are captured in detail. Interim visits are summarized with significant events.*
- *Repeated information has not been captured in the chronology*
- *Case specific details have been highlighted in yellow color for easy reference*
- *A snap shot of the provider signature is given when the provider's name is illegible*

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I. Police Report/Accident Scene Investigation Report

Page Reference: *Not applicable*

PARAMETER	DETAILS		BATES REF	PDF REF
Date and Time of Accident				
Location	(City, County, Intersection Details)			
Direction of Travel				
Speed *(of the vehicle)*				
Scene of Accident	(Weather, Road, Lighting Conditions)			
No of Vehicles Involved				
Party Details				
Vehicle Details	Model			
	Year			
	Color			
	VIN Number			
	Policy Number			
Description of Accident				
Did Airbag Deploy?				
Seat Belt Applied?				
Seating Position				
Vehicle Damages/ Vehicle Towed				
Property loss (Damage amount)				
Violation Code/Reason for Accident/ Sobriety and Distraction Factors				
Parties Cited/At Fault Party				
Was 911 Called?				
Who Arrived at the scene First?	Fire Department/Police/EMS			
Other Details (Witness statements, etc)				

II. EMS Report

Page Reference: *Not applicable*

PARAMETER	DETAILS		BATES REF	PDF REF
Date of report				
EMS Name with Crew details				
Time Details	Time Called			

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PARAMETER	DETAILS		BATES REF	PDF REF
	Time Arrived			
	Time Departed			
	Time Arrived at Hospital			
Response Code/Level of Medical Care	**ALS/BLS**			
Status of Patient on Arrival	**Extricated, Ambulatory at Scene, etc**			
Chief Complaints				
Narrative of EMS personnel				
Vitals/ Pain Level/Physical examination				
Loss of Consciousness				
Impression	➢ **Primary** ➢ **Secondary**			
Treatment				
Neck Collar Applied?				
Backboard Support?				
Destination				
Other details				

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III. Injury Report

PARAMETER	DETAILS	BATES REF	PDF REF
Date of injury	MM/DD/2018	XX Center (recs + bills) – 000006	1
Related Injuries and Medical Condition Before incident	**Past medical history:** Unavailable **Past surgical history:** Unavailable		
Damages Developed/Sustained as a result of incident (diagnoses alone)	• Bilateral leg/knee strain • Lumbar spondylosis without radiculopathy • Right knee chondromalacia • Left knee medial meniscus tear • Chronic neck pain	XX YY (recs + bills) – 000003, XXXX – 000068, XX YY (recs + bills) – 000053, XX Anesthesia & Pain (recs + bills) - 000018	13, 222, 258, 171
Surgeries or procedures underwent as a result of incident	**Procedures:** • **MM/DD/2018:** Cortisone injection to both knees • **MM/DD/2018:** Cortisone injection to both knees • **MM/DD/2019:** Right cervical facet joint injection at C4-7 **Surgeries:** • **MM/DD/2019:** Left knee partial medial meniscectomy and left knee extensive synovectomy.	XX YY (recs + bills) – 000008, 000050, XXX Specialists (bill + recs) – 000001 – 000003, XX Center (recs + bills) – 000001 – 000002	109, 223, 253-255, 266-267
Postsurgical	None		

PARAMETER	DETAILS	BATES REF	PDF REF
complications (infection, DVT, etc)			
Aggravation of pre-existing conditions (Physician or therapist's statement alone)	Physician or therapist's statement regarding pre-existing is unavailable for review.		
Did patient return to work (Date and work status as per the last few visits/therapies)	As on MM/DD/2019, patient may not return to work.	XX YY (recs + bills) – 000061	273
Disability (Physician or therapist's statement alone)	Physician or therapist's statement regarding disability is unavailable for review.		

IV. Brief Summary/Flow of Events: Not applicable

V. Missing Medical Records

What Records are Needed	Hospital/ Medical Provider	Date/Time Period	Is Record Missing Confirmatory or Probable?	Hint/Clue that records are missing	BATES REF	PDF REF
Emergency Room visit	Unknown	MM/DD/2018	Confirmatory	Mentioned in visit dated MM/DD/2018	XXXX – 000011	3
Physical therapy records	XX Therapy	MM/DD/2018-MM/DD/2019	Confirmatory	Medical bills are available	XX Therapy (recs + bills) – 000130 – 000133, 000135-000137	89-92, 94-96
Medical Records	XXX Medicine	MM/DD/2019	Confirmatory	Medical bills are available	XX YY (recs + bills) - 000064	279

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VI. Patient History

Past medical history: Hypertension (BATES REF: XXXX - 000011) (PDF REF: 3)

Past surgical history: No prior surgeries (BATES REF: XXXX - 000011) (PDF REF: 3)

Prior occupational history: XXX as a forklift driver (BATES REF: XXXX - 000012) (PDF REF: 4)

Current occupational status: As on MM/DD/2019, patient may not return to work. (BATES REF : XX YY (recs + bills) – 000061) (PDF REF: 273)

Family history: High blood pressure and diabetes (BATES REF: XX YY (recs + bills) - 000036) (PDF REF: 17)

Social history: Never smoker and no alcohol use (BATES REF: XXXX - 000012) (PDF REF: 4)

Drug allergy: No known drug allergies (BATES REF: XXXX - 000011) (PDF REF: 3)

Other allergies: Unavailable

Detailed Chronology

DATE	PROVIDER	OCCURRENCE/TREATMENT	BATES REF	PDF REF
		Work Place Injury – MM/DD/2018		
MM/DD/2018	XX Center *Provider unavailable*	**X-ray of thoracic spine:** **Clinical indication:** Injury at work, upper/mid back pain. **Findings:** There is minimal superimposed artifact at the cervicothoracic junction on the lateral view per technique. Vertebral bodies: Vertebral bodies body heights are preserved. Disc spaces: Low grade generative disc disease inferior thoracic spine including T10-11, T11-12. Alignment: There is no spondylolisthesis. Soft tissue: There is no focal paraspinal line deviation/hematoma. **Impression:** Low grade spondylolisthesis inferior thoracic spine. No acute fracture or malignant. **Reviewer's comment: The corresponding radiological order records are unavailable for review.*	XX Center (recs + bills) – 000006	1
MM/DD/2018	XX Center Kristen XXX, M.D.	**CT scan of thoracic and lumbar spine:** **Clinical history:** Fall, rule out compression fracture. **Findings:** No acute fracture or malalignment of the thoracic or lumbar	XX Center (recs + bills) – 000001	2

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<table>
<tr><th>DATE</th><th>PROVIDER</th><th>OCCURRENCE/TREATMENT</th><th>BATES REF</th><th>PDF REF</th></tr>
<tr><td></td><td></td><td>spine. There is normal alignment of the spine.

There is preservation of height of the vertebral bodies. Degenerative endplate changes are seen at L5-S1 with disc desiccation.

The height of the intervertebral discs of otherwise maintained.

There is no evidence of osseous spinal canal and neural foraminal stenosis.

Punctate left nonobstructing renal calculus.

Impression: No evidence of fracture or subluxation of the thoracic or lumbar spine.

*Reviewer’s comment: The corresponding radiological order records are unavailable for review.</td><td></td><td></td></tr>
<tr><td>MM/DD/2018</td><td>XXX Surgery, S.C.

Sean XXX, M.D.

Elizabeth XXX, P.A.-C.</td><td>Initial consultation for lower back pain and bilateral knee pain:
I saw patient in the office today for an initial consultation. He reports an injury at work on MM/DD/2018. He describes that he was operating a forklift inside a truck and that the brakes had not been set on the truck and as he was backing out of the truck the truck jerked and his forklift ended up falling off the truck.

He had a harness belt on which prevented him from falling out of the truck but as a result he was twisted. Since that time he has had pain in the right scapular region, the low back, the bilateral knees and the bilateral feet. He was taken to the Emergency Room where he was treated and released; however, he went back to the Emergency Room a day or so later because of ongoing pain and he had what sounds like a CT and discharged home with a script for pain medication.

*Reviewer’s comment: The corresponding Emergency Room records are unavailable for review.

Currently he complains of constant pain in the low back without radiation into the legs. He has pain in the right scapular region. He also has pain in the knees and the feet.

He rates his pain as an 8/10. He is currently not working. Prior to this injury he denies any complaints as outlined above and states he was a very active person.

Review of systems: Musculoskeletal: Back pain and joint pain.

Cervical examination: Range of motion: Forward flexion 45</td><td>XXXX – 000001 – 000005, 000011 – 000014,

XX YY (recs + bills) – 000043</td><td>3-12</td></tr>
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DATE	PROVIDER	OCCURRENCE/TREATMENT	BATES REF	PDF REF
		degrees, hyperextension 40 degrees, right lateral flexion 20 degrees, left lateral flexion 20 degrees, right lateral rotation 80 degrees and left lateral rotation 80 degrees. **Lumbosacral exam: Range of motion:** Forward flexion 50 degrees, hyperextension 20 degrees, right lateral bending 20 degrees, and left lateral bending 20 degrees. **Problems:** • Hypertension • Low back pain • Bilateral knee pain Patient has low back and knee pain as a result of the described work injury. Given there are no red flags either by history or on examination he was advised to begin a course of physical therapy for the lumbar spine going 2-3 x/week for 4-6 weeks. He was additionally prescribed a Medrol Dosepak 4 mg and Mobic 7.5 mg to be taken after completing the steroid pack. For his knee pain he was referred to Orthopedics for further evaluation. He will return for re-evaluation after the therapy to assess his response to the above. **Physical therapy treatments for lumbar spine strain:** • Range of motion • Strengthening • Stabilization • Conditioning • Home program **Frequency and duration:** 2-3 x/week for 4 weeks. This patient is released to return to work beginning MM/DD/2018 with the following restrictions: **Restrictions:** He can work at a desk work capacity of no lifting/pushing/pulling more than 10 lbs, no bending/twisting for more than 3 x/hour and alternate sitting/standing every 30-45 minutes as needed. **Related records:** Correspondence records, orders and prescription records.		
MM/DD/2018	XXXX Medicine Christos XXX, M.D.	**Follow-up visit for bilateral leg pain:** Patient is seen here today for consultation regarding his legs and his back. He had an injury on MM/DD/ when his truck went forward into the dock. He had to brace himself. He noticed pain in his back and legs as well as his feet. He is here today for	XX YY (recs + bills) – 000003, 000033 – 000036	13-17

TRIVENT LEGAL

DATE	PROVIDER	OCCURRENCE/TREATMENT	BATES REF	PDF REF
		further follow-up. The pain is improving but he is still having some spasm in his leg. **Review of systems: General:** Headache, loss of sleep. **Physical examination:** The left knee reveals full range of motion. He has some pain posterior medially and posterior laterally. The right knee reveals full range of motion. There is some spasm and pain in the hamstring posteriorly. **Assessment:** Bilateral leg strain. **Plan:** We will do a couple of weeks of physical therapy. I don't think is anything serious. I will see him in a couple of weeks for recheck. Physical therapy 3 x/week for 2 weeks. Patient may not return to work. **Related records:** Orders, patient information.		
MM/DD/2018	XX Therapy Naha XXX, P.T.	**Physical therapy initial evaluation report for back pain: Primary/Rehab diagnosis:** Lumbar pain. **Primary complaint:** Pain in bilateral knees and low back. Difficulty with prolonged standing and walking. He also has difficulty with sustained positions. **Current level of function:** Patient reports limitations with pulling/pushing tasks, squatting or bending forward, transferring in/out of forklift, driving a forklift walking prolonged. **Prior level of function:** Unlimited with all activities. **Pain scale:** At rest 0/10; during activity 6-7/10; functional activity - Walking and pain comment – aching. **Nature of injury: M.D. diagnosis:** Bilateral knee pain. Patient reports he was injured at work. He states that he was taking pallates off of a truck. He was on the forklift and he fell down while seated on the lift. He braced himself during the fall and but hurt his knees and low back. He went to the M.D. because he was having pain in feet, knees, low back, and groin. **Physical exam: Movement loss: Lumbar flexion:** Minimum. **Manual muscle testing:** Left hip: Flexion 4+, bilateral knee extension 4+. Left trunk flexion 4-/5. **Flexibility:**	XX Therapy (recs + bills) – 000068 – 000073, 000106 – 000112	21-33

TRIVENT LEGAL

DATE	PROVIDER	OCCURRENCE/TREATMENT	BATES REF	PDF REF
		Bilateral piriformis: Minimal tightness. Bilateral quadriceps: Minimal tightness. Bilateral hamstrings: Minimal tightness. Bilateral gastrocnemius: Minimal tightness. **Joint mobility:** Sacroiliac: Overpressure slightly tender. **Palpation:** Tightness noted in lumbar paraspinals. **Modified Oswestry:** 34%. **VR-12 Mental Component Summary:** 24 points. **VR-12 Physical Component Summary:** 38 points. **Assessment:** Patient presents to physical therapy with signs and symptoms consistent with physician's diagnosis of low back pain. Patient presents today with decreased strength, balance, soft tissue mobility and increased pain, as well as impairments with body mechanics and lifting mechanics. These deficits limit his ability to perform pulling/pushing tasks of 50# or more, squatting or bending forward to the floor, lifting 50 feet from floor, transferring in/out of forklift, driving a forklift, and walking prolonged. Currently, he is able to lift 17# box from floor to waist 5x and carry 17# for 100 feet consecutively. Patient demonstrates a need for stretching, strengthening, modalities, manual techniques, home exercise program education, and education on safe lifting techniques. Prior to injury, patient worked as a forklift driver for XX's that requires a PDL of medium as per DOT code: 921.683-050. Patient will benefit from skilled therapy to allow him to meet set goals and return to prior level of function. After a course of therapy, patient may benefit from first work conditioning/hardening to further improve functional strength for return to fully duty work. **Rehab potential/prognosis:** Good. **Plan of treatment:** 3 x/week for 2 weeks. **Treatments:** Therapeutic exercise, manual therapy, neuromuscular reeducation, therapeutic activities, hot pack, cold pack, ultrasound, electrical stimulation and self-care/home management training. **Related records:** Medical history.		
MM/DD/2018	XX Therapy	**Physical therapy initial evaluation for bilateral knee pain:** **Primary complaint:** Pain in bilateral knees and low back.	XX Therapy (recs + bills) –	34-40

TRIVENT LEGAL

DATE	PROVIDER	OCCURRENCE/TREATMENT	BATES REF	PDF REF
	Naha XXX, P.T.	Difficulty with prolonged standing and walking, especially on left side. 1 **Current level of function:** Patient reports limitations with driving a forklift, lifting 50# from floor, sustained standing, walking more than 1 mile. **Prior level of function:** Unlimited with all activities. **Pain scale:** At rest 0/10; during activity 6-7/10; functional activity prolonged standing; Pain comment: Sharp. **Nature of injury:** M.D. diagnosis: Bilateral knee pain. Patient reports he was injured at work. He states that he was taking pallates off of a truck. He was on the forklift and he fell down while seated on the lift. He braced himself during the fall and but hurt his knees and low back. He went to the M.D. because he was having pain in feet, knees, low back, and groin. **Physical exam: Manual muscle testing:** Left hip flexion 4+, bilateral knee flexion 4+. **Flexibility:** Bilateral piriformis: Minimal tightness. Bilateral quadriceps: Minimal tightness. Bilateral hamstrings: Minimal tightness. Bilateral gastrocnemius: Minimal tightness. IKDC Subjective Knee Evaluation: 43.7 points. VR-12 Mental Component Summary: 24 points. VR-12 Physical Component Summary: 38 points. **Assessment:** Patient presents to Physical Therapy with signs and symptoms consistent with physician's diagnosis of bilateral knee pain. Patient presents today with decreased strength, balance, flexibility and increased pain, as well as impairments with body mechanics and lifting mechanics. These deficits limit the patient's ability to perform driving a forklift, lifting 50# from floor, sustained standing, and walking more than 1 mile. Currently, he is able to lift 17# box from floor to waist 5x and carry 17# for 100 feet consecutively. Patient demonstrates a need for stretching, strengthening, modalities, home exercise program education, and education on safe lifting techniques. Prior to injury, patient worked as a forklift driver for XX's that requires a PDL of Medium as per DOT code: 921.683-050. Currently, patient is not working. Patient will benefit from skilled therapy to allow the patient to meet set goals and return to prior level of function. After a course of therapy, patient may	000058 – 000064	

TRIVENT LEGAL

DATE	PROVIDER	OCCURRENCE/TREATMENT	BATES REF	PDF REF
		benefit from first work condoning/hardening to further improve work activity tolerance for safe return to full work duty. **Rehab potential:** Excellent. **Plan of treatment:** 3 x/week for 12 weeks. **Treatments:** Therapeutic exercise, manual therapy, neuromuscular reeducation, therapeutic activities, hot pack, cold pack, ultrasound, electrical stimulation and self-care/home management training.		
MM/DD/2018 – MM/DD/2018	XX Therapy Naha XXX, P.T. Nadia XXX, P.T.A.	**Summary of multiple interim physical therapy visits for bilateral knee pain:** **Total no. of visits:** 4. **Treatment rendered:** Therapeutic exercise, manual therapy, neuromuscular reeducation, therapeutic activities, hot pack, cold pack, ultrasound, electrical stimulation and self-care/home management training. **Summary of events:** **MM/DD/2018:** Patient reports feeling the same. Patient reports no new complaints. Patient tolerated session well but required moderate rest breaks during treatment due to increase in fatigue. Patient required multiple verbal cues for posture during exercises. **MM/DD/2018:** Patient reports feeling the same. Patient reports no new complaints. Patient was able to complete exercises with minor verbal cues for posture. Patient required minor tactile cues for body mechanics during exercises. Patient demonstrates increased control of knee stabilization noted during BOSU lunges. **MM/DD/2018:** Patient reports feeling better. Patient reports feeling "good". Patient tolerated new exercises well but required moderate verbal cues for proper heel push off during walking lunges. Patient is able to perform squats without increase in bilateral knee pain. **MM/DD/2018:** Patient reports feeling better. Patient reports no new complaints. Patient continues to demonstrate increase in endurance. Patient reported some pain with lateral step ups. Patient was encouraged to ice knees at home to help avoid stiffness of bilateral knees. **Reviewer's comment: Multiple interim physical therapy visits are summarized with significant events.*	XX Therapy (recs + bills) – 000052 – 000057	43, 46, 51-53, 57
MM/DD/2	XX Therapy	**Physical therapy discharge summary:**	XX Therapy	60-66

TRIVENT LEGAL

DATE	PROVIDER	OCCURRENCE/TREATMENT	BATES REF	PDF REF
018	Naha XXX, P.T. Nadia XXX, P.T.A. Ashley XX, P.T.	**Primary complaint:** Patient reports still feeling soreness and some occasional pain of bilateral knees, mainly on lateral side of knee. **Functional limitations:** Walking more than 1 mile, driving forklift, lifting from floor 50#, and sustained standing for more than 30 minutes. **Pain scale:** At rest 0/10; during activity 6/10; functional activity - lateral movements; pain comment – patient reports feeling a sharp pain. **Physical exam: Flexibility:** Bilateral piriformis: Minimal tightness. Bilateral quadriceps: Minimal tightness. Bilateral gastrocnemius: Minimal tightness. Patient's hamstring flexibility increased. IKDC (International Knee Documentation Committee) Subjective Knee Evaluation: 51.7 points. VR-12 Mental Component Summary: 63 points. VR-12 Physical Component Summary: 25 points. **Assessment:** Patient presents to physical therapy with signs and symptoms consistent with physician's diagnosis of bilateral knee pain. Patient has attended made objective improvements with flexibility of bilateral lower extremities muscles and bilateral lower extremities balance. This has improved his ability to tolerate standing for more than 1 hour, lifting 17# from floor to waist, leg press 97#, single leg press 57#, and tolerate exercises in therapy. Patient continues to present with impairments involving occasional pain that has lowered in intensity since beginning of therapy. These deficits limit patient's ability to perform tasks such as walking more than 1 mile, driving forklift for work, and lifting 50# from the floor. Prior to injury, patient worked as a forklift drive for XX's Company that requires a PDL of Medium as per DOT code: 921.683-050. Currently, patient is not working. At this time, patient has reached maximum benefit for bilateral knees from therapy and has been discharged from physical therapy with home exercise program.	(recs + bills) – 000045 – 000051	
MM/DD/2 018	XXXX Medicine Christos XXX, M.D.	**Follow-up visit for bilateral leg pain:** Patient returns today for follow-up. He is little bit better. He states that his right knee marginally twisted. **Plan:** We did talk about the option of cortisone injection today	XX YY (recs + bills) – 000005 – 000006	71-72

TRIVENT LEGAL

DATE	PROVIDER	OCCURRENCE/TREATMENT	BATES REF	PDF REF
		and he doesn't want to do this at this time. He has also been complaining of some stabbing pain in his fret. He is going to see the foot specialist for this. As far as the knee is concerned, he will continue with range of motion exercises. I will see him in couple of weeks. If the symptoms persist we can order an MRI of his right knee and possibly do an injection. He expressed understanding. Patient may not return to work.		
MM/DD/2018 – MM/DD/2018	XX Therapy Naha XXX, P.T. Nadia XXX, P.T.A.	**Summary of multiple interim physical therapy visits for back pain:** **Total no. of visits:** 10 **Treatment rendered:** Therapeutic exercise, manual therapy, neuromuscular reeducation, therapeutic activities, hot pack, cold pack, ultrasound, electrical stimulation and self-care/home management training. **Summary of events:** **MM/DD/2018:** Patient reports feeling the same. "It's feeling better than it was". Patient tolerated session well. Patient reported feeling less stiffness of low back after warming up with exercises. Patient was able to complete exercises with minimal rest breaks and minimal verbal cues for posture and body mechanics. **MM/DD/2018:** Patient reports feeling the same. Patient reports that he feels "wonderful". Patient tolerated new and progressive exercises well. Patient continues to demonstrate high tolerance for current exercises in treatment plan. Patient was encouraged to perform hamstring stretch at home to prevent soreness and stiffness during weekend away from therapy as well as lumbar rotations. **MM/DD/2018:** Patient reports feeling better. Patient reports no new complaints. Patient treatment session was focused primarily on standing exercises to increase patient's endurance for exercises. Patient tolerated session well. Patient required minimal verbal cues for core activation during some exercises. **MM/DD/2018:** Patient reports feeling the same. Patient reports that his back feels better. Patient is able to complete exercises with little to no difficulty. Patient continues to respond well to ultrasound and heat pack stating that he feels no stiffness after session. **MM/DD/2018:** Patient reports feeling the same. Patient reports no new complaints. Patient was able to complete 27# during lift and carry without reports of pain or discomfort. Patient	XX Therapy (recs + bills) – 000085 – 000105	42, 44-45, 47-50, 55-56, 58-59, 68-69, 73-81

TRIVENT LEGAL

DATE	PROVIDER	OCCURRENCE/TREATMENT	BATES REF	PDF REF
		experienced difficulty during floor to waist carry of 17#, reporting that he felt discomfort in his groin area. Patient tolerated all other exercises well and was able to finish with treadmill cool down without reports of low back pain. **MM/DD/2018:** Patient reports feeling the same. Patient reports feeling "fine" and "a little better". Patient was able to complete exercises with minor increase in discomfort. Patient required minimal verbal cues for posture and parameters of exercises. Patient was encouraged to perform core activating exercises at home to increase core activation when he carries heavier objects from waist or floor level. **MM/DD/2018:** Patient reports feeling the same. Patient reports no new complaints. Patient tolerated session well. Focused more on functional activities today for improving work task tolerance. Patient was able to complete floor to waist lift without increase in discomfort. Patient was encouraged to stretch at home to prevent stiffness of hamstrings. Patient required multiple rest breaks during exercises. **MM/DD/2018:** Patient reports feeling the same. Patient reports feeling knee and low back soreness. Patient tolerated session well. Patient session was focused first on stretching of his lower back to ease patient into strengthening exercises. Patient was able to tolerate mm progressions as he is improving his tolerance for activities. **MM/DD/2018:** Patient reports feeling better. Patient reports no new complaints. Patient tolerated session well. Held off on ultrasound to focus on exercises. Patient given verbal cues as he tends to lose focus to remain focused and count repetitions. **MM/DD/2018:** Patient reports feeling the same. Patient reports feeling better but still having ankle pain. Patient demonstrates increase in TA bracing activation noted during unsupported low back exercises. Patient required minimal tactile and verbal cues for body mechanics during lifting exercises. **Reviewer's comment: Multiple interim physical therapy visits are summarized with significant events.*		
MM/DD/2018	XX Therapy Naha XXX, P.T.	**Physical therapy discharge summary:** **Primary complains:** Pain in bilateral knees and low back. Difficulty with prolonged standing and walking. He also has difficulty with sustained positions. **Functional limitations:** Transferring in/out of forklift and driving a forklift.	XX Therapy (recs + bills) – 000081 – 000083	82-84

TRIVENT LEGAL

DATE	PROVIDER	OCCURRENCE/TREATMENT	BATES REF	PDF REF
		Pain scale: At rest 0/10, during activity 3-4/10, functional activity: Walking. Pain comment: Aching. **Objective:** Palpation: Improved muscle integrity noted in lumbar paraspinals. **Modified Oswestry:** 20%. **VR-12 Mental Component Summary:** 25 points. **VR-12 Physical Component Summary:** 43 points. **Assessment:** Patient presents to physical therapy with signs and symptoms consistent with physician's diagnosis of low back pain. Patient has attended 12 sessions of therapy compliantly. He has made objective improvements with range of motion, strength, flexibility, as well as shown improvements with posture, body mechanics, lifting mechanics, and activity tolerance. These improvements have increased his ability to perform pulling/pushing tasks with 50#, squatting or bending forward, walking prolonged, lifting 37# from floor to waist and carrying it for 100 consecutive feet. Patient continues to present with impairments involving occasional pain, that is in his foot and not low back, which limits his ability to walk prolonged. He is also limited in transferring in/out of forklift and driving a forklift as these activities were not performed in therapy. Prior to injury, patient worked as a forklift driver for XX's that requires a PDL of medium as per DOT code 921.683-050. At this time, patient has reached maximum benefit from therapy and has been discharged from physical therapy with home exercise program.		
MM/DD/2018	XXXX Medicine Christos XXX, M.D.	**Follow-up visit for bilateral leg pain:** Patient is here today for follow-up. He is having persistent pain in his knees. He is wondering if there is anything we can do. **Physical examination:** On exam, he is tender over the anterolateral aspect of the knees. He has full range of motion and no effusion but there is pain there. **Plan:** I did inject both knee with 2 cc of Depo-Medrol and 6 cc of Lidocaine. Again I told him that I don't think it is anything serious and should resolve with time. Hopefully these injections will and I will see him in 2 weeks for recheck. Patient may not return to work.	XX YY (recs + bills) – 000007 – 000008	108-109
MM/DD/2018	XXXX Medicine	**Follow-up visit for bilateral knee pain:** Patient returns today for follow-up. Cortisone injections did help him but he is still feeling some soreness in his legs. He also	XX YY (recs + bills) – 000009 – 000011	112-114

TRIAL

DATE	PROVIDER	OCCURRENCE/TREATMENT	BATES REF	PDF REF
	Christos XXX, M.D.	complains of some weakness. **Physical examination:** The quadriceps does have some atrophy. He does have some pain over the medial joint lines bilaterally. There is a lack of about 10 degrees of flexion in each knee. **Assessment:** Right knee chondromalacia. **Plan:** He has only had a couple of weeks of physical therapy. I want to get him back into physical therapy to work on quad strengthening, range of motion and isometrics. He will do this, come and see me in 4 weeks. 1 told him that I don't think anything major is going on. I don't recommend any type of surgical intervention. Physical therapy 3 x/week for 4 weeks. Patient may not return to work. I will see him in 4 weeks for recheck.		
MM/DD/2018	XX Therapy Naha XXX, P.T.	**Physical therapy initial evaluation for bilateral knee pain:** **Primary complaint:** Pain in bilateral knees that is present occasionally with sudden movements, lifting and carrying tasks, and prolonged standing. **Current level of function**: Patient reports limitations with lifting 50# from floor, carry 50# 100 consecutive feet, operating a forklift, climb ladder, pulling/pushing 100#, running, standing more than 1 hour, standing from sitting prolonged, sudden movements. **Pain level of function:** Unlimited with all activities. **Pain scale:** At rest 0/10, during activity 8/10, functional activity – sustained standing, pain comment – aching and sharp. **Nature of injury: M.D. diagnosis:** Bilateral knee chondromalacia. Patient was on the back of the truck on a forklift. The truck rolled forward and he rolled backward and fell off the truck. He had his seat belt on so that saved him from more injury. **Previous treatment:** Physical therapy, injection, physical therapy for low back and bilateral knee. **Physical examination: Manual muscle testing:** Left hip flexion 4+, left hip extension 4+, left knee flexion 4+. **Flexibility:**	XX Therapy (recs + bills) – 000035 – 000040, 000024 – 000032	115-129

TRIVENT LEGAL

DATE	PROVIDER	OCCURRENCE/TREATMENT	BATES REF	PDF REF
		Bilateral quadriceps: Minimal tightness. Bilateral hamstring: Minimal tightness. Bilateral gastrocnemius: Minimal tightness. Flexibility: Patient able to squat 75% of the way with discomfort in anterior knee on bilateral lower extremities. **Palpation:** Tenderness over lateral knee area due to injection placement. **IKDC Subjective Knee Evaluation:** 24.1 points. **VR-12 Mental Component Summary:** 33 points. **VR-12 Physical Component Summary:** 26 points. **Assessment:** Patient presents to physical therapy with signs and symptoms consistent with physician's diagnosis of bilateral knee pain. Patient presents today with decreased strength, balance, flexibility and increased pain, as well as impairments with body mechanics, lifting mechanics, and exercise tolerance. These deficits limit the patient's ability to perform lifting 50# from floor, carry 50# 100 consecutive feet, operating a forklift, pulling/pushing 100#, running, standing more than 1 hour, standing from sitting prolonged, and sudden movements. Patient demonstrates a need for strengthening, balance training, modalities, ergonomic training, home exercise program education, and education on safe lifting techniques. Prior to injury, patient worked as a forklift driver at XX's that requires a PDL of Medium as per DOT code: 921.683-050. Patient will benefit from skilled therapy to allow the patient to meet set goals and return to prior level of function. After a course of therapy, patient will benefit from transitioning to first work conditioning program to further improve functional strength as well as a functional capacity evaluation to determine PDL level for safe return to work. **Rehab potential/prognosis:** Good. **Plan of treatment:** 2-3 x/week for 4 weeks. **Treatments:** Therapeutic exercises, manual therapy, neuromuscular reeducation, therapeutic activities, hot/cold pack, ultrasound, electrical stimulation and self-care/home management training.		
MM/DD/2018	XXX Surgery, S.C. Sean XXX,	**Correspondence regarding follow-up consultation for lower back pain:** I saw patient in the office today for a follow-up consultation. He has continued to go to physical therapy and feels much	XXXX - 000006 – 000010, 000016	135-140

TRIVENT LEGAL

DATE	PROVIDER	OCCURRENCE/TREATMENT	BATES REF	PDF REF
	M.D. Natalie XX, P.A.-C.	improvement in his complaints. He no longer complains of pain in the low back but only feels a tightness sensation occasionally but has not done any heavy activities. He feels pain in the bilateral knees for which he got injections per ortho but no surgery is needed. He was injured at work on *MM/DD/2018*. He is not currently working. **Review of systems: Musculoskeletal:** Joint pain. **Lumbosacral exam: Range of motion:** Forward flexion 70 degrees, hyperextension 20 degrees, right lateral bending 20 degrees and left lateral bending 20 degrees. **Impression:** • Low back pain • Knee pain **Recommendation:** Patient is doing well with near resolution of his low back pain. He should continue physical therapy per his orthopedic physician and once cleared to start a Work Conditioning Program (WCP) should undergo 5 x/week for 2 weeks. He will return after the WCP for a release to work. Continue physical therapy 2-3 x/week for lumbar spine strain until he is cleared by ortho to start Work Conditioning Program 5 x/week for 2 weeks. • Stabilization • Strengthening • Conditioning Patient is released to return to work beginning MM/DD/2018 with the following restrictions: **Restrictions:** He can work at a desk work capacity of no lifting/carrying/pushing/pulling more than 10 lbs, no bend/twist more than 3 times per hour and no forklift driving.		
MM/DD/2018 – MM/DD/2018	XX Therapy Naha XXX, P.T. Nadia XXX, P.T.A.	**Summary of multiple interim physical therapy visits for bilateral knee pain:** **Total no. of visits:** 10. **Treatment rendered:** Therapeutic exercises, manual therapy, neuromuscular reeducation, therapeutic activities, hot/cold pack, ultrasound, electrical stimulation and self-care/home	XX Therapy (recs + bills) – 000007 – 000023	130-134, 141-152

TRIVENT LEGAL

DATE	PROVIDER	OCCURRENCE/TREATMENT	BATES REF	PDF REF
		management training. **Summary of events:** **MM/DD/2018:** Patient reports feeling better. Patient reports he felt better after stretching yesterday. Patient initiated and tolerated treatment session well. Continued with stretching exercises and incorporated functional strengthening in order to progress towards goals of return to work. Minimal verbal cues given for body mechanics and lifting mechanics. **MM/DD/2018:** Patient reports feeling better. Patient reports no new complaints. Patient tolerated treatment session well. Incorporated more activities per patient tolerance to progress towards functional goals. He required minimal verbal cues for body mechanics but demonstrates improved posture with activities. **MM/DD/2018:** Patient reports feeling better. Patient reports no new complaints. Continued with exercises per patient tolerance with verbal cues for body mechanics. Patient requires less frequent rest breaks as he is improving muscle strength and endurance to tolerate repetitive exercises. **MM/DD/2018:** Patient reports feeling better. Patient reports he is feeling better. Incorporated new strengthening exercises per patient tolerance in order to progress towards strengthening goals. Added in activities for upper extremities and core/trunk strengthening in order to progress towards transition to first. **MM/DD/2018:** Patient reports feeling the same. Patient reports no new complaints. Patient tolerated treatment session well. Continued with exercises with min progressions in repetitions. Patient demonstrates improvements with posture as he requires less cuing, but requires few reminders for body mechanics and lifting mechanics. **MM/DD/2018:** Patient reports feeling the same. “It’s going to be alright”. Patient tolerated session well. Patient was able to complete progressive exercises without difficulty or increase in pain. Patient was encouraged to ice at home to help prevent increase in pain and soreness. **MM/DD/2018:** Patient reports feeling better. Patient reports that he occasionally gets pain in his knees over the weekend because he isn't doing anything at home. Minimal progressions made in exercises. Focused on lifting and body mechanics today in order to improve ability to perform work related tasks without discomfort and with proper ergonomics to prevent further injury. Patient is progressing well towards long term goals.		

TRIVENT LEGAL

DATE	PROVIDER	OCCURRENCE/TREATMENT	BATES REF	PDF REF
		MM/DD/2018: Patient reports feeling better. Patient reports feeling no pain. Patient continues to demonstrate increase in tolerance for current exercise program. Patient was able to complete exercises which were progressed without increase in fatigue or pain. **MM/DD/2018:** Patient reports feeling better. "It's a good day today". Patient experienced some minor pain of right lateral knee after walking lunges. Patient reported feeling better after stretching and was able to finish session without pain. Incorporated abdominal series to help patient core activation during lifting exercises. **MM/DD/2018:** Patient reports feeling better. Patient reports he is feeling great. Incorporated jogging at beginning of session in order to progress with cardiovascular endurance. He was able to tolerate 3 x 1 minutes of running at speed of 5.0 miles per hour with run 1', walk 1' pattern. Continued with exercises per patient tolerance. Patient did report fatigue by the end of the session. **Reviewer's comment: Multiple interim physical therapy visits are summarized with significant events.*		
MM/DD/2018	XX Therapy Naha XXX, P.T.	**Physical therapy discharge summary:** Patient reports that he still feels soreness after activity. **Functional limitations:** Lifting 50 lb from floor, carry 50# for 100 consecutive feet, operating forklift, climb ladder, pulling/pushing 100#. **Pain scale:** Rest 0/10, during activity 0/10, pain comment – soreness. **Physical exam: Flexibility:** Bilateral hamstring: Less than minimal tightness. Bilateral gastrocnemius: Less than minimal tightness. **Palpation:** Tenderness over lateral knee area due to injection placement. **IKDC Subjective Knee Evaluation:** 80.5 points. **VR-12 Mental Component Summary:** 46 points. **VR-12 Physical Component Summary:** 54 points. **Assessment:** Patient presents to physical therapy with signs and symptoms consistent with physician's diagnosis of bilateral knee pain. Patient had attended 12 sessions of therapy previously and received cortisone injections, after which he was recommended to continue with therapy.	XX Therapy (recs + bills) – 000004 – 000006	153-155

TRIVENT LEGAL

DATE	PROVIDER	OCCURRENCE/TREATMENT	BATES REF	PDF REF
		Patient has attended 12 sessions of therapy since the cortisone shot he received. Since the start of therapy, he has made objective improvements with range of motion, strength, flexibility, balance, and exercise tolerance. These improvements have increased his ability to perform short time jogging, sudden movements, floor to waist lift 37# 10 repetitions, push/pull 60# 15 repetitions, leg press 130#, straight leg press 90#, incline press 50#, and lift and carry 37# for 100 feet. Patient continues to present with impairments involving occasional discomfort in his knees with vigorous activities. These deficits limit his ability to perform lifting 50 lb from floor, carry 50# for 100 consecutive feet, operating forklift, climb ladder, and pulling/pushing 100#. Prior to injury, patient worked as a forklift driver at XX's that requires a PDL of medium as per DOT code: 921.683-050. Currently, he is not working. At this time, patient has reached maximum benefit from therapy. It is recommended he be transitioned to first work conditioning at this time in order to further improve functional strength. After work conditioning, he would benefit from a functional capacity evaluation to determine PDL level for safe return to work. At this time, patient has been discharged from physical therapy.		
MM/DD/2018	XXXX Medicine Christos XXX, M.D.	**Follow-up visit for bilateral leg pain:** Patient returns today for follow-up. He is doing substantially better. He has finished with his physical therapy. He doesn't have any significant pain. Occasional aches and pains with going up and down stairs. **Physical examination:** On exam, he has full range of motion both knees. **Assessment:** Bilateral knee strain resolved. **Plan:** From my standpoint, he can return to his activities as tolerated. We will see him as needed. **Work status:** Continue regular work duties on MM/DD/2018.	XX YY (recs + bills) – 000012 – 000013	162-163
MM/DD/2018	XXX Surgery, S.C. Sean XXX, M.D. Elizabeth XXX, P.A-C.	**Follow-up visit consultation for low back pain:** I saw patient in the office today for a follow-up consultation. He has completed two weeks of work conditioning and states that he is feeling good. He notes only a very low grade ache in the back at times but states it is nothing like it was when he first injured himself. He notes that he has changed his diet and that as a result is feeling much better overall and has lost 15 lbs. He denies any leg pain, weakness, falls, bowel or bladder incontinence. He is not	XXXX – 000069 – 000072	166-169

TRIVENT LEGAL

DATE	PROVIDER	OCCURRENCE/TREATMENT	BATES REF	PDF REF
		taking anything for pain. He was injured at work on *MM/DD/2018*. He is not currently working. **Review of systems: Musculoskeletal:** Back pain. **Lumbosacral spine: Range of motion:** Forward flexion 60 degrees, hyperextension 20 degrees, right lateral bending 20 degrees, and left lateral bending 20 degrees. **Impression:** Low back pain. **Recommendation:** Patient continues to do well with minimal residual low back pain. At this time he is released to work full duty without restrictions. He was told that he does not need to return for follow-up but that he is more than welcome to come back in the future should the need so arise. He was encouraged to continue to perform his home exercises on a daily basis and to perform home exercises. Patient has been released to return to work on MM/DD/2018 with no restrictions. **Related records:** Correspondence record.		
MM/DD/2018	XX Thomas XX, M.D.	**Follow-up visit for neck pain:** **Chief complaint:** Neck pain (8/10). Patient reports that on the day of injury at work he was operating a forklift inside a truck and that the brakes had not been set on the truck and as he was backing out of the truck the truck jerked and his forklift falling off of the truck. He had a harness belt on which prevented him from falling out of the truck but as a result he was twisted. He was taken to the Emergency Room a date or so later because of ongoing pain and he had what sounds like a CT and was later discharged home with a prescription for pain medication. He has been treated for his low back and knees as a result of this work related injury in the past. He denies any treatment to his neck as a result of this work related injury. He reports that he did mention that he did report having neck pain but that he was never really worked up for this and denies any imaging for his neck. He also mentions that his neck pain had increased once he returned to work. Currently, he complains of neck pain to the right side of his neck	XX Anesthesia & Pain (recs + bills) – 000017 – 000022	170-175

TRIVENT LEGAL

DATE	PROVIDER	OCCURRENCE/TREATMENT	BATES REF	PDF REF
		that is without any radiation of pain or radiculopathy symptoms. The pain is described as sharp in nature. On average, the pain is a 8/10 on a 1-10 numeric rating scale with 1 being the least amount of pain and 10 being the most. The pain is worsened with waking up in the morning from sleep and improved with nothing. He has not been able to sleep much since the accident due to their level of pain. The patient has never had pain in these areas before and has never been treated for pain or an injury in these areas before either. He has been working without any restrictions as he feels he is able to perform his current job without any restrictions. **Review of systems: Constitutional:** Usual state of health. **Objective: Neuro/Musculoskeletal:** Pain with neck extension; (+) pain with neck rotation to the left; Grade 2 tenderness and myospasm to palpation over the right cervical paraspinous muscles at the C3 to C6 levels; (+) right cervical facet loading. Cervical range of motion: Flexion: 45 degrees, extension: 15 degrees, left lateral bending: 45 degrees, right lateral bending: 45 degrees. **Diagnoses:** • Painful neck • Chronic neck pain **Plan:** • Discussed patient's condition at length, educating them about expectations and alternatives to treatment • Script for physical therapy given. Diagnosed cervical pain. 2-3 times per week x 4-6 weeks and reassess at the conclusion of this • Order cervical MRI without contrast for cervical pain. I feel that the injuries reported in today's visit are due to the *MM/DD/2018* accident described in this visit and not due to a pre-existing condition • Prescription for Cyclobenzaprine 7.5 mg • Prescription for Meloxicam 7.5 mg • Prescription for Pantoprazole 20 mg • Prescription for Tramadol 50 mg • Lidocaine patches given to try and minimize oral medication use due to side effects associated with oral medications. To be used at night while asleep and while patient would not normally be taking oral medications. This will also help with sleep • Lidocaine 5% cream to be used during the day while patches to be used at night to minimize oral medication use and to		

TRIVENT LEGAL

DATE	PROVIDER	OCCURRENCE/TREATMENT	BATES REF	PDF REF
		minimize side effects • Schedule for diagnostic C3-C6 right sided medial nerve branch block (paravertebral facet (zygapophyseal) joint injection with imaging guidance). If patient experiences more than 80% pain reduction and improvement in functionality for the duration of the local anesthetic given, will proceed with radio-frequency ablation (destruction by neurolytic agent, paravertebral facet joint nerves, with imaging guidance) at the same sites tested. Patient will also be instructed to continue their home exercises following the procedure • Continue regular work without restrictions. Return to clinic 4 weeks.		
MM/DD/2018	XXX, SC XX Thomas XX, M.D.	**Follow-up visit for neck pain:** *History reviewed.* Currently, today he complains of increased neck pain to the right side of his neck that is without any radiation of pain or radiculopathy symptoms that began the next day when he returned to work. The pain is described as sharp in nature. On average, the pain is an 8/10 on a 1-10 numeric rating scale with 1 being the least amount of pain and 10 being the most. The pain is worsened with waking up in the morning from sleep and improved with nothing. He also mentions that his pain is increased when he is at work when operating the forklift. He has been taking Tramadol, Flexeril, and Meloxicam as previously described and he does not feel this is helping much. He is also using the Lidocaine patches and cream and feels this helps some. He has been working without any restrictions as he feels he is able to perform his current job without any restrictions. He states that he is scheduled for his MRI for his cervical spine near the end of the month. **Review of systems: Constitutional:** Usual state of health. **Objective: Neuro/Musculoskeletal:** Pain with neck extension; (+) pain with neck rotation to the left; grade 2 tenderness and myospasm to palpation over the right cervical paraspinous muscles at the C3 to C6 levels; positive right cervical facet loading. Cervical range of motion: Flexion: 45 degrees, extension: 15 degrees, left lateral bending: 45 degrees, right lateral bending: 45 degrees. **Assessment:** Neck painful.	XX Anesthesia & Pain (recs + bills) – 000023 – 000026	176-179

TRIVENT LEGAL

DATE	PROVIDER	OCCURRENCE/TREATMENT	BATES REF	PDF REF
		Plan: • Discussed patient's condition at length, educating them about expectations and alternatives to treatment • Continue physical therapy given. 2-3 times per week x 4-6 weeks and reassess at the conclusion of this • Order cervical MRI without contrast for cervical pain • I feel that the injuries reported in today's visit are due to the *MM/DD/2018* accident described in this visit and not due to a preexisting condition. • Continue for Cyclobenzaprine 7.5 mg • Continue for Meloxicam 7.5 mg • Continue for Pantoprazole 20 mg • Continue for Tramadol 50 mg • Offered Norco for pain and patient refused this. • Lidocaine patches given to try and minimize oral medication use due to side effects associated with oral medications. To be used at night while asleep and while patient would not normally be taking oral medications. This will also help with sleep • Lidocaine 5% cream to be used during the day while patches to be used at night to minimize oral medication use and to minimize side effects • Schedule for diagnostic C3-C6 right sided medial nerve branch block (paravertebral facet (zygapophyseal) joint injection with imaging guidance). If patient experiences more than 80% pain reduction and improvement in functionality for the duration of the local anesthetic given, will proceed with radio-frequency ablation (destruction by neurolytic agent, paravertebral facet joint nerves, with imaging guidance) at the same sites tested. Patient will also be instructed to continue their home exercises following the procedure • H-Wave home unit 30 days free trial • Return to work without restrictions Return to clinic in 3 weeks after completing MRI of cervical spine.		
MM/DD/2018	XXX, SC Thomas XX, M.D.	**Addendum report:** Patient has tried and failed TENS (Transcutaneous Electrical Nerve Stimulation) and physical therapy. Per ODG, I am ordering a free 1-month trial of H-Wave for the reduction of inflammation and pain. If the patient does not show improvement in the trial period, no order furthering treatment will be assessed.	XX Anesthesia & Pain (recs + bills) –000025	178
MM/DD/2018	XXX, SC Thomas XX, M.D.	**Follow-up visit for neck pain:** Patient has not had his MRI, and his injection is currently pending. There have been no changes in his pain over the past couple weeks. He continues to have neck pain mostly on the right	XX Anesthesia & Pain (recs + bills) – 000027 – 000032	181-186

TRIVENT LEGAL

DATE	PROVIDER	OCCURRENCE/TREATMENT	BATES REF	PDF REF
	Angie XX, P.A.-C.	side of his neck that is without any radiation of pain or radiculopathy symptoms that began the next day when he returned to work. The pain is described as sharp in nature. The pain is a 8/10 visual analogue scale. The pain is worsened with waking up in the morning from sleep and improved with nothing. He also mentions that his pain is increased when he is at work when operating the forklift. He has been taking Tramadol, Flexeril, and Meloxicam as previously described and he does not feel this is helping much. He is also using the Lidocaine patches and cream and feel this helps some. He has been working without any restrictions as he feels he is able to perform his current job without any restrictions. **Initial presentation:** Date of injury: *MM/DD/2018*. Patient reports that on the day of injury at work he was operating a forklift inside a truck and that the brakes had not been set on the truck and as he was backing out of the truck the truck jerked and his forklift falling off of the truck. He had a harness belt on which prevented him from falling out of the truck but as a result he was twisted. He was taken to the Emergency Room a date or so later because of ongoing pain and he had what sounds like a CT and was later discharged home with a prescription for pain medication. He has been treated for his low back and knees as a result of this work-related injury in the past. He denies any treatment to his neck as a result of this work-related injury. He reports that he did mention that he did report having neck pain but that he was never really worked up for this and denies any imaging for his neck. He also mentions that his neck pain had increased once he returned to work. **Physical exam: Neuro/musculoskeletal:** Pain with neck extension, pain with neck rotation to the left; grade 2 tenderness and myospasm to palpation over the right cervical paraspinous muscles at the C3 to C6 levels. Positive right cervical facet loading. Cervical range of motion: Flexion 45 degrees, extension 15 degrees, left lateral bending 45 degrees, right lateral bending 45 degrees. **Assessment:** Patient with severe/chronic neck pain. I feel that the injuries reported in today's visit are due to the *MM/DD/2018* accident described in this visit and not due to a pre-existing condition. **Plan:** • Discussed patient's condition at length, educating them about		

TRIVENT LEGAL

DATE	PROVIDER	OCCURRENCE/TREATMENT	BATES REF	PDF REF
		expectations and alternatives to treatment • Continue to recommend physical therapy for cervical pain. 2-3 times per week x 4-6 weeks • Order cervical MRI without contrast for cervical pain • Continue for Cyclobenzaprine 7.5 mg • Continue for Meloxicam 7.5 mg, Pantoprazole 20 mg, and Tramadol 50 mg • Continue using Lidocaine patches and Lidocaine 5% cream • Patient has tried and failed TENS and Physical therapy. Per ODG, I am ordering a free 1-month trial of H-Wave for the reduction of inflammation and pain. If the patient does not show improvement in the trial period, no order furthering treatment will be assessed • Continue to recommend for diagnostic C3-C6 right sided medial nerve branch block (paravertebral facet (zygapophyseal) joint injection with imaging guidance). If patient experiences more than 80% pain reduction and improvement in functionality for the duration of the local anesthetic given, will proceed with radio-frequency ablation (destruction by neurolytic agent, paravertebral facet joint nerves, with imaging guidance) at the same sites tested. Patient will also be instructed to continue their home exercises following the procedure • Continue to work without restrictions Return to clinic 2-3 weeks after completing MRI of cervical spine.		
MM/DD/2018	XX Imaging XXX, M.D.	**MRI of the cervical spine:** **History:** Radiculopathy, neck pain. **Findings:** There is normal lordotic curvature of the cervical spine. The craniocervical junction is unremarkable. Disc desiccation, broad based posterior disc osteophyte complex, uncovertebral hypertrophy involving C4-5, C5-6 and C6-7, causing mild to moderate mass effect to the central spinal canal. The cervical spinal cord is grossly normal is caliber, morphology and signal intensity. **Axial images:** **C1-2:** No central spinal stenosis. No neural foraminal narrowing. **C2-3:** Mild disc bulging, arthropathy of the facet joints, causing mild central spinal stenosis. No neural foramina narrowing. **C3-4:** Mild disc bulging, arthropathy of the facet joints, causing mild central spinal stenosis. No neural foramina narrowing.	XX Imaging (recs + bills) – 000001 – 000002	187-188

TRIVENT LEGAL

DATE	PROVIDER	OCCURRENCE/TREATMENT	BATES REF	PDF REF
		C4-5: Mild broad-based posterior disc osteophyte complex, along with uncovertebral hypertrophy, facet joints hypertrophy, causing mild deformity of the thecal sac. No spinal cord compression. Mild bilateral neural foraminal narrowing, no encroachment of exiting nerve roots. **C6-7:** Mild to moderate, broad-based posterior disc osteophyte complex, along with uncovertebral hypertrophy, facet joints hypertrophy, causing mild deformity of the thecal sac. No spinal cord compression. Mild to moderate bilateral neural foraminal narrowing, causing mild encroachment of bilateral exiting nerve roots. **C7-T1:** Mild disc bulging, arthropathy of the facet joints, causing mild central spinal stenosis. No neural foramina narrowing. **Impression:** • Moderate central spinal stenosis, bilateral neural foraminal narrowing at level of C5-6, causing mild to moderate deformity of the thecal sac. No spinal cord compression. Mild to moderate encroachment of bilateral exiting nerve roots • Mild to moderate central spinal stenosis and the neural foramina narrowing at level of C4-5, C6-7		
MM/DD/2018	XX Imaging XXX, M.D.	**MRI of the lumbar spine:** **History:** Radiculopathy, low back pain. **Findings:** For purposes of numbering lumbar vertebral bodies on this study the most inferior normal diameter disc space will be considered L5-S1. No transitional vertebral body segments. Plain film radiographs would be required to confirm nomenclature used in this report, particularly prior to any spine intervention. **Vertebral body height:** Normal. No compression deformities. **Disc height and disc signal:** Disc desiccation and loss of intervertebral disc height at level L5-S1. Moderate facet arthropathy involving L5-S1. **Alignment:** Normal. No spondylolisthesis. **Bone marrow signal:** Degenerative changes, with osteophyte formation, and endplates degeneration involving L5-S1. **Conus medullaris:** Normal. Extends to the L1 level. **Paraspinal soft tissues:** Unremarkable.	XX Imaging (recs + bills) – 000003 – 000004	189-190

TRIVENT LEGAL

DATE	PROVIDER	OCCURRENCE/TREATMENT	BATES REF	PDF REF
		Axial images: **L1-2:** Intervertebral disc, facet joint, are normal in morphology and signal intensity. No disc bulging. No disc protrusion. No central spinal stenosis or neural foraminal narrowing. **L2-3:** Intervertebral disc, facet joint, are normal in morphology and signal intensity. No disc bulging. No disc protrusion. No central spinal stenosis or neural foraminal narrowing encroachment of the exiting nerve roots. **L5-S1:** Moderate broad-based posterior disc osteophyte complex, superimposed by 6 mm x 15 mm x 7 mm central disc protrusion, along with moderate bilateral facet arthropathy, thickened ligamentum flavum, causing moderate deformity of the thecal sac and effacement of the bilateral traversing nerve roots. There is mild to moderate bilateral neural foraminal narrowing, causing mild encroachment of the bilateral exiting nerve roots. **Impression:** Moderate broad-based posterior disc osteophyte complex at the level of L5-S1, superimposed by 6 mm x 15 mm x 7 mm central disc protrusion, along with moderate bilateral facet arthropathy, thickened ligamentum flavum, causing moderate deformity of the thecal sac and effacement of the bilateral traversing nerve roots. There is mild to moderate bilateral neural foraminal narrowing, causing mild encroachment of the bilateral exiting nerve roots.		
MM/DD/2018	XXX, SC Mark XX, M.D. Angie XX, P.A.-C.	**Follow-up visit for MRI scan results review:** **Chief complaint:** Neck and low back pain. Patient returns today after his MRI, and his injection is pending. His pain has remained the same. He continues to have neck pain mostly on the right side of his neck that is without any radiation of pain or radiculopathy symptoms that began the next day when he returned to work. The pain is described as sharp in nature. The pain is an 8/10 visual analogue scale. The pain is worsened with waking up in the morning from sleep and improved with nothing. He also mentions that his pain is increased when he is at work when operating the forklift. He has been taking Tramadol, Flexeril, and Meloxicam as previously described, and he does not feel this is helping much. He is also using the Lidocaine patches and cream and feel this helps some. He has been working without any restrictions as he feels he is able to perform his current job without any restrictions.	XX Anesthesia & Pain (recs + bills) – 000033 - 000038	191-196

TRIVENT LEGAL

DATE	PROVIDER	OCCURRENCE/TREATMENT	BATES REF	PDF REF
		History reviewed. The low back pain continues to bother him. **Review of systems: General:** Usual state of health. **Physical exam: Neck:** Pain with neck extension pain with neck rotation to the left, grade 2 tenderness and myospasm to palpation over the right cervical paraspinous muscles at the C3 to C6 levels; positive right cervical facet loading. Cervical range of motion: Flexion 45 degrees, extension 15 degrees, left lateral bending 45 degrees, right lateral bending 45 degrees. **Assessment:** Patient with severe/chronic neck and low back pain. I feel that the injuries reported in today's visit are due to the *MM/DD/2018* accident described in this visit and not due to a pre-existing condition. **Plan:** • Continue physical therapy given for cervical and low back pain. 2-3 times per week x 4-6 weeks and reassess at the conclusion of this • Discussed cervical and lumbar MRI results • Refilled Cyclobenzaprine 10 mg, Meloxicam 15 mg, Pantoprazole 20 mg and Tramadol 50 mg • Offered Norco for pain and patient is not interested • Continue Lidocaine patches and Lidocaine 5% cream • Continue wearing spinal Q • Referral to spine surgeon for neck and low back pain • Patient has tried and failed TENS and physical therapy. Per ODG, I am ordering a free 1-month trial of H-Wave for the reduction of inflammation and pain. If the patient does not show improvement in the trial period, no order furthering treatment will be assessed • Given patient's symptoms and physical exam findings, will plan for facet joint steroid injections at the right C4-7 levels. I counseled the patient about the procedure including expectations, risks, and benefits and they would like to proceed • Recommend referral to spine surgeon for evaluation of ongoing pain refractory to conservative treatment cervical and lumbar Follow up in 4 weeks.		
MM/DD/2018	XXX, SC William XX, P.A.-C	**Follow-up visit for low back, neck and bilateral knee pain:** Since the accident his pain has improved but it is still bothersome. It is all right sided in nature. There is no radiation. The pain is described as sharp in nature. The pain is a 6/10. It is	XX Anesthesia & Pain (recs + bills) – 000001 – 000002, 000039-	198-203

TRIVENT LEGAL

DATE	PROVIDER	OCCURRENCE/TREATMENT	BATES REF	PDF REF
		constant. He also mentions that his pain is increased when he is at work and when operating the forklift. The low back pain is also still bothersome. This is an achy pain that comes and goes. He will follow up with Dr. XX with regards to this in next couple of weeks. He has been having some increased pain in his knees recently. Ambulation is difficult due to the pain. He had a steroid injection in his knees in the past that did seem to help but the pain has returned. He has been taking Tramadol, Flexeril, and Meloxicam as previously described and he does not feel this is helping much. He is also using the Lidocaine patches and cream and feel this helps some. He has been working without any restrictions as he feels he is able to perform his current job without any restrictions. **Physical exam: Back:** Bilateral lumbar paraspinal tenderness with muscle rigidity. Grade of tenderness – 2/4. **Neck:** Positive pain with neck extension, neck rotation to the right; grade 2 tenderness and myospasm to palpation over the right cervical paraspinous muscles at the C3 to C6 levels. Positive cervical facet loading. **Cervical range of motion:** Flexion 45 degrees, extension 15 degrees, left lateral bending 45 degrees, right lateral bending 45 degrees. **Diagnoses:** • Low back pain • Neck pain • Bilateral knee pain **Plan:** Right facet joint injections to C3-C6. MRI of bilateral knee • Continue physical therapy 2-3 times per week x 4-6 weeks and reassess at the conclusion of this • Discussed cervical and lumbar mri results • Continue Cyclobenzaprine 10 mg, Meloxicam 15 mg, Pantoprazole 20 mg and Tramadol 50 mg • Schedule for bilateral knee MRI's without contrast to evaluate for pain • Continue Lidocaine patches and Lidocaine 5% cream • Continue wearing spinal Q • Follow up with Dr. XX • Given patient's symptoms and physical exam findings, will plan for facet joint steroid injections at the right C4-7 levels.	000042	

TRIVENT LEGAL

DATE	PROVIDER	OCCURRENCE/TREATMENT	BATES REF	PDF REF
		I counseled the patient about the procedure including expectations, risks, and benefits and they would like to proceed • Recommend referral to spine surgeon for evaluation of ongoing pain refractory to conservative treatment cervical and lumbar Follow-up in 4 weeks.		
MM/DD/2018	XX Imaging XXX, M.D.	**MRI of left knee:** **History:** Chronic medial knee pain. **Impression:** • Small, slightly displaced oblique tear involving the posterior periphery of the lateral meniscus superimposed on type II signal degeneration • Grade 1 partial tear of the medial collateral ligaments • Small joint effusion • Mild degeneration changes, and the post stress changes of the medial and lateral compartments	XX Imaging (recs + bills) – 000008 – 000010	207-209
MM/DD/2018	XX Imaging XXX, M.D.	**MRI of right knee:** **History:** Right knee pain, instability. **Impression:** • Small, slightly displaced oblique tear involving the posterior periphery of the lateral meniscus superimposed on type II signal degeneration • Type II signal degeneration of the posterior horn of the medial meniscus • Grade 1 partial tear of the medial collateral ligaments • Small joint effusion	XX Imaging (recs + bills) – 000005 – 000007	204-206
MM/DD/2018	XX Specialists, S.C. Angie XX, P.A.-C.	**Follow-up visit for neck, bilateral knee and back pain:** Since the accident his pain has improved but it is still bothersome. He has had his bilateral knee MRI's since his last visit. He has not been able to follow up with Dr. XX because his MRI appointment was at the same time. The low back pain is also still bothersome. He is continuing to have intermittent tingling on the bottom of the foot and the top of the foot near the ankle. This is an achy pain that comes and goes. He will follow up with Dr. XX with regards to this on MM/DD/2019. It is all right sided in nature. There is no radiation. The pain is described as sharp in nature. The pain is a 6/10 visual analogue scale. It is constant. He also mentions that his pain is increased when he is at work and when operating the forklift. This has not changed. He continues to have bilateral knee pain that is worse with walking. He had a steroid injection in his knees in the past that	XX Anesthesia & Pain (recs + bills) – 000045 – 000050	212-218

TRIVENT LEGAL

DATE	PROVIDER	OCCURRENCE/TREATMENT	BATES REF	PDF REF
		did seem to help but the pain returned. He continues to take Tramadol, Flexeril, and Meloxicam as previously described, and he does not feel this is helping much. He is also using the Lidocaine patches and cream and feel this helps some. He has been working without any restrictions as he feels he is able to perform his current job without any restrictions. **Physical exam: Back:** Palpation: Bilateral lumbar paraspinal tenderness with muscle rigidity. Grade of tenderness: 2/4. Facet loading (extension and lateral bending of the lumbar spine reproducing patient's pain): Positive bilaterally. **Neck:** Pain with neck rotation to the left; grade 2 tenderness and myospasm to palpation over the right cervical paraspinous muscles at the C3 to C6 levels, positive right cervical facet loading. **Cervical range of motion:** Flexion 45 degrees, extension 15 degrees, left lateral bending 45 degrees, right lateral bending 45 degrees. **Left knee:** Tenderness: Medial and lateral joint line tenderness, medial collateral ligament and lateral collateral ligament tenderness. **Valgus stress (MCL):** Positive. McMurray's and Apley's (meniscal tears): Positive. Active range of motion flexion 100 degrees and extension 0 degrees. **Right knee: Valgus stress (MCL):** Positive. McMurray's and Apley's (meniscal tears): Positive. Active range of motion flexion 100 degrees and extension 0 degrees. **Assessment:** Patient with severe/chronic neck and low back pain. I feel that the injuries reported in today's visit are due to the *MM/DD/2018* accident described in this visit and not due to a pre-existing condition. **Plan:** • Completed physical therapy • Continue Cyclobenzaprine 10 mg, Meloxicam 15 mg, Pantoprazole 20 mg and Tramadol 50 mg • Discussed bilateral knee MRI results • Continue Lidocaine patches and Lidocaine 5% cream • Continue wearing spinal Q • Continue to recommend right C4-C7 facet joint injections • Follow up with Dr. XX on MM/DD/2019		

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DATE	PROVIDER	OCCURRENCE/TREATMENT	BATES REF	PDF REF
		• Recommend Electromyography/Nerve Conduction Velocity of bilateral lower extremities to evaluate for radiculopathy/neuropathy • Patient counseled on lifestyle modifications, discussed patient's condition thoroughly and all questions were answered • Continue regular work duties on MM/DD/2018 Follow-up in 4 weeks.		
MM/DD/2019	XXX Surgery, S.C. Sean XXX, M.D. Natalie XX, P.A.-C.	**Correspondence regarding follow-up consultation for low back pain:** I saw patient in the office today for a follow up consultation. Since his last visit be returned to work without restrictions but started having worsening low back pain with time. He states that he can do the heavy work but the next day his back will be sore. He rates it about a 9/10 in the left lower back. He has also developed pain in the right side of the neck that radiates up to the top of the head, worse when he is turning his head while driving the forklift. He rates this pain an 8/10. He denies any leg pain, weakness, falls, bowel or bladder incontinence. He has done 6 weeks of physical therapy recently. He takes 4 different pain medications from his pain management physician but cannot recall the names. He was injured at work on *MM/DD/2018*. He is working full duty. **Review of systems: Musculoskeletal:** Complains of back pain. **Cervical exam: Range of motion:** Forward flexion 40 degrees, hyperextension 30 degrees, right lateral flexion 20 degrees, left lateral flexion 20 degrees, right lateral rotation 70 degrees and left lateral rotation 70 degrees. **Lumbosacral exam:** Palpation spinal tenderness: Abnormal. **Range of motion:** Forward flexion 45 degrees, hyperextension 10 degrees, right lateral bending 10 degrees and left lateral bending 10 degrees. **Sitting straight leg raise:** Left side positive in back only. **Impression and recommendation:** • **Degeneration disc disease lumbosacral spine** • **Lumbar spondylosis without radiculopathy** – Patient has had worsening of his low back pain and neck pain with return to his regular work. His low back pain due to the described work injury is secondary to aggravation of L5-S1 disc disease. His neck pain may be due to the bulging disc at C6-7 for which I do not recommend any aggressive	XXXX – 000065 – 000068	219-222

TRIVENT LEGAL

DATE	PROVIDER	OCCURRENCE/TREATMENT	BATES REF	PDF REF
		treatment. For his low back pain, given failure or conservative care I recommend surgical intervention in the form of a left L5-S1 Transforaminal Lumbar Interbody Fusion (TLIF). Risks, benefits and alternatives to a lumbar decompression and fusion with allograft were explained to the patient. I also had a discussion of intraoperative neuromonitoring by Dr. Kimberly XX to assess the nerve root status. Patient understood the contents of our discussion. Risks of the surgery including death, myocardial infarction, deep venous thrombosis, pulmonary embolus, pneumonia, infection deep or superficial, cerebrospinal fluid leak, lack of fusion requiring a repeat operation, instrumentation failure necessitating a repeat operation, paralysis, nerve root injury, stroke, lack of symptom relief or worsening of the symptoms despite the surgery, bowel or bladder incontinence and the need for post-operative assistive devices despite surgery were all explained. Patient understood what was discussed and would like to proceed with the surgery I reviewed with the patient the post-operative plan in detail. He will return to the clinic at two weeks post-operatively for re-evaluation and at 3 weeks post-operative starting a 4-6 weeks course of physical therapy and return to clinic with upright anterior/posterior lateral X-rays of lumbar spine. At that point in time the patient may return to work with desk work/light duty capacity by which he cannot lift more than 20 lbs, push/pull weight more than 35 lbs, no repetitive bending or twisting and alternate between sit/stand every 30-45 minutes. He will follow these restrictions until completion of a Work Conditioning Program (WCP) to be started no sooner than 6 months postoperatively. The WCP is for 4 weeks 5 days a week. He will return at the conclusion of the WCP with a final lumbar X-ray. At that time, he will be released back to work based on a valid functional capacity evaluation.		
MM/DD/2019	XXXX Medicine Christos XXX, M.D.	**Follow-up visit for bilateral knee pain:** Patient returns today for follow-up. He is having a flareup of pain in both of his knees. He has been having this for quite some time. He brings some new MRI's that were done in summer for review. **Past medical history:** Unchanged since the last time I saw him. **Physical examination:** On exam, he is tender to palpation over the medial and lateral joint lines bilaterally. He has some pain with flexion/extension and some pain with circumduction. Looking at his MRI he does have a medial meniscus tear on the left knee, little bit of degenerative changes on the right knee. No gross meniscus pathology or ligament injury.	XX YY (recs + bills) - 000050	223

TRIVENT LEGAL

DATE	PROVIDER	OCCURRENCE/TREATMENT	BATES REF	PDF REF
		Plan: I did inject both knees with 2 cc of Depo-Medrol and 6 cc of Lidocaine as he did get better after the last injections. I will see him in 3 weeks for recheck.		
MM/DD/2019	XX Specialists, S.C. Jason XX, P.A.-C Thomas XX, M.D.	**Follow-up visit for neck, low back and bilateral knee pain:** Patient presents for follow-up visit for his neck, low back and bilateral knee pain. He continues to follow up with Orthopedics for his bilateral knees. He was given a bilateral knee cortisone injection and will be following up with them for further recommendations. Since his last visit he had cancelled his Electrocardiogram due to Dr. XX recommending surgical intervention with a fusion. He was last seen by Dr. XX in the beginning of January 2019. He is currently recommending proceeding with surgical intervention of the lumbar spine. His neck pain continues to improve since his last visit. It is all right sided in nature. There is no radiation. The pain is described as sharp in nature. The pain is a 6/10 visual analogue scale. It is constant. He also mentions that his pain is increased when he is at work and when operating the forklift. This has not changed. He continues to have bilateral knee pain that is worse with walking. He had a steroid injection in his knees in the past that did seem to help but the pain returned. He continues to take Tramadol, Flexeril, and Meloxicam as previously described, and he does not feel this is helping much. He is also using the Lidocaine patches and cream and feel this helps some. He has been working without any restrictions as he feels he is able to perform his current job without any restrictions. **Physical exam: Back: Palpation:** Bilateral lumbar paraspinal tenderness with muscle rigidity. Grade of tenderness: 2/4. Facet loading (extension and lateral bending of the lumbar spine reproducing patients' pain): Positive bilaterally. **Neck:** Pain with neck rotation to the left, grade 2 tenderness and myospasm to palpation over the right cervical paraspinous muscles at the C3 to C6 levels, positive right cervical facet loading. Cervical range of motion: Flexion 45 degrees, extension 15 degrees, left lateral bending 45 degrees, right lateral bending 45 degrees. **Left knee:** Tenderness: Medial and lateral joint line tenderness,	XX Anesthesia & Pain (recs + bills) – 000003 – 000010	224-231

TRIVENT LEGAL

DATE	PROVIDER	OCCURRENCE/TREATMENT	BATES REF	PDF REF
		medial collateral ligament and lateral collateral ligament tenderness. Positive McMurray's and Apley's (meniscal tears). Active range of motion is flexion (normal 120): 100 degrees. Active range of motion is extension (normal 0): 0 degrees. **Right knee:** Positive McMurray's and Apley's (meniscal tears). Active range of motion is flexion (normal 120): 100 degrees. Active range of motion is extension (normal 0): 0 degrees. **Assessment:** Patient with severe/chronic neck and low back pain. I feel that the injuries reported in today's visit are due to the *MM/DD/2018* accident described in this visit and not due to a pre-existing condition. **Plan:** • Completed physical therapy • Continue wearing spinal Q • Continue to recommend right C4-C7 facet joint injection • Continue to follow up with Dr. XX • Continue to follow up with Orthopedics • Patient counseled on lifestyle modifications • Discussed patient's condition thoroughly and all questions were answered • Refilled Cyclobenzaprine 10 mg, Meloxicam 15 mg, Pantoprazole 20 mg, and Tramadol 50 mg • Refilled Lidocaine patches • Continue Lidocaine 5% cream • Continue current meds as prescribed • I counseled patient thoroughly on the use, risks, and adverse effects of these medications and they expressed understanding Continue regular work duties on MM/DD/2019. Follow-up in 4 weeks.		
MM/DD/2019	XXX Surgery, S.C. Sean XXX, M.D. Elizabeth XXX, P.A.-C.	**Follow-up consultation visit for back pain:** I saw patient in the office today for a follow up consultation. He continues to complain of significant pain in the low back which he states most of the time is 10/10 and on a good day will only go down to a 6/10. He is taking four different medications per pain management but states these are not really helping. He was injured at work on *MM/DD/2018*. He is working full duty. **Review of systems: Musculoskeletal:** Complains of back pain. **Lumbosacral exam:** Palpation-spinal tenderness: Abnormal.	XXXX – 000062 – 000064	233-235

TRIVENT LEGAL

DATE	PROVIDER	OCCURRENCE/TREATMENT	BATES REF	PDF REF
		Lumbosacral and left posterior iliac crest tenderness. **Range of motion:** Forward flexion 60 degrees, hyperextension 10 degrees, right lateral bending 20 degrees and left lateral bending 20 degrees. **Impression and recommendation:** Degenerative disc disease, lumbosacral spine. Patient has ongoing mechanical back pain secondary to single level disc disease at L5-S1 for which I continue to recommend surgical intervention in the form of a left L5-S1 Transforaminal Lumbar Interbody Fusion (TLIF). The risks and benefits were previously discussed, and he continues to wish to proceed. This will be scheduled once authorization is received.		
MM/DD/2019	XXXX Medicine Christos XXX, M.D.	**Follow-up visit for bilateral knee pain:** **Chief complaint:** Bilateral knee pain, left worse than right. Patient returns today for follow-up. He has his good days and bad days. He states that the left knee has been bothering him. He does have history of chondromalacia in his knee. We did talk about the option of gel injections and he wants to take some time to think about it. He expressed understanding and I will see him in the future as needed.	XX YY (recs + bills) – 000051	236
MM/DD/2019	XX Specialists, S.C. Thomas XX, M.D.	**Follow-up visit for back, low back and bilateral knee pain:** Patient presents for follow-up visit for his neck, low back and bilateral knee pain. He continues to follow up with Orthopedics for his bilateral knees. He was given a bilateral knee cortisone injection and will be following up with them for further recommendations. He most recently saw them this month and they are considering surgery versus viscosupplementation injections. Since his last visit he had cancelled his Electromyography due to Dr. XX recommending surgical intervention with a fusion. He was last seen by Dr. XX in the beginning of January 2019. He is currently recommending proceeding with surgical intervention of the lumbar spine. His neck pain is similar to last visit. It is all right sided in nature. There is no radiation. The pain is described as sharp in nature. The pain is a 6/10 visual analogue scale. It is constant. He also mentions that his pain is increased when he is at work and when operating the forklift. This has not changed. He continues to have bilateral knee pain that is worse with walking. He had a steroid injection in his knees in the past that did seem to help but the pain returned. He continues to take Tramadol, Flexeril, and Meloxicam as	Midwest Anesthesia & Paini (add'l recs) – 000007 – 000012	237-242

TRIVENT LEGAL

DATE	PROVIDER	OCCURRENCE/TREATMENT	BATES REF	PDF REF
		previously described, and he does not feel this is helping much. He is also using the Lidocaine patches and cream and feels this helps some. He has been working without any restrictions as he feels he is able to perform his current job without any restrictions. **Physical exam: Back:** Palpation: Bilateral lumbar paraspinal tenderness with muscle rigidity. Grade of tenderness: 2/4. Facet loading (extension and lateral bending of the lumbar spine reproducing patients' pain): Positive bilaterally. **Neck:** Pain with neck rotation to the left; grade 2 tenderness and myospasm to palpation over the right cervical paraspinous muscles at the C3 to C6 levels, positive right cervical facet loading. **Cervical range of motion:** Flexion 45 degrees, extension 15 degrees, left lateral bending 45 degrees, right lateral bending 45 degrees. **Left knee:** Medial and lateral joint line tenderness, Medial Collateral Ligament (MCL) and Lateral Collateral Ligament (LCL) tenderness. Positive Valgus stress (MCL). Positive McMurray's and Apley's test (meniscal tears). Active range of motion: Flexion 100 degrees and extension 0 degrees. **Right knee:** Positive Valgus stress (MCL). Positive McMurray's and Apley's test (meniscal tears). Active range of motion: Flexion 100 degrees and extension 0 degrees. **Assessment:** • Cervicalgia • Low back pain • Right knee pain • Left knee pain • Other specific arthropathies, not elsewhere classified, other specified site **Plan:** • Completed physical therapy • Continue wearing spinal Q • Continue to recommend right C4-C7 facet joint injection. This is scheduled for 03/05/2019 • Continue to follow up with Dr. XX . Is awaiting lumbar surgery approval • Continue to follow up with Orthopedics. Is considering surgery for his knee.		

TRIVENT LEGAL

DATE	PROVIDER	OCCURRENCE/TREATMENT	BATES REF	PDF REF
		• Patient counseled on lifestyle modifications, Discussed patient's condition thoroughly and all questions were answered • Continue Cyclobenzaprine 10 mg, Pantoprazole 20 mg, and Tramadol 50 mg • Discontinue Meloxicam 15 mg • Continue Lidocaine patches • Continue Lidocaine 5% cream • New script given for Ibuprofen 800 mg • Continue current medications as prescribed. • I counseled patient thoroughly on the use, risks, and adverse effects of these medications and they expressed understanding Return to limited duties. Follow up in 4 weeks.		
MM/DD/2019	XX Specialists, S.C. Angie XX, P.A.-C. Thomas XX, M.D.	**Follow-up visit for neck, back and bilateral knee pain status post work related injury:** Patient presents for follow-up visit for his neck, low back and bilateral knee pain. He went to get his injection on Tuesday but his blood pressure was too high. He saw his primary care physician yesterday, and will be picking up the medication after today's visit. His overall pain has not changed. He follows up with Orthopedics for his bilateral knee pain. He was given a bilateral knee cortisone injection which helped but the pain returned. The last time he followed up with them they were considering surgery versus viscosupplementation injections. He is currently awaiting approval for further treatment. Since his last visit he had cancelled his Electrocardiogram due to Dr. XX recommending surgical intervention with a fusion. He was last seen by Dr. XX in the beginning of January, 2019. He is currently recommending proceeding with surgical intervention of the lumbar spine, which is pending approval. It is all right sided in nature. There is no radiation. The pain is described as sharp in nature. The pain is a 6/10 visual analogue scale. It is constant. He also mentions that his pain is increased when he is at work and when operating the forklift. There have been no changes. He was taking Tramadol, Flexeril, and Meloxicam, but stopped taking them. He is now taking Ibuprofen 800 mg which has been more helpful. He is also using the Lidocaine patches and cream and feels this helps some.	XX Anesthesia & Pain (recs + bills) – 000012 – 000020	243-248

TRIVENT LEGAL

DATE	PROVIDER	OCCURRENCE/TREATMENT	BATES REF	PDF REF
		He has been working without any restrictions as he feels he is able to perform his current job without any restrictions. **Physical exam: Back: Palpation:** Bilateral lumbar paraspinal tenderness with muscle rigidity. Grade of tenderness: 2/4. Facet loading (extension and lateral bending of the lumbar spine reproducing patients pain): Positive bilaterally. Motor testing of all muscle groups: 5/5 strength in bilateral lower extremities. **Neck:** Pain with neck extension; pain with neck rotation to the left; Grade 2 tenderness and myospasm to palpation over the right cervical paraspinous muscles at the C3 to C6 levels; positive right cervical facet loading. **Cervical range of motion:** flexion 45 degrees, extension 15 degrees, left lateral bending 45 degrees, right lateral bending: 45 degrees. **Left knee: Tenderness:** Medial and lateral joint line tenderness, MCL and LCL tenderness. Valgus stress (MCL): Positive. McMurray's and Apley's (meniscal tears): Positive. **Right knee:** Valgus stress (MCL): Positive. McMurray's and Apley's (meniscal tears): Positive. **Assessment:** Patient with severe/chronic neck, low back, and bilateral knee pain. I feel that the injuries reported in today's visit are due to the *MM/DD/2018* accident described in this visit and not due to a pre-existing condition. Of note, re-iterated the importance of getting his blood pressure controlled by taking his medication and healthier eating and life style changes. Discussed if he is having any worsening symptoms to go to the Emergency Room, but at this time he is not having any symptoms beyond the neck/back/knee pain. Patient expressed understanding. **Plan:** • Completed physical therapy. • Continue wearing spinal Q. • Continue to recommend right C4-C7 facet joint injection. This is scheduled for MM/DD/2019. This had to be rescheduled due to high blood pressure • Continue to follow up with Dr. XX . Is awaiting lumbar surgery approval • Continue to follow up with Orthopedics. Is considering surgery for his knee • Patient counseled on lifestyle modifications, Discussed patients condition thoroughly and all questions were answered		

TRIVENT LEGAL

DATE	PROVIDER	OCCURRENCE/TREATMENT	BATES REF	PDF REF
		• Continue Cyclobenzaprine 10 mg, Pantoprazole 20 mg, and Tramadol 50 mg • Discontinue Meloxicam 15 mg • Continue Lidocaine patches • Continue Lidocaine 5% cream • Continue taking Ibuprofen 800 mg • Continue current medications as prescribed. • I counseled patient thoroughly on the use, risks, and adverse effects of these medications and they expressed understanding Continue regular work duties on MM/DD/2019. Follow-up in 4 weeks.		
MM/DD/2019	XXX Surgery, S.C. Sean XXX, M.D. Natalie XX, P.A.-C.	**Correspondence to Ms. XX regarding follow-up consultation for low back pain:** I saw patient in the office today for a follow-up consultation. He continues to complain of pain in the low back with lifting or repetitive bending. He rates the pain up to a 9/10 at times. He denies any radiation of pain down into the legs or any associated weakness, falls, bowel or bladder incontinence. He is taking Ibuprofen for pain. He is having a cervical injection on Friday. He was injured at work on *MM/DD/2018*. He is working full duty. **Review of systems: Musculoskeletal:** Complains of back pain. **Exam: Cervical: Range of motion:** Forward flexion 40 degrees, hyperextension 30 degrees, right lateral rotation 80 degrees and left lateral rotation 80 degrees. **Lumbosacral:** Tenderness left posterior iliac crest. **Range of motion**: Forward flexion 70 degrees, hyperextension 15 degrees, right lateral bending 10 degrees and left lateral bending 10 degrees. **Impression:** • Lumbar spondylosis without radiculopathy • Degenerative disc disease lumbosacral spine **Recommendation:** Patient continues with mechanical low back pain due to disc disease at L5-S1 for which I continue to recommend surgical intervention in the form of a left L5-S1 Transforaminal Lumbar Interbody Fusion (TLIF). The risks and details of surgery were previously discussed and this will be scheduled at a mutually convenient date.	XXXX – 000059 – 000061	249-251
MM/DD/2019	XX Specialists, S.C.	**Procedure report for right cervical facet joint injection:** **Indication:** Based on the physical examination, it was determined that the patient may benefit from the above procedure and that the patient has failed with conservative treatment.	XXX Specialists (bill + recs) – 000001 – 000003, 000009	253-256

TRIVENT LEGAL

DATE	PROVIDER	OCCURRENCE/TREATMENT	BATES REF	PDF REF
	XX XX Surgical Center Thomas XX, M.D.	**Procedure performed:** Right C4-7 cervical facet joint injection at C4-7. **Procedure:** Fluoroscopy was used to identify the facet joints and articular pillars at each level. The ipsilateral and contralateral cervical articular pillars were superimposed. Under fluoroscopic guidance a 1.5 inch 25-gauge needle was inserted to the posterior aspect of the facet joint at each level. At each level, the needle was felt passing through the capsule. Trace amount of contrast dye was injected revealing appropriate intra-articular spread at each level. Aspiration was negative for blood or cerebrospinal fluid. Then 1 cc of a solution containing 0.5 cc 1% Lidocaine and 20 mg Depo-Medrol was injected at each level for a total of 40 mg Depomedrol. **Assessment/Plan:** The procedure was well tolerated. Prior to leaving the office, they were observed to ambulate in normal fashion. There was no headache noted, weakness or numbness observed in either upper or lower extremity. The patient was discharged home in good condition, with instructions to notify the office with any problems. They were told to do what they normally would do in their daily routine to accurately assess their level of improvement. They were also told to continue medications as prescribed and normal activity levels. **Follow up:** Patient advised to follow up in 2 weeks. **Related records:** Anesthesia record, photos.		
MM/DD/2019	XXXX Medicine Christos XXX, M.D.	**Follow-up visit for bilateral knee pain:** Patient returns today for follow-up. He is having pain in both of his knees, left one much worse than the right. On the left side he does have a medial meniscus tear. On the right he has got some chondromalacia. **Physical examination:** On exam, there is tenderness to palpation of the medial joint line. On the left he has got positive McMurray's. Pain with flexion/extension. **Assessment:** • Right knee chondromalacia • Left knee meniscus tear **Plan:** At this point, with the left knee, it has been quiet some time. He has had couple of injections in therapy. I will recommend arthroscopy to address the meniscus tear. As far as the right we did talk about the option of gel injections to see if they can help him. We will get the authorization for that as well.	XX YY (recs + bills) – 000052 – 000053	257-258

TRIVENT LEGAL

DATE	PROVIDER	OCCURRENCE/TREATMENT	BATES REF	PDF REF
		He expressed understanding. I will see him for surgical intervention of his left knee. **Work disposition:** Return to regular work. **Next appointment:** Surgery pending.		
MM/DD/2019	XXXX Medicine Christos XXX, M.D.	**Follow-up visit for bilateral knee pain:** Patient returns today for follow-up. No changes. We are waiting for surgical intervention of his left knee. Again he continues to have pain with pivoting or twisting maneuvers. **Physical examination:** On exam, he is tender over the medial joint line with positive McMurray's. There is pain with flexion/extension. **Assessment:** Left knee medial meniscus tear. **Plan:** He is scheduled to get independent medical examination this Monday. We will see him what the results of that are and hopefully they concur with the surgical recommendation. Awaiting surgery. **Work status:** Continue regular work duties on 05/07.	XX YY (recs + bills) – 000054 – 000055	260-261
MM/DD/2019	XXX Surgery, S.C. Sean XXX, M.D. Elizabeth XXX, P.A.-C.	**Correspondence to Ms. XX regarding follow-up consultation for low back and left knee pain:** I saw patient in the office today for a follow-up consultation. Following his last visit he went for an independent medical evaluation for his low back as well as an independent medical evaluation for his knees. He states he continues to have constant pain in the low back, mostly on the left side, but is now noticing more pain on the right side as well. He feels the pain is worsening and states sometimes it will go up to a 10/10. He denies any weakness, falls, bowel or bladder incontinence. He does sometimes get numbness radiating into the legs. He is taking Ibuprofen 800 mg. He also continues pain in the bilateral knees. He was injured at work on *MM/DD/2018*. He is working full duty. **Review of systems: Musculoskeletal:** Complains of back pain and joint pain. **Neurological:** Complains of paresthesias. **Physical exam: Lumbosacral:** Left posterior iliac crest tenderness. **Range of motion:** Forward flexion 40 degrees, hyperextension 10 degrees, right lateral bending 20 degrees, left lateral bending 20 degrees. **Impression:**	XXXX – 000056 – 000058	263-265

TRIENT LEGAL

DATE	PROVIDER	OCCURRENCE/TREATMENT	BATES REF	PDF REF
		• Lumbar spondylosis without radiculopathy • Degenerative disc disease lumbosacral spine **Recommendation:** Patient has ongoing mechanical low back pain due to disc disease at L5-S1 for which I continue to recommend surgical intervention in the form of a left L5-S1 Transforaminal Lumbar Interbody Fusion (TLIF). Risks and benefits were previously discussed. It is anticipated once the independent medical evaluation report is completed surgery will be authorized and this will then be scheduled at a mutually convenient date.		
MM/DD/2019	XX Center Christos XXX, M.D.	**Operative report for left knee partial medial meniscectomy and left knee extensive synovectomy:** **Indications for operation:** This is a pleasant gentleman who was seen today for surgical intervention of his left knee. Risks and benefits were discussed. **Preoperative diagnoses:** • Pain left knee medial meniscus tear • Left knee swelling **Procedure performed:** • Left knee partial medial meniscectomy • Left knee extensive synovectomy **Anesthesia:** General. **Operation and findings:** He was met in the preoperative room by me. The knee was marked. He was given appropriate antibiotics. We did a time out to confirm that we were doing the correct knee and his antibiotics were given. He was intubated and sedated. The knee was prepped and draped as per usual. A lateral portal was created. The knee joint revealed a slight effusion and synovitis throughout the compartment. There was a complex tear in the medial meniscus. The anterior collateral ligament, posterior collateral ligament were intact. The lateral meniscus was intact. No significant chondromalacia was found in the knee. At this point a medial portal was brought in. A thorough debridement of the medial, lateral and superior and notch synovium was performed with a high speed shaver in both the medial and lateral portals. We then focused our attention to the medial meniscus using biting instruments and shavers. We resected about 50 to 60% of the posterior horn of the medial meniscus to a smooth stable base. At this point final pictures were obtained. The patient was taken to the recovery room in excellent condition. **Complication:** None.	XX Center (recs + bills) – 000001 – 000002	266-267

TRIVENT LEGAL

DATE	PROVIDER	OCCURRENCE/TREATMENT	BATES REF	PDF REF
		Postoperative diagnoses: • Left knee complex tear of the posterior horn medial meniscus • Left knee extensive synovitis		
MM/DD/2019	XXXX Medicine Christos XXX, M.D.	**Follow-up visit for left knee pain:** Patient is here today for his post-operative visit, I removed the sutures, and the cast is off. **Physical examination:** On examination, possible range of motion is from about 5 degrees to 8 degrees. **Assessment:** Left knee medial meniscus tear. **Plan:** Things are progressing well. We will start supervised course of physical therapy 3 x/week. He can transition away from the crutches, and I will see him in four weeks for recheck. **Work status:** Patient may not return to work.	XX YY (recs + bills) -000056 – 000058	268-270
MM/DD/2019	XXXX Medicine Christos XXX, M.D.	**Follow-up visit for left knee pain:** Patient is here today for follow-up. He is approximately six weeks out from surgery. He is still having some pain, especially with going up and down stairs. **Physical examination:** On examination, well-healed incisions. Quadriceps atrophy is present. He has difficulty with extension of the knee. **Assessment:** Medial meniscus tear, left knee. **Plan:** We will do another month of physical therapy 3 x/week for 4 weeks. He will continue with ice and anti-inflammatories. **Work status:** Patient may not return to work. I will see him in four weeks for recheck.	XX YY (recs + bills) – 000061 – 000063	273-275
MM/DD/2019	XX Specialists, S.C. XX Store Thomas XX, M.D.	**Pharmacy record:** **Drug:** Ibuprofen 800 mg.	XX Anesthesia & Pain (recs + bills) – 000064	282

TRIVENT LEGAL