Acupuncture

PATIENT
[redacted]

AGE	48 yrs
SEX	Female
PRN	CR481805

FACILITY
Dr. [redacted] **Hsu**
[redacted]
1412 Sweet Home Road
Suite 6
Amherst, NY 14228

ENCOUNTER
Office Visit

NOTE TYPE	Procedure Note
SEEN BY	Laura Jean [redacted]
DATE	01/26[redacted]
AGE AT DOS	48 yrs

Electronically signed by Laura Jean [redacted] at 01/29[redacted]01:40 pm

Chief complaint

Neck and back pain (left more than right in lumbar)
(Appt time: 10:30 AM) (Arrival time: 10:21 AM)

Vitals for this encounter

No vitals recorded

PROCEDURE NOTE

The patient reports pain from her occiput down into the thoracic region and into the lumbar. When it gets down to the lumbar it's more on the left side. She was in a MVA Oct. 31[redacted]nd was hit from behind. The seat was not adjusted properly. She is 5'1" and it was adjusted for a 6'7" person (her father). So she got whip lash and was thrust forward farther than normal because the seat was back so far. They were on an off ramp. The pain level in her neck varies, and is present every day. The pain level ranges from a 5-7/10 from cervical through the thoracic region. It is a little better laying down flat. The C7 / T1 area is one of the major pain areas. The lumbar pain comes and goes, but can range from a 2-10/10. It has only gone up to a 9-10/10 maybe 5 times since the accident. In the second week of January was the last time her lumbar pain was high.

1st acupuncture visit: The patient was prone for the treatment. The acupuncture points were palpated and swabbed with alcohol. The following points were needled. Bilateral: GB 20, 21, UB 10, 15, HTJJ C 2, 4, 5, 6, 7, T 5, 6, 7, 9, 11, UB 23, 25, Right: UB 44, Left: UB 13, 24, 26, 33, 34, (2) Ashi at lateral sacrum, and GB 30. Infrared heat was placed over the patient's neck. The patient didn't want the heat for the whole treatment so it was taken off after 15 minutes. After the needles were removed tuina was done on the patient's neck and back, focusing more on the left side at the lumbar and hip areas. The patient responded well to the treatment, except that she was a little light headed. Total treatment time was 60 minutes with 45 minutes of acupuncture and 15 minutes of massage.

practice fusion

PATIENT
[redacted]
AGE 48 yrs
SEX Female
PRN CR481805

FACILITY
Dr. [redacted] Hsu
[redacted]
1412 Sweet Home Road
Suite 6
Amherst, NY 14228

ENCOUNTER
Office Visit
NOTE TYPE Procedure Note
SEEN BY Laura Jean [redacted]
DATE 01/29/[redacted]
AGE AT DOS 48 yrs
Electronically signed by Laura Jean [redacted] at 02/14/[redacted] 04:31 pm

Chief complaint

Neck and back pain (left more than right in lumbar)

Vitals for this encounter

No vitals recorded

PROCEDURE NOTE

The patient states that she felt "whoozy" after the last visit, but more relaxed and her pain level was down. She didn't notice any pain until the next morning in her neck and it was lower than before. The pain gradually increased to a 5/10 which is where she was at today. The patient currently is having a migraine and cramps due to her period, in addition to her neck and back pain. The patient reports that she did not have any spikes in pain in her left lumbar since she was here last.

Hx: The patient reports pain from her occiput down into the thoracic region and into the lumbar. When it gets down to the lumbar it's more on the left side. She was in a MVA Oct. 31, [redacted] and was hit from behind. The seat was not adjusted properly. She is 5'1" and it was adjusted for a 6'7" (her father). So she got whip lash and was thrust forward farther than normal because the seat was back so far. They were on an off ramp. The pain level in her neck varies, and is present every day. The pain level varies from a 5-7/10 from cervical through the thoracic region. It is a little better laying down flat. The C7 / T1 area is one of the major pain areas. The lumbar pain comes and goes, but can range from a 2-10/10. It has only gone up to a 9-10/10 maybe 5 times since the accident. In the second week of January was the last time her lumbar pain was high.

2nd acupuncture visit: The patient was prone for the treatment. The acupuncture points were palpated and swabbed with alcohol. The following points were needled. Bilateral: GB 20, 21, UB 10, 15, HTJJ C 2, 4, 5, 6, 7, T 5, 6, 7, 9, 11, UB 23, 25, 27, Left: UB 24, 26, 33, 34, (2) Ashi at lateral sacrum, Yao yan, and GB 30. Infrared heat was placed over the patient's neck. Estim was applied from the left ashi lateral to sacrum to GB 30, and Left UB 10 to HTJJ C 6. The estim was gradually turned up to a comfortable level for the patient. After the needles were removed tuina was done on the patient's neck and back, focusing more on the left side at the lumbar and hip areas. The patient responded well to the treatment. Total treatment time was 60 minutes with 45 minutes of acupuncture and 15 minutes of massage.

PATIENT
[redacted]

AGE	48 yrs
SEX	Female
PRN	CR481805

FACILITY
Dr. [redacted] Hsu
[redacted]
1412 Sweet Home Road
Suite 6
Amherst, NY 14228

ENCOUNTER
Office Visit

NOTE TYPE	Procedure Note
SEEN BY	Laura Jean [redacted]
DATE	02/02/[redacted]
AGE AT DOS	48 yrs

Electronically signed by Laura Jean [redacted] at 02/15[redacted] 03:04 pm

Chief complaint

Neck and back pain
(Appt time: 10:30 AM) (Arrival time: 10:47 AM)

Vitals for this encounter

No vitals recorded

PROCEDURE NOTE

The patient reports that her pain level today is a 7/10. The patient is feeling frustrated with her pain and impatient for relief.

Hx: The patient reports pain from her occiput down into the thoracic region and into the lumbar. When it gets down to the lumbar it's more on the left side. She was in a MVA Oct. 31, [redacted] and was hit from behind. The seat was not adjusted properly. She is 5'1" and it was adjusted for a 6'7" (her father). So she got whip lash and was thrust forward farther than normal because the seat was back so far. They were on an off ramp. The pain level in her neck varies, and is present every day. The pain level varies from a 5-7/10 from cervical through the thoracic region. It is a little better laying down flat. The C7 / T1 area is one of the major pain areas. The lumbar pain comes and goes, but can range from a 2-10/10. It has only gone up to a 9-10/10 maybe 5 times since the accident. In the second week of January was the last time her lumbar pain was high.

3rd acupuncture visit: The patient was prone for the treatment. The acupuncture points were palpated and swabbed with alcohol. The following points were needled. Bilateral: GB 20, 21, UB 13, 15, 18, 23, 26, 27, 32, 33, HTJJ C 3, 4, 5, 7, T 8, 11, (2) Ashi at lateral sacrum Infrared heat was placed over the patient's neck. Estim was applied bilaterally from HTJJ C5 to UB 33. The estim was gradually turned up to a comfortable level for the patient. The patient responded well to the treatment. Total treatment time was 45 minutes.

Chiropractic Records

Chart Notes

[redacted]

Brian [redacted]
4164 North Buffalo Rd
Orchard Park, NY 14127-2415
[redacted]

Patient: [redacted] DOB: [redacted]
Ins Co Liberty Mutual Insurance Pol # Insured ID [redacted]

Date 10/24/[redacted]
Provider: BRIAN [redacted] PT

Subjective:
[redacted] reports low back, left hip/ buttock, right hip/buttock, left high, left leg, left ankle and left foot pain and pins & needles rating 8 out of 10 for 100% of the day. The problem is limiting sleeping, sitting, getting up from sitting, standing, walking, bending , lifting, carrying and stair climbing. This problem started 10/31[redacted] with from a car accident. Her walking tolerance is less than a mile but with left limping and increasing pain. She states increased left leg pain upon waking from surgery which has continued down the left leg, worst in her shin and foot. She reports more pain walking 10 feet without socks and shoes.
Accident History:
[redacted] reported the following facts regarding a motor vehicle incident that took place on or about 10/31/[redacted]. She was the passenger in an SUV which was stopped when the it was involved in a rear impact collision with a mid-size car. At the moment of impact she was totally unaware that the incident was impending; she was restrained by a seat belt and shoulder harness. She recalls that at impact, her head was rotated to the left; his body was rotated to the left. The vehicle incurred moderate damage.
An MRI report from 4-17-[redacted] states L5 left paracentral disc herniation with severe lateral recess stenosis. She said PT often caused more pain. She had L5 microdiscectomy 8-16-[redacted] She reports increased left leg pain upon waking from surgery which hasn't changed.

Objective:

She is unable to sit normally and changes positions often.
Chair transfers demonstrated with difficulty and using arms to assist and avoids using left leg.
The patient's gait demonstrated limping on left moderate.
Abnormal posture noted: trunk shifted right avoiding weight bearing left moderate.
She stood for less than one minute before leaning her back on the wall for relief. We discussed how avoiding weight bearing leads to more weakness.
Single leg standing balance test unable for 2 seconds on left.
Active range of motion: lumbar flexion 75% with pain.
Active range of motion: lumbar rotation, 66% with pain.
Left hip abduction strength 3/5 with pain. Left ankle dorsiflexion 3+/5.
Standing squat motion 33% (fingertips to knees) with pain shifts right to avoid weight bearing left .
She was unable to do heel or toe walking for 5 feet, however, it's difficult to assess foot weakness vs. pain avoidance.

Assessment:
Low back pain with left leg radicular pain, dysfunction after MVA with L5 disc injury and microdiscectomy.
Significant dysfunction due to motor vehicle injuries persists [redacted] requires further

treatment to continue restoring function to her pre-injury level. She is expected to make further progress and is not at maximal level of improvement or pre-injury status. [redacted] is progressing slower than expected. Recommend MD consider EMG test for left leg.

Prognosis: The prognosis is guarded at this time based on status.

Plan:

Diagnosis: low back pain with left radicular symptoms.
Treatment included: Examination: 45 minutes face to face and Therapeutic Exercise 30 minutes and home exercise protocols were reviewed and demonstrated.
Treatment was causally related to the motor vehicle accident (MVA) injury. She has likely reached MMI.
Plan of care: 2 times a week four weeks to 11/23[redacted]
Treatment Goals: to increase patient's ADL tolerance 10% and to increase patient's ROM 10% and to restore full pre-injury function.

Electronically Signed [redacted]
BRIAN [redacted] PT 11/02/2018 08:47 AM

Correspondence

[redacted]

Physical Therapist

Center for [redacted] **REHABILITATION**
[redacted] Professional Park
3085 Southwestern Blvd., Suite 108 • Orchard Park, NY 14127

October 19, [redacted]

[redacted]
5959 Big Tree Rd.
Orchard Park, NY 14127

INITIAL FINDINGS

[redacted]

Dear [redacted]

[redacted] is a 49-year-old female seen at this office with the chief complaint of 5-10 lower back pain and 7-10 tingling and numbness sensations from her left knee down to the last 3 digits of her left foot. These symptoms occurred following a motor vehicle accident on October 31, [redacted] On August 16, [redacted] she had a microdiscectomy at L4-5 and L5-S1 according to the patient.

PAST MEDICAL HISTORY:
Other past medical history is known to your office.

MEDICATIONS:
Are known to your office.

IMAGE STUDIES:
Unknown to this therapist.

OBSERVATION:
Patient exhibits good posture.

PALPATION:
Reveals severe soft tissue dysfunctions, spasms and fascial restrictions of the lumbosacral complex with bilateral piriformis muscle spasms. She has noted tenderness throughout the lower back area and is hypersensitive throughout the left lower leg. Patient has noted swelling throughout her lower back area.

STRENGTH:
Reveals 3+ out of 5 plantar and dorsiflexors on the left side.

RANGE OF MOTION:
Reveals a 50% restriction upon flexion with pain, a 30% restriction upon extension with pain and a 10% restriction upon bilateral lateral flexion.

REFLEXES:
Reveal 2 out of 5 of the right Achilles versus 0 out of 5 of the left Achilles.

SENSATION:
Reveals hypersensitivity throughout the left L5-S1 dermatome.

SPECIAL TESTS:
Reveal a positive right standing flexion test, a positive right sitting flexion test and a positive left straight-leg raise test.

IMPRESSION:
[redacted] is status post microdiscectomy with a radicular issue and multiple soft tissue dysfunctions, spasms and fascial restrictions throughout the lumbosacral complex. She has fair/good rehab potential.

GOALS:
1. Decrease symptomatology 75%.
2. Improve posture to normal.
3. Improve range of motion to within functional limits.
4. Restore proper mechanics throughout the lumbosacral complex.
5. Increase muscle strength ½ muscle grade.

PLAN:
Manual therapy, therapeutic exercise, physical agents PRN and home exercise program.

Thank you for your kind referral.

Professionally,

[redacted]

DICTATED BUT NOT READ

Electrodiagnostic Study

Costanzo, Rebecca ID #: 812223

UBMD Neurology/UNI
Univ. at [redacted] General Medical Center
1001 Main Street, Conventus Building
Buffalo, NY 14203

Name: [redacted]
Address:

Patient ID: 812223
Date of Birth: 9/23/[redacted]
Gender: Female
Date of Exam: 12/4/[redacted] 1:14 PM

Referring Physician:
Examining Physician: [redacted]

Patient History:
She is a 49 yo woman with migraines who underwent an L4-5 lumbar decompression in Augus[redacted] for refractory left-sided sciatica impacting the thigh, posterior leg and lateral foot. There was no similar involvement on the right side. Of note, she was in an MVA the prior year. After the lumbar surgery, the proximal pain has improved somewhat but she has severe pain and dysesthesia along the S1 distal dermatome especially in the foot. She is on Lyrica but takes it only at night. It is somewhat effective in helping with her nocturnal pain.

On brief examination she had full power in both lower limbs. DTRs were 2 exceptfor an absent left ankle response. Pinprick sensation was reduced in the left S1 distribution. Skin temperature in the left leg was 29.8C.

Motor Nerve Conduction:

Nerve and Site	Latency	Amplitude	Segment	Latency Difference	Distance	Conduction Velocity
Peroneal.L						
Ankle	5.2 ms	4.9 mV	Extensor digitorum brevis-Ankle	5.2 ms	80 mm	m/s
Fibula (head)	10.6 ms	4.8 mV	Ankle-Fibula (head)	5.4 ms	252 mm	47 m/s
Tibial.L						
Ankle	4.1 ms	17.6 mV	Abductor hallucis-Ankle	4.1 ms	80 mm	m/s
Popliteal fossa	12.3 ms	13.1 mV	Ankle-Popliteal fossa	8.2 ms	340 mm	41 m/s

[redacted]

ID #: 812223

Sensory Nerve Conduction:

Nerve and Site	Onset Latency	Peak Latency	Amplitude	Segment	Latency Difference	Distance	Conduction Velocity
Sural.L							
Lower leg	3.2 ms	3.9 ms	12 μV	Ankle-Lower leg	3.2 ms	140 mm	44 m/s

Needle EMG Examination:

	Insertional	Spontaneous Activity			Volitional MUAPs					Max Volitional Activity		
Muscle	Insertional	Fibs	+Wave	Fasc	Duration	Amplitude	Poly	Config	Recruitment	Amplitude	Pattern	Effort
Tibialis anterior.L	Normal	None	None	None	Normal	Normal	None	Normal	Normal	Normal	Full	Max.
Gastrocnemius (Medial head).L	Normal	None	None	None	Sl. Incr.	Normal	None	Normal	Normal	Normal	Full	Max.
Vastus medialis.L	Normal	None	None	None	Normal	Normal	None	Normal	Normal	Normal	Full	Max.
L5 paraspinal.L	Normal	None	None	None								
S1 paraspinal.L	Normal	1+	2+	None								

Findings:

The examination was somewhatdifficult due to dysesthesia to light touch in the left foot and lower leg.

1. The left sural sensory response was normal.
2. The left peroneal motor response was normal.
3. The left tibial motor response was also normal.
4. Needle EMG of muscles representing the left L2 to S2 myotomes showed scattered fibrillation potentials and positive sharp waves in the S1 paraspinal muscle. All other muscles studied were normal.

Impression:

This is a mildly abnormal study.

1. There is electrophysiologic evidence of ongoing active denervation in left S1 paraspinal musculature, consistent with an active left S1 radiculopathy. This degree of active denervation change is commonly observed postoperatively. Of note, there was no evidence of a more diffuse acute or chronic denervating process, a relatively favorable electrodiagnostic finding.
2. There was no evidence of a polyneuropathy.

[redacted]

Professor and Chair of Neurology

Medical Bills

[redacted]MEDICAL IMAGING
1750 E VILLA DR
SUITE K
COTTONWOOD, AZ 86326-4687
[redacted]

Fax:
Tax ID:

Patient: 504426 - [redacted]
Date Created: Monday, February 10, [redacted] 10:41 AM

DATE	REF. DOCTOR	DOCTOR	PROCEDURE	CHARGES	PAYMENTS	ADJUSTMENTS	BALANCE	PAYSOURCE	INS PLAN
12/09[redacted]	[redacted]	[redacted]	70450 - CT HEAD/	$133.00					
				$133.00	**$0.00**	**$0.00**	**$133.00**		
12/09[redacted]	[redacted]	[redacted]	G9637 - FINAL REP	$0.00					
01/03[redacted]	4847559		Adjustment		$0.00	$0.00		SOUTHERN CA	164459
				$0.00	**$0.00**	**$0.00**	**$0.00**		
			Account Total:	**$133.00**	**$0.00**	**$0.00**	**$133.00**		

Operative Report

MR# M000831403 Account # V00005270541 Report# 0605-1064

[redacted] COUNTY MEDICAL CENTER CORPORATION
OR-Attending Operative Report
462 Grider St Buffalo NY 14215
[redacted]

Patient's Name [redacted]
Report# 0605-1064
[redacted]
Attending Physician: [redacted]
Dictating Provider: [redacted]
Primary Provider: [redacted]

[redacted]
Age/Sex: 48/F
Admission Date/Time:
Admitting Service:
Dictating Date/Time: 06/05[redacted]1449

Operative Report

Interlaminar Lumbar Epidural Steroid Injection Under Fluoroscopic Guidance
Lumbar Epidurogram

DATE OF OPERATION: 06/05/[redacted]

No fault carrier: Stafe Co
DOB: 09/23/[redacted]
Date of accident 10/31/[redacted]
[redacted]

SURGEON: [redacted]

PREOP DIAGNOSIS: Lumbar radiculopathy with disc herniation and stenosis
POSTOP DIAGNOSIS: Same

PROCEDURE: 1 - Fluoroscopically Guided Interlaminar Lumbar Epidural Steroid Injection.
2- Lumbar epidurogram

Informed consent was obtained. The patient was taken to the fluoroscopy suite and placed prone on the fluoroscopic table. The low back was prepped times 3 with Betadine and sterilely draped. At the L5/S1interspace, just to the left of midline. The skin was anesthetized with 1% Lidocaine. Using loss of resistance technique with an 18 gauge Tuohy needle, the epidural space was identified without complication.

Injection of Isovue M 300 under live x-ray showed good epidural spread without vascular pick-up. (Please see separate epidurogram report)

After negative aspiration, 10 mg of Preservative Free Dexamethasone was injected in small boluses without complication. The needle was then cleared with 1 cc of 0.125 % marcaine and the needle was withdrawn. Provocation of normal back and buttock symptomatology occurred during active injection. The area cleansed, and band-aid applied. The patient was taken to the recovery area and observed for an appropriate period of time, then discharged in stable condition.

COMPLICATIONS: None

FINDINGS/NOTES:

MR# M000831403 [redacted] Report# 0605-1064

The patient is status post a motor vehicle accident. She has a radiologically documented left disc herniation. She is complaining of pain in the low back with radiation to the left buttock to the posterior thigh in the posterior leg to the bottom of her left foot she on also says she has some pain in the bilateral proximal anterior thighs. She has been referred by her spine surgeon for an interlaminar L5/S1 epidural steroid injection. Risks benefits and alternatives were discussed. She denies contraindications.

LUMBAR EPIDUROGRAM:

The patient was brought to the procedure room for an epidural steroid injection. At the time of the injection, a diagnostic epiduragram was performed in order to the presence of any filling defects or pathology, needle placement, spread of injectate, and ensure absence of vascular uptake. This information can be used to help direct future treatment.

The needle was visualized to the left of midline at L 5/S1. Injection of contrast under live x-ray showed good epidural spread, without evidence of vascular pick-up. Contrast spread bilaterally, left greater than right across L5/S1. There was contrast visualize bilaterally in the lateral gutters across L4 5 and centrally into the left across L4/5. There was some proximal spread into the proximal left L5 and S1 dural sleeves. On lateral view there was some anterior spread noted at higher lumbar levels with some and displace the anterior epidural space at the level of discs but mostly posterior at L5/S1.

Based on this study, should she continue to have pain, we could consider transforaminal injections to improve spread into the dural sleeves and anteriorly.

The study was saved, printed and attached to the chart for future reference.

DRAGON DISCLAIMER: Dragon voice-recognition software may have been used to prepare this typewritten note. Although each note is personally scanned for syntactic or grammatical errors, unintended but conspicuous translational errors can occur. Please contact ECMC if there are any questions about the contents of this note.

[redacted] Jun 5, [redacted] 14:49

<Electronically signed by [redacted] 06/05 [redacted] 1449

,

,

PC Physician: [redacted]
Ref Physician:
Copies To:
~

Orders

INJURY PHYSICIANS [redacted]
(833) 472-3627
[redacted]

PRELIMINARY STATUS SHEET

DOCTOR: [redacted]

PATIENT NAME: [redacted] **DATE:** 10-1-[redacted]

DATE OF BIRTH: [redacted]

DIAGNOSIS:

1. Neck pain w/ Radiculopathy
2.
3.
4.
5.

RECOMMENDATIONS:

MRI (1.5T OR GREATER):

CT SCAN WITHOUT CONTRAST:

EMG/NCV:

X-RAYS:

OTHER: **(Surgical clearance to include full H&P with review of systems) Chem Panel, CBC, PT, PTT, UA, CXR , EKG and COVID-19 PCR TEST**

Physician Signature: [redacted]

Radiological Study

Radiology Exam Report

Patient Name: [redacted]
MRN: 34029872
FIN: 340298724092
Patient Type: Outpatient
Accession No: 04-097-000503
Exam Date/Time: 4/6 [redacted] 0:17 AM
Ordering Physician: [redacted]
Transcribed Date/Time: 4/6 [redacted] 5:08 PM
Radiologist: [redacted]
Reason for Exam: RETROPERITONEAL MASS

DOB/Age/Sex: [redacted] 46 Years Male
Location: SW Hosp OP Rad/ /
Exam: Chest w contrast CT
Exam Status: Completed
Transcriptionist: [redacted]
Report Status: Final
Resident:

RADIOLOGY REPORT

DATE/TIME OF DICTATION: 04/06[redacted] 1602

4/[redacted] CT SCAN OF THE CHEST WITH CONTRAST:

The lungs are clear and inflated. The heart is normal in size. There are no pleural or pericardial effusions. There is no mediastinal, hilar, or axillary adenopathy. The thoracic aorta is normal.

The spleen is generous in size and measures 13.3 cm in sagittal dimensions. This is compatible with mild splenomegaly. There is also a left retroperitoneal mass, only the cephalad extent of which is seen.

IMPRESSION:

1. NEGATIVE CT SCAN OF THE CHEST WITH CONTRAST.

2. MILD SPLENOMEGALY.

3. LEFT RETROPERITONEAL MASS BARELY DISCERNIBLE.

RLV/rt

Read by: [redacted]
Transcribed Date/time: 04/06[redacted] 5:08
Electronically Signed by: [redacted] 04/06[redacted] 0:59
FINAL REPORT

*** END OF REPORT ***

Others

[redacted]

Legal Services

Where Knowledge and Service Matter

CLIENT: [redacted]

ATTENTION: [redacted]

FILE NUMBER: 209693

CASE NAME:

VS

RECORDS ON: [redacted]

FROM: [redacted]

☒ THE ENCLOSED RECORDS COMPLETE YOUR REQUEST FROM THIS CUSTODIAN

☐ THIS REQUEST IS INCOMPLETE FOR THE FOLLOWING REASON:

- ☐ Billing records were not available at the time of copying and will be fowarded to your office when they become available.
- ☐ X-Rays were not available at the time of copying and will be forwarded when available.

☐ THERE ARE NO RECORDS AT THE ABOVE LOCATION

☐ OTHER: _____

_____

Our Reference No.: SU329123-01

2050 W 190th Street, Suite 200
Torrance, CA 90504

Order SU329123-01/CPROOF21auth