Medical Chronology/Summary/Timeline

Confidential and privileged information

Usage guideline/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".

Illegible 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 accident** on **MM/DD/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.*
- *Prior visits for other medical conditions have been included in brief for reference.*
- *Only reason for the visit and/or assessment and plan were captured from unrelated visits*
- *Lab reports from prior records were not captured.*

Injury Report:

DESCRIPTION	DETAILS
Prior injury details	Low back pain
Date of injury	MM/DD/YYYY
Description of injury	Motor vehicle crash, Patient was driver, restrained with lap & shoulder harness. Vehicle was impacted on rear end. Air bags were not deployed. Did not impact windshield. Vehicle did not roll over.
Injuries as a result of accident	• Motor vehicle accident-induced cervical disk herniation with myelopathy. • C5-6, C6-7 cervical disc herniation with cord compression and radiculopathy • Cervicalgia • Strain of muscle, fascia and tendon of lower back • Sprain of left wrist • Major depressive disorder • Pain in right shoulder • Residual pain syndrome at C5-6, C6-7, facet-mediated.
Treatments rendered	**Pain medications** **Physical therapy:** 02/06/YYYY – 03/07/YYYY 05/28/YYYY – 06/29/YYYY **Procedures:** **01/07/YYYY:** Cervical dorsal medial branch blocks with fluoroscopic needle localization **02/11/YYYY:** Radiofrequency thermo coagulation of the cervical dorsal median branches with Fluoroscopic needle localization recovery **Surgery:** **05/20/YYYY:** 1. Anterior cervical decompression, C5-6, C6-7. 2. Zavation PEEK 7 mm C5-6 and mm C6-7 cage with demineralized bone matrix inter body implant. 3. Simplicity titanium cervical plate placement, C5 to C6
Condition of the patient as per the last available record	As on 06/29/YYYY, she reported that her cervical pain continues to improve.

Patient History

Past Medical History: Diabetes type 2, Hypothyroidism, hypertension

Surgical History: 2 Caesarean, Hysterectomy

Family History: Father: Diabetes type 2, High blood pressure [hypertension] Mother: Depression

Social History: **Tobacco:** Patient is current every day smoker, She smokes 1 pack(s) per day, 10 cigarettes(s) per day for 20 year(s): Alcohol: Patient drinks alcohol socially. Drug: The patient does not use drugs.

Allergy: Hydrocodone

Detailed Summary

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Prior Injury records	
08/28/YYYY	Facility/Provider Name	**Office visit for sinusitis:** **Chief complaint:** low grade fever, sore throat productive cough gags, nasal drainage **History of presenting illness:** nasal congestion sore throat fever **Diagnosis:** Sinusitis	270
12/29/[redacted]	Provider Name	**Office visit for sore throat:** *Illegible notes* **Chief complaint:** Sore throat, productive cough**,** elevated temperature **History of presenting illness:** Vomiting, increased pain **Assessment:** Acute asthma bronchitis, mild _____	266
01/11/YYYY	Facility/Provider Name	**X-ray of Chest:** **History:** Complete physical exam**.** **Technique:** Two views. **Findings:** The heart size and pulmonary vasculature are normal. No consolidation or pleural effusion is seen. No pneumothorax or bony abnormality is seen**.** **Impression:** No acute cardiopulmonary disease.	342
10/24/YYYY	Facility/Provider Name	**X-ray of chest:** **History:** CPE (Cardiogenic pulmonary edema) **Technique:** Frontal and lateral views of the chest. **Findings:** The cardiac silhouette is not enlarged. There is no pulmonary vasculature congestion. No consolidation, effusions or pneumothorax are identified. The regional bones are intact.	341

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Impression: No radiographic abnormalities identified	
02/22/YYYY	Facility/Provider Name	**Off visit for Type 2 diabetes mellitus** Patient here for DM and ____ check up. Controlled well. TSH: 2.0, Patient with the history of impaired glucose, UA negative, HbA1c 6.1. On Metformin 500 mg daily A/p: GERD. DM 2: Not yet but continued that impaired fasting glucose can lead to DM – Low calorie diet and take meds. Hypothyroid: Cont Synthroid. F/u in 1 month.	255
12/30/YYYY	Facility/Provider Name	**Office visit for low back pain:** *Illegible notes* **Chief complaint:** After moving furniture – Low back pain 41-year old with low back pain with moving _____ But tender to palpation paralumbar muscles. Diagnosed with lumbar strain Flexeril, Mobic and Medrol dose pack	253
01/10/YYYY	Facility/Provider Name	**Off visit:** **History of presenting illness:** Patient here for annual checkup and fasting labs. **Assessment**: Hypothyroidism. IFG (Impaired fasting glucose). Dyslipidemia. Follow-up in 3 months.	254
01/10/YYYY	Facility/Provider Name	**X-ray of chest:** **History:** PE **Comments:** Heart size within normal limits. The lungs are well-expanded and clear. No focal infiltrates are seen. No significant non calcified pulmonary nodules. No pneumothorax is present No pleural effusions. **Impression:** • No active chest disease. • The lungs are clear.	340
07/24/YYYY	Facility/Provider Name	**Office visit for hyperlipidemia, diabetes mellitus, and hypothyroidism**	252
07/24/YYYY	Facility/Provider Name	**X-ray of chest:** **Clinical history:** Physical. **Comparisons:** 1/10/YYYY. **Findings:** The mediastinum and cardiac silhouette are within normal limits. The lungs are clear. No pleural effusion or pneumothorax is seen. The osseous structures and soft tissues are unremarkable. **Impression:** No acute intrapulmonary disease. No evidence of acute tuberculosis.	339
09/21/YYYY	Facility/Provider Name	**Off visit for bronchitis**	251
Motor Vehicle Accident on 12/01/YYYY			
12/01/YYYY	Facility/Provider Name	**Traffic collision report:**	509–516

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF

- **Time of crash**: @1954 hours
- Township Leesville
- **County of crash**: Vernon

Roadway Information:

- **Crash occurred on**: 12/01/YYYY
- **Road classification**: U.S high way
- **High way No**: 171
- **Roadway Name**: S 5th street
- **Street highway**: Boone street

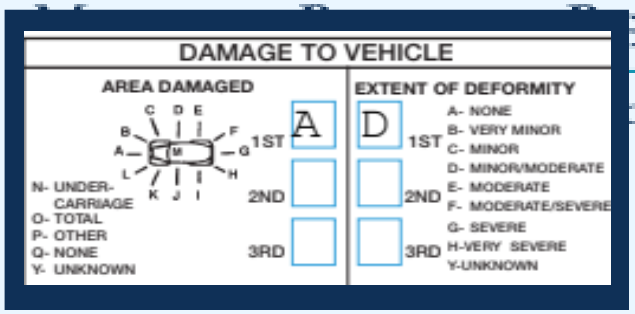
Crash information:

- **Light condition**: Dark continuous street light
- **Weather condition**: clear
- **Roadway condition**: dry

Vehicle information

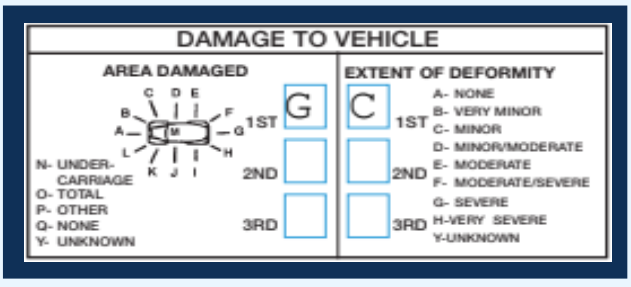
Vehicle #01:

- **VIN No**: XXXX
- **Year**: YYYY
- **Make**: Toyota
- **Model**: Camry new G4
- **Towed due to damage**: No
- **Vehicle traveling direction**: South

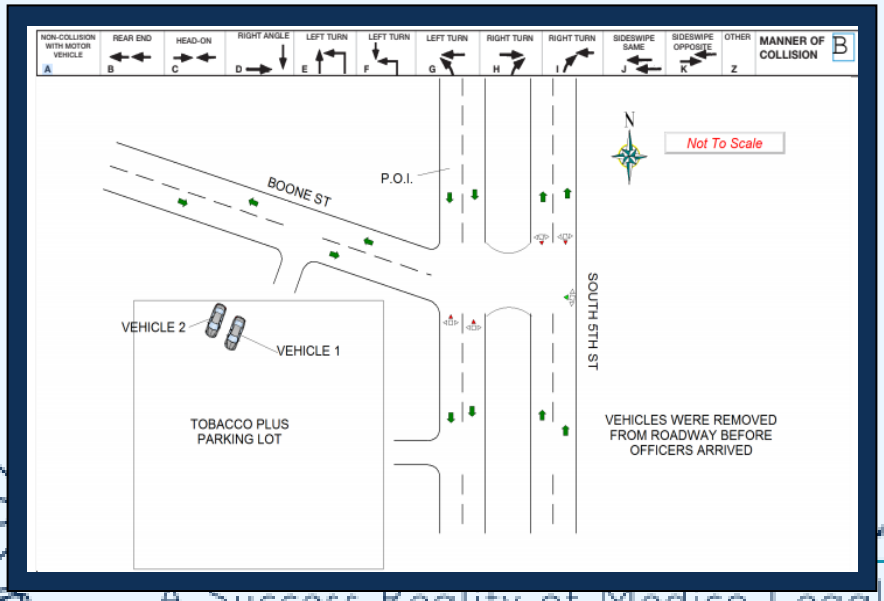


Vehicle#02:

- **VIN No**: XXXX
- **Year**: YYYY
- **Make**: KIA
- **Model**: optima Lx
- **Towed due to damage**: No
- **Vehicle travelling direction**: South



DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Person record: Vehicle#: 01 • **Passenger name**: Name: XXXX Jr • **Seating position:** Driver – Front seat left side • **Air Bag**: Non-Deployed • **Occupant Protection system used**: Shoulder belt and lap belt is used • **Injury**: Minor • **Ejection**: Not ejected • **Condition of the driver**: Inattentive • **Violation**: Careless operation • **Vehicle speed**: 35 • **Citation No**: XXXX – Careless operation **Vehicle#02**: • **Person travelled**: XXXX • **Seating position:** Driver – Front seat left side • **Air Bag**: Non-Deployed • **Occupant Protection system used**: Shoulder belt and lap belt is used • **Ejection**: Not ejected • **Vehicle speed**: 35 • **Injury**: pain in the neck and left wrist, back pain • **Ejection**: No ejection **Narrative:** On 12/1/YYYY at approximately 1954 hours, P/O XXXX was dispatched to Tobacco Plus on South 5th street, in reference to a traffic collision involving 2 vehicles that had moved from the roadway. XXXX arrived on scene and made contact with the driver of each vehicle. XXXX asked if they required any medical attention, but both drivers declined treatment, stating they were alright. XXXX requested driver and vehicle information and spoke with each driver separately. Driver of vehicle 1, identified by a XXXX Driver's License as XXXX, advised he was traveling Southbound on South 5th street, in the right lane of travel as he approached the intersection of Boone street. XXXX stated he was looking around and wasn't watching the vehicles in front of him at that time of the incident. XXXX looked up and realized vehicle 2 had come to a complete stop in front of his vehicle. XXXX advised he attempted to stop the vehicle, but was unable to do so, and made contact with the rear end of vehicle 2. P/O XXXX observed the damage to vehicle 1, which sustained minor to moderate impact damage to the front grill and middle bumper. Driver of vehicle 2, identified by a Louisiana Driver's License as XXXX, advised she came to a stop at the intersection of South 5th street, and Boone street, due to a red traffic signal. She advised she was in the right lane of travel and had several stopped vehicles in front of her. XXXX stated she looked in her rearview mirror just in time to observe vehicle 1 right before it made contact with the rear end of her vehicle. XXXX advised after contact was made, both vehicles activated their emergency flashers and the driver of vehicle 1 came up to her and asked if she was alright. After determining that both parties were okay, the decided to move their vehicles from the roadway, deciding to park at Tobacco Plus and clear the roadway. XXXX observed the damage to vehicle 2, which sustained minor scrapes and scratches to the middle of the rear bumper. **Refer to each by vehicle number:** Based on driver statements and the damage to each vehicle, P/O XXXX determined the driver of vehicle 1, XXXX, to be at fault for the collision. XXXX completed a vehicle exchange form and provided a copy to	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		both parties. XXXX explained the form and advised both parties that a crash report would be filed with Leesville Police Department and made available in the next 3 to 5 business days. XXXX verified with both parties that their vehicles were operational and that neither party required medical attention. P/O XXXX issued a citation for RS 32:58 Careless Operation to XXXX and remained on scene until both parties left the area in their vehicles. **Diagram for reference** 	
12/02/YYYY	Facility/Provider Name	**Emergency department visit for motor vehicle accident:** **Triage Assessment:** Pain: Complains of pain in left wrist, back Pain currently is 6 out of 10 on a pain scale. Recent Travel History: No recent travel within the last 21 days. **Presentation:** **Presenting complaint:** Patient states: Occurrence "last night". States was restrained driver of vehicle that was struck from behind while at rest. Denies LOC (Loss of Consciousness). Complaints of pain to left wrist and back. Accompanied by Self. **Mechanism of Injury:** Motor vehicle crash, Patient was driver, restrained with lap & shoulder harness. Vehicle was impacted on rear end. Force of Impact was Not extricated from vehicle. Air bags were not deployed. Did not impact windshield. Vehicle did not roll over. Leesville City Police Dept. This 43 yrs old White Female presents to ED via POV with complaints of Motor Vehicle Collision (MVC) The patient was a driver of a. 12/02 The patient was of a car. The patient was restrained by a lap belt, with a shoulder harness, the vehicle was impacted on rear end, and was traveling at moderate speed, The vehicle did not rollover, the patient was not ejected from the vehicle, extrication of the patient from vehicle was not required, the patient was ambulatory at the scene, the force of impact was moderate.	13–18

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Onset: The symptoms/episode began/occurred acutely, 1 day(s) ago, and became worse today, and became persistent yesterday. **Associated injuries:** The patient sustained injury to the low back, tenderness, Left wrist. Associated signs and symptoms: The patient has no apparent associated signs or symptoms, Loss of consciousness: The patient experienced no loss of consciousness. S**everity of symptoms:** At their worst the symptoms were moderate, a "7" out of "10", In the emergency department the symptoms are unchanged. The patient has not experienced similar symptoms in the past. The patient has not recently seen a physician**.** **Method Of Arrival: POV:** Ambulatory. Acuity. Level 4. **Review of system (ROS):** MS/extremity: Positive for contusion, pain, swelling, tenderness, of the left wrist and lower back. Patient is anxious. Back: Pain that is moderate, of the low back area, ROM (range of motion) is decreased, with all movement. Musculoskeletal/extremity: Pain to left wrist and lower back. **Diagnosis:** Other specified sprain of left wrist, initial encounter: Driver injured in collision with unspecified motor vehicles in traffic accident, initial encounter**:** Strain of muscle, fascia and tendon of lower back, initial encounter **Discharged to Home:** **Impression:** Driver injured in collision with unspecified motor vehicles in traffic accident, initial encounter, Other specified sprain of left wrist, Initial encounter, Strain of muscle, fascia and tendon of lower back, initial encounter. Condition is Stable. **Discharge Instructions**: Lumbosacral Strain, Motor Vehicle Collision Injury, Wrist Sprain. Prescriptions for Ibuprofen 800 mg Oral Tablet -take 1 tablet by oral route every 8 hours As needed take with food; 12 tablet. Cyclobenzaprine 10 mg Oral Tablet - take 1 tablet by oral route every 8 hours; 15 tablet. **Follow up**: Private Physician; When: 1 - 2 days; **Reason**: Worsening of condition, Recheck today's complaints, Continuance of care. Problem is new. Symptoms are unchanged.	
12/02/YYYY	Facility/Provider Name	**X-ray of cervical spine:** **Indication:** Pain with trauma**.** **Findings:** Three views of the cervical spine dated. December 2, YYYY, are presented for evaluation. No old films are available for review. The study is made problematic due to the patient's very large body habitus. The cervicothoracic junction is not visualized in the lateral projection. This area is seen in the AP projection and does appear normal. However, for any further clinical concern in this region would require CT. The visualized vertebral bodies- and intervertebral disks are well maintained. There is some degree of degenerative change however. This appears to predominate at C5-6 and C6-7 manifested primarily by facet arthropathy and uncovertebral joint arthropathy. No prevertebral soft tissue swelling is noted.	22–23

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Impression: • Technically difficult study with difficult visualization of the cervicothoracic junction. Further clinical concern would require CT. • Degenerative change, with no definite fractures given the limit of the technique	
12/02/YYYY	Facility/Provider Name	**X-ray of lumbar spine:** **Indication:** Low back pain with trauma. **Findings**: Three views of the lumbar spine dated December 2, YYYY, are presented for evaluation. No old films are available for review. Routine views of the lumbosacral spine reveal the vertebral bodies to be of normal height with adequate maintenance of the intervertebral disk spaces. There is no evidence of traumatic, neoplastic, or significant arthritic change. There is no evidence of spondylolysis or spondylolisthesis. **Impression:** Normal Lumbosacral Spine	19–20
12/02/YYYY	Facility/Provider Name	**X-ray of left wrist:** **Indication:** Pain with trauma. **Findings:** Three views of the left wrist dated December 2, YYYY, are presented for evaluation. No old films are available for review. Routine views of the left wrist reveal no evidence of fracture, dislocation, arthritic, or inflammatory change. There is some degenerative change in the radioulnar joint with some bony remodeling. **Impression:** No fractures identified.	21
12/18/[redacted]	Provider Name	**Correspondence to Mr. XXXX:** Ms. XXXX was seen on December 18, YYYY. She presented as a pleasant 43-year-old female status post motor vehicle accident December 1, YYYY. The patient was the restrained driver of a car stopped at a traffic light when suddenly impacted from the rear by another car. There was no loss of consciousness, although she was apparently dazed. Both hands were on the steering wheel with the right foot on the brake. She was seen the next day at XXXX Hospital Emergency Room with cervical and lumbar x-rays, left wrist X-rays, and discharged with prescriptions. She continues to report neck and lower back pain and left wrist pain. Bowel and bladder function remain stable. She denied any peripheral paresthesias. Past medical history is significant for having some lower back pain approximately four years ago having moved some furniture in her home. She was seen by a primary physician and treated with medications and had resolution of symptoms within three to four weeks. Examination revealed a pleasant right-handed female in no acute distress. Palpation of the cervical area revealed increased tone in the left-greater-than-right cervical paraspinous muscles, the bilateral levator scapulae muscles, bilateral rhomboideus minor muscles, and the left-greater- than-right infraspinatus muscles. Cervical range of motion revealed flexion to be 75% normal with pain and extension 50% normal with pain. Bilateral flexions were 50% normal with pain. Right rotation was 50%	39–40

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		normal and left rotation 75% normal, again with complaints of pain. Motor examination of the arms was within normal limits. There was pain challenge in wrist extensors and flexors on the left side. Sensory examination was intact to pinprick and light touch. Reflexes were trace and symmetric biceps, triceps, and brachioradialis reflexes. There was no obvious muscle atrophy noted in either arm or hand. The patient had a negative Adson test. Finkelstein test was positive on the left. There was also tenderness in the wrist around the ulnar styloid. After manipulation, pain improved. With regard to the lower back, motor examination of the legs was within normal limits. Sensory examination was intact to pinprick and light touch. Reflexes were trace and symmetric patella reflexes with 1+ and symmetric. Achilles reflexes. Babinski response was absent bilaterally. The patient had negative straight- leg raise test. Faber test was positive bilaterally with increased lower back pain noted during right Faber maneuver. She noted a tight right piriformis muscle and was tender to palpate the right PSIS (Posterior Superior Iliac Spine) region of the lower back. Lastly noted was that she had tenderness over the TMJ (Temporomandibular Joint) with lateral deviation to the left when opening and closing the mouth and increased tone in the left masseter muscle. My impression is that of a cervical strain, bilateral rotator cuff strain, TMJ sprain, right piriformis strain, right iliolumbar ligament sprain, lumbar facet sprain, a left wrist sprain, and left de Quervain syndrome. At this point, I am going to place her on a home exercise program and will see her back in January YYYY. If she is unable to work this out in the home environment, I am going to anticipate a course of therapy at that time. I did do some acupuncture with improvement in pain before she left the office.	
01/02/YYYY	Facility/Provider Name	**Office visit for multiple problems:** **History of present illness:** 44 year old female here for fever with body aches. Some chills and cough **Assessment and plan:** Acute sinusitis. Take medications as directed. Acute bronchitis, unspecified Cough. Pain in throat. Fever. Essential HTN (Hypertension). Other specified hypothyroidism. Follow up in 10 days. **Reviewer's comments: This visit is not elaborated since it was unrelated to the injury*	79–80
01/15/YYYY	Facility/Provider Name	**Correspondence to Mr. XXXX:** Ms. XXXX was seen in follow-up on January 15, YYYY. She continued with neck and shoulder pain with intermittent paresthesias in the hands. She also reports lower back pain but improved. She has been doing therapeutic exercises over the holidays. She is reporting some increased symptoms recently she feels are related to coughing secondary to a diagnosis of pneumonia. She is using her splint for her wrist, especially at nighttime. At this point, I am going to anticipate beginning physical therapy to address her soft tissue abnormalities. I am going to anticipate setting up a schedule three times a week for four weeks. She is to continue her Ibuprofen t.i.d (thrice a day), for anti-inflammatory and analgesic effects. I am going to see Ms. XXXX when she completes PT and will keep you posted as to status. If she continued with symptoms at that time, I am going to anticipate objective workup.	82
02/06/YYYY	Facility/Provider Name	**Initial physical therapy evaluation for neck and back pain:** *Illegible notes* **Chief complaints:** Pain in neck, upper back, right lumbar, right gluteal, left wrist.	118–122, 116–117

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12/01/YYYY driver got rear ended.

Location of pain: Cervical interscapular, lumbar, right ileolumbar sprain, left wrist, bilateral posterior shoulder girdle, rotator cuff strain.

Distal pain: No pain radiating down to bilateral upper extremities and bilateral lower extremities

Tingling/numbness: Over left shoulder area. None in bilateral upper extremities/ hands, bilateral lower extremities/ feet.

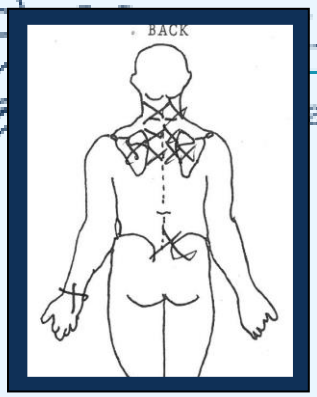
Aggravating factors: Answering phone, work and typing

Temporarily alleviated by: Aleve

Patient condition since injury: My neck is a little worst but my wrist and lower back are getting better.

Physical exam:
Increased muscle tone, reduced muscle flexibility, over right ____, bilateral levator scapula, bilateral _____ and right piriformis.

Tenderness: _____, bilateral infraspinatus.



Upper and lower extremities – Pain rating:
Bilateral ___, levator scapula, rhomboids, infraspinatus: 4/5. Right ileolumbar, right piriformis: 2/5. Left wrist: 2/5

Cervical active range of motion:
Flexion: 45 no pain
Extension: 40, right side neck pain
Lateral bending to right: 25 – no pain
Lateral bending to left: 25, right side neck pain
Rotation to right: 55 no pain
Rotation to left: 55, right side neck pain

Lumbar active range of motion:
Flexion: 85 no pain

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		Extension: 20, pain right side **Lateral bending to right and left:** 10– no pain **Rotation to right:** 30 no pain **Rotation to left:** 30 no pain **Diagnosis:** Cervical strain, right ileolumbar sprain, right piriformis strain, lumbar strain, piriformis strain, ___ **Plan:** HMP (Hot/Moist Pack), Paraffin, ultrasound, soft tissue mobilization, home exercise program **Frequency/ duration:** PT 3x/ week for 4 weeks	
02/13/YYYY	Facility/Provider Name	**Office visit for medication refills:** **History of presenting illness:** 44-year Old female here for medication refills and fasting labs. **Assessment and plan:** Essential (primary) hypertension (unchanged) Plan: Continue to monitor- stressed has diet. Other specified hypothyroidism (unchanged) Plan: Continue to monitor get labs Generalized anxiety disorder (new) Plan: Start Buspar. Watch for side effects. Ordered and check labs. Follow up in 10 day(s) **Reviewer's comments: This visit is not elaborated since it was unrelated to the injury*	77–78
02/08/YYYY - 03/06/YYYY	Facility/Provider Name	**Summary of multiple physical therapy visits:** **Treatment dates:** 02/08/YYYY, 02/16/YYYY, 02/19/YYYY, 02/21/YYYY, 02/22/YYYY, 02/28/YYYY, 03/02/YYYY, 03/06/YYYY **Summary of significant events:** She complained of pain in her neck, upper back, right ileolumbar spine, right gluteus and left wrist at a range of 1-4/5. She had decreased pain after the treatment. Her range of motion was improved in her cervical and lumbar spine after treatment. **Treatment rendered:** Her treatment included soft tissue mobility, paraffin bath, ultra sound, and hot/cold packs **Reviewer's comments: Multiple physical therapy visits have been combined and summarized with significant details.*	87–93, 96–99, 103–115
03/07/YYYY	Facility/Provider Name	**Physical therapy discharge summary:** **Chief complaints:** Pain in neck, upper back, low back, right gluteal, left wrist **Upper and lower extremities – Pain rating:** Bilateral cervical paraspinal 0-1/5, levator scapula, rhomboids, infraspinatus: 0-1/5. Right ileolumbar: 0-1/5, right piriformis and Left wrist: 0/5 **Cervical active range of motion:** **Flexion:** 45 no pain **Extension:** 40, no pain	101–102, 105

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Lateral bending to right: 25 – no pain **Lateral bending to left:** 25, no pain **Rotation to right and left:** 55 no pain **Lumbar active range of motion:** **Flexion:** 80 no pain **Extension:** 20 no pain **Lateral bending to right and left:** 10– no pain **Rotation to right:** 30 no pain **Rotation to left:** 30 no pain **Comments:** Patient responded fairly well in therapy. Improved muscle strength and flexibility. Pain level decreasing frequency **Diagnosis:** Cervical strain, right ileolumbar sprain, right piriformis strain, rotator cuff strain. **Discharge Plan:** Patient discharged from PT service. Transition to home treatment program. Follow-up with MD.	
03/07/YYYY	Facility/Provider Name	**Correspondence to Mr. XXXX:** Ms. XXXX was seen in follow up on March 7, YYYY. She is doing well with therapy as outlined with minimal neck and upper shoulder pain. We discussed the option to try to resolve this with a home exercise program. I have encouraged Ms. XXXX to resume her regular activities as tolerated. I am going to see the patient back in four to six weeks in follow up or sooner if needed. If she maintained stability at that time, I am going to anticipate discharge from my care.	94
04/06/YYYY	Facility/Provider Name	**Correspondence to Mr. XXXX:** Ms. XXXX was seen in follow up on April 5, YYYY. Since last seen, she has resumed her regular activities without difficulty. She does report some occasional left-sided neck pain but is able to stretch out adequately. There does appear to be some increased tone in the left cervical paraspinous muscles at approximately C5-6. At this time, though, Ms. XXXX appears stable, and I am going to discharge her from my care.	123
08/14/YYYY	Facility/Provider Name	**Correspondence report for neck pain:** Ms. XXXX was seen in follow-up on August 14, YYYY. Since seen in April YYYY, her lower back has been stable. She continued with neck pain with some headaches. Symptoms also increase with Valsalva-type effects. Because of chronicity and the Valsalva responses, I would like to obtain cervical MRI scan. She apparently is claustrophobic, and I am going to premedicate her with valium with instructions to have someone drive her. If I can be of any further assistance, please do not hesitate to contact me. I am,	135
08/24/YYYY	Facility/Provider Name	**MRI cervical spine without contrast:**	138–139,

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Indication: Chronic neck pain since MVC 12/01/YYYY. **Comparison:** No prior comparison**.** **Findings:** Osseous/Alignment: Straightening of the normal cervical lordosis. No fracture. Normal bone marrow signal. Spinal Cord and Skull base: Flattening of the cervical spinal cord related to spinal canal stenosis. No cord signal changes. Normal appearance of the skull base and craniocervical junction. Soft Tissues: Bilateral maxillary sinus disease with small fluid air levels. **Evaluation of individual levels:** C2-C3: Disc height loss. Thickening of the posterior longitudinal ligament. Mild bilateral facet disease. No stenosis. C3-C4: Disc height loss. Mild anterior disc bulging with small osteophytes. Thickening of the posterior longitudinal ligament. Pedicular hypoplasia. Mild spinal canal narrowing. No neural foraminal stenosis. C4-C5: Disc height loss. Mild anterior disc bulging. Thickening of the posterior longitudinal ligament. Pedicular hypoplasia. Mild spinal canal narrowing. No neural foraminal stenosis. C5-C6: Disc height loss. Mild disc bulging. Thickening of the posterior longitudinal ligament and large central disc protrusion with annular tearing abutting the spinal cord. Pedicular hypoplasia. Moderate spinal canal stenosis with flattening of the spinal cord. No neural foraminal stenosis. C6-C7: Disc height loss. Mild disc bulging with small anterior osteophytes. Small bilateral uncovertebral osteophytes. Large central disc protrusion and inferior disc extrusion with annular tearing. Pedicular hypoplasia. Severe spinal canal stenosis with flattening of the spinal cord. C7-T1: Disc height loss. Thickening of the posterior longitudinal ligament. Mild bilateral facet disease. Mild bilateral neural foraminal narrowing. No spinal canal stenosis**.** **Impression:** 1. Multilevel degenerative disc disease and facet arthropathy superimposed on pedicular hypoplasia causing areas of significant stenosis. Findings are worse at C5-C6 and C6-C7. 2. C5-C6: Moderate spinal canal stenosis with flattening of the spinal cord. 3. C6-C7: Severe spinal canal stenosis with flattening of the spinal cord. No cord signal changes to suggest myelopathy. Moderate bilateral neural foraminal stenosis. 4. Loss of the normal cervical lordosis, which is nonspecific but can be seen with muscle spasm. 5. Bilateral maxillary sinus mucosal disease	143–144
08/27/YYYY	Facility/Provider Name	**Office visit for hypertension and hypothyroidism:** **Assessment and plan:** Essential (primary) hypertension Plan: Continue to monitor- stressed has diet Other specified hypothyroidism Plan: Continue to monitor get labs **Reviewer's comments: This visit is not elaborated since it was unrelated to the injury*	73–74, 75–76

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08/28/YYYY	Facility/Provider Name	**Prescription record:** *Illegible notes* Spine surgery and _____ HNP (Herniated Nucleolus Pulposus) **Reviewer's comments: Corresponding office visit is not available for review*	142
08/29/YYYY	Facility/Provider Name	**Telephone summary:** Dear Mr. XXXX: I had a phone conversation with Ms. XXXX on August 28, YYYY, regarding her abnormal cervical MRI scan. She is noted to have what appears to be a herniation and/or large protrusion at another level. I would suggest considering spine surgical evaluation given chronicity of symptoms. I am also going to place her on a 10- to 20-pound lifting restriction until further notice.	140
10/09/YYYY	Facility/Provider Name	**Office visit for neck pain:** **Chief complaint:** Neck pain, bilateral arm numbness and tingling. **History of present illness:** Patient is a 44-year-old right-handed female, who on 12/01/YYYY, was the restrained solo driver of a YYYY Kia Optima in Leesville, Louisiana. She was working as a manager of a loan company. She was at a red light controlled intersection stopped when she was struck from behind by a sedan. There was no loss conscious, no airbag deployment, no windshield breakage. She declined EMS services after law enforcement arrived. She does recall her neck being stiff at the scene. She was shaken up in general. After being excused by law enforcement, she drove the same vehicle home, and the next morning awoke to have neck pain and left wrist pain, as well as right hip pain. She was seen at a local hospital, XXXX Memorial, in the Emergency Room where she was evaluated, treated, and released. She was given Ibuprofen. She refused narcotics. She since that time has seen you in your office and undergone evaluation as well Is physical therapy. The physical therapy she said was occasionally associated with manual palpation of the cervical spine leading to a sensation of electricity in her arms. It has since been discontinued. She has continued to be working, trying not aggravate her problem, taking over-the-counter medications. She presents today after cervical MRI scan, which was performed on 08/24/YYYY, for Neurosurgery consultation based on the results. She denies any bowel or bladder control difficulty. **Physical examination:** She has 75% full range of motion of the head and neck, limited by pain. **Imaging:** Her cervical spine MRI scan performed on 08/24/YYYY at MR Imaging Systems in Alexandria demonstrates C5-6 and C6-7 disk herniations into the spinal cord, changing the spinal cord profile. I agree with the radiology reading. **Impression**: Motor vehicle accident-induced cervical disk herniation with myelopathy. **Plan**: Financial authorization, anterior cervical discectomy and fusion at C5-6 and C6-C7. We will get cervical flexion and any other adjacent levels need to be included in the surgical construct. I am not comfortable prescribing any more physical therapy for her or cervical traction, as the Lhermitte's phenomena described by the patient during physical therapy most likely will prevent future application of	497–498

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		manual techniques of any kind. Risks, benefits, alternatives to the surgery discussed. I am going to prescribe Diclofenac 75 mg p.o. b.i.d. (Twice a day), as the patient is reluctant to engage in narcotic pain therapy. She had a husband who became addicted and overdosed from narcotics and died. She has an understandable fear of the phenomena. I will see her back for re-evaluation, if she decides she wants to go forward with a surgical treatment plan.	
11/15/YYYY	Facility/Provider Name	**Follow-up visit for multiple problems:** **Assessment and plan**: Essential HTN. Other unspecified hypothyroidism. Type 2 DM without complication. Other abnormalities findings in urine, continue medications. Follow-up in 10 days. Ordered and check labs. **Reviewer's comments: This visit is not elaborated since it was unrelated to the injury*	70–72
01/15/YYYY	Facility/Provider Name	**Office visit for dysuria:** **Complaint:** Dysuria **Assessment and plan:** Acute cystitis with hematuria **Plan:** Macrobid as directed push fluid. Return to check in one week Essential HTN. Other unspecified hypothyroidism. Type 2 DM without complication. Other abnormalities findings in urine, continue medications. Follow up in 7 day(s) **Reviewer's comments: This visit is not elaborated since it was unrelated to the injury*	67–69
01/31/YYYY	Facility/Provider Name	**Follow-up visit for acute cystitis:** **Assessment and plan:** Acute cystitis with hematuria **Plan:** Seems to be resolved urine analysis is within normal limits. Symptoms has resolved. Follow-up in 10 days. **Reviewer's comments: This visit is not elaborated since it was unrelated to the injury*	65–66
03/15/YYYY	Facility/Provider Name	**X-ray of cervical spine:** **Indications:** Cervical disc herniation **AP and lateral views** indicate evidence of osteophyte right is of the facet joints. Sclerosis and spurring of the structures noted. Oblique views indicate significant foraminal stenosis at C6- 7 on the right **Flexion and extension** views do not show any evidence of subluxation or instability. Intravertebral disc spaces demonstrate posterior spondylosis formation at C5-6. Normal remaining bone structures and disc spaces. Normal paraspinal soft tissues**.** **Impression:** 1. Osteoarthritis the facets at all levels. 2. Right foraminal at C6-7. 3. Posterior spondylosis formation at C5-6.	508

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03/20/YYYY	Facility/Provider Name	**Office visit for neck pain:** **Complaint:** Neck pain. **History of presenting illness:** 45-year-old female here for history of neck pain. She is needing pre op clearance from her neuro M.D. she has some of the labs that were done Which shows she has an elevated WBC and UTI **Review of systems:** History of neck pain **Physical exam:** Head and neck: Tenderness to the cervical spine, cervical pain with palpation **Assessment and plan**: Essential HTN: Plan: States that she stopped the medications that I gave. States that this caused her to be dizzy advised to avoid salt take medications as directed. Type 2 DM. UTI. **Cervicalgia.** **Plan:** She is needing clearance. However have explained that we will have to get additional labs and chest x-ray/ EKG. Pending those results we can clear her. She stated that she needs this done by the first. She states that this injury was from a status post MVA, explained that we would do whatever we could do to help her. But we will have to get the labs/ chest x-ray done first, also explained that we do not do treat MVA injuries. **Reviewer's comments: Only case specific details have been updated from the above visit*	63–64
03/21/YYYY	[redacted] Provider Name	**Work status report:** **Diagnosis:** Cervical disc disease, herniation 722.0 **Surgical procedure:** Anterior cervical discectomy and fusion C5-7 **Current medications:** Diclofenac **Frequency of treatment:** Monthly **Patient able to perform his/her job:** No **Patient continuously unable to work:** From 05/20/YYYY – 11/01/YYYY **Estimate date patient return to work:** 10/YYYY **Reviewer's comments: Corresponding visit is not available for review*	153
03/26/YYYY	Facility/Provider Name	**Office visit for pre-operative clearance:** **Complaint:** Neck pain. **History of presenting illness:** Pre-operative clearance for her neck, status post MVA YYYY **Review of systems:** History of neck pain, headaches	61–62

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		Physical exam: Neck: Tenderness to the cervical spine, cervical pain with palpation **Assessment and plan**: Cervicalgia. She is needing clearance, will get the labs, she will need to see cardiology for cardiac clearance, will get a chest x-ray **Reviewer's comments: Only case specific details have been updated from the above visit*	
04/11/YYYY	Facility/Provider Name	**office visit for hematuria:** **Assessment and plan:** Hematuria-Plan: Possibly a stone she does not have a UTI. She needs CT scan and being in the afternoon she will go to the ER for evaluation now. Follow up as needed **Reviewer's comments: This visit is not elaborated since it was unrelated to the injury*	59–60
04/26/YYYY	Facility/Provider Name	**Office visit for pre-operative clearance:** **Complaint:** Clearance for neck surgery **History of presenting illness:** 45-year-old female here for clearance for her neck surgery, she seen cardiology this am and was told that she was cleared. She was diagnosed recently with a renal stone in the which she is feeling better. **Assessment and plan**: Encounter for other pre-procedural examination. **Plan:** She was cleared by cardiology labs, and chest X-ray done. She is cleared for surgery Follow up in 30 days **Reviewer's comments: Only case specific details have been updated from the above visit*	57–58
05/13/YYYY	Facility/Provider Name	**office visit:** **Chief complaint**: Neck pain, lateral arm numbness and tingling with right greater than left numbness and tingling. **History of present illness**: Ms. XXXX is a 45-year-old female who was involved in a motor vehicle accident on 12/01/YYYY. She was shaken up. After law enforcement excused her, drove the same vehicle home. The next morning, she woke up having eek pain, left wrist pain, and right hip pain. She was seen at a local hospital in the emergency room where she was evaluated, treated, and released, given ibuprofen. Since that time, she has undergone chiropractic treatment and physical therapy. Physical therapy led to a sensation of electricity in her arms and it has been discontinued. She has continued to work, trying no aggravate her problem, taking over-the-counter medications. Presents today or neurosurgical consultation for cervical spine surgery. Denies any bowel or bladder difficulty**.** **Physical examination:** She has 75% full range of motion of the head and neck in all directions, limited by pain, more so limited on right rotation.	154–155

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		Impression: Motor vehicle accident-induced cervical disk herniation with myelopathy. **Plan**: Anterior cervical diskectomy and fusion at C5-C6 and C6-C7. **Preoperative note:** I saw Ms. XXXX in the office today for a preoperative evaluation of her upcoming procedure. We went through the consent form line by line and paragraph by paragraph. After all of her questions were answered, we reviewed her preoperative laboratories, EKG, and cardiac clearance and found that to be acceptable, with the exception of a UA that will need to be repeated. At the end of the discussion, she was satisfied with delivering informed consent for the procedure. Discussed bringing the Aspen collar with her to the hospital. She will have someone at home with her to assist in wound care postoperatively. She does not have any known drug allergies and she was given Diazepam, Keflex, and Percocet to be filled prior to surgery. These 3 medications will be for the postoperative course of her care. The patient has been told that nonsteroidal anti-inflammatories should not be taken for 6 months following surgery because it can interfere with the integrity of the fusion process.	
05/20/YYYY	Facility/Provider Name	**Operative report for cervical decompression:** **Preoperative diagnosis:** C5-6, C6- 7 cervical disc herniation with cord compression and radiculopathy. **Post-operative diagnosis**: C5-6, C6-7 cervical disc herniation with cord compression and radiculopathy **Procedures performed:** 1. Anterior cervical decompression, C5-6, C6-7. 2. Zavation PEEK 7 mm C5-6 and mm C6-7 cage with demineralized bone matrix interbody implant. 3. Simplicity titanium cervical plate placement, C5 to C7 **Anesthesia:** General The patient was reversed from general endotracheal anesthesia, awake moving all four extremities, taken to the recovery room in stable condition.	158–159
06/20/YYYY	Facility/Provider Name	**Post-operative visit:** **Subjective**: I saw Ms. XXXX in the office today. She is now1 month status post anterior cervical diskectomy and fusion. C5-6 and C6-7. I reviewed her most recently done AP and lateral cervical spine x-ray, and the placement of the hardware looks ideal. She says her upper extremity symptoms are dramatically improving. **Physical examination**: She is awake and alert. Cranial nerves are intact. Normal motor and sensory function upper and lower extremities, 1+ DTRs. No straight leg raising signs. Her gait and station are normal. She ambulates unassisted. **Impression**: One month status post 2-level cervical fusion. **Plan**: Continue present management. Add Restoril 15 mg at bedtime for sleep, and I will see her for her next follow-up appointment.	162–163
06/20/YYYY	Facility/Provider Name	**X-ray of cervical spine:** **History**: Cervical disc disease, herniation, fusion 5/20/YYYY, MVA 12/1/YYYY,	166

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		subsequent encounter for follow-up evaluation **Findings**: 6 views of the cervical spine are provided to include repeat swimmer's views. Compared to prior LSSH study of 3/15/YYYY. Prevertebral soft tissues are prominent, compatible with recent surgery. C1 and C2 articulate normally. There is straightening of normal cervical lordosis. Cervical vertebral body height is maintained. Alignment appears to be fairly well-maintained. There is generalized facet hypertrophy. Disc space narrowing is seen at C4-5. There has been interval ACDF with attempted interbody fusion to include discectomy and graft placement as well as anterior fusion plate and screws from C5 to the C7 level. Prominent styloid processes are noted. **Impression**: 1. Straightening of normal cervical lordosis. 2. Interval ACDF (Anterior Cervical Diskectomy and Fusion) from C5 to the C7 level. 3. Disc space narrowing at C4-5 with mild generalized facet hypertrophy. 4. Prominent styloid processes which can be seen with Eagle syndrome.	
07/17/YYYY	Facility/Provider Name	**Post-operative visit:** **Subjective**: I saw Ms. XXXX in the office today. She is now 2 months status post C5 to C7 ACDF. Her swallowing is improving. Her neck pain is persistent. She had a little bit of a catch when turning her head the other day. Her head turning is restricted. We are working on that with exercise. **Physical examination**: Awake and alert. Cranial nerves are intact. Normal motor and sensory function upper and lower extremities, l+ DTRs. No straight leg raising signs. Gait and station normal, ambulates unassisted. Her incision is healing nicely. **Impression**: Two months status post 2-level cervical fusion. **Plan**: The patient is reluctant to go back to work because of the pain anticipation with that. I told her that she could take 2 Aleve once or twice a week for episodic pain without affecting the safety refusion. More persistent use of that could jeopardize her success of fusion. She understands that. We would like to stay away from anti-inflammatories for 6 months postoperatively if possible. Once in a while usage is not associated with known complications. She understands that, and she will return in the next follow up period at 3 months, and she will contact us when she would like to have a release to return to work at a desk job using computers.	174
07/29/YYYY	Facility/Provider Name	**Follow-up visit for neck pain:** **Subjective:** I saw Ms. XXXX in the office today. Since her last appointment here, she has had some episodes with a right-sided lower right neck catch when she turns her head to the right side. This happens from time to time. She does not feel the frequency is increasing or decreasing. She says it takes about an hour or two to subside when it occurs. She no longer has the radiating right upper extremity pain syndrome or the breathtaking pain in the neck that she had prior to the surgery. She is happy about that. **Physical examination:** She is awake and alert. Cranial nerves are intact. I would say 50% normal range of motion with left head turning, 40% right head turning, 40% to 50% flexion and extension. Normal motor and sensory upper and lower extremities, l+ DTRs.	177

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		Impression: Two and a-half month status post anterior cervical diskectomy and fusion, C5-6, C6-7. **Plan:** Physical therapy. I discussed pain management with the patient in terms of injections, and she does not feel that her symptoms are severe enough to warrant that. She is fearful of pain management, as she attributes it to the death of her husband in the past. I have reassured her that the pain management process may involve pain-relieving injections, and she is going to consider that if she is not able to achieve satisfactory relief with physical therapy and: Aleve each morning and morning of therapy. I will see her back for her regularly scheduled appointment**.**	
08/05/YYYY	Facility/Provider Name	**Telephone conversation for pain management:** **Patient Call For:** XXXX M.D., **Summary of Call:** Ms. XXXX, called today to report that she would like to move forward with pain management at this time. I informed the patient that the referral will be re-written and we will proceed with have her referred to pain management. She verbalized understanding of this.	178
08/13/YYYY	Facility/Provider Name	**Office visit for diabetes mellitus:** **Assessment and plan**: Essential (primary) hypertension, Type 2 diabetes mellitus without complications **Plan:** Repeat labs today, continue Glimepiride the 4 mg, stressed a strict DM (Diabetes Mellitus) diet, will get lab results gastro-esophageal reflux disease without esophagitis. **Reviewer's comments: This visit is not elaborated since it was unrelated to the injury*	54–56
09/09/[redacted]	Provider Name	**Office visit for neck and back pain**: **Chief Complaint**: Neck and Back **History of Present Illness**: Neck pain that radiates into Right shoulder and Back pain. The quality of pain is described as constant, aching, sharp, burning Neck - constant aching, sharp, dull burning Back - Sometimes aching and a severity / intensity level of 8 out of 10 8/10 - Neck 5/10 - Back. 8/12/YYYY Patient presents today for an IOV. She was involved in an MVA on 12/1/YYYY. Patients states that she was the diver of a 4 door car when a car rear ended her while she was at a complete stop. No air bag deployment and no loss of consciousness. She was treated the following day at XXXX Regional where X-rays were taken, she was treated and released. Her PCP referred to her for chiropractic care where she received therapy and MRI ordered. Dr. XXXX referred her to Dr. XXXX who did a C5-6 and C6-7 ACDF in May YYYY. Primary complaint today is neck pain with radiation into the Right shoulder. She also complains of depression since the MVA and surgery. She is less than 3 months since the ACDF. 09/09/YYYY Patient presents today for routine follow-up. She states she is still having continued back and neck pain. She states the neck pain radiates to the right shoulder. Currently, she rates her pain a 5/10. She says she was taking pain	188–194

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		medications at her last visit, but she didn't feel any relief from them so she quit taking them. 06/20/YYYY Envision Imaging Cervical Spine X-ray 1. Straightening of the normal cervical lordosis. 2. Interval ACDF from C5-C7. 3. Disc space narrowing at C4/5 with mild generalized facet hypertrophy. 4. Prominent styloid processes which can be seen with Eagle Syndrome **Review of system:** **General:** Positive, fatigue/malaise/lethargy, significant weight gain **HEENT:** Positive, vision changes, sinus trouble **Neck:** Positive, pain, stiffness **Physical examination:** **Musculoskeletal:** Cervical: 3+ pain with flexion, Right lateral bending and Right rotation. 2+ pain with Left lateral bending, Left rotation and extension. *MRI of cervical spine on 08/24/YYYY was reviewed* **Assessment and plan**: She continues to have significant neck pain since the surgery. She was referred to Dr. XXXX for depression and was prescribed Cymbalta and Elavil. Reports not having much relief with Percocet so she does not take it. Discussed future treatment options. Return to check in 2 months.	
09/10/YYYY	Facility/Provider Nam	**Psychiatric visit for sadness:** Patient presented for treatment for sadness, crying spells, irritable mood, isolation and nervousness after a motor vehicle crash in December YYYY. At this session patient also reported feeling guilt, anxiety triggered by roadway cues and insomnia. At this session patient appeared well groomed, her mood was moderately depressed, moderately anxious and mildly irritable. Patient was tearful throughout the session. The psychiatric plan for the session: Start Cymbalta 20 mg by mouth in the morning. Start Elavil 10 mg, by mouth at bedtime as needed for sleep. Refer for counseling.	185
09/27/YYYY	Facility/Provider Name	**Follow-up visit for depression:** At this session patient and her counselor completed an intake assessment. She stated, I was wreck in December YYYY my life changed dramatically. **Plan for therapy:** Counselor and patient will continue counseling session every five to seven day utilizing CBT (Cognitive Behavioral Therapy) intervention to address hopelessness, stress and trauma.	197
10/25/YYYY	Facility/Provider Name	**Follow-up visit for depression:** Ms. XXXX stated, "I am in a lot of pain and my life been pretty efficient. I just want to feel better." Patient reports more depression, anxiety, and believing she doesn't have control over her life. Patient counselor reviewed coping skills. **Plan for therapy:** Ms. XXXX and counselor will continue to utilize CBT interventions to reduce depression. Follow-up in two weeks.	198

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10/30/YYYY	Facility/Provider Name	**Follow-up visit for depression:** Ms. XXXX stated, "I'm not crying as much. Every now and then I start crying out of nowhere." She also described symptoms of social avoidance. At this session, Ms. XXXX appeared well groomed. Her mood was mildly to moderately depressed and anxious, and mildly irritable. She elaborated on her mood, "Being aggravated is normal now." The psychiatric plan for this session: Increase Cymbalta to 30 mg by mouth in the morning. Continue other medications unchanged. Keep scheduled appointment with Dr. XXXX.	200
11/05/YYYY	Facility/Provider Name	**Follow-up visit for neck pain:** **HPI:** Neck pain. The quality of pain is described as constant, aching, sharp, dull, burning, radiating pain neck radiates to right shoulder and a severity / intensity level of 5 out of 10. 7/10 - Neck 5/10 - Back. Primary complaint today is neck pain with radiation into the right shoulder. She also complains of depression since the MVA and surgery. She is less than 3 months since the ACDF. Patient presents today for follow-up appointment. She continues to complain of neck pain that radiates to her right shoulder and back pain that she says changes in location daily. **Review of systems:** **General:** Positive, fatigue/malaise/lethargy, significant weight gain **HEENT:** Positive, vision changes, sinus trouble **Neck:** Positive, pain, stiffness **Respiratory:** Positive, wheezing Snoring **Gastrointestinal:** Positive, heartburn **Musculoskeletal:** Positive, backache, knee pain, hip pain **Physical examination:** Cervical: 3+ pain with flexion, Right lateral bending and Right rotation. 2+ pain with Left lateral bending, Left rotation and extension. **Assessment and plan:** She continues to have significant neck pain since the surgery. PA from Dr. XXXX's office has recommended PT, no arrangements have been made as of yet. Will proceed with RFA as previously discussed once 6 months post op. return 4 weeks post op	204–209
11/11/YYYY	Facility/Provider Name	**Follow-up visit for neck pain:** **Subjective:** I saw Ms. XXXX in the office today. She is now 6 months status post her anterior cervical discectomy and fusion two-level at C5-C6 and C6-C7. The patient tolerated the procedure well and says she definitely has improvement of her neck pain and radiating arm pain. She still has some residual pain on the right side of her neck that she is seeing Dr. XXXX for. They are entertaining the ideal of possible further treatments involving interventional procedures. **Impression:** Six months status post two-level anterior cervical discectomy and fusion with residual pain syndrome, possibly facet-mediated.	213

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		Plan: MRI scan of the cervical spine without contrast. If uneventful surgically, then she can pursue interventional treatments with Dr. XXXX and we will see her back on an as-needed basis going forward**.**	
11/18/YYYY	Facility/Provider Name	**Psychiatric evaluation:** *History reviewed* Ms. XXXX was referred to EMW by her pain manager, Dr. XXXX, for evaluation and treatment of "Major depressive disorder" after a motor vehicle crash on 12/01/YYYY. I ask her chief psychiatric complaint and Ms. XXXX responds, "The way I feel," and, "My husband says I'm a crier." She adds, "And of course the pain." She continues, "Since I was a teenager, I've always worked. I had finally gotten to where I wanted to be.. " She explains, "I had surgery, then I lost my job at Amerisafe... " She indicates she has a history of depression, but her mood problems have increased since the motor vehicle crash. She describes lack of motivation which is out-of-character and states, "I've always been the type to just buckle down." On further review of symptoms, Ms. XXXX describes insomnia which is marked by fractured sleep patterns, although these have improved with time and treatment. She states, "I'm sleeping more than I was four ... four, five {hours) now" (clarification added). She reports her recent typical sleep profile is from approximately 12:00 am to 4:00 am. She describes decreased interest, and decreased engagement, in prior hobbies and leisure pursuits. She states she previously enjoyed, "A lot of family stuff...Church stuff ... Bowling ... " She indicates she has also reduced, "Going to ball games. I LSU game. ... Now I can't sit in the bleachers and be comfortable." She adds, "Can't even get into Dad's pool." I ask about her energy and she describes variable energy levels, and she feels her fatigue is linked to her pain. She endorses poor concentration and states, "It's kinda hard." She also endorses out-of-character irritability and states, "I find myself getting aggravated." She reports a variable appetite accompanied by a post-crash weight loss of over 20 pounds. She weighs 291 pounds in the clinic on a medical scale the date of my comprehensive assessment. She weighed 303 pounds in September on the date of her first clinical visit with Mr. XXXX. I ask her about anxiety. She describes specific, triggered anxiety symptoms that present, "When I get behind the wheel of a car." She also describes social avoidance. I ask about sexual function and Ms. XXXX describes decreased sexual activity due to low interest and, "Scared I'm gonna hurt my neck." She indicates she and her husband were typically physically intimate, "At least once or twice a week," prior to the motor vehicle crash. She states the frequency of their intimacy has decreased to, "None since this wreck." I ask if she is experiencing any other distressing symptoms and Ms. XXXX states, "I recognized when I get depressed ... don't wanna clean don't wanna go anywhere ... " She continues, "My husband and I were the life of the party before." She adds, "I don't feel like myself at all." On mental status exam, Ms. XXXX appeared somewhat unkempt, and mildly tired. She was fully oriented to time, place, person, and the overall situation. Her attitude was friendly and cooperative. I observed her motor state to be moderately hypoactive. Her speech was soft and slow without significant linguistic abnormalities. Her thought process was coherent, logical, and goal directed. She preserved the ability to form abstractions and displayed no evidence of a thought disorder. I observed mild cued symptoms. Her thought content was notable for poverty of ideas in the form of mild negative rumination about her physical health.	216–241

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		She denied both suicidal and homicidal thinking and appeared to be future oriented. Her mood was moderately depressed, mildly to moderately anxious, and mildly irritable. Her affect was mood congruent and moderately constricted, but non-labile. Ms. XXXX's cognitive functioning and memory were within normal limits. Her judgment and insight appeared to be intact. Overall, I estimated she represented a low substance withdrawal risk and a low formal safety risk. Her reported symptoms were consistent with my observations on mental status examination. In summary, I consider the five psychometric tests sufficiently consistent with one another. The results were consistent with the psychiatric diagnostic interview. The results support the diagnostic conclusions below. **Diagnoses** Non-Axial Diagnoses Derived from Psychiatric Interview, Psychometric Battery, and Review of Available Medical Records, per the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (American Psychiatric Association, YYYY), are as follows: **1) Major Depressive Disorder, Recurrent Episode, Severe without Psychotic Features** (MDD F33.2), pre-existing but exacerbated. Ms. XXXX displays greater than a year of clinically relevant depressive symptoms, with continuous treatment for nearly three months. She had been free from significant depression for many years and does not believe she has taken medications for mood or anxiety since roughly 2004. The current depressive episode was caused by a motor vehicle crash with significant cervical spinal injuries. Her depressive symptoms have been perpetuated by her musculoskeletal and [illegible] pain. Ms. XXXX meets the following DSM-5 Major Depressive Episode criteria Al (greater than two weeks of depressed mood, apathy, low energy, joylessness, and irritability), 2 (marked reduction in her prior leisure activities such as going to church and engaging in church events, bowling, swimming in her father's pool, and engaging in family social events), 3 (variable appetite, although there has been a recent weight loss associated with starting two new medications at EMW in September YYYY), 4 (insomnia with ongoing difficulty remaining asleep despite treatment with a sedative medication), 5 (moderately hypoactive motor state), +/6 (variable low energy, seemingly linked to her daily pain burden); B; C; D; E. The diagnosis is supported by the presently completed psychometric testing, and both the PHQ·9 and 801-11 suggest Medical Major Depression. The depression scale within the TSl-2 was also elevated. **2) Other Specified Trauma- and Stressor-Related Disorder** (F43.8; Subsyndromic PTSD). After her involvement in a motor vehicle crash with significant cervical spinal injuries, Ms. XXXX has developed clinically relevant symptoms which have persisted. Although her symptoms do not fully and independently satisfy the full the DSM-5 criteria for PTSD, she meets the following DSM·S PTSD criteria: Al (motor vehicle crash associated with significant injuries, and a marked fear response at the time of the crash); 04 (mild negativity), 5 (marked reduction in her prior leisure and recreational activities), 6 (social withdrawal and decreased engagement with family and friends); E1 (mild observable irritability), 6 (ongoing sleep maintenance problems despite pharmacological treatment); F, G, H. She has no pre-crash history of trauma-related illness. The presently completed psychometric tools support the OTSRO/PTSD diagnosis, and both the PCL·C and the TSI-2 are consistent with formal PTSD.	

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		3) Tobacco Use Disorder (TUD; F17.200) Also, of note, Ms. XXXX is not engaged in any illicit substance use or any level of alcohol use which would be reasonably predicted to predispose, precipitate, perpetuate, or exacerbate her cognitive or behavioral health symptoms. Although she is smoking about a half pack of cigarettes per day, her tobacco use represents an independent treatment target, and I do not estimate it is materially causing or perpetuating her cognitive or psychiatric symptoms. In fact, on the contrary, her cognitive and psychiatric symptoms may be making it harder for her to completely quit smoking. I estimate her present Global Assessment of Function (GAF) score to be 58. Since the crash, with significant cervical spinal injuries, it has been no higher than 60. I estimate her GAF prior to the crash and injuries was 78. All opinions are held to a reasonable degree of medical certainty and are based on the available evidence. Should new information become available, my opinions are subject to change. **Treatment:** Ms. XXXX agrees to the following treatment with informed consent: Psychiatric Medications and Medical Management: • Ms. XXXX agrees to continue her psychiatric care via the team and me at Elite Medical Wellness. • Ms. XXXX is presently prescribed, and taking, the SNRI Duloxetine/Cymbalta, at the low conservative dose of 30 mg by mouth every day. She reports she is not experiencing any intolerable side effects, but she describes incomplete efficacy to date. Ms. XXXX and I again discussed the potential risks, benefits, and side effects of this agent. She has lost over 10 pounds since starting this agent. We also discussed her holistic health, and other target symptoms. She agrees to a trial of the Norepinephrine-dopamine reuptake inhibiting (NDRI) medication Bupropion/Wellbutrin/Zyban, at the lowest dose in the sustained release (SR) preparation, 100 mg. This addition is intended to offer greater improvement in her low energy, and greater reduction of her anhedonic depressive symptoms. This NORI is also FDA labeled for smoking cessation, and as one half of the weight loss medication, Bupropion-Naltrexone/Contrave, it is often associated with weight loss. • Ms. XXXX has been taking a low dose of the sedative tricyclic antidepressant (TCA) Amitriptyline/Elavil, 10 mg by mouth every night. She vocalizes improvement in her sleep, although she persists with total sleep of only four to five hours per night. She also continues to need the benzodiazepine hypnotic, Temazepam/Restoril, which was prescribed by her neurosurgeon. Accordingly, I offered her, and she accepts, a trial of increasing the Amitriptyline/Elavil to 25 mg tablet, one half to one (12.5 to 25 mg) by mouth every night, while trying to hold the Temazepam/Restoril. • I requested Ms. XXXX sign an ROI for her PCM Dr. XXXX, her pain manager Dr. XXXX, and her neurosurgeon Dr. XXXX. In addition to data gathering, these ROI permits will allow for coordination of multi-disciplinary clinical care moving forward. • I have requested a copy of Ms. XXXX's labs on a release of information permit (ROI). Should laboratory study results prove to be unavailable, incomplete, or outdated, I will likely reorder another set including a complete blood count, thyroid panel, full chemistry with liver function tests, C-reactive protein, erythrocyte sedimentation rate, fasting lipids, and a vitamin D level. • Diet and generalized wellness promotion will be a focus of Ms. XXXX's holistic treatment. Should there be any challenges during routine physician-level treatment, I may refer her to a Clinical Dietician and/or Certified Health Educator. I will advise her of, and encourage, a diet which approximates the	

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		Mediterranean diet, a whole food diet, or the DASH diet. • Ms. XXXX should regularly engage in low-impact exercise such as walking or riding a bicycle, provided it is permitted by her primary care manager, pain manager, and spinal surgeon. Healthy activity including regular exercise is psychiatrically assistive and has been shown, in multiple research studies, to confer a treatment effect on the order of medication interventions. At a minimum, supervised exercise in the protective environment of physical therapy may be beneficial, although I defer formal PT referral to her pain manager and surgeon. • Next psychiatric follow-up appointment was directed to be booked 14 to 28 days from the date of my comprehensive assessment. **Psychotherapy:** 1) Mr. XXXX referred Ms. XXXX for psychotherapy, and she has initiated care with Mr. XXXX. a. I recommend CBT-based therapy no less than four times monthly, for at least the next six to twelve months. b. The CBT targets are recurrent symptoms of anhedonic and apathetic depression, with an overlay of trauma-induced symptoms. c. The recommendation for therapy includes an initial burst pack of visits following evidence-based guidelines and standards of care. A course of PE typically lasts eight to 15 sessions, while a course of CPT typically lasts 12 sessions. The modality EMOR can be completed in 12 sessions, as well. Non-manualized trauma focused CBT (TF-CBT) can be more variable in its scheduling. d. However, Ms. XXXX's response to treatment will help forecast the overall length, frequency, and intensity of her psychotherapy. e. The standard of care is these courses are often modified to best fit the patient's scheduling realities and preference, treatment response, and symptom trajectory	
11/20/[redacted]	[redacted] Provider Name	**Follow-up visit for depression:** On November 18, YYYY, she was seen at the office of Elite Medical Wellness. At this session, Ms. XXXX stated, "I have so much in my life and my pain. I worry all the time." Patient and counselor processed her fears, coping with pain, and loss of identity and independence since the accident. **Plan for therapy:** Ms. XXXX and counselor will continue utilizing CBT to reduce anxiety and depression, gain in a sense of purpose, and encourage mindfulness.	217
12/06/YYYY	Facility/Provider Name	**MRI of cervical spine without contrast:** **History**: Subsequent encounter to evaluate chronic neck pain. Patient had attempted cervical fusion on 05/20/YYYY. **Findings:** The central canal is small on a developmental basis. Air-fluid level seen within the sphenoid sinus. The visualized posterior fossa is unremarkable. Anterior endplate screw device and intradiscal fusion material noted at C5-C6 and C6-C7. There is straightening of the cervical spineC2-C3: The central canal is small measuring 9.6 mm in AP diameter. Preserved CSF (Cerebrospinal Fluid) signal surrounding the cord. There is facet hypertrophy without foraminal stenosis. **C3-C4:** Central canal is small measuring 9.6 mm in AP diameter. Preserved CSF signal surrounding the cord. There is facet hypertrophy without foraminal stenosis. **C4-C5:** Disc space narrowing and anterior spurring. Central disc	245–247

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		protrusion/herniation resulting in mild central canal stenosis. The AP diameter of the central canal measures 9.6 mm. Mild flattening of the cord. CSF signal ventral to the cord is partially effaced. There is facet hypertrophy without foraminal stenosis. **C5-C6:** Central posterior spondylosis resulting in mild central canal stenosis. The AP diameter of the central canal measures 9 mm. Preserved CSF signal surrounding the cord. Facet hypertrophy without foraminal stenosis. **C6-C7:** Posterior spondylitic ridging resulting in mild to moderate central canal stenosis. The AP diameter of the central canal measures 8.6 mm. **C7-T1:** There is low signal within the epidural space posterior to the posterior longitudinal ligament at the mid C7 level. This extends from the C6-C7 to the C7-T1 disc space and may represent extruded disc material or thickening of the posterior longitudinal ligament. This results in mild-to moderate central canal stenosis at the mid C7 level. The AP diameter of the central canal measures 8.4 mm. **Impression:** • The central canal is small on a developmental basis. Status post ACDF at C5-C6 and C6-C7. There is straightening of the cervical spine. • Diffuse facet hypertrophy. • Central disc protrusion/herniation at C4-C5 resulting in mild central canal stenosis. • Mild central canal stenosis at C5-C6 secondary to posterior spondylitic ridging. • Mild-to-moderate central canal stenosis at C6-C7 secondary to posterior spondylitic ridging. • Moderate to severe bilateral foraminal stenosis. • Low signal extending posterior to the C7 vertebral body suggesting extruded disc material or thickening of the posterior longitudinal ligament. This results in mild-to-moderate central canal stenosis at the mid C7 level. Mild bilateral foraminal stenosis at C7-T1. • Moderate to severe right foraminal stenosis at T1 -T2.	
12/08/YYYY	Facility/Provider Name	**Follow-up visit for neck and back:** **Chief Complaint**: Neck and Back **History of Present Illness**: Neck pain that radiates into right shoulder and back pain. The quality of pain is described as constant, aching, sharp, dull, burning Neck - constant aching, sharp, dull burning Back - Sometimes aching and a severity / intensity level of 8 out of 10. 8/10 – Neck. 5/10 – Back **Review of Systems**: **General:** Positive, fatigue/malaise/lethargy, significant weight gain **HEENT:** Positive, vision changes, sinus trouble **Neck:** Positive, pain, stiffness **Physical exam:** **Musculoskeletal:** Cervical: 3+ pain with flexion, right lateral bending and right rotation. 2+ pain with left lateral bending, left rotation and extension. **Assessment:** She continues to have significant neck pain since the surgery. She also is suffering from depression.	179–184

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		Plan: RTC (Return to Check) 1 month Refer to Dr. XXXX for depression treatment. Consider interventional management after an appropriate healing period. (Bilateral C3/4, C4/5 DMBB (Diagnostic Medical Branch Block).	
12/10/YYYY	Facility/Provider Name	**Follow-up visit for depression:** On December 3, YYYY, Ms. XXXX was seen by XXXX, LPC, at the office of Elite Medical illness. At this session, Ms XXXX stared, "I feel so defeated. The holidays have taken a toll on me." Patient and counselor processed her fears, depression, and feelings of purposelessness. She is making life-style changes, such as healthy eating, positive thinking, prayer and improving communication. **Plan for therapy:** Ms XXXX and counselor will continue utilizing CBT and coping skills to reduce depression, anxiety. feelings of being overwhelmed	244
01/07/YYYY	Facility/Provider Name	**Follow-up visit for neck and back pain:** **Chief Complaint:** MBB/ Facet Injection **History of Present Illness**: neck pain: The quality of pain is described as constant, aching, sharp, dull, burning, radiating pain neck radiates to right Shoulder and a severity/intensity level of 5 out of 10 7/10 Neck. 5/10 - Back. Patient presents today for right C5-6, C6-7 DMBB. **Review of Systems**: **General:** Positive, fatigue/malaise/lethargy, significant weight gain **HEENT:** Positive, vision changes, sinus trouble **Neck:** Positive, pain, stiffness **Physical exam:** **Musculoskeletal:** Cervical: 3+ pain with flexion, right lateral bending and right rotation. 2+ pain with left lateral bending, left rotation and extension. **Assessment**: Right C5/6 and C6/7 D-MBB discussed to include the procedure as well as expectations. All questions answered to her satisfaction. **Plan:** **Procedure:** 1. Cervical dorsal medial branch blocks 2. Fluoroscopic needle localization **Medical necessity:** The patient has failed all conservative therapy up to this point. The patient has tried pharmacological intervention, also physical therapy if tolerated. Although the patient may be a surgical candidate, my patient has elected to choose interventional treatment to potentially avoid surgery. At this time the patient feels their function has deteriorated. The patient would like to proceed with interventional therapy and modalities in an attempt to improve their pain and function. Should interventional pain management not be successful, surgery may be indicated. Prior to the procedure, the patient was informed of the risks, options, and benefits of	350–361

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		the elected procedure, but not limited to the potential for: increased pain, no pain relief, bleeding, infection, nerve injury, dural puncture headaches, spinal cord injury, pneumothorax, difficulty breathing, potential paralysis, loss of use of one or more extremities, stiff neck/ back, medication/ steroid reaction, muscle spasms, elevated blood pressure, elevated glucose, swelling, CHF, and difficulty sleeping. The patient understood, was given opportunity for question/ answer dialogue, agreed for the procedure, and consent form was obtained. **Recovery:** The patient was transferred to recovery area awake, alert, and conversant; and was discharged to home when the appropriate criterion was met.	
01/14/YYYY	Facility/Provider Name	**Follow-up visit for depression:** On January 14, YYYY, Ms. XXXX was seen by XXXX, LPC, at the office of Elite Medical Wellness. At this session, Ms. XXXX stated, "I am worrying a lot and I get so down on myself." She described feelings of worthlessness without her occupation. Patient and counselor worked on mindfulness and coping skills. **Plan for therapy**: Ms XXXX and counselor will continue using CBT to work to reduce depression anxiety, and trauma response.	366
01/20/YYYY	Facility/Provider Name	**Follow-up visit for neck pain:** **Chief Complaint**: Procedure follow up **History of Present Illness**: Neck pain The quality of pain is described as constant, aching, sharp, dull, burning, radiating pain neck radiates to RT Shoulder and a severity/intensity level of 3 out of 10 3/10 – Neck 2/10 – Back Patient presents today for post-op visit following a right C5-6, C6-7 DMBB performed on 01/07/20. She has stated, "relief from procedure and decrease in pain." She rates pain 2/10 today. **Review of systems**: **General:** Positive, fatigue/malaise/lethargy, significant weight gain **HEENT:** Positive, vision changes, sinus trouble **Neck:** Positive, pain, stiffness **Musculoskeletal:** Positive back ache and knee pain **Physical exam:** **Musculoskeletal:** Cervical: 1+ pain with flexion, right lateral bending and right rotation. 1+ pain with left lateral bending, left rotation and extension. **Assessment:** Patient states she received 80-90% relief of pain the day of her procedure. She still states that she has some relief but is not at the 80-90% that she had the day of the procedure. She stated approximate 3 days after the procedure the symptoms started to return. Patient states that her pain is not as bad as it was prior to the procedure but she still has pain Patient states that she would like to proceed with scheduling the RFA. She will follow up in our office in 4 weeks post procedure for evaluation. **Plan:** RFA (Radiofrequency Ablation) right C5-6 and C6-7 ordered today.	372–383

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		Return to clinic 4 weeks post-procedure.	
01/21/YYYY	Facility/Provider Name	**Follow-up visit for neck pain:** **Subjective:** I saw Ms. XXXX in the office today. She is now 8 months status post anterior cervical discectomy and fusion at C5/6 and C6/7 She states that her preoperative neck pain and radiating arm pain have improved. She continues to have some residual right-sided neck pain and has been following up with Dr. XXXX for medial branch blocks and has a radiofrequency ablation scheduled in the upcoming weeks. **Objective**: On physical examination, she is awake and alert. Cranial nerves are intact. She has 75% range of motion of the head neck in all directions. Sensory and motor functions o the upper lower extremities are grossly intact with l+ DTRs **Imaging**: MRI scan of the cervical spine without contrast done at Envision imaging on 12/06/YYYY demonstrates postoperative changes at C5/6, C6/7 **Impression**: Eight months status post 2-level anterior cervical discectomy and fusion at C5-6 and C6-7 with residual pain syndrome, facet-mediated. **Plan:** Patient to continue follow up with Dr. XXXX for interventional treatments of her cervical spine. Dr. XXXX met with the patient and discussed the diagnosis and treatment plan. We will see the patient back on an as needed basis.	384
02/06/YYYY	Facility/Provider Name	**Follow-up visit for depression:** On January 9, YYYY, Ms. XXXX was seen by XXXX, LPC, at the office of Elite Medical Wellness. At this session, Ms. XXXX reported decreased depression, but persistent ruminating anxiety and phobia of driving. Her counselor worked on mindfulness and positive thinking paradigm. **Plan for therapy**: Ms. XXXX and her counselor will continue therapy every two weeks working on CBT interventions**.**	362
02/11/YYYY	Facility/Provider Name	**Follow-up visit for neck and back pain:** **Chief Complaint:** RFA **History of Present Illness**: Neck pain that radiates into right shoulder and back pain. The quality of pain is described as constant, aching, sharp, burning Neck - constant aching, sharp, dull burning Back - Sometimes aching and a severity / intensity level of 8 out of 10 8/10 – Neck 5/10 – Back Patient presents today for a Right C5/6, C6/7 RFA. **Review of Systems**: **General:** Positive, fatigue/malaise/lethargy, significant weight gain **HEENT:** Positive, vision changes, sinus trouble **Neck:** Positive, pain, stiffness **Musculoskeletal:** Positive, backache, knee pain, hip pain **Physical exam:** **Musculoskeletal:** Cervical: 3+ pain with flexion, right lateral bending and right	390–395, 398–403

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		rotation. 2+ pain with left lateral bending, left rotation and extension. **Assessment**: Right C5/6 and C6/7 RFA discussed to include the procedure as well as expectations. All questions answered to her satisfaction. **Plan:** **Procedure:** 1. Radiofrequency thermocoagulation of the cervical dorsal median branches 2. Fluoroscopic needle localization recovery **Medical necessity:** The patient has failed all conservative therapy up to this point. The patient has tried pharmacological intervention including pain medications, anti-inflammatories, muscle relaxers, and other medications as indicated, also physical therapy if tolerated. Although the patient may be a surgical candidate, my patient has elected to choose interventional treatment to potentially avoid surgery. At this time the patient feels their function has deteriorated. The patient would like to proceed with interventional therapy and modalities in an attempt to improve their pain and function. Should interventional pain management not be successful, surgery may be indicated. Prior to the procedure, the patient was informed of the risks, options, and benefits of the elected procedure. The patient understood, was given opportunity for question/answer dialogue, agreed for the procedure, and consent form was obtained. **Recovery:** The patient was transferred to recovery area awake, alert, and conversant, and was discharged to home when the appropriate criteria was met. The patient was instructed to contact my office if any complications or problems arise including any significant increase in pain, or if any complications or reactions occur. The patient agreed.	
02/19/YYYY	Facility/Provider Name	**Follow-up visit for depression:** On January 14, YYYY, Ms. XXXX was seen by XXXX, FPMHNPBC at the office of Elite Medical Wellness. At this session, Ms. XXXX stated, "I'm doing good. I don't feel so overwhelmed anymore when I'm driving." She added, "I still don't like to be around people."For this appointment, Ms. XXXX demonstrated real-world avoidance. Her thought content was no table for mild somatic negative rumination. She was mildly to moderately depressed and anxious, and trace irritable. **The psychiatric plan for this session**: Continue medications unchanged. Continue psychotherapy Follow up in 4 to 6 weeks.	389
02/26/YYYY	Facility/Provider Name	**Follow-up visit for depression:** On January 28, YYYY, Ms. XXXX was seen by XXXX, LPC, at the office of Elite Medical Wellness. At this session, Ms. XXXX stated, "I am doing ok. Stress is getting me too worried. I just worried about so much." She and her counselor worked on goals for the future and coping skills. **Plan for therapy**: Ms. XXXX will continue therapy every two weeks utilizing CBT interventions to work on developing coping skills.	386
03/09/YYYY	Facility/Provider Name	**Follow-up visit for neck pain:** **Chief Complaint:** Procedure Follow Up	406–410

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		History of Present Illness: Neck pain that radiates into right shoulder and back pain. The quality of pain is described as constant, aching, sharp, burning, neck - constant aching, sharp, dull burning Back - Sometimes aching and a severity / intensity level of 8 out of 10 8/10 Neck 5/10 – Back Primary complaint today is neck pain with radiation into the right shoulder. She also complains of depression since the MVA and surgery. She is less than 3 months since the ACDF. Patient presents today for procedure follow up for right C5/6, C6/7 RFA that was performed on 02/11/YYYY. She states that she has constant neck aching pain that gets sharp pains at times. She rates her pain 4/10 today. **Review of Systems**: **General:** Positive, fatigue/malaise/lethargy, significant weight gain **HEENT:** Positive, vision changes, sinus trouble **Neck:** Positive, pain, stiffness **Musculoskeletal:** Positive, backache, knee pain **Physical exam:** **Musculoskeletal:** Cervical: 1+ pain with flexion, right lateral bending and right rotation. + pain with left lateral bending, left rotation. Complaints of tightness into bilateral trapezius with rotation of neck **Assessment**: Range of motion of neck has improved and pain has greatly decreased since RFA. I recommend to continue to monitor the progression of pain relief status post RFA. Patient will follow up in 6 weeks for further evaluation. All patient's questions were answered to her satisfaction. Patient stated understanding of everything discussed on today's visit **Plan**: 1. Continue to monitor pain relief status post RFA. 2. Return to clinic in 6 weeks for re evaluation	
04/07/YYYY	Facility/Provider Name	**Follow-up visit for depression:** On March 10, YYYY, Ms. XXXX was seen by XXXX, LPC, at the office of Elite Medical Wellness. At this session, Ms. XXXX stated, "I am really struggling with depression and my family (relationships)" (clarification added). She and her counselor discussed communication skills and boundaries. They also worked to process and replace self blame with encouragement. **Plan for therapy**: Ms. XXXX will continue therapy every two weeks utilizing CBT interventions to reduce depression and anxiety.	412
04/11/YYYY	Facility/Provider Name	**Follow-up visit for depression:** On March 24, YYYY, Ms. XXXX was seen by XXXX, LPC, via telehealth through the office of Elite Medical Wellness. At this session, Ms. XXXX stated, "I am just so stressed by all this corona stuff. This is just so much to handle on top of what I was already dealing with .... " She and her counselor processed anxiety and	415

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		depression. They also worked on coping skills, positive reframing, mindfulness, and self-care. **Plan for therapy**: Ms. XXXX will continue therapy every two weeks utilizing CBT interventions to reduce depression, anxiety, and trauma**.**	
04/12/YYYY	Facility/Provider Name	**Follow-up visit for depression:** On March 31, YYYY, Ms. XXXX was seen by XXXX, FPMHNPBC via telehealth through the office of Elite Medical Wellness. At this session, Ms. XXXX stated, "I still worry a lot and feel restless." She reported racing and intrusive thoughts. For this appointment, Ms. XXXX's thought content was notable for negative rumination about her physical symptoms and financial concerns. Her mood was mildly depressed, trace irritable, and mildly to moderately anxious. The psychiatric plan for this session: Increase Elavil to 25 mg, one to two tablets at night as needed for sleep. Continue other medications unchanged. Continue psychotherapy. Follow up in four to six weeks.	420
04/12/YYYY	Facility/Provider Name	**Follow-up visit for depression:** On March 31, YYYY, Ms. XXXX was seen by XXXX, LPC, via telehealth through the office of Elite Medical Wellness. At this session, Ms. XXXX stated, "This isolation is so difficult and my sleep is so bad and my anxieties out of control." She and her counselor processed her anxiety and continued to work on coping skills and CBT plans. **Plan for therapy**: Ms. XXXX will continue therapy every two weeks utilizing CBT interventions to reduce depression, anxiety, and trauma**.**	418
04/27/ [redacted] Provider Name		**Follow-up visit for depression:** On April 14, YYYY, Ms. XXXX was seen by XXXX, LPC, via telehealth through the office of Elite Medical Wellness. At this session, Ms. XXXX stated, "I am just getting more down, I get in pain and it affects my mood." She and her counselor processed and worked on mindfulness in regard to pain management and self-care. **Plan for therapy**: Ms. XXXX will continue therapy every two weeks utilizing CBT interventions to work on positive coping skills**.**	500
05/01/YYYY	Facility/Provider Name	**Follow-up visit for depression:** On April 27. YYYY, Ms. XXXX was seen by XXXX, LPC, via telehealth through Elite Medical Wellness. At this session. Ms. XXXX stated, "The quarantine is hard. I haven't seen my grandchildren. l felt overwhelmed. "Within this session. Ms. XXXX and her counselor employed talk therapy and mindful interventions to improve the patient's mood, depression, and anxiety. The counselor noted Ms. XXXX is gaining insight, but is struggling with isolation. **Plan for therapy**: Ms. XXXX will follow-up with counselor for Cognitive Based Therapy.	501
05/19/YYYY	Facility/Provider Name	**Follow-up visit for depression:** On May 12, YYYY, Ms. XXXX was seen by XXXX, LPC, at the office of Elite	502

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		Medical Wellness. At this session, Ms. XXXX stated, "I am doing better, a little less depressed, things are a little more hopeful." She reported difficulty with social isolation and uncertainty in her future She and her counselor employed Cognitive Behavioral Therapy to address depression, anxiety, and improving her outlook. **Plan for therapy**: Ms. XXXX will continue therapy every two weeks utilizing CBT interventions to work on healthy coping skills**.**	
05/27/YYYY	Facility/Provider Name	**Follow-up visit for depression:** On May 12, YYYY, Ms. XXXX was seen by XXXX, FPMHNPBC at the office of Elite Medical Wellness. At this session, Ms. XXXX stated she was, "Up and down." She also stated "My medications are pretty much on point " For this appointment, Ms. XXXX's thought content was notable for mild negative rumination about her physical limitations and finances. Her mood was trace to mildly depressed and anxious and trace irritable. **The psychiatric plan for this session**: Continue medications unchanged. Continue psychotherapy. Follow up in 8 to 12 weeks.	506
05/27/YYYY	Facility/Provider Name	**Follow-up visit for depression:** On May 26, YYYY, Ms. XXXX was seen by XXXX, LPC, at the office of Elite Medical Wellness. At this session, Ms. XXXX stated, "I am working on my irritation. It's hard, I hurt all the time and it makes me so frustrated." She and her counselor processed her frustration, which she acknowledged stems from fear. **Plan for therapy**: Ms. XXXX will continue therapy every two weeks utilizing CBT interventions to work on healthy coping skills such as socializing with family.	503–504
05/28/[redacted]	Provider Name	**Initial physical therapy evaluation for neck and right shoulder pain:** **Reason for Visit:** Right shoulder and cervicalgia **Subjective:** Patient is a 46-year-old female with complaint of constant cervical and right shoulder pains beginning after Motor Vehicle Accident in YYYY. States she has since undergone C5-6-7 Fusion surgery in May YYYY followed by RFA in March of YYYY. Recent MRI has revealed C4-5 HNP. States surgery was a success in eliminating the right upper extremity radicular pains and paresthesia. Pain in - 6/10 **Prior functional status:** Self care, functional mobility – Independent **Patient has Pain? Yes** **Location #1 Mid cervical area right** **Pain level:** At rest: 6. Worst pain: 8 **Exacerbating Factors** Household Chores Other (Turning head) **Functional problems:** **ADLs (Activities of Daily Living):** 3 **Sleeping:** 0 **Driving:** 2	429–434

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		Oswestry disability index score: 0 Neck disability index 30/50 **Palpation:** Moderate tenderness noted in the right cervical paraspinals into the right Upper/Middle trapezius **Range of motion/strength:** **Cervical range of motion:** **Flexion:** 40 degrees **Right lateral flexion:** 25 degrees **Right lateral rotation:** 60 degrees **Extension:** 40 degrees **Left lateral flexion:** 20 degrees **Left lateral rotation:** 60 degrees **Diagnosis:** M50.121 Cervical disc disorder at C4-C5 level with radiculopathy M54.2 Cervicalgia M25.511 Pain in right shoulder **Assessment:** Patient signs and symptoms are consistent with MRI findings of C4-5 HNP; causing right upper extremity radicular pains and interfering with performance of all activity. **Prognosis:** Good potential to reach the established goals **Treatment:** Exercise, modalities, moist heat, electrical stimulation, ultrasound and home exercise program. **Frequency:** 3 times a week for 6 weeks	
06/01/YYYY	Facility/Provider Name	**Follow-up visit for neck and back pain:** **Chief Complaint:** Follow-up routine **History of presenting illness:** Neck pain that radiates into right shoulder and back pain. The quality of pain is described as constant, aching, sharp, burning Neck - constant aching, sharp, dull burning and a severity / intensity level of 4 out of 10 8/10 - Neck. - She was involved in an MVA on 12/1/YYYY. Patients states that she was the driver of a 4 door car when a car rear ended her while she was at a complete stop. No air bag deployment and no loss of consciousness. She was treated the following day at XXXX Regional where X-rays were taken, she was treated and released. Her PCP (Primary Care Physician) referred to her for chiropractic care where she received therapy and MRI ordered. Dr. XXXX referred her to Dr. XXXX who did a C5-6 and C6-7 ACDF in May YYYY. Patient presents today for routine follow up. Patient's states some right sided neck pain going into right shoulder. She reports significant improvement since starting Gabapentin at last visit. She rates her pain 3-4/10 today and reports significant improvement with ROM (Range of Motion) in neck.	436–439

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Review of Systems: **General:** Positive, fatigue/malaise/lethargy, significant weight gain **HEENT:** Positive, vision changes, sinus trouble **Neck:** Positive, pain, stiffness **Musculoskeletal:** Positive, backache, knee pain, hip pain **Physical exam:** **Musculoskeletal: Cervical:** Full ROM (range of motion) and no discomfort noted with flexion and extension. Decreased ROM with right rotation. Some tenderness to palpation of the paraspinal muscles on right side into trapezius region. **Assessment:** Patient states significant improvement with the neck pain since starting Gabapentin at last visit as well as resuming PT. All questions and concerns were answered to her satisfaction. She verbalized understanding of plan of care and will continue PT. She had no further questions at this time and was satisfied with her visit**.** **Plan:** 1. Continue PT regimen. 2. Will call for Gabapentin RX when needed. 3. RTC 2 months**.**	
06/04/YYYY - 06/19/YYYY	Facility/Provider	**Summary of multiple physical therapy visits for neck and right shoulder pain:** **Treatment dates:** 06/04/YYYY, 06/08/YYYY, 06/10/YYYY, 06/12/YYYY, 06/17/YYYY, 06/18/YYYY, 06/19/YYYY **Summary of significant events:** She complained of pain in her neck, right shoulder and back. The pain limited her activities. After treatment, cervical pain was improving. As of 06/19/YYYY, she complained of bilateral knee pain. **Diagnosis:** M50.121 Cervical disc disorder at C4-C5 level with radiculopathy M54.2 Cervicalgia M25.511 Pain in right shoulder **Treatment:** Exercise, modalities, moist heat, electrical stimulation, ultrasound and home exercise program.	447–449, 451–453, 456–458, 461–463, 466–468, 471–473, 475–477
06/29/YYYY	Facility/Provider Name	**Final physical therapy visit for right shoulder and neck pain:** **Reason for visit**: Right shoulder and cervicalgia **Subjective:** Her cervical pain continues to improve **Functional problems:** **ADLs (Activities of Daily Living):** 3 **Sleeping:** 0 **Driving:** 2 **Diagnosis:** M50.121 Cervical disc disorder at C4-C5 level with radiculopathy M54.2 Cervicalgia M25.511 Pain in right shoulder	480–482

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Assessment: Patient progressing as expected **Prognosis:** Good potential to reach the established goals **Treatment:** Exercise, modalities, moist heat, electrical stimulation, ultrasound and home exercise program. **Frequency:** 3 times a week for 6 weeks. Continue with current treatment plan.	

Other records:

PDF REF: 440, 507, 18, 250, 301, 343–347, 348–349, 363–365, 367–371, 385, 387–388, 396–397, 404–405, 413–414, 416–417, 419–427, 444–446, 450, 454–455, 459–460, 464–465, 469–470, 474, 478–479, 483–488, 435, 499, 48–53, 302–338, 202–203, 248–249, 242–243, 411, 505, 297, 296, 293–295, 290–292, 287–289, 283–285, 8–12, 37–44, 5–7, 81, 83–86, 100, 100, 286, 1–4, 95, 125, 124, 127–132, 137, 126, 141, 146, 145, 147–149, 150, 212, 151–152, 156–157, 160–161, 171–172, 164–165, 173, 167–170, 175–176, 195–196, 45–47, 187, 210, 211, 214–215, 186, 428, 286, 134, 135–136, 137

**Reviewer's comments: These records contain orders, authorization, fax sheets, lab reports, legal documents, medications sheets, insurance assessments, details, medical bills, etc. Upon review, we did not find any significance and hence we have not elaborated these records.*

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