

Narrative Summary

Mr. Doe is a YY-year-old man employed as a forklift driver for XX. He has not undergone surgeries in the past. He was active and he had no limitations on his activities of daily living and work until he sustained injuries at his workplace.

On MM DD, 2018, John Doe III was working as a forklift driver for XX's. As usual, he would drive his forklift into the semi-truck to unload deliveries. However, in this instance, the truck driver had failed to lock down the brakes on his semi-truck prior to Mr. Doe entering to unload the delivery. As Mr. Doe was backing out of the truck, the semi-truck had shifted and jerked backwards due to not being locked down properly which caused the forklift to fall out of the semi-truck. Because Mr. Doe was wearing a safety harness, he stayed attached to the forklift and as a result, was twisted in the harness as the forklift fell. Although Mr. Doe did not fall out of the semi-truck inside the forklift, he had sustained multiple injuries as a result of being caught and twisted by the safety harness.

On the same day, Mr. Doe presented to XXX Center. The X-ray of his mid-back revealed low-grade spondylolisthesis (*a slipping of vertebra that occurs, in most cases, at the base of the spine*) in his inferior thoracic spine.

On MM DD, 2018, Mr. Doe was operating a forklift inside a truck whose brakes were not set on the truck. When he was backing out of the truck, all of a sudden, the truck jerked because of which his forklift fell off the truck. Although he was restrained by a harness belt that prevented him from falling out of the truck, he got twisted as the forklift fell and sustained injuries to his right shoulder, low back, knees and feet.

On MM DD, 2018, Mr. Doe presented to XXX Center. The CT scan of his mid-back revealed no evidence of fracture or subluxation of his mid-back or low back.

On MM DD, 2018, Mr. Doe presented to Sean XX, M.D., at XXX Surgery. He had pain in his right scapula, low back, knees and feet. He quantitated his pain level as 8/10. He could not resume working with his ongoing pain. A physical examination revealed guarded movements of his neck and low back. Medrol Dosepak and Mobic were prescribed. He was instructed to work at desk and refrain from lifting, pushing and pulling over ten pounds, bending and twisting for over three hours, and alternate between sitting and standing every thirty to forty five minutes. He was referred to an orthopedist for further evaluation of his knee injuries. He was advised to receive physical therapy two to three times a week for four to six weeks, and follow up after completing the therapy.

On MM DD, 2018, Mr. Doe presented to Christos XXX, M.D., at XXX Medicine. He had pain in his low back, legs and feet. A physical examination revealed spasms in his posterior hamstrings. He was diagnosed with bilateral leg strain. He was advised to begin physical therapy, remain off work and follow up in two weeks.

On MM DD, 2018, Mr. Doe was seen by Naha XXX, P.T., at XX Therapy. He had pain in his low back. He experienced difficulty performing pulling and pushing tasks, squatting, bending forward,

getting in and out of forklift, driving a forklift, and protracted walking. A physical examination revealed tightness in his low back paraspinals and on both sides of his piriformis, quadriceps, hamstrings and gastrocnemius, and tenderness over his sacroiliac joints. He demonstrated a need for stretching, strengthening, modalities, home exercise education, and education on safe lifting techniques. He was advised to receive physical therapy three times a week for four weeks. His treatment included therapeutic exercises, manual therapy, neuromuscular reeducation, therapeutic activities, hot/cold pack applications, ultrasound, electrical stimulation, and self-care/home management training.

On the same day, Mr. Doe presented to Naha XXX, P.T., He had pain in his knees and low back which worsened with protracted standing and walking. He quantitated his pain level as 6-7/10. A physical examination revealed tightness on both sides of his piriformis, quadriceps, hamstrings and gastrocnemius. There was a decrease in his strength, balance, soft tissue mobility as well as impairments with his body mechanics and lifting mechanics. The deficits limited his ability to drive a forklift, lifting 50# from floor, protracted standing and walking more than one mile. He was advised to receive physical therapy three times a week for two weeks. His treatment included therapeutic exercises, manual therapy, neuromuscular reeducation, therapeutic activities, hot/cold pack applications, ultrasound, electrical stimulation, and self-care/home management training.

Mr. Doe received physical therapy for his knee pain through MM DD, 2018, at XX Therapy. His treatment included therapeutic exercises, manual therapy, neuromuscular reeducation, therapeutic activities, hot/cold pack applications, ultrasound, electrical stimulation, and self-care/home management training.

On MM DD, 2018, Mr. Doe was seen by Ms. XXX, P.T. He experienced persistent soreness in his knees, especially along the lateral aspect. He continued to have limitations with walking, driving a forklift lifting 50# from floor, and protracted standing. As he reached maximum benefit from the therapy, he was discharged.

On MM DD, 2018, Mr. Doe returned to Dr. XXX. He had pain in his legs and feet. He was encouraged to continue performing range of motion for his knees. An MRI of his right knee for further evaluation and the administration of a corticosteroid injection were discussed. He was advised to remain off work and follow up in two weeks.

Mr. Doe received physical therapy for his low back pain through MM DD, 2018, at XX Therapy. He has made objective improvements with range of motion, strength, and flexibility as well with posture, body mechanics, lifting mechanics, and activity tolerance. The improvements have increased his ability to perform pulling/pushing tasks with 50#, squatting, bending forward, walking for long distances, lifting 37# from floor to waist and carrying it for 100 consecutive feet. Nevertheless, he continued to have impairments and occasional pain in his foot and not low back, which limited his ability to walk. He continued to have difficulty transferring in and out of forklift and driving a forklift as the therapy did not include measures to help him resume those activities. As he reached maximum benefit from the therapy, he was discharged. He was encouraged to perform exercises at home.

On MM DD, 2018, Mr. Doe returned to Dr. XXX. He suffered from persistent pain in his knees. A physical examination revealed tenderness over the anterolateral aspect of his knees. Depo Medrol and Lidocaine were administered in his knees. He was advised to remain off work and follow up in two weeks.



On MM DD, 2018, Mr. Doe returned to Dr. XXX. He had soreness and weakness in his legs although his pain subsided with receiving the injection. A physical examination revealed tenderness over the medial joint lines of his knees and atrophy of his quadriceps. The movements of his knees were guarded. He was advised to begin physical therapy focusing on strengthening of his quadriceps, range of motion and isometrics, remain off work, and follow up in four weeks.

On MM DD, 2018, Mr. Doe presented to Ms. XXX, P.T., at XX Therapy. He had pain in his knees which worsened with sudden movements, lifting, carrying and protracted standing. He quantitated his pain level as 8/10. He had limitations with lifting 50# from floor, carrying 50# for 100 consecutive feet, operating a forklift, climbing on a ladder, pulling/pushing 100#, running, standing more than one hour, and standing from sitting position. A physical examination revealed tightness in his quadriceps, hamstrings, and gastrocnemius with tenderness over his lateral knee area. He was advised to receive physical therapy two to three times a week for four weeks. His treatment included therapeutic exercises, manual therapy, neuromuscular reeducation, therapeutic activities, hot/cold pack applications, ultrasound, electrical stimulation, and self-care/home management training.

On MM DD, 2018, Mr. Doe presented to Dr. XX. He experienced occasional tightness in his low back and pain in his knees. He was recommended to continue receiving physical therapy until his orthopedist cleared to begin a work conditioning program five times a week for two weeks focusing on stabilization, strengthening and conditioning. He was advised to resume working desk job from June 1, 2018, with restrictions on lifting, carrying, pushing and pulling more than ten pounds, refraining from activities involving bending and twisting for more than three times per hour and no forklift driving.

Mr. Doe received physical therapy for his knees through MM DD, 2018. His treatment included therapeutic exercises, manual therapy, neuromuscular reeducation, therapeutic activities, hot/cold pack applications, ultrasound, electrical stimulation, and self-care/home management training. He made objective improvements with his range of motion, strength, flexibility, balance, and exercise tolerance. The improvements increased his ability to perform short time jogging, sudden movements, lifting from floor to waist 37# for 10 repetitions, push/pull 60# for 15 repetitions, leg press 130#, straight leg press 90#, incline press 50#, and lift and carry 37# for 100 feet. Nevertheless, he continued to experience pain in his knees and impairments with performing vigorous activities. It was recommended he be transitioned to work conditioning at that juncture in order to further improve his functional strength. After the work conditioning is completed, he would benefit from a functional capacity evaluation to determine PDL level for his safe return to work. He was discharged from the therapy as he reached maximum benefit from the therapy.

On MM DD, 2018, Mr. Doe returned to Dr. XXX. The pain in his knees had resolved except for occasional pain when climbing up and downstairs. He completed the physical therapy. He was advised to resume activities according to his tolerance and return to regular work duties from MM DD, 2018.

On MM DD, 2018, Mr. Doe returned to Dr. XX. He completed two weeks of work conditioning. He experienced a low-grade pain in his low back. A physical examination revealed diminished deep tendon reflexes in his legs. He was advised to resume working full duty without restrictions and perform exercises at home.

On MM DD, 2018, Mr. Doe presented to Thomas XX, M.D., at XXX Specialists. He had pain in his neck which was also injured along with his low back. He quantitated his pain level as 8/10. A physical examination revealed grade II tenderness and myospasms in his right C3-6 paraspinal muscles. The movements of his neck were guarded. He was diagnosed with chronic neck pain. Dr. XX stated that Mr. Doe's neck pain was as a result of the workplace injury. He was advised to begin physical therapy. An MRI of his neck was ordered. Cyclobenzaprine, Tramadol, Lidocaine patches and cream, and Meloxicam were prescribed. He was recommended to undergo medial branch blocks at his right C3-6 and a radiofrequency ablation later if his pain subsided with the former procedure. A follow up in four weeks was scheduled.

On MM DD, 2018, Mr. Doe returned to Dr. XX. He experienced persistent pain in his neck which did not subside with taking the prescribed medications. He quantitated his pain level as 8/10. A physical examination revealed grade II tenderness and myospasms in his right C3-6 paraspinal muscles. The movements of his neck were guarded. He was advised to begin physical therapy, return to work without restrictions, continue taking Cyclobenzaprine, Tramadol, Lidocaine patches and cream, and Meloxicam. An MRI of his neck was ordered. He was recommended to undergo medial branch blocks at his right C3-6 and a radiofrequency ablation later if his pain subsided with the former procedure. An H Wave unit was dispensed for his use at home. A follow up in three weeks along with the MRI results was scheduled.

On MM DD, 2018, Mr. Doe returned to Dr. XX. He experienced persistent pain in his neck. He quantitated his pain level as 8/10. A physical examination revealed grade II tenderness and myospasms in his right C3-6 paraspinal muscles. The movements of his neck were guarded. He was advised to begin physical therapy, continue taking Cyclobenzaprine, Tramadol, Lidocaine patches and cream, and Meloxicam. An MRI of his neck was ordered. He was recommended to undergo medial branch blocks at his right C3-6 and a radiofrequency ablation later if his pain subsided with the former procedure. A follow up in three weeks was scheduled.

On MM DD, 2018, Mr. Doe presented to XX Imaging, Inc. The MRI of his neck revealed moderate central spinal stenosis, bilateral neural foraminal narrowing at his C5-6 level causing mild to moderate deformity of the thecal sac, mild to moderate encroachment of bilateral exiting nerve roots, mild to moderate central spinal stenosis and neural foramina narrowing at his C4-5 and C6-7 levels. The MRI of his low back revealed moderate broad-based posterior disc osteophyte complex at his L5-S1 which was superimposed by a central disc protrusion measuring 6 mm x 15 mm x 7 mm along with moderate bilateral facet arthropathy and thickened ligamentum flavum causing moderate deformity of the thecal sac

and effacement of the bilateral traversing nerve roots. There was mild to moderate bilateral neural foraminal narrowing causing mild encroachment of the bilateral exiting nerve roots.

On MM DD, 2018, Mr. Doe presented to Mark XX, M.D., at XXX Specialists. He had persistent pain in his neck and low back. He quantitated his pain level as 8/10. Nevertheless, he was able to perform his work without any restrictions. A physical examination revealed grade II tenderness and myospasms in his right C3-6 paraspinal muscles. The movements of his neck were guarded. The MRI results of his neck and low back were reviewed. He was recommended to consult a spine surgeon and receive facet joint injections in his right C4-7. He was advised to continue receiving physical therapy, continue taking his medications, continue using the spinal Q and H-wave unit at home, and follow up in four weeks.

On MM DD, 2018, Mr. Doe presented to William XXX, P.A.-C., at XXX Specialists. He had pain in his neck, low back and knees. He quantitated his pain level as 6/10. His pain worsened with operating a forklift at work. A physical examination revealed grade II tenderness over his low back paraspinals with muscle rigidity, and grade II tenderness and myospasms in his right C3-6 paraspinal muscles. The movements of his neck and low back were guarded. The MRI results of his neck and low back were reviewed. The MRI studies of his knees were ordered. He was advised to receive facet joint injections in his right C4-7, continue receiving physical therapy, continue taking his medications, and continue using the spinal Q. A referral to spine surgeon for the evaluation of his ongoing pain refractory to conservative treatment was recommended. A follow up in four weeks was scheduled.

On MM DD, 2018, Mr. Doe presented to XX Imaging, Inc. The MRI of his left knee revealed small and slightly displaced oblique tear involving the posterior periphery of the lateral meniscus superimposed on type II signal degeneration. There was grade I partial tear of the medial collateral ligaments, small joint effusion, mild degeneration changes, and post-stress changes of the medial and lateral compartments. The MRI of his right knee revealed small and 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 I partial tear of the medial collateral ligaments, and small joint effusion.

On MM DD, 2018, Mr. Doe was seen by Angie XXX, P.A.-C., at XXX Specialists. He had persistent pain in his knees and low back along with intermittent tingling in the bottom and top of his foot near the ankle. He quantitated his pain level as 6/10. His pain worsened when he was at work, walking and driving a forklift. A physical examination revealed grade II tenderness over his low back paraspinals with muscle rigidity, and grade II tenderness over his right C3-6 paraspinals with myospasms. There was tenderness over his medial and lateral joint lines, medial and lateral collateral ligaments of his knees. The movements of his neck and knees were guarded. The MRI results of his knees were reviewed. He was diagnosed with severe chronic neck and low back pain. He was advised to continue taking the medications, continue wearing spinal Q, continue working full duty, obtain an electromyogram of his legs, and follow up in four weeks.

On MM DD, 2019, Mr. Doe returned to Dr. XX at XXX Surgery. He experienced pain in his low back which worsened with his return to regular work duties. He quantitated his pain level as 9/10. A physical examination revealed tenderness over his low back paraspinals. The movements of his low back

were guarded. He was diagnosed with degeneration disc disease of lumbosacral spine and lumbar spondylosis. Dr. XX stated that Mr. Doe's low back pain due to the described work injury was secondary to the aggravation of his L5-S1 disc disease, and his neck pain was probably due to the bulging disc at his C6-7 for which no aggressive treatment was recommended. Given the failure of conservative care, surgical intervention in the form of a left L5-S1 transforaminal lumbar interbody fusion (TLIF) was recommended for further treatment. He expressed his consent to proceed with the surgery. Dr. XX briefed Mr. Doe the post-operative plan which included a follow up in two weeks after the surgery, physical therapy in three weeks after the surgery, and return to clinic with an upright anterior/posterior lateral X-rays of his low back. At that point in time, Mr. Doe might return to work with desk work/light duty capacity with restrictions on lifting not more than twenty pounds, push or pull weight more than 35 pounds, refrain from repetitive bending or twisting, and alternate between sitting and standing every 30-45 minutes. He was emphasized to follow those restrictions until the completion of a Work Conditioning Program (WCP) which was to be started not sooner than six months postoperatively for a course of four weeks. A follow up after the conclusion of the WCP with a final lumbar X-ray was ordered. At that time, he would be released back to work based on a valid functional capacity evaluation.

On MM DD, 2019, Mr. Doe returned to Dr. XXX. He had persistent pain in his knees. A physical examination revealed tenderness over the medial and lateral joint in his knees. The MRI results of his knees were reviewed. Depo Medrol and Lidocaine was administered in his knees. He was advised to follow up in three weeks.

On MM DD, 2019, Mr. Doe returned to Dr. XX. He continued to have pain in his neck, low back and knees. His pain worsened when he was at work, operating a forklift and walking. He quantitated his pain level as 6/10. A physical examination revealed grade II tenderness over his low back paraspinals with muscle rigidity, and grade II tenderness over his right C3-6 paraspinals with myospasms. There was tenderness over his medial and lateral joint lines, medial and lateral collateral ligaments of his knees. The movements of his neck and knees were guarded. He was advised to continue using the spinal Q, continue taking his medications, receive C4-C7 facet joint injection, continue working regular duties, and follow up in four weeks.

On MM DD, 2019, Mr. Doe returned to Dr. XX. He suffered from persistent pain in his low back. He quantitated his pain level as 10/10. A physical examination revealed tenderness over his lumbosacral region and left posterior iliac crest. The movements of his low back were guarded. He was diagnosed with lumbosacral degenerative disc disease. He was recommended to undergo the recommended surgical intervention in the form of left L5-S1 transforaminal lumbar interbody fusion (TLIF).

On MM DD, 2019, Mr. Doe returned to Dr. XXX. He continued to have pain in his knees, especially the left. He did have history of chondromalacia in his knees. He was recommended to receive gel injections and follow up on an as needed basis.

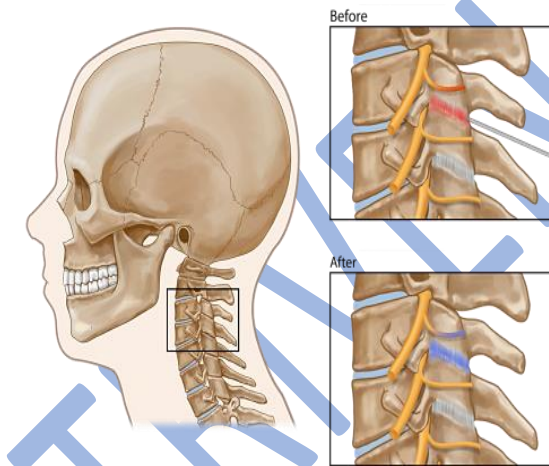
On MM DD, 2019, and MM DD, 2019, Mr. Doe was seen by Dr. XX. He continued to have pain in his neck and low back, and recurrent pain in his knees. He quantitated his pain level as 6/10. Although he resumed working regular duty, his pain worsened with operating a forklift at his workplace and walking. A physical examination revealed grade II tenderness over his low back paraspinals with muscle

rigidity, and grade II tenderness over his right C3-6 paraspinals with myospasms. There was tenderness over his medial and lateral joint lines, medial and lateral collateral ligaments of his knees. The movements of his neck and knees were guarded. Ibuprofen was prescribed. He was advised to stop taking Meloxicam, continue taking other medications, receive C4-7 facet joint injection, and follow up in four weeks.

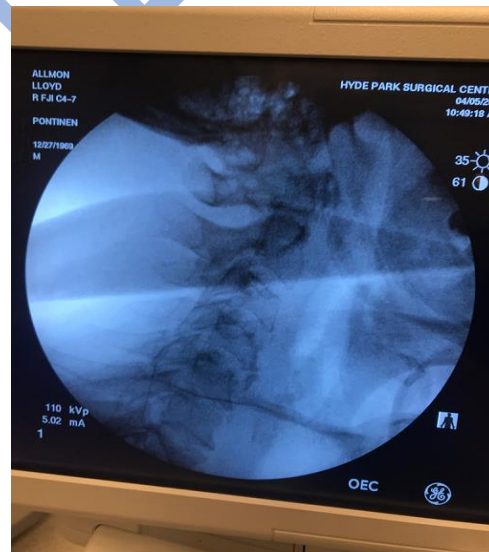


On MM DD, 2019, Mr. Doe returned to Dr. XX. He had persistent pain in his low back which worsened with lifting and repetitive bending. He quantitated his pain level as 9/10. A physical examination revealed tenderness over his posterior iliac crest. The movements of his low back were guarded. He was diagnosed with lumbar spondylosis. He was advised to undergo the recommended surgical intervention.

On MM DD, 2019, Mr. Doe presented to Dr. XX. He received facet joint injection in his right C4-7 (a minimally invasive procedure in which a physician injects a small amount of local anesthetic and/or medication to numb a facet joint and provide pain relief. Fluoroscopy, a form of real-time X-ray, or CT is used to guide the placement of the needle into the facet joint). He was advised to follow up in two weeks.



Facet joint injection



Fluoroscopy used for Mr. Doe's procedure

On MM DD, 2019, Mr. Doe returned to Dr. XXX. He had persistent pain in his knees, especially his left which had a medial meniscus tear, and chondromalacia in his right knee. A physical examination revealed tenderness over the medial joint line of his left knee. The movements of his knees were guarded. He was diagnosed with right knee chondromalacia and left knee medial meniscus tear. He was recommended to undergo arthroscopy and viscosupplementation injections. He was advised to continue working regular duties.

On MM DD, 2019, Mr. Doe returned to Dr. XXX. He experienced persistent pain in his knees, especially with pivoting and twisting maneuvers. A physical examination revealed tenderness over the

medial joint line of his left knee. The movements of his knees were guarded. He was diagnosed with left knee medial meniscus tear (*a tear in the cartilage which cushions and stabilizes the knee joint*). An independent medical evaluation was scheduled whose approval on the surgical recommendation was anticipated. He was otherwise advised to continue working regular duties.

On MM DD, 2019, Mr. Doe returned to Dr. XX. He experienced constant pain in his low back with numbness radiating in his legs, and pain in his knees. He quantitated his pain level as 10/10. A physical examination revealed tenderness over his posterior iliac crest. The movements of his low back were guarded. He was recommended to undergo the surgical intervention for his low back.

On MM DD, 2019, Mr. Doe presented to Dr. XXX at XXX Center. He underwent partial medial meniscectomy (*removal of as little of the meniscus as possible in which unstable meniscal fragments are removed, and the remaining meniscus edges are smoothed so that there are no frayed ends*) and an extensive synovectomy (*the surgical removal of the membrane (synovium) that lines the joint*) in his left knee.

On MM DD, 2019, Mr. Doe returned to Dr. XXX for a post-operative follow up. He was advised to remain off work, use crutches for moving around, begin physical therapy, and follow up in four weeks.

On MM DD, 2019, Mr. Doe returned to Dr. XXX. He experienced pain in his knees, especially when climbing up and downstairs. A physical examination revealed atrophy of his quadriceps. He had difficulty with the extension of his left knee. He was advised to continue receiving physical therapy for a month, apply ice packs, take anti-inflammatory medications, and follow up in four weeks.

