Narrative Summary

Motor Vehicle Accident on MM/DD/YYYY

On December 01, YYYY, at 07:54 hours, XXXX was the restrained driver of a YYYY Kia Optima in Leesville, Vernon County, Louisiana. She stopped her vehicle for the traffic light. At the same time, XXXX, the restrained driver of a YYYY Toyota Camry, failed to stop his vehicle on time and struck the rear of Ms. XXXX vehicle.

On December 02, YYYY, Ms. XXXX was examined by XXXX, R.N., and XXXX, M.D., in the Emergency Department of XXXX Hospital. She complained of pain in her left wrist and back. She reported her pain level as 6/10. She stated that her pain started from previous night. She also had contusion, pain, swelling, and tenderness in her left wrist and lower back. She had moderate pain in her lower back. On examination, she had tenderness in her left wrist. Her range of motion was decreased with all movements. She was diagnosed with sprain in her left wrist, and strain of muscle fascia, and tendon of her lower back. Ibuprofen 800 mg and Cyclobenzaprine 10 mg were prescribed to her. She was recommended to follow-up with her private physician in one to two days.

On the same day *(December 02, YYYY)*, Mr. XXXX had an X-ray of her cervical and lumbar spine which was obtained by XXXX, M.D. at XXXX Hospital. The X-ray of her cervical spine revealed some degree of degenerative change predominately at her C5-6 and C6-7 levels which manifested primarily by facet arthropathy and uncovertebral joint arthropathy. The X-ray of her lumbar spine revealed vertebral bodies to be of normal height with adequate maintenance of the intervertebral disk spaces. There was no evidence of traumatic, neoplastic, or significant arthritic changes.

On the same day *(December 02, YYYY)*, Mr. XXXX had an X-ray of her left wrist which was [redacted] XXX, M.D. at XXXX Hospital. The study revealed no evidence of fracture, dislocation, arthritic, or inflammatory changes. There was some degenerative change in her radioulnar joint with some bony remodeling.

On December 18, YYYY, XXXX, M.D. drafted a correspondence report to Mr. XXXX regarding the pain in her neck and back. She was apparently dazed immediately after the collision. Her both hands were on the steering wheel and her right foot was on the brake. She had pain in her neck, lower back and left wrist. On examination, she had increased tone in her muscles (left greater than right) in her cervical paraspinous, bilateral levator scapula, levator scapula, and bilateral rhomboids minor muscle. She had restricted range of motion in her cervical spine associated with pain. She had pain with wrist extensor and flexors on her left side. She had tenderness in her wrist around the ulnar styloid. After she had manipulation her pain was improved. The Achilles reflexes and Babinski was absent bilaterally. Faber test was positive bilaterally with increased lower back pain. She had a tight right piriformis muscle and had tenderness in her right posterior superior iliac spine region. Lastly noted was that she had tenderness over the temporomandibular joint with lateral deviation to her left when opening and closing the mouth and increased tone in her left masseter muscle. She was diagnosed with a cervical strain, bilateral rotator cuff strain, temporomandibular joint sprain, right piriformis strain, right iliolumbar ligament sprain, lumbar facet sprain, a left wrist sprain, and left de Quervain syndrome. Physician placed her on a home exercise program and she was recommended to follow up in January YYYY. She was informed that if she was unable to work out in her home environment, she was recommended to take a course of therapy. She received some acupuncture treatment with improvement in pain.

On January 15, YYYY, XXXX, M.D. drafted a correspondence report to Mr. XXXX regarding the persistent pain in her neck and right shoulder. She also had intermittent paresthesias in her hands. She also reported she had pain in her lower back which was improved. She performed therapeutic exercises during her holidays. She reported that she used splint on her wrist, especially at nighttime. Dr. XXXX recommended her to receive physical therapy for her soft tissue abnormalities. Dr. XXXX requested to undergo physical therapy three times a week for four weeks. She was recommended to continue taking Ibuprofen. If Ms. XXXX continued to have symptoms, Dr. XXXX reported that she would require objective work-up.

On February 06, YYYY, Ms. XXXX had an initial physical therapy evaluation for her neck and back pain at XXXX Physical Medicine Clinic. She had complaints of pain in her cervical interscapular, lumbar, right ileolumbar, left wrist, bilateral posterior shoulder girdle, and rotator cuff. She had tingling and numbness over her left shoulder area. Her pain was aggravated by answering the phone, working and typing. Her left wrist pain and lower back pain were getting better. On examination, her muscle tone was increased. Her muscle flexibility was reduced over her bilateral levator scapula, and right piriformis. She had tenderness over her bilateral infraspinatus. She had increasing pain in her bilateral levator scapula, rhomboids, infraspinatus, right piriformis and left wrist. She had restricted cervical and lumbar range of motion. She was diagnosed with cervical strain, right ileolumbar sprain, right piriformis strain, lumbar strain, piriformis strain, and rotator cuff strain. Her treatment plan was comprised of HMP (Hot/Moist Pack), Paraffin, ultrasound, soft tissue mobilization, and home exercise pr[illegible]

On February 13, YYYY, Ms. XXXX presented to Dr. XXXX at XXXX Family Medical Clinic for medication refill. Dr. XXXX planned to monitor her anxiety levels and lab reports were ordered for her general anxiety problems.

From February 08, YYYY until March 06, YYYY, Ms. XXXX received physical therapy at XXXX Physical Medicine Clinic for the complaints of pain in her neck, upper back, right ileolumbar spine, right gluteus, and left wrist. Her treatment included soft tissue mobility, paraffin bath, ultrasound, and hot/cold pack.

On March 07, YYYY, Ms. XXXX had a final physical therapy treatment at XXXX Physical Medicine Clinic for the complaints of pain in her neck, upper back, low back, right gluteal, and left wrist. She continued to have mild pain in her levator scapula, rhomboids, infraspinatous, right ileolumbar, and right piriformis. She had a good cervical and lumbar range of motion. She had responded fairly well to the pain after receiving therapy. Her muscle strength and flexibility was improved. The frequency of her pain level was decreased. She was diagnosed with cervical strain, right ileolumbar sprain, right piriformis strain, and rotator cuff strain. She was discharged from physical therapy service and she was recommended to perform exercises at her home. She was advised to follow up with her primary care physician.

On March 07, YYYY, XXXX, M.D. drafted a correspondence to Mr. XXXX regarding her neck and shoulder pain. The pain in her neck and back was improved after receiving therapy with minimal neck and upper shoulders pain. She was advised to perform a home exercise program to resolve the pain in her neck and upper shoulders. Dr. XXXX recommended her to resume her regular activity as tolerated. She was recommended to follow up in six weeks.

On April 06, YYYY, XXXX, M.D. drafted a correspondence to Mr. XXXX regarding her neck and shoulder pain. She was able to resume her regular activities without difficulty. She reported some occasional pain in her left side of the neck but she was able to stretch out adequately. On examination, she showed some increased tone in the left cervical paraspinous muscle, approximately at her C5-C6 level. Ms. XXXX appeared stable, and she was discharged from Dr. XXXX's care.

On August 14, YYYY, Ms. XXXX presented to XXXX, M.D. at XXXX Physical Medicine Clinic. Since April YYYY, her low back pain was stable. She had complained of continuous pain in her neck associated with some headaches. Her symptoms increased with Valsalva-type effects. She was recommended to have an MRI of her cervical spine. She was claustrophobic. She was prescribed Valium. She was also instructed to have assistance for driving.

On August 24, YYYY, Ms. XXXX had an MRI of her cervical spine which was obtained by XXXX, M.D., at XXXX Imaging systems. The study revealed straightening of the normal cervical lordosis, flattening of the cervical spinal cord related to spinal canal stenosis. She had bilateral maxillary sinus disease with the presence of small fluid filled air levels. There was a loss in disc height at her C2-C3 levels. There was thickening of her posterior longitudinal ligament, and mild bilateral facet disease in her C2-C3 levels. Mild anterior disc bulging with small osteophytes, thickening of the posterior longitudinal ligament, pedicular hypoplasia, mild spinal canal narrowing, and a loss in disc height was also observed at her C3-4 and C4-5 levels. Loss of disc height, 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 were observed at her C5-6 levels. Loss of disc height, mild disc bulging with small anterior osteophytes, small bilateral uncovertebral osteophytes, large central disc protrusion and inferior disc extrusion with annular tearing, pedicular hypoplasia, and severe spinal canal stenosis with flattening of the spinal cord were observed at her C6-7 levels. There was a loss in the disc height, thickening of the posterior longitudinal ligament, mild bilateral facet disease and mild bilateral neural foraminal narrowing observed at her C7-T1 levels.

On August 29, YYYY, Dr. XXXX had a telephone conversation with Mr. XXXX regarding her abnormal MRI of cervical spine results. She was noted to have herniation and/or large protrusion at her cervical spine. She was recommended to have a spine surgical evaluation for her spine chronicity symptoms. She was advised to restrict lifting any objects over 10 to 20 pounds.

On October 09, YYYY, Ms. XXXX presented to XXXX, M.D. at Neurosurgical Solutions of XXXX LLC. She had a complaint of pain in her neck. She had numbness and tingling in her bilateral arm. She was working as a manager of a loan company. She declined EMS (Emergency Medical Services) after law enforcement arrived. She reported that her neck was being stiff at the scene. She was shaken up in general. After being excused by law enforcement, she drove the same vehicle to her home, and the next morning awoke to have pain in her neck and left wrist pain, as well as in her right hip. She was seen at a local hospital, XXXX, in the Emergency Room where she was evaluated, treated, and released. She was given Ibuprofen. She refused narcotics. She also had physical therapy treatment. She reported that manual palpation of her cervical spine caused an electric sensation in her arms. She continued going to her work and took over-the-counter medications to overcome her pain. On examination she had a limited range of motion in her neck associated with pain. She was diagnosed with motor vehicle accident-induced cervical disk herniation with myelopathy. Dr. XXXX recommended her to undergo an anterior cervical discectomy and fusion at her C5-6 and C6-C7 levels. The risks, benefits, and alternative of surgery were discussed with Ms. XXXX. She was prescribed

Diclofenac 75 mg. Ms. XXXX was reluctant to engage in narcotic therapy. She was advised to follow up for re-evaluation.

On March 15, YYYY, Ms. XXXX had an X-ray of her cervical spine which revealed osteophyte of her facet joints. Sclerosis and spurring of the structures were also noted. Oblique views indicate significant foraminal stenosis at her C6- 7 levels on the right. Flexion and extension views did not show any evidence of subluxation or instability. Intravertebral disc spaces demonstrated posterior spondylosis formation at her C5-6 level.

On March 20, YYYY, Mr. XXXX presented to XXXX, A.P.R.N. at XXXX Medical Clinic for pre-operative clearance. She had complaints of pain in her neck. She needed pre-operative clearance from her neuro physician. Her lab reports showed elevated white blood count and urinary tract infection. On examination, she had tenderness to her cervical spine. She had pain in her cervical spine with palpation. Dr. XXXX recommended her to receive additional lab work, chest X-ray, and electrocardiogram.

On March 21, YYYY, XXXX, M.D. drafted a work status report. She was diagnosed with cervical disc disease and herniation. Dr. XXXX recommended her to undergo anterior cervical discectomy and fusion at her C5-7 levels. She was taking Diclofenac. Dr. XXXX reported that she was unable to work from May 20, YYYY until November 01, YYYY. She was recommended to return to work on October YYYY.

On March 26, YYYY, Mr. XXXX presented to XXXX, A.P.R.N. at XXXX Medical Clinic. She had complained of pain in her neck and also had headaches. She presented for pre-operative clearance for her neck. On examination, she had tenderness to her cervical spine. She was diagnosed with cervicalgia. Dr. XXXX recommended her to obtain lab reports and X-ray of her chest. She was [illegible] consult her cardiologist for cardiac clearance.

On April 26, YYYY, Mr. XXXX presented to XXXX, A.P.R.N.at XXXX Medical Clinic for pre-operative clearance for her neck surgery. She was cleared from cardiology to proceed with the surgery. She was diagnosed recently with a renal stone. Her lab reports and chest X-ray were reviewed.

On May 13, YYYY, Mr. XXXX presented XXXX, M.D.at Neurological solutions of XXXX. She had complained of pain in her neck. She also had numbness and tingling in her lateral arm right greater than left. On examination, she had a restricted range of motion in her head and neck, limited by pain, more so limited with right rotation movements. She was diagnosed with motor vehicle accident-induced cervical disk herniation with myelopathy. She was recommended to undergo anterior cervical discectomy and fusion at her C5-C6 and C6-C7 levels. Physician reviewed her preoperative laboratories, EKG, and cardiac clearance and found that to be acceptable, with the exception of a urinalysis that will need to be repeated. At the end of the discussion, she was satisfied and elected to proceed with the surgery. She was instructed to bring the Aspen collar with her to the hospital post-surgery. She was instructed to have someone at her home to assist her in wound care postoperatively. She was prescribed Diazepam, Keflex, and Percocet to be filled prior to surgery. She had been told that non-steroidal anti-inflammatories should not be taken for 6 months following surgery because it can interfere with the integrity of the fusion process.

On May 20, YYYY, Mr. XXXX presented to XXXX, M.D. at XXXX Hospital. She underwent anterior cervical decompression, at C5-6, and C6-7 levels, Zavation PEEK 7 mm C5-6 and C6-7 cage

with demineralized bone matrix interbody implant placement, and titanium cervical plate placement, at her C5 to C7 levels under general anesthesia. She was in stable condition after the procedure.

On June 20, YYYY, Mr. XXXX present to XXXX, M.D. at for XXXX solutions of XXXX for post-operative evaluation. She was 1-month status post anterior cervical discectomy and fusion at her C5-6 and C6-7. Dr. XXXX reviewed her and the X-rays of her cervical spine were reviewed, and the placement of the hardware looks ideal. She reported that her upper extremity symptoms were dramatically improving. Dr. XXXX recommended her to continue management and prescribed Restoril 15 mg at bedtime for sleep, and to follow-up for further management.

On the same day *(June 20, YYYY)*, Mr. XXXX had an X-ray of her cervical spine performed by XXXX, M.D. at Envision imaging which revealed prevertebral soft tissues, compatible with recent surgery. There was straightening of normal cervical lordosis. Cervical vertebral body height was maintained. There was generalized facet hypertrophy. Disc space narrowing was seen at C4-5 levels. An anterior cervical decompression and fusion with attempted interbody fusion to include discectomy and graft placement and anterior fusion plate and screws from her C5 to C7 level were observed. Prominent styloid processes were noted.

On July 17, YYYY, Ms. XXXX present to XXXX, M.D. at for Neurological solutions of XXXX for post-operative evaluation. Her swallowing function was improving. Her neck pain was persistent. She was unable to turn her head completely on both sides. Dr. XXXX recommended to continue performing exercises. She was reluctant to go back to work due to her anticipating pain. She was instructed to take 2 Aleve once or twice a week for episodic pain and she was instructed to avoid taking anti-inflammatories for six months postoperatively. She was recommended to follow up after three months.

[redacted]y 29, YYYY, Ms. XXXX presented to XXXX, M.D. at Neurological solutions of XXXX. She had some episodes of catch up at her right-sided lower right neck when she turned her head to the right side. She did not feel the frequency was increasing or decreasing. She reported that it took about an hour or two to subside when it occurred. She no longer had the radiating pain in her right upper extremity or the breathtaking pain in her neck that she had prior to the surgery. She was happy about that. On examination, she had a restricted range of motion in her cervical spine. Dr. XXXX recommended her to receive physical therapy treatment and also discussed pain management with her in terms of injections. She was fearful for pain management, as she attributed it to the death of her husband in the past. She was recommended to follow up for further management.

On August 05, YYYY, Ms. XXXX had a telephone conversation with XXXX PA., for management of her pain. She elected to proceed with pain management. Dr. XXXX informed her that a referral letter will be re-written.

On September 09, YYYY, Ms. XXXX presented to XXXX, M.D. at XXXX Health, LLC for the complaints of pain in her neck and back. Her neck pain radiates into her right shoulder and she also had pain in her back. She described her pain as constant, aching, sharp, burning pain in her neck. She also had constant aching, sharp, dull burning pain in her back. She rated her pain level as 8/10 in her back and 5/10 in her neck. She stated to have continues pain in her back and neck. She stated her neck pain radiated to her right shoulder. She complained of worsening pain symptoms despite taking pain medications. On examination of her cervical spine, she had 3+ pain with flexion, right lateral bending and right rotation and 2+ pain with left lateral bending, left rotation and extension. She continued to

have significant neck pain since the surgery. She was referred to Dr. XXXX for depression and was prescribed Cymbalta and Elavil. She stopped taking Percocet, since it was not beneficial. The future treatment options for her injury were discussed with her. She was advised to follow up in two months.

On September 10, YYYY, Ms. XXXX presented to XXXX, FPMHNPB at XXXX, LLC. She reported that she had sadness, crying spells, irritable mood, isolation and nervousness after a motor vehicle crash in December YYYY. She also reported feeling guilt, anxiety triggered by roadway cues and insomnia. On examination, her mood was moderately depressed, moderately anxious and mildly irritable. She was tearful throughout the session. She was prescribed with Cymbalta 20 mg and Elavil 10 mg. She was recommended to receive counseling.

On October 25, YYYY, Ms. XXXX presented to XXXX, LPC: at XXXX, LLC. She stated that she was in a lot of pain and her life was been pretty efficient and she yearned to feel better. She reported more depression, anxiety, and she believed that she did not have control over her life. She was recommended to continue taking counseling along with CBT (Cognitive Behavioral Therapy) interventions to reduce depression. She was recommended to follow-up in two weeks.

On October 30, YYYY, Ms. XXXX presented to XXXX, FPMHNPB at XXXX, LLC. She stated that she was crying frequently out of nowhere. She also described symptoms of social avoidance. She had a depressed, anxious, and irritable mood. A plan was made to increase the Cymbalta dosage to 30mg. She was advised to follow up with Dr. XXXX.

November 05, YYYY, Ms. XXXX presented to XXXX, M.D. at XXXX, LLC. She complained of pain as constant, aching, sharp, dull, burning, and radiating to her neck and right shoulder. She rated her neck pain level as 5/10 and her back pain level as 5/10. She also had pain in her knees and hip. She also complained of depression since the MVA and surgery. The pain in her changes a daily basis. She continued to have significant pain in her neck since the surgery. She was recommended to receive physical therapy and to receive radiofrequency ablation. She was advised to follow up in four weeks.

On November 11, YYYY, Ms. XXXX presented to XXXX, M.D., XXXX at Neurological solutions of XXXX. She reported that she had improvement of her neck pain and radiating pain in her arms. She still had some residual pain on her right side of her neck. Treatment options including interventional procedures were suggested by Dr. XXXX. She was recommended to receive an MRI of her cervical spine. She was recommended to follow up for further management.

On November 18, YYYY, Ms. XXXX presented to XXXX M.D. at XXXX Medical Wellness for a psychiatric evaluation. She reported how she was doing and she also complained of pain. Since from her teenage she was working and she was not able to work then. She also explained that she had surgery and she lost her job in XXXX. She indicated that she had a history of depression, but her mood problems increased since the motor vehicle crash. She described she had a lack of motivation which was an out-of-her character. She stated that she always did her task with determination. She stated that she had changes in her sleep pattern and she slept more than four to five hours between 12 in the morning to 4 in the morning. She described she had decreased engagement and interest in her prior hobbies and leisure pursuits. She had previously enjoyed being with her family, in church and doing bowling. She also stated that she had lost interest in ball games, and LSU games. She stated that she can't sit in the beaches and she also stated that she can't get into the pool in her dad's house. She had varied energy levels. She had fatigue due to pain and she also had poor concentration. Her appetite was increased after

her motor vehicle accident. Her weight was increased to 20 pounds. She was anxious and her anxiety was aggravated when she went behind the car wheel. She avoided social interaction. She stated that her sexual relationship was affected due to the pain in her neck. She also reported that she was very depressed, lack of interest in doing things and she was not her prior self.

On mental status exam, she appeared unkempt, tired and hypoactive. Her speech was soft and slow without significant linguistic abnormalities. Her thought content was notable for poverty of ideas in the form of mild negative rumination about her physical health. Her mood was moderately depressed, mildly to moderately anxious, and mildly irritable. Her mood and affect were congruent and moderately constricted. Overall, she represented a low substance withdrawal risk and a low formal safety risk.

The following tests were done: 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) Ms. XXXX displayed clinically relevant depressive symptoms for more than a year, 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. Dr. XXXX opined that her current depressive episode was caused by a motor vehicle crash with significant cervical spinal injuries and her depressive symptoms were perpetuated by her musculoskeletal and apparent neuropathic pain. The depression scale within the TSl-2 was also elevated. She was diagnosed with recurrent and severe major depressive disorder without psychotic features, stress related disorder, and tobacco use disorder.

Dr. XXXX opined that Ms. XXXX had developed clinically relevant symptoms which have persisted, although her symptoms do not fully and independently satisfy the full DSM-5 criteria for post-traumatic stress disorder. Dr. XXXX opined that although she was smoking about a half pack of cigarettes per day, her tobacco use represented an independent treatment target, and did not estimate to materially perpetuate her cognitive or psychiatric symptoms. Her Global Assessment of Function (GAF) score was 58,since the crash, with significant cervical spinal injuries, it was no higher than 60. Ms. XXXX was recommended to continue her psychiatric care at XXXX. She was currently taking Duloxetine/Cymbalta. The potential risks, benefits, and side effects of the medications were discussed with her. She had lost over 10 pounds since starting the medication. Her holistic health and other target symptoms were discussed and she agreed to a trial of the Norepinephrine-dopamine re uptake inhibiting (NORI) medication (Bupropion/Wellbutrin/Zyban, at the lowest dose in the sustained release (SR) preparation, 100 mg greater improvement in her low energy, and greater reduction of her an hedonic depressive symptoms. Ms. XXXX has been taking a low dose of the sedative Tricyclic Antidepressant (TCA) Amitriptyline/Elavil, 10 mg by mouth every night. She vocalized improvement in her sleep, although she had a total sleep of only four to five hours per night. She also continuously needed the benzodiazepine hypnotic, Temazepam/Restoril, which was prescribed by her neurosurgeon. A trial of increasing the Amitriptyline/Elavil to 25 mg tablet, one half to one (12.5 to 25 mg) by mouth every night was recommended, while trying to hold the Temazepam/Restoril. A plan was made to order lab reports including complete blood count, thyroid panel, and full chemistry with liver function tests, C-reactive protein, erythrocyte sedimentation rate, fasting lipids, and a vitamin D level, if her prior lab reports were not available. Diet and generalized wellness promotion was included in her holistic treatment. She was recommended to consult a Clinical Dietician and/or Certified Health Educator if she faced any challenges during routine physician-level treatment. She was advised to take a Mediterranean diet, a whole food diet, or the DASH diet. Ms. XXXX was recommended to regularly engage in low-impact exercise such as walking or riding a bicycle, provided if it was permitted by her primary care manager, pain manager, and spinal surgeon. She was advised to follow-up after14 to 28 days.

On November 20, YYYY, Ms. XXXX had a follow-up visit with XXXX, L.P.C., at XXXX. She complained of lot of pain and worries. She had a discussion regarding her fears, coping with pain and loss of identity and independence since the accident. She was recommended to continue receiving CBT to reduce anxiety and depression, gain in a sense of purpose, and encourage mindfulness.

On December 06, YYYY, an MRI of her cervical spine was obtained by XXXX, M.D at Envision Imaging. The study revealed a small central canal. Air-fluid level was seen within the sphenoid sinus. Anterior endplate screw device and intradiscal fusion material were noted at her C5-C6 levels and C6-C7 levels. There was straightening of the cervical spine at her C2-C3 level in the central canal which was small measuring 9.6 mm in AP diameter and preserved CSF (Cerebrospinal Fluid) signal surrounding the cord was observed. There was facet hypertrophy without foraminal stenosis and central canal measuring 9.6 mm in AP diameter was observed at her C3-4 levels. There was disc space narrowing and anterior spurring at her C4-5 levels. There was central disc protrusion/herniation resulting in mild central canal stenosis at her C4-5 levels. The AP diameter of the central canal measured 9.6 mm and mild flattening of the cord. CSF signal ventral to the cord was partially effaced. There was facet hypertrophy without foraminal stenosis. C5-C6 showed central posterior spondylosis resulting in mild central canal stenosis. The AP diameter of the central canal measured 9 mm. Preserved CSF signal surrounding the cord was observed. Facet hypertrophy without foraminal stenosis was observed. C6-C7 showed posterior spondylitic ridging resulting in mild to moderate central canal stenosis. The AP diameter of the central canal measured 8.6 mm. C7-T1 showed there was low signal within the epidural space posterior to the posterior longitudinal ligament at the mid C7 level which extended from the C6-C7 to the C7-T1 disc space and might represent extruded disc material or thickening of the posterior longitudinal ligament. There was central canal stenosis at her mid C7 level. The AP diameter of the central canal measured 8.4 mm.

On December 08, YYYY, MS. XXXX presented to XXXX, M.D. at XXXX, LLC for the complaints of pain in her neck and back which radiated to her right shoulder. She also complained of pain in her back. The pain in her neck was described as constant, aching, sharp, dull, and burning. She also had constant aching, sharp, dull burning pain in her back. The pain level in her neck and back was 8/10 and 5/10 respectively. On examination, she had pain with movements of her neck and back. She continued to have significant neck pain since the surgery. She was also suffering from depression. She was referred to Dr. XXXX for treatment of her depression. Interventional management was recommended after an appropriate healing period.

On December 10, YYYY, Ms. XXXX had a follow-up visit with XXXX, LPC at XXXX, LLC. She stated that she feel so defeated. The holidays had taken a toll on her. She and counselor discussed about her fears, depression, and feelings of purposelessness. She was making life-style changes, such as healthy eating, positive thinking, and prayer and improving communication. Her treatment included CBT and coping skills to reduce depression, anxiety, and feelings of being overwhelmed

On January 07, YYYY, Ms. XXXX presented to XXXX, M.D. at XXXX, LLC. She had pain in her neck. She had constant, aching, sharp, dull, burning, radiating pain in her neck which radiates to her right shoulder and her pain level in her neck and back was 7/10 and 5/10. She was scheduled for right C5-6, C6-7 Medial Branch Block. On examination showed cervical 3+ pain with flexion, right lateral bending and right rotation. 2+ pain with left lateral bending, left rotation and extension. She had cervical dorsal medial branch blocks, and Fluoroscopic needle localization. Her conservative therapy was failed at this point. She would like to proceed with interventional therapy and modalities in an

attempt to improve her pain and function. If interventional pain management was not successful, surgery may be indicated.

On January 14, YYYY, Ms. XXXX presented to XXXX, LPC at XXXX, LLC. She was worried all the time. She discussed with the counselor regarding her fears, coping with pain, and loss of identity and independence since the accident. She described feelings of worthlessness without her occupation. Her treatment included CBT to reduce anxiety and depression, gain in a sense of purpose, and encourage mindfulness.

On January 20, YYYY, Ms. XXXX presented to XXXX, APRN, ANP-C and XXXX, M.D at XXXX, LLC. She had complained of pain in her neck as constant, aching, sharp, dull, burning, and radiating pain in her neck and radiated to her right shoulder and a severity and intensity level in her neck as 3/10 and her back was 2/10. On examination, she had pain with left lateral bending, left rotation and extension movements of her cervical spine. She stated that she received 80-90 percentage relief of pain after the procedure. She stated approximately three days after the procedure the symptoms were started to return. She was elected to proceed with radiofrequency ablation. She was recommended to follow-up in four weeks.

On January 21, YYYY, Ms. XXXX presented to XXXX, P.A.C. and XXXX, M.D. at Neurosurgical Solutions of XXXX LLC. She had improvement with pain in her neck which was radiating to her arms. She continued to have some residual right-sided pain in her neck and had been following up with Dr. XXXX for medial branch blocks and radiofrequency ablation. On physical examination, she was awake and alert. She had 75 percentage range of motion of her head and neck in all directions. She was diagnosed with residual pain syndrome, facet-mediated in her cervical spine. She was advised to follow-up with Dr. XXXX for interventional treatments of her cervical spine. She was recommended to follow up on an as needed basis.

On February 06, YYYY, Ms. XXXX presented to XXXX, FPMHNPB at XXXX, LLC. She reported decreased depression, but persistent ruminating anxiety and phobia of driving. Her counselor discussed about mindfulness and positive thinking paradigm. She was recommended to continue receiving therapy every two weeks working on CBT interventions.

On February11, YYYY, Ms. XXXX had a follow up visit with XXXX, M.D. at XXXX, LLC for the persistent pain in her neck and back. She described her pain as constant, aching, sharp, burning in her neck and constant aching, sharp, dull burning in her back. She had failed all conservative therapy up to this point. She had tried pharmacological intervention including pain medications, anti-inflammatories, muscle relaxers, and other medications as indicated, and physical therapy. Her overall function was deteriorated. She underwent radiofrequency thermocoagulation of the cervical dorsal median branches along with fluoroscopic needle localization. She was recommended to proceed with interventional therapy and modalities to improve their pain and function. Dr. XXXX stated that if interventional pain management was not successful, surgery was indicated to her.

On February 19, YYYY, Ms. XXXX presented to XXXX, FPMHNPB at XXXX, LLC. She stated that she was doing well. She did not feel so overwhelmed anymore when she was driving. She did not like to be present around people. She also demonstrated avoidance from real-world. Her thought content was not stable for mild somatic negative rumination. She was depressed and anxious, and irritable. She was recommended to continue taking medications and to continue psychotherapy with a follow up in four to six weeks.

On February 26, YYYY, Ms. XXXX presented to XXXX, LPC: at XXXX, LLC. She was worried and stressful. She had a discussion regarding her goals for the future and coping skills. She was recommended to continue receiving therapy every two weeks utilizing CBT interventions to work on developing coping skills.

On March 09, YYYY, Ms. XXXX presented to XXXX, APRN at XXXX – LLC for the persistent pain in her neck which radiated to her right shoulder. She also had pain in her back. She also complained of depression since the MVA and surgery. She reported constant aching pain in her neck with frequent sharp pains at times despite receiving radiofrequency ablation. She reported her neck pain level as 4/10. On examination, she had pain with flexion, right lateral bending, right rotation, left lateral bending, and left rotation of her cervical spine. She also complained of tightness into bilateral trapezius with rotation movements of her neck. The range of motion of her neck had improved and pain had greatly decreased since the radiofrequency ablation procedure. She was recommended to continue to monitor the progression of her pain. She was advised to follow up in six weeks for further evaluation.

On April 7, YYYY, Ms. XXXX had a follow-up visit with XXXX, LPC at XXXX, LLC, for the complaints of depression and struggled relationships with her family. She had a discussion regarding communication skills and boundaries. She was also asked to work and process for replacement of self-blame with encouragement. She was recommended to receive therapy including CBT.

On April 11, YYYY, Ms. XXXX had a follow-up visit with XXXX, LPC at XXXX, LLC, for complaints of anxiety and depression. She was stressed due to the corona pandemic. She had a discussion regarding coping skills, positive reframing, mindfulness, and self-care. She was recommended to continue receiving therapy every two weeks utilizing CBT interventions to reduce depression and anxiety.

On April 12, YYYY, Ms. XXXX had a follow-up visit with XXXX, FPMHNPB at XXXX, LLC. She reported that she worried a lot and felt restless. She also reported racing and intrusive thoughts. She had a discussion regarding negative rumination about her physical symptoms and financial concerns. Her mood was mildly depressed, irritable, and mildly to moderately anxious. The psychiatric plan for this session was to increase Elavil to 25 mg, one to two tablets at night and as needed for sleep. She was recommended to continue receiving psychotherapy and to follow up in four to six weeks.

On April 12, YYYY, Ms. XXXX presented to XXXX, LPC at XXXX, LLC. She stated that isolation for the pandemic was so difficult on her and her sleep was so bad. She also reported that her anxiety was out of control. She and her counselor had a discussion regarding her anxiety and continued to work on coping skills and CBT**.**

On April 27, YYYY, Ms. XXXX presented to XXXX, LPC at XXXX, LLC. She stated that she was just getting more down, due to the pain and it affected her mood. She and her counselor processed and worked on mindfulness with regards to her pain management and self-care. Dr. XXXX recommended her to continue receiving therapy every two weeks utilizing CBT interventions to work on positive coping skills**.**

On May 01, YYYY, Ms. XXXX presented to XXXX, LPC at XXXX, LLC. She stated that the quarantine was hard on her. She was not able to see her grandchildren and she felt overwhelmed. She

and her counselor employed talk therapy and mindful interventions to improve her mood, depression, and anxiety. The counselor reported that she was gaining insight, but she was struggling with isolation. She was recommended to follow-up with her counselor for CBT.

On May 19, YYYY, Ms. XXXX presented to XXXX, LPC at XXXX, LLC. She stated that she was doing better, less depressed and hopeful. She reported difficulty with social isolation and uncertainty with her future. She and her counselor employed Cognitive Behavioral Therapy to address depression, anxiety, and improving her outlook. She was recommended to receive continued therapy every two weeks utilizing CBT interventions to work on healthy coping skills.

On May 27, YYYY, Ms. XXXX presented to XXXX, FPMHNPB at XXXX, LLC. She had a discussion regarding negative rumination about her physical limitations and finances. She was mildly depressed and anxious and irritable. She was recommended to continue taking her medications and to continue receiving psychotherapy. She was recommended to follow up in 8 to 12 weeks.

On May 27, YYYY, Ms. XXXX presented to XXXX, LPC at XXXX, LLC. Ms. XXXX stated that she was working on her irritation symptoms. She reported that the pain symptoms were hard on her and she hurt all the time and which was frustrating for her. She had a discussion regarding her frustration, which she acknowledged that it stemmed from her fear. Dr. XXXX recommended continuing therapy every two weeks utilizing CBT interventions to work on healthy coping skills such as socializing with family.

On May 28, YYYY, Ms. XXXX had an initial physical therapy evaluation with XXXX, M.P.T. at XXXX, Inc. She complained of pain in her right shoulder and cervicalgia. She had complaints of constant pain in her cervical spine and right shoulder due to the motor vehicle accident on YYYY. She had a fusion surgery on May YYYY followed by radiofrequency ablation on March YYYY at her C5, [illegible] levels. She had an MRI of her cervical spine which revealed herniated nucleus pulpous at her C4-5 levels. The radicular pain in her right upper extremities and paresthesias were resolved after the surgery. She rated her neck pain level was 6/10. She had increased pain in her neck after performing her house hold work and turning her head. Her neck disability score was 30/50. On examination, she had tenderness in her right cervical paraspinals and right upper medial trapezium. She had a restricted cervical range of motion. She was diagnosed with cervical disc disorder at C4-C5 level with radiculopathy, cervicalgia, and pain in her right shoulder. It was opined that her symptoms were consistent with the MRI findings of C4-5 herniated nucleus pulpous, causing right upper extremity radicular pains and interfering with performance of all of her activities. Her treatment was comprised of exercise, modalities, moist heat, electrical stimulation, ultrasound and home exercise program. She was recommended to receive physical therapy three times a week for six weeks.

On June 01, YYYY, Ms. XXXX presented to XXXX, M.D.at XXXX LLC. She complained of pain in her neck which radiated into her right shoulder. Her pain was improved after taking Gabapentin. She reported her neck pain level as 3-4/10. She had improvement in range of motion of her cervical spine. She also had complaints of fatigue/malaise/lethargy, significant weight gain, vision changes, sinus trouble, pain and stiffness in her neck, and pain in her back, knees, and hip. On examination, she had full range of motion with flexion and extension in her cervical spine. She had a decreased range of motion with right rotation in her cervical spine. She had tenderness to palpation in her paraspinal muscle on the right side of her trapezium region. Dr. XXXX assessed her and reported that she had significant improvement with the neck pain since starting Gabapentin as well as receiving physical therapy. Dr.

XXXX recommended her to continue receiving physical therapy, continue taking Gabapentin and to follow-up in two months.

From June 4, YYYY, until June 19, YYYY, Ms. XXXX received multiple sessions of physical therapy by XXXX M.P.T., at XXXX for the complaints of pain her neck, right shoulder and back. The pain limited all her activities. After the treatment, her cervical pain was improved. As of June 19, YYYY, she complained of bilateral knee pain. Her treatment was comprised of exercise, modalities, moist heat, electrical stimulation, ultrasound and home exercise program.

On June 29, YYYY, Ms. XXXX had a final physical therapy treatment evaluation with XXXX, M.P.T., at XXXX for pain in her right shoulder and cervicalgia. Her cervical pain continued to improve. She was diagnosed with cervical disc disorder at C4-C5 level with radiculopathy, cervicalgia, and pain in her right shoulder. Her treatment was comprised of exercises, modalities, moist heat, electrical stimulation, ultrasound and home exercise program. She was recommended to continue receiving physical therapy treatment.

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