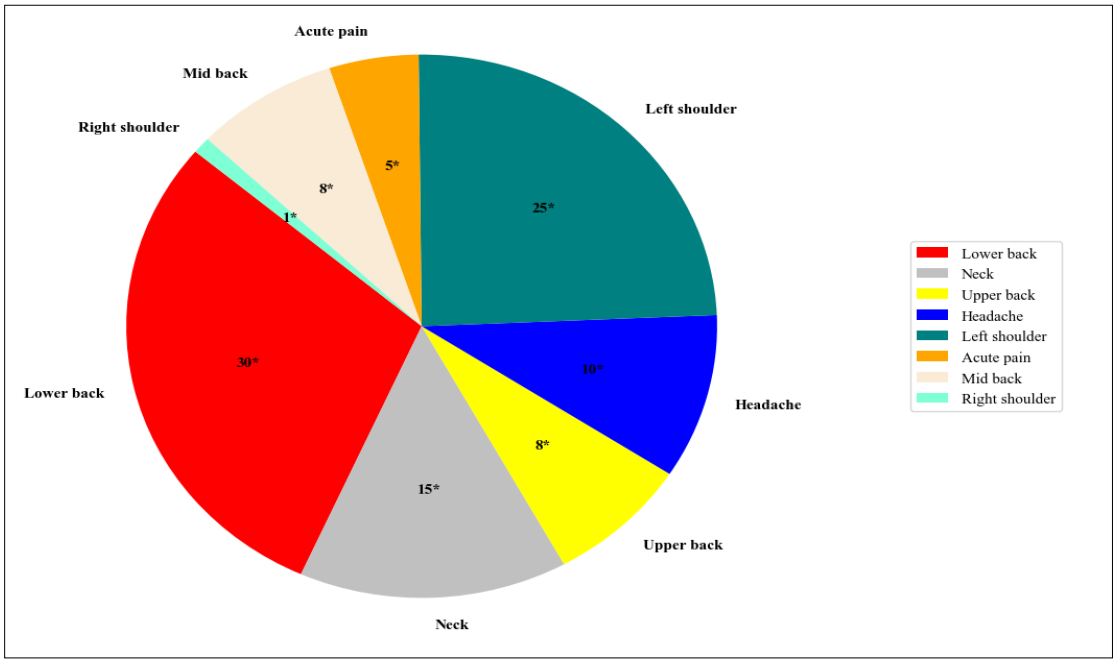
Case Capsule

Case Overview

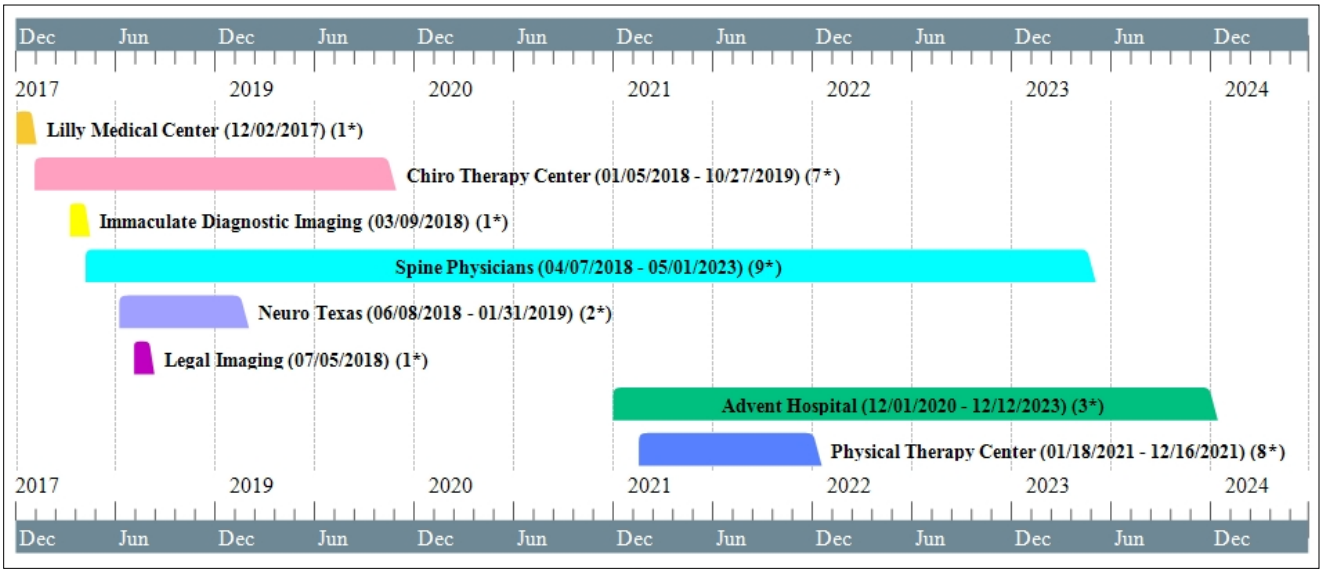
Mr. Johnson was involved in a motor vehicle collision on 12/02/2017 and sustained injuries to his neck, right and left shoulders, upper back, lower back, arms, and leg pain. He was diagnosed with back contusion and was discharged home with medications. He received multiple physical and chiro therapy from 01/05/2018 through 12/16/2021. He underwent multiple steroid injections. As on 12/12/2023, he was advised to continue exercises.

Treated Body Parts/Medical Conditions Chart



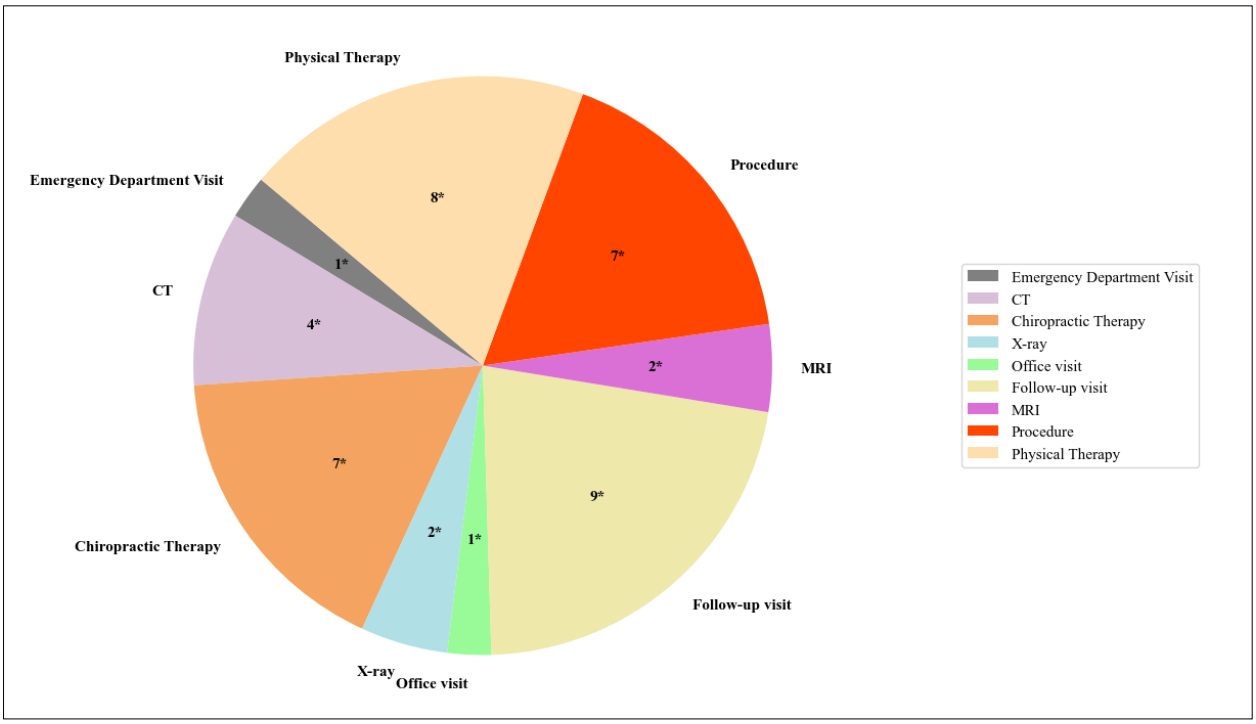
**No of times each parts/medical conditions treated*

Treating Providers Timeline



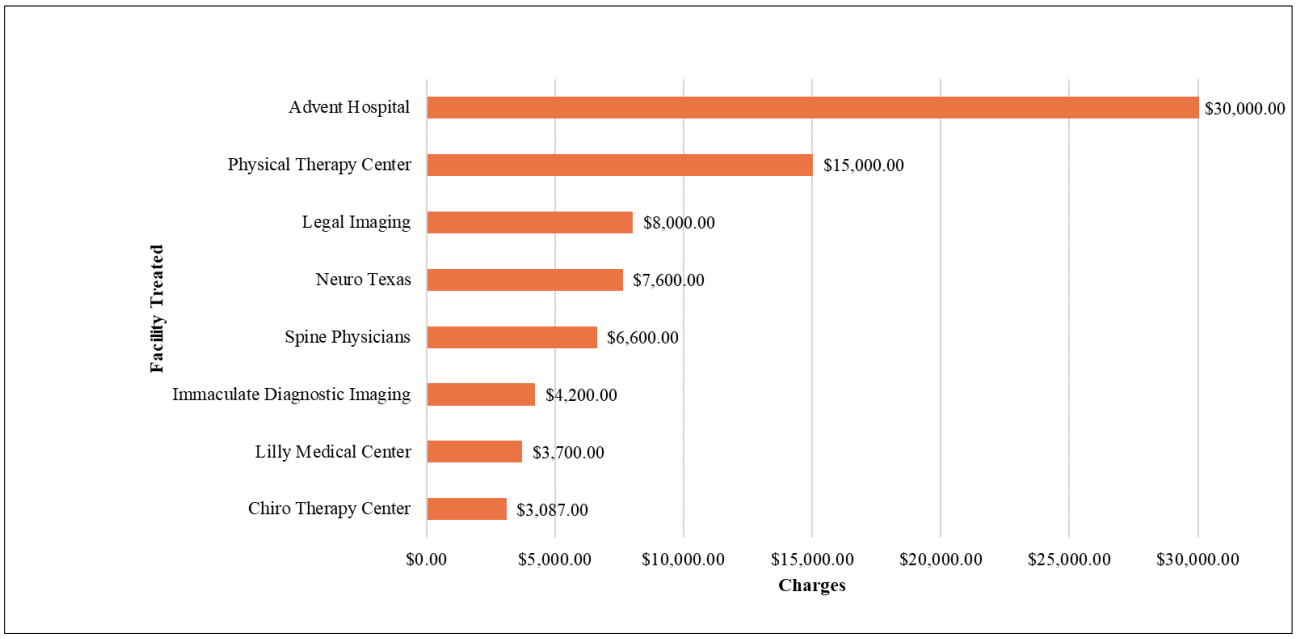
**No. of times treated*

Medical Visit Chart



**No of Occurrences*

Key Medical Expenses*



**If Medical Expense Summary Service requested*

Accident Report

Page Reference to Police Report/Accident Scene Investigation Report: 6-9

PARAMETER	DETAILS		PDF REF
Date and Time of Accident	**Date of accident:** 12/02/2017 **Time of accident:** @1350 hours		6
Location	**County:** Cameron		6
	City: Outside city limit		
	Road on which crash occurred: • **Roadway system**: Farm to market • **Highway number**: 803 • **Roadway part:** Main/proper lane		
	Intersecting road, or if crash not at intersection, nearest intersecting road or reference marker: • **At intersection**: No • **Roadway part**: Main/proper lane • **Street name**: St. Francis • **Street suffix**: Avenue		
	Distance from intersection or reference marker: 500 **Direction from intersection or reference marker**: North		
Direction of Travel	South		7
Speed	50		6
Scene of Accident	**Weather condition:** Clear. **Light condition:** Daylight. **Surface condition:** Dry **Roadway type:** Two-way, not divided. **Roadway alignment:** Straight, level. **Traffic control:** No passing zone.		7
No of Vehicles Involved	Two		6
Party Details	**Unit #1:** XXXX YYYY, Driver **Unit #2:** XXXX YYYY		6, 8
Vehicle Details #1	**Make/Model/Body Style**	GMC/Yukon/SV	6
	Year	2008	
	Color	Black	
	VIN Number	1GK638	
	Policy Number	PR2-06	
Vehicle Details #2	**Make/Model/Body Style**	Dodge/Magnum/P4	6
	Year	2005	
	Color	Blue	
	VIN Number	2D4F104	
	Policy Number	PR-00072-02	
Description of Accident	Unit #1 was traveling north on FM 803. Unit #2 was traveling south on FM 803. Unit #1's back left tire blew out, which caused unit #1 to lose control. Unit #1 veered onto the path of unit #2. The driver of unit #2 attempted to take evasive action by veering right. Unit #1 struck unit #2 on the left side with its front left and continued a side-swipe motion. The driver of unit #2 was pronounced deceased at the		7

PARAMETER	DETAILS	PDF REF
	scene by Justice of the Peace Judge Juan Mendosa at approximately 2:22 PM. The body was transported to Valley Baptist Medical Center Morgue by Thomae-Garza Funeral Home. Two passengers in unit# 2 were pronounced deceased at a local hospital.	
Did Airbag Deploy?	Deployed, multiple	8
Seat Belt Applied?	Unknown	8
Seating Position	Front right	8
Vehicle Damages/ Vehicle Towed	**Unit #2:** **Vehicle towed:** **Towed by:** All Valley Wide #956-233-4840 **Towed to**: 1202 S. Arroyo Blvd, Los Fresnos, Tx	6
Property loss	**In your opinion, did this crash result in at least $1,000 damage to any one person's property?** Yes.	6
Violation Code/Reason for Accident/ Sobriety and Distraction Factors	**Unit #1:** **Reason for accident:** **Vehicle defects**: Defective or slick tires	7
Parties Cited/At Fault Party	**At fault party:** **Unit #1:** Griselda Solis de Calixto, Driver.	7
Was 911 Called?	Yes. Notified Los Fresnos Fire Department	7, 9
Who Arrived at the scene First?	Police. Department of Public Safety, State of Texas	7
Other Details	*Unavailable*	

EMS Report Abstract

Page Reference to EMS Report: 36-39.

PARAMETER	DETAILS		PDF REF
Date	12/02/2017		36
EMS Name	McKinney Fire Department **Crew members:** James Manolis: Driver-Response, Driver- Transport, Other Caregiver – At scene Joel Davis: Lead-at scene, lead-transport		38
Time Details	**Time Called**	@0038 hours	38
	Time Arrived	@0044 hours	
	Time Departed	@0114 hours	
	Time Arrived at Hospital	@0120 hours	
Response Code/Level of Medical Care	Basic life support		39
Status of Patient on Arrival	Patient observed to be conscious and alert, walking around the scene.		37
Chief Complaints	My ear is ringing and hurts, my neck kind of hurts		36
Narrative	M2 dispatched and responded to an MVA. M2 arrived on scene and observed 2 vehicles involved with major damage. All occupants were out of the vehicles and ambulatory when M2 arrived. M2 observed two pickup trucks, one with damage to the front of the vehicle and one with damage to the entire right side of the passenger compartment. Patient was in the second vehicle with right sided damage. M2 observed airbag deployment in the front and sides (curtain type airbags). M2 made patient contact with the 48-year-old male patient observed to be conscious and alert, walking around the scene. Patient observed to be Alert and oriented x 4 (A&O4) with GCS of 15. Patient advised the right side of his neck hurt, as well as a ringing in his ear that he claimed was from the curtain airbag deploying. Patient ambulated to the back of the med unit for further assessment. In the med unit, M2 obtained the patient's baseline vital signs and observed the pt to be in stable condition. Patient denied any head, or back pain as well as spinal pain and denied loss of consciousness or use of blood thinners. Patient advised he has hemophilia and cannot take blood thinners. M2 palpated the patient’s neck and found no deformity, crepitus or swelling but observed seatbelt signs in the form of redness. Patient advised he was the driver of the vehicle at the time of the accident. Patient advised he was making a left-hand turn when the other truck "ran a red light and plowed into us." Patient initially did not want to be transported to the hospital. M2 explained to the patient that due to the Mode of Injuries (MOI) and his injuries sustained that transport is highly recommended. Patient then agreed to transport with another passenger of the vehicle. M2 placed a Cervical collar on the patient due to MOI and initiated transport to Baylor McKinney code 1. During transport, the patient was continuously monitored with vital signs (as recorded) and report was given via phone. Patient maintained his mental status of Alert and oriented x 4, GCS of 15 during transport.		37

	Upon arrival at the hospital, patient was taken to triage, and report was given to the ER RN. Once all signatures were obtained, M2 cleared and returned to service with no further action.	
Vitals/ Pain Level/Physical exam	**@0115 hours: BP:** 146/96, **Pulse:** 98, **Respiratory rate:** 16, **SpO2:** 98, **Pain:** 6/10. Patient has left sided neck pain secondary to a car accident. Left ear pain and tenderness. Neck pain and tenderness.	36-37
Loss of Consciousness	No	37
Impression	➢ **Primary:** Injury of ear ➢ **Secondary:** Injury of neck	36
Treatment	**Medications:** Folic acid.	36
Neck Collar Applied?	Yes	37
Backboard Support?	Unavailable	
Destination	Baylor Scott & White – McKinney	38
Other Details	**Condition at destination:** Improved	38

Injury Report

PARAMETER	DETAILS	PDF REF
Date of injury	12/02/2017	24-34
Related Injuries and Medical Condition Before incident	**Past medical history:** *Unavailable* **Past surgical history:** Lower back surgery in 2001	1, 68
Damages Developed/Sustained as a result of incident (diagnoses alone)	• Back contusion • Cervical region radiculopathy • Cervicothoracic region radiculopathy • Lumbar region radiculopathy • Sacral and sacrococcygeal region radiculopathy • Acute post-traumatic headache, not intractable • Sprain of cervical ligaments • Cervicalgia • Sprain of lumbar ligaments • Sprain of sacroiliac joint • Sacroiliitis • Pain in thoracic spine • Sprain of ligaments of thoracic spine • Pain in left shoulder • Acute pain due to trauma • Foraminal stenosis of lumbar region • Mechanical back pain • Lumbar region spondylolisthesis • Right shoulder rotator cuff tear • Pain in right shoulder • Left shoulder labrum tear	32, 4, 69, 74, 77, 84, 89, 94
Surgeries or procedures underwent as a result of incident	**Procedures:** **12/02/2018:** Underwent lumbar epidural steroid injection to L5-S1 and left glenohumeral joint injection under fluoroscopy. **12/18/2019:** Underwent caudal epidural steroid injection and left glenohumeral joint injection under fluoroscopy **12/01/2020:** Underwent left shoulder corticosteroid injection. **12/31/2019:** Underwent caudal epidural steroid injection. **04/06/2022:** Underwent right shoulder corticosteroid injection. **12/21/2022:** Underwent left L3-4, L4-5 and L5-S1 facet injections **05/01/2023:** Underwent Left L3-4, L4-5 and L5-S1 rhizotomies **Surgeries:** *Unavailable*	70-71, 81-82, 83-84, 89, 90, 93, 87
Postsurgical complications (infection, DVT, etc)	*Unavailable*	-

PARAMETER	DETAILS	PDF REF
Aggravation of pre-existing conditions (Physician or therapist's statement alone)	*Physician or therapist's statement for aggravation of pre-existing conditions are unavailable for review.*	-
Did patient return to work (Date and work status as per the last few visits/therapies)	As of 12/12/2023, he was working as much as he can.	15
Disability (Physician or therapist's statement alone)	*Physician or therapist's statement regarding disability was unavailable for review.*	-
Causation (Physician or therapist's statement alone)	*Unavailable*	-
Loss of Consortium	*Unavailable*	-
Non-Compliance	*Unavailable*	-

Patient History

Past medical history: Diabetes mellitus II, hypertension, kidney disease/stones. *(Pdf ref: 68, 25)*

Past surgical history: Lower back surgery in 2001, knee surgery in 2001, ankle and wrist surgery in 1996. *(Pdf ref: 1, 68)*

Prior occupational history: *Unavailable*

Current occupational status: As of 12/12/2023, he was working as much as he can. *(Pdf ref: 15)*

Family History: Rheumatoid arthritis and high blood pressure. *(Pdf ref: 83)*

Social History: Drinks alcohol socially, denies tobacco or illicit drug use. *(Pdf ref: 68)*

Drug Allergy: No known drug allergies. *(Pdf ref: 68)*

Other Allergy: *Unavailable*

Detailed Chronology

Date	Provider	Occurrence/Treatment	PDF REF
		Motor Vehicle Accident – 12/02/2017	
12/02/2017	Lilly Medical Center John Doe, M.D.	**@ 0603 hours: Emergency room visit for back pain and neck pain**: Chief complaint: Back pain, neck pain Onset occurred: Today Symptom duration: Constant Progression since onset: Unchanged Collision details - Speed moderate Safety measures - Airbag not deployed, Seatbelt worn Position in vehicle - Driver Location - Neck, Back Quality - Painful Severity: Onset Mild Severity: Current Mild Exacerbated by: Nothing Relieved by: Nothing Glasgow Coma Scale (GCS) Score: 15. **Physical exam:** Neck: Muscle tenderness in the left and right paraspinal. Back: Thoracic paraspinal tenderness, thoracic spine tenderness, lumbar paraspinal tenderness, lumbar spine tenderness. **Prescriptions**: • Albuterol Sulfate • Albuterol/Ipratropium • Methocarbamol • Morphine sulfate • Hydrocodone Bitrat/Acetaminophen • Morphine sulfate **Condition**: Stable. Medical decision-making notes: Getting CT head/spine to assess Patient with spine pain after MVC low back pain worse. **Re-evaluation**: Patient presenting with back pain. On re-evaluation feels improved after MVC. EKG independently reviewed and interpreted. Imaging independently reviewed and interpreted by me include: CT head shows no intracranial hemorrhage. CT cervical spine shows no cervical-spine fracture. Given labs and imaging findings, patient's past medical history, and patient's condition/diagnosis, the plan is to discharge patient with medications to help control pain. Patient has history of back surgery and the back problems are likely contributing to patient's pain due to the	24-34

Date	Provider	Occurrence/Treatment	PDF REF
		exacerbation giving a Norco to help with the acute on chronic pain and giving muscle relaxers and lidocaine patches. Prescriptions: Norco. Robaxin also given-in addition please see depart section for prescriptions. **Clinical impression** **Primary impression**: Back contusion **Secondary impressions**: MVC (motor vehicle collision) **Disposition decision**: Discharged to Home. **Prescriptions:** • Hydrocodone/Acetaminophen 5-325 mg • Methocarbamol 1000 mg • Lidocaine 5% patch. **Patient instructions**: ED Back Contusion, ED MVA, General **Provider referral**: Roger Butler, MD **Resource referral**: Accidental Care Clinic; Follow-up **Provider referral**: Rajesh Arakal, MD; Follow-up Return to work: Return to work in 3 Days I have personally seen the patient and I evaluated the patient along with involvement of the PA/NP. I agree with the PA/NPs findings and plan. I have performed all aspects of MOM as documented including: evaluation of the patient/patient's conditions, review and analysis of available data, and determination of risk of patient management decisions.	
12/02/2017	Lilly Medical Center John Doe, M.D.	**CT of cervical spine without contrast:** **Indication**: Head injury. **Comparison**: None **Impression**: No evidence of acute fracture or traumatic subluxation.	35
12/02/2017	Lilly Medical Center John Doe, M.D.	**CT of lumbar spine without contrast:** **History**: Injury. **Comparison**: None available. **Impression**: • No fracture or subluxation • Status post decompressive laminectomy at L3-L4 and L4-L5. • Transitional anatomy of the lumbar spine with a small right L1 rib and a symmetric disc at S1-S2. • Moderate to severe neuroforaminal narrowing at L5-S1.	37-38
12/02/2017	Lilly Medical Center	**CT of thoracic spine without contrast:** **History**: Injury.	39-40

Date	Provider	Occurrence/Treatment	PDF REF
	John Doe, M.D.	**Comparison**: None available. **Impression**: • No fracture or subluxation • Status post decompressive laminectomy at L3-L4 and L4-L5. • Transitional anatomy of the lumbar spine with a small right L1 rib and a symmetric disc at S1-S2. • Moderate to severe neuroforaminal narrowing at L5-S1.	
12/02/2017	Lilly Medical Center John Doe, M.D.	**CT of head/brain without contrast:** **Indication**: Concussion. **Comparison**: None **Impression**: No acute intracranial process.	36
01/05/2018	Chiro Therapy Center Lin Anddy, D.C.	**Initial chiropractic therapy visit for neck, shoulders, upper back, lower back, arms and leg pain:** **Chief complaint**: Neck, shoulders, upper back, lower back, arms and legs. **History of present illness** **Patient symptoms**: Pain and stiffness **Date of first symptom:** 12/02/2017 – Motor Vehicle Collision (MVC). **How incident occurred**: Patient states he was in a MVC with an 18 wheeler. He states he was the restrained driver. He states the airbags did not deploy. He states at the time of the MVC his left shoulder struck the driver's side door extremely hard. He states directly following the MVC he had severe lower back pain which felt like it did prior to his lower back surgery. **Pain scale (0-10):** 10 **Aggravating factors**: Everything. He states he is unable to find a comfortable position. **Relieving factors**: He states moving positions will provide temporary relief but the pain never goes away. He states after a short time the pain will intensify again. **Radiating symptoms**: He states he is having discomfort in both arms and both legs. He states the traveling pain is slightly worse in both the left arm and left leg. **Review of systems** **Neurological**: He states he is having some mild headaches on the right side of his head. He states he also cannot sleep more than 2 hours at a time before waking. Work: He states he is on light duty at work. Exercise: He states he is unable to do anything at this time. Oswestry: 64%.	1-4

Date	Provider	Occurrence/Treatment	PDF REF
		Objective: **Musculoskeletal**: J-Tech and Myo are not performed at this time. The patient is extremely uncomfortable trying to stand and move around at all. **Head and neck:** See J-tech results for Range of Motion (ROM) and strength testing. Pain during palpation of the cervical spinal region pain presented bilaterally. Increased pain presented at the cervical thoracic junction. Palpation of the mid cervical region C3-C5 produced discomfort. Palpation of the levator and upper trap revealed spasms and trigger points that produced pain. Pain during palpation of the C7 and T1 spinous processes. Palpation of the left deltoid, bilateral infraspinatus cause moderate to severe discomfort. **Spine, ribs, pelvis**: Palpation of the thoracic region produced pain along the paraspinal region Spasm noted in the thoracic paraspinal along with rhomboids, mid trap, and lower trap. Pain during palpation of the Lumbar spine presented bilaterally. Pain during palpation of the left Quadratus Lumborum (QL) and Glute med produce moderate discomfort. **Skin**: Head and neck: Moderate FHP Trunk: Moderate thoracic hyper kyphosis Left upper extremity: He is unable to raise his left arm above parallel without moderate to severe discomfort. Neurological: The patient was well oriented to time, space and person. Recent and remote memory appeared to be intact. The patient's attention span and memory appeared normal. There did not appear to be difficulty with Language or general awareness. The patients ROM is severely limited and painful. For these reasons orthopedic tests are not performed based on the outcome of all would be positive. Multiple subluxations were gently mobilized with cups and noted with spasm, hypomobility and end point tenderness in the C5, C6, C7, T1, T2, T3, T4 Active trigger points in the levator scap, upper trap, cervical and thoracic paraspinals. bilateral infraspinatus, left deltoid. The part of a muscle fiber that actually does the contracting is a microscopic unit called a sarcomere. Contraction occurs in a sarcomere when its two parts come together and interlock like fingers. Millions of sarcomeres have to contract in your muscles to make even the smallest movement, a trigger point exists when over stimulated sarcomeres are chemically prevented from releasing from their interlocked state. Normally, when a muscle is working, its sarcomeres act like tiny pumps, contracting and relaxing to circulate blood through the capillaries that supply their metabolic needs.	

Date	Provider	Occurrence/Treatment	PDF REF
		Assessment: Patient's prognosis is guarded and uncertain at this time. There was no change after treatment. This means that there is a 60% chance of a need for long-term treatment. It also means that there is a 60 to 80% chance of long-term residuals of patient's primary presenting musculoskeletal, orthopedic and neurological complaints. **Plan**: **Prognosis**: Unknown due to the severity of the symptoms and the overall presentation of the patient. **Treatment recommendations**: Immediate referral to a neurosurgeon and pain management specialist. **Treatment plan**: A treatment will be set up following the consultations with Neurosurgery and pain management. **Diagnosis**: • Radiculopathy, cervical region • Radiculopathy, cervicothoracic region • Radiculopathy, lumbar region • Radiculopathy, sacral and sacrococcygeal region • Acute post-traumatic headache, not intractable • Sprain of cervical ligaments, initial • Cervicalgia • Sprain of lumbar ligaments, initial • Sprain of sacroiliac joint • Sacroiliitis, not elsewhere classified • Pain in thoracic spine • Sprain of ligaments of thoracic spine, initial encounter • Pain in left shoulder	
03/09/2018	Immaculate Diagnostic Imaging Lin Anddy, D.C.	**X-ray of lateral lumbar and thoracic spine, anterior, posterior and five view cervical spine:** **Report**: • Mild left convexity of the mid lumbar spine. • Moderate hypolordosis and posterior weight-bearing of the lumbar spine. • Mild retrolisthesis of L5. • Mild anterior weight-bearing of the cervical spine. • Severe restriction of cervical spine flexion and extension. • Early enthesopathy along the lateral margins of the iliac crest bilaterally. • Early to moderate spondylosis throughout the lumbar spine. • Laminectomy defect at L3 and L4. Correlation with patient history is suggested. • Early to moderate physiologic calcification of the costal cartilage. • Early to moderate spondylosis at C3-4 through C6-7.	19

Date	Provider	Occurrence/Treatment	PDF REF
		• Moderate physiologic calcification of the thyroid cartilage. **Recommendation**: Spot views of symptomatic or questionable areas not well seen on the current study.	
04/07/2018	Spine Physicians Micheal Geroge, M.D.	**Office visit for lower back pain, bilateral shoulder pain, and neck pain:** **Reason for appointment**: Lower back pain, bilateral shoulder pain, and neck pain. **History of present illness** **Pain management**: This is a 55-year-old male who presents for an initial visit. The patient presents with low back, left shoulder, and neck pain that started from a head on collision with an 18-wheeler on 12/02/2017. He rates his pain as a 10/10 in severity and describes it as a constant, sharp, stabbing, stinging, burning, deep, tingling, and aching pain. His pain is aggravated by bending forward, sitting, morning, standing, night, cold weather, walking and stress. He has yet to find anything to alleviate his pain. He is currently seeing a chiropractor. He has a history of surgery on his lumbar spine at L3-5 in 2001. He sees Dr. Salinas tomorrow for a consult. He has radicular symptoms into his Left Lower Extremity (LLE). He has decreased range of motion of his Left Upper Extremity (LUE) due to the pain in his shoulder. **Examination:** **Neck/thyroid**: Tenderness to palpation to the cervical spine and paraspinal muscles. Facet loading positive bilaterally. **Back**: Tenderness to palpation to the lumbosacral spine and paraspinal muscles. Facet loading is positive bilaterally. Positive Straight Leg Raise (SLR) on the left. **Musculoskeletal**: The upper and lower extremities have normal muscle, joint, and bone structure. Decreased range of motion is noted in the left upper extremity. Tenderness To Palpation (TTP) to the glenohumeral joint. **Assessments** • Acute pain due to trauma • Radiculopathy, lumbosacral region • Pain in left shoulder **Treatment**: • Acute pain due to trauma - Order MRI lumbar spine due to radicular symptoms and a MRI left shoulder due to concerns for possible rotator cuff damage. Recommend Lumbar Epidural Steroid Injection (LESI) left, L5-S1 for radicular pain and a left shoulder injection. Risks and benefits explained. Start Gabapentin and Methocarbamol as needed. Continue home exercises. Consider PT referral. • Others - Start Methocarbamol Tablet, 750 mg, 1 tablet as needed, orally, every 8 hours, 90 tablet, refills 2. Start Gabapentin Tablet, 300 mg, 1 tablet, orally, three times a day, 90 tablet, refills 0	68-69

Date	Provider	Occurrence/Treatment	PDF REF
		Follow-up: 4 weeks.	
06/08/2018	Neuro Texas Micheal Geroge, M.D.	**Follow-up visit for back pain**: **Reason for appointment**: Back. **History of present illness**: Patient is here today as a new patient and states back pain. He brings in an CT of his head. Cervical, thoracic and lumbar spine. He states he was the driver and had a semitruck that got in front of him causing the patient to T-bone him. The airbags did not deploy. He presented to Medical City Piano ER after he was involved in a MVC. He was treated with Norco and Robaxin. Patient reports sharp back pain which is constant. Their pain is 75% back and 25% left leg. He also states numbness and tingling in his leg. Patient rates their back pain as 10/10 and has taken Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) with little relief. Patient indicates that pain is worse with sitting, standing, walking, lying down. Patient indicates that sitting, standing, heat reduces pain. In order to avoid back pain, patient reports not standing for long periods, not walking long distances, not sitting for long, not lifting weight, not twisting, not bending, not working out. Patient presents with neck pain also since the MVA. He states the pain radiates into his left shoulder He states his pain is constant and describes his pain as radiating. Their pain is 50% and 50% left shoulder/arm. He has been getting chiropractic treatment at Chiro Concepts since on or around 03/01/2022. He states little relief. Patient rates their back pain as 10/10 and has taken NSAIDs with little relief. Patient indicates that pain is worse with sitting, standing, walking, lying down. Patient indicates that sitting, standing, heat reduces pain. In order to avoid neck pain, patient reports not standing for long periods, not walking long distances, not sitting for long, not lifting weight, not twisting, not bending, not working out. **Review of systems:** **Musculoskeletal**: Back pain and neck pain. **Neurologic**: Tingling/Numbness **Assessments:** • Foraminal stenosis of lumbar region • Mechanical back pain **Treatment** • Foraminal stenosis of lumbar region - Patient is here and reports back pain that radiates into his left leg after MVA 12/02/2017 . CT lumbar-spine shows severe foraminal stenosis at L5-S1. Multilevel facet degeneration is noted. Recommend MRI L-spine without contrast to further evaluate foraminal stenosis, degeneration, and central canal stenosis. Recommend X-ray L-spine 5V to rule out instability. Recommend conservative measurements such as PT,	72-74

Date	Provider	Occurrence/Treatment	PDF REF
		injections, and medications. Recommend L1-L5 ESI to alleviate lumbar symptoms. The requested studies are to evaluate patient for possible surgical intervention. Will need the review requested studies in order to recommend surgical intervention. Return to clinic after completion of requested studies. Educated to call with worsening signs or symptoms. • Mechanical back pain – X-ray of lumbar spine 6 views.	
07/05/2018	Legal Imaging Henry Evan, M.D.	**X-ray of lumbar spine 6 views:** **Clinical indication**: Dorsalgia, unspecified. **Comparison**: No prior exam submitted for comparison. **Impression**: • Moderate disc space narrowing L5-S1 with facet hypertrophy, foraminal narrowing and mild retrolisthesis of L5. • Prior laminectomies L3-L4 and L4-L5. • Severe restricted flexion and extension ROM. • Mild left lateral curve of the lumbar region.	20
07/05/2018	Legal Imaging Henry Evan, M.D.	**MRI of left shoulder without contrast:** **Clinical indication**: Unresolved posttraumatic left pain with limited ROM from an injury sustained in a motor vehicle collision on 12/02/2017 . Left shoulder pain. **Comparison**: There were no prior radiological exams submitted for comparison. **Impression**: • Grade 2 partial tear at the insertion of the supraspinatus the greater tuberosity. • Type II Superior Labrum From Anterior to Posterior (SLAP) lesion/tear of the superior labrum with tear extending into the biceps anchor intrasubstance. • Mild bicipital tenosynovitis. • Mild tendinosis at the insertion of the infraspinatus. • Narrowing of the acromial outlet due to configuration of the acromion.	21
07/05/2018	Legal Imaging Henry Evan, M.D.	**MRI of lumbar spine without contrast:** **Clinical indication:** Unresolved posttraumatic low back pain from an injury sustained in a motor vehicle collision on 12/02/2017 . Lumbosacral radiculopathy. **Impression**: • Lumbosacral transitional anomaly; lumbarization of S1. • Evidence of prior laminectomy at L4-L5 and L3-L4. • Moderate disc space narrowing L5-S1 with 3 mm central bulge and retrolisthesis causing subarticular compression of the	22-23

Date	Provider	Occurrence/Treatment	PDF REF
		traversing S1 nerve roots and foraminal encroachment of the L5 nerve root. • Secondary hypertrophic arthropathy of the facet joints at L4-L5 and L3-L4 causing significant central stenosis with compression of the respective traversing L5 and L4 nerve roots in the subarticular zones	
12/02/2018	Spine Physicians Micheal Geroge, M.D.	**Procedure report for left glenohumeral joint injection and lumbar epidural steroid injection:** **Pre and post-operative diagnosis:** • Lumbar radiculitis • Shoulder pain **Operation**: • Lumbar Epidural Steroid Injection (LESI) L5-S1 • Left glenohumeral joint injection under fluoroscopy **Anesthesia**: General. The needles were removed intact, and Band-Aids were applied. The patient was transferred to the recovery area. The patient was monitored, reassessed, and discharged after an appropriate observatory period. No complications were noted. **Complications**: None	70-71
01/31/2019	Neuro Texas Micheal Geroge, M.D.	**Follow-up visit for review of images:** **Reason for appointment**: Review images. **History of present illness**: Patient is here today to review an MRI and X-ray of his lumbar spine for review. He saw Dr. Badiyan and has been started on Methocarbamol 750mg TID, Gabapentin 300mg TID, and Celecoxib 200 mg with no relief. He had a L5-S1 ESI with 0% relief and left glenohumeral joint injection completed with 0% relief by Dr. Badiyan. **Review of systems:** **Musculoskeletal**: Back pain and neck pain. **Neurologic**: Tingling/numbness **Physical exam:** • Foraminal stenosis of lumbar region • Mechanical back pain **Examination**: Mechanical back pain and L4-5 lumbar radiculopathy. **Assessments:** • Spondylolisthesis, lumbar region • Foraminal stenosis of lumbar region • Mechanical back pain • Pain in left shoulder	75-78

Date	Provider	Occurrence/Treatment	PDF REF
		Treatment: • Spondylolisthesis, lumbar region - Patient is here and reports back pain that radiates into his left leg after MVA 12/02/2017 . Patient also reports rotator cuff in the left shoulder. MRI lumbar-spine shows transitional vertebrae at S1. Spondylolisthesis with moderate foraminal stenosis noted at L5-S1. Discussed surgical and nonsurgical options with the patient. At this time, recommend conservative measurements such as Injections, PT, and medications. Patient to follow up with Dr. Badiyan for injections. If patient's symptoms do not improve with conservative measures, recommend surgical intervention at that time. Return to clinic in 3-6 months • Foraminal stenosis of lumbar region - Start Oxycodone-Acetaminophen Tablet, 5-325 mg, 1 tablet as needed, Orally, every 6 hrs. 14 days, 56 Tablets, Refills 0. • Pain in left shoulder - Patient with reports of left shoulder pain after a MVA 12/02/2017 . MRI left shoulder report reads Patient also reports rotator cuff in the left shoulder. Patient educated to follow up with orthopedic surgeon for an evaluation on his left shoulder pain	
02/02/2019 - 09/02/2019	Chiro Therapy Center Lin Anddy, D.C.	**Multiple chiropractic therapy visits for neck, shoulders, upper back, lower back, arms:** **Total number of chiropractic therapy visits**: 5 visits *(Excluding initial and final therapy visits).* **Chief complaint**: Neck, shoulders, upper back, lower back, arms and legs. **Significant events:** **02/02/2019:** The patient rated the discomfort a 10 out of 10, on a scale from 0 to 10, with 10 being the worst. Patient states he is not feeling any better. He states he is still having a lot of difficulty with sleep. **04/02/2019**: The patient rated the lower back discomfort a 10 out of 10, on a scale from 0 to 10, with 10 being the worst. Patient states he is not feeling any better. He states he is still feeling pain into his left leg down to the knee, he states he is feeling pain in his right glute. He states he is also unable to stand up straight due to the discomfort. The patient rated the neck upper back and left shoulder discomfort a 8 out of 10, on a scale from 0 to 10, with 10 being the worst. He states he is feeling slightly less discomfort and stiffness. **06/02/2019**: The patient rated the lower back discomfort a 10 out of 10, on a scale from 0 to 10, with 10 being the worst. Patient states his discomfort is unchanged. The patient rated the neck upper back and left shoulder discomfort a 8 out of 10, on a scale from 0 to 10, with 10 being the worst. He states he is feeling the same as the previous visit. **08/02/2019:** The patient rated the lower back discomfort a 7 out of 10, on a scale from 0 to 10, with 10 being the worst. The patient rated the neck	5-6, 7-8, 9-10, 11-12, 13-14

Date	Provider	Occurrence/Treatment	PDF REF
		upper back and left shoulder discomfort a 6 out of 10. on a scale from 0 to 10, with 10 being the worst. Patient states he saw the Neurosurgeon and the pain specialist at the end of last week. He states he was given a series of injections in his neck, upper back and lower back. **09/02/2019**: The patient rated the lower back discomfort a 7 out of 10, on a scale from 0 to 10, with 10 being the worst. The patient rated the neck upper back and left shoulder discomfort a 5 out of 10, on a scale from 0 to 10, with 10 being the worst. Patient states that his discomfort is slightly better today. **Reviewers comment: Interim therapy visits have been summarized with significant events comprising of pain complaints.*	
10/27/2019	Chiro Therapy Center Lin Anddy, D.C.	**Final chiropractic therapy visit for neck, shoulders, upper back, lower back, arms and leg pain:** **Chief complaint**: Neck, shoulders, upper back, lower back, arms and legs. **History of present illness** **Pain scale (0-10):** 5 in his neck and upper back, 7 in his lower back **Aggravating factors**: Standing from a seated position. **Relieving factors**: He states moving positions will provide temporary relief but the pain never goes away. He states after a short time the pain will intensify again. **Radiating symptoms**: He states he has pain in his hips and legs. He states his left shoulder is still very sore. **Review of systems** **Neurological**: He states he is having some mild headaches on the right side of his head. He states he also cannot sleep more than 2 hours at a time before waking. Work: He states he is working as much as he can. Exercise: He states he has not resumed fishing or any other extra activities. **Objective**: **Musculoskeletal**: J-Tech and Myo are not performed at this time. The patient is extremely uncomfortable trying to stand and move around at all. **Head and neck:** Pain during palpation of the cervical spinal region pain presented bilaterally. Increased pain presented at the cervical-thoracic junction. Palpation of the mid cervical region C3-C5 produced discomfort. Palpation of the levator and upper trap revealed spasms and trigger points that produced pain. Pain during palpation of the C7 and T1 spinous processes. Palpation of the left deltoid, bilateral infraspinatus cause moderate to severe discomfort. **Spine, ribs, pelvis**: Palpation of the thoracic region produced pain along the paraspinal region Spasm noted in the thoracic paraspinal along with rhomboids, mid trap, and lower trap. Pain during palpation of the Lumbar spine presented bilaterally. Pain during palpation of the left QL and Glute med produce moderate discomfort.	15-18

Date	Provider	Occurrence/Treatment	PDF REF
		Skin: **Head and neck:** Moderate FHP **Trunk:** Moderate thoracic hyperkyphosis **Left upper extremity:** He is unable to raise his left arm above parallel without moderate to severe discomfort. **Neurological:** Empty can test on the left is positive. Kemp's Test was positive. With the patient standing, the examiner stands behind the patient with one hand anchoring the pelvis and sacrum and the other hand he grasps the opposite shoulder; holding the pelvis, the shoulder is firmly forced obliquely backward, downward and medialward. Low back pain radiating into the lower extremity indicates a positive test. A positive test is indicative of a disk protrusion or prolapse. Yeoman's Test was positive. This test is done with the patient in a prone position. The examiner exerts downward pressure over the suspected sacroiliac joint, while maximally flexing the ipsilateral knee. Then the thigh is hyperextended while holding down the pelvis. Deep pain in both sacroiliac joints from the above action indicates a strain of the anterior sacroiliac ligaments. Multiple subluxations were gently mobilized with cups and noted with spasm, hypomobility and end point tenderness in the C5, C6, C7, T1, T2 Active trigger points in the levator scap, upper trap, cervical and thoracic paraspinals. bilateral infraspinatus. The part of a muscle fiber that actually does the contracting is a microscopic unit called a sarcomere. Contraction occurs in a sarcomere when its two parts come together and interlock like fingers. Millions of sarcomeres have to contract in your muscles to make even the smallest movement, a trigger point exists when over stimulated sarcomeres are chemically prevented from releasing from their interlocked state. Normally, when a muscle is working, its sarcomeres act like tiny pumps, contracting and relaxing to circulate blood through the capillaries that supply their metabolic needs. **Assessment**: Patient reported feeling better after the treatment. **Plan**: **Prognosis**: Unknown due to the severity of the symptoms and the overall presentation of the patient. **Treatment recommendations:** Based on the recommendation of the pain management specialist, patient will continue with care with the PT. **Treatment plan**: A treatment will be set up following the consults with Neurosurgery and pain management.	

Date	Provider	Occurrence/Treatment	PDF REF
		Diagnosis: • Radiculopathy, cervical region • Radiculopathy, cervicothoracic region • Radiculopathy, lumbar region • Radiculopathy, sacral and sacrococcygeal region • Acute post-traumatic headache, not intractable • Sprain of cervical ligaments, initial • Cervicalgia • Sprain of lumbar ligaments, initial • Sprain of sacroiliac joint • Sacroiliitis, not elsewhere classified • Pain in thoracic spine • Sprain of ligaments of thoracic spine, initial encounter • Pain in left shoulder	
11/06/2019	Spine Physicians Micheal Geroge, M.D.	**Follow-up visit for mid to lower back and left shoulder pain:** **Reason for appointment:** Mid to lower back and left shoulder pain. **Interim history**: This is a 55-year-old male who presents for a follow up visit. The patient presents status post LESI L5-S1 and left glenohumeral joint injection. He has received minimal to no relief thus far. He continues to have low back, left shoulder, and neck pain that started from a head on collision with an 18-wheeler on 12/02/2017 . He rates his pain as a 8/10 in severity and describes it as a constant, sharp, stabbing, stinging, burning, deep, tingling, and aching pain. His pain is aggravated by bending forward, sitting, morning, standing, night, cold weather, walking and stress. He has yet to find anything to alleviate his pain. He denies any bowel or bladder incontinence. He is currently seeing a chiropractor. He has a history of surgery on his lumbar spine at L3-5 in 2001. He has radicular symptoms into his LLE. He has decreased range of motion of his LUE due to the pain in his shoulder. He is scheduled to start Physical Therapy this week. He increased Gabapentin 600 mg TID and hasn't noticed much change. **Review of systems**: Positive for back pain, neck pain and morning stiffness today. **Examination:** **Neck:** Tenderness to palpation to the cervical spine and paraspinal muscles. Facet loading positive bilaterally. **Back**: Tenderness to palpation to the lumbosacral spine and paraspinal muscles. Facet loading is positive bilaterally. Positive SLR on the left. **Musculoskeletal**: The upper and lower extremities have normal muscle, joint, and bone structure. Decreased range of motion is noted in the left upper extremity. TTP to the glenohumeral joint.	79-80

Date	Provider	Occurrence/Treatment	PDF REF
		Assessments: • Acute pain due to trauma • Radiculopathy, lumbosacral region • Pain in left shoulder **Treatment:** Acute pain due to trauma - MRI lumbar spine and Left Shoulder reviewed. Recommend trial Caudal ESI for radicular pain. Risks and benefits explained. Will refer to ortho for left shoulder evaluation as no relief after injection. Continue Gabapentin and Methocarbamol as needed. Clinical Notes: A minimum of 30 minutes were spent in one or more of the following activities: reviewing imaging prior to see the patient, obtaining and reviewing medical history, performing medical exam, educating patient/family on pertinent findings, ordering radiographic imaging and diagnostic studies, referring/communicating with other healthcare providers and facilities, documenting clinical information, independently reviewing diagnostic studies and communicating those results to the patient and other care providers. Prior to leaving the room, I answered all the patients' questions, and the patient verbally acknowledged my answers. If the patient has any additional questions not answered during their visit, they are to reach out to me at their convenience to answer any additional questions that may come up. Referral to: Sean Haslam - Orthopedic Surgery. Reason: Evaluate and Treat left shoulder Others - Continue Methocarbamol tablet, 750 mg, 1 tablet as needed, Orally, every 8 hours, 90 tablet, refills 2. Continue Gabapentin tablet, 600 mg, 1 tablet, orally, three times a day, 90 tablet, refills 0.	
12/18/2019	Spine Physicians Micheal Geroge, M.D.	**Procedure report for caudal epidural steroid injection and left glenohumeral joint injection:** **Pre and post-operative diagnosis:** Lumbar radiculitis and shoulder pain. **Operation**: • Caudal epidural steroid injection • Left glenohumeral joint injection under fluoroscopy **Anesthesia**: General. The needles were removed intact, and band-aids were applied. The patient was transferred to the recovery area. The patient was monitored, reassessed and discharged after an appropriate observatory period. No complications were noted. **Complications**: None	81-82
12/01/2020	Advent Hospital John Tylor, M.D.	**Follow-up visit for left shoulder pain:** **Chief complaint**: Left shoulder pain. **History of present illness:** This 55-year-old male patient had a car accident on February 20 and hurt his left shoulder. He has had an MRI,	83-84

Date	Provider	Occurrence/Treatment	PDF REF
		and he is here for evaluation. He says he had a steroid injection. I think that is wrong; I think they did it after that. He started Celebrex; he took one a week and then stopped. He still has some numbness and tingling in his fingers at times. He is here now for evaluation. He holds his arm at his side, protecting it, and does not move it that much. **Physical examination**: Exam shows the patient to be tender over his rotator cuff and over his coracoid. He has impingement sign, Hawkins sign, and a little bit of tenderness over the biceps also with supinator test, so he is inflamed everywhere. **Assessment and plan**: Rotator cuff tear, left shoulder. At this point in time, I think we can still treat this conservatively, but we have to get more aggressive. I am going to inject his joint properly, right in front in the subacromial space and in the area. **Procedure**: After discussion of the risks and benefits of corticosteroid injections, the patient gave verbal consent to proceed. The left shoulder area right in front of the subacromial space was prepped in a sterile fashion and was injected with a mixture of 2 mL of Kenalog 40 and 4 mL of 1 % Lidocaine without complications. The patient tolerated the procedure well without any complications. I am going to change his medications up. I want him on a muscle relaxer, Flexeril, since he only took the other one for a short time, and an anti-inflammatory, Diclofenac, and he has to be better in a couple of weeks. If he is better, fine; we can go from there. If he is not better and this does not do much, we are going to have to check his neck and an Electromyography (EMG) here going forward because of the numbness and tingling in his fingers. It is just more subjective at this point in time, but it is definitely there, and some of it may be coming from his neck, which was not looked at. We will see how he does with this and proceed from there.	
01/18/2021	Physical Therapy Center William Marsh, P.T.	**Initial physical therapy visit for low back pain, neck pain, and shoulder pain:** **Diagnosis**: • Radiculopathy, cervical region • Radiculopathy, cervicothoracic region • Radiculopathy, lumbar region • Radiculopathy, sacral and sacrococcygeal region • Acute post-traumatic headache, not intractable • Sprain of ligaments of cervical spine, initial encounter • Cervicalgia • Sprain of ligaments of lumbar spine, initial encounter • Sprain of sacroiliac joint, initial encounter • Sacroiliitis, not elsewhere classified • Pain in thoracic spine	45-48, 41-44

Date	Provider	Occurrence/Treatment	PDF REF
		• Pain in left shoulder • Sprain of ligaments of thoracic spine, initial encounter **Subjective**: History of present condition/mechanism of injury: Patient was involved in MVC on 12/02/2017 . Since then patient complains of low back, neck and shoulder pain which bothers him with his activities. Chief complaint: Patient complains of low back pain which interferes with his sleep, work and Activities of Daily Livings (ADLs). Patient also adds left shoulder pain and neck pain which bothers him with lifting and grabbing heavy objects. **Before the injury/onset/change of status date, the patient was able to perform the following activities:** Self-care: Hygiene; sleep; Independent Activities of Daily Livings (IADLS); household chores; drive community distance; volunteering; caregiving Changing and maintaining body position: Maintaining a Body Position; Transfers; IADLs Mobility: Walking and moving around: IADLs; Use of an assistive device; walking; moving around; moving around in different locations; negotiate obstacles. Carrying, moving and handling objects: IADLS; hand and arm use; fine hand use; moving objects with lower extremities; community integration/access; work/vocation/occupation; recreation Current functional limitations: Self-care: Sleep Changing and maintaining body position: Maintaining a body position: Remaining seated, remaining standing. squatting, sitting, standing Mobility: Walking & moving around: Walking Carrying, Moving & handling objects: Community integration/access; work/vocation/occupation: Recreation Pain location: Low back Pain scale: Worst: 10; Best: 5; Current: 7 Pain description: Constant Pain follow-up plan: PT, Home Exercise Program (HEP) Pain location: Neck pain Pain scale: Worst: 7; Best: 3; Current: 3 Pain description: Constant Pain follow-up plan: PT. HEP Pain location: Left shoulder Pain scale: Worst: 7; Best: 3; Current: 5 Pain description: Constant Pain follow-up plan: PT. HEP	

Date	Provider	Occurrence/Treatment	PDF REF

Aggravating factors: Sitting, standing, walking, stairs - up, stairs – down. Bending.
General health: Good
Home health care: No

Patient goals: Return to normal quality of life, strength, ROM and tolerance.

Objective:
Standing posture: Forward head, abnormal, rounded shoulders, increased lumbar lordosis.

Thoracic Active Range of Motion (AROM) standing
Forward – 10%
Bending – 10%
Backward bending – 5%
Right rotation – 5%
Left rotation – 5%
Right side bending – 5%
Left side bending – 5%

Lumbar AROM
Forward bending - 20%
Backward bending - 25%
Right rotation - 15%
Left rotation - 15%
Right side bending - 15%
Left side bending - 15%
Lumbar AROM Comments - Limited ROM

Hip AROM	**Right**	**Left**
Flexion	10%	10%
Extension	10%	10%
Abduction	10%	10%
Adduction	Within Functional Limits (WFL)	WFL
Internal rotation	10%	10%
External rotation	10%	10%

Comments: Limited ROM.

Gross muscle tests lower:

Hip	**Right**	**Left**
Hip flexion	4/5	4/5
Hip extension	4/5	4/5

Assessment and diagnosis: Patient is a 55-year-old male referred to physical therapy primarily for low back pain. Patient currently presents

Date	Provider	Occurrence/Treatment	PDF REF
		with a decrease in active ROM in lumbar spine, hips and thoracic spine. Decreased strength in the posterior chain muscles of the hip. Myofascial restrictions noted in the lumbar spine paraspinals, QL, Piriformis and Glutes bilaterally. These impairments lead to limited activity tolerance to work, sleep and recreational activity. Patient would continue to benefit from skilled PT to address remaining deficits. **Patient clinical presentation**: The clinical presentation is stable and/or uncomplicated. **Patient education**: Patient was educated on prognosis, goals, HEP and plan of care. **Patient demonstrates compliance with prescribed HEP**: Following the evaluation and extensive patient education regarding diagnosis, prognosis, and treatment goals, the patient (parent/guardian, power of attorney holder) actively participated in the creation of the current goals and agrees to the current treatment plan. **Rehab potential**: Good **Contraindications to therapy**: None **Patient problems:** • Increased Pain • Decreased strength • Decreased ROM • Decreased mobility • Limited tolerance to activity and work **Plan:** **Frequency**: 2-3 times a week. **Duration**: 8 weeks **Procedures**: Therapeutic exercises, therapeutic activity, gait training, neuromuscular rehabilitation, manual therapy, massage. splinting/taping, patient education, self-care. remote therapeutic monitoring. **Modalities:** To improve (Pain relief, decrease inflammation, increase blood flow), ultraviolet.	
04/06/2021	Spine Physicians Micheal Geroge, M.D.	**Follow-up visit for mid to left shoulder pain, left lower back and left leg pain:** **Reason for appointment:** Left shoulder pain, left lower back and left leg pain. **Interim history**: This is a 55-year-old male who presents for a follow up visit. Patient is status post caudal ESI and left glenohumeral joint injection under fluoroscopy. Patient has received 80% relief from the left glenohumeral injection and approximately 40-50% relief from caudal ESI. He feels he has better relief from caudal ESI versus LESI.	85-86

Date	Provider	Occurrence/Treatment	PDF REF
		He has started Physical Therapy twice weekly. He continues Gabapentin, Celebrex, and Robaxin with relief. **Review of systems**: Positive for back pain, neck pain and morning stiffness. **Examination:** **Neck:** Tenderness to palpation to the cervical spine and paraspinal muscles. Facet loading positive bilaterally. **Back**: Tenderness to palpation to the lumbosacral spine and paraspinal muscles. Facet loading is positive bilaterally. + SLR on the left. **Musculoskeletal**: The upper and lower extremities have normal muscle, joint, and bone structure. Decreased range of motion is noted in the left upper extremity. TTP to the glenohumeral joint. **Assessments:** • Acute pain due to trauma • Radiculopathy, lumbosacral region • Pain in left shoulder **Treatment:** Acute pain due to trauma - Recommend repeating Caudal ESI for radicular pain. Risks and benefits explained. Continue PT. Recommend taking Celebrex consistently at this time. Continue Gabapentin and Methocarbamol. Left shoulder stable at this time. **Prescriptions:** • Continue Methocarbamol tablet, 750 mg, 1 tablet as needed, orally, every 8 hours, 90 tablet, refills 2. • Continue Gabapentin tablet, 600 mg, 1 tablet, orally, three times a day, 90 tablet, refills 0.	
05/06/2021	Physical Therapy Center William Marsh, P.T.	**Interim re-evaluation physical therapy visit for low back pain, neck pain, and shoulder pain:** **Subjective**: Patient states his shoulder is comparatively doing better than before. Patient had an injection on his back on last Friday, but he feels like injection didn't help him at all. **Assessment:** Patient continues to show improved ROM and mobility of the shoulder. Patient yet continues to show limited ROM and mobility of lumbar spine and hips. Patient also shows increased tissue tension of paraspinals of low back. Active strengthening and stretching of low back muscles was sued to improve tissue strength. Patient tolerated manual therapy well and will continue to feel better from skilled PT. Patient clinical presentation: The clinical presentation is stable and/or uncomplicated. Patient demonstrates compliance with prescribed HEP **Rehab potential**: Good	57-60, 61-63

Date	Provider	Occurrence/Treatment	PDF REF
		Contraindications to therapy: None **Patient problems:** • Increased Pain • Decreased strength • Decreased ROM • Decreased mobility • Limited tolerance to activity and work **Plan:** **Frequency**: 2-3 times a week. **Duration**: 8 weeks **Procedures**: Therapeutic exercises, therapeutic activity, gait training, neuromuscular rehabilitation, manual therapy, massage. splinting/taping, patient education, self-care. remote therapeutic monitoring. **Modalities:** To improve (Pain relief, decrease inflammation, increase blood flow), ultraviolet.	
06/06/2021 - 12/06/2021	Physical Therapy Center William Marsh, P.T.	**Interim physical therapy visit for low back pain, neck pain, and shoulder pain:** **Total number of visits:** 5 visits. *(Excluding initial, re-evaluation and final therapy visits)* **Treatment rendered**: Therapeutic exercises, therapeutic activity, gait training, neuromuscular rehabilitation, manual therapy, massage. splinting/taping, patient education, self-care. remote therapeutic monitoring. **Significant events:** **06/06/2021:** Patient states the left shoulder was sore from previous PT session. Patient continues to complain of back pain and activities like bending over. **07/08/2021**: Patient continues to have pain in the left shoulder and low back. He has been keeping his arm very still and not doing much walking to prevent more issues. **09/08/2021**: Patient states since Sunday his left leg is getting numb and due to that he loses his balance. Patient is worried about the numbness and has MD's appointment this week. **11/08/2021**: Patient states he had a follow-up with MD and MD has scheduled him for an injection on Friday. Patient states he has advised him to hold off on back PT and continue with shoulder exercises. **12/06/2021:** Patient states he walked over the weekend but does experience pain with walking. Patient adds his shoulder is moving beer than before.	49-50, 51-52, 53-54, 55-56, 64-65

Date	Provider	Occurrence/Treatment	PDF REF
		**Reviewers comment: Interim therapy visits have been summarized with significant events comprising of pain complaints.*	
12/16/2021	Physical Therapy Center William Marsh, P.T.	**Final physical therapy visit for low back pain, neck pain, and shoulder pain:** **Subjective**: Patient states he has doctor appointment today for his neck. he states his back has been bothering him with all his ADLs. Patient adds he is unable to reach on the top shelf due to shoulder pain. Patient goals: Return to normal quality of life, strength, ROM and tolerance. **Assessment**: Patient continues to have limited ROM and mobility of the lumbar spine. Active strengthening and hip stabilization exercises were used to improve strength and mobility of the lumbar musculatures. Patient responded well to scapular strengthening and manual therapy without any discomfort. Patient will continue to progress as able. Patient demonstrates compliance with prescribed HEP Rehab potential: Good Patient problems: • Increased Pain • Decreased strength • Decreased ROM • Decreased mobility • Limited tolerance to activity and work **Reviewer's comment: Further medical records corresponding to physical therapy or discharge summary is not available for review.*	66-67
01/18/2022	Spine Physicians Micheal Geroge, M.D.	**Follow-up visit for lower back and left shoulder pain:** **Reason for appointment**: Lower back and left shoulder pain. **Interim history:** This is a 55-year-old male who presents for a follow up visit. Patient is status post caudal ESI on 12/31/2019. He received 25% relief from the procedure. His pain is primarily located in the left low back now (70%). 30% in the LLE. He sees the orthopedic surgeon next Tuesday for his left shoulder. He continues to have low back, left shoulder, and neck pain that started from a head on collision with an 18-wheeler on 12/02/2017 . He rates his pain as a 7/10 in severity and describes it as a constant, sharp, stabbing, stinging, burning, deep, tingling, and aching pain. He is still in PT. He has a history of surgery on his lumbar spine at L3-5 in 2001. He continues Gabapentin, Celebrex, and Robaxin with relief. **Examination:** **Neck:** Tenderness to palpation to the cervical spine and paraspinal muscles. Facet loading positive bilaterally.	87-88

Date	Provider	Occurrence/Treatment	PDF REF
		Back: Tenderness to palpation to the lumbosacral spine and paraspinal muscles. Facet loading is positive bilaterally. + SLR on the left. **Musculoskeletal**: The upper and lower extremities have normal muscle, joint, and bone structure. Decreased range of motion is noted in the left upper extremity. TTP to the glenohumeral joint. **Assessments:** • Acute pain due to trauma • Radiculopathy, lumbosacral region • Pain in left shoulder **Treatment**: • Acute pain due to trauma - Recommend left L3-S1 facet injections for axial low back pain. Risks and benefits explained. Continue PT. Follow up with other specialists. **Prescriptions:** • Continue Methocarbamol tablet, 750 mg, 1 tablet as needed, orally, every 8 hours, 90 tablet, refills 2. • Continue Gabapentin tablet, 600 mg, 1 tablet, orally, three times a day, 90 tablet, refills 0. **Follow-up**: 2 Weeks	
04/06/2022	Advent Hospital John Tylor, M.D.	**Follow-up visit for right shoulder pain:** **Chief complaint**: Right shoulder pain. **History of present illness**: This 55-year-old male patient comes in, and he is doing better, but the problem is that he is still tender, still has impingement sign, and he is still sore. He is still participating in physical therapy. **Physical examination**: On exam of the right shoulder, he still has tenderness, soreness, and positive impingement sign. **Assessment and plan**: Pain, right shoulder. I am going to inject him one more time and see if we can get him to a steady state. If not, he will have to have surgery to fix this. **Procedure**: After discussion of the risks and benefits of corticosteroid injections, the patient gave verbal consent to proceed. The right shoulder was prepped in a sterile fashion and was injected with a mixture of 2 mL of Kenalog 40 and 4 mL of 1% lidocaine without complications. The patient tolerated the procedure well without any complications. I went over his limitations. We will now see him back in about 6 to 8 weeks and see how he is doing.	89

Date	Provider	Occurrence/Treatment	PDF REF
12/21/2022	Spine Physicians Micheal Geroge, M.D.	**Procedure report for facet injections:** **Pre- and post-operative diagnosis:** Lumbar spondylosis. **Operation**: Left L3-4, L4-5 and L5-S1 facet injections. **Anesthesia**: General. **Complications**: None	90
03/07/2023	Spine Physicians Micheal Geroge, M.D.	**Follow-up visit for left sided low back pain:** **Reason for appointment**: Left sided low back pain. **Interim history**: This is a 55-year-old male who presents for a follow up visit. Patient is status post left L3-4,14-5, and L5-S1 facet injections. He has received 50% relief from the procedure thus far. He saw the ortho surgeon for his left shoulder. He had another injection with him and will be following up with him soon. He is finishing PT this week. He continues to have low back, left shoulder, and neck pain that started from a head on collision with an 18-wheeler on 12/02/2017 . He rates his pain as a 6/10 in severity and describes it as an intermittent, sharp, stabbing, stinging, burning, deep, tingling, and aching pain. He has a history of surgery on his lumbar spine at L3-5 in 2001. He continues Gabapentin, Celebrex, and Robaxin with relief. **Review of systems**: Positive for back pain, neck pain and morning stiffness today. **Examination:** **Neck**: Tenderness to palpation to the cervical spine and paraspinal muscles. Facet loading positive bilaterally. **Back**: Tenderness to palpation to the lumbosacral spine and paraspinal muscles. Facet loading is positive bilaterally. + SLR on the left. **Musculoskeletal**: The upper and lower extremities have normal muscle, joint, and bone structure. Decreased range of motion is noted in the left upper extremity. TTP to the glenohumeral joint. **Assessments:** • Acute pain due to trauma • Radiculopathy, lumbosacral region • Pain in left shoulder **Treatment**: • Acute pain due to trauma - Recommend left L3-S1 rhizotomies for axial low back pain since he had 50% relief from the facet injections. Risks and benefits explained. Continue PT. Follow up with other specialists.	91-92

Date	Provider	Occurrence/Treatment	PDF REF
		Prescriptions: • Refill Methocarbamol tablet, 750 mg, 1 tablet as needed, orally, every 8 hours, 90 tablet, refills 2. • Refill Gabapentin tablet, 600 mg, 1 tablet, orally, three times a day, 90 tablet, refills 2. **Follow-up**: 2 weeks	
05/01/2023	Spine Physicians Micheal Geroge, M.D.	**Procedure report for left glenohumeral joint injection and lumbar epidural steroid injection:** **Pre- and post-operative diagnosis:** Lumbar spondylosis. **Operation**: Left L3-4, L4-5 and L5-S1 rhizotomies. **Anesthesia**: General. The needles were removed intact and band-aids were applied. The patient was transferred to the recovery area. The patient was monitored, reassessed and discharged after an appropriate observatory period. No complications were noted.	93
12/12/2023	Advent Hospital John Tylor, M.D.	**Follow-up visit for left shoulder pain:** **Chief complaint**: Follow-up left shoulder. **History of present illness:** This 55-year-old male patient returns for follow-up. He is doing well with his left shoulder. He says he is 85-90% better. **Physical examination:** On examination of the left shoulder, he doesn't have any of the findings of significant impingement or Hawkins sign or tenderness at this point in time. His grip strength is a little better. **Assessment and plan:** Labrum tear, left shoulder. The labium tear is not causing severe problems. This is a small tear that can be followed. The rest of the shoulder tendonitis has settled down with treatment. We discussed this. At this point in time, he is clinically finished with treatment, but he will require future treatment. He has a tear and underlying pathology that will act up again, Over time, he will need an injection. He may require a surgery eventually, but not right now. At this point in time, he is at maximal improvement at least from an orthopedic standpoint. A little more therapy may help him. Somewhere down the line, because of the tear, that could propagate and cause problems, or it may stay there. He will require constant follow-up and treatment in the future. Right now, at this point in time, he does not need surgery. He should stay on the medications during this time period - he will always need to be on medication to keep him functional as long as we can. I will see the patient back as needed.	94