RECORDS

Applicant/Plaintiff	[redacted]
Case No.	[redacted]
Defendant	[redacted]
Date of Injury	[redacted]
File/Claim Num	[redacted]
Date Published	6/20/2012
Records of	[redacted]
Location Copied	[redacted]
Type of Records	Medical records

Control No: [redacted]

Medical Record Excerpt & Outline

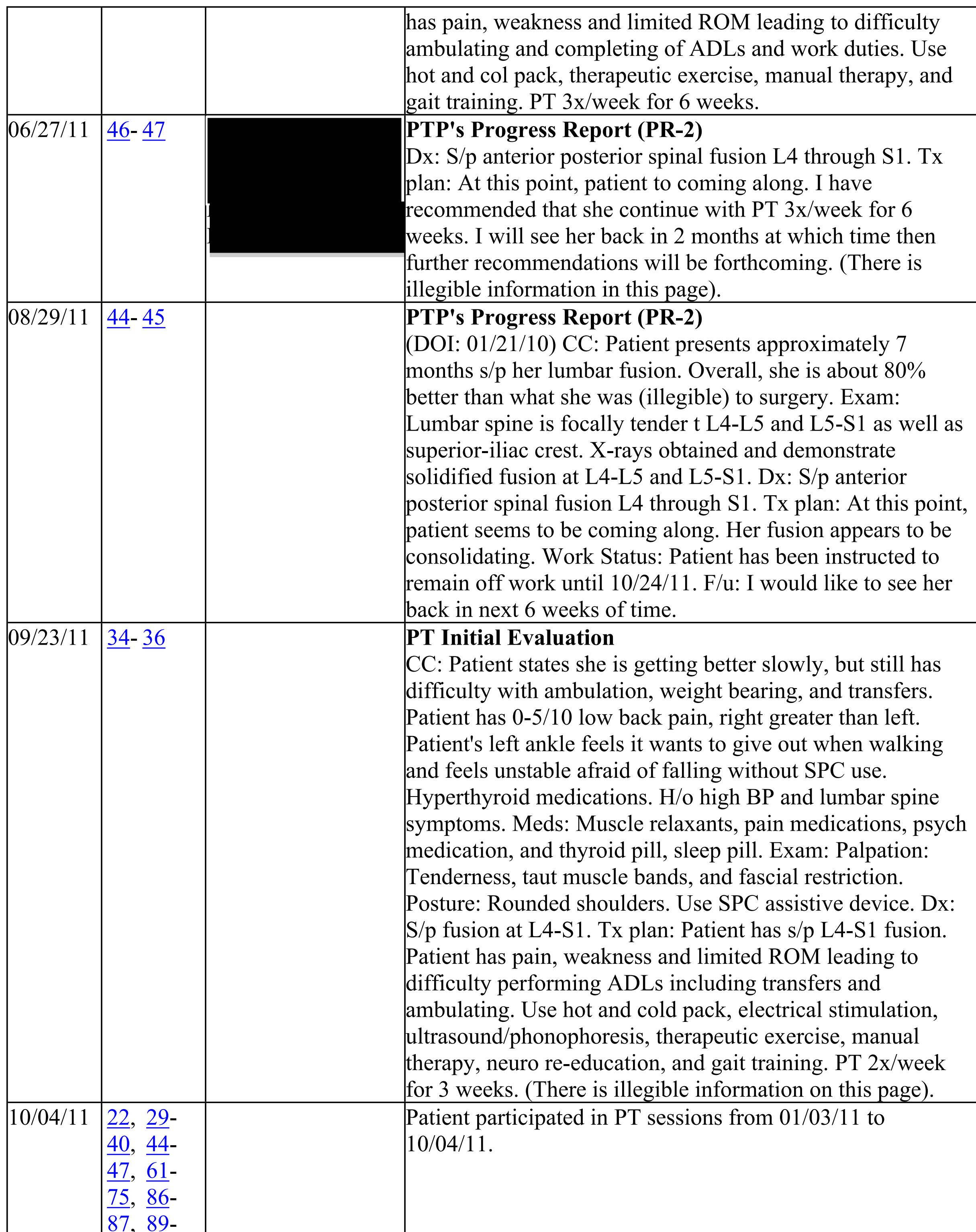
Patient Name :
WCAB # :
Social Security No. :
Date of Birth :
Employer :
Records of :

Date of Injury :

Date of Service	Page No.	Provider	Excerpt
10/18/10	50- 52	[redacted]	**PTP's Progress Report (PR-2)** (DOI: 01/21/10) CC: Patient presents after last being evaluated by myself on 09/20/10. Since that time, she has continued pain. Exam: Lumbar spine: Demonstrates focal midline tenderness at L4-L5 and L5-S1. There is tenderness along the superior iliac crest. There is moderate to severe central stenosis and lateral recess stenosis at L5-S1 and to a lesser external at L4-L5. There is evidence of disc bulging and multilevel disc desiccation at L3 through S. There is evidence of facet arthropathy. Dx: Lumbar spondylosis with radiculopathy at L3 through S1 maximally so at L5-S1. Tx plan: At this point, patient clearly has continued symptoms with regards to her back as well as radiation in her legs. The MRI confirms moderately severe stenosis at L5-S1 and to a lesser extent L4-L5. There is evidence of facet arthrosis at these levels. I have recommended that she undergo SPECT/CT scan of the lumbar spine. Upon completion then further recommendations will be forthcoming. Work Status: Patient has been instructed to remain off work until 11/15/10.
10/27/10	41- 43	[redacted]	**PT Initial Evaluation** CC: Patient has 6-9/10 low back pain due to catching and falling on 01/20/10. Patient has muscle spasms from mid back into bilateral leg pain and muscle spasms increase from prolonged sitting and standing. She complains of radicular numbness and tingling, right greater than left. Hyperthyroid

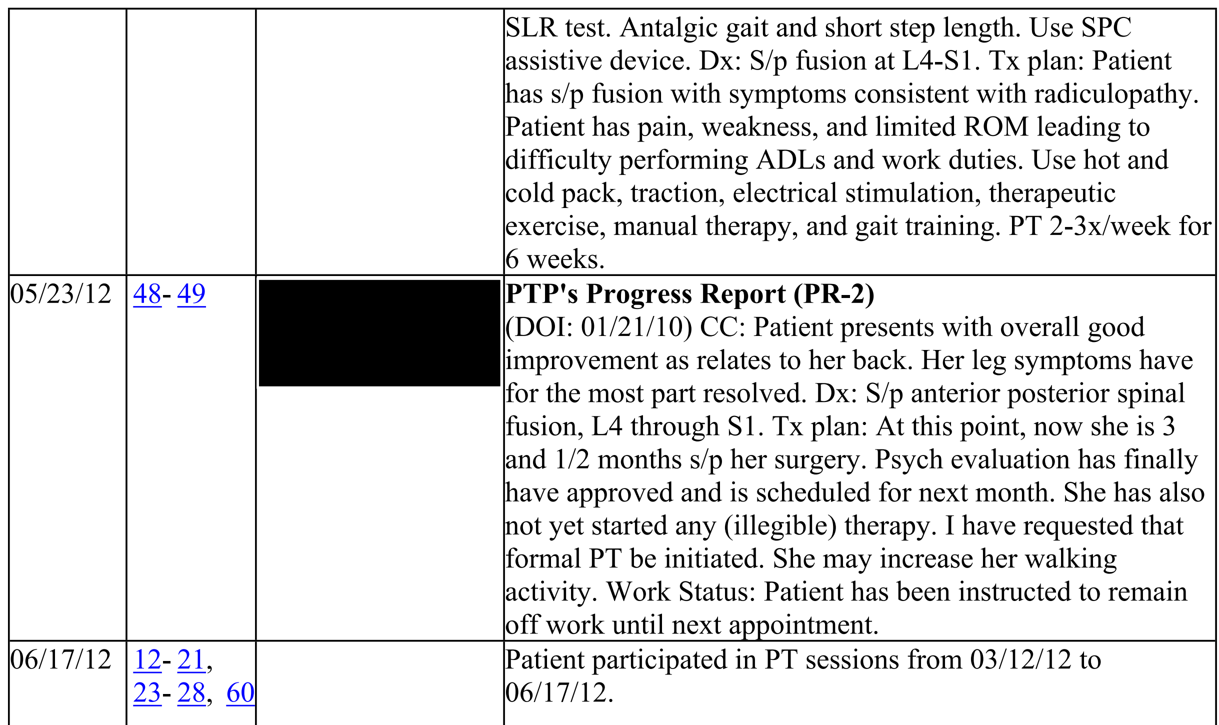
			meds. Patient has high BP. Meds: Flexeril and ibuprofen. Exam: Palpation: Tenderness, taut muscle bands, and trigger points. Unable to assess cervical spine mobility secondary to muscle spasms, guarding, and hypersensitive to palpation. Posture: Rounded shoulders. Positive right slump and compression test. Positive SLR. Antalgic gait. Dx: Low back pain. Tx plan: Patient with low back pain and symptoms constant with radiculopathy. Patient has muscle spasms, pain, limited ROM, and weakness leading to difficulty ambulating and performing ADLs and work duties. Use hot and cold pack, traction, electrical stimulation, therapeutic exercise, and manual therapy. PT 3x for 4 weeks. (There is illegible information on this page).
11/15/10	53- 55	.	**PTP's Progress Report (PR-2)** (DOI: 01/21/10) CC: Patient presents after last being evaluated by myself last month. Since that time, she has undergone the SPECT scan and the CT scan of the lumbar spine. Exam: She is focally tender at the L4-L5 and L5-S1 as well as superior iliac crest. She is able to walk, but does do with a limp. She is unable to walk on her toes and heels due to pain. The SPECT scan confirm increased uptake at L4-L5 and L5-S1 consistent with arthropathy. The MRI of the lumbar spine was once again reviewed demonstrating moderately severe stenosis at the L4-L5 and L5-S1 levels. Upon CT scan review, she does have fairly significant vacuum phenomenon within the facet joints of L4-L5 and L5-S1. Dx: 1) Advanced arthropathy at L4-L5 and L5-S1. 2) Moderately severe spinal stenosis at L4-L5 and L5-S1. Tx plan: At this point, I have had a lengthy and frank discussion with patient. It is my opinion based on the current diagnostic studies namely the MRI, which shows advanced arthropathy and stenosis as well as the SPECT scan, which demonstrates increased uptake at the facet joints as well as the CT scan that demonstrates vacuum phenomenon within the facet joints at L4-L5 and L5-S1 that a combined decompression and fusion would be necessary at the L4-L5 and L5-S1 levels. Due to the high disc heights, it is my recommendation that an anterior posterior approach to be undertaken. Patient does understand. I will see her buck in the next 4 weeks to check on her status. Work Status: Patient has been instructed to remain off work until 12/13/10.
12/13/10	56- 58	[redacted]	**PTP's Progress Report (PR-2)** (DOI: 01/21/10) CC: Patient presents with persistent pain in her lower back as well as both lower extremities right side worse than left. Exam: She is focally tender at the L4-L5 and L5-S1 as well as superior iliac crest. She is able to walk, but

			does do with a limp. She is unable to walk on her toes and heels due to pain. Dx: 1) Advanced arthropathy at L4-L5 and L5-S1. 2) Moderately severe spinal stenosis at L4-L5 and L5-S1. Tx plan: At this point, I have had a lengthy and frank discussion with patient. It remains my opinion that she is indeed a candidate for surgical intervention. Surgery request has been submitted, the results are not yet available. I would like to see patient back in next 4 weeks hopefully by then definitive authorization can be obtained at which time then further recommendations will be forthcoming. I have refilled her medications. Work Status: Patient has been instructed to remain off work until 01/10/10.
12/31/10	41- 43, 50- 58, 75- 84, 91- 93, 101- 104		Patient participated in PT sessions from 09/20/10 to 12/31/10.
01/28/11	89	-	**PT Discharge Report** CC: Patient is able to lie supine for greater than 1 hour, transfers and walks better. Patient has less pain after. Patient is scheduled for lumbar spine surgery. Patient has 5 minutes difficulty performing supine to sit transfers and sit to/from stand transfers after manual traction was applied. However, residual symmetric gait remains. Once patient was able to tolerate a supine position manual traction was applied leading to decreased pain, muscle spasms, and overall improvement is on patient's ability to transfer and ambulate. Patient has slowly progressed toward goals. Dx: Low back pain and radiculopathy. Tx plan: Use Hot and cold pack, traction, electrical stimulation, manual therapy, and therapeutic exercise. Continue PT 2x/week for 2 more weeks. Discussed if patient to receive lumbar spine symptoms.
06/10/11	37- 40		**PT Initial Evaluation** CC: On 02/15/11, patient has arthrodesis symptoms at L4-S1 fusion. She uses low back support brace, muscles tighten up without it. Patient has 0-4/10 sharp pain in lumbar spine and left hip. Her initial injury on 01/20/10. She uses bone stimulator. Patient with history of high BP. Meds: Muscle relaxants, pain meds, psych medication, and hyperthyroid medications. Exam: Palpation: Tenderness, taut muscle bands, trigger points, and fascial restriction. Posture: Rounded shoulders. Positive SLR and slump test. Hamstring tightness. Patient complains of increased numbness to the foot. Use SPC assistive device. Dx: Lumbar spine spondylosis, stenosis, disorders of sacrum s/p arthrodesis. Tx plan: Patient has s/p lumbar spine surgery and fusion. Patient



			has pain, weakness and limited ROM leading to difficulty ambulating and completing of ADLs and work duties. Use hot and col pack, therapeutic exercise, manual therapy, and gait training. PT 3x/week for 6 weeks.
06/27/11	46- 47		**PTP's Progress Report (PR-2)** Dx: S/p anterior posterior spinal fusion L4 through S1. Tx plan: At this point, patient to coming along. I have recommended that she continue with PT 3x/week for 6 weeks. I will see her back in 2 months at which time then further recommendations will be forthcoming. (There is illegible information in this page).
08/29/11	44- 45		**PTP's Progress Report (PR-2)** (DOI: 01/21/10) CC: Patient presents approximately 7 months s/p her lumbar fusion. Overall, she is about 80% better than what she was (illegible) to surgery. Exam: Lumbar spine is focally tender t L4-L5 and L5-S1 as well as superior-iliac crest. X-rays obtained and demonstrate solidified fusion at L4-L5 and L5-S1. Dx: S/p anterior posterior spinal fusion L4 through S1. Tx plan: At this point, patient seems to be coming along. Her fusion appears to be consolidating. Work Status: Patient has been instructed to remain off work until 10/24/11. F/u: I would like to see her back in next 6 weeks of time.
09/23/11	34- 36		**PT Initial Evaluation** CC: Patient states she is getting better slowly, but still has difficulty with ambulation, weight bearing, and transfers. Patient has 0-5/10 low back pain, right greater than left. Patient's left ankle feels it wants to give out when walking and feels unstable afraid of falling without SPC use. Hyperthyroid medications. H/o high BP and lumbar spine symptoms. Meds: Muscle relaxants, pain medications, psych medication, and thyroid pill, sleep pill. Exam: Palpation: Tenderness, taut muscle bands, and fascial restriction. Posture: Rounded shoulders. Use SPC assistive device. Dx: S/p fusion at L4-S1. Tx plan: Patient has s/p L4-S1 fusion. Patient has pain, weakness and limited ROM leading to difficulty performing ADLs including transfers and ambulating. Use hot and cold pack, electrical stimulation, ultrasound/phonophoresis, therapeutic exercise, manual therapy, neuro re-education, and gait training. PT 2x/week for 3 weeks. (There is illegible information on this page).
10/04/11	22, 29-40, 44-47, 61-75, 86-87, 89-		Patient participated in PT sessions from 01/03/11 to 10/04/11.

	90, 94, 97- 101		
10/04/11	33		**PT Discharge Report** CC: Patient stats that she is feeling better, right greater than left lumbar spine pain. Patient slowly progressing with PT increasing ROM, muscle activation, improving ambulation. Improved symmetry of gait with SPC use. Dx: S/p fusion at L4-S1. Tx plan: Recommend patient discharge to PT and continue with HEP. Use hot and col pack, electrical stimulation, gait training, ultrasound/phonophoresis, manual therapy, balance training, and therapeutic exercise. F/u: Discharge to HEP trail.
03/12/12	27- 28		**PTP's Progress Report (PR-2)** (DOI: 01/21/10) CC: Patient presents after last being evaluated by myself on 01/16/12. She did undergo lumbar epidural injection at L3-L4 without much improvement, if anything, it brought on ore pain. The therapy, though seems to be the most beneficial for her. Her pain overall is about 65% better than where it was prior to surgery. At times, she still does get some radiation down the right lower extremity. Exam: X-rays obtained demonstrate hardware in good position. Fusion appears to be full)' solidified. Dx: 1) S/p spinal fusion L4 through S1. 2) Severe stenosis at L3-L4 with facet arthrosis. 3) Mild-to-moderate stenosis at L2-L3. Tx plan: At this point, patient seems to have responded to therapy and the injection. Despite the fact that the injection did bring on initial worsening of pain, I suspect that a lot of her symptomatic relief has been from the injection. At this point, I am cautiously optimistic that she will continue to improve. I have encouraged her to complete her current course of physical therapy. At this point, I anticipate being able to release her from active care as already a year has passed since her 2-level spinal fusion. Work Status: This patient has been instructed to remain off work until next appointment. F/u: I will see her back in 4-6 weeks.
04/18/12	23- 26		**Initial Evaluation** CC: Patient has fusion at L4-S1 02/15/11and received epidural injection on 03/12/12, low back muscle spasms began again first week of March along with numbness and tingling into right lower extremity. Patient feels like hardware is poking and tender. Pain increases wit activity level through day on 05/09/10 sharp pain. Meds: Pain medication, antiinflammatory, and pill for sleep. Exam: S/p fusion at L4-S1. Palpation: Tenderness, taut muscle bands, and trigger points. Right side of lumbar spine muscle spasms, TTP. Posture: Rounded shoulders. Distraction, Slump, and



			SLR test. Antalgic gait and short step length. Use SPC assistive device. Dx: S/p fusion at L4-S1. Tx plan: Patient has s/p fusion with symptoms consistent with radiculopathy. Patient has pain, weakness, and limited ROM leading to difficulty performing ADLs and work duties. Use hot and cold pack, traction, electrical stimulation, therapeutic exercise, manual therapy, and gait training. PT 2-3x/week for 6 weeks.
05/23/12	48- 49		**PTP's Progress Report (PR-2)** (DOI: 01/21/10) CC: Patient presents with overall good improvement as relates to her back. Her leg symptoms have for the most part resolved. Dx: S/p anterior posterior spinal fusion, L4 through S1. Tx plan: At this point, now she is 3 and 1/2 months s/p her surgery. Psych evaluation has finally have approved and is scheduled for next month. She has also not yet started any (illegible) therapy. I have requested that formal PT be initiated. She may increase her walking activity. Work Status: Patient has been instructed to remain off work until next appointment.
06/17/12	12- 21, 23- 28, 60		Patient participated in PT sessions from 03/12/12 to 06/17/12.