Medical Chronology/Summary

Confidential and privileged information

Usage guidelines/Instructions

Verbatim summary: All the medical details have been included "word by word' or "as it is" from the provided medical records to avoid alteration of the meaning and to maintain the validity of the medical records. The sentence available in the medical record will be taken as it is without any changes to the tense.

Case synopsis/Flow of events: For ease of reference and to know the glimpse of the case, we have provided a brief summary including the significant case details.

Injury report: Injury report outlining the significant medical events/injuries is provided which will give a general picture of the case.

Comments: We have included comments for any noteworthy communications, contradictory information, discrepancies, misinterpretation, missing records, clarifications, etc for your notification and understanding. The comments will appear in red italics as follows: **"**Comments*".**

Indecipherable notes/date: Illegible and missing dates are presented as "00/00/0000" (mm/dd/yyyy format). Illegible handwritten notes are left as a blank space "_____" with a note as ***"Illegible Notes"*** in heading reference.

Patient's History: Pre-existing history of the patient has been included in the history section.

Snapshot inclusion: If the provider name is not decipherable, then the snapshot of the signature is included. Snapshots of significant examinations and pictorial representation have been included for reference.

De-Duplication: Duplicate records and repetitive details have been excluded.

General Instructions:

- *The medical summary focuses on **Motor vehicle collision** on **04/17/YYYY,** the injuries and clinical condition of **XXXX** as a result of accident, treatments rendered for the complaints and progress of the condition.*
- *Initial and final therapy evaluation has been summarized in detail. Interim visits have been presented cumulatively to avoid repetition and for ease of reference.*

Injury Report:

DESCRIPTION	DETAILS
Prior injury details	*No prior injury records available.*
Date of injury	04/17/YYYY
Description of injury	The patient was the restrained driver involved in a rear end collision. The airbags did not deploy.
Injuries/ Diagnoses	• Unequal limb length (acquired), unspecified tibia and fibula, left longer than right • Sprain of sacroiliac joint, subsequent encounter • Sprain of ligaments of lumbar spine, subsequent encounter, at L5-S1 level • Contusion of left shoulder, subsequent encounter • Biceps tendinitis of left shoulder • Bulging lumbar disc, at L3-L4 and L5-S1 • Lumbar disc herniation, at L4-L5 • Sprain of left acromioclavicular joint, initial encounter
Treatments rendered	• Diclofenac Sodium Solution, 1.5 % • Meloxicam Tablet, 15 MG • Metaxalone Tablet, 800 MG • Referral to Orthopedic Surgery • Referral to Physical Therapy **Therapy:** **11/09/YYYY to 12/21/YYYY:** Multiple physical therapy sessions at Atlanta Rehabilitation & Performance Center
Condition of the patient as per the last available record	As of **01/17/YYYY,** Patient was examined by XXXX, M.D. at Thrive Medical Partners – Gainesville for evaluation of low back pain. She described the pain as constant and dull, and was worsened with physical activity. She also reported radicular symptoms from the low back going into the left hip stopping at the ankle with numbness going down the left leg. She estimated her pain level as 3/10. She reported that her low back pain had remained the same since the accident. On review of her systems, she was noted to be positive for back pain and tingling/numbness. On lumbar exam, she described maximal pain at the left-sided low back. On palpation, she exhibited maximal tenderness to palpation over the left sacroiliac joint. Straight leg raise test and FABER test was positive on the left side. She reported subjective numbness and tingling down the left lower extremity all the way to the foot. She was assessed with sprain of ligaments of lumbar spine, lumbar disc herniation, lumbar paraspinal muscle spasm, sprain of sacroiliac joint, and lumbar radiculopathy. She was referred to Pain Medicine for Left SIJI/ Left TFESI L4-L5. Based on exam findings, it was suspected that the majority of her lumbar spine pain was likely due to spraining of the left sacroiliac joint, spraining of the ligaments of the lumbar spine, and discogenic injury. She was recommended to continue with a home exercise program. Due to her persistent lumbar spine pain symptoms being radicular and focal to the left sacroiliac joint, left sacroiliac joint injection with corticosteroid and a left transforaminal epidural steroid injection at L4-L5 was recommended. Indications and contraindications

	about the injections were discussed and she wished to proceed. She was recommended to follow-up in 2 weeks for a procedural visit. XXXX, M.D. stated that her symptoms, exam, and MRI findings were likely due to motor vehicle accident on April 17, YYYY. Restrictions included sedentary/light work, and lifting 10 lbs maximum until the next follow-up appointment was recommended.

Patient History

Past Medical History: Asthma (**PDF Ref:** 83)

Surgical History: Denies past surgical history (**PDF Ref:** 83)

Family History: Father: Alive; Daugher(s): Asthma; Mother: Alive, asthma (**PDF Ref:** 83, 79)

Social History: Single, nonsmoker, drinks alcohol socially, works full-time as a Kubota Associate (**PDF Ref:** 83)

Allergy: No known drug allergies (**PDF Ref:** 83)

Detailed Summary

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF	MEDICAL BILLS
		**Reviewer's Comments: Medical records prior to MVA are not available for review.*		
		Motor Vehicle Collision on 04/17/YYYY		
04/17/YYYY	Provider/ Hospital	**Accident Scene Investigation Report:** **Estimated crash:** 04/17/YYYY at 1447 hours **Dispatch:** 04/17/YYYY at 1451 hours **Arrival:** 04/17/YYYY at 1451 hours **Total number of:** **Vehicles:** 2 **Injuries:** 0 **Fatalities:** 0 **Road of occurrence:** Georgia Highway 320 **At its intersection with:** Interstate 85 NB Exit ramp MM164 **Unit #2:** Driver **Narrative:** Vehicle #1 was traveling north on the off ramp of Interstate 85 at exit 164 in the right tuning lane. Vehicle #2 was traveling west on Georgia Highway 320. The driver of vehicle #1 attempted to cross Georgia highway 320 to enter onto Interstate 85 northbound on ramp. Vehicle #1 struck the driver side rear of vehicle #2 with its front. The area of	48-50	NA

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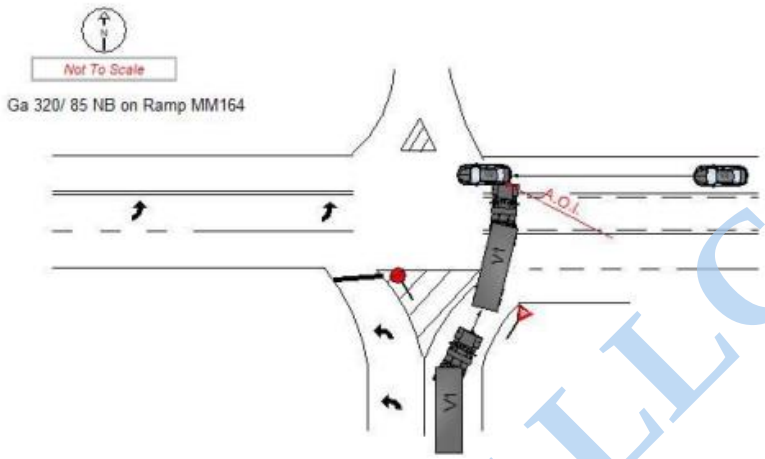
		impact occurred in the westbound lane of Georgia highway 320. **Photos taken:** No  		
		**Reviewer's Comments: Medical records from 04/17/YYYY to 09/14/YYYY are not available for review.*		
09/15/YYYY	Provider/ Hospital	**@ 0735 hours: MRI of the Left Shoulder without Contrast:** **Physician:** XXXX. **Reviewer's Comments: The corresponding physician report is not available for review.* **History:** Motor vehicle collision dated 04/17/YYYY with left shoulder pain. **Findings:** **Rotator cuff:** The supraspinatus, infraspinatus, teres minor, and subscapularis tendons are intact. They appear unremarkable. There is no evidence for tearing of the rotator cuff. **Labrum:** The labrum is normally positioned in the glenoid. There is no definite evidence for labral tearing. **Biceps tendon:** The long head of the biceps tendon is normally located in the bicipital groove, and it appears normal. **Osseous structures and soft tissues:** There is a joint effusion present. There is fluid in the subacromial/subdeltoid space. The alignment is near anatomic. The acromioclavicular and glenohumeral joints are intact. **Impression:** • Joint effusion. • Subacromial/subdeltoid inflammation.	78 51	$2,400.00

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		Thank you for your kind referral.		
09/15/YYYY	Provider/ Hospital	**@ 0854 hours: MRI of Lumbar Spine without Contrast:** **Physician:** XXXX. **Reviewer's Comments: The corresponding physician report is not available for review.* **History:** Low back pain following a motor vehicle collision dated 04/17/YYYY. **Findings:** The conus medullaris appears normal. The lordotic curvature of the lumbar spine is preserved. No evidence for abnormal solid or cystic lesions is identified. No prevertebral or paravertebral masses or fluid collections are seen and there is no evidence for abnormal marrow replacing lesion. There is edema in the interspinous ligament at the level of L5-S1. This is consistent with an acute ligament injury at this level. **Segmental analysis of the lumbar spine is as follows:** At L1-2, there is no evidence for disc herniation, canal stenosis or neural foraminal stenosis. At L2-3, there is no evidence for disc herniation, canal stenosis or neural foraminal stenosis. At L3-4, there is disc bulging and mild disc desiccation. This results in anterior impression on the thecal sac. There is no right or left neuroforaminal stenosis. At L4-5, there is a left paracentral disc herniation. This is superimposed on disc bulging and mild disc desiccation. There are no associated vertebral osteophytes present. The herniated disc material extends beyond the bone. There is intradiscal edema and paradiscal inflammatory reaction seen on STIR imaging, consistent with an acute injury. This results in mild left lateral recess stenosis. There is no right or left neuroforaminal stenosis. At L5-S1, there is bulging of the disc. This results in an anterior impression on the thecal sac. There is no central canal stenosis or foraminal stenosis. **Impression:** • There is edema in the interspinous ligament at the level of L5-S1. This is consistent with an acute ligament injury at this level. See Figure 1, Image 29, Series 4. This is a STIR image where fluid is bright. The circled arrow is pointing to the bright signal in the interspinous ligament at L5-S1, consistent with edema. • At L3-4, there is disc bulging and mild disc desiccation. This	73-77 51	$2,400.00

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		results in anterior impression on the thecal sac. • At L4-5, there is a left paracentral disc herniation. This is superimposed on disc bulging and mild disc desiccation. There are no associated vertebral osteophytes present. The herniated disc material extends beyond the bone. There is intradiscal edema and paradiscal inflammatory reaction seen on STIR imaging, consistent with an acute injury. This results in mild left lateral recess stenosis. See Figure 2, Image 30, Series 4. The arrow is pointing to the L4-5 herniated disc. Bright signal in the herniation can be seen on this image. • At L5-S1, there is bulging of the disc. This results in an anterior impression on the thecal sac. • Given the patient's history and findings, it is medically probable that the disc herniation at L4-5 and the injury to the interspinous ligament at L5-S1 are related to the 04/17/YYYY motor vehicle collision. Clinical correlation is recommended to confirm that these findings are related to the patient's symptoms following the motor vehicle collision.		
10/18/YYYY	Provider/ Hospital	**Office Visit:** **Reason for Appointment:** **FU:** Low back and Left shoulder pain **History of present illness:** **Follow up:** **History:** Patient is a 26-year-old female. Right-hand dominance. She is currently employed as a Kubota associate. Patient complains of pain in her left shoulder and lower back, which is the result of a motor vehicle accident that occurred on 04/17/YYYY. The patient presents today for MRI review of the lumbar spine and left shoulder. **Athletic Trainer:** Jonathan Parker LAT, ATC, OTC. **Lumbar Spine/Lower Back:** **Low back pain:** The patient rates the pain a 1 on the 0-10 pain scale today but states it can reach a 7 on the 0-10 pain scale with certain activities. The patient localizes the pain diffusely across the low back. The patient describes their pain symptoms as an intermittent aching and shooting sensation. The patient denies radicular symptoms with no numbness or tingling in the lower extremities. The patient denies bowel or bladder changes currently. The patient reports they use their lumbar corset brace occasionally noting significant improvement when wearing it. The patient denies sleep disturbances due to their low back pain symptoms. The patient reports their low back pain symptoms have improved some since the last visit. **Shoulder/Upper arm:** **Shoulder pain:** The patient's secondary pain complaint today is the left shoulder. The patient rates the pain a 1 on the 10 pain scale today the patient localizes the pain to the anterior aspect of the shoulder. The	83-88	NA

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		pain is described as an intermittent aching sensation. The patient denies radicular symptoms with no numbness or tingling in the upper extremities. The pain is improved with rest and aggravated by nothing in particular at this time. The patient denies clicking, popping, locking, or swelling of the shoulder. The patient denies sleep disturbances due to their left shoulder pain symptoms. The patient reports their left shoulder pain symptoms have improved since their last visit. **Current medications:** **Taking:** • Lumbar Back Brace/Support Pad - Miscellaneous as directed • Heel Liners - Pad as directed • Medication List reviewed and reconciled with the patient **Review of systems:** **Musculoskeletal:** Patient denies joint stiffness, neck pain. Patient complains of pain in shoulder(s), painful joints, back pain *All other systems reviewed and are negative.* **Vital Signs:** Temperature: 98.3 F, HR: 107 /min, BP: 120/79 mm Hg, Wt: 154 lbs, BMI: 28.16 Index, Ht: 62 in, RR: 18 /min, Oxygen sat %: 98 %, Ht-cm: 157.48 cm, Wt-kg: 69.85 kg. **Physical examination:** **Lumbar examination:** **Lumbar:** **Patient complaint:** The patient describes the maximal pain at the left and right sides of low back. **Inspection:** I see no obvious scars, deformities, redness, or edema. **Palpation:** There is tenderness to palpation over the sacroiliac joints. There is no tenderness to palpation over the lumbar paraspinal musculature. There is a negative straight leg raise bilaterally, positive bilateral SI distraction test, positive bilateral thigh thrust test, positive bilateral faber test, positive bilateral pelvic compression test, and positive bilateral Gaenslen test. Limb lengths are unequal to supine examination testing with the left lower extremity being longer than the right lower extremity by 1cm. **Range of Motion:** 25 degrees of left lateral bending, 25 degrees of right lateral bending, 60 degrees of forward lumbar flexion, 25 degrees of lumbar extension. **Strength Right Lower Extremity:** 5/5 hip flexion, 5/5 knee extension, 5/5 ankle dorsiflexion, 5/5 great toe extension,5/5 ankle plantar flexion. **Strength Left Lower Extremity:** 5/5 hip flexion, 5/5 knee extension, 5/5 ankle dorsiflexion, 5/5 great toe extension, 5/5 ankle plantar flexion. **Reflexes:** 2+ patellar tendon reflex, 2+ Achilles tendon reflex bilaterally.		

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		Sensation: There are normal sensations to the lower extremities to light touch and skin pricking. **Vascular:** Both calves are supple with a negative Homans sign bilaterally. There are no clinical signs for DVT. Brisk capillary refill in all toes. Dorsal pedal pulse, and posterior tibial pulse +2/2. **X-rays:** 5 View Lumbar Spine (AP, lateral, Obliques, L5 spot) taken *07/05/YYYY (Must be "07/05/YYYY")*. I do not see an obvious fracture. There is well-maintained disc spaces and vertebral body heights. I see no evidence of spondylolysis or spondylolisthesis. There is a tilt to the pelvis with the left side higher and a compensatory lumbar tilt to the left noted. **Reviewer's Comments: Direct radiology report is not available for review.* **MRI of the lumbar spine performed at advanced imaging centers on 09/15/YYYY:** *Reviewed.* **Left shoulder:** **Palpation:** **Patient complaint:** The patient describes mild pain at the anterior aspect of the shoulder. **Inspection:** I see no obvious scars, deformities, redness, edema, or effusion. I see no elevation of the distal clavicle. **Palpation:** There is mild tenderness over the AC joint. There is no pain reproduced with crossarm adduction testing. There is no pain reproduced with impingement testing. Overhead circumduction maneuvers do not reproduce pain. I find mild tenderness over the long head of the biceps tendon. Speeds test is negative for reproduction of biceps pain. I find full sensation in all fingers. **Range of Motion:** Glenohumeral range of motion testing reveals 90 degrees of abduction, 80 degrees of external rotation, and internal rotation to the lumbar level. Shoulder range of motion reveals 180 degrees of abduction, 170 degrees of forward flexion, and 50 degrees of extension **Strength Testing:** Strength testing reveals 5/5 external rotation strength, 5/5 internal rotation strength, and 5/5 abduction strength in the empty can position. **Vascular:** There is a 2+ radial pulse and brisk capillary refill in all digits. **Sensations:** There is full sensation to light touch and skin pricking of the upper extremity, hand and fingers. **X-rays:** 3 View Left Shoulder (AP neutral, AP external, AP internal) taken 07/05/YYYY. I do not see an obvious fracture. No bony abnormalities, subluxations, or dislocations noted. Bone mineralization appears normal. There is a downsloping curve to the distal clavicle which is a normal variant. I see no elevation of the distal clavicle.		

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		Reviewer's Comments: Direct radiology report is not available for review.* **MRI of the left shoulder performed at advanced imaging centers on 09/15/YYYY: *Reviewed.* **Assessments** • Unequal limb length (acquired), unspecified tibia and fibula, left longer than right • Sprain of sacroiliac joint, subsequent encounter • Sprain of ligaments of lumbar spine, subsequent encounter, at L5-S1 level • Contusion of left shoulder, subsequent encounter • Biceps tendinitis of left shoulder • Bulging lumbar disc, at L3-L4 and L5-S1 • Lumbar disc herniation, at L4-L5 • Sprain of left acromioclavicular joint, initial encounter **Treatment** **Unequal limb length (acquired), unspecified tibia and fibula** Start Diclofenac Sodium Solution, 1.5 %, 40 drops, Externally, Four times a day Start Meloxicam Tablet, 15 MG, 1 tablet, Orally, Once a day, 30 day(s), 30 Start Metaxalone Tablet, 800 MG, 1 tablet, Orally, at bedtime as needed for muscle spasm, 60 day(s), 60, Refills 0 **Sprain of sacroiliac joint, subsequent encounter** **Referral To:** Orthopedic Surgery **Reason:** Bilateral sacroiliac joint injections **Sprain of ligaments of lumbar spine, subsequent encounter** **Referral To:** (MS) Acute Physical Therapy Physical Therapist **Reason:** Start physical therapy. I want the patient to attend 2-3 sessions a week for the next 4 to 6 weeks. I want the physical therapist to focus on the patient's lumbar spine and left shoulder the use of modalities, stretching, strengthening, range of motion, and teaching a home exercise program **Contusion of left shoulder, subsequent encounter** **Referral To:** (MS) Acute Physical Therapy Physical Therapist **Reason:** Start physical therapy. I want the patient to attend 2-3 sessions a week for the next 4 to 6 weeks. I want the physical therapist to focus on the patient's lumbar spine and left shoulder the use of modalities, stretching, strengthening, range of motion, and teaching a home exercise program **Others**		

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		Clinical Notes: The patient returns today with continued lumbar spine and left shoulder pain symptoms. Last visit we ordered an MRI of the lumbar spine and left shoulder. These reports are available for review today. Today we will reevaluate, review the MRI findings, and further develop the patient's treatment plan. The patient's primary pain complaint today is the lumbar spine. MRI of the lumbar spine performed on 09/15/YYYY demonstrates and interspinous ligament injury at the L5-S1 level consistent with acute trauma, a disc bulge at the L3-L4 level, a disc herniation at the L4-L5 level with peridiscal inflammatory reaction consistent with acute injury, and a disc bulge at the L5-S1 level. Upon reevaluation today, the patient had tenderness to palpation over the sacroiliac joints. When performing orthopedic special testing of the lumbar spine there were multiple clinical findings for reproduction of pain symptoms to the sacroiliac joints. When performing lower motor neurological testing no neurological deficits were found. Based on my reevaluation and MRI findings I believe most the patient's lumbar spine pain symptoms stem from an acute impaction injury causing spraining of the ligaments of the lumbar spine with an interspinous ligament injury at L5-S1, multilevel disc bulging at L3-4, L5-S1, a lumbar disc herniation at L4-L5, and spraining of the sacroiliac joints. I believe the patient's lumbar spine pain symptoms will improve with formal physical therapy. I recommend the patient start physical therapy today. If the patient's lumbar spine pain symptoms persist on their next visit they may benefit from bilateral sacroiliac joint injections with corticosteroid. I also recommend the patient try a couple of anti-inflammatory medications and a muscle relaxer. I will dispense Metaxalone 800 mg tablets, Meloxicam 15 mg tablets, and Diclofenac sodium 1.5% topical ointment today. The patient's secondary pain complaint today is the left shoulder. MRI of the left shoulder performed on 09/15/YYYY demonstrates joint effusion and subacromial/subdeltoid inflammation. Upon reevaluation today, the patient had mild tenderness to palpation over the AC joint and biceps tendon. When performing orthopedic special testing of the left shoulder testing was unremarkable for clinical findings. The patient had normal range of motion and strength of the left shoulder. Based on my reevaluation and MRI findings I believe most of the patient's left shoulder pain symptoms stem from an acute impaction injury causing a contusion of the left shoulder, spraining of the AC joint, and secondary biceps tendon. I believe the patient's left shoulder pain symptoms improved with formal physical therapy. I recommend the patient start formal physical therapy for the left shoulder today as well. Given the fact that the patient has no previous history of lumbar spine and left shoulder pain prior to the recent motor vehicle accident. It is		

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		with a reasonable degree of medical probability that the patient's objective findings on today's exam and MRI findings are a direct result of the patient's recent motor vehicle accident that occurred on 04/17/YYYY. My plan for the patient today is to start formal physical therapy. The patient is currently employed and informed me they did not need a work status today. However, I recommend the patient self-limit themselves with their activities of daily living and while working. I would like to see the patient back in my office in 1 month to reevaluate. **Medications dispensed:** The patient was dispensed 150 mg of topical diclofenac 1.5% solution today. I recommend the patient apply to affected areas 3 times a day for the next several weeks. The patient was dispensed Meloxicam 15 mg, 30 tablets. I want the patient to take 1 tablet daily. The patient was dispensed Metaxalone 800 mg, 60 tablets. I want the patient to take 1 tablet before bedtime. **Medication disclaimer:** I want the patient to take an oral NSAID. The patient denies history of gastroesophageal reflux disease or bleeding ulcers. I told the patient to take the NSAID after a large meal to avoid any GI symptoms. I want the patient to take an oral muscle relaxer. I instructed the patient to take this medication before bedtime because it may cause somnolence. The patient was instructed about the medication dosage and was told not to take more medications than prescribed. Risks and benefits of each medication was discussed with the patient. The patient was instructed to discontinue any medication immediately if the patient experiences any negative side effects or allergic reactions. **Procedure codes:** Metaxalone 800mg #60 Meloxicam 15mg Tab #30 Diclofenac 1.5% Solution **Follow Up:** 4 Weeks (Reason: Post PT possible bilateral SI joint injections).		
11/09/YYYY	Provider/ Hospital	**Physical Therapy Record – Initial Examination:** **Referring physician(s):** XXXX. **Injury/Onset/Change of Status Date:** 04/18/YYYY New Injury, MVA **Diagnosis:** • Sprain of ligaments of lumbar spine, subsequent encounter • Contusion of left shoulder, subsequent encounter	7-15 2	$614.30

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		Treatment Diagnosis: • Sprain of ligaments of lumbar spine, subsequent encounter • Contusion of left shoulder, subsequent encounter **Subjective:** **History of Present Condition/Mechanism of Injury:** Pt reports HX of MVA 04/18/YYYY being a restrained driver, hit on driver's side. Pt reports that her shoulder has improved since onset, but by the end of her work week, it is sore. She states that her back pain has not changed since April. She reports she had an MRI and was told she had a bulging disc and her bones had shifted on the left side. She states that her pain is on the left side, that it increases over her work week so that by Friday it is aching and does not go away overnight. Pt works at Kabota 5-6 days/wk for 10hrs, breaks every 2 hours. Her job requires standing, bending and lifting. **Primary Concern/Chief Complaint:** Pt C/O tightness in her back in AM, that loosens up as she moves around. She reports that her pain gradually comes on over the week so that by Thursday and Friday her pain is not relieved by laying and sleeping overnight. She does not report any numbness or tingling in extremities **Before the injury/onset/change of status date, the patient was able to perform the following activities:** **Self-Care:** Hygiene; Sleep; IADLs; Household Chores; Drive Community Distance; Volunteering; Caregiving **Changing & Maintaining Body Position:** Maintaining a Body Position; Transfers; IADLs **Mobility: Walking & Moving Around:** IADLs; Use of an Assistive Device; Walking; Moving Around; Moving Around in Different Locations; Negotiate Obstacles **Carrying, Moving & Handling Objects:** IADLs; Hand & Arm Use; Fine Hand Use; Moving Objects with Lower Extremities; Community Integration/Access; Work/Vocation/Occupation; Recreation **Current Functional Limitations:** **Self-Care:** **Changing & Maintaining Body Position:** **Mobility: Walking & Moving Around:** **Carrying, Moving & Handling Objects:** **Pain Location:** Shoulder, Lower Back, Hip **Pain Scale:** Worst: 9 Best: 1 Current: 5 **Pain Description:** Ache/Pain, Numbness/Tingling, Tenderness **Pain Follow-up Plan:** Reassess 4 wks **Aggravating Factors:** Sitting, Standing, Bending; lifting **Home Health Care:** No **Medical History:** No Known Significant PMH To Affect Treatment, Asthma, Back Injury **Diagnostic Testing/Imaging:** MRI: bulging disc, pt unsure what level		

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Complicating/Personal Factors: Lifestyle (work requires heavy lifting, pushing and pulling, prolonged standing), Litigation, Time since onset of injury/illness (04/18/YYYY)
Medical History Review: The patient has a history of present problem with a history of 1-2 personal factors and/or comorbidities that impact the plan of care.
Mental Status/Cognitive Function Appears Impaired? No
Patient Goals: Minimize my pain level

Objective
Inspection
Outcome measurement tools:
Spine:
Modified Oswestry low back pain: 24% disability
Upper extremity:
Upper extremity quick DASH: 47.73/100

Observation:
Standing posture: Normal
Gait: Normal

Range of motion:
Cervical AROM
Forward Bending: WNL
Backward Bending: WNL
Right Rotation: WNL
Left Rotation: WNL
Right Side Bending: WNL
Left Side Bending: WNL

Lumbar AROM
Forward Bending: 75%
Backward Bending: 100%
Right Rotation: 100%
Left Rotation: 100%
Right Side Bending: 75%
Left Side Bending: 75%
Lumbar AROM Comments: Pain over L SIJ with lumbar flexion

	Right	Left
Hip AROM		
Flexion	WNL	WNL
Extension	WNL	WNL
Abduction	WNL	WNL
Adduction	WNL	WNL
Internal rotation	WNL	WNL
External rotation	WNL	WNL
Hip PROM		

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Flexion	WNL	WNL
Extension	WNL	WNL
Abduction	WNL	WNL
Adduction	WNL	WNL
Internal rotation	WNL	WNL
External rotation	WNL	WNL
Knee AROM		
Flexion	WNL	WNL
Extension	WNL	WNL

Comments:
Shoulder AROM:
Left: Flexion: 143, abduction: 160, ER: T2, IR: T4
Right: Flexion: 148, abduction: 155, ER: T2, IR: T4

Strength:
Comments:
Bilateral upper extremities: Grossly 4/5, no pain reported with MMT
Bilateral lower extremities: Grossly 4/5, pain over left SIJ with resisted left hip flexion

Neurovascular:
Complaints of any radicular symptoms in either extremity: No

	Right	Left
Myotomes lower		
L1, 2 Iliopsoas	Normal	Normal
L3 Quadriceps	Normal	Normal
L4 Anterior Tibialis	Normal	Normal
L5 EHL	Normal	Normal
S1 Gastroc	Normal	Normal
S2 Hamstrings	Normal	Normal
Dermatomes lower		
L1, 2 mid anterior thigh	Normal	Normal
L3 distal inner thigh	Normal	Normal
L4 anterior tibialis	Normal	Normal
L5 EHL	Normal	Normal
S1 lateral foot	Normal	Normal
S2 Mid gastoc/hamstring	Normal	Normal
Lasegue's SLR	Negative	Negative
Seated dural stretch	Negative	Negative

Special tests:
Innominate/sacral positioning: Normal

	Right	Left

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SI compression	Negative	Negative
DI distraction	Negative	Negative
Stork stand SI mobility test	Negative	Negative
Labrum integrity grip		
FABER	Negative	Negative

Palpation:
Comments: Tender over left SIJ with palpation

Assessment:
Assessment/Diagnosis: Pt presents 7 months s/p MVA with side impact. She is reporting decreased tolerance to standing, bending, lifting activities required at work, that get progressively worse over the week. She is reporting some L shoulder discomfort by the end of the week as well, but does not feel it is a concern. She does not demonstrate any limitations with L shoulder today. Pt will benefit from skilled therapy to decrease back pain, improve ROM and core strength to increase tolerance to work requirements and return to PLOF without limitations.

Patient Clinical Presentation: The clinical presentation is stable and/or uncomplicated.
Patient Education: Pt instructed in and demonstrated exercises to start HEP, pt education in anatomy, possible pathologies and prognosis

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:
Pain leading to decreased function
Decreased tolerance to bending and lifting activities
Decreased tolerance to standing/walking activities

Short Term Goals:
- (2 Weeks); Pt will be independent with HEP
- (4 Weeks); Pt will decrease pain report to at least 3/10 at its worst
- (4 Weeks); Pt will report pain as intermittent and less than daily

Long Term Goals:
- (8 Weeks); will decrease pain report to at least 1/10 at its worst and less than weekly
- (8 Weeks); Pt will tolerate work requirements without pain

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		• (8 Weeks); Improve Oswestry by MCID of 6 points indicating meaningful, functional improvements related to the lumbar spine • (8 Weeks); Improve Quick Dash by MCID of 9 points indicating meaningful, functional improvements related to the UE. **Plan** **Frequency:** 2 times a week **Duration:** 8 weeks **Plan:** Begin Plan as Outlined **Instructions:** Progressing patient next visit Progress per IE **Treatment to be provided:** **Procedures:** Therapeutic Exercises, Therapeutic Activity, Neuromuscular Rehabilitation, Manual Therapy, Patient Education **Modalities:** To Improve (Pain Relief, Decrease Inflammation, Increase Blood Flow, Improve Tissue Healing), Electrical Stimulation, Ultrasound/Phonophoresis. **Objective:** **Therapeutic exercise:** See flowsheet HL hip ABD: Doubles/singles: ylw/blk x 20 ea Bridging with strap: Ylw/blk x 20 HL hip ADD: 5ct x 20 **Neuromuscular Re-Education:** See Flowsheet HS str w/ strap: 10ct x 10 HL trunk rot: x 20 Piriformis str (fig4): 30s x 4 (B) Prone up on hands: 5ct x 10 **Therapeutic Activity/Kinetic:** See Flowsheet Pt instructed in and demonstrated exercises to start HEP, pt education in anatomy, possible pathologies and prognosis **PT Evaluation:** Low Complexity **Hot/Cold Packs** Hot MHP to lumbar spine prior to stretching.		

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11/16/YYYY - 12/14/YYYY	Provider/ Hospital	**Summary of interim Physical Therapy visits for injuries sustained in MVA:** **Referring physician(s):** XXXX. **Injury/Onset/Change of Status Date:** 04/18/YYYY New Injury **Diagnosis:** • Sprain of ligaments of lumbar spine, subsequent encounter • Contusion of left shoulder, subsequent encounter **Treatment Diagnosis:** • Sprain of ligaments of lumbar spine, subsequent encounter • Contusion of left shoulder, subsequent encounter **Treatment dates:** 11/16/YYYY, 11/20/YYYY, 11/22/YYYY, 11/27/YYYY, 11/30/YYYY, 12/05/YYYY, 12/07/YYYY, 12/12/YYYY, 12/14/YYYY **Treatment provided:** • Therapeutic exercise • Neuromuscular re-education • Therapeutic activity/kinetic • Hot/cold packs • E-stimulation unattended • Manual therapy • Patient education **As of 01/11/YYYY:** **Reviewer's comments: The interim visits are summarized with significant events.*	16-44 3-4	$4,488.20
12/21/YYYY	Provider/ Hospital	**Physical Therapy Record – Last Available Record:** **Referring physician(s):** XXXX. **Injury/Onset/Change of Status Date:** 04/18/YYYY New Injury **Diagnosis:** • Sprain of ligaments of lumbar spine, subsequent encounter • Contusion of left shoulder, subsequent encounter **Treatment Diagnosis:** • Sprain of ligaments of lumbar spine, subsequent encounter • Contusion of left shoulder, subsequent encounter **Subjective:** **Current Complaints / Gains:** Pt states back is okay today. Has been doing a lot more walking around work more and the past few days has started to notice her back along the (L) hip has been aching more. **Before the injury/onset/change of status date, the patient was able to perform the following activities:** **Self-Care:** Hygiene; Sleep; IADLs; Household Chores; Drive	45-47 4	$549

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		Community Distance; Volunteering; Caregiving **Changing & Maintaining Body Position:** Maintaining a Body Position; Transfers; IADLs **Mobility: Walking & Moving Around:** IADLs; Use of an Assistive Device; Walking; Moving Around; Moving Around in Different Locations; Negotiate Obstacles **Carrying, Moving & Handling Objects:** IADLs; Hand & Arm Use; Fine Hand Use; Moving Objects with Lower Extremities; Community Integration/Access; Work/Vocation/Occupation; Recreation **Current Functional Limitations:** **Self-Care:** **Changing & Maintaining Body Position:** **Mobility: Walking & Moving Around:** **Carrying, Moving & Handling Objects:** **Aggravating Factors:** Sitting, Standing, Bending; lifting **Home Health Care:** No **Medical History:** No Known Significant PMH To Affect Treatment, Asthma, Back Injury **Complicating/Personal Factors:** Lifestyle (work requires heavy lifting, pushing and pulling, prolonged standing), Litigation, Time since onset of injury/illness (4/18/23) **Mental Status/Cognitive Function Appears Impaired?** No **Objective:** **Therapeutic Exercise** See Flowsheet HL hip ABD: doubles/singles: red/blk x 20 ea Bridging with strap: red/blk x 20 HL hip ADD: 5ct x 20 Prone alt UE/LE x 20 Standing hip 3way: Lt grn band x 20 (B) S/L QL sets/stretch 2x10x20" **Neuromuscular Re-Education:** See Flowsheet DKC 15x5" PPT 20x 3sec count to contract 3 sec count to release 3:3 HS str w/ strap: 3x20" HL trunk rot, hip drop: 15x5" SL clams: Red/blk strap x 20(B) Piriformis str (fig4): 4x20" (B) Prone up on hands: 15x5" Cat/cow str: 15x3-5" Childs pose 3way str: 30s x 5 ea Mini squats x 20* Squats: VC for core, quad and glut activation x 20 2x walk out, 2x press out c dbl grn tb x10 ea way CA marching c blu tb 2x10		

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		Manual Therapy: (L) hip PROM lumbo-pelvic mobs IA-STM/MFR to SIJ region **Hot/Cold Packs** Hot Pre: MHP to lumbar spine C LE support **Assessment:** **Assessment/Diagnosis:** Pt continues with increased (L) sided lower back/hip pain. Area of complaint consistent with QL regions. Instructed through S/L QL stretch and encouraged to incorporate into HEP. **Rehab Potential:** Good **Patient Problems:** Pain leading to decreased function Decreased tolerance to bending and lifting activities Decreased tolerance to standing/walking activities **Short Term Goals:** • (2 Weeks); Pt will be independent with HEP • (4 Weeks); Pt will decrease pain report to at least 3/10 at its worst • (4 Weeks); Pt will report pain as intermittent and less than daily **Long Term Goals:** • (8 Weeks); Pt will decrease pain report to at least 1/10 at its worst and less than weekly • (8 Weeks); Pt will tolerate work requirements without pain • (8 Weeks); Improve Oswestry by MCID of 6 points indicating meaningful, functional improvements related to the lumbar spine • (8 Weeks); Improve Quick Dash by MCID of 9 points indicating meaningful, functional improvements related to the UE. Documentation and services listed above were reviewed and approved by the therapist supervising treatment and deemed to be medically indicated and necessary. **Plan:** **Instructions:** Progressing patient next visit Progress per IE.		
01/17/YYYY	Provider/ Hospital	**Office Visit:** **Reason for Appointment:** **New Patient:** Low back pain	79-82	NA

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		History of present illness: **Consultation:** **Chief Complaint:** The patient is a 26 year old female who is right hand dominant. The patient is currently employed as a Kubota Associate who continues to work despite sustained injuries. The patient is present in clinic today due to injuries sustained to her low back as a result of a motor vehicle collision that occurred on 04/17/YYYY. The patient was the restrained driver involved in a rear end collision. The airbags did not deploy. She denies loss of consciousness and head injury at the time of the collision. The patient was initially treated at Stevens County Hospital where she was examined, radiographic studies were obtained, medications were prescribed, and the patient was discharged home in stable condition. The patient was advised to follow up with an out-patient facility for persistent or worsening pain. **Reviewer's Comments: Medical records pertinent to Stevens County Hospital is not available for review.* She currently takes nothing for pain relief. She denies trouble sleeping. The patient states that the pain is affecting their ability to perform regular day-today activities including bending. The patient denies previous pain in the mentioned areas. Medical Assistant: Daisha Williams, MA. **Lumbar Spine/Lower Back:** **Low back pain:** The patient states that her low back pain is her primary pain complaint today. She rates the pain a 3 on a 0-10 pain scale. She states that the pain is constant and describes it as dull. She states the pain is worsened with physical activity and is improved by rest. She admits to radicular symptoms from the low back going into the left hip stopping at the ankle with numbness going down the left leg. The patient denies bowel and bladder changes. The patient notes her low back pain has remained the same the accident. **Review of systems:** **Musculoskeletal:** Patient denies leg cramps, joint pain, knee pain, hip pain, neck pain, shoulder pain. Back pain - Admits **Neurologic:** Patient denies balance, difficulty, loss of strength, insomnia, memory loss. Tingling/numbness - Admits **Vital Signs:** BP: 126/81 mm Hg, HR: 98 /min, RR: 18 /min, Oxygen sat %: 83 %, Temp: 98.0 F, Wt: 155.8 lbs, Wt-kg: 70.67 kg. **Physical examination:** **Lumbar:** **Patient complaint:** The patient describes the maximal pain at the left-sided low back. **Inspection:** I see no obvious scars, deformities, redness, or edema. **Palpation:** There is maximal tenderness to palpation over the left sacroiliac joint. There is a positive straight leg raise test on the left		

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		side. There is a negative straight leg raise test on the right side. There is a positive FABKR test on the left side. There is a negative FABRR test on the right side. There is a negative thigh thrust test on the left side. There is a negative thigh thrust test on the right side. **Range of Motion:** 25 degrees of left lateral bending, 25 degrees of right lateral bending, 60 degrees of forward lumbar flexion, 25 degrees of lumbar extension. There is no reproduction of pain symptoms with lumbar facet loading. **Strength Right Lower Extremity:** 5/5 hip flexion, 5/5 knee extension, 5/5 ankle dorsiflexion, 5/5 great toe extension, 5/5 ankle plantar flexion. **Strength Left Lower Extremity:** 5/5 hip flexion, 5/5 knee extension, 5/5 ankle dorsiflexion, 5/5 great toe extension, 5/5 ankle plantar flexion. **Reflexes:** 2+ patellar tendon reflex, 2+ Achilles tendon reflex bilaterally. **Sensation:** There are normal sensations to the lower extremities to light touch and skin pricking. However, the patient reports subjective numbness and tingling down the left lower extremity all the way to the foot. **Vascular:** Both calves are supple with a negative Homans sign bilaterally. There are no clinical signs for DVT. Brisk capillary refill in all toes. Dorsal pedal pulse, and posterior tibial pulse +2/2 **Assessments** • Sprain of ligaments of lumbar spine, initial encounter • Lumbar disc herniation • Lumbar paraspinal muscle spasm • Sprain of sacroiliac joint, subsequent encounter • Radiculopathy, lumbar region **Treatment** **Sprain of ligaments of lumbar spine, initial encounter** **Referral To:** Pain Medicine **Reason:** Left SIJI/ Left TFESI L4-L5 **Others:** **Notes:** The patient presents today as a new patient involved in a motor vehicle accident that occurred on 04/17/YYYY sustaining injuries to their lumbar spine. The patient reports no pain in the lumbar spine prior to the motor vehicle accident. The patient has already undergone MRI of the lumbar spine and this report is available for review today. The patient has also attended multiple sessions of physical therapy noting some improvement from attending but states the benefits have plateaued and are now participating in a home exercise program. Today we will evaluate, review the lumbar MRI, and develop a treatment plan.		

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		The patient's primary pain complaint is the lumbar spine. Lumbar MRI demonstrates a left paracentral disc herniation at L4-L5 with intradiscal edema and peridiscal inflammatory reaction, and a disc bulge at L5-S1. Upon physical examination today, The patient had focal tenderness to palpation of the left sacroiliac joint. When performing special testing of the lumbar spine there was a clinical finding for reproduction of pain symptoms to the left sacroiliac joint. When performing lower motor neurological testing no neurological deficits were found. However, there was a positive straight leg raise test on the left side causing reproduction of radicular symptoms down the left lower extremity. Based on exam findings I suspect that the majority of patient's lumbar spine pain is likely due to spraining of the left sacroiliac joint, spraining of the ligaments of the lumbar spine, and discogenic injury. I recommend the patient continue with a home exercise program. Due to the patient's persistent lumbar spine pain symptoms being radicular and focal to the left sacroiliac joint. I recommend the patient undergo a left sacroiliac joint injection with corticosteroid and a left transforaminal epidural steroid injection at L4-L5. Indications and contraindications about the injections were discussed with the patient. The patient wishes to proceed. The patient will return in 2 weeks for a procedural visit. Given that the patient denies any previous history of lumbar spine pain prior to the motor vehicle accident, it is within reasonable degree of medical certainty that the patient's symptoms, exam, and MRI findings are likely due to motor vehicle accident on 04/17/YYYY. **Work Status:** The patient was given a work status today of sedentary/light work restrictions. Lifting 10 lbs max and occasionally lifting/carrying of paperwork or small tools. These restrictions are to remain in effect until the next follow-up appointment. The patient verbalized understanding of the current treatment plan and was amenable. All questions were answered. If the patient has any additional questions, the patient can call the office for details. **Follow-up:** 2 weeks (Reason: Left SIJI and left TFESI at L4-5)		

Other related records:

Others, Solera Vehicle Claims

PDF REF: *6, 52-72*

****Reviewer's Comments:*** *All the significant details are included in the chronology. These records have been reviewed and do not contain any significant information. Hence they are not elaborated.*

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***Reviewer's Comments:** Further medical records are not available for review.*				