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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION
APPELLATE PANEL

Appellate Case No.: 2022-000214
W.C.C. Case No.: 1805291

Stara S. McLeod, Employee,

Appellant,

v.

CW Group, Inc., Employer, and PMA Insurance Group, Carrier,

Respondents.

RECORD ON APPEAL

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DECISION AND ORDER
OF THE APPELLATE PANEL OF THE
SOUTH CARLINA WORKERS' COMPENSATION COMMISSION
WCC FILE NO: 1805291

STARA S. MCLEOD,

Claimant,

vs.

CW GROUP, INC.,

Employer,

and

PMA INSURANCE GROUP,

Carrier.

Defendants.

APPELLATE PANEL
DECISION & ORDER

STATEMENT OF THE CASE

This matter is before the Appellate Panel of the South Carolina Workers Compensation Commission ("Appellate Panel") up the Form 30, *Request for Commission Review*, of the claimant, Stara McLeod ("Claimant"). Claimant seeks review of an August 2, 2021, Decision and Order of Commissioner Susan S. Barden ("Single Commissioner") in which the Single Commissioner denied Claimant benefits under the South Carolina Workers' Compensation Law (the "Act") for an alleged March 26, 2018 work-related accident.

This is a denied case. It is Defendants' contention that Claimant did not sustain a compensable injury by accident on March 26, 2018. Defendants contend that the evidence demonstrates that Claimant had a pre-existing condition for which she underwent a microdiscectomy at L5-S1 in 2017 and that she remained symptomatic following that procedure prior to and beyond the alleged date of injury of this claim. There was also a dispute regarding

the applicable compensation rate for the claim as Claimant alleged she had concurrent employment at the time of her injury.

In her Order, the Single Commissioner denied the claim on the basis that Claimant had failed to meet her burden of proof of a compensable injury by accident. The Single Commissioner further ruled the Claimant did not provide any admissible evidence of her wages for her concurrent employment and denied Claimant's request to hold this issue in abeyance. Claimant subsequently and timeline filed her Form 30. A hearing on the Form 30 was held before the Appellate Panel on October 18, 2021.

Based on the entirety of the record, the briefs of the parties, and the arguments of counsel at the hearing, the Appellate Panel finds, as set forth fully below, that the decision and order of the Single Commissioner is **AFFIRMED.**

EVIDENCE OF THE CASE

Medical Evidence

Claimant had a lumbar MRI performed on October 25, 2016 that revealed an abnormal left L5-S1 disc protrusion with impingement on the left S1 nerve root. (Def. APA, p. 1) Claimant was seen by Dr. Todd Warrick, Sumter Spine and Pain Center, on October 27, 2016. (Def. APA, p. 13. Dr. Warrick notes that Claimant was a new patient with pain on her left side, lower back, that radiates into her left hip, leg, and foot for about two weeks. Claimant reported numbness and tingling in her left leg and foot. Dr. Warrick diagnosed Claimant with acute radicular pain from leftward L5-S1 HNP with S1 displacement and compression. (Def. APA, p. 15) Dr. Warrick recommended a transforaminal lumbar epidural steroid injection and noted consideration of a referral for a microdiscectomy. On November 28, 2016, Claimant reported 50% relief from the injection for 2.5 to 3 weeks. (Def. APA, p. 22) Dr. Warrick ordered a repeat injection. On

December 22, 2016, Claimant reported the second injection gave her no relief and actually made her pain worse. (Def. APA, p. 25). Dr. Warrick referred Claimant to Dr. Paul D. deHoll, Palmetto Health USC Orthopedic Center. On January 6, 2017, Dr. deHoll recommended a left-sided microdiscectomy at L5-S1. (Def. APA, p. 38) Claimant underwent this procedure on February 1, 2017. (Def. APA, p. 93)

Claimant was seen post-op by Dr. deHoll on February 10, 2017. (Def. APA, p. 42) Claimant reported overall that her leg pain had substantially improved but she did continue to complain of some continued generalized malaise and back pain. (Def. APA, p. 43) On February 23, 2017, Claimant reported her leg pain had largely resolved but she was having a little bit of numbness. (Def. APA, p. 49) Dr. deHoll released her back to work with restrictions of no lifting.

Claimant returned to Dr. deHoll on November 30, 2017. (Def. APA, p. 53) Dr. deHoll notes that Claimant reported that her pain has worsened since her last visit in February. He notes that she reported intermittent pain radiating into her left leg, as well as minimal numbness and tingling in her toes. (Def. APA, p. 54) Under his review of systems, Dr. deHoll notes that Claimant's left ankle reflex is "absent." (Def. APA, p. 47) Dr. deHoll referred Claimant for physical therapy with consideration of additional injections if her symptoms did not improve. (Def. APA, pp. 47, 55)

On April 13, 2018, Claimant was seen by Dr. deHoll for a follow up. (Def. APA, p. 56) Dr. deHoll notes that Claimant was last seen in November 2017 and that she has been doing physical therapy since that visit. (Def. APA, p. 58) Dr. deHoll ordered a lumbar x-ray that showed loss of disc height at L5-S1. (Def. APA, pp. 58, 60) He ordered additional physical therapy with follow up after completion.

Claimant presented to Palmetto Health Tourney Emergency Room on April 23, 2018 (Def. APA, p. 3) According to the note, Claimant reported emptying a mop bucket "two weeks ago at work", that she felt something "pop," and "now has pain to buttocks, and has numbness to left leg." The note further reflects that Claimant reported her symptoms were similar to previous episodes. (Def. APA, p. 6) Claimant was prescribed medications and told to follow up with her primary care physician. (Def. APA, p. 10)

Claimant returned to Palmetto Health USC on April 27, 2018 and was seen by Douglas Dow, PA. (Def. APA, p. 61) Mr. Dow notes that Claimant had continued lower back pain for the past couple of years with a previous surgery in 2017. He also notes that Claimant had attempted physical therapy but her pain increased to the point she was unable to do it. Claimant reported decreased strength in her left leg and that she's been taking NSAIDs since December without any relief in her pain or symptoms. (Def. APA, p. 62). Mr. Dow ordered an MRI of her lumbar spine. (Def. APA, p. 63) The MRI was performed on May 3, 2018. (Def. APA, p. 34)

Claimant was seen at Sumter Physical Therapy Clinic on April 30, 2018. (Def. APA, p. 94) The therapist notes for this visit indicate that Claimant was unable to relieve her radicular symptoms during that session. An August 8, 2018 discharge note indicates that Claimant no-showed at her next appointment and did not return. She was discharged from care. (Def. APA, p. 97)

On May 3, 2018, Dr. deHoll reviewed Claimant's MRI. He notes that there is minimal bulging and evidence of her prior hemilaminotomy but no recurrent herniation. (Def. APA, p. 69) He did note severe discogenic collapse at L5-S1 with mild modic endplate changes. Dr. deHoll notes a preference to avoid any possible surgery so he recommended a left-sided SI joint

injection. Claimant received an SI injection from Dr. Warrick on June 18, 2018. (Def. APA, p. 31)

On July 19, 2018, Claimant returned to Dr. deHoll reporting worsening of her pain after her SI injection. (Def. APA, p. 73) Dr. deHoll states that his surgical recommendation at that time would be for a ALIF procedure at L5-S1 but that Claimant wanted to try to avoid that. Dr. deHoll referred her to Dr. Koranloo for pain management to see if he could improve her symptoms. On August 7, 2018, Dr. Koranloo recommended an EMG/NCS and an L5-S1 LESI. (Def. APA, pp. 76-77) Claimant EMG/NCS was normal. (Def. APA, pp. 82-83) On August 22, 2018, Dr. Koranloo indicates that Claimant got minimal relief from the injections and she was going to return to Dr. deHoll for the next course of action. (Def. APA, p. 85)

Claimant was seen by Dr. Donald Johnson for an IME on August 23, 2018. (Clmt APA, pp. 36-37). Dr. Johnson notes that Claimant had undergone an L5-S1 laminectomy in January 2016 and that Claimant did well from the surgery and was able to return to all activities. Dr. Johnson states that he reviewed records from Dr. deHoll, including August 7, 2018. He also reviewed her MRI and noted that she does not have a large recurrent disc herniation but did have disc space collapse. Dr. Johnson states that he agrees with Dr. deHoll's recommendation of an ALIF at L5-S1 and that Claimant would be a good candidate. Dr. Johnson further states that it is his opinion to a reasonable degree of medical certainty that Claimant's current symptoms are causally related to her work injury of March 26, 2018 "by way of an exacerbation of a symptomatic exacerbation of a pre-existing asymptomatic condition." (Clmt APA, p. 37) Dr. Johnson states that Claimant is not at maximum medical improvement.

Deposition of Dr. Douglass deHoll

Dr. deHoll was deposed in this matter on August 23, 2018. Dr. deHoll testified that he had previously performed surgery on Claimant sometime in late-2016, early-2017, but he wasn't sure of the exact date without referencing any records. (Def. APA, pp. 105-6) He testified that he saw Claimant for follow-ups from that procedure in February and November of 2017. (Def. APA, p. 107) Dr. deHoll stated that in November 2017, Claimant presented with worse back pain and pain radiating into her left leg. (Def. APA, p. 108) He testified that when Claimant returned to him in April of 2018, she was there for the same complaints. (Def. APA, p. 108). He testified that her symptoms on April 27, 2018 were "basically what she's been complaining about in the last several months." (Def. APA, p. 110) Dr. deHoll testified that he did not recall having any conversation with Claimant about a work injury. (Def. APA, p. 110) He stated that he did not make any diagnosis that was different from any of her prior visits. (*Id.*) He testified that he ordered an MRI in May 2018 in order to rule out a re-herniation at the surgical level and concluded that she had not. (Def. APA, pp. 110-11) Dr. deHoll did testify that there was a degenerative collapse at that level and that it was "not an injury; it's wear and tear." (Def. APA, p. 111). When asked whether Claimant aggravated her prior condition in her alleged work accident, Dr. deHoll responded that had no history of anything happening at work and that it was never mentioned to him. (Def. APA, p. 119) He further explained that the absence of any such reference was important because he uses a scribe and does not write his own notes. (Def. APA, p. 120) He testified that the first time a work accident was mentioned was during his most recent visit. (Def. APA, p. 121) Dr. deHoll did testify that it is possible for someone to aggravate or get hurt while lifting and pouring. (Def. APA, p. 122) He further testified that since his records

reflect no reference to or report of a work injury, there is no way for him to correlate her issues to a work incident. (Def. APA, p. 126)

Dr. deHoll did testify that a Form 14B was apparently prepared by his office but that form should be disregarded as he was not involved in its preparation. (Def. APA, pp. 129-30) A blank Form 14B containing the hand written message "No knowledge of a work-related injury in treatment of this patient" was done by him. (*Id.*) According to Dr. deHoll, his diagnosis and treatment recommendations would not have changed even if he had knowledge of an alleged work injury. (Def. APA, p. 130-31)

Hearing Testimony

At the hearing, Claimant testified on her own behalf. Claimant testified that she resides in Dalzell, South Carolina with her husband and 16-year old daughter. Claimant graduated from Sumter High School and later attended Allen University but did not graduate. Claimant's work history includes working as a page at the South Carolina State House, some part-time work, and jobs with various health care providers. She has been employed by the South Carolina Department of Mental Health since 2015 and is currently an employment specialist. While still working the Department of Mental Health, Claimant took a second job working for Employer in October/November of 2017 performing janitorial services. Claimant was stationed to work at Shaw Air Force Base. Claimant described the various duties she performed in this job, including details regarding utilizing mops and buckets.

Claimant testified that she had surgery on her back in 2017.[1] Claimant testified that prior to this surgery she had experienced some pain and tightening in her back for which she sought

[1] The hearing testimony regarding the date of surgery was internally inconsistent in many places and included references to dates in late-2016, and early-2017. On cross-examination, Claimant was presented with documentation that the surgery actually took place on February 1, 2017.

chiropractic treatment. She was later referred to a pain specialist, Dr. Todd Warrick, and finally to Dr. deHoll for surgery. Claimant testified that she had follow ups with Dr. deHoll after her surgery with the last being in February, 2017. Claimant testified that she had no problems with her back between February, 2017 and when she started working for Employer. According to Claimant, she returned to Dr. deHoll in November 2017 "as a precaution." She explained that she had been doing strenuous work for Employer and wanted to make sure she was fine. Claimant testified that she told Dr. deHoll that she did have some "tightening" in her back and that he was fully aware that she was working a second job. She testified that Dr. deHoll did not take her out of work and that she then returned to work for employer.

Claimant testified that her accident occurred on either a Wednesday or Thursday at around 7:00 – 8:00 p.m. She testified that she was working in a building. She described that she took a mop bucket into the janitorial space with a floor sink and proceeded to turn the bucket over to empty it in the sink. As she was standing back up, she felt a popping, burning sensation in her back. She described feeling an immediate tingling with numbness and pain shooting down her butt area, down into her left leg. She testified that she didn't do anything about it at first but continued to work to finish up that building. She testified she did mention something to a co-working about her back hurting. According to Claimant, this co-worker came over and started massaging her butt area. Claimant testified that she called in sick the next Friday and has not been back to work for Employer at all since.

Claimant admitted that the surgery could have taken place on that date and she was just uncertain of the exact date. (*See* Hearing Transcript, pp. 43-45). An operation note in the record confirms the date of February 1, 2017. (*See* Defendants' APA #6, p. 93). References to this surgery in this order shall refer to the correct date, rather than the date erroneously referenced during the testimony.

Claimant testified that she was later told by Ms. Teresa to go see a doctor. Claimant testified that she tried to go to Doctors Care about a week after the incident but the office visit was not authorized by Employer. Claimant testified she then went to see Dr. deHoll on April 16, 2017. She also later went to the ER.

According to Claimant, the pain following this incident is different from the pain she felt prior to her 2017 surgery. She described the new pain as being more in her tailbone, like she's sitting on something. She testified that she still has pain down her leg and numbness in her toes and foot.

Claimant testified that in December of 2018, she was diagnosed with breast cancer and started treatment for that in January, 2019. Claimant testified that she has had surgeries, as well as chemotherapy and radiation. She continues to treat for this condition while also still experiencing back pain. Claimant testified that her back problems affect her ability to carry on various activities because she can't sit for long periods of time. Claimant's limited treatment that she has received to her back since the injury has been paid for by her, out of pocket.

On cross-examination, Claimant testified that the tingling and numbness down her left leg after this accident was something that she had previously after her 2017 surgery. When asked about Dr. deHoll's notes from November 2017 that reference radiating pain and numbness/tingling, Claimant denied that she was experiencing those symptoms at that time. She also denied experiencing worsening pain in November 2017 as referenced in Dr. deHoll's notes. Claimant reiterated that went to Dr. deHoll because she was feeling "tightness" in her back and wanted to have it checked out.

Following her alleged date of accident, Claimant returned to Dr. deHoll on April 13, 2017. While the note indicates that Claimant had been doing physical therapy since November,

Claimant testified that she had only been to one therapy session but she did not go back. She testified that she did tell Dr. deHoll that her problems were work related despite the fact that the records do not contain any reference to it. Claimant did admit to have some additional treatment to her back since her accident, including injections and a physical therapy session in April 2018. According to Claimant, she only had one session of PT because the pain was so bad that the therapist said there was no need to do more until her pain got under control. Claimant disputed the discharge note saying she was discharged for no-showing at her next visit.

Following the May 26, 2021 hearing, the Single Commissioner made the following findings of fact and conclusions of law:

FINDINGS OF FACT

1. Claimant alleges that she injured her low back and left leg in a work-related accident on March 26, 2018, aggravating a pre-existing condition.

2. Claimant is 43 years of age. (This finding is based on the medical evidence establishing Claimant's date of birth as November 4, 1977; *see also* Claimant's Deposition, p. 6).

3. Claimant is a high school graduate. She also attended college, and is 11 hours shy of a bachelor's degree in business administration/management (This finding is based on testimony of Claimant; Claimant's Deposition, pp. 14-15; Claimant's APA, Exhibit B, pp. 3-4).

4. Claimant's job with Employer was custodian (This finding is based on the testimony of Claimant. *See also* Claimant's Deposition, p. 21; Claimant's APA, Exhibit B, pp. 1 and 4).

5. Although employment tenure is never dispositive with regard to compensability, it is evidence to consider: Claimant had only worked for several months when the alleged accident occurred. Claimant testified that she took the job as she needed to pay for private school

and college tuition. She also testified that she has credit card debt. (This finding is based on the testimony of Claimant, pp. 26, 53; *see also* Claimant's Deposition, pp. 20 and 24-25).

6. Claimant's pre-existing low back condition (beginning in 2016) involved herniation at L5-S1, including left-side S1 nerve root compression affecting the leg/foot (This finding is based on Defendants' APA #1, p. 1; Defendants' APA #2, pp. 15 and 27; Defendants' APA #4, pp. 38-41).

7. Notwithstanding various misstatements in the record as to the date of Claimant's prior lumbar surgery (*See* Hearing Transcript, pp. 23, 24, 43-45; Deposition of Dr. deHoll, pp. 6-7 and 31; Dr. Koranloo's misstatement as contained in Claimant's APA #1, p. 17, and Claimant's APA #7, p. 39; Claimant's Deposition that she underwent prior back surgery in 2015, p. 31 and 34, and that the surgery was to L4--a different spinal level than that which was operated on), Claimant actually underwent the prior L5-S1 surgery with Dr. deHoll on February 1, 2017. (This finding is based on the Operative Report of February 1, 2017, as contained in Defendants' APA #6, p. 93).

8. Prior to the alleged injury of March 2018, Claimant returned to her treating surgeon (Dr. deHoll, a spine specialist) in November 2017 with worsening back pain, such that Dr. deHoll ordered physical therapy. This evidence contradicts and is inconsistent with Claimant's testimony that she had no back problem other than some "tightness," and that the November 2017 medical visit was only preventative. At this visit, Claimant's left ankle reflex is noted to be "absent" (*See* Hearing Transcript, pp. 42-43, 47-48, 60; Claimant's Deposition, pp. 33-34; Defendants' APA #4, pp. 47 and 53-55; Deposition of Dr. deHoll, pp. 4 and 7-9).

9. Additionally, Claimant told Physician Assistant Dow that she had "been taking NSAIDs *since December [2017] without any relief in her [back] pain or symptoms*" [emphasis added] (*See* Claimant's APA #1, p. 5, dated April 2018; Defendants' APA #4, p. 62).

10. Claimant reported an alleged work accident to Employer on April 2, 2018 (*See* Claimant's APA, Exhibit B, p. 18).

11. Claimant returned to Dr. deHoll on **April 13, 2018** (*See* Claimant's APA #1, pp. 1-3) and reported further worsening back pain, restricted range of motion, numbness, and tingling. Dr. deHoll referred Claimant to more physical therapy and prescribed various medications. **Claimant never reported a work injury to Dr. deHoll**, a finding I base on these records and on Dr. deHoll's deposition testimony (*See* Defendants' APA #5, p. 92, in which Dr. deHoll writes "no knowledge of a work related injury;" Deposition of Dr. deHoll, e.g., pp. 8-9, 19-21, 26, and 29: "I have no history of anything happening at work" and "She didn't mention anything specific about work.")

12. Dr. deHoll states that given the evidence in this case, there is no way for him to correlate Claimant's current back condition to an alleged work injury (*See* Deposition of Dr. deHoll, p. 26).

13. Dr. deHoll states that Claimant had no different diagnosis after the date of the alleged accident than she had prior (*See* Deposition of Dr. deHoll, pp. 9-11).

14. Claimant went to the Emergency Room on **April 23, 2018**, stating that she had sustained a work injury 2 weeks earlier (placing the accident date at approximately April 9). Instead of mentioning the worsening which began in November 2017, Claimant described her back and leg pain as "sudden," i.e., "now" for "2 weeks" occurring with the alleged retroactive date of an accident (*See* Claimant's APA #2, e.g., pp. 20-23; Defendants' APA #1, pp. 2-12).

15. In the summer of 2018, Claimant advised Dr. deHoll that he would be deposed and that she had sustained a work injury (*See* Deposition of Dr. deHoll, p. 21).

16. Claimant's post-alleged accident MRI shows that Claimant's pre-accident herniation "is gone," but Claimant has "significant discogenic collapse with modic changes at L5-S1." There is no re-herniation, re-rupture, or other acute finding; Dr. deHoll states that there is instead degenerative collapse of the L5-S1 disc or "wear and tear" (*See* Claimant's APA #1, p. 15; Defendants' APA #4, p. 69; Deposition of Dr. deHoll in its entirety, but see particularly pp. 11, 13, 15, 18, and 25).

17. "Clinical History" in Claimant's MRI report of May 2018 states that Claimant has had "low back pain since November 2017." (See Claimant's APA #4, p. 31; Defendants' APA #3, p. 34).

18. Dr. Koranloo's medical record states that there was an injury in April 2018—not March 2018. Dr. Koranloo did not provide a causation/aggravation statement (*See* Defendants' APA #4, pp. 76 and 85; Defendants' APA #5, p. 89).

19. Dr. Troyer's record states that Claimant's symptoms have been present "since April [2018]" (*See* Defendants' APA #7, p. 98).

20. Dr. deHoll, who has treated Claimant both prior to and after the date of the alleged accident, states that Claimant never contemporaneously reported a work accident to him. When deposed, the most he would opine to is that Claimant's alleged accident "can" cause, "could" cause, or "could have" caused Claimant's condition. He does not opine that it did (This finding is based on the Deposition of Dr. deHoll in its entirety, including but not limited to pp. 14, 18-20, 22, and 31-32).

21. Dr. Warrick, a pain specialist who treated Claimant for her back/leg both before and after the alleged work accident, did not provide a causation/aggravation statement. (This finding is based on medical evidence in its entirety; Claimant's Deposition, pp. 32 and 40).

22. As Claimant's treating physicians did not provide causation/aggravation statements, Claimant provided a causation opinion with a one-time IME (Dr. Johnson), who opined that Claimant's "asymptomatic [pre-existing] condition" was aggravated, an opinion unsupported by Dr. deHoll's and other treatment records [emphasis added]. I give greater weight to Dr. deHoll's treatment records and to his deposition testimony than I give to Dr. Johnson's inaccurate statement that Claimant's pre-existing condition was "asymptomatic" (*See* Claimant's APA #6, pp. 36-37).

23. Although by no means dispositive or pivotal, the mechanics of the alleged accident are also not entirely consistent: Claimant testified at the Hearing and at her deposition that she was standing back up after emptying a water bucket when she sustained an alleged injury (*See* Hearing Transcript, pp. 29-30 and Claimant's Deposition, p. 38, lines 8-13). Employer's accident report states that Claimant was lifting up the bucket and pouring when she injured her back (*See* Claimant's APA, Exhibit B, p. 19). The Emergency Room records states that Claimant was in the process of emptying a bucket (*See* Defendants' APA #1, pp. 3 and 5); and Claimant's counsel seems to indicate to Dr. deHoll that Claimant was lifting when she felt a pop (*See* Deposition of Dr. deHoll, p. 12, lines 22-24; p. 13, lines 24-25; and p. 14, lines 6-7).

24. Benefits under the Act are denied. Although pre-existing conditions may be readily aggravated, there are simply too many inconsistencies in the record for me to find this claim compensable.

25. Claimant's average weekly wage is $169.91, yielding a compensation rate of $113.28. I base this finding on the payroll records as contained in Claimant's APA, Exhibit B, pp. 20-21. This claim has been pending since 2018 (i.e., for more than 3 years), and no concurrent employment Form 20 has ever been filed with the Commission. Nor was there a Motion made to leave the record open for a concurrent employment Form 20. The Commission cannot require a claimant to file a concurrent Form 20, as the law requires her to file one only if she wants other income considered. I decline to hold—or ask another commissioner to hold--another hearing for an issue over which Claimant has had ample time and opportunity to address. This was not a "surprise" hearing, but one that was properly noticed.

CONCLUSIONS OF LAW

Accordingly, as provided in the South Carolina Code of Laws, 1976, as amended, §42-17-40, it is the determination of this Commissioner that:

1. Under S.C. Code §42-3-180, this Commissioner has jurisdiction over the parties to hear the issues in dispute.

2. Under S.C. Code §42-1-130, Stara S. McLeod was a covered employee.

3. Under S.C. Code §42-1-140, CW Group, Inc. was a covered employer.

4. Under S.C. Code §42-3-150, there was an employer/employee relationship between the parties.

5. Under S.C. Code §42-17-20, venue in Sumter County, South Carolina, was proper and agreed to by the parties.

6. Under S.C. Code §1-23-320(b) and Regulation 67-607, notice of hearing was timely and properly served upon all parties of interest.

7. Under S.C. Code §42-1-160, the claimant, Stara S. McLeod, has failed to meet her burden of proof to show a compensable injury by accident arising out of and in the course of her employment. Likewise, Claimant has failed to meet her burden of proof to show a compensable aggravation of a pre-existing condition under S.C. Code §42-9-35.

8. Under S.C. Code §42-1-40, the claimant's average weekly wage is $169.91, yielding a compensation rate of $113.28. Claimant's alleged average weekly wage and compensation rate are unsupported by a Form 20 as required by S.C. Code Reg 67-1603(H). As such, any alleged concurrent employment wages cannot be considered in computing the average weekly wage and compensation. No motion was made to leave the record open for submission of a Form 20 was made so this determination is made in accordance with the Act.

9. All benefits under the Act are DENIED.

DECISION OF THE APPELLATE PANEL

Based upon its review of the record, the briefs of the parties, and the arguments of counsel, the Appellate Panel finds that the Single Commissioner did not err with respect to her order denying Claimant's claim. Therefore, after careful consideration, the Appellate Panel **Affirms** the decision and order of the Single Commissioner, as set for the below.

Following the October 18, 2021 hearing, and based on the record as a whole, the briefs of the parties, and the arguments of counsel, the Appellate Panel makes the following findings of fact and conclusions of law:

FINDINGS OF FACT

1. Claimant alleges that she injured her low back and left leg in a work-related accident on March 26, 2018, aggravating a pre-existing condition.

2. Claimant is 43 years of age. (This finding is based on the medical evidence establishing Claimant's date of birth as November 4, 1977; *see also* Claimant's Deposition, p. 6).

3. Claimant is a high school graduate. She also attended college, and is 11 hours shy of a bachelor's degree in business administration/management (This finding is based on testimony of Claimant; Claimant's Deposition, pp. 14-15; Claimant's APA, Exhibit B, pp. 3-4).

4. Claimant's job with Employer was custodian (This finding is based on the testimony of Claimant. *See also* Claimant's Deposition, p. 21; Claimant's APA, Exhibit B, pp. 1 and 4).

5. Although employment tenure is never dispositive with regard to compensability, it is evidence to consider: Claimant had only worked for several months when the alleged accident occurred. Claimant testified that she took the job as she needed to pay for private school and college tuition. She also testified that she has credit card debt. (This finding is based on the testimony of Claimant, pp. 26, 53; *see also* Claimant's Deposition, pp. 20 and 24-25).

6. Claimant's pre-existing low back condition (beginning in 2016) involved herniation at L5-S1, including left-side S1 nerve root compression affecting the leg/foot (This finding is based on Defendants' APA #1, p. 1; Defendants' APA #2, pp. 15 and 27; Defendants' APA #4, pp. 38-41).

7. Notwithstanding various misstatements in the record as to the date of Claimant's prior lumbar surgery (*See* Hearing Transcript, pp. 23, 24, 43-45; Deposition of Dr. deHoll, pp. 6-7 and 31; Dr. Koranloo's misstatement as contained in Claimant's APA #1, p. 17, and Claimant's APA #7, p. 39; Claimant's Deposition that she underwent prior back surgery in 2015, p. 31 and 34, and that the surgery was to L4--a different spinal level than that which was operated on), Claimant actually underwent the prior L5-S1 surgery with Dr. deHoll on February

1, 2017. (This finding is based on the Operative Report of February 1, 2017, as contained in Defendants' APA #6, p. 93).

8. Prior to the alleged injury of March 2018, Claimant returned to her treating surgeon (Dr. deHoll, a spine specialist) in **November 2017** with worsening back pain, such that Dr. deHoll ordered physical therapy. This evidence contradicts and is inconsistent with Claimant's testimony that she had no back problem other than some "tightness," and that the November 2017 medical visit was only preventative. At this visit, Claimant's left ankle reflex is noted to be "absent" (*See* Hearing Transcript, pp. 42-43, 47-48, 60; Claimant's Deposition, pp. 33-34; Defendants' APA #4, pp. 47 and 53-55; Deposition of Dr. deHoll, pp. 4 and 7-9).

9. Additionally, Claimant told Physician Assistant Dow that she had "been taking NSAIDs *since December [2017] without any relief in her [back] pain or symptoms*" [emphasis added] (*See* Claimant's APA #1, p. 5, dated April 2018; Defendants' APA #4, p. 62).

10. Claimant reported an alleged work accident to Employer on April 2, 2018 (*See* Claimant's APA, Exhibit B, p. 18).

11. Claimant returned to Dr. deHoll on **April 13, 2018** (*See* Claimant's APA #1, pp. 1-3) and reported further worsening back pain, restricted range of motion, numbness, and tingling. Dr. deHoll referred Claimant to more physical therapy and prescribed various medications. **Claimant never reported a work injury to Dr. deHoll**, a finding I base on these records and on Dr. deHoll's deposition testimony (*See* Defendants' APA #5, p. 92, in which Dr. deHoll writes "no knowledge of a work related injury;" Deposition of Dr. deHoll, e.g., pp. 8-9, 19-21, 26, and 29: "I have no history of anything happening at work" and "She didn't mention anything specific about work.")

12. Dr. deHoll states that given the evidence in this case, there is no way for him to correlate Claimant's current back condition to an alleged work injury (*See* Deposition of Dr. deHoll, p. 26).

13. Dr. deHoll states that Claimant had no different diagnosis after the date of the alleged accident than she had prior (*See* Deposition of Dr. deHoll, pp. 9-11).

14. Claimant went to the Emergency Room on **April 23, 2018**, stating that she had sustained a work injury 2 weeks earlier (placing the accident date at approximately April 9). Instead of mentioning the worsening which began in November 2017, Claimant described her back and leg pain as "sudden," i.e., "now" for "2 weeks" occurring with the alleged retroactive date of an accident (*See* Claimant's APA #2, e.g., pp. 20-23; Defendants' APA #1, pp. 2-12).

15. In the summer of 2018, Claimant advised Dr. deHoll that he would be deposed and that she had sustained a work injury (*See* Deposition of Dr. deHoll, p. 21).

16. Claimant's post-alleged accident MRI shows that Claimant's pre-accident herniation "is gone," but Claimant has "significant discogenic collapse with modic changes at L5-S1." There is no re-herniation, re-rupture, or other acute finding; Dr. deHoll states that there is instead degenerative collapse of the L5-S1 disc or "wear and tear" (*See* Claimant's APA #1, p. 15; Defendants' APA #4, p. 69; Deposition of Dr. deHoll in its entirety, but see particularly pp. 11, 13, 15, 18, and 25).

17. "Clinical History" in Claimant's MRI report of May 2018 states that Claimant has had "low back pain since November 2017." (See Claimant's APA #4, p. 31; Defendants' APA #3, p. 34).

18. Dr. Koranloo's medical record states that there was an injury in April 2018—not March 2018. Dr. Koranloo did not provide a causation/aggravation statement (*See* Defendants' APA #4, pp. 76 and 85; Defendants' APA #5, p. 89).

19. Dr. Troyer's record states that Claimant's symptoms have been present "since April [2018]" (*See* Defendants' APA #7, p. 98).

20. Dr. deHoll, who has treated Claimant both prior to and after the date of the alleged accident, states that Claimant never contemporaneously reported a work accident to him. When deposed, the most he would opine to is that Claimant's alleged accident "can" cause, "could" cause, or "could have" caused Claimant's condition. He does not opine that it did (This finding is based on the Deposition of Dr. deHoll in its entirety, including but not limited to pp. 14, 18-20, 22, and 31-32).

21. Dr. Warrick, a pain specialist who treated Claimant for her back/leg both before and after the alleged work accident, did not provide a causation/aggravation statement. (This finding is based on medical evidence in its entirety; Claimant's Deposition, pp. 32 and 40).

22. As Claimant's treating physicians did not provide causation/aggravation statements, Claimant provided a causation opinion with a one-time IME (Dr. Johnson), who opined that Claimant's "asymptomatic [pre-existing] condition" was aggravated, an opinion unsupported by Dr. deHoll's and other treatment records [emphasis added]. I give greater weight to Dr. deHoll's treatment records and to his deposition testimony than I give to Dr. Johnson's inaccurate statement that Claimant's pre-existing condition was "asymptomatic" (*See* Claimant's APA #6, pp. 36-37).

23. Although by no means dispositive or pivotal, the mechanics of the alleged accident are also not entirely consistent: Claimant testified at the Hearing and at her deposition

that she was standing back up after emptying a water bucket when she sustained an alleged injury (*See* Hearing Transcript, pp. 29-30 and Claimant's Deposition, p. 38, lines 8-13). Employer's accident report states that Claimant was lifting up the bucket and pouring when she injured her back (*See* Claimant's APA, Exhibit B, p. 19). The Emergency Room records states that Claimant was in the process of emptying a bucket (*See* Defendants' APA #1, pp. 3 and 5); and Claimant's counsel seems to indicate to Dr. deHoll that Claimant was lifting when she felt a pop (*See* Deposition of Dr. deHoll, p. 12, lines 22-24; p. 13, lines 24-25; and p. 14, lines 6-7).

24. Benefits under the Act are denied. Although pre-existing conditions may be readily aggravated, there are simply too many inconsistencies in the record for me to find this claim compensable.

25. Claimant's average weekly wage is $169.91, yielding a compensation rate of $113.28. The Appellate Panel bases this finding on the payroll records as contained in Claimant's APA, Exhibit B, pp. 20-21. This claim has been pending since 2018 (i.e., for more than 3 years), and no concurrent employment Form 20 has ever been filed with the Commission. Nor was there a Motion made to leave the record open for a concurrent employment Form 20. The Commission cannot require a claimant to file a concurrent Form 20, as the law requires her to file one only if she wants other income considered. We decline to hold—or ask another commissioner to hold--another hearing for an issue over which Claimant has had ample time and opportunity to address. This was not a "surprise" hearing, but one that was properly noticed.

CONCLUSIONS OF LAW

Accordingly, as provided in the South Carolina Code of Laws, 1976, as amended, §42-17-40, it is the determination of this Commissioner that:

10. Under S.C. Code §42-3-180, this Commissioner has jurisdiction over the parties to hear the issues in dispute.

11. Under S.C. Code §42-1-130, Stara S. McLeod was a covered employee.

12. Under S.C. Code §42-1-140, CW Group, Inc. was a covered employer.

13. Under S.C. Code §42-3-150, there was an employer/employee relationship between the parties.

14. Under S.C. Code §42-17-20, venue in Sumter County, South Carolina, was proper and agreed to by the parties.

15. Under S.C. Code §1-23-320(b) and Regulation 67-607, notice of hearing was timely and properly served upon all parties of interest.

16. Under S.C. Code §42-1-160, the claimant, Stara S. McLeod, has failed to meet her burden of proof to show a compensable injury by accident arising out of and in the course of her employment. Likewise, Claimant has failed to meet her burden of proof to show a compensable aggravation of a pre-existing condition under S.C. Code §42-9-35.

17. Under S.C. Code §42-1-40, the claimant's average weekly wage is $169.91, yielding a compensation rate of $113.28. Claimant's alleged average weekly wage and compensation rate are unsupported by a Form 20 as required by S.C. Code Reg 67-1603(H). As such, any alleged concurrent employment wages cannot be considered in computing the average weekly wage and compensation. No motion was made to leave the record open for submission of a Form 20 was made so this determination is made in accordance with the Act.

18. All benefits under the Act are DENIED.

ORDER

IT IS THEREFORE ORDERED that Claimant's request for benefits under the Act is DENIED.

AND IT IS SO ORDERED.

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

Chairman, T. Scott Beck

Commissioner Avery B. Wilkerson, Jr.

Commissioner Aisha Taylor

CERTIFICATE OF SERVICE

This is to certify that the undersigned has on this date served a copy of this order in the above entitled action upon all parties to this case by sending an electronic copy hereof by electronic mail addressed to the attorneys for said parties; or if there is an unrepresented party(ies), by depositing a copy hereof, postage paid in the United States mail, first class, addressed to the unrepresented party(ies) and to the attorney(s) for the represented party(ies).

By Valerie Deller on January 20, 2022

DECISION AND ORDER
OF THE
SOUTH CARLINA WORKERS' COMPENSATION COMMISSION
WCC FILE NO: 1805291

STARA S. MCLEOD,

Claimant,

vs.

CW GROUP, INC.,

Employer,

and

PMA INSURANCE GROUP,

Carrier.

Defendants.

HEARING: Held on May 26, 2021, in Sumter, South Carolina

APPEARANCE: The claimant was represented by Dwight C. Moore of Sumter, South Carolina.

The defendants were represented by Lee E. Dixon of Columbia, South Carolina

PURPOSE OF HEARING: To determine the issues as set forth on the Form 21.

OPINION AND AWARD: Susan S. Barden, Commissioner.

FILED: ____ *August 2, 2021*

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STIPULATIONS

1. That the purpose of the hearing was to determine all issues in dispute as set forth in the Form 21.

2. That the claimant and the defendants were subject to and bound by the provisions of the South Carolina Workers' Compensation Act.

3. That notice of the hearing was timely and properly served upon all parties of interest.

4. All parties agreed upon venue as set in Sumter County, South Carolina.

5. That there was an employer/employee relationship between the parties and, therefore, the South Carolina Workers' Compensation Commission has jurisdiction to determine the issues in dispute.

6. The Workers' Compensation Commission's file, with the exception of unstipulated medicals and self-serving declarations, was made part of the record.

7. That the purpose of the hearing was to determine whether the claimant has sustained a compensable injury by accident; and, if so, whether the claimant was entitled to any causally-related medical treatment.

APA SUBMISSIONS

Pursuant to the Administrative Procedures Act, the following medical and expert witness reports submitted into evidence.

Claimant's Exhibits

TAB	NAME OF PHYSICIAN/OTHER	DATE OF REPORTS	NO.
1	Palmetto Health USC Orthopedic	04/13/18 – 08/08/18	1 – 18
2	Palmetto Health Tuomey	04/23/18	19 – 27
3	Sumter Physical Therapy	04/30/18 and 08/08/18	28 – 30
4	Image Care	05/03/18	31 – 33
5	Encompass Health Rehab	08/16/18	34 – 35

6	Southeastern Spine Institute	08/23/18	36 – 37
7	Sumter Pain and Spine Center	03/01/18 – 10/30/20	38 - 53

TAB	EXHIBIT	NO.
A	Claimant's deposition transcript	1 – 57
B	Personnel File	1 – 21
C	Dr. deHoll's deposition transcript	1 – 15

Defendants' Exhibits

TAB	NAME OF PHYSICIAN/OTHER	DATE OF REPORTS	NO.
1	Palmetto Health Toumey	10/25/16 – 04/23/18	1 – 12
2	Sumter Spine & Pain Center	10/27/16 – 06/18/18	13 – 33
3	Image Care	05/03/18	34 – 35
4	Palmetto Health – USC Orthopaedic Center	01/06/17 – 08/22/18	36 – 88
5	Palmetto Health Baptist	02/01/17	89 – 92
6	Sumter Physical Therapy Clinic	04/30/18 – 08/08/18	93 – 97
7	Encompass Health Rehab	08/19/18	98 – 99

TAB	EXHIBIT	NO.
A	Dr. deHoll's deposition transcript	100 – 146
B	Claimant's deposition transcript	147 – 193

STATEMENT OF THE CASE

This matter arises out of denied March 26, 2018 alleged work-related accident. Prior to this hearing, Claimant had filed no fewer than three (3) Form 50, *Requests for Hearing*.[1] In each, Claimant has alleged an injury to her back and left leg arising out of a March 26, 2018 incident in which she sustained her injuries while lifting a bucket of water. Pursuant to Claimant's most recent Form 50, a hearing was set on November 17, 2020. That hearing was cancelled by a Commission Order returning the case to the general files due to Claimant undergoing medical treatment for a personal health condition and additional relevant medical records not having been received by the parties.

[1] Form 50s filed on May 15, 2018; December 6, 2018; and September 3, 2020.

On February 24, 2021, the employer, CW Group, Inc. ("Employer")[2] and its carrier, PMA Insurance Group ("Carrier")(collectively, "Defendants"), filed a Form 21, *Employer's Request for Hearing*. Defendant requested a determination of compensability of this denied claim.[3] A hearing was set for May 26, 2021. After a statement of the parties' positions, the parties agreed and consented that the issues be tried to a decision on the merits by the undersigned Commissioner.

It is Defendants' contention that Claimant did not sustain a compensable injury by accident on March 26, 2018. Defendants contend that the evidence demonstrates that Claimant had a pre-existing condition for which she underwent a microdiscectomy at L5-S1 in 2017 and that she remained symptomatic following that procedure prior to and beyond the alleged date of injury of this claim. Defendants deny that Claimant had a compensable accident on March 26, 2018, as no such event was contemporaneously reported. Furthermore, Defendants rely on the testimony of Claimant's surgeon, Dr. deHoll who saw Claimant for a follow-up after the alleged March 26, 2018 incident and Claimant did not report to him any work-place accident. Dr. deHoll also testified that he saw no evidence of any acute injury in her post-accident MRI or treatment. It is Defendants' position that there is insufficient evidence to find a compensable injury by accident and insufficient medical evidence to support a claim for an aggravation of a pre-existing condition.

Defendants further contend that Claimant's average weekly wage should be computed using her payroll records from Employer and the corresponding Form 20, *Statement of Earnings*, on file with the Commission. The Form 20 reflects an average weekly wage of $169.91, and a

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[2] Employer's legal name is CW Group, Inc. Employer also utilizes a d/b/a of CW Resources, Inc. To the extent that there are any inconsistencies in the testimony or Commission file, the proper defendant entity in this Claim is CW Group, Inc.

[3] To the extent that the Form 21 was not the proper method for seeking a determination on compensability, the undersigned Commissioner finds that the issues addressed at the hearing were tried by consent of the parties without any objection.

corresponding compensation rate of $113.28. While Defendants concede the Claimant testified to concurrent employment at the time of her alleged accident, Claimant has not produced the required Form 20 from such concurrent employer and has not produced any corresponding payroll records. Defendants argue that this claim is over three (3) years old and Claimant has had ample time to produce such records if she intended to have such earnings considered as part of her compensation rate in this claim.

It is Claimant's position that the evidence in the record does support a finding of a compensable injury by accident and/or an aggravation of a pre-existing condition. Claimant relies on evidence of an emergency room visit on April 23, 2018 which references an incident at work "two weeks ago". Claimant further relies on an August 23, 2018, IME report from Dr. Donald R. Johnson, II, who stated that it was his opinion that Claimant's current symptom are causally-related to her work injury on March 26, 2018.

With regard to her compensation rate, Claimant's Pre-Hearing Brief alleges an average weekly wage of $291.00, with a corresponding compensation rate of $194.01. Claimant argues that this issue should be held in abeyance for a subsequent hearing as Claimant has not obtained the wage records or a Form 20 from her concurrent employer. Defendants objected to this request on the basis that the issue is ripe for determination and Defendants are entitled to an adjudication of compensation rate and compensability given the age of the case.

EVIDENCE OF THE CASE

Medical Evidence

Claimant had a lumbar MRI performed on October 25, 2016 that revealed an abnormal left L5-S1 disc protrusion with impingement on the left S1 nerve root. (Def. APA, p. 1) Claimant was seen by Dr. Todd Warrick, Sumter Spine and Pain Center, on October 27, 2016. (Def. APA, p. 13. Dr. Warrick notes that Claimant was a new patient with pain on her left side, lower back, that radiates into her left hip, leg, and foot for about two weeks. Claimant reported numbness and tingling in her left leg and foot. Dr. Warrick diagnosed Claimant with acute radicular pain from leftward L5-S1 HNP with S1 displacement and compression. (Def. APA, p. 15) Dr. Warrick recommended a transforaminal lumbar epidural steroid injection and noted consideration of a referral for a microdiscectomy. On November 28, 2016, Claimant reported 50% relief from the injection for 2.5 to 3 weeks. (Def. APA, p. 22) Dr. Warrick ordered a repeat injection. On December 22, 2016, Claimant reported the second injection gave her no relief and actually made her pain worse. (Def. APA, p. 25). Dr. Warrick referred Claimant to Dr. Paul D. deHoll, Palmetto Health USC Orthopedic Center. On January 6, 2017, Dr. deHoll recommended a left-sided microdiscectomy at L5-S1. (Def. APA, p. 38) Claimant underwent this procedure on February 1, 2017- - approximately one year prior to the date of the alleged injury. (Def. APA, p. 93)

Claimant was seen post-op by Dr. deHoll on February 10, 2017 (Def. APA, p. 42) Claimant reported overall that her leg pain had substantially improved, but she did continue to complain of some continued generalized malaise and back pain. (Def. APA, p. 43) On February 23, 2017, Claimant reported her leg pain had largely resolved but she was having a little bit of numbness. (Def. APA, p. 49) Dr. deHoll released her back to work with restrictions of no lifting.

Claimant returned to Dr. deHoll on November 30, 2017, with worsened pain - - 4 months prior to the date of the alleged injury. (Def. APA, p. 53) Dr. deHoll notes that Claimant reported that her pain had worsened since her last visit in February. He notes that she reported intermittent

pain radiating into her left leg, as well as minimal numbness and tingling in her toes. (Def. APA, p. 54) Under his review of systems, Dr. deHoll notes that Claimant's left ankle reflex is "absent." (Def. APA, p. 47) Dr. deHoll referred Claimant for physical therapy with consideration of additional injections if her symptoms did not improve. (Def. APA, pp. 47, 55)

On April 13, 2018, Claimant was seen by Dr. deHoll for a follow up. (Def. APA, p. 56) Dr. deHoll notes that Claimant was last seen in November 2017 and that she has been doing physical therapy since that visit. (Def. APA, p. 58) Dr. deHoll ordered a lumbar x-ray that showed loss of disc height at L5-S1. (Def. APA, pp. 58, 60) He ordered additional physical therapy with follow up after completion. Claimant did not mention any work accident to Dr. deHoll.

Claimant presented to Palmetto Health Toumey Emergency Room on April 23, 2018 (Def. APA, p. 3) According to the note, Claimant reported emptying a mop bucket "two weeks ago at work", that she felt something "pop," and "now has pain to buttocks, and has numbness to left leg." The note further reflects that Claimant reported her symptoms were similar to previous episodes. (Def. APA, p. 6) Claimant was prescribed medications and told to follow up with her primary care physician. (Def. APA, p. 10)

Claimant returned to Palmetto Health USC on April 27, 2018 and was seen by Douglas Dow, PA. (Def. APA, p. 61) Mr. Dow notes that Claimant had continued lower back pain for the past couple of years with a previous surgery in 2017. He also notes that Claimant had attempted physical therapy but her pain increased to the point she was unable to do it. Claimant reported decreased strength in her left leg and that she's been taking NSAIDs since December without any relief in her pain or symptoms. (Def. APA, p. 62). Mr. Dow ordered an MRI of her lumbar spine. (Def. APA, p. 63) The MRI was performed on May 3, 2018. (Def. APA, p. 34)

Claimant was seen at Sumter Physical Therapy Clinic on April 30, 2018. (Def. APA, p. 94) The therapist notes for this visit indicate that Claimant was unable to relieve her radicular symptoms during that session. An August 8, 2018 discharge note indicates that Claimant no-showed at her next appointment and did not return. She was discharged from care. (Def. APA, p. 97)

On May 3, 2018, Dr. deHoll reviewed Claimant's MRI. He notes that there is minimal bulging and evidence of her prior hemilaminotomy but no recurrent herniation. (Def. APA, p. 69) He did note severe discogenic collapse at L5-S1 with mild modic endplate changes. Dr. deHoll notes a preference to avoid any possible surgery, so he recommended a left-sided SI joint injection. Claimant received an SI injection from Dr. Warrick on June 18, 2018. (Def. APA, p. 31)

On July 19, 2018, Claimant returned to Dr. deHoll reporting worsening of her pain after her SI injection. (Def. APA, p. 73) Dr. deHoll states that his surgical recommendation at that time would be for a ALIF procedure at L5-S1 but that Claimant wanted to try to avoid that. Dr. deHoll referred her to Dr. Koranloo for pain management to see if he could improve her symptoms. On August 7, 2018, Dr. Koranloo recommended an EMG/NCS and an L5-S1 LESI. (Def. APA, pp. 76-77) Claimant EMG/NCS was normal. (Def. APA, pp. 82-83) On August 22, 2018, Dr. Koranloo indicates that Claimant got minimal relief from the injections and she was going to return to Dr. deHoll for the next course of action. (Def. APA, p. 85)

Claimant was seen by Dr. Donald Johnson for an IME on August 23, 2018. (Clmt APA, pp. 36-37). Dr. Johnson notes that Claimant had undergone an L5-S1 laminectomy in January 2016 and that Claimant did well from the surgery and was able to return to all activities. Dr. Johnson states that he reviewed records from Dr. deHoll, including August 7, 2018. He also reviewed her MRI and noted that she does not have a large recurrent disc herniation but did have disc space

collapse. Dr. Johnson states that he agrees with Dr. deHoll's recommendation of an ALIF at L5-S1 and that Claimant would be a good candidate. Dr. Johnson further states that it is his opinion to a reasonable degree of medical certainty that Claimant's current symptoms are causally related to her work injury of March 26, 2018 "by way of an exacerbation of a symptomatic exacerbation of a pre-existing asymptomatic condition." (Clmt APA, p. 37) Dr. Johnson states that Claimant is not at maximum medical improvement.

Deposition of Dr. Douglass deHoll

Dr. deHoll was deposed in this matter on August 23, 2018. Dr. deHoll testified that he had previously performed surgery on Claimant sometime in late-2016, early-2017, but he wasn't sure of the exact date without referencing any records. (Def. APA, pp. 105-6) He testified that he saw Claimant for follow-ups from that procedure in February and November of 2017. (Def. APA, p. 107) Dr. deHoll stated that in November 2017, Claimant presented with worse back pain and pain radiating into her left leg. (Def. APA, p. 108) He testified that when Claimant returned to him in April of 2018, she was there for the same complaints. (Def. APA, p. 108). He testified that her symptoms on April 27, 2018 were "basically what she's been complaining about in the last several months." (Def. APA, p. 110) Dr. deHoll testified that he did not recall having any conversation with Claimant about a work injury. (Def. APA, p. 110) He stated that he did not make any diagnosis that was different from any of her prior visits. (*Id.*) He testified that he ordered an MRI in May 2018 in order to rule out a re-herniation at the surgical level and concluded that she had not. (Def. APA, pp. 110-11) Dr. deHoll did testify that there was a degenerative collapse at that level and that it was "not an injury; it's wear and tear." (Def. APA, p. 111). When asked whether Claimant aggravated her prior condition in her alleged work accident, Dr. deHoll responded that had no history of anything happening at work and that it was never mentioned to him. (Def. APA, p. 119)

He further explained that the absence of any such reference was important because he uses a scribe and does not write his own notes. (Def. APA, p. 120) He testified that the first time a work accident was mentioned was during his most recent visit. (Def. APA, p. 121) Dr. deHoll did testify that it is possible for someone to aggravate or get hurt while lifting and pouring. (Def. APA, p. 122) He further testified that since his records reflect no reference to or report of a work injury, there is no way for him to correlate her issues to a work incident. (Def. APA, p. 126)

Dr. deHoll did testify that a Form 14B was apparently prepared by his office but that form should be disregarded as he was not involved in its preparation. (Def. APA, pp. 129-30) A blank Form 14B containing the hand written message "No knowledge of a work-related injury in treatment of this patient" was done by him. (*Id.*) According to Dr. deHoll, his diagnosis and treatment recommendations would not have changed even if he had knowledge of an alleged work injury. (Def. APA, p. 130-31)

Hearing Testimony

At the hearing, Claimant testified on her own behalf. Claimant testified that she resides in Dalzell, South Carolina with her husband and 16-year old daughter. Claimant graduated from Sumter High School and later attended Allen University but did not graduate. Claimant's work history includes working as a page at the South Carolina State House, some part-time work, and jobs with various health care providers. She has been employed by the South Carolina Department of Mental Health since 2015 and is currently an employment specialist. While still working the Department of Mental Health, Claimant took a second job working for Employer in October/November of 2017 performing janitorial services. Claimant was stationed to work at Shaw Air Force Base. Claimant described the various duties she performed in this job, including details regarding utilizing mops and buckets.

Claimant testified that she had surgery on her back in 2017.[4] Claimant testified that prior to this surgery she had experienced some pain and tightening in her back for which she sought chiropractic treatment. She was later referred to a pain specialist, Dr. Todd Warrick, and finally to Dr. deHoll for surgery. Claimant testified that she had follow ups with Dr. deHoll after her surgery with the last being in February, 2017. Claimant testified that she had no problems with her back between February, 2017 and when she started working for Employer. According to Claimant, she returned to Dr. deHoll in November 2017 "as a precaution." She explained that she had been doing strenuous work for Employer and wanted to make sure she was fine. Claimant testified that she told Dr. deHoll that she did have some "tightening" in her back and that he was fully aware that she was working a second job. She testified that Dr. deHoll did not take her out of work and that she then returned to work for employer.

Claimant testified that her accident occurred on either a Wednesday or Thursday at around 7:00 – 8:00 p.m. She testified that she was working in a building. She described that she took a mop bucket into the janitorial space with a floor sink and proceeded to turn the bucket over to empty it in the sink. As she was standing back up, she felt a popping, burning sensation in her back. She described feeling an immediate tingling with numbness and pain shooting down her butt area, down into her left leg. She testified that she didn't do anything about it at first but continued to work to finish up that building. She testified she did mention something to a co-working about

[4] The hearing testimony regarding the date of surgery was internally inconsistent in many places and included references to dates in late-2016, and early-2017. On cross-examination, Claimant was presented with documentation that the surgery actually took place on February 1, 2017. Claimant admitted that the surgery could have taken place on that date and she was just uncertain of the exact date. (*See* Hearing Transcript, pp. 43-45). An operation note in the record confirms the date of February 1, 2017. (*See* Defendants' APA #6, p. 93). References to this surgery in this order shall refer to the correct date, rather than the date erroneously referenced during the testimony.

her back hurting. According to Claimant, this co-worker came over and started massaging her butt area. Claimant testified that she called in sick the next Friday and has not been back to work for Employer at all since.

Claimant testified that she was later told by Ms. Teresa to go see a doctor. Claimant testified that she tried to go to Doctors Care about a week after the incident but the office visit was not authorized by Employer. Claimant testified she then went to see Dr. deHoll on April 16, 2017. She also later went to the ER.

According to Claimant, the pain following this incident is different from the pain she felt prior to her 2017 surgery. She described the new pain as being more in her tailbone, like she's sitting on something. She testified that she still has pain down her leg and numbness in her toes and foot.

Claimant testified that in December of 2018, she was diagnosed with breast cancer and started treatment for that in January, 2019. Claimant testified that she has had surgeries, as well as chemotherapy and radiation. She continues to treat for this condition while also still experiencing back pain. Claimant testified that her back problems affect her ability to carry on various activities because she can't sit for long periods of time. Claimant's limited treatment that she has received to her back since the injury has been paid for by her, out of pocket.

On cross-examination, Claimant testified that the tingling and numbness down her left leg after this accident was something that she had previously after her 2017 surgery. When asked about Dr. deHoll's notes from November 2017 that reference radiating pain and numbness/tingling, Claimant denied that she was experiencing those symptoms at that time. She also denied experiencing worsening pain in November 2017 as referenced in Dr. deHoll's notes. Claimant

reiterated that went to Dr. deHoll because she was feeling "tightness" in her back and wanted to have it checked out.

Following her alleged date of accident, Claimant returned to Dr. deHoll on April 13, 2017. While the note indicates that Claimant had been doing physical therapy since November, Claimant testified that she had only been to one therapy session but she did not go back. She testified that she did tell Dr. deHoll that her problems were work related despite the fact that the records do not contain any reference to it. Claimant did admit to have some additional treatment to her back since her accident, including injections and a physical therapy session in April 2018. According to Claimant, she only had one session of PT because the pain was so bad that the therapist said there was no need to do more until her pain got under control. Claimant disputed the discharge note saying she was discharged for no-showing at her next visit.

ORDER

Based on the foregoing, as well as the evidence submitted as whole, including the Commission file, depositions, testimony, and arguments of the parties, the undersigned Commissioner makes the following:

FINDINGS OF FACT

1. Claimant alleges that she injured her low back and left leg in a work-related accident on March 26, 2018, aggravating a pre-existing condition.

2. Claimant is 43 years of age. (This finding is based on the medical evidence establishing Claimant's date of birth as November 4, 1977; *see also* Claimant's Deposition, p. 6).

3. Claimant is a high school graduate. She also attended college, and is 11 hours shy of a bachelor's degree in business administration/management (This finding is based on testimony of Claimant; Claimant's Deposition, pp. 14-15; Claimant's APA, Exhibit B, pp. 3-4).

4. Claimant's job with Employer was custodian (This finding is based on the testimony of Claimant. *See also* Claimant's Deposition, p. 21; Claimant's APA, Exhibit B, pp. 1 and 4).

5. Although employment tenure is never dispositive with regard to compensability, it is evidence to consider: Claimant had only worked for several months when the alleged accident occurred. Claimant testified that she took the job as she needed to pay for private school and college tuition. She also testified that she has credit card debt. (This finding is based on the testimony of Claimant, pp. 26, 53; *see also* Claimant's Deposition, pp. 20 and 24-25).

6. Claimant's pre-existing low back condition (beginning in 2016) involved herniation at L5-S1, including left-side S1 nerve root compression affecting the leg/foot (This finding is based on Defendants' APA #1, p. 1; Defendants' APA #2, pp. 15 and 27; Defendants' APA #4, pp. 38-41).

7. Notwithstanding various misstatements in the record as to the date of Claimant's prior lumbar surgery (*See* Hearing Transcript, pp. 23, 24, 43-45; Deposition of Dr. deHoll, pp. 6-7 and 31; Dr. Koranloo's misstatement as contained in Claimant's APA #1, p. 17, and Claimant's APA #7, p. 39; Claimant's Deposition that she underwent prior back surgery in 2015, p. 31 and 34, and that the surgery was to L4--a different spinal level than that which was operated on), Claimant actually underwent the prior L5-S1 surgery with Dr. deHoll on February 1, 2017. (This finding is based on the Operative Report of February 1, 2017, as contained in Defendants' APA #6, p. 93).

8. Prior to the alleged injury of March 2018, Claimant returned to her treating surgeon (Dr. deHoll, a spine specialist) in **November 2017** (several months before the alleged injury in issue) with worsening back pain, such that Dr. deHoll ordered physical therapy. This evidence

contradicts and is inconsistent with Claimant's testimony that she had no back problem other than some "tightness," and that the November 2017 medical visit was only preventative. At this visit, Claimant's left ankle reflex is noted to be "absent" (*See* Hearing Transcript, pp. 42-43, 47-48, 60; Claimant's Deposition, pp. 33-34; Defendants' APA #4, pp. 47 and 53-55; Deposition of Dr. deHoll, pp. 4 and 7-9).

9. Additionally, Claimant told Physician Assistant Dow that she had "been taking NSAIDs *since December [2017] without any relief in her [back] pain or symptoms*" [emphasis added] (*See* Claimant's APA #1, p. 5, dated April 2018; Defendants' APA #4, p. 62).

10. Claimant reported an alleged work accident to Employer on April 2, 2018 (*See* Claimant's APA, Exhibit B, p. 18).

11. Claimant returned to Dr. deHoll on **April 13, 2018** (*See* Claimant's APA #1, pp. 1-3) and reported further worsening back pain, restricted range of motion, numbness, and tingling. Dr. deHoll referred Claimant to more physical therapy and prescribed various medications. **Claimant never reported a work injury to Dr. deHoll**, a finding I base on these records and on Dr. deHoll's deposition testimony (*See* Defendants' APA #5, p. 92, in which Dr. deHoll writes "no knowledge of a work related injury;" Deposition of Dr. deHoll, e.g., pp. 8-9, 19-21, 26, and 29: "I have no history of anything happening at work" and "She didn't mention anything specific about work.")

12. Dr. deHoll states that given the evidence in this case, there is no way for him to correlate Claimant's current back condition to an alleged work injury (*See* Deposition of Dr. deHoll, p. 26).

13. Dr. deHoll states that Claimant had no different diagnosis after the date of the alleged accident than she had prior (*See* Deposition of Dr. deHoll, pp. 9-11).

14. Claimant went to the Emergency Room on **April 23, 2018**, stating that she had sustained a work injury 2 weeks earlier (placing the accident date at approximately April 9). Instead of mentioning the worsening which began in November 2017, Claimant described her back and leg pain as "sudden," *i.e.*, "now" for "2 weeks" occurring with the alleged retroactive date of an accident (*See* Claimant's APA #2, e.g., pp. 20-23; Defendants' APA #1, pp. 2-12).

15. In the summer of 2018, Claimant advised Dr. deHoll that he would be deposed and that she had sustained a work injury (*See* Deposition of Dr. deHoll, p. 21).

16. Claimant's post-alleged accident MRI shows that Claimant's pre-accident herniation "is gone," but Claimant has "significant discogenic collapse with modic changes at L5-S1." There is no re-herniation, re-rupture, or other acute finding; Dr. deHoll states that there is instead degenerative collapse of the L5-S1 disc or "wear and tear" (*See* Claimant's APA #1, p. 15; Defendants' APA #4, p. 69; Deposition of Dr. deHoll in its entirety, but see particularly pp. 11, 13, 15, 18, and 25).

17. "Clinical History" in Claimant's MRI report of May 2018 states that Claimant has had "low back pain since November 2017." This November 2017 date pre-dates the alleged injury. (See Claimant's APA #4, p. 31; Defendants' APA #3, p. 34).

18. Dr. Koranloo's medical record states that there was an injury in April 2018—not March 2018 as pled by Claimant. Dr. Koranloo did not provide a causation/aggravation statement (*See* Defendants' APA #4, pp. 76 and 85; Defendants' APA #5, p. 89).

19. Dr. Troyer's record states that Claimant's symptoms have been present "since April [2018]" (*See* Defendants' APA #7, p. 98).

20. Dr. deHoll, who has treated Claimant both prior to and after the date of the alleged accident, states that Claimant never contemporaneously reported a work accident to him. When

deposed, the most he would opine to is that Claimant's alleged accident "can" cause, "could" cause, or "could have" caused Claimant's condition. He does not opine that it did or likely did (This finding is based on the Deposition of Dr. deHoll in its entirety, including but not limited to pp. 14, 18-20, 22, and 31-32).

21. Dr. Warrick, a pain specialist who treated Claimant for her back/leg both before and after the alleged work accident, did not provide a causation/aggravation statement. (This finding is based on medical evidence in its entirety; Claimant's Deposition, pp. 32 and 40).

22. As Claimant's treating physicians did not provide causation/aggravation statements, Claimant provided a causation opinion with a one-time IME (Dr. Johnson), who opined that Claimant's "*asymptomatic* [pre-existing] condition" was aggravated, an opinion unsupported by Dr. deHoll's and other treatment records [emphasis added]. I give greater weight to Dr. deHoll's treatment records and to his deposition testimony than I give to Dr. Johnson's inaccurate statement that Claimant's pre-existing condition was "asymptomatic" (*See* Claimant's APA #6, pp. 36-37).

23. Although by no means dispositive or pivotal, the mechanics of the alleged accident are also not entirely consistent: Claimant testified at the Hearing and at her deposition that she was standing back up after emptying a water bucket when she sustained an alleged injury (*See* Hearing Transcript, pp. 29-30 and Claimant's Deposition, p. 38, lines 8-13). Employer's accident report states that Claimant was lifting up the bucket and pouring when she injured her back (*See* Claimant's APA, Exhibit B, p. 19). The Emergency Room records states that Claimant was in the process of emptying a bucket (*See* Defendants' APA #1, pp. 3 and 5); and Claimant's counsel seems to indicate to Dr. deHoll that Claimant was in the process of lifting when she felt a pop (*See* Deposition of Dr. deHoll, p. 12, lines 22-24; p. 13, lines 24-25; and p. 14, lines 6-7).

24. Benefits under the Act are denied. Although pre-existing conditions may be readily aggravated, there are simply too many inconsistencies in the record for me to find this claim compensable.

25. Claimant's average weekly wage is $169.91, yielding a compensation rate of $113.28. I base this finding on the payroll records as contained in Claimant's APA, Exhibit B, pp. 20-21. This claim has been pending since 2018 (*i.e.*, for more than 3 years), and no concurrent employment Form 20 has ever been filed with the Commission. Nor was there a Motion made to leave the record open for a concurrent employment Form 20. The Commission cannot require a claimant to file a concurrent Form 20, as the law requires her to file one only if she wants other income considered. I decline to hold—or ask another commissioner to hold--another hearing for an issue over which Claimant has had ample time and opportunity to address. This was not a "surprise" hearing, but one that was properly noticed.

CONCLUSIONS OF LAW

Accordingly, as provided in the South Carolina Code of Laws, 1976, as amended, §42-17-40, it is the determination of this Commissioner that:

1. Under S.C. Code §42-3-180, this Commissioner has jurisdiction over the parties to hear the issues in dispute.

2. Under S.C. Code §42-1-130, Stara S. McLeod was a covered employee.

3. Under S.C. Code §42-1-140, CW Group, Inc. was a covered employer.

4. Under S.C. Code §42-3-150, there was an employer/employee relationship between the parties.

5. Under S.C. Code §42-17-20, venue in Sumter County, South Carolina, was proper and agreed to by the parties.

6. Under S.C. Code §1-23-320(b) and Regulation 67-607, notice of hearing was timely and properly served upon all parties of interest.

7. Under S.C. Code §42-1-160, the claimant, Stara S. McLeod, has failed to meet her burden of proof to show a compensable injury by accident arising out of and in the course of her employment. Likewise, Claimant has failed to meet her burden of proof to show a compensable aggravation of a pre-existing condition under S.C. Code §42-9-35.

8. Under S.C. Code §42-1-40, the claimant's average weekly wage is $169.91, yielding a compensation rate of $113.28. Claimant's alleged average weekly wage and compensation rate are unsupported by a Form 20 as required by S.C. Code Reg 67-1603(H). As such, any alleged concurrent employment wages cannot be considered in computing the average weekly wage and compensation. No motion was made to leave the record open for submission of a Form 20 was made so this determination is made in accordance with the Act.

9. All benefits under the Act are DENIED.

ORDER

IT IS THEREFORE ORDERED that Claimant's request for benefits under the Act is DENIED.

AND IT IS SO ORDERED.

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

Susan S. Barden

CERTIFICATE OF SERVICE

This is to certify that the undersigned has on this date served a copy of this order in the above entitled action upon all parties to this case by sending an electronic copy hereof by electronic mail addressed to the attorneys for said parties; or if there is an unrepresented party(ies), by depositing a copy hereof, postage paid in the United States mail, first class, addressed to the unrepresented party(ies) and to the attorney(s) for the represented party(ies).

By Barbara Skarbek on August 2, 2021

August 2, 2021

Order served via email:

Lee Dixon
LDixon@hedrickgardner.com

Dwight C Moore
MooreLawFirm@ftc-i.net

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
803-737-5675 www.wcc.sc.gov

WCC File #: **1805291**
Carrier File #:
Carrier Code #:
Employer FEIN #:

Claimant's Name: Stara McLEod SSN: [redacted] Employer's Name: CW Resources
Address: [redacted] Address: 416 Recreation Street
City: [redacted] State: [redacted] Zip: [redacted] City: Shaw Air Force Base State: SC Zip: 29152
Home Phone: [redacted] Work Phone: ( ) - Insurance Carrier: PMA Group Insurance
Preparer's Name: Dwight C. Moore Law Firm: Moore Law Firm, LLC Preparer's Phone #: (803) 778 - 6520

REQUEST FOR COMMISSION REVIEW

Request for Commission Review by ☒ Claimant ☐ Employer (check one) Date of Injury or Illness: 3/26/2018 (mm/dd/yyyy)

The undersigned makes application for review of the findings of the Commissioner in the above-captioned case. The request for review is based on the following grounds: (State the grounds of your appeal in the form of questions presented. Each question presented must contain a concise statement of one proposition of law or fact. Refer to evidence by title and exhibit number. Use additional pages if necessary).

See Attached Document.

(Check one) Oral argument ☒ is ☐ is not requested. Appellant's request for oral argument is waived if not indicated on this form.
I certify I have served this document pursuant to Reg. 67-211 by delivering a copy to Ms. Amy Bracy, Judicial Director, SC Workers' Compensation Comission address PO BOX 1715 Columbia, SC 29202 on the 13th day of August 2021,
by ☒ first class postage ☐ certified mail ☐ personal service ☐ electronic service

Preparer's Signature

Attorney
Title

moorelawfirm@ftc-i.net
Email

August 13, 2021
Date

Check this box if you are not represented by an attorney ☐

Questions about the use of this form should be directed to the Judicial Department at 803.737.5675 or appeals@wcc.sc.gov.

If the claimant appeals and is not represented by counsel, the Judicial Department will properly serve this form pursuant to Reg. 67-607 C. Pursuant to Reg. 67-205 and Reg. 701, the appeal must be postmarked no later than 14 days from the date of service of the Decision and Order of the Hearing Commissioner along with the filing fee. Attach a Form 32, if you are unable to pay the filing fee. Refer to Reg. 67-211 and Reg. 67-701 through 711.

ATTACHMENT
WCC Form #30: Request For Commission Review
GROUNDS

1. **Is there sufficient evidence in the record to support a finding that Claimant suffered a compensable injury by accident on March 26, 2018?**

"An injury is unexpected, bringing it within the category of accident, if the workers' compensation claimant did not intend it or expect it would result from what he was doing; therefore, if an injury is unexpected from the claimant's point of view, it qualifies as an injury by accident." Landry v. Carolinas Healthcare Systems, 396 S.C. 149, 719 S.E.2d 288 (2011), reh'g denied.

The Opinion And Award of Commissioner Susan S. Barden addresses evidence and testimony in the record that the Claimant sustained an injury to her back and left leg on March 26, 2018, arising out of and in the course of her employment while performing janitorial services for the Defendants. The accident occurred when Claimant emptying water out of a mop bucket into a floor sink. "As she was standing back up, she felt a popping, burning sensation in her back. She described feeling an immediate tingling with numbness and pain shooting down her butt area, down into her left leg." Order, 08/02/2021, p. 10, Hearing Testimony. Although conceding that the mechanics of the accident are neither dispositive nor pivotal, the Single Commissioner's Findings of Fact delves into the mechanics of this particular accident to support her conclusion that the Claimant has failed to meet her burden of proof to show a compensable injury by accident. The following inconsistencies are recited in Finding No. 23:

- "Claimant testified at the Hearing and at her deposition that she was standing back up after emptying a water bucket when she sustained an alleged injury;"
- "Employer's accident report states that Claimant was lifting up the bucket and pouring when she injured her back;"
- "The Emergency Room records states that Claimant was in the process of emptying a bucket; and"

- "Claimant's counsel seems to indicate to Dr. deHoll that Claimant was in the process of lifting when she felt a pop."

Order, 08/02/2021, p. 17, Findings of Fact, No. 23

Claimant contends that the issue here is not the frame-by-frame characterizations of what occurred; rather, the primary issue for consideration is whether or not an injury by accident occurred to Claimant's back and left leg in the process of emptying water out of a mop bucket into a floor sink and the fact that the actual occurrence of the injury was perceptible to the Claimant, reflected in the records of the Defendants, and recorded in the notes of the medical providers. Claimant asserts that the record contains substantial evidence that the Claimant suffered a compensable injury by accident on March 26, 2018.

"In determining whether a work-related injury is compensable, courts liberally construe the Workers' Compensation Law toward providing coverage and resolve any reasonable doubt as to the construction of the Law in favor of coverage." Whigham v. Jackson Dawson Communications, 410 S.C. 131, 763 S.E.2d 420 (2014), reh'g denied.

2. Is there sufficient evidence in the record to support a finding that the Claimant suffered aggravation of a pre-existing condition arising in the course of and out of her employment with the Defendant?

In denying the Claimant's claim for benefits under the Workers' Compensation Act, the Single Commissioner adopted the position of the Defendants that there was insufficient medical evidence in the record to support a claim for an aggravation of a pre-existing condition.

Claimant had a lumbar MRI performed on October 25, 2016, that revealed an abnormal left L5-S1 disc protrusion with impingement on the left S1 nerve root. She was seen by Dr. Todd Warrick, Sumter Spine and Pain Center on October 27, 2016, who noted that Claimant was a new patient with pain on the left side, lower back, that radiates into her left hip, leg, and foot for about two weeks. She reported numbness and tingling in her left leg and foot. Dr. Warrick's

diagnosis was acute radicular pain from leftward L5-SI HNP with S1 displacement and compression. He recommended a transforaminal lumbar epidural steroid injection ad noted consideration of a referral for a microdiscectomy. On November 28, 2016, the Claimant reported 50% relief from the injection for two and a half to three weeks and Dr. Warrick ordered a repeat injection. On December 22, 2016, Claimant reported the second injection gave her no relief and actually made her pain worse. Dr. Warrick referred Claimant to Dr. Paul D. deHoll of Palmetto Health US Orthopedic Center, who recommended and performed a left-sided microdiscectomy at L-5-S1 on February 1, 2017, Claimant was seen by Dr. deHoll post op on February 10, 2017, and on February 23, 2017, when she reported that her leg pain had largely resolved but she was having a little bit of numbness. He released her back to work with restrictions of no lifting and referred her for physical therapy. She last saw Dr. deHoll on November 2017. She was still employed, and the accident occurred on March 26, 2018.

Claimant was seen by Dr. deHoll on April 13, 2018. He ordered a lumbar x-ray that showed loss of disc height at L5-S1 and ordered additional physical therapy.

Claimant presented to Palmetto Health Tuomey Emergency Room on April 23, 2018, and the notes from that encounter was that Claimant reported emptying mop bucket "two weeks ago at work," that she felt something "pop," and "now has pain to buttocks, and has numbness to left leg."

Subsequently, the Claimant was seen by Douglas Dow, PA, at Palmetto Health USC, on April 27, 2018, He notes that Claimant reported decreased strength in her left leg and that she had been taking NSAIDs since December without any relief in her pain or symptoms. He ordered an MRI, which was performed on May 3, 2018. On April 30, 2018, Claimant was seen at Sumter Physical Therapy Clinic, at which time the therapist notes state that Claimant was

unable to relieve her radicular symptoms during that session. Medical records and notes reflect that Claimant's condition has continued to worsen despite continuing with various prescribed treatments.

On August 21, 2018, Claimant was seen by Dr. Donald Johnson for an IME. Dr. Johnson notes that she had undergone an L5-S1 laminectomy in January 2016, that she had done well from the surgery and was able to return to all activities. He states that he reviewed the records from Dr. deHoll, her MRI, and that she does not have a large recurrent disc herniation, but did have disc space collapse. He states that he agrees with dr. deHoll's recommendation of an ALIF at L5-S1 and that Claimant would be a good candidate. Dr. Johnson further states that it is his opinion to a reasonable degree of medical certainty that Claimant's current symptoms are causally related to her work injury of March 26, 2018 "by way of an exacerbation of a symptomatic exacerbation of a pre-existing asymptomatic condition." Dr. Johnson states that Claimant is not at maximum medical improvement.

Dr. deHoll reported in his deposition that he did not recall having any conversation with the Claimant about a work injury, and that he had no history of anything happening at work and that it was never mentioned to him. He testified that the first time a work accident was mentioned was during his most recent visit. Dr. deHoll did testify that it is possible for someone to aggravate or get hurt while lifting and pouring. He further testified that since his records reflect no reference to or report of a work injury, there is no way for him to correlate her issues to a work incident. Order, 08/02/2021, pp. 5 -10, Medical Evidence

The record does not reflect an opinion by Dr. deHoll on Claimant's issue of aggravation of a pre-existing condition. The only opinion is from Dr. Johnson from whom an opinion is given to a reasonable degree of medical certainty.

"In workers' compensation cases, a work-related accident which aggravates or accelerates a pre-existing condition, infirmity, or disease is compensable unless it is due solely to the natural progression of a pre-existing condition, and it is not defense that the accident, standing alone, would not have caused claimants condition, because the employer takes the employee as it finds him or her." Hargrove v. Tital Textile Co., 360 S.C. 276, 599 S.E.2d 604 (2004).

3. Did the Claimant timely report her accident within the requirements of the South Carolina Workers' Compensation Law?

"Defendants deny that Claimant had a compensable accident on March 26, 2018, as no such event was contemporaneously reported." Order, 08/02/2021, p. 4, Statement of the Case. Substantial evidence in the record shows that the accident was timely reported.

4. Should the issue of Claimant's average weekly wage be held in abeyance to allow the acquisition of a Form 20 and use of Claimant's wages from a concurrent employer to be to be factored into the computation of her average weekly wage?

"If the claimant alleges he or she worked for two or more employers when the injury occurred, the claimant may request the additional wages be included as part of his or her average weekly wage" pursuant to R.67-207.

According to S.C. Code Ann. § 42- 1- 40 (Supp.2009), The Workers' Compensation Act defines average weekly wage as "the earnings of the injured employee in the employment in which he was working at the time of the injury during the period of fifty-two weeks immediately preceding the date of the injury…".

In this case, the Claimant's total average weekly wage was not included in the computation because the issue was not held in abeyance for Claimant to obtain all wages and file a Form 20 calculating the claimant's wages including wages from second job.

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737-5675 www.wcc.sc.gov

WCC File #: 1805291
Carrier File #:
Carrier Code #:
Employer FEIN #:

Claimant's Name: Stara S. McLeod SSN: [redacted] Employer's Name: CW Resources, Inc.

Address: [redacted] Address: 416 Recreation Street

City: [redacted] State: [redacted] Zip: [redacted] City: Shaw AFB State: SC Zip: 29152

Home Phone: [redacted] Work Phone: Insurance Carrier: PMA Insurance Group

Preparer's Name: Lee E. Dixon Law Firm: Hedrick Gardner Kincheloe & Garofalo LLP Preparer's Phone #: 803-727-1215

The date of injury reported on Form 12A is: 3/26/2018 (m/d/yyyy)

Check appropriate section(s). The Employer's Representative requests a hearing to:

I. ☐ **Stop payment of compensation.** Claimant has reached maximum medical improvement and Claimant continues to receive temporary compensation payments. The employer's representative requests a hearing pursuant to § 42-9-260(D) to stop payment of temporary compensation. A hearing requested pursuant to this section must be held within sixty days of the date of the request.

Claimant reached maximum medical improvement on___ (m/d/yyyy) (copy of medical report must be attached).
Compensation payments are current as of ___ (m/d/yyyy) and shall continue until otherwise ordered or until Form 17 is signed by the claimant.
A Form 17 was offered and refused on ___ (m/d/yyyy).

II. ☐ **Address suspension, termination, or reduction of temporary disability payments for any cause.**
☐a. At any time pursuant to § 42-9-260(E).
☐b. After the one-hundred-fifty day period has expired pursuant to § 42-9-260(F), R.67-505 and R.67-506.
The basis for the termination/suspension is

III. ☒ **Determine if compensation is due** pursuant to § 42-9-10, § 42-9-20 or § 42-9-30 and, if so, in what amount, based on the following grounds:

Claimant released at maximum medical improvement on 5/3/2018 with no permanent physical impairment.
Claimant reached maximum medical improvement on 5/3/2018 (m/d/yyyy) (copy of medical report must be attached).

IV. ☐ **Request Credit for Overpayment of temporary compensation pursuant to § 42-9-210.**

V. ☐ **Determine amount of compensation for claims involving a fatality.**
☐a. Payment of unpaid balance of compensation when employee dies pursuant to § 42-9-280.
☐b. Amount of compensation for death of employee due to accident pursuant to § 42-9-290.

VI. ☐ **Mediation**
☐a. Mediation is requested to be ordered pursuant to Reg. 67-1801 B.
☐b. Mediation is required pursuant to Reg. 67-1802.
☐c. Mediation is requested by consent of the Parties pursuant to Reg. 67-1803.
☐d. Mediation has been conducted by a duly qualified mediator and resulted in an impasse.
Failure to respond pursuant to Reg. 67-208 B in writing result in ordered mediation pursuant to Reg. 67-1801 B.
Questions regarding mediation may be submitted to mediation@wcc.sc.gov.

I certify that I have served this document pursuant to Reg. 67-211 by delivering a copy to Dwight C. Moore address Post Office Box 1229, Sumter, SC 29151-1229 on 24th day of February, 2021, by ☐first class postage ☐ certified mail ☐ personal service ☐ electronic service. A $50.00 filing fee and updated Form 18 is required.

Preparer's Signature | Attorney for Employer/Carrier (Title) | ldixon@hedrickgardner.com (Email) | February 24, 2021 (Date)

Questions about the use of this form should be directed to the Judicial Department at 803-737-5675, or judicial@wcc.sc.gov or mediation@wcc.sc.gov
Refer to Regulations 67-211, 67-504, 67-505, 67-506; and 67-510

South Carolina Workers' Compensation Commission
P.O. Box 1715 • 1333 Main Street, Suite 500
Columbia, South Carolina 29202-1715
(803) 737-5700

WCC File # 1805291
Carrier File #
Carrier Code #
Employer FEIN

Stara S. McLeod [redacted]
Claimant's Name SSN

[redacted]
Address City State Zip

[redacted]
Home Phone Work Phone

CW Resources, Inc.
Employer's Name

416 Recreation Street
Shaw AFB, SC 29152
Address City State Zip

PMA Insurance Group
Insurance Carrier

Lee E. Dixon 803-727-1215
Preparer's Name Phone #

1. Date of injury: 3/26/2018
month day year

2. Total Weeks of Compensation Paid: 0

3. Type of Compensation Paid (TP or TT)/Periods of Payment:

Type: _____ From: _____ To: _____

Type: _____ From: _____ To: _____

Type: _____ From: _____ To: _____

4. Date of First Payment: _____
month day year

5. Total Amount Paid (a) Compensation: $0.00

(b) Medical (Include Nursing, Hospital Drugs, Etc.): $0.00

Lee E Dixon 803-727-1215 02/23/2021
Employer's Representative Phone Date

Type or print all information. File this form 6 months after the alleged injury date and each 6 months until the Commission's File is closed. Form 18 must be filed whether or not compensation is ongoing. Check "yes" after number 6 to request an informal conference. Refer to R.67-413, R.67-507, and R.67-804 for further information.

MCLEOD, STARA (id #286433, dob: 11/04/1977)

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500 • Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737-5675
www.wcc.sc.gov

Physician's Statement

Claimant's Name:	Stara McLeod	Employer's Name:	CW Group Inc CW Resources
Physician's Name:	Dr. Paul Douglas DeHoff	Insurance Carrier:	PA Manufacturers Assn. Ins. Co.
Practice/Clinic:	Palmetto Health USC Orthopedic Center	SCWCC File No:	1805291
Preparer's Name:		Phone:	

The undersigned physician has been authorized to evaluate or treat this Claimant for his or her work injury or illness pursuant to *South Carolina Code Sections* 42-15-60, 42-15-60, 42-1-172, or 42-11-10.

Date of injury: 03/28/2018 Date of first office visit: 1/16/2017 Date of last office visit: 5/3/2018

The medical opinions below are stated to a reasonable degree of medical certainty.

Diagnosis or nature of injury or illness: M48.061-Spinal Stenosis

Body part(s) injured: Lumbar Spine Body part(s) affected: Lumbar Spine

Date of maximum medical improvement: 5/3/2018

Has the Claimant sustained permanent physical impairment as a result of the work injury? ____ Yes X No

If so, the permanent physical impairment is: ____ % medical impairment to the _____ (injured body part).

If there is a permanent physical impairment to other body part(s) as a result of the work injury, please indicate below:
____ % medical impairment to the _____ (additional body part injured or affected).

The impairment rating(s) above are based upon the following:

X The AMA's *Guides to the Evaluation of Permanent Impairment* ____ Edition; or
____ Other medical treatise: _____ or
____ Other: _____

Does the Claimant have permanent physical limitations as a result of the injury? ____ Yes X No

If so, the permanent physical limitations are: _____

Does the Claimant possess retained hardware as a result of the injury? X Yes ____ No

If so, the retained hardware is: Lumbar Microdiscectomy 5/1 Date: 2/1/17

Is there medical, surgical, hospital or other treatment that the Claimant needs as a result of the injury for an additional time that will tend to lessen the period of disability or maintain the current level of function: X Yes ____ No

If so, the medical care and treatment that is needed is/are:

Sacroiliac joint Injection - left SI joint

*An indication or statement that future medical care "may be necessary" or "might be necessary" is not sufficient and will require further clarification.

I certify that I am a physician or other licensed healthcare provider, I have personally read and prepared this document, and the opinions reflected above are mine.

D. DeHoff M.D.

Treating or Evaluating Physician

6/23/2018
Date

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500 • Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737-5723 www.wcc.sc.gov

WCC File #: **1805291**
Carrier File #: **W002335075**
Carrier Code #:
Employer FEIN #:

Claimant's Name: Stara McLeod SSN: [redacted]
Address: [redacted]
City: [redacted] State: [redacted] Zip: [redacted]
Home Phone: [redacted] Work Phone: ( ) -

Employer's Name: CW Resources Inc.
Address: 416 Recreation Street
City: Shaw Air Force Base State: SC Zip: 29152
Insurance Carrier: PMA Insurance Group

Preparer's Name: Dwight C. Moore Law Firm: Moore Law Firm, LLC Preparer's Phone #: (803) 778 - 6520

A claim for workers' compensation benefits is made based on the following grounds:
☒ Injury ☐ Illness ☐ Repetitive Trauma ☐ Occupational Disease ☐ Physical Brain Injury ☐ Concurrent Jurisdiction

1. The claimant sustained an injury to back and left leg (Part(s) of Body Injured) on 3/26/2018 (Month/Day/Year) in Sumter county, state of SC.
2. Body part(s) affected are: Back and left leg.
   Briefly describe how the accident occurred. Claimant sustained injuries to the back and left leg by lifting a bucket of water.
3. Both the claimant and the employer were subject to the South Carolina Workers' Compensation Act at the time of injury.
4. The relationship of employer and employee existed at the time of injury.
5. At the time of the injury the claimant was performing services arising out of and in the course of employment.
6. Notice of the accidental injury was given to the Employer on 3/26/2018 (Month/Day/Year) in the following manner:
   Notified supervisor: Annie Crawford

SCWCC
SEP 09 2020
JUDICIAL

☒ 7. Due to injury, the claimant is in need of (check one):
   ☐ (a) medical examination and treatment for: ____
   ☒ (b) additional medical examination and treatment for: back and left leg.

☒ 8. Due to injury, the claimant requests temporary total disability benefits because of lost compensable time from work and wages for the period of:
   3/26/2018 to present

☒ 9. Due to the injury, the Claimant has permanent disability of the following nature and extent (check one):
   ☒ (1) General Disability: ☐ Total ☒ Partial ☐ (2) Specific Disability: ☐ Total ☐ Partial ☐ (3) Wage Loss
   9a. Claimant at MMI: ☐ Yes ☒ No

☐ 10. Due to the injury, the Claimant has a serious bodily disfigurement consisting of:

10a. At the time of the injury, the Claimant was paid weekly wages of $291.00, and demands accounting of days worked and wages earned as provided by law.

10b. Give names and addresses of all employers for whom the Claimant has worked since the date of the accident:
Santee-Wateree Mental Health Center, 215 N. Magnolia Street Sumter, SC 29150

11. Further grounds or unusual aspects of claim:
Defendants contend that Claimant has not sustained a compensable work related injury.

11a. List names and addresses of all physicians or other medical specialists who have seen or treated the Claimant as a result of the accident:
See Attachment A

11b. To the best of your knowledge, did you have any prior permanent disability? N/A
If yes, describe: ____

12. Appropriate benefits as provided in the Act for the above grounds and other relief as the Workers' Compensation Commission may direct as just and proper.

☐ 13. **I am filing a claim. I am not requesting a hearing at this time.** Estimated time needed for hearing: _____

☒ 14. **I am requesting a hearing. A $50 fee is required.**

☐ **Mediation**
- ☐ a. Mediation is requested to be ordered pursuant to Reg. 67-1801 B.
- ☐ b. Mediation is required pursuant to Reg. 67-1802.
- ☐ c. Mediation is requested by consent of the Parties pursuant to Reg. 67-1803.
- ☐ d. Mediation has been conducted by a duly qualified mediator and resulted in an impasse.

Questions regarding mediation may be submitted to mediation@wcc.sc.gov.

I certify I have served this document pursuant to Reg. 67-211 by delivering a copy to: Lee E. Dixon, Esquire
address 1230 Main Street, Suite 325 Columbia, SC 29201 **on the** 3rd **day of** September **2020 ,by** ☒ **first class postage** ☐ **certified mail** ☐ **personal service** ☐ **electronic service**

I verify the contents of this form are accurate and true to the best of my knowledge.

Preparer's Signature	Attorney (Title)	moorelawfirm@ftc-i.net (Email)	9/2/20 (Date)

Questions about the use of this form should be directed to the Claims Department at 803.737.5723. Refer to Regulations 67-204 through 67-211 and Regulations 67-601 through 67-615 as well as Reg. 67-1801.

11a: List names and addresses of all physicians or other medical specialist who have seen or treated the claimant as a result of the accident

Attachment

Palmetto Health - USC Spine Center
101 Business Park Blvd, Suite D
Columbia, SC 29203
Dr. P. Doug DeHoll
Dr. Kamran Koranloo

Palmetto Health Tuomey
129 N. Washington Street
Sumter, SC 29150
Phone: 803-774-6824

Sumter Spine Pain Center
100 North Sumter Street, Suite 320
Sumter, SC 29150
Phone: 803-774-6824
Fax: 803-774-8977
Dr. Todd Warrick

Sumter Physical Therapy
1185 Wilson Hall Road
Sumter, SC 29150
Phone (803) 469-3213
Fax (803) 469-3233

Encompass Health Rehabilitation Hospital
2935 Colonial Drive
Columbia, SC 29203
Phone (803) (803) 254-7777
Dr. Devin Troyer

Southeastern Spine Institute
1106 Chuck Dawley Blvd. Suite 200
Mt. Pleasant, SC 29464
Phone (843) 849-1551
Dr. Donald R. Johnson II

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500 • Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737-5723 www.wcc.sc.gov

WCC File #: 1805291
Carrier File #: W002335075
Carrier Code #:
Employer FEIN #:

Claimant's Name: Stara McLeod SSN: [redacted]
Address: [redacted]
City: [redacted] State: [redacted] Zip: [redacted]
Home Phone: [redacted] Work Phone: [redacted]

Employer's Name: CW Resources Inc.
Address: 416 Recreation Street
City: Shaw Air Force Base State: SC Zip: 29152
Insurance Carrier: PMA Group Insurance

Preparer's Name: Atty. Dwight C. Moore Law Firm: Moore Law Firm, LLC Preparer's Phone #: (803) 778 - 6520

A claim for workers' compensation benefits is made based on the following grounds: **Date of Injury or Illness: 3/26/2018**

☒Injury ☐ Illness ☐ Repetitive Trauma ☐Occupational Disease ☐Physical Brain Injury ☐Concurrent Jurisdiction

1. The claimant sustained an injury to back and leg (Part(s) of Body Injured) on 3/26/2018 (Month/Day/Year) in Sumter county, state of SC.
2. Body part(s) affected are: Back and leg
   Briefly describe how the accident occurred. Claimant injured back by lifting a bucket of water.
3. Both the claimant and the employer were subject to the South Carolina Workers' Compensation Act at the time of injury.
4. The relationship of employer and employee existed at the time of injury.
5. At the time of the injury the claimant was performing services arising out of and in the course of employment.
6. Notice of the accidental injury was given to the Employer on 3/26/2018 (Month/Day/Year) in the following manner:
   Notified supervisor: Annie Crawford

☒7. Due to injury, the claimant is in need of (check one):

☒(a) medical examination and treatment for: back and leg

☐(b) additional medical examination and treatment for: ____

☒8. Due to injury, the claimant requests temporary total disability benefits because of lost compensable time from work and wages for the period of:
May 26, 2018 to present.

☒9. Due to the injury, the Claimant has permanent disability of the following nature and extent (check one):

☒(1) General Disability: ☐Total ☒ Partial ☒(2) Specific Disability: ☐Total ☒ Partial ☒ (3) Wage Loss

9a. ☐A determination of permanent disability is premature at this time.

☐10. Due to the injury, the Claimant has a serious bodily disfigurement consisting of:

10a. At the time of the injury, the Claimant was paid weekly wages of $291.00, and demands accounting of days worked and wages earned as provided by law.

10b. Give names and addresses of all employers for whom the Claimant has worked since the date of the accident:
Santee-Wateree Mental Health Center, 215 N. Magnolia Street. Sumter, SC 29150

11. Further grounds or unusual aspects of claim:

11a. List names and addresses of all physicians or other medical specialists who have seen or treated the Claimant as a result of the accident:
See attachment A

11b. To the best of your knowledge, did you have any prior permanent disability? ____
If yes, describe: ____

12. Appropriate benefits as provided in the Act for the above grounds and other relief as the Workers' Compensation Commission may direct as just and proper.

☐13a. **I am filing a claim. I am not requesting a hearing at this time.**

14. Estimated time needed for hearing: 1 Hour

☒13b. **I am requesting a hearing. A $50 fee is required.**

☐ **Mediation**

- ☐a. Mediation is requested to be ordered pursuant to Reg. 67-1801 B.
- ☐b. Mediation is required pursuant to Reg. 67-1802.
- ☐c. Mediation is requested by consent of the Parties pursuant to Reg. 67-1803.
- ☐d. Mediation has been conducted by a duly qualified mediator and resulted in an impasse.

Questions regarding mediation may be submitted to mediation@wcc.sc.gov.

WCC
DEC 2 [illegible]

I certify I have served this document pursuant to Reg. 67-211 by delivering a copy to PMA Group Insurance, Lee Dixon & R. Daniel Addison Address PO Box 5231, Janesville, WI 53547, P.O. Box 11267 Columbia, SC and P.O. Box 7637 Columbia, SC 29202 on the 18th day of December 20 18 , by ☒ first class postage ☐certified mail ☐personal service.

I verify the contents of this form are accurate and true to the best of my knowledge.

Preparer's Signature	Attorney Title	moorelawfirm@ftc-i.net Email	12/18/18 Date

Questions about the use of this form should be directed to the Claims Department at 803.737.5723. Refer to Regulations 67-204 through 67-211 and Regulations 67-601 through 67-615 as well as Reg. 67-1801.

WCC Form # 50
Revised 7/18

50 **Employee's Notice of Claim and/or Request for Hearing**

11a: List names and addresses of all physicians or other medical specialists who have seen or treated the Claimant as a result of the accident:

Attachment A

Palmetto Health - USC Spine Center
101 Business Park Blvd, Suite D
Columbia, SC 29203
Dr. P. Doug DeHoll
Dr. Kamran Koranloo

Palmetto Health Tuomey
129 N. Washington Street
Sumter, SC 29150
Phone: 803-774-6824

Sumter Spine Pain Center
100 North Sumter Street, Suite 320
Sumter, SC 29150
Phone: 803-774-6824
Fax: 803-774-8977
Dr. Todd Warrick

Sumter Physical Therapy
1185 Wilson Hall Road
Sumter, SC 29150
Phone (803) 469-3213
Fax (803) 469-3233

Encompass Health Rehabilitation Hospital
2935 Colonial Drive
Columbia, SC 29203
Phone (803) (803) 254-7777
Dr. Devin Troyer

Southeastern Spine Institute
1106 Chuck Dawley Blvd. Suite 200
Mt. Pleasant, SC 29464
Phone (843) 849-1551
Dr. Donald R. Johnson II

C201805210004520

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500 • Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737-5675 www.wcc.sc.gov

WCC File #: _____
Carrier File #: _____
Carrier Code #: _____
Employer FEIN #: _____

Claimant's Name: Stara S. McLeod SSN: [redacted] Employer's Name: CW Resources Inc.

Address: [redacted] Address: 416 Recreation Street

City: [redacted] State: [redacted] Zip: [redacted] City: Shaw AFB State: SC Zip: 29152

Home Phone: [redacted] Work Phone: _____ Insurance Carrier: Twin City Fire Insurance

Preparer's Name: Dwight C. Moore Law Firm: Moore Law Firm Preparer's Phone #: (803) 778-6520

A claim for workers' compensation benefits is made based on the following grounds: Date of Injury or Illness: 3/26/2018

☑ Injury ☐ Illness ☐ Repetitive Trauma ☐ Occupational Disease ☐ Physical Brain Injury ☐ Concurrent Jurisdiction

1. The claimant sustained an injury to back, butt and leg (Part(s) of Body Injured) on 3/26/2018 (Month/Day/Year) in Sumter county, state of SC. Body part(s) affected are: Back, butt and leg
2. Briefly describe how the accident occurred. Claimant was throwing out a bucket of water.
3. Both the claimant and the employer were subject to the South Carolina Workers' Compensation Act at the time of injury.
4. The relationship of employer and employee existed at the time of injury.
5. At the time of the injury the claimant was performing services arising out of and in the course of employment.
6. Notice of the accidental injury was given to the Employer on 3/26/2018 (Month/Day/Year) in the following manner: Annie Crawford

☑ 7. Due to injury, the claimant is in need of (check one):
☑ (a) medical examination and treatment for: Back, butt and leg
☐ (b) additional medical examination and treatment for: _____

☑ 8. Due to injury, the claimant requests temporary total disability benefits because of lost compensable time from work and wages for the period of: May 26 to the present.

☑ 9. Due to the injury, the Claimant has permanent disability of the following nature and extent (check one):
☑ (1) General Disability: ☐ Total ☑ Partial ☑ (2) Specific Disability: ☐ Total ☑ Partial ☑ (3) Wage Loss

☐ 9a. ☐ A determination of permanent disability is premature at this time.

☐ 10. Due to the injury, the Claimant has a serious bodily disfigurement consisting of:

10a. At the time of the injury, the Claimant was paid weekly wages of $291.00, and demands accounting of days worked and wages earned as provided by law.

10b. Give names and addresses of all employers for whom the Claimant has worked since the date of the accident:
Santee-Wateree Mental Health Center, 215 N. Magnolia Street Sumter, SC 29150

11. Further grounds or unusual aspects of claim:

11a. List names and addresses of all physicians or other medical specialists who have seen or treated the Claimant as a result of the accident:
Palmetto Health Tuomey 129 N. Washington St Sumter, SC; Palmetto Health -USC Orthopedic 100 N. Sumter, Suite 200 Sumter SC

11b. To the best of your knowledge, did you have any prior permanent disability?
If yes, describe:

12. Appropriate benefits as provided in the Act for the above grounds and other relief as the Workers' Compensation Commission may direct as just and proper.

☐ 13a. I am filing a claim. I am not requesting a hearing at this time.

☑ 13b. I am requesting a hearing. A $25 fee is required.

14. Estimated time needed for hearing: 1 Hour

☐ Mediation
- ☐ a. Mediation is requested to be ordered pursuant to Reg. 67-1801 B.
- ☐ b. Mediation is required pursuant to Reg. 67-1802.
- ☐ c. Mediation is requested by consent of the Parties pursuant to Reg. 67-1803.
- ☐ d. Mediation has been conducted by a duly qualified mediator and resulted in an impasse.

Questions regarding mediation may be submitted to mediation@wcc.sc.gov.

I certify I have served this document pursuant to Reg. 67-211 by delivering a copy to PMA Group Insurance address PO Box 5231, Jamesville, WI 53547 on the 15 day of May 2018, by ☑ first class postage ☐ certified mail ☐ personal service.

I verify the contents of this form are accurate and true to the best of my knowledge.

Preparer's Signature	Title	Email	Date
[signature]	Attorney	moorelawfirm@fic-l.net	05/15/2018

Questions about the use of this form should be directed to the Claims Department at 803.737.5723. Refer to Regulations 67-204 through 67-211 and Regulations 67-601 through 67-615 as well as Reg. 67-1801.

WCC Form # 50
Revised 7/13

50

Employee's Notice of Claim and/or Request for Hearing

PMA CRDATE 05212018

STATE OF SOUTH CAROLINA
BEFORE THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
WCC No. 1805291

Stara McLeod,	)
	)
Claimant,	)
	)
v.	)
	)
CW Group,	)
	)
Employer,	)
	)
and	)
	)
PA Manufacturing Association Insurance Company,	)
	)
Carrier/Defendants.	)
	)

FULL COMMISSION HEARING

****

Monday, October 18, 2021
1:32 p.m. - 1:52 p.m.

The Full Commission Hearing was conducted virtually before Commissioners Aisha Taylor, T. Scott Beck, and Avery B. Wilkerson, Jr. on the 18th day of October, 2021, before Katherine M. Boone, Court Reporter and Notary Public in and for the State of South Carolina.

APPEARANCES

Dwight C. Moore, Esquire
Moore Law Firm, LLC
26 North Main Street
Sumter, South Carolina 29150
moorelawfirm@ftc-i.net
Attorney for the Claimant

Lee E. Dixon, Esquire
Hedrick Gardner Kincheloe & Garofalo, LLP
1230 Main Street, Suite 325
Columbia, South Carolina 29201
ldixon@hedrickgardner.com
Attorney for the Defendants

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EXHIBITS

(There were no exhibits marked during the hearing.)

STIPULATIONS

It is stipulated and agreed that this deposition is being taken pursuant to the Administrative Procedures Act and the South Carolina Rules of Civil Procedure.

CALL TO ORDER:

COMMISSIONER TAYLOR: Madam Court Reporter, can you please call the case?

COURT REPORTER: Today is October 18, 2021. This is South Carolina Workers' Compensation Case Number 1805291. This is the case of Stara McLeod, Claimant, versus CW Group, Employer, and Pennsylvania Manufacturers Association Insurance Company, Carrier. The Appellant is the Claimant, represented by Dwight C. Moore. The Respondent is represented by Lee Dixon. Each side is allowed ten minutes for oral argument, and the Appellant three minutes in reply. You are requested to argue the grounds of exception and stay within the record.

COMMISSIONER TAYLOR: Okay. Mr. Moore.

CLAIMANT'S CASE:

MR. MOORE: My name is Dwight Moore and I represent Ms. Stara McLeod in this matter relative to CW Group, Employer. Just a little bit about her and I'll get straight into the issues. A 43 year old married lady, has two children, had one in high school at the time. Had worked for the Department of Mental Health since 2015. Had started with CW Group in November of 2017

as a janitor. Her primary responsibility at the Department of Mental Health was administrative there where she still currently works. The issue before the Commissioner is whether there's substantial evidence in the record that will lend itself to this claim being compensable by accident as of 3/26/2018. I'll start my arguing by referring the Commission to the brief of the single commissioner, relative to our basis for believing that this matter is compensable. Page six of the actual brief -- I'm sorry, of the actual opinion, bottom of that page, reads this way. And I'll wait 'til everyone -- because we're not sitting in front of each other, I can't tell whether you have it pulled up or not.

COMMISSIONER TAYLOR: We do. We're good.

MR. MOORE: Okay. Thank you. Page 6, it said the Claimant returned to Dr. DeHoll on November 30th, 2017 with worsening pain four months prior to the alleged date of injury. What is really important here is that the time for which she started to have the pain was about the exact time she started with the new job as

a janitor. This meant lifting buckets, mopping. She worked from 6:00 to midnight, Monday through Friday. So that was her job. And so she went to Dr. DeHoll, who had done a prior surgery a year or so earlier, as a follow up, because she thought -- because of some tightening, as she testified, in the lower back. So actually, she went back to Dr. DeHoll prior to the -- we believe the date of injury, i.e. the popping and discomfort in the lower back when she picked herself up, or leaned up, as she was pouring water into a basin on the floor. So she went to Dr. DeHoll, who -- and this claim is denied -- who was her treating physician and had been so prior, from the prior surgery. So she goes to Dr. DeHoll, reported the discomfort, described this pain radiating down her left leg, as well as some numbness. April 13th, after going to the ER and being sent to the doctor by her employer, she was seen by Dr. DeHoll again as a follow up. Dr. DeHoll ordered an MRI. MRI came back. I assume he had the records from the referral. And it showed a loss of disc height, for which he ordered additional physical therapy. This

is all about April 13th, in the order. Again, in the ER note from April 23rd, she told what she believed had happened to her back, went to Dr. Dial, who I think is the PA for Dr. DeHoll. On May 3rd, saw Dr. DeHoll. He noted severe discogenic collapse at L-5, S-1, mild modic endplate changes. So now we have a difference of diagnosis from the first surgery to the second surgery. There was an issue made about her not going to the doctor, having complaints. She did go to the doctor in November, shortly after starting her job as a janitor, had the MRI. Now we have some issues. She saw Dr. DeHoll, told him about the worsening pain. Dr. DeHoll said that she would need a fusion to correct the problem. She went to Dr. Johnson, a IME. He agreed, said that she was not at MMI. That is in the actual document.

Now what's peculiar about this is because she started with Dr. DeHoll, who was not a doctor who was recommended by the Carrier, he followed her care and he treated -- my opinion based upon 14B as referenced in his deposition -- that because she was not a workman's comp case, he treated her as a person by way of

referral for a prior surgery and did not inquire as to why and what happened that caused her to come back. He was just trying to figure out was there a re-rupture of the disc that he repaired before. And from this deposition, he treated it as such. And so based upon what's in the actual opinion, we believe that there is sufficient evidence for this matter to be compensable. In the hearing that was before, or the deposition portion of the actual opinion, he testified about the MRI. She testified about having no problem with the back between February and the time she started working for the employer. And she talked about returning to Dr. DeHoll in November of '17 as a precaution.

COMMISSIONER BECK: I assume, Mr. Moore, that you would at least think that Dr. DeHoll would be in the best position to -- I mean, he saw her before and after the alleged date of injury. Yet, at least based on Finding of Fact 12, even he couldn't render an opinion as to any aggravation, or even correlate her current conditions to the alleged work injury.

MR. MOORE: Well, he said in his deposition that the

mechanics of what she described as I gave them to him could cause the issues that she was experiencing. Again, in his deposition, he was looking for a re-rupture. He didn't spend much time, it appears to me, based upon my taking of the deposition, on anything else other than that. And so even after he saw the MRI and noted the two issues I just brought before you, other than physical therapy, he didn't prescribe anything else. And, again, what's peculiar about this is when he -- we sent the 14B to him. In his deposition he didn't want to react to or respond to, because, in his words, he was not told this is a workman's comp case, to give the impression he would treat one different than he would treat the other.

And so we took it from that -- and, again, this claim denied, the Carrier didn't provide any care. Sent to Dr. Johnson and he -- even though the single commissioner discounted what he said by his opinion, he piggybacked, basically, what Dr. DeHoll said and just offered an opinion that this -- that the aggravation occurred by what happened in March of 2018. There was no other independent doctor

offered by the Carrier to give any other opinion. And if you go through the record, he does not say that what happened did not cause the injury. Doesn't say that at all. If you wrestle with this a good bit, he basically said that it could cause it. And he gave that based upon a reasonable degree of medical certainty. Now, was he -- was he a hundred percent? No, sir, he wasn't. Did he go back and forth with it? Yes, sir. He did. But if, based upon the law relative to burden of proof and who gets to benefit that burden, the actual employee does, and the testimony medically from the three witnesses, Ms. McLeod, Dr. DeHoll to the extent that he saw her, and the other doctors who indicate that there was a change, based upon the MRI that was done in May, there's sufficient evidence in the record that shows that this particular injury is compensable. And so as the order is set forth, it is just given an opinion by a single commissioner that even though there's ample evidence in the record, there's no negative inferences that I could tell from the record, that the decision was basically made upon Dr. Johnson, who was

just credited as a doctor who gave the IME. And because Dr. DeHoll would not affirmatively commit, at best, to the injury, the claim was denied, or found not compensable. Now, the question was, did she ever tell Dr. DeHoll about her injury? Dr. DeHoll said if she had, it would not have changed his course of treatment. She said she did. And all the records, ER record, record from the first doctor she saw, all indicated the popping and the discomfort from the actual lifting of the -- or pouring out of water of this mop bucket, which caused the problem.

COMMISSIONER TAYLOR: Mr. Moore, that's your time. You'll have three minutes on rebuttal, okay?

MR. MOORE: Yes, ma'am. Thank you.

COMMISSIONER TAYLOR: Thank you. All right. Mr. Dixon.

DEFENDANTS' CASE:

MR. DIXON: Yes. Thank you, Madam Chair and Commissioners. I appreciate your time today. I do want us to indicate I think the credible issue here is, in fact, that November 30, 2017 office visit with Dr. DeHoll. Interesting and what Mr. Moore is arguing was that that

coincided with her starting at CW Group. I'm not sure if he's trying to indicate that that was an injury back then or not, but if that's the argument, certainly it wasn't reported within 90 days of that start date of the work. So that being set aside, on November 20th, 2017 she went to see Dr. DeHoll for a follow up from her procedure that he had done back the previous February. She notes -- or he notes that she was complaining of increased pain, radiation down into her leg, numbness, tingling.

You know, all of these are symptoms -- denies that she was reporting in that time frame. She denied it in her deposition. She denied it at the hearing. Said all she was feeling at that time was quote, unquote, tightness. I pointed out to her in the record, that's not included in any of the records. All that's referenced there, November 30th, is increased pain, radiating numbness and tingling, which, coincidentally are exactly the same symptoms that were noted in the April 13th, 2018 note with Dr. DeHoll. So you've got a -- certainly a clear continuation to draw a

line from April -- from November 30 to April 13, and at least according to Dr. DeHoll's records and what he confirmed in his deposition, she was there to see him in April for the same complaint she was reporting to him for months previous, which is what -- and this is what the single commissioner found was that this was a -- essentially a continuation of the problems that she had been reporting for months, which was a continuation of complications from her prior procedure, and, you know, the note -- the only corroborating medical notes that the Claimant was able to provide was a single ER visit that does reference this pop that was about a month after the incident, and an IME from Dr. Johnson, who, in his opinion, states she was -- had an asymptomatic pre-existing condition, which the November 30th note completely is inconsistent with that opinion. So the single commissioner, rightfully so, we feel, gave the greatest weight to Dr. DeHoll's opinion, which was that this is a continuation. He said that she had never reported any work injury to him. He did order an MRI in April, just to see what was

going on. He was concerned she might have re-herniated her disc. He said that she did not. He references the discogenic collapse would have been wear and tear, specifically says that it is not evidence of an acute injury.

So all of this comes together to suggest that this is a continuation of a problem that she had for which she had gotten surgery the beginning of 2017. The discussion with Dr. DeHoll in his deposition about whether this could have been caused by or might have been caused by, the single commissioner pointed out in her order that that's not a statement to a reasonable degree of medical certainty that something did in fact cause it. He said he's never heard of a workers' comp claim, never heard of this injury, frankly, based on what he saw in the radiographic images that he did. He wouldn't have treated her any different, but he considered it to be a continuation of what he'd seen and treated her for prior to her date of injury. We think, frankly, that that -- that testimony, those opinions from Dr. DeHoll, the medical records showing the exact symptoms pre-dating this injury by four or five months,

support the single commissioner's decision that this was a non-compensable injury and that the claim is denied on that basis.

I do know there was also an issue of her comp rate that the Claimant raised. I just want to touch on that briefly. Again, our position was that this was a hearing that was noticed, properly noticed after three years from the date of injury. There's certainly nothing that would suggest that the Claimant wasn't capable of obtaining these records from her current employer and as the regulation provides, if a Form 20 from the concurrent employer must be submitted, if the Claimant wants to have this issue adjudicated on those wages. Nothing was ever submitted to us. It wasn't submitted at the hearing. There was a request to hold it in abeyance, which the single commissioner's discretion, decided that she wasn't going to hold that off for another hearing when it had been properly noticed and put in front of the Commission on the Form 58 as her comp rate. We think that was the correct decision and that the decision of the single Commissioner should be affirmed in its

entirety.

COMMISSIONER TAYLOR: Okay. Thank you. All right. Mr. Moore, you have three minutes in rebuttal.

CLAIMANT'S REBUTTAL:

MR. MOORE: Yes, ma'am. Go back to the -- to the November '17 date. Again, that's when she started working. Because she didn't feel it necessary to report a claim and did not wait until -- or waited until such time that she felt something different, i.e. the popping sensation, is when she reported the claim. And so the implication is that because she didn't do anything right away, but waited until the incident occured, in her mind, in March, that she should be penalized for that. In Dr. DeHoll's records, when he released her from the first surgery, saying that she was at completely recovered and can go back to her normal activities, which she did. She didn't have issues until November of '17, which was some time after she had been released from the initial surgery. So there was no issue until she started working for the CW Group. I rely on the -- on the record.

The one thing that complicated this a

little bit was the fact that she went through a period of treatment for cancer that had her out for an extended period of time, and of course that, at the time, was a little more important than this was to her health. She still needs a fusion, as Dr. DeHoll said and Dr. Johnson said. The only thing that Dr. Johnson said that he didn't know about, the mechanics of the injury. It was never reported to him. There was sufficient records that I believe he had. Secondly, my client said that she did advise him of that. Even though he said he would not have not have done anything differently, and certainly we don't -- whether this is a workman's comp client, or workers' comp case, or not, should not matter in the treatment. Whatever the treatment was, the treatment was. And that's our position. She still has the issue today. She still has the back pain and discomfort today. And we believe that there's sufficient evidence in the record, based upon the case law that any -- any doubt I think should go to the Claimant if there is -- I don't think this record has any doubt in it. The issue has to do with a doctor who was

a prior physician, who treated her for a prior surgery and his -- his -- based upon what he testified to, he wanted to make sure there was not a re-rupture. And, of course, there wasn't, but there was indeed an injury. That's our position. We thank you for your time.

COMMISSIONER TAYLOR: Okay. Thank you very much. If there are no further questions, then that concludes this matter. Thank you.

(There being nothing further, the hearing concluded at 1:52 p.m.)

STATE OF SOUTH CAROLINA
BEFORE THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
WCC No. 1805291

Stara McLeod,	)
Claimant,	)
v.	)
CW Group, Inc.,	)
Employer,	)
and	)
CW Resources,	)
Carrier/Defendants.	)

COMMISSIONER'S HEARING

****

Wednesday, May 26, 2021
11:20 a.m. - 12:21 p.m.

The Commissioner's Hearing was heard before Commissioner Susan S. Barden, at the Legal Studies Center, 111 South Main Street, Courtroom D105, Sumter, South Carolina, 29150, on the 26th day of May, 2021, before M. Sean Cary, Court Reporter and Notary Public in and for the State of South Carolina.

APPEARANCES

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EXHIBITS

(No exhibits were marked during the hearing.)

STIPULATIONS

It is stipulated and agreed that this hearing is being taken pursuant to the Administrative Procedures Act and the South Carolina Rules of Civil Procedure.

CALL TO ORDER:

COMMISSIONER BARDEN: Today's date is May 26, 2021. This is South Carolina Workers' Compensation Commission File Number 1805291. This is the case of the Claimant Ms. Stara McLeod, who's present today and represented by Attorney Dwight Moore versus the Employer. And Mr. Dixon is gonna check on this. We believe that the correct and accurate name of the employer is CW Resources, Inc. But he's gonna check on that because we also have named as a defendant CW Group, it could be doing business as is, our dba is missing from there. I'm not really sure, but Mr. Dixon is going to provide some clarification on that. And -- and so please let Mr. Moore and myself know that -- being notified of that so we can make sure we have that correct. The carrier in this case is Pennsylvania Manufacturer's Association, and both of which are represented by Attorney Lee Dixon. The purpose of today's hearing is to determine issues raised in Form 20 -- Defendant's Form 21. Defendants file that 21 to have this claim adjudicated, it is a denied claim. I guess it was that or a petition for

hearing, but any event they filed a Form 21. But just to emphasize, according to Mr. Dixon, because I was confused about this and -- and I have been corrected in the pre-hearing conferences, is that this claim has been denied from the outset, it was never admitted because I assumed incorrectly that it was originally admitted and I always do put in the record whether it's admitted or -- or denied as far as the posture is concerned. Nor is there any kind of agreement on average weekly wage and corresponding compensation rate. It's the Claimant's position that those correct figures are respectively $291 and $194.01. The Defendant's position is that those figures are 169.91 and 113.28, respectively. I am -- was advised in the pre-hearing conference that the Claimant had concurrent employment. I was further advised that there has been no Form 20 filed for the concurrent employment. So that kind of ties my hands as far as any adjudication of that issue. Mr. Dixon, on behalf of his clients, believes that any and all issues should be adjudicated, and if the Claimant is not prepared to prove her claim for

concurring employment that the claim fails as far as that, the heightened or the increased average weekly wage and compensation rate. It is the Claimant's position that she is not requesting any temporary benefits at this juncture. So that should be held in abeyance, or that issue should be held in abeyance. So I'm holding that issue in abeyance right now temporarily, and we'll address it in my order instructions. The date of this alleged accident, which Mar- -- was March 26, 2018. Are there any objections to APAs, jurisdiction, venue or any other items? Mr. Dixon, you repre- -- represent the moving party, so I'll start with you. Any ---

MR. DIXON: No ---

COMMISSIONER BARDEN: --- objections?

MR. DIXON: --- objections.

COMMISSIONER BARDEN: Mr. Moore?

MR. MOORE: No, thank you.

COMMISSIONER BARDEN: Thank you. Without objection, the Commission File becomes a part of the record with the exception of self serving declarations and unstipulated medical reports. Prior to going on the record, we held a pre-hearing

conference. It's the position of the Defendants as to moving party that this is a denied claim, has been denied from the outset. It is the Defendant's position that any problem for which the Claimant suffers is the result of a pre-existing condition that was not aggravated by any alleged works -- work accident. If there was any -- any popping that occurred on the date, which Claimant alleges. which the Defendants contend that there was not any spinal injury, that that aggravation would be temporary. However, the Defendant's believe that there was no injury, was no aggravation. This has been denied from the outset. The Defendants would point to my attention the fact that the Claimant underwent surgery in 2017, a microdiscectomy with Dr. Deholl, she had follow-ups prior to this injury, which showed worsen pain including but not limited to radiculopathy into her toes. That she returned to doctor and at no time did she allege any work accident, including when she returned to Dr. Deholl in April of 2018, with the same symptoms, no reference to the work injury but a recheck. And then the same -- in May of 2018, there was no

new, no injury referenced, I don't believe in that, as well. But anyway, Dr. Deholl was deposed. It is the Defendant's position, certainly not the Claimant's, but Defendant's, but Defendant's position that Dr. Deholl says that he was no long- -- he was not told about any injury, and that any problem which the Claimant continues to suffer was wear and tear, and he had ultimately, according to the Defendants, no opinion as to causation. So, the Defendants believe that Dr. Deholl, who treated the Claimant prior to the injury and after the alleged injury, was in a better position than any one time IME to determine causation or to render an opinion as to causation. Further, the Defendants believe that there are errors in the causation statement of Dr. Johnson. The Claimant, on the other hand, would contend that this is a compensable injury that she has a mere preponderance standard to meet, and that she can readily meet that. She seeks reach -- does not seek temporary benefits at this juncture. She does seek reimbursement for any expenses she's incurred thus far with regard to the evaluation and treatment of her condition. She seeks an

order requiring the defense to provide her with a tru- -- a back specialist for her back condition and she is not at MMI. Any determination of permanency would be pre- -- would be premature. And she does request that the average weekly wage and compensation rate issue be deferred or held in abeyance. It's her position that as far as Dr. Deholl is concerned, that his deposition is inconsistent, at best, it's equivocal, and that he does state that it could have aggravated her -- her back injury of March 2018. He does ultimately say that it could have aggravated her pre-existing condition but the -- the Claimant would contend that she has supplied a causation statement with a specialist, that being Dr. Johnson, who's opinion should be given greater weight. That Dr. Johnson says, Yes, the surgery dealt with one level but that he sees a different -- a bulge that was not addressed by surgery. And Dr. Johnson believes that that is the result of the March 2018 date of accident. So the Claimant would contend that she can in fact, meet her burden of proof. And that she relies on Dr. Johnson's causation statement, who does

state that it was an exacerbation of a symptomatic exacerbation of a pre-existing asymptomatic condition. And again, the Defendants believe that the Claimant was not asymptomatic. But I've gone back and forth, and -- and the parties have told me great detail about their respective positions. In the interest of time, I'm going to, I believe, end right there, unless there's something else that I may have missed as far as the Claimant's situation here. The Claimant did try to get treatment at Doctors Care, but there was no authorization for her to receive treatment. This would be sometime after the March 26, 2018, date of accident. And she ultimately went to the emergency room on April 23rd, 2018, and she reported the pop that she felt at work. All right, gentlemen, is that a fair, obviously abbreviated, summary of your respective positions or is there anything that I need to correct or clarify because we have -- I've just received these APAs so I am not as familiar as you both are at this juncture, but certainly do plan to read them at the conclusion of the hearing. Unless there's something else perhaps

you've neglected to tell me in the pre-hearing conference that you would like placed on the record, I'm happy to hear one or both of you. And again, I will start with you, Mr. Dixon, because you represent the moving party, the party that brought us here together today.

DEFENDANT'S POSITION:

MR. DIXON: Thank you, Commissioner. May it please the Court, the only thing I would -- I would say you did summarize the details of our position very well. I would certainly point to the record for some elaboration on some of those issues. But the only one I want to specifically point out to you, Commissioner, is the issue of Dr. Johnson's IME. He -- I don't believe he in fact says that there is any additional herniation or bulge in his report.

COMMISSIONER BARDEN: Okay.

MR. DIXON: In fact, he notes at Page 36 of Claimant's APA, she does not have a large recurrent disc herniation. He does note disc space collapse, but that's not the same thing. And I just ---

COMMISSIONER BARDEN: Okay.

MR. DIXON: --- want to make sure that is consistent

in there. Do want to just state on -- on the record, Commissioner, I do apologize for the unusual procedural posture of the case. I know we are -- it's a little bit unusual in the circumstances. We are here three years after a date of alleged injury on a alle- -- on a denied case with no determination of compensability. My clients have simply asked for the opportunity to have that determination made. We think it is more than fair to determine all issues that are before the Commission including the compensation rate based on the record before you having ample opportunities on both sides to produce records showing additional -- additional wages within the reg- -- within the regulations of the -- excuse me, within the regulations of the Commission, and having no evidence of that we would ask you to determine that compensation rate. But as to the rest, we are asking for a denial of -- of the claim as no evidence of an aggravation or an injury occurring as alleged in Claimant's testimony in her pleadings.

COMMISSIONER BARDEN: Okay. Mr. Moore, do you have any changes or clarification you wish to make, sir?

MR. MOORE: Ma'am, I'm satisfied with your rendition ---

COMMISSIONER BARDEN: Okay.

MR. MOORE: --- of where we are.

COMMISSIONER BARDEN: Thank you. All right. And our first and only witness today, because I understand Mr. Dixon's relying on the medicals, is Ms. McLeod. And our first one, was that correct?:

MR. MOORE: Yes, ma'am.

COMMISSIONER BARDEN: Ms. McLeod, you're fine right where you are and you're fine seated. If you'll just raise your right hand, please.

(Witness complies.)

COMMISSIONER BARDEN: Do you swear or affirm the testimony you're about to give in this proceeding is the truth, the whole truth and nothing but the truth?

MS. McLEOD: Yes.

COMMISSIONER BARDEN: Please state your full name for the record.

MS. McLEOD: My full name is Stara Shaneiqua McLeod.

COMMISSIONER BARDEN: All right. Could you kindly spell your middle name for our court reporter, please.

MS. McLEOD: Sure. It's S-H-A-N-E-I-Q-U-A.

COMMISSIONER BARDEN: Thank you so much. Please answer any questions Mr. Moore has for you first.

MR. MOORE: Now, Commissioner there is -- her transcript was a part of the record. I won't go through every question the transcript, just want to give the Commissioner some flavor of -- of her background, okay?

COMMISSIONER BARDEN: Okay.

MR. MOORE: Just some of her background.

STARA McLEOD, having been duly sworn, testifies as follows:

MS. McLEOD - DIRECT EXAMINATION BY MR. MOORE:

Q: Ms. McLeod, you've given your name. Where do you live, currently, ma'am?

A: I currently live in Dalzell, South Carolina.

Q: Okay.

COMMISSIONER BARDEN: And I -- are you having a little bit of trouble ---

MR. MOORE: Pull your mask ---

COMMISSIONER BARDEN: --- because I am. Can you pull that down? I think we're -- we're suitably distanced, if you're comfortable. Are you comfortable like that?

(No audible response.)

COMMISSIONER BARDEN: Okay. Because you're about, I would guess, maybe ---

MR. MOORE: Twelve.

COMMISSIONER BARDEN: --- at least 15, 20 feet. So I think you're -- you're good. All right. Could you -- could you kindly say that again?

A: I currently live in Dalzell, South Carolina.

COMMISSIONER BARDEN: Thank you. That's so much better, thank you.

Q: Who do you live there with?

A: I live there with my husband and my daughter.

Q: And how old is your daughter?

A: She is ---

COMMISSIONER BARDEN: Your husband and your what? This is kind of a big room and there are cars that are zooming by here. Could you speak up a little bit?

MS. McLEOD: Okay.

Q: Okay. You live there with your daughter. Is that correct?

A: My daughter and my husband.

Q: Okay.

COMMISSIONER BARDEN: Thank you.

Q: All right. And your daughter's how old?

A: My daughter is 16.
Q: Is she in high school?
A: She's in high school.
Q: Okay. And your --- tell me about your husband. Is he currently employed or what's his situation?
A: He is currently retired from the military, as well as retired from the US Postal Service.
Q: Tell us a little bit about you, your education background.
A: I attended Sumter High School. I later went to Allen University, which is located in Columbia, South Carolina.
Q: Okay. Did you get your degree?
A: I did not. I am 11 credits away.
Q: Okay.
COMMISSIONER BARDEN: Now, what did you study at Allen?
A: Business administration.
COMMISSIONER BARDEN: All right. Thank you. And so you are 11 credits, did you say, shy?
A: Yes, ma'am.
COMMISSIONER BARDEN: Okay. Thank you.
Q: You -- what was your first job after college?
A: My first job after college. I was a page at the

State House.
Q: Okay. Who'd you work for?
A: I worked for Gilda Cobb-Hunter as well as Senator Strom Thurmond.
Q: Okay. After leaving there, what did you do, work wise?
A: After leaving there, I then had a part time job at McDonald's. And I also secured a job at Colonial Health.
Q: Okay. How long were you -- how long were you there?
A: I was there 11 years.
Q: Okay. After Colonial, is that Colonial in Columbia?
A: In Columbia. Yes, sir.
Q: So you drove from Sumter to Columbia every day?
A: Correct.
Q: After leaving Colonial, where did you go?
A: After leaving Columbia, I then secured jobs at Eaton Corporation. I also worked for Amedisys Home Health. I also went back to Columbia and worked for Aprostesis in Columbia. And then I gained employment for the State of South Carolina.
Q: And what -- what agency would that have been?

A: At Department of Mental Health.
Q: How long have you been down there?
A: I've been there since 2015.
Q: Okay.
COMMISSIONER BARDEN: 2000 what?
A: 15.
COMMISSIONER BARDEN: Thank you. And what did you do at Eaton?
A: I -- I worked in the accounting department, Accounting Specialist.
COMMISSIONER BARDEN: Accounting Specialist?
A: Yes, ma'am.
COMMISSIONER BARDEN: Okay. Thank you. And how about -- I heard medical, was that, home health?
A: Amedisys Home Health.
Q: Amed- ---
COMMISSIONER BARDEN: Okay.
Q: --- Amedisys?
COMMISSIONER BARDEN: Okay. Thank you.
A: Home Health.
COMMISSIONER BARDEN: All right. And what did you do for mental health?
A: Currently, I am an employment specialist. At the time of the incident, I was a peer support specialist. So I've gotten a new position.

COMMISSIONER BARDEN: Okay. And you're -- you're currently there as an employment sp- ---

A: Yes.

COMMISSIONER BARDEN: And what does an employment specialist do at the Department of Mental Health?

A: A employment specialist help clients seek gainful employment in the community.

COMMISSIONER BARDEN: Thank you so much. Mr. Moore?

Q: Yes, ma'am. And then you went to work for CW Group or CW Incorporated, and -- and while you was still working for the Department of Mental Health?

A: Correct.

Q: Do you recall about what date you started your employment with them?

A: It was around October, Novemberish. Late Octoberish, early November.

Q: Of what year?

A: 2017.

Q: So, up until the job at CW, your jobs were basically administrative or office type of work?

A: Correct.

Q: Okay. And then you started CW on or about October, early November time frame?

A: Correct.
Q: Now, why did you start working for them?
A: My daughter was in public school and we wanted to transfer her to private school. She was having some issues and it was more income.
Q: Okay. So, you started work at CW for that purpose?
A: Correct.
Q: What was your job duties there?
A: Janitorial.
Q: Okay. So, is this a janatorial company?
A: Correct.
Q: And where did they work out of?
COMMISSIONER BARDEN: I'm having a little bit of trouble. Did you say janitorial?
A: Janitorial.
COMMISSIONER BARDEN: Got it, got it. Thank you.
Q: And is there a address or place -- site that you worked on?
A: The site was located at Shaw Air Force base.
Q: Okay. And when you took the job, you took it as a janitorial person?
A: Correct.
Q: Had you ever done that kind of work before going in commercial business?

A: No, sir.
Q: Okay. Tell us what type of organization it was. What did you actually do for them and what time of day did your day start and what time did it end?
A: My day started at 6:30 approximately. Our responsibilities were cleaning the buildings that were located on base. We would clean up to five or six buildings nightly. Some of these buildings included gyms, but most of the buildings included the day-cares and youth center .
Q: Okay. And what did -- what was a night of work -- what -- what did it look like? Did you sweep floors, did you mop floors, did you clean desks, what -- what did you do?
A: On a daily basis I swept, I mopped, I cleaned glasses, I wiped tables, I wiped the student's desks, the student's chairs, and took out trash.
Q: Okay.
A: And vacuumed.
Q: And I assumed you used mop buckets?
A: Mop -- commercial mop buckets. The yellow commercial bucket.
Q: Can you describe for -- for us, how deep that

is?

A: It would be approximately about this big (indicating) and it would have an attachment that you would put your mop inside of to squeeze or to get -- wring the water out of.

COMMISSIONER BARDEN: Are you indicating maybe 18 to 24 inches tall? Would that be ---

A: Yes, ma'am.

COMMISSIONER BARDEN: Okay.

A: It's about that big (indicating) you know, and -- and they're bulky. So, they're about this big (indicating).

COMMISSIONER BARDEN: About two feet wide ---

A: Uh-huh.

COMMISSIONER BARDEN: --- 18 to two feet ---

A: Yes, ma'am.

COMMISSIONER BARDEN: --- wide? Okay.

Q: How many gallons of water do you think in -- in that bucket?

A: It had to be more than -- at least five gallons because you had to do several different classrooms.

Q: All right. Did you have buildings you would have to do -- do per night and -- or rooms you have to have -- how would you ---

A: You ---
Q: --- schedule your work and where?
A: We would have assigned buildings, and within the assigned buildings we had different crews. One crew may start on one side of the building, you may start on another corridor, other building. But we had different classrooms that everybody had to do.
Q: How many persons are in a crew?
A: Some nights, the maximum probably would've been five. Some nights people didn't come in so you could have three to four people. It just depends on the crew at the time.
Q: Okay. Let's stop right there for a second, okay. We stopping at the crew. Now, let's go back to whether or not you didn't have -- ever had any hospitalization before? Any health issues?
A: No.
Q: Okay.
A: No, sir.
Q: Okay. You had two children?
A: Yes, sir.
Q: Other than childbirth, were you -- have you ever had any surgeries for anything?

A: I did have eye surgery. I was injured as a child. I got stabbed in the eye with a pencil.
Q: Okay.
A: Other than that, I did not.
Q: Okay. Any back problems, any neck problems, anything like that up until the surgery in 2016?
A: No, I was ---
Q: Okay.
A: --- healthy and active.
Q: Okay. Now, you had surgery in 2016, is that correct?
A: That's correct.
Q: What led up to that surgery?
A: I just had some pain and some tightening in my back.
Q: Did you go to a chiropractor?
A: I did. I actually seeked out a chiropractor first.
Q: Did he later refer to someone for tr- -- other additional treatment?
A: He did -- he did at that time suggested that I seek advice from a pain specialist. And so I went to Dr. Todd Warrick.
Q: Okay.
A: At the Spain -- pain specialist at Tana, Toumey,

I 'm sorry, Prisma.
Q: Okay. And then were you then referred to Dr. Deholl?
A: I was then referred to Dr. Deholl.
Q: And then December of 2016 is the approximate date for the surgery that you had?
A: That is correct.
Q: And I understand you had a discectomy. Is that basically what your understanding was?
A: I had a discectomy at Baptist Hospital in Columbia.
COMMISSIONER BARDEN: And what was the date of that in 2018?
Q: It was in 2016.
COMMISSIONER BARDEN: Excuse me, 2016. And ---
A: Yes, ma'am.
COMMISSIONER BARDEN: --- what was the date, December?
A: December.
COMMISSIONER BARDEN: Thank you so much.
Q: And you -- you saw Dr. Deholl after surgery, maybe in January and February of 2017?
A: Correct. I had follow-ups with Dr. Deholl.
Q: Okay.
A: In January and February.

Q: And February was the last date that you actually saw Dr. Deholl for that surgery. Is that correct?

A: That is correct.

Q: Okay. Now, you went from -- up until the time you took the job at CW, late October, early November, from February you first saw -- last saw Dr. Deholl up until early November -- early November, late October, did you have any back problems?

A: I did not have any back problems.

Q: Did you see a doctor between February and October for anything related to your back?

A: No, sir. Not at all.

Q: You took the job at CW, late October, November. You saw Dr. Deholl late November 2016?

A: Correct.

Q: Why did you go see him then?

A: Just a precaution, I know that I had been doing like some part of the job had been -- you know, entailed strenuous stuff, so just wanted to make sure that I was fine?

Q: Okay. And the records -- the notes are in the record, but you saw him during that time, did he -- do you recall exactly what you told him?

A: I told him that I had had some tightening in my -- in my back. He was fully aware that I was actually taking a second job because he and my husband joshed around about me and my credit card debts. So he was fully aware that I had taken a job. But other than that ---

Q: And that -- and that was in November?

A: That was at the November, yes.

Q: Okay. All right. Did he tell you not to work?

A: He did not tell me not to work at all. Didn't give me anything that I should not be doing.

Q: Okay. And you went back to work. Is that correct?

A: I went back to work.

Q: All right. And back to work meaning back at CW?

A: Back at CW.

Q: When you got -- let's go back to the -- to the crew issue now. You said there were five people per crew max and there were times when people were short of people ---

A: Correct.

Q: --- to come in and you were short. And you -- you described for us the mop bucket. How many times would you have to lift -- fill or empty a mop bucket per shift?

A: Sometimes we would have to empty and -- fill and empty a mop bucket at least two to three times. It just depended on the amount of dirt or things that we actually had to clean. So there were times that you may have had to do it two times in one night in that particular building.

Q: Okay. And how many buildings did you have per night?

A: Five to six buildings.

Q: Okay. So, if you did three times per building, am I safe in saying you -- we -- that's probably 18 times ---

A: Correct.

Q: --- a night? Okay. And that went along with the other cleaning, right?

A: Correct.

Q: On or about the time of the -- the injury, you would come in to work, that -- is that right?

A: Correct.

Q: And how far along in the shift did you go before you got this popping sensation?

A: We were in the second building.

Q: Okay. And if you got to work at six, how long would it take you to get to the second building?

A: It may have been 7:30, eight. We normally spent

about 45 minutes to an hour or so in each building. Or it also just depends on the, you know, how clean the building was. So if it was real dirty, have to stay longer. If it wasn't so bad, you may be in there 45 minutes. It just depends.

Q: This night, as far as your crew is concerned, how many persons were working?

A: I think it was five of us.

Q: Okay.

A: Four of us. Yeah, four of us.

Q: Okay.

A: It was me and one gentleman in one building and our crew leader and another gentleman in another building.

Q: Okay. And so all four or five of you clean these five buildings every night?

A: Every night, yes.

Q: So, are you -- you -- are you assigned an area where you're there by yourself and you help out if you finish early? How -- how does that work?

A: Correct. So if you finish your area, because your area may not be as bad as someone else's area, we would help each other. We -- it was a team effort.

Q: Okay. Do you remember what day of the week this -- this incident occurred on?

A: If I'm not mistaken, it was either a Wednesday or a Thursday, because that Friday I called in.

Q: Okay. And you said it was about seven -- seven o'clock?

A: Sevenish, eightish, yes.

Q: Okay. Can you describe for us what you were doing prior to as you heard -- heard the pop in your back?

A: When we're working in that particular building, we kind of work from the back forward. So we were wrapping up because the lights actually cut off. They're timed. So, we were on the last classroom. The gentleman that was working along with me was, you know, coming out. So, what I did was to help out to get out of the building faster, was that I took the mop bucket into -- it's a closet area or a janitorial space. On the floor, there is a sink like area. So I took the mop bucket, and it's heavy so I had it by its wheels to turn over. But you have to do it slowly, because if not it's gonna splash out because the sink is not deep enough. So I reached over, turned it over and you have to

hold on to the -- to the top part because that's the area with -- where you mop is. I turned it over. In coming back up, you guys are saying popping, but it's not like you hear a popping. I felt like a popping, burning sensation in my back. I stood up and you know, was, you know, ooh, you know 'cause I -- I felt the popping, pulling sensation. But then I noticed immediately like, a tingling. Like I started getting like a numb feeling, and the pain started like shooting down my butt area, down my leg (indicating)---

COMMISSIONER BARDEN: And you're indicating your left leg?

A: Left leg, correct. Really didn't think anything about it at the time. Just kind of kept going on 'cause again, these lights are timed, so it's time for us to get out. If I'm not mistaken I continued to help the gentleman get out of that building, taking bags or our cleaning towels, or sprays or whatever we were using at the time. I did mention to him, you know like, ooh, you know that hurt or whatever. So the next building is the daycare, so it's -- it has two corridors, so, one way was our -- to the left

was ours and to the le- -- to the right was the others. So, it -- and it's a long hall. So walking down the hall, I kind of -- my foot was numb. So when I got to the end of the hall where our station is, I took my shoe off at first. And so I'm kind of like hitting my foot on the floor, whatever, like okay, what's going on. And I'm still trying to get, again, you go in and you get your next bucket and you put your stuff in and fill it with water. It was, like, picking up in intensity. So I walked down that long -- back up the long corridor to my other corridor and my crew leader was in a classroom. So, I kind of stood at the sink area in the classroom and I kind of did like this (indicating). And she asked me what was wrong and I told her when I was in the annex, it's called the children's annex, I hurt my back with the mop bucket. So she kind of came over to me and started like massaging, like my butt area. She actually told me to ---

MR. DIXON: Objection, Your Honor. Hearsay.

MR. MOORE: You've got to ---

A: Sorry.

Q: So -- so you told your -- you told your crew

leader?
A: Yes.
Q: What's her name?
A: Annie Crawford.
Q: Okay. Is -- do you know if Annie got word to anyone else?
A: I don't know.
Q: Did anyone else call you regarding the injury?
A: Not that night. No, sir.
Q: Okay. Did anyone else call you at all regarding the injury?
A: No, sir.
Q: Okay. Did someone direct you to a doctor?
A: Yes.
Q: And who was that?
A: Her name is Ms. Teresa, but I don't know her last name.
Q: Okay. So you have your supervisor, what's her name again -- or your crew leader, what's her name?
A: Her name was Annie Crawford.
Q: And the person you got the telephone call from was who?
A: Ms. Teresa.
Q: Okay. And did anyone else contact you regarding

this incident that night?

A: No.

Q: Okay.

COMMISSIONER BARDEN: Now, let me back you up a minute 'cause you're indicating and I know the record won't reflect this. When you talk about the sink, you talking about one of those kind of concrete things on the floor ---

A: Uh-huh.

COMMISSIONER BARDEN: --- where it's raised. It's not a sink like we have sinks at our house that are ---

A: Correct.

COMMISSIONER BARDEN: --- out -- but it's that that thing -- and I only reason I'm thinking that's what you're talking about, because I've seen one in our building. Where it's on the floor ---

A: Right.

COMMISSIONER BARDEN: --- you can get water that way ---

A: Right.

COMMISSIONER BARDEN: --- as well? Okay.

A: Right.

COMMISSIONER BARDEN: Thank ---

A: Correct.

COMMISSIONER BARDEN: --- you.
A: So, it's like a water, it's a water faucet ---
COMMISSIONER BARDEN: A trough, that kind of ---
A: Right. A trough. So, it's about this thick (indicating), it's a ---
COMMISSIONER BARDEN: Maybe six inches up?
A: Right.
COMMISSIONER BARDEN: Okay. Thank you so much.
A: You're welcome.
COMMISSIONER BARDEN: All right.
MR. MOORE: Thank you Madame Commissioner.
Q: So -- so, these two people knew, and one person called and told you about going to a doctor's appointment?
A: Correct.
Q: Now, you went to see Dr. Deholl in, I think, April 16th, there about?
A: Correct.
Q: And between -- and this -- and this -- this injury you felt happened a couple of weeks prior to seeing Dr. Deholl?
A: About two weeks or so.
Q: Okay. After you -- after you injured yourself on that Wednesday or Thursday night, you said -- did you -- did you call in that Friday?

A: Yes.
Q: And so the weekend preceeding?
A: That's correct.
Q: And then you started -- went to work on that Monday?
A: Right.
Q: Did you go to work that Monday?
A: No, not at CW. I went to my regular job.
Q: Okay. And then, when did you go back to CW?
A: I did not go back to CW at all.
Q: Okay. You'll -- you'll -- but -- but did anyone call and say, what's going on?
A: Right. At that t- -- after that -- after they advised me to go to Doctors Care, I spoke to Miss -- I can't think of her name at this point. She has a funny name. So, I spoke with her and she was not sure as to what to do. And so, that's how I ended up contacting my doctor because it was a denial when I went to Doctors Care. They would not authorize it.
Q: So you were told to go there?
A: I was told to go there.
Q: But they wouldn't see you?
A: That's correct.
Q: How many days after the actual injury did you --

took for you to get to the Doctors Care?
A: Maybe a week or so because we had -- I had text message exchanges about not coming in and the --
-
MR. DIXON: Objection, Your Honor. Hearsay also.
COMMISSIONER BARDEN: Sustained.
MR. MOORE: Can't -- can't say what anyone said.
A: Okay. Ms. Vanessa is the lady that I spoke with in regard to going to -- or not coming back into work.
Q: Okay. And it had to do with your -- your back

A: Correct.
Q: Right. Went to Doctors Care a week later. Were you still having problems at that point?
A: Yes, sir.
Q: And then, when did you first go to the ER?
A: I think I went to the ER around the 20-something, 23rd or 26th, if I'm not mistaken.
MR. MOORE: And that medical, Commissioner, that's in the record as far as the date that she went to the ER.
COMMISSIONER BARDEN: Thank you.
Q: So you had a conversation with these three people from CW regarding this injury and -- and

seeing a doctor.
A: That's correct.
Q: Then you went to the ER, then you went to Dr. Deholl?
A: Correct.
Q: All right. What was the difference in pain between the injury or the situation that led up to the first -- leading up to the first surgery, and now where you were immediately after this particular incident that happened April 18th?
A: This pain is different because it's more so in my tailbone area. It actually feels like I'm sitting on something. And, as you noticed, I'm -- I have more weight on my right side than on my left side. So, I'm conditioned more now to just put more weight on that side. As far as the pain down the leg, I still have the pain down the leg and I also still have numbness in my toes and in my foot. But this pain is just, again, more so in my tailbone area where it was not before when I had the first surgery.
Q: Now, you saw Dr. Deholl in April and May. Have you seen anyone after you saw Dr. Deholl regarding your back?
A: Not that's treated me. I've seen individuals

but not that has treated me.
Q: Okay. Then you had health issue in December.
A: Correct.
Q: December of '18, is that correct?
A: Correct.
Q: Tell -- tell me what that was.
A: In December of 18, I was diagnosed with breast cancer after having a normal mammogram in November of that year. I was told by four different doctors ---
Q: You can't say what they say.
A: I'm sorry.
Q: But you were diagnosed.
A: I was diagnosed, yes.
Q: Were you diagnosed here in Sumter?
A: I was diagnosed in Sumter, yes.
Q: And again, where did you receive the treatment?
A: I received my treatment at Cancer Treatment Centers of America in Atlanta.
Q: When did you start?
A: I started January of that -- of that year.
Q: So, that would have been '19?
A: 2019, correct.
Q: And tell me about the treatment.
A: The treatment was rough. To go from not having,

you know, anything, to that being a surprise, I've gone through the gamut of treatments. I've had consecutive surgeries. I've had seven months of chemotherapy, followed by radiation, followed by double mastectomy, followed by a full hysterectomy, followed by several reconstructive surgeries. So, it's just been a lot altogether.

Q: Okay. So, this is 2021. You talking about approximately two years of -- of cancer treatment. Is that correct?

A: Correct.

Q: Are you still being seen by a oncologist?

A: I'm still being treated.

Q: How often do you go see the doctor?

A: I see that doctor now, one- -- once monthly.

Q: Okay. And are you under any current treatment as of today?

A: I am currently under chemotherapy. I currently take oral chemotherapy as well as an estrogen suppressant.

Q: Now, despite all of that ---

A: Uh-huh.

Q: --- do you still today have problems with your back?

A: I absolutely still have problems with my back.
Q: You at a good place now with the cancer, is that fair to say?
A: I'm at a stable place, but I still have more surgeries in the future.
Q: Okay.
COMMISSIONER BARDEN: You have more surgeries coming up for cancer?
A: Yes, ma'am. I actually have one in July.
COMMISSIONER BARDEN: Okay.
Q: Now, is there anything that the cancer doesn't allow you to do and the diagnosis and treatment, when you're just going through treatment and nothing else like now? Is there anything that you cannot do?
A: I'm not going to say there's anything that I cannot do, there are limited things that I cannot do. As far as my energy level, I am still very fatigued. I still ache very badly because of the chemotherapy, that is a side effect. So yes, I am very much still affected.
Q: Are there some things that you can't do because of the back injury, that you really cannot do because of the back situation?
A: There are everyday things that I would like to

be able to do because of the cancer. You know my daughter played softball. I'm not able to enjoy a full game of softball because I can't sit down that long. Even going back and forth to Atlanta, our trips are longer because we have to stop about two hours or so because I'm uncomfortable with driving. Cooking, family events, holidays, I can't stand up and cook as long as everybody else cooks, because it hurts. So there's just, you know, several things that just everyday normal things, I cannot do.

COMMISSIONER BARDEN: Is the surgery you have upcoming, is that to your -- in your in your back or some other area where ---

A: No, ma'am. That's still pertaining to the cancer, to reconstruction -- reconstructive on my breast.

COMMISSIONER BARDEN: Oh, reconstruction surgery.

A: Yes.

COMMISSIONER BARDEN: Thank you.

A: Uh-huh.

Q: So as far as treatment on the back, you treat-- your treatment has been treatment you've paid for, is that correct?

A: That's correct.

Q: And along with the cancer treatments, and you still deal with the effects of the back. Is that -- I believe you said that.

A: Right. Absol- -- I think I deal with it a little bit more now because anyone that goes through chemotherapy knows that a side effect is it affects your bones. It -- your -- your bones ache just from the chemotherapy alone, so it's compiled with the problem that I still have, and the side effects of the chemo.

Q: Okay. Now this job at CW, was this the first manual labor job you ever had to do?

A: Yes, it was.

Q: All right. And other than what you do at your home previous to this injury, that's the most you've ever done, what you do at your house?

A: Yes, sir.

Q: Was doing what you're doing at CW a shock for you?

A: A shock?

Q: Yes.

A: Yes, I didn't think it was going to be that much when I applied for the position.

Q: Okay. And again, the reason you went to Dr. Deholl in November of 2017 was because you had

felt some tightness from working approximately a month before that day. Is that correct?

A: Right. And just to make sure that I had not done anything and that I was fine to continue working.

Q: Okay. All right. And that you did?

A: That I did.

Q: Those are my questions, Madame Commissioner.

COMMISSIONER BARDEN: All right. Thank you. Please answer any questions that Mr. Dixon had for you.

MS. McLEOD - CROSS-EXAMINATION BY MR.DIXON:

Q: Thank you. Good afternoon. How are you doing, Ms. McLeod?

COMMISSIONER BARDEN: Speak up as best you can.

A: Good.

Q: Good. I'm not going to be too long, I just have a couple of questions for you. Want to clarify a few things wi- -- in your testimony with Mr. Moore you said your surgery was in 2016. Is it possible that it was in early '17 and not 2016?

A: It could be a possibility.

Q: All right. And the reason I point that out is there -- there is a office note from Dr. Deholl, which is Page 36 and our APA, Commissioner. It's dated January the 6th of

2017.

A: It could be.

Q: And in that office note is one where he reviews your prior MRI and notes that it had showed a disc extrusion, and his recommendation at that time it was for a minimally invasive micro discectomy at L5 and S1. So it seemed to be that this surgery occurred sometime after January 6th of 2017.

A: That could be a possibility, from late December, early January, correct.

Q: And at -- at Page 71, Commissioner, there is a 14(b) that we obtained from Dr Deholl's office, which is discussed in his deposition at some length, but -- and I'll *won't go into the details of that. But that does note your surgery date was February the 1st of 2017. Does that sound ---

A: It could be ---

Q: --- like it could have been?

A: It could be. Yes, sir.

Q: Okay. Just for the record, I want to make sure the Commissioner gets the timeline straight. So thank ---

A: Okay.

Q: --- you for helping
A: Thank ---
Q: --- me ---
A: --- you ---
Q: --- with that. Now, you talked about the -- the incident that occurred at work. You said it happened on a Wednesday or a Thursday. Is that correct?
A: Correct.
Q: You s- -- we were doing this thing with the mop bucket and you felt a pop in your back.
A: Correct.
Q: And you described that you immediately felt some tingling and numbness running down your left leg and into your toes.
A: Correct.
Q: Okay. Had you ever had that sensation before?
A: No, I did not.
Q: First time since you had any of these back problems that you'd had that numbness and tingling in your legs?
A: No. The numbness and tingling thing was a -- he said was a side effect from the discectomy. So, the numbness and tingling is -- I - I -- I felt it before to answer your questions, I have felt

it before.
Q: Okay. Gotcha. And I was gonna ask -- because do you recall going to see Dr. Deholl, and I think your attorney asked you about it, in November of 2017?
A: Correct.
Q: And we're talking but out, I guess it would be, 10 months or so after your surgery?
A: Correct.
Q: Okay. And you were there -- the date on that one is November the 30th, 2017, that's at Page 53 of our APA, Commissioner.
COMMISSIONER BARDEN: Thank you.
Q: And in that note, Dr. Deholl indicates that you were there for a recheck it and that he had last seen you in February of 2017 with minimal pains. Is that what you remember?
A: Correct.
Q: Okay. He notes here that her pain has worsened, and she reports intermediate pain radiating into her left leg, as well as a minimal numbness and tingling in her toes. Did I read that -- do you remember having that -- those symptoms at -- in November of 2017?
A: No, I do not.

Q: Okay. Do you have any reason to believe that -- that Dr. Deholl's records are inaccurate?
A: No, I do not. Other than that he -- that we did discuss me working.
Q: Okay. And - and -- and do you think if he -- if he noted that you told him that you were having radiating pain into your left leg with numbness and tingling in your toes, do you think he made that up?
A: I'm not saying that he made that up. The numbness and tingling what have been normal from the surgery. I had noticed the tingling from - since the discectomy and I'm not sure if he discussed that in January or February. But that-- the numbness and tingling have been kind of consistent as far as the -- the surgery.
Q: Well you -- you do say -- he does also note that you have some pain worsening at this time in November. Is that fair to say, did you ---
A: I understand ---
Q: --- remember having worsening pain?
A: No. I understand that's what he said.
Q: Because I think you testified earlier that the reason you saw him in November was just for a checkup because you had some tightness?

A: That is correct.
Q: I don't know if you've seen these notes, but he doesn't mention tightness in there, just this pain and numbness and tingling.
A: Well.
Q: So, I just want to make sure that we're clear about that. Do you w- -- so definitely agree that at that time you were feeling numbness and tingling in your toes prior to this date of injury?
A: That's correct.
Q: Okay. And you were having increased pain prior to this injury?
A: Prior to the injury -- what -- can you repeat that?
Q: Prior to the March injury ---
A: Uh-huh.
Q: --- you -- that prior to that you were having increased pain in your back related ---
A: No ---
Q: --- to ---
A: --- I ---
Q: --- your ---
A: --- was not.
Q: --- surgery?

A: No.
Q: All right. Fair enough. But the record -- Dr. Deholl's record speak for themself's on that issue. Now you mentioned that you -- you tried to go to Doctors Care to get some -- some treatment. Do you remember when that was?
A: I think that would have been the week following or two weeks following. I can't remember the exact date.
Q: Okay. And that was when you reported to your supervisor that you were having issues and she said that you should go to the doctor. Is that ---
A: That is ---
Q: --- what you ---
A: --- correct.
Q: --- testified to?
Q: Okay. So ---
COMMISSIONER BARDEN: So did you actually go to the Doctors Care and they wouldn't see you?
A: I actually went and I was waiting because we were trying to get it over th- -- the information over the phone.
Q: Okay. Did you ever get a -- a document or any paperwork from Doctors Care saying that they

wouldn't see you?
A: No, sir.
Q: Okay. And just so we've got the timeline straight on what you did after this incident, and I may a just -- may a misheard the testimony, but you did see Dr. Deholl after your injury. You saw him once before you went to the ER, is that correct?
A: Can you repeat that?
Q: Do you recall seeing Dr. Deholl at some point after this incident but before you went to the ER?
A: Yes.
Q: Okay. Does th- -- does it sound correct if the record shows that you saw him on April the 13th of 2018, does that sound about right to you?
A: That -- it was sometime in April, I don't know the exact date, so.
Q: Okay. So, this is April the 13th, we're talking about three weeks or so after your incident, correct?
A: I know it was within about two to three weeks time frame. Yes, correct.
Q: And in his notes there, he indicates similar to what he noted in the previous November note,

that you were there for a check-up. He notes that you were last seen in November with some pain and that your pain has worsened and you were reporting pain radiating into your left leg as well as minimal numbness and tingling in your toes. Is that -- that what you reported to him in April?

A: I also reported that I was having increased pain in my tailbone.

Q: Okay. And he says in here in his notes that you had been doing physical therapy since November of 2017. Do you recall doing any physical therapy?

A: No. I think I had one visit or so, and I did not go back.

Q: Okay. Was there a reason why you didn't go back?

A: It's not a reason. No, sir.

Q: Okay.

COMMISSIONER BARDEN: It's not what?

A: It's not a reason why I didn't go back. The physical therapy was recommended following the surgery that I had in -- if you saying that was January.

Q: The physical therapy that you were -- we

recommended for you was in November, correct? You saw him in November before all of this?

A: Not that I recall. I -- I was thinking that the physical therapy had to be from the prior surgery.

MR. DIXON: Commissioner, I was just referencing at Page 55 in our APA, there is a referral order for physical therapy dated November the 30th of 2017.

COMMISSIONER BARDEN: Okay.

Q: So if the records show that Dr. Deholl sent you to physical therapy on November the 30th, of 2017, is that when you believe you would have gone that one time?

A: I don't recall, I don't remember.

Q: Okay. And again, his notes from April indicate that you told him that you had been to physical therapy since November 2017. Does that help you remem- ---

A: Not that I ---

Q: --- refresh your ---

A: --- not that I recall. And if so, that physical therapy would of been, again, related to that January. It h- -- wouldn't have anything to do with April.

Q: Okay, gotcha. Do you recall talking to Dr. Deholl, or did you tell Dr. Deholl that the problems you were having when you saw him on April the 13th were related to a work injury?

A: Yes. Yes, I did. Because again, he was aware that I'd got a job because my hus- -- his -- my husband -- he and my husband were joshing me about working and paying off a credit card. So, he would have been aware in November.

Q: But -- just want to make sure my -- my question -- I don't want you to tell me what you think Dr. Deholl knew.

A: Okay, I'm sorry.

Q: Do you recall telling him on April the 13th that this problem that you were having was related to an incident that occurred at work?

A: Yes.

Q: You're aware his note does not reflect that?

A: I understand.

Q: Do you believe that's just something he forgot to put into the note?

MR. MOORE: I object.

A: I can't speculate, sir, to ---

MR. MOORE: I object.

COMMISSIONER BARDEN: Sustained ---

MR. MOORE: Fair enough.

COMMISSIONER BARDEN: --- as to speculation as to what the doctor thought.

Q: Okay. You mentioned earlier to your attorney, I think you said that you hadn't -- since you saw Dr. Deholl and went to the ER in that April time frame, that you had not gotten any treatment to your back since then. Did I hear that correctly?

A: That's correct.

Q: Okay. But I just want to ask, I -- I believe there are some records in there reflecting that you had some injections from Dr. Warrick in May and June of 2018?

A: Right.

Q: Okay. So you did get some treatment.

A: Some treatment, but as far as my primary doctor, Dr. Deholl, that's what I was meaning. Dr. Deholl was my primary back doctor. So, that's what I was referring to.

Q: Okay. And you recall being sent for an -- a nerve conduction study?

A: Yes, I was.

Q: Did Dr. Deholl order that?

A: He did.

Q: Okay. And it was Dr. Koranloo, I believe that did the nerve ---

A: I think ---

Q: --- conduction ---

A: --- that's his ---

Q: --- study.

A: --- name. Yes, sir, at Health South.

Q: All right. Do you recall what -- what Dr. Ku- -- what your -- do you recall if Dr. Koranloo told you anything about the results of that nerve conductor study?

A: I do not.

Q: Okay.

MR. DIXON: That note I'm referencing, Commissioner's, at Page 75. And the EMG report itself is at Page 82.

Q: And then it does appear that you did get some physical therapy after that as well. Do you recall -- do you recall going to physical therapy at Sumter Physical Therapy Clinic?

A: Yes.

Q: Looks like you had a visit there in April of 2018, correct?

A: Yes, I remember that physical therapy.

Q: Okay. And that one visit that you had with

them, as well, correct?

A: Right. And that was because the pain was too bad and she said that there was no need to try to do any physical therapy until I got the pain under control.

Q: There's a subsequent note in here from August, August 8th of 2017.

MR. DIXON: Page 97 of the APA, Commissioner.

Q: This looks like -- it appears to be a discharge document from Sumter Physical Therapy, where they indicate you no-showed from your next appointment.

A: Right. I was a no-showed based upon, I guess, my previous visit.

Q: So they -- is it -- so it's your understanding you went on April the 30th and they told you at that point you didn't need to have anymore appointments?

A: Right. Because she said at that -- what they were trying to do, it was too painful to do.

Q: But this note from August suggests that you had a subsequent appointment and you just didn't show up and didn't return to physical therapy?

A: I wouldn't have not just showed up. I only stopped according to what the lady recommended.

Q: I don't think I have any other questions, Commissioner.

COMMISSIONER BARDEN: Okay. Anything on redirect, Mr. Moore?

MR. MOORE: Just briefly.

MS. McLEOD - REDIRECT EXAMINATION BY MR. MOORE:

Q: This -- this PT issue, you never received PT after the March, April injury of 2018, did you?

A: No.

MR. DIXON: Objection, it's not consistent with the records.

COMMISSIONER BARDEN: All right. Well, I haven't read them, so.

MR. DIXON: Okay.

COMMISSIONER BARDEN: So, you believe you had no physical therapy after -- and what was that date again, Mr. Moore?

MR. MOORE: April 17th, I believe was date that she saw Dr. Deholl.

COMMISSIONER BARDEN: But no physical therapy -- your testimony is no physical therapy after ---

MR. MOORE: After Deholl.

COMMISSIONER BARDEN: --- after April ---

MR. MOORE: After April 2018.

COMMISSIONER BARDEN: --- with Deholl, that visit.

Is that correct?

A: That's correct.

COMMISSIONER BARDEN: Okay.

Q: Any physical therapy you thought you would have gotten, you would have gotten as a result of the surgery in -- in late '17?

A: Correct.

Q: And that's the only surgery you had?

A: That's the only surgery that I had.

Q: And that's -- and you had physical therapy other than what we just talked to you about, on the back surgery itself?

A: Only back surgery itself.

Q: All right. And y- -- and it was referenced by counsel ---

MR. MOORE: Madame Commissioner, it's on Page 97 of this commission -- submission.

Q: You had ph- -- physical therapy at Sumter Physical Therapy?

A: Correct.

Q: You know who prescribed that?

A: Dr. Deholl, I believe.

Q: Okay. So you had Dr. Deholl, after the injury, prescribe physical therapy that you went on or about 8/8/2017?

A: Say that again. I'm sorry.
Q: You went to physical therapy at -- at Sumter Physical Therapy Clinic on or about 8/8 of '17. Is that correct?
A: Correct.
Q: Okay. And that was the one you went for the one visit?
A: Uh-huh.
COMMISSIONER BARDEN: Is that a yes?
MR. MOORE: Yes, it is.
A: That's a yes, I'm sorry.
Q: Okay.
MR. MOORE: Madame Commissioner, the progress summary says patient seen for IE, unable to relieve radicular symptoms. That's on -- that's in the record, okay.
COMMISSIONER BARDEN: Okay.
A: That's the one that I was referring to ---
Q: Okay.
A: --- when I said that they said that I to -- don't come back anymore because it was too ---
Q: Right.
COMMISSIONER BARDEN: And that was in August of 2017?
MR. MOORE: Yes, ma'am.
COMMISSIONER BARDEN: Okay.

MR. MOORE: It's at 97 of the -- 2018.

COMMISSIONER BARDEN: 2018.

MR. MOORE: 2018. 8/8/18.

COMMISSIONER BARDEN: All right.

Q: And so it's this document that you went, couldn't do anything ---

A: Right.

Q: --- because they couldn't correct the pain, and you didn't go back ---

A: Right.

Q: --- to them? Now, pre -- pre-November of 2018, describe the -- the tingling that you described as -- as what the difference was before you went in in November and after you went in -- after -- after the injury itself. Let me do this again, before you went in, when you had the tightness, describe what you felt then exactly.

A: The tightness was just tightness. It wasn't pain, it wasn't -- it wasn't any different tingling. I've always had tingling or numb where it's -- my toes are numb. That's what I mean when I said tingling.

Q: Uh-huh.

A: Because it's numb. In April, when I did the mop bucket, that is a different type of tingling.

It's not -- it's a -- it's a sensation. It's a running, not the numbness like in my toes, tingling. So, it was a different type of tingling.

Q: So, the numbness in your toe, you had since you had ---

A: I've had ---

Q: --- the surgery.

A: --- since I've had the surgery. And maybe he did note that in January and February it was the same type of tingling in my toes.

Q: Okay. And then you, in November, you still had the tingling in your toes, but now a tightness in the back?

A: Right.

Q: Okay. In March, April, particular April when you saw him, you had a different kind of tingling?

A: Right. And -- and I shouldn't maybe have described it as tingling, it's a more of a sensation. It's a running down your butt cheek, tingling or -- I don't know how to describe it but, it's -- it's -- it's different than this -- in -- my toes do this (indicating) like tingling. This is like a running down my leg

(indicating), tingling, if that makes sense.
Q: Right. And that's what -- that's what you felt after -- after April?
A: Right.
Q: Okay.
A: The numbness in my toes has always been consistent till today, it's always there.
Q: And that's plus the tailbone.
A: Plus the tailbone issue.
Q: Okay. Those are my questions.
MR. DIXON: Commissioner, if I may just real briefly, to clarify the issue of the physical therapy.

MS. McLEOD - RECROSS-EXAMINATION BY MR. DIXON:

Q: You saw Dr. Deholl, after your injur- -- after your alleged injury, you saw him on April the 13th, correct?
A: Correct.
COMMISSIONER BARDEN: Why don't you give a date?
Q: Of 2018?
COMMISSIONER BARDEN: There you go.
A: 2018, okay.
Q: And did he order you to go to physical therapy from that visit?
A: I don't recall.
Q: You do recall going to Sumter Physical Therapy,

correct?

A: Right. The dates are just confusing me.

Q: I -- I understand. That's why I've got the documents here, I just want to make sure for the Commissioner's benefit that we get the timeline right.

A: Right.

Q: There is a note from them, it's on Page 94, Commissioner, in our ---

COMMISSIONER BARDEN: Okay.

Q: --- APA. Shows a d- -- your additional evaluation was done there at Sumter Physical Therapy on April the 30th of 2018?

A: Okay.

Q: Okay. And in that note, I mean, there's some extensive notes in here, but it does indicate that you were unable to relieve your radicular symptoms during that visit.

A: Uh-huh.

Q: Okay. The subsequent note that I was asking you about was from August of that -- of 2018 where they note that you no-showed after this April 30th visit.

A: Right. I would've no-showed from that visit because that visit they would inform me that

they couldn't do anything because I was hurting so much. So there's no reason for me to have gone back.

Q: Okay. So the therapy visit you did have was in April of 2018 after you saw Dr. Deholl for the first time after this incident?

A: For that particular injury, yes.

Q: Okay. And do you recall then also having another physical therapy before this incident?

A: I do not.

Q: Okay. That's all the questions.

COMMISSIONER BARDEN: Okay. Anything else? Okay, that concludes this proceedings.

(There being nothing further, the commissioner's hearing concluded at 12:21 p.m.)



Transcript of the
Deposition of

P. Douglas deHoll, MD

08/23/2018

Stara S. McLeod v. CW Resources, Inc., et al.
1805291

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South Carolina Workers' Compensation Commission
W.C.C. File No. 1805291

Stara S. McLeod, Claimant, v. CW Resources, Inc., Employer, and PA Manufacturers Assn. Ins. Co., Carrier/Defendants.	Deposition of P. Douglas deHoll, MD

Date: August 23, 2018

Time: 12:22 p.m.

Location: Palmetto Health Orthopedics,

101 Business Park Boulevard, 2nd Floor Conference Room,

Columbia, South Carolina

Reported by
Starla Stidham

APPEARANCES

For the Claimant: Dwight C. Moore, Esq.
Moore Law Firm, LLC
Sumter, South Carolina

For the Employer/Carrier: Nikole D. Haltiwanger, Esq.
Hedrick Gardner Kincheloe & Garofalo, LLP
Columbia, South Carolina

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STIPULATIONS

It is stipulated by and between counsel for the respective parties that all objections are reserved until the time of trial, except as to the form of the questions.

This deposition is being taken pursuant to the South Carolina Workers' Compensation Act and all applicable rules.

- - - -

The reading and signing of this deposition is waived by the deponent and counsel for the respective parties.

Pre-marked Plaintiff's Exhibit Number 1, Tuomey ER record.

Whereupon,

P. Douglas deHoll, MD, being duly sworn and cautioned to speak the truth, the whole truth, and nothing but the truth, testified as follows:

EXAMINATION

BY MR. MOORE:

Q Good afternoon, Doctor. My -- my name is Dwight Moore. We met a couple of years ago --

A Yes, sir.

Q -- when you were working out of Sumter. I'll be

asking you some questions about a patient of yours by the name of Stara McLeod. You've done this before so I won't -- I won't bother with preliminaries.

The rules require that I ask you some -- some credentialing questions so we can have you deemed as an expert with -- with counsel's permission, so, if you just give me some background information and just -- just some for the record, I'd appreciate it.

A Undergraduate: The Citadel; medical school: University of South Carolina. Orthopaedic residency at University of Texas; spine Fellowship at University of Louisville. My practice is essentially a hundred percent spine surgery.

Q Okay. And how long have you been practicing orthopaedic medicine approximately?

A I began practice in 2004.

Q Okay.

MR. MOORE: (To Ms. Haltiwanger) At this time, I liked to deem Dr. deHoll as an expert in the field of orthopaedic medicine, with your permission.

MS. HALTIWANGER: Yes.

MR. MOORE: Okay.

Q All right. Doctor, you had the occasion to have Mrs. Stara McLeod as a patient of yours. Do you recall, off the top of your head, when -- when the first time you may have had any dealings with her?
A I believe it was back when I was still practicing in Sumter.
Q Okay. And you told us that you practice in orthopedic medicine, spine work in particular. Did you have -- have the occasion to perform any surgery on her, back in 2016 -- late 2016/early 2017?
A I performed a microdiscectomy, to my recollection, on her, yes.
Q Okay. And that would've been late 2016; is that correct? Early 2017?
A I -- I don't remember the date. I don't have the records from that prior clinic.
Q Okay. And when did you move to Columbia?
A I began practicing back in Columbia in 2014.
Q Okay. All right. And -- and, if I can show you --
A Her surgery was in '16?
Q I guess I need to grab the record for you.
A So the group that I'm in, we were the Moore Clinic in -- in -- two years ago we were rolled into Palmetto, and so the prior hospital, Providence,

has not been very forthcoming with records from there. So that -- I must've seen her not in Sumter, but I must've seen her under the Providence --

Q Okay.

A So our group -- the entire practice left Providence Hospital, and Providence Hospital would not release records to us.

Q Okay. I -- I would ask you to -- to take my word for it that you saw her in '16, surgery in December -- I think, of '16 --

A Okay.

Q -- and some follow-up in early '17. Does that sound fair?

A Yes.

Q Okay. And you had the occasion to treat her in April of 2018; is that correct?

A I did.

Q Okay. And do you recall the date that you first saw her in April of 2018?

A Well, I saw her in 2017; I saw her in April 14th of 2018 and April 27th of 2018.

Q Okay. Prior to -- to April of 2018, can you give me the dates that you saw her in early '18 and late '17?

A January 6th of 2017.
Q Okay.
A February 10th, 2017; February 23rd, 2017; November 30 of 2017.
Q Okay. And those follow-ups were -- were for what purpose?
A They were essentially back following up with complaints of -- of back and leg pain.
Q Okay. Was that from the prior surgery?
A It was all basically the same complaints, essentially.
Q Okay. And can you tell me exactly what the complaints were?
A Well, depending on where but it's mostly back pain.
Q Okay. Was it muscle tightness and stiffness?
A Back and leg pain is what we were really . . .
Q Okay. And did you have the occasion to see her after February 30th?
A After February 30th of --
Q -- 2017?
A I saw her November 30th of 2017.
Q Okay. And, just for the record again, the surgery was on or about December of 2016; is that correct, as far as you can recall?
A As far as I can recall, yes.

Q Okay. And you saw her again in November of 2017?
A Correct.
Q And how did she present on that day?
A Worse back pain. She was having some pain radiating into her left leg.
Q Okay. That's 2017?
A Correct.
Q Do you -- did you see any -- was there any -- and that discectomy was done with the lumbar or cervical?
A Lumbar.
Q Lumbar. And do you recall what -- at what level that lumbar --
A I don't, but I have a copy of an MRI report from 2016 indicating L5-S1 on the left side, and so that would be a fairly safe guess. If we have the records from the Providence practice, that would solidify that.
Q All right. And did you see her again after November '17?
A I did. I began -- she came back in April.
Q Okay. And how did she present in April?
A So, in April, I think it was the same complaints.
Q Okay.
A She stated that her pain was worse than when I saw

her in November. She's still having pain in the back and left leg and some numbness. She's been doing physical therapy.

Q Did she say who prescribed the physical therapy?

A I think we did.

Q Okay. And do you -- you have a day of that prescription?

A When I saw her on the 11/30/17 encounter, the plan was she was referred for physical therapy.

Q Okay. So she had physical therapy from the -- at least prescribed from the November visit?

A Correct.

Q Okay. And did she complete that physical therapy?

A According to the April note, she has -- in her words, she has been going to physical therapy since she saw us.

Q Okay. And did you see her after the April 13th visit?

A April 27th.

Q Okay. And how did she present on April 27th?

A Continued back pain.

Q Was there any --

A Increased pressure in her tailbone; increased pressure in her left leg.

Q Were those symptoms different than what she had

presented with before?
A That was basically what she's been complaining about in the last several months.
Q The -- the tailbone --
A The tailbone was new.
Q Okay. And increased pressure, is that a different pressure than it was prior to that date?
A It's the first time she had ever used that word.
Q Okay. Was there a prescription -- medications prescribed on this visit?
A Does not appear to be, no.
Q Was there any diagnosis that was different from the prior visits?
A Not that I'm aware, no.
Q Was there any conversation during any of the visits prior to that date regarding any work or occupations or what her work situation was?
A Not that I recall, and not that's in the record, no.
Q Okay. Did you see her again in May, was it?
A May 3rd?
Q Yes, sir.
A Yes.
Q Okay. And how did she present on this day?
A That's a follow-up visit after obtaining an MRI.

She's still having the same back pain and left leg pain.

Q Okay. Was the -- did -- what did the MRI indicate?

A My main reason for getting an MRI was to see if she had re-herniated at the same level. I basically show that she had not re-ruptured; that she had degenerative collapse of the 5-1 disc.

Q Okay. Now, relative to the earlier surgery, where is that exactly?

A Same level.

Q Okay. 5-1 disc, is it -- is it a different diagnosis than the -- than the diagnosis earlier that necessitated the surgery? In other words, is it a different spot than -- than you performed the surgery on?

A No.

Q Okay. Is it a different kind of injury?

A It's not an injury; it's wear and tear.

Q Okay. If -- if -- if she had presented -- and I want to show you a note from Palmetto Tuomey. Where did I hide it? Ask you to look at that for a second, please.

A (Complies.) Okay. So this is an ER visit.

Q Yes, sir. Can you look at that note and -- and where she was triaged -- the triage note I think on

the first page -- Page 1 of 2, it indicates, "Patient reports that she was emptying a mop bucket two weeks ago at work, felt something pop, and now has pain in the buttocks and numbness in the left leg. She's tried heat, ice, OTC medications with no relief. Patient reports, 'It's more in the bone kind of hurt, not so much muscular.' She reports that when she sits straight up, it feels like she is sitting on something." If -- this presentation is not in the note that you have when you saw her on or about the 27th. If she had presented to you -- or you had this note, would that have changed any diagnosis that you may have had or any opinion that you may have had regarding what she deemed as increased pressure or pain in the tailbone area?

A I'm not sure I understand your question, but my inclination is the answer is no. I mean, it wouldn't have changed any diagnosis; it wouldn't have changed anything that I would've done differently.

Q Okay. Well, ask a better question.

If you had the information that she was lifting a bucket of water and she heard a popping and she felt increased pain from -- from that popping sensation, would -- would that be important

for you to know as far as your treatment and diagnosis?

A I mean, maybe initially, because, again, my first thought is, "Has she re-herniated?" The answer to that's no. And that's answered by the MRI, so, I mean, probably would've taken the same course, which is: conservative measure first; if that didn't work, get an MRI; if the MRI doesn't show a re-herniation, then she hasn't re-herniated.

Q Okay. Can -- can the popping -- lifting and popping sensation that resulted from that, as she indicated in that note, cause some discomfort or discomfort that she presented to you with?

A Sure. I mean, if she felt something change in her back and had a pain --

Q Okay.

A -- she has a pain.

Q Okay.

A But, from a mechanical perspective, which is really my role, there's no re-rupture.

Q Okay. But there -- there -- one can injure themselves lifting a bucket of water and pouring it mechanically?

A So you're asking a hypothetical: Can someone injure themselves lifting? Yes.

Q Doctor, well -- okay. You answered part of my question, and I appreciate that.

The -- if she -- as she described the -- the -- the issue in the -- in the -- in the ER note, can a person injure themselves that way?

A Can a person lift -- injure themselves lifting things? The answer is yes.

Q Okay. In particular in that note as she describes it, can -- talking about Ms. McLeod -- can -- could -- could she have injured herself based upon the mechanics of what she was doing?

A Could she? Yes.

Q Okay. And that -- you've indicated that may not have altered your treatment, but she could've very well injured herself doing that?

A Yes.

Q Okay. And then you went on to say that you had a MRI done --

A Correct.

Q -- as a result of the visit on -- on May 3rd, thereabout; is that correct?

A Her repeat MRI was done May 3rd.

Q Okay. And the initial MRI was done when?

A Initial MRI at Tuomey was October 25th of 2016.

Q Okay. And what did that -- that MRI indicate?

A Well, one was done at Tuomey, and that's where she had the left side at L5-S1 disc herniation. It also showed L5-S1 disc-space narrowing.
Q And then you had a second MRI done, and -- and that was as a result of that -- that -- that visit -- that -- the May -- May visit?
A Correct.
Q And what did that MRI indicate?
A MRI primarily indicated that she had disc-space narrowing at L5-S1, and, basically, that there was not a re-herniation of the 5-1 disc.
Q Okay. And is there a difference between what the MRI showed from Tuomey and what the MRI showed that was done the second time?
A Well, the -- I mean, a lot, so -- so, first off, it's almost two years later.
Q Okay.
A Second off, she's had surgery at that level, so it's going to change the morphology of what the disc looks like. And, third off, the surgery that she had was for a disc rupture, and we took the disc rupture out, so that's now gone. So -- and -- and, forth, they're two different MRI machines, so they're different.
Q Okay. What would that -- what would the two

machines show different -- different?
A I mean, it's kind of like comparing an apple to an orange. I mean, MRI machines aren't all the same. They have different power; they have different strength, so you can make -- you can make assessments of one MRI to another, but the -- the best is if it's done on the same magnet. I mean, MRI machines are like cars. You have different horsepower.
Q Okay.
A You have different models.
Q The earlier one, is that a better horsepower MRI than --
A They're -- they're -- they're both good scans. They're -- Tuomey has a good machine; ImageCare has a good machine, but, you know, it -- it -- it bears mentioning that they're not -- you can't -- MRI-to-MRI comparison has to be taken into some consideration --
Q Okay.
A -- at least from my perspective.
Q And so was there a MRI done after your surgery?
A Shouldn't be, no.
Q Okay. As -- as your opinion that -- that the initial surgery, the first surgery, basically

repaired the issue that she came to you for the first time?
A Well, we took a piece of disc out.
Q Right.
A That's all we did.
Q Okay. Is that "repair," for a layperson?
A I -- I -- I -- I don't know if I would call it "repair." It -- it -- the simpler thing is it's like you're walking around with a rock in your shoe, and all we did was take the rock out.
Q Okay.
A So we haven't repaired your shoe. We took the rock out that --
Q Okay.
A -- was pushing on your foot.
Q Okay.
A That -- that's . . .
Q And does -- is it fair to say, using that analogy, that -- that now she has another rock in her shoe with the second MRI?
A No. It's like the tread's worn down on her shoe --
Q Okay. But --
A -- is a better analogy.
Q Okay. So there's nothing wrong with her; it's the shoe?

A Well, her disc is worn. She ruptured part of her disc, so she lost part of her disc when you do that. So you have the normal aging wear-and-tear process that we all have; then you have people that rupture. So that means part of the disc squirts out, so there's less disc in there.

Q Okay. Where the language is used in the second MRI "disc narrowing with disc desiccation without vacuum phenomenon is noted with mild diffuse symmetric circumferal bulge at L5-S1," to a layperson, what does that mean?

A That means it's worn out.

Q Okay.

A There's less -- there's less jelly inside the jelly doughnut.

Q Okay. And, if a person is actively using their back by lifting and picking and -- up and -- and pushing and dumping water, does that aggravate or cause additional back problems at that level?

A It can.

Q Yeah. And, if that's what she was doing as she alleges that that's when the onset -- the aggravation or the increased onset of problems, is it -- is it your medical opinion that then -- then these -- this incident, the popping that she felt,

if not caused and aggravated the prior surgery -- the back disc at the prior -- that was repaired at the prior surgery?

MS. HALTIWANGER: Object to the form.

Q Okay. Let me ask it, again.

A I -- I -- I mean, I guess -- so I have no history of anything happening at work --

Q Okay.

A -- in my notes.

Q Okay.

A So it was never mentioned to me. If your question is can a vigorous, physical job exacerbate a pre-existing condition, my answer would be yes.

Q Okay. And -- and -- and -- and I don't want to belabor this, but, if you had this note -- this medical note from Tuomey to -- to -- when -- when you saw her on the 28th, other than the diagnosis, would that have -- that help you understand what happened that would've cause this aggravation or onset of additional pain?

A No.

Q It wouldn't have?

A No.

Q So, if she said, "Doctor, I was lifting a big bucket of water at a second job, and I heard -- I

heard this popping; all of a sudden I felt this pain," as described in the ER note . . .

A Wouldn't -- wouldn't really change anything for me.

Q Okay. Maybe I'm -- I'm -- I'm -- I'm not understanding when you say "change anything." You would've -- your diagnosis would've been the same?

A I would've done everything the same.

Q Right. But, as far as knowing what happened, you would've had the information to say if that could've -- could have and may have caused this problem?

A So, you know, I mean it depends on how far you want to debate. I mean, so you can go back and say, "How did I end up seeing her in the first place? How did she rupture her disc?" There doesn't have to be a work injury. So -- so people -- you know, I hate to say it -- maybe watch too much TV and think that everyone that has a spine problem either had a car accident or got hurt at work. Most of them are degenerative; most of that happens because of how we're built and normal bending, lifting, twisting. My records: She didn't mention anything specific about work. And what's important to note is: I don't write my notes. I have a scribe.

Q Uh-huh.

A So the whole thing is recorded, so I can at least rely on the fact that she didn't mention anything about work. She mentioned the emergency room, and so that is in my record. So, as far as the work and this lady -- and I know her well because I've seen her for a long time -- I -- I had no direct knowledge of her having a work injury other than the document that you showed me.

Q Right. And -- and you know that now based upon this document, right?

A (Nods head up and down.)

Q Is that -- that fair?

A Correct.

Q Did she ever tell you after May of this year that she hurt her back at work or tell you that she had this sensation after the lifting?

A So the last time I saw her she said, "I -- by the way, you're going to have a deposition."

And I said, "Why?" I didn't realize this was work-related.

And then that's when she said, "Oh, yeah. I hurt myself at work," so I mean that's -- that's the extent of my direct knowledge with her.

Q I see.

A Because she comes with her -- I guess her husband.

I don't know if it's husband/boyfriend -- the gentleman. I mean, I know exactly who they are, so, I mean, that's -- that's kind of where I am with her.

Q Sure. And -- and -- and, to wind this up, and -- and correct me if I -- if I don't state this properly -- it is your opinion that the -- the mechanics of the lifting and -- and pouring could've aggravated or hurt her back?

A Correct.

Q Okay. That wouldn't change your treatment but that could've happened?

A Correct.

Q Okay. And, as far as you know based upon this medical record and her -- your conversation with her a while back maybe in May or so, that -- that she was at work when this happened?

A I -- I think the last time that I saw her she informed me of that fact.

Q Okay. After you saw her in May, did you have the occasion to see her, again?

A April, May -- I saw her 7/19 of '18.

Q Okay. What -- what -- what happened at that visit, or what did you do as far as diagnosis and -- and continue treatment?

A I think at some point along the way she had seen my physician's assistant. They had tried an SI joint injection in an attempt to see if that would help some of her pain, to see if that's where her pain was coming from, and, apparently, that did not do a whole lot.
Q Okay. What is the option at this point if the injection did not give her any relief?
A In my opinion, an anterior fusion.
Q And, for a layperson, what exactly is that?
A Sorry. That means we're going to go through the front of her belly and take the disc out -- take the entire disc out and put a large wafer of bone in the space to kind of recreate the height that she's lost and stabilize that segment to make her pain better.
Q And that's at L5-S1?
A Correct.
Q Okay. And then she would go through the normal course of physical therapy and rehab and --
A Usually, in a anterior fusion, which is the one through the belly, it's done on young, healthy, active people, like Ms. McLeod. I don't usually do a whole lot of physical therapy afterwards. I just tell them to get back to walking for exercise, but

yes. There is a rather lengthy recovery from a surgery of that magnitude.

Q And how long does the person normally stay in the hospital once that surgery's been completed?

A Again, usually it's young people. For me, when it's through the belly, usually overnight, but you know, bone to heal, it's probably something like four months.

Q Okay. And then they would basically return to work?

A Yes.

Q Okay. All right. And, Doctor, is all your opinions given to me today based upon a reasonable degree of medical certainty?

A Yes.

Q Okay.

MR. MOORE: (To the deponent) Thank you, sir.

EXAMINATION

BY MS. HALTIWANGER:

Q Doctor, my name is Nikole Haltiwanger, and I represent the employer in this workers' comp claim. And I just have a few questions for you.

First of all, we talked some about how Ms. McLeod did not report a workers' comp injury to you; is that correct?

A Correct.
Q Okay. And then I -- I think you said something kind of important earlier. You indicated from the MRI -- the -- the most recent MRI, the May 2018 MRI, that this is a wear-and-tear -- I'm not explaining this very well. Let me try this again -- that the most recent MRI compared to the older MRI that --
A Uh-huh.
Q -- it shows more of a wear-and-tear, and it's not an injury; is -- is that correct? Am I stating that correctly?
A There's not an -- there's not an acute finding on the MRI.
Q Okay.
A Meaning there's not one specific item that you can definitively say is an acute change.
Q All right. And you -- you also said there's not a re-rupture --
A Correct.
Q -- that it's -- it's more of a wear-and-tear issue; is that correct?
A Correct. Yes.
Q Okay. And, when Mr. Moore was questioning you, he was asking a lot of questions about -- related to

the work injury and compared to her prior issues with you, and I -- I think there was an indication that she had continued to treat throughout the time period; is -- is that correct? I -- I think she stopped -- she saw you in November of 2007, correct?

A Seventeen?

Q Seventeen.

A Correct.

Q And then she was still getting physical therapy up until the time that she saw you again in April of 2018, and I think that's what the medical record indicates?

A Correct.

Q Okay. So, apparently, there were still -- she was still having back issues throughout that time period?

A Correct.

Q Okay. And your notes have no history of anything having happened at work?

A That is correct.

Q So there's -- there's no way for you to correlate this issue that's going on with her back now to a work injury?

A Correct.

Q Okay. You did complete a Form 14B back in June of 2018. Do recall doing that?
A No.
Q Then I can show that to you. But, basically, it didn't give any kind of a rating, but it does have that -- it's a little odd, so I wanted to ask about it while I had it here.
A Okay.
Q And we just talked about the anterior fusion being something that would be needed in addition to that, so I wanted to kind of clarify since we have this form kind of where we would be at this point. Can you -- can you tell me -- do recall that at all?
A No. I don't.
Q Okay.
A And that's a stamp. That's not my signature.
Q Okay. So would your --
A That's a strange --
Q -- opinion be at this point that she does still need the additional treatment we were talking about a little while ago?
A So, for -- you're talking about the -- how -- how -- how do you definitively fix what her problem is?
Q Well, that's where I -- where I'm kind of going. I'm trying to figure out -- because, normally, a

physician -- you know, when you do a 14B, you're saying that she's at maximum medical improvement, and -- and that's where we are. But this one doesn't assign a rating or anything, so --

A So my -- my first question would be -- if they handed me a 14B, I say, "Why am I getting a 14B? I didn't see her under worker's comp."

Q Okay.

A So that would've been my --

Q Yeah.

A -- first red flag. Somebody must've really wanted this badly, and it looks like the girls must have tried to do some of this. It's a little strange.

Q Okay. All right. I just wanted to clarify while I had it. Okay.

A (Reads softly to himself.)

Q Okay. Just one second.

I think that's all of my questions. I -- I would just like to confirm that your opinions that you have given to me today were stated to a reasonable degree of medical certainty; is that correct?

A Correct.

MS. HALTIWANGER: All right. Okay.

MR. MOORE: (To the deponent) I have a -- I

have a few more questions about the 14B.

REEXAMINATION

BY MR. MOORE:

Q Let me show them to you. I -- I have two that were done that indicate "Date of Injury: 3/26/18," and a "Date of First Office Visit: 1/6/2017; Date of Last Office Visit 5/3/2018." And I have "Diagnosis of injury or illness: spinal stenois," and it goes on. And I think -- are we -- to -- to -- first -- my -- my first question from this: Are we to disregard this, basically?

A So the second page is -- I knew I had seen this. That's my handwriting. "No knowledge of a work-related injury in treatment of this patient."

Q Okay. So --

MS. HALTIWANGER: Okay.

A That's what I told the girls to send back.

Q Okay. All right. So we are to disregard the first page -- the first one, though?

A Clearly, someone felt that was me being a smarty-pants and that was probably going to get me in trouble with somebody, but I don't know how to be anything other than straightforward. That would be my assessment is: I -- the handwritten one is mine; the other one is somebody in the office staff

trying to do the right thing, but that is not my actual signature.

Q Okay.

A I would probably disregard it.

Q All right.

A It doesn't say anything, either.

Q Okay.

MS. HALTIWANGER: Yes.

Q Based -- based upon that, I'll -- I'm -- I want to ask you this hypothetical: If -- if you had informational knowledge that she presented at Tuomey hospital with -- with the symptoms that she presented with and her indication was "increased pain in the leg, tailbone discomfort etc.," that wouldn't change the fact that she still needs a possible fusion, would it?

A The situation? No.

Q Okay.

A Whether it was work-related or not work-related, that --

Q -- that -- that wouldn't --

A -- wouldn't change the situation.

Q -- change any -- any of the diagnosis and treatment at -- at this point.

If she had said to you on the -- on the -- on

or about the 27 -- the 28th of -- of -- of -- of -- of April that she had these symptoms, and she had this popping situation at work, she was working two jobs, second job working as a housekeeping person at Shaw Air Force Base, and she had this popping, and this -- it made it worse, in your opinion, could that in fact have made it worse? If her testimony --

A So -- so the hypothetical is: Patient has pain; can a physical job exacerbate the pain? The answer to that hypothetical would be yes.

Q Okay. And counsel asked you about wear and tear. If you've had a prior back surgery in 2016 thereabouts, December in particular, you take a job six months later as a house-cleaning person where you do essentially manual labor, that's use and to some extent overuse when it comes to the back; is that fair to say?

MS. HALTIWANGER: Object to the form.

A I -- I -- I -- I don't know that I would agree with that.

Q Okay. So, if -- if someone --

A I mean, she's thin; she's 40; she's healthy. She had a microdiscectomy. I wouldn't restrict what she did going forward.

Q Okay. Let me ask a better question. If she's lifting trash bags that weigh 25 to 50 pounds, if she's lifting buckets of water consistently every night two to three times a night, could that aggravate, by use and overuse of her back, that already has -- has -- has been operated on?
A It can.
Q Yeah. Okay. And, if she presented to you -- if this information you had when you first saw her in April, though it wouldn't have changed your diagnosis or treatment, can you state within a reasonable degree of medical certainty that that could've aggravated her back, if you knew that at the time?
A Well, I mean, I think I stated a long time ago in this deposition that yes.
Q Okay.
A It could exacerbate a pre-existing condition of her back.
Q All right. And, if you had to -- if I had to ask you these questions on this document and I -- I -- I told you that she alleges an aggravation of date of injury as of -- of -- of April -- beginning of April and it -- and it -- and it -- and it had to do with her back, is she at MMI as we speak today?

A No. I would say not.
Q Okay. And you've already said that -- that -- that she is a candidate for a possible fusion; is that correct?
A Correct.
Q Okay. And does the -- her current condition limit her activities currently?
A Her pain limits her activities.
Q Does -- does -- would you recommend that she continue lifting buckets of water, or could she work a manual job, like a housekeeping job where she lifts trash and water and mops floors and sweeps floors? Could she do that job? Would you recommend her continuing to do that job?
A So, again, you're asking a hypothetical?
Q Yes.
A Could someone with a degenerative disc do a manual labor job? The answer is yes.
Q Okay. Is --
A There's thousands of people out there doing stuff like that --
Q Does --
A -- that had prior surgery.
Q Does a person who's recommended for a current fusion do that job currently? Would you recommend

them do that job now?
A No.
Q Okay. And, again, your -- your opinions are based upon a reasonable degree of medical certainty; is that correct?
A Yes.

MR. MOORE: No further questions.

FURTHER DEPONENT SAITH NOT.

(Whereupon, there being no further questions, the deposition was concluded at 1:00 p.m.)

Plaintiff's Exhibit Number 2, Two 14B forms.

(*This transcript may contain quoted material. Such material is reproduced as read or quoted by the speaker.)

(**Certificate accompanies sealed original only.)

Chart Copy

ADMISSION RECORD

Patient Name / Address	Account No.	Room / Bed	Type	Location / Service	Medical Rec. No.
MCLEOD,STARA SHANEIQUA [redacted] Phone [redacted] Social Security No. [redacted] Employer SANTEE WATEREE MENTAL HEA	A00043924224		ER	ED	M000443101

Date of Birth	Age	Sex	MarStat	Religion	Ethnicity	Race	Smoker
[redacted]	40	F	M	HOL	NHISLAT	B	

Guarantor / Address	Person to Notify / Address	Relationship
MCLEOD,STARA SHANEIQUA [redacted] Phone [redacted] Relationship Same as Patient Guarantor Employer SANTEE WATEREE MENTAL H	[redacted]OHNSON,ANDRE [redacted] Home Phone [redacted] Other Phone	SPOUSE
Financial Class |	Next of Kin / Address JOHNSON,ANDRE [redacted] Home Phone [redacted] Other Phone	Relationship SPOUSE

Insurance Name	Policy Number	Coverage Number	Subscriber / Insured Name
UNITED HEALTHCARE CHAMPVA	943460441		JOHNSON,ANDRE G MCLEOD,STARA SHANEIQUA

Accident Information	Reason for Visit
ONSET OF SYPTOM	BACK PAIN, LEFT LEG NUMBNESS

Accident Date / Time	Comments	Height / Weight	Arrival Mode
04/23/18			

Admit Date / Time	Admitting Physician	Attending Physician	ED Physician	User
04/23/18 0108		OLSON,DAVID	OLSON,DAVID	NSAYS

Hospital Days	HOME	OMI	SNF	ICF	HH	DIED AUTOPSY	Surgeon	Consult	Discharge Date / Time
	☐	☐	☐	☐	☐	☐ ☐	Anesthesiologist	Consult	

Admitting Diagnosis

Diagnosis and Procedure Code

Principal Diagnosis

Secondary Diagnosis

Procedure

Does pt have Advance Directive (Living Will)? No
Does pt have Health Care Power of Attorney? No
Does patient want info on Advance Directive? No
Are you an organ donor? No

If yes, Living Will copy received?
If yes, Health Care Power of Attorney copy received?

PALMETTO HEALTH TUOMEY
129 North Washington Street
Sumter, South Carolina 29150

Admission Record (Chart Copy)

00000 Rev. 01/01/2004

MCLEOD,STARA SHANEIQUA
Acct: A00043924224 **Unit:** M000443101
OLSON,DAVID
ER
F B **Age:** 40 **DOS:** 04/23/18
DOB: [redacted]

PLAINTIFF'S EXHIBIT
tabbies
129

PRESENTING PROBLEM (Mon Apr 23, 2018 01:17 LAH2)
Presenting problems: Leg Injury-Pain-Swelling.
ALLERGY (01:17 LAH2)
NKDA
CURRENT MEDICATIONS
No recorded medications
PRESCRIPTION
No recorded prescriptions
TRIAGE (Mon Apr 23, 2018 01:17 LAH2)
TRIAGE NOTES: Pt to ED with reports of pt emptied mop bucket two weeks ago at work, felt something pop, and now has pain to buttocks, and has numbness to left leg. Pt reports that she has tried heat, ice and OTC medications with no relief. Pt CAOx3. Pt reports "it's more in the bone kind of hurt, not so much muscular." Pt reports that when she sits straight up, it feels like she is sitting on something. (Mon Apr 23, 2018 01:17 LAH2)
PATIENT: NAME: McLeod, Stara S, AGE: 40, GENDER: female, DOB: [redacted], TIME OF GREET: Mon Apr 23, 2018 01:09, PREFERRED LANGUAGE: Pref. Lang. for Rec.Health info: English, RACE: African American, ETHNICITY: Non-Hispanic or Non-Latin, Fall related visit?: No, New onset weakness: No, Pt abuse/neglect?: No, SI/HI Thoughts?: NA, Zip Code: [redacted], KG WEIGHT: 72.57, PHONE: 803-236-8199, MEDICAL RECORD NUMBER: M000443101, ACCOUNT NUMBER: A00043924224, PAYMENT: Insurance, Attending: Saunders, Katherine. (Mon Apr 23, 2018 01:17 LAH2)
ADMISSION: URGENCY: ESI Level 4, TRANSPORT: Walked, BED: LOBBY. (Mon Apr 23, 2018 01:17 LAH2)
VITAL SIGNS: BP: 157/90, MAP: *, Pulse: 84, Resp: 16, Temp: 98.2, Pain: 9, O2 sat: 100 on (RA), End-Tidal CO2: *, Time: 4/23/2018 01:14. (01:14 LAH2)
COMPLAINT: leg pain, numbness. (Mon Apr 23, 2018 01:17 LAH2)
ASSESSMENT: . (Mon Apr 23, 2018 01:17 LAH2)
COLUMBIA SUICIDE SEVERITY RATING A: Patient denies wishing they were dead or wishing they could go to sleep and not wake up in the last month, thoughts of wanting to end one's life/die by suicide. (Mon Apr 23, 2018 01:17 LAH2)
PREVIOUS VISIT ALLERGIES: NKDA. (Mon Apr 23, 2018 01:17 LAH2)
PAST MEDICAL HISTORY (Mon Apr 23, 2018 01:17 LAH2)
MEDICAL HISTORY: No past medical history.
SURGICAL HISTORY FEMALE: Surgical history of hysterectomy, Date of surgery 2015.
PSYCHIATRIC HISTORY: History of depression, Currently under outpatient psychiatric treatment.
SOCIAL HISTORY: Denies alcohol abuse, Denies tobacco abuse, Denies drug abuse, Lives at home with family.
FAMILY HISTORY: Family history is not contributory to this case.
VITAL SIGNS (01:14 LAH2)
VITAL SIGNS: BP: 157/90, MAP: *, Pulse: 84, Resp: 16, Temp: 98.2, Pain: 9, O2 sat: 100 on (RA), Time: 4/23/2018 01:14.
EVENTS (Mon Apr 23, 2018 01:17 LAH2)
TRANSFER: Triage to Emergency Lobby.
GREET (01:09 RRM)
GREET: Greet: Mon Apr 23, 2018 01:09.
NOTES: Patient arrived ambulatory.
ADMIN

CHART VIEW (01:18 LAH2)
   XML View. (01:19 MDC)
   XML View. (01:38 MDC)
MERGE: Greet Mon Apr 23, 2018 01:09. (Mon Apr 23, 2018 01:17
      LAH2)
CHART PRINT (01:17 LAH2)
   (01:18 LAH2)
Key:
  LAH2=Hudson, RN, Latae MDC=Interface, Ed RRM=Matthews, EDT, Rebecca R.

DIAGNOSIS (06:26 OLSD)
FINAL: PRIMARY: LLE sciatica.
PRESENTING PROBLEM (Mon Apr 23, 2018 01:17 LAH2)
Presenting problems: Leg Injury-Pain-Swelling.
DISPOSITION
PATIENT: Disposition: Home, Disposition Transport: Ambulatory, Condition: Stable. (06:26 OLSD)
Pain Scale: 09, O2 used while in ED?: No, Psych related visit: No, Disposition Transport: Family/Friend Drive, Patient left the department. (07:16 BLF)
ALLERGY (01:17 LAH2)
NKDA
CURRENT MEDICATIONS
No recorded medications
MEDICATION ADMINISTRATION SUMMARY
Drug Name: *Norco, Dose Ordered: 1 tab(s), Route: PO, Status: Given, Time: 07:12 4/23/2018,
Drug Name: Dexamethasone Sodium Phosphate, Dose Ordered: 8 mg, Route: IM, Status: Given, Time: 06:37 4/23/2018, *Additional information available in notes, Detailed record available in Medication Service section.
PRESCRIPTION (06:27 OLSD)
Norco: Tablet : 325 Mg-5 Mg : Oral : Quantity: *** 5 *** Unit: milligram(s) Route: Oral Schedule: every 6 hours as needed Dispense: *** 12 ***
May substitute. Refills: *** No Refills ***
POTENTIAL SEVERE INTERACTION: Dexamethasone Sodium Phosphate (dexamethasone sodium phosphate) [dexamethasone]
Notes: ,
for pain.
Norflex: Tablet, Extended Release : 100 mg : Oral : Quantity: *** 1 *** Unit: tab Route: Oral Schedule: 2 times a day Dispense: *** 15 ***
May substitute. Refills: *** No Refills ***
Notes: ,
for muscle relaxation.
O2SAT INTERPRETATION (06:21 OLSD)
O2SAT: Single pulse oximetry, Oxygen saturation 100%, on room air, Oxygen saturation interpretation: Normal, No intervention required.
INSTRUCTION (06:27 OLSD)
FOLLOWUP: Follow up with Primary Care Physician As Needed.
SPECIAL: Rest, ice until pain resolved
Follow up with your back specialist if symptoms persist.
TRIAGE (Mon Apr 23, 2018 01:17 LAH2)
TRIAGE NOTES: Pt to ED with reports of pt emptied mop bucket two weeks ago at work, felt something pop, and now has pain to buttocks, and has numbness to left leg. Pt reports that she has tried heat, ice and OTC medications with no relief. Pt CAOx3. Pt reports "it's more in the bone kind of hurt, not so much muscular." Pt reports that when she sits straight up, it feels like she is sitting on something. (Mon Apr 23, 2018 01:17 LAH2)
PATIENT: NAME: McLeod, Stara S, AGE: 40, GENDER: female, DOB: [redacted], TIME OF GREET: Mon Apr 23, 2018 01:09, PREFERRED LANGUAGE: Pref. Lang. for Rec.Health info: English, RACE: African

American, ETHNICITY: Non-Hispanic or Non-Latin, Fall related visit?: No, New onset weakness: No, Pt abuse/neglect?: No, SI/HI Thoughts?: NA, Zip Code: [redacted], KG WEIGHT: 72.57, PHONE: 803-236-8199, MEDICAL RECORD NUMBER: M000443101, ACCOUNT NUMBER: A00043924224, PAYMENT: Insurance, Attending: Saunders, Katherine. (Mon Apr 23, 2018 01:17 LAH2)

ADMISSION: URGENCY: ESI Level 4, TRANSPORT: Walked, BED: LOBBY. (Mon Apr 23, 2018 01:17 LAH2)

VITAL SIGNS: BP: 157/90, MAP: *, Pulse: 84, Resp: 16, Temp: 98.2, Pain: 9, O2 sat: 100 on (RA), End-Tidal CO2: *, Time: 4/23/2018 01:14. (01:14 LAH2)

COMPLAINT: leg pain, numbness. (Mon Apr 23, 2018 01:17 LAH2)

ASSESSMENT: . (Mon Apr 23, 2018 01:17 LAH2)

COLUMBIA SUICIDE SEVERITY RATING A: Patient denies wishing they were dead or wishing they could go to sleep and not wake up in the last month, thoughts of wanting to end one's life/die by suicide. (Mon Apr 23, 2018 01:17 LAH2)

PREVIOUS VISIT ALLERGIES: NKDA. (Mon Apr 23, 2018 01:17 LAH2)

HPI BACK (06:29 OLSD)

HISTORY OF PRESENT ILLNESS: 40 y/o female s/p lumbar laminectomy for HNP 1-2 yrs ago dev'd recurrent pain lt LS area with radiation into buttock and post thigh after lifting heavy bucket 2 wks ago. She is followed by Dr. DeHall in Columbia. Mild tenderness and +SLR @ 60 degrees.

CHIEF COMPLAINT: Patient presents for evaluation of pain, Denies swelling, Patient presents for evaluation of tenderness.

HISTORIAN: History provided by patient.

MECHANISM OF INJURY: Mechanism of injury: Body motion, lifting.

LOCATION: Symptoms are localized to the back, to lumbar spine.

QUALITY: Pain is sharp in nature, Described as similar to previous episodes.

SEVERITY: Maximum severity of symptoms moderate, Currently symptoms are moderate.

TIME COURSE: Sudden onset of symptoms, Symptoms are worsening.

ASSOCIATED WITH: No associated problems with urination, Associated with radiation of pain, to the left buttock, Associated with sciatica.

EXACERBATED BY: Patient's condition exacerbated by extension, Patient's condition exacerbated by flexion.

RELIEVED BY: Patient's condition relieved by nothing.

PAST MEDICAL HISTORY (Mon Apr 23, 2018 01:17 LAH2)

MEDICAL HISTORY: No past medical history.

SURGICAL HISTORY FEMALE: Surgical history of hysterectomy, Date of surgery 2015.

PSYCHIATRIC HISTORY: History of depression, Currently under outpatient psychiatric treatment.

SOCIAL HISTORY: Denies alcohol abuse, Denies tobacco abuse, Denies drug abuse, Lives at home with family.

FAMILY HISTORY: Family history is not contributory to this case.

ROS (06:32 OLSD)

CONSTITUTIONAL: Historian denies fever.

EYES: Historian denies eye redness, denies eye discharge, denies vision changes.

ENT: Historian denies epistaxis.

CARDIOVASCULAR: Historian denies chest pain, denies diaphoresis,

denies syncope.
RESPIRATORY: Historian denies cough, denies wheezing.
GI: Historian denies abdominal pain, denies diarrhea, denies vomiting.
GENITOURINARY FEMALE: Historian denies dysuria.
MUSCULOSKELETAL: Historian reports back pain, Historian denies joint swelling.
SKIN: Historian denies rash.
NEUROLOGIC: Historian denies focal weakness, Historian reports paresthesias, sensory changes.
PSYCHIATRIC: Historian denies memory loss.
PHYSICAL EXAM (06:32 OLSD)
CONSTITUTIONAL: Vital signs reviewed, Patient afebrile.
HEAD: normocephalic.
EYES: Pupils equally round and reactive to light, Extraocular muscles intact.
NECK: Neck exam included findings of normal range of motion, no tenderness.
RESPIRATORY CHEST: Respiratory exam included findings of no respiratory distress.
CARDIOVASCULAR: Cardiovascular exam included findings of heart rate regular rate and rhythm.
ABDOMEN FEMALE: no distension.
BACK: Tenderness, paraspinal to the left lower back, Straight leg raise, with pain on the left at 60 degrees, Back exam included findings of normal inspection.
UPPER EXTREMITY: Upper extremity exam included findings of inspection normal, Range of motion normal.
LOWER EXTREMITY: Lower extremity exam included findings of inspection normal, Range of motion normal.
NEURO: Neuro exam findings include patient oriented to person, place and time, no focal motor deficits.
SKIN: Skin exam included findings of skin warm, dry.
PSYCHIATRIC: Psychiatric exam included findings of patient oriented to person place and time.
NURSING PROCEDURE: NURSE NOTES (06:57 BLF)
NURSES NOTES: Patient resting quietly, Assistance offered to patient, Notes: Pt resting on stretcher in POC, resps even, nonlabored, reports no relief from pain at all, discussed d/c instruction and Rx with pt, states understanding, aware this writer to speak with Dr. Olson about further medication prior to d/c.
SAFETY: Side rails up, Cart/Stretcher in lowest position, Call light within reach, Hospital ID band on.
NURSING PROCEDURE: DISCHARGE NOTE (07:12 BLF)
DISCHARGE: Patient discharged to home, ambulating without assistance, friend driving, unaccompanied, Discharge instructions given to patient, Simple or moderate discharge teaching performed, by Barbara Fowler, RN, Prescriptions given and instructions on side effects given, Name of prescription(s) given: norco; norflex, Above person(s) verbalized understanding of discharge instructions and follow-up care, Patient treated and evaluated by physician, Notes: Pt resting on stretcher in POC, resps even, nonlabored. Pt made aware to take all meds as prescribed, to f/u with PMD, call to arrange f/u care. Pt states understanding to all.
BELONGINGS: Belongings remain with patient, Valuables remain with

patient.
SAFETY: Side rails up, Cart/Stretcher in lowest position, Call light within reach, Hospital ID band on.
VITAL SIGNS (01:14 LAH2)
VITAL SIGNS: BP: 157/90, MAP: *, Pulse: 84, Resp: 16, Temp: 98.2, Pain: 9, O2 sat: 100 on (RA), Time: 4/23/2018 01:14.
NURSING ASSESSMENT: EXTREMITY LOWER (06:36 BLF)
CONSTITUTIONAL: History obtained from patient, Patient appears, in distress due to pain, moderate pain distress observed, Patient cooperative, alert. Oriented to person, place and time, Skin warm, Skin dry, Skin normal in color, Mucous membranes pink, moist. Patient is well-groomed.
PAIN: numb pain, sharp pain, to the right upper leg, to the left lower leg, L buttock, Onset of pain 2 weeks ago, constant, on a scale 0-10 patient rates pain as 9.
LEFT LOWER EXTREMITY: Left lower extremity assessment findings include capillary refill less than 2 seconds, Skin color normal, Skin temperature warm, Distal sensation intact, Muscle tone normal.
RIGHT LOWER EXTREMITY: Right lower extremity assessment findings include capillary refill less than 2 seconds, Skin color normal, Skin temperature warm, Distal sensation intact, Muscle tone normal.
NOTES: Patient tolerated procedure well, Notes: Pt reports 2 weeks of pain to L buttock radiating down L leg, now with some numbness, has concerns for something other than sciatica r/t hx of, "a screwed up disc." Pt made aware s/s fit sciatica, to please f/u. with her back doctor, especially if tx recommended today does not help after a few days, pt states understanding to all.
SAFETY: Side rails up, Cart/Stretcher in lowest position, Call light within reach, Hospital ID band on.
EVENTS
TRANSFER: Triage to Emergency Lobby. (Mon Apr 23, 2018 01:17 LAH2)
Emergency Lobby to 2)Main ER 16. (05:02 MER1)
Removed from Emergency 2)Main ER 16. (07:16 BLF)
GREET (01:09 RRM)
GREET: Greet: Mon Apr 23, 2018 01:09.
NOTES: Patient arrived ambulatory.
MEDICATION SERVICE
Dexamethasone Sodium Phosphate: Order: Dexamethasone Sodium Phosphate (dexamethasone sodium phosphate) - Dose: 8 mg : IM
Ordered by: David Olson, MD
Entered by: David Olson, MD Mon Apr 23, 2018 06:26 ,
Acknowledged by: Fowler, RN Barbara Mon Apr 23, 2018 06:34
Documented as given by: Barbara Fowler, RN Mon Apr 23, 2018 06:37
Patient, Medication, Dose, Route, Schedule verified prior to administration., IM medication, Amount given: 8 mg, Medication administered to left buttock, Correct patient, time, route, dose and medication confirmed prior to administration, Patient advised of actions and side-effects prior to administration, Allergies confirmed and medications reviewed prior to administration, Patient tolerated procedure well, Patient in position of comfort, Side rails up, Cart in lowest position, Call light in reach.
Norco: Order: Norco (acetaminophen/hydrocodone bitartrate) - Dose: 1 tab(s) : PO

Notes: per VORB per Dr. Olson received @ 0702
Ordered by: David Olson, MD
Entered by: Barbara Fowler, RN Mon Apr 23, 2018 07:05 ,
Acknowledged by: Fowler, RN Barbara Mon Apr 23, 2018 07:05
Documented as given by: Barbara Fowler, RN Mon Apr 23, 2018 07:12
Patient, Medication, Dose, Route, Schedule verified prior to administration., Verbal order read back and verified, Amount given: 1 tab, , Site: Medication administered P.O., Correct patient, time, route, dose and medication confirmed prior to administration, Patient advised of actions and side-effects prior to administration, Allergies confirmed and medications reviewed prior to administration, Patient tolerated procedure well, Patient in position of comfort, Side rails up, Cart in lowest position, Call light in reach.

ADMIN
CHART VIEW (01:18 LAH2)
XML View. (01:19 MDC)
XML View. (01:38 MDC)
(03:29 RRM)
(04:37 LAH2)
(04:39 LAH2)
(05:32 GMC)
(05:57 BLF)
(06:21 OLSD)
(06:21 OLSD)
XML View. (06:28 MDC)
(06:29 OLSD)
(06:42 BLF)
(06:59 BLF)
(07:15 BLF)
XML View. (07:16 MDC)
(07:16 BLF)
XML View. (07:16 MDC)
(07:17 MAB1)
XML View. (07:18 MDC)
XML View. (19:07 MDC)
MERGE: Greet Mon Apr 23, 2018 01:09. (Mon Apr 23, 2018 01:17 LAH2)
FORM
WORK RELEASE (06:28 OLSD)
Blank (07:11 BLF)
ADMIN
CHART PRINT (01:17 LAH2)
(01:18 LAH2)
Chart sent by text interface. (01:38)
Chart sent by text interface. (01:38)
Chart sent by text interface. (07:16)
Chart sent by text interface. (07:16)
Chart sent by text interface. (07:16)
Chart sent by text interface. (07:16)
CHART FAX: KATHERINE SAUNDERS 8037744626 . (07:16 BLF)
PATIENT DATA CHANGE: Primary Nurse changed from (none) to Barbara Fowler, RN. (05:30 MER1)
Attending changed from (none) to David Olson, MD. (06:04 OLSD)
A08 232046462 by Interface, SSN: 251377085. (06:28)
A08 232046516 by Interface. (06:31)

DIGITAL SIGNATURE: Fowler, RN, Barbara. (07:15 BLF)
Olson, MD, David. (19:04 OLSD)
Key:
BLF=Fowler, RN, Barbara GMC=Clanton, MD, Garrett LAH2=Hudson, RN, Latae
MAB1=Briley, RN, Tony MDC=Interface, Ed MER1=Russell, RN, Marybeth
OLSD=Olson, MD, David RRM=Matthews, EDT, Rebecca R.

INSTRUCTIONS
* The examination and treatment you received in the emergency department has been rendered on an emergency basis only and is not meant to replace complete care from a personal physician or clinic. *
FINAL DIAGNOSIS LLE sciatica FOLLOWUP CONTACTS SAUNDERS, KATHERINE, PEDIATRICS1278 N LAFAYETTE DRSUMTER SC 29150 Phone: 803-774-4500Follow up with Primary Care Physician As Needed SPECIAL INSTRUCTIONS Rest, ice until pain resolved Follow up with your back specialist if symptoms persist PRESCRIPTIONS (2) Printed (2) Norco : Tablet : 325 Mg-5 Mg : Oral Quantity: 5, Unit: milligram(s), Route: Oral, Schedule: every 6 hours as needed, Dispense: 12 Norflex : Tablet, Extended Release : 100 mg : Oral Quantity: 1, Unit: tab(s), Route: Oral, Schedule: 2 times a day, Dispense: 15_____* X-rays. X-rays are read initially by the emergency physician. The X-ray will be read by a radiology physician specialist within 24 hours. If the radiologist notes any differences, you will be contacted by the emergency department. ** Lab Work. Results of lab testing done in the Emergency Department are available to your private physician. Lab results cannot be given over the Emergency Department phone.* IMPORTANT: If your condition gets worse or you have any concerns and you cannot contact your physician, return promptly to Tuomey Healthcare Systems Emergency Department. (803)774-9111**Disclaimer: Home medications and allergies listed on Patient Medication History Record are as reported by patient/family to Tuomey ED staff.** DISCHARGE INSTRUCTIONS RECEIPT FINAL DIAGNOSIS LLE sciatica FOLLOWUP CONTACTS SAUNDERS, KATHERINE, PEDIATRICS1278 N LAFAYETTE DRSUMTER SC 29150 Phone: 803-774-4500Follow up with Primary Care Physician As Needed THE FOLLOWING SPECIAL INSTRUCTIONS WERE GIVEN Rest, ice until pain resolved Follow up with your back specialist if symptoms persist THE FOLLOWING PRESCRIPTIONS WERE GIVEN Printed (2) Norco : Tablet : 325 Mg-5 Mg : Oral Quantity: 5, Unit: milligram(s), Route: Oral, Schedule: every 6 hours as needed, Dispense: 12 Norflex : Tablet, Extended Release : 100 mg : Oral Quantity: 1, Unit: tab(s), Route: Oral, Schedule: 2 times a day, Dispense: 15_____
_____Patient Signature
Date/Time_____ ____:____Rn/LPN Ini. TIME

TUOMEY
HEALTHCARE SYSTEM

Name: McLeod, Stara S
Age: 40Y DOB: [redacted]
Gender: F Wt: 72.57 kg Ht:
MedRec: M000443101
AcctNum: A00043924224
Attending: OLSD
Primary RN: BLF
Bed: ED 2–ER 16

TUOMEY HEALTHCARE
DISCHARGE INSTRUCTIONS

* The examination and treatment you received in the emergency department has been rendered on an emergency basis only and is not meant to replace complete care from a personal physician or clinic. *

FINAL DIAGNOSIS
LLE sciatica

FOLLOWUP CONTACTS

SAUNDERS, KATHERINE, PEDIATRICS
1278 N LAFAYETTE DR
SUMTER SC 29150
Phone: 803–774–4500

Follow up with Primary Care Physician As Needed

?ECIAL INSTRUCTIONS
Rest, ice until pain resolved
Follow up with your back specialist if symptoms persist

PRESCRIPTIONS (2)

Printed (2)

Norco : Tablet : 325 Mg–5 Mg : Oral
Quantity: 5, Unit: milligram(s), Route: Oral, Schedule: every 6 hours as needed, Dispense: 12

Norflex : Tablet, Extended Release : 100 mg : Oral
Quantity: 1, Unit: tab(s), Route: Oral, Schedule: 2 times a day, Dispense: 15

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* X–rays. X–rays are read initially by the emergency physician. The X–ray will be read by a radiology physician specialist within 24 hours. If the radiologist notes any differences, you will be contacted by the emergency department. *

* Lab Work. Results of lab testing done in the Emergency Department are available to your private physician. Lab results cannot be given over the Emergency Department phone.

* IMPORTANT: If your condition gets worse or you have any concerns and you cannot contact your physician, return promptly to Tuomey Healthcare Systems Emergency Department. (803)774–9111

Disclaimer: Home medications and allergies listed on Patient Medication History Record are as reported by patient/family to Tuomey ED staff.

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500 • Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737-5675
www.wcc.sc.gov

Physician's Statement

Claimant's Name:	Stara McLeod	Employer's Name:	CW Group Inc CW Resources
Physician's Name:	Dr. Paul Douglas DeHoll	Insurance Carrier:	PA Manufacturers Assn. Ins. Co.
Practice/Clinic:	Palmetto Health USC Orthopedic Center	SCWCC File No:	1805291
Preparer's Name:		Phone:	

The undersigned physician has been authorized to evaluate or treat this Claimant for his or her work injury or illness pursuant to *South Carolina Code Sections 42*-15-60, 42-15-80, 42-1-172, or 42-11-10.

Date of injury: 03/26/2018 Date of first office visit: 1/6/2017 Date of last office visit: 5/3/2018

The medical opinions below are stated to a reasonable degree of medical certainty.

Diagnosis or nature of injury or illness: M48.061-Spinal Stenosis

Body part(s) injured: Lumbar Spine Body part(s) affected: Lumbar Spine

Date of **maximum medical improvement:** 5/3/2018

Has the Claimant sustained **permanent physical impairment** as a result of the work injury? ____ Yes X No

If so, the permanent physical impairment is: ____ % medical impairment to the ____ (injured body part).

If there is a permanent physical impairment to other body part(s) as a result of the work injury, please indicate below:
____ % medical impairment to the ____ (additional body part injured or affected).

The impairment rating(s) above are based upon the following:

X The AMA's *Guides to the Evaluation of Permanent Impairment* ____ Edition; or
____ Other medical treatise: ____ or
____ Other: ____

Does the Claimant have **permanent physical limitations** as a result of the injury? ____ Yes X No

If so, the permanent physical limitations are: ____

Does the Claimant **possess retained hardware** as a result of the injury? X Yes ____ No

If so, the retained hardware is: Lumbar Microdisectomy 5/1 Date: 2/1/17

Is there **medical, surgical, hospital or other treatment** that the Claimant needs as a result of the injury for an additional time that will tend to lessen the period of disability or maintain the current level of function: X Yes ____ No

If so, the medical care and treatment that is needed is/are:

Sacroiliac joint Injection - left SI joint

*An indication or statement that future medical care "may be necessary" or "might be necessary" is not sufficient and will require further clarification.

I certify that I am a physician or other licensed healthcare provider, I have personally read and prepared this document, and the opinions reflected above are mine.

D. deHoll M.D.

Treating or Evaluating Physician

6/23/2018
Date

PLAINTIFF'S EXHIBIT deHoll 2 8-28-18 SCSCWCC

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500 • Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737-5675
www.wcc.sc.gov

Physician's Statement

Claimant's Name: Stara McLeod
Physician's Name: Dr. Paul Douglas DeHoff
Practice/Clinic: Palmetto Health USC Orthopedic Center
Preparer's Name:

Employer's Name: CW Group Inc CW Resources
Insurance Carrier: PA Manufacturers Assn. Ins. Co.
SCWCC File No: 1805291
Phone:

The undersigned physician has been authorized to evaluate or treat this Claimant for his or her work injury or illness pursuant to *South Carolina Code Sections* 42-15-60, 42-15-90, 42-1-172, or 42-11-10.

Date of Injury: 03/28/2018 Date of first office visit: _____ Date of last office visit: _____

The medical opinions below are stated to a reasonable degree of medical certainty.

No knowledge of a work related

Diagnosis or nature of injury or illness: _____

Body part(s) injured: _____ Body part(s) affected: _____

Date of maximum medical improvement: _____

Has the Claimant sustained **permanent physical impairment** as a result of the work injury? ____ Yes ____ No

If so, the permanent physical impairment is: _____ % medical impairment to the _____ (injured body part).

If there is a permanent physical impairment to other body part(s) as a result of the work injury, please indicate below:
_____ % medical impairment to the _____ (additional body part injured or affected).

The impairment rating(s) above are based upon the following:

_____ The AMA's *Guides to the Evaluation of Permanent Impairment* _____ Edition; or
_____ Other medical treatise: _____ or
_____ Other: _____

Does the Claimant have **permanent physical limitations** as a result of the injury? _____ Yes No of

If so, the permanent physical limitations are: _____

Does the Claimant possess retained hardware as a result of the injury? _____ Yes _____ No Yhis Dr

If so, the retained hardware is: _____

Is there **medical, surgical, hospital or other treatment** that the Claimant needs as a result of the injury for an additional time that will tend to lessen the period of disability or maintain the current level of function: _____ Yes _____ No

If so, the medical care and treatment that is needed is/are:

"An indication or statement that future medical care "may be necessary" or "might be necessary" is not sufficient and will require further clarification.

I certify that I am a physician or other licensed healthcare provider, I have personally read and prepared this document, and the opinions reflected above are mine.

Treating or Evaluating Physician **Date**

South Carolina Workers' Compensation Commission
WCC File # 1805291

Stara S. McLeod, Employee, Claimant, vs. CW Resources, Inc., Employer, PMA Insurance Group, Carrier, Defendants.	Deposition of **Stara S. McLeod**

Deposition of Stara S. McLeod, taken pursuant to the South Carolina Rules of Civil Procedure and the Administrative Procedures Act, commencing at the hour of 2:58 p.m., Thursday, June 28, 2018, at Moore Law Firm, LLC, 26 North Main Street, Sumter, South Carolina.

COPY

Reported by
Barbara P. Scott, CVR-M

Appearances

For the Employee/ Claimant:	Dwight C. Moore, Esquire Moore Law Firm, LLC 26 North Main Street Sumter, SC 29150
For Employer/Carrier:	R. Daniel Addison, Esquire Hedrick Gardner Kincheloe & Garofalo, LLP 1230 Main Street, Suite 325 P.O. Box 11267 (29211) Columbia, SC 29201
Reported By:	Barbara P. Scott, CVR-M

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Exhibits

No exhibits marked.

Court Reporter's Note: This transcript may contain quoted material. Such material is reproduced as read or quoted by the speaker. Double hyphens (--) denote interruption of speech, incomplete sentence/phrase, or trailing off. [ph] denotes phonetically written. [sic] denotes written as spoken. Social Security number, if present, has been partially or fully redacted or blacked out.

Stipulations

The reading and signing of this deposition transcript is waived by the deponent and counsel for the respective parties.

Whereupon,

Stara S. McLeod, being duly sworn and cautioned to speak the truth, the whole truth, and nothing but the truth, testified and deposed as follows:

The Court Reporter: State your name for the record.

The Deponent: My first name is Stara. Last name is McLeod.

Examination

By Mr. Addison:

Q Ms. McLeod, my name is Dan Addison. I'm here on behalf of CW Group in regard to the workers' compensation claim that you've filed. I'm here today to ask you some questions about your claim. This is what's called a discovery deposition. It means just that. This is my opportunity to discover any information about you that I feel is necessary for the case. I'm going to ask you lots of questions about yourself, your health history, work history, things I need in order to get

information that I feel is needed for the case, okay?

A Okay.

Q Some of the questions I ask you may seem a little personal in nature. They're not all meant to harm you -- or none of them meant to harm you in any way.

A Okay.

Q They're all meant to gather information. Things about marriage and children, that type of stuff, may seem a little personal. It's not meant to try to pick at you at all. It's just trying to get information.

A Okay.

Q If I ask you a question that you do not understand, I need you to tell me that you do not understand the question as asked. I will try to ask the question in a different way or I will explain my question to you if you tell me you didn't understand, okay?

A Okay.

Q Is that fair enough?

A That's fair.

Q If you answer a question, I will assume that you've understood it as asked. Is that fair?

A That's fair.
Q Okay. You're a little soft-spoken. If you'll try to keep your voice up. The court reporter is recording this. Sometimes she has to go back and listen to the recording to be able to figure out what you or I said, --
A Okay.
Q -- so if you get too soft-spoken, I'll ask you to please raise your voice, okay?
A Okay.
Q All right. Whenever answering a question that requires a yes-or-no answer, if you would always use the word yes or no instead of uh-uh or uh-huh or some other nonword. If you say one of the nonwords, I will ask you do you mean yes or no.
A Yes.
Q You may add to a yes or no all that you want to. You understand all that?
A Yes.
Q All right. Have you ever given a deposition before for any reason?
A No, sir.
Q Okay. Are you taking any kind of medication that would affect your ability to give this deposition today, anything that makes you confused, dazed,

dizzy?
A No, sir.
Q Okay. If you would, give me your full name. You gave us your name as Stara McLeod. Do you have any middle name?
A I do.
Q Okay. What's your middle name?
A My middle name is Shaneiqua.
Q Okay. Can you spell that version of Shaneiqua for me, please?
A S-h-a-n-e-i-q-u-a.
Q Okey-doke. And McLeod is a married name or a maiden name?
A It is my maiden name.
Q Okey-doke. All right. How old are you, Ms. McLeod?
A I am forty.
Q What's your date of birth?
A [redacted].
Q Where were you born?
A I was born in Sumter County, Sumter, South Carolina.
Q All right. Have you pretty much lived in the -- in the Sumter area most of your life?
A Yes, sir.

Q What is your current address?
A My current address is [redacted]. That's in [redacted], [redacted].
Q Okay.
A ZIP code, [redacted].
Q All right. How long have you lived at that address?
A 2008.
Q Okay. All right. Okay. Give me your Social Security number. She will redact this, but give me that number, if you would, please.
A XXX-XX-XXXX.
Q Alrighty. And do you have a driver's license?
A I do.
Q South Carolina, I presume?
A Yes.
Q Do you have that with you?
A Yes.
Q Can you tell me the number without looking at it?
A No.
Q All right. Pull it out and tell me that number, if you would.
A [redacted].
Q Is that a standard driver's license?
A Yes, sir.

Q Have you ever held a commercial driver's license?
A No, sir.
Q Do you have any restrictions on your driver's license, glasses, anything like that?
A Yes, sir.
Q Okay. What is it? Is it glasses or what?
A Yes.
Q Okey-doke. All right. Are you married?
A Yes.
Q What is your husband's name?
A His first name is Andre, A-n-d-r-e. Last name is Johnson.
Q Okay. How long have you and Mr. Johnson been married?
A Four years.
Q Are y'all currently still living together?
A Yes.
Q Okey-doke. Have you been married other than to Mr. Johnson?
A No, sir.
Q What does Mr. Johnson do for a living?
A He is retired, military and postal worker.
Q He currently works as a postal worker but he's retired military, or he's both retired from military and from the postal service?

A Yes.
Q Okay. All right. Is he retired on just standard retirement or did he retire on disability or --
A Disability.
Q Okey-doke. What is the nature of his disability?
A He is physically disabled from the VA, and because of him having I guess the years, he was able to also retire from the post office.
Q Okay. Is he a hundred percent disabled?
A He is 100 percent disabled.
Q Per the VA?
A Per the VA.
Q What type of disability does he have? I understand physical. What kind of physical disability does he have?
A He was a paratrooper, so he messed up his knee in the service.
Q Okay. All right. Does he receive some type of retirement from the postal service, as well, like a disability retirement from them, as well?
A Yes, sir, he does.
Q Okay. All right. When did he last work for the postal service, while y'all were married or before you got married?
A He officially retired maybe three years ago.

Q Okay.
A I can't recall the exact date.
Q How old is your husband?
A He is forty-eight. Forty-nine. I'm sorry.
Q Okay. Do you have any children?
A Yes, sir. I have two children of my own.
Q Okay.
A He has five children. So, we have seven children.
Q All right. Are any of the children of his yours?
A No, sir.
Q Okay. All right. Your two children you had --
A Prior to marriage.
Q Okay. How old are your children?
A They are just turning eighteen and thirteen.
Q Okay. Do both of them live with you?
A Yes, sir.
Q And how about of the five children? How many of the five children of your husband's live with y'all?
A Zero.
Q Okay. All right. Your eighteen-year-old, what is that child's name?
A His name Ja'Quest -- and it's J-a-'-Q-u-e-s-t, --
Q Okay.
A -- McLeod.

Q All right. Is he a high school -- a high school student now or --

A No, sir. He is off to college in just a couple of weeks.

Q Okay. Fantastic. All right. And then your thirteen-year-old?

A Her name is [redacted]. It's [redacted]. And her last name is [redacted], [redacted].

Q Okay. And she lives with you?

A She does.

Q And she is going to school, obviously, I would think?

A She's a rising eighth grader.

Q Okey-doke. Alrighty. Is there anyone else that lives in the home with you and your husband other than your children?

A Our three dogs.

Q Okay. People?

A No, sir.

Q All right. So, no other -- nobody -- no other family members living there?

A No, sir.

Q Dogs are family members, but no other human family members living there with y'all?

A No, sir.

Q Okay. Do you provide any kind of support to any other member of your family on a regular basis that doesn't live in the home with you?
A No, sir.
Q Okay. Do you receive any child support for your thirteen-year-old?
A No, sir.
Q Is there any type of court order that would give you child support for that child?
A No, sir.
Q Okay. Alrighty. Have you yourself ever served in the military?
A No, sir.
Q All right. As a result of your husband's service, do you have TRICARE?
A We have CHAMPVA.
Q Okey-doke. So, you have coverage through your husband's retirement from the military?
A Yes, sir.
Q Okay. All right. Do you use that at all for medical?
A Yes, sir.
Q Okay. Where do you get your medicals done as a result of any medical that you've done through your husband's military retirement benefits? Where have

you gone and gotten any medical from, any medical care? Have you gone somewhere -- like to a military hospital or have you gone to private hospitals and just used the insurance?

A Just the private sector.

Q Okay.

A And that CHAMPVA is only a supplemental insurance.

Q Okay. Alrighty. Do you have any sort of criminal record within the past ten years?

A No, sir.

Q Okey-doke. Do you have any driving record that affects your ability to drive, too many tickets, DUI, DUS, anything like that?

A No, sir.

Q All right. Do you own your own vehicle?

A Yes, sir.

Q Okay. What type of car do you own?

A I have two vehicles.

Q Okey-doke.

A I have a 2008 Nissan Maxima, --

Q Okay.

A -- and I have a 2008 Landrover.

Q Both of those are yours alone?

A Yes, sir.

Q Okey-doke. Are both vehicles in operating

condition?
A Yes, sir.
Q Okay. All right. All right. Let's talk about your work history now. Tell me about your first full-time job. What did you do work-wise?
A My first full-time job?
Q No. Actually, I forgot to ask you about your education. Tell me about your education background.
A I'm a graduate of Sumter High School, 1996.
Q Okay.
A I attended Allen University in Columbia, South Carolina for just about four years.
Q Okay. All right. Did you get a degree of any sort?
A I did not.
Q All right. How shy of a degree are you?
A Eleven hours.
Q Have you attempted to go back to college at all to try to get those 11 hours?
A I need to, but I have not.
Q When did you last attend any college courses?
A 2000.
Q Okey-doke. All right. And what was your degree that you were working on?

A Business administration.
Q Okay. All right. Have you done anything other than the Allen college courses? Have you done any college courses or technical courses at any other location, any other institution?
A No, sir.
Q Okey-doke. Have you ever received any training in any area that has given you certifications in any specialty areas?
A Yes, sir. Several.
Q Okay.
A All of them were probably based on employment at the time.
Q Okay.
A So, where would you like to --
Q Tell me which ones you have.
A I've had business writing. I have business tax writing. I've had -- gosh -- training with another employer as a positivist assistant. I've had training with my current employer because I have to be certified with that particular job, so --
Q To do what? What are you --
A It's called peer support, and you -- you go to school, basically, to be able to do this particular job, and you have to have so many credit hours.

Q Okay. And where do you go to that school?
A It's not a school. It's a retreat every year.
Q Okay.
A And I'm assuming that the people that teach it have some type of schooling or degree on it.
Q Okay.
A The last training was held in Charleston. The training before that -- or several trainings before that was in White Oak, South Carolina.
Q Okay. And which employer is it you're talking about?
A South Carolina Department of Mental Health.
Q Okey-doke. All right. Any other training of any sort?
A No, sir.
Q Okay. Now we'll talk about your work history.
A Okay.
Q Tell me your first full-time job that you had.
A My first full-time job was in 1996, and I worked at the House of Representatives as a page.
Q Okay. Who were you paging for?
A Gilda Cobb.
Q Okay.
A I can't remember her whole name now. And I also paged for Senator Strom Thurmond.

Q Okay. In DC, obviously?
A No. In Columbia.
Q Oh. Okay. At his office in Columbia?
A At his office in Columbia. Correct. And that would have been my second full-time job. I was an office assistant for him.
Q How long did you work at Senator Thurmond's office?
A Maybe about three years --
Q Okay.
A -- or so.
Q All right. And then after that, what was your next job?
A My next job was Colonial Life & Accident, and my tenure there was 11 years. I left there in 2004, I believe.
Q Okay. What did you do at Colonial Life?
A I was a customer service rep, and then I became a trainer.
Q In the customer service area?
A Correct.
Q Like training other CSRs?
A Correct.
Q Okay. All right. And that was --
A Yes. I'm sorry.
Q Was that the position you were in when you were

last there, was a trainer?
A Yes.
Q Okay. All right. That's Colonial Life. What was your next job?
A My next job would have been -- I think it was Eaton, Eaton Corporation.
Q All right. What did you do for Eaton?
A I was in the accounting department.
Q And which location of Eaton?
A Sumter, --
Q Okay.
A -- 15 South.
Q How long did you work for Eaton?
A I was there only a year. They had a layoff.
Q All right. All right. What was your job after Eaton?
A My next job was Amedisys Home Health.
Q All right. What did you do for them?
A I was an office assistant.
Q All right. And was that here in Sumter?
A That's correct.
Q How long did you work for Amedisys?
A About a year, I think.
Q Doing the same type stuff the whole time, --
A Correct.

Q -- the office stuff?
A Yes.
Q Okay.
A The following job would have been Advanced Prosthetics --
Q Okay.
A -- in Columbia. Also same type, administrative.
Q Doing office stuff?
A Mm-hmm. Administrative.
Q How long did you work for them?
A About a year. And these are all estimates on --
Q Sure.
A -- dates. I can't recall back that long.
Q All right. After Advanced Prosthetics, where did you go?
A I started working for the -- the State of South Carolina, Department of Mental Health.
Q All right. And where did you work for DMH, or where do you work for DMH?
A I currently work at 215 North Magnolia.
Q In Sumter?
A Here in Sumter.
Q Okey-doke. What is that facility for DMH? Is that like a local --
A It's just a local mental health --

Q -- mental health office?
A -- community center. Mm-hmm.
Q Okay. All right. When did you start with DMH?
A I started January of 2015.
Q And what is your job with DMH?
A My title is peer support/human services specialist I.
Q What does that mean in non-DMH employee speak?
A That just means that you -- you counsel individuals, you help them find housing, you help them find employment. You're kind of the community liaison.
Q Okay.
A More administrative stuff, pretty much.
Q All right. Alrighty. And are you continuing to work in that same position?
A That's correct. Yes.
Q And you've been continuously in that job since January of 2015?
A Yes.
Q Okay. Alrighty. And then how did you come to work -- When did you end up working with CW?
A I became employed with CW in November.
Q Okay. Of 2017?
A Yes, sir.

Q Okay. All right. So, is CW -- You'll have to kind of explain. I understand a little bit about who they are, but kind of --

A Mm-hmm.

Q I mean, did they come in and take over the contract -- Are you under a contract position? Are you in something different with CW? What are you doing?

A Yeah, I do something totally different --

Q Okay. What do you --

A -- with CW. CW is -- There are two parts. There's a -- There's a landscaping part, and there's a janitorial part. The part that I was employed was under the janitorial.

Q Okay. And where were you doing the janitorial work?

A At Shaw Air Force Base here in Sumter.

Q Okay. Was this a second job?

A Yes, sir.

Q Okay. And how often were you doing this -- Your work with CW, how often were you doing it?

A The job was Monday through Friday.

Q Okay. So, was it full-time doing that?

A Yes.

Q Okay. All right. Were you working full-time at DMH, as well?

A Yes, sir.
Q Okey-doke. Working the morning shift at one and evening shift at the other, that type of thing?
A Yes, sir.
Q Okay. All right. CW does this at Shaw Air Force Base?
A That's correct.
Q Were you designated any particular area or were you going to different buildings every day, or how does that --
A You were assigned to different buildings.
Q Okay. And you would be assigned when you would show up, Okay, we're going to work on the so-and-so building today, building 3 and 5, or something like that, or how does that -- Kind of explain to me how it works first off.
A Pretty much, I guess. When you start, you're assigned at that particular time, but say for instance if they need help or they're short-staffed, you could be asked if you want to work another building.
Q Okay. All right. All right. Let me go backwards a little bit. What is your rate of pay at DMH? How are you paid there? Is it salary or is it hourly?

A It's hourly.
Q Okay. What is your rate of pay?
A 11.55.
Q Is that full-time?
A Yes.
Q So, it's 40 hours, or what is it?
A It's 37.5.
Q All right. And Advanced Prosthetics, how were you paid there? Was it hourly or --
A Hourly.
Q How much were you making hourly there?
A If I can recall, it may have been $13.
Q Okay. Was that full-time?
A Yes, sir.
Q All right. And how about Amedisys? How were you paid there?
A Hourly, as well.
Q Do you remember how much you were being paid there hourly?
A Maybe around $11, 11 to 13. I can't recall.
Q Full-time?
A Yes, sir, full-time. And that was 40-plus.
Q How about Eaton? How were you paid?
A Oh, gosh. Eaton, also approximately $13 an hour, and that was 40-plus.

Q Were you salaried at Colonial Life?
A No, sir.
Q Hourly, as well, there?
A Yes.
Q And I know it's kind of far back. Do you remember what you were earning there?
A I was making 60,000 a year.
Q Sixty?
A Yes, about 60, if I can recall.
Q All right. Alrighty. When you worked at Advanced Prosthetics, did you have any additional employment other than Advanced?
A No, sir.
Q Okay. How about with Amedisys? Were you working any second jobs --
A No, sir.
Q -- with them, as well? Okay. How about with Eaton?
A No, sir.
Q You started with DMH in 2015. You didn't get a second job until November of 2017?
A Correct.
Q Did you work a second job at all between January of '15 and November of 2017?
A I have never worked another second job.

Q Okey-doke. All right. What precipitated the decision to take on a second job?
A I had a daughter that was enrolled in private school, so I had private school tuition, --
Q Okay.
A -- as well as I had a child that was graduating, starting college this July.
Q Okay. All right. Okay. Who was the supervisor you were reporting to at CW?
A We didn't have a direct supervisor. We had a crew leader.
Q Okay.
A However, we didn't have a direct supervisor.
Q All right. Who was the crew leader?
A Her name was Annie Crawford.
Q Is that who you would come see every day and say, Where are we working today? I mean, how would it work when you would come in?
A Well, it's kind of understood as far as what buildings were your buildings. You would speak to the crew leader if you were having any types of issues or anything, but you pretty much -- you worked independently, so you knew --
Q Okay. What was -- What was your schedule? What were you working when you first started with CW in

November?

A 6:30, and sometimes it would be till one. The hours fluctuate. You're allowed at least -- a minimum of 20 hours.

Q Okay. Per?

A Per week.

Q Okay. 6:30 PM?

A PM, yes, sir.

Q Till one AM?

A Till one AM. A lot -- When I initially started, my hours were 6:30 to about 11 maybe.

Q Okay. Alrighty. Was there anyone else that you were supposed to report to other than Annie?

A No, sir, --

Q Okay.

A -- not me directly.

Q All right. When you say not you directly, Annie would be reporting to someone else?

A Right. If she had any difficulties, she had whoever she spoke with.

Q Who was she supposed to speak to? Do you know?

A I can't recall her name right now.

Q Was she onsite, though?

A She is not onsite.

Q Where would she have been?

A Home.
Q Hmm?
A Home.
Q Okay. But I mean she's physically in the area and works --
A No, sir.
Q -- out of y'all's location, or where would that person have been? Where is home?
A Meaning on the shift or where would she be at when we're working? I don't understand.
Q Sure. What I'm asking is, I mean, is that person somebody that's local, here in Sumter, or --
A Yes.
Q -- that Annie could talk to out there?
A She is local.
Q So, that person might work there during the day; they just weren't there --
A Right.
Q -- physically --
A Correct.
Q -- when you were there in the evening?
A Right.
Q Okay. But Annie would be there physically when you were there --
A Yes.

Q -- in the evening?
A Yes, sir.
Q Okay. All right. And, so, you would come in, do your shift starting roughly around 6:30. What time would you get off from DMH?
A Five.
Q Okay. All right. And then you would do the job at CW, go home and sleep, do the same thing the next day?
A Yes, sir.
Q Okay. All right. And are you still working for CW at all?
A No, sir, I'm not.
Q When was your last day working with CW?
A It would have been the first week in April.
Q Okey-doke. All right. Did you have to clock in or anything with them?
A Yes, sir.
Q All right. And have you missed any time from DMH?
A Yes.
Q How much time have you missed with DMH?
A A collective time, maybe about a week, --
Q Okay.
A -- approximately, and that would include sick time as well as appointments.

Q So, you didn't take an actual full week off; you just --
A No, sir.
Q This is time over a period of --
A Over a --
Q -- a period of weeks?
A -- period of time, yes, sir.
Q Did you take all that as your PTO from DMH?
A That's correct. Or sick time.
Q All right. Okey-doke. Okay. Let's talk about your health history now. Tell me about any kind of significant medical conditions that you've had in the past for which you've had to receive medical treatment, medical conditions, things like high blood pressure, diabetes, those types of things, not injury-related-type stuff, okay? Have you ever had any types of medical conditions that you've had to have medical treatment for?
A I don't have any medical conditions such as diabetes or hypertension or anything like that, --
Q Okey-doke.
A -- thyroid, nothing.
Q Do you have a family doctor?
A Yes, I do.
Q Who's your family doctor?

A Dr. Kathy Saunders at Pinewood Family Medical.
Q Okay. How long has Dr. Saunders been your --
A Maybe the last two years.
Q And before Dr. Saunders, who was your family doctor?
A Lexington Family Practice, --
Q Okay.
A -- and that's in Lexington, South Carolina.
Q Did you live over there or something?
A I worked over there a lot, so it was easier for me to have a doctor's appointment there versus coming back to Sumter.
Q That's because you worked at Colonial Life, I assume, at some point?
A Right. I worked at Colonial, and Advanced Prosthetics is also in Columbia, so most times I worked in Columbia, not in Sumter.
Q Okay. All right. All right. Tell me about any kind of significant injuries you've had in the past that you've had to have any medical treatment for, just kind of any injury of any sort, not just the workers' comp injury but any type of an injury that you've had to have treatment.
A I haven't had any injuries. I did have a childhood injury when I was in fifth -- fourth grade -- third

or fourth grade. I had an eye injury.
Q Which eye?
A Right.
Q What did you have to have done for your right eye?
A I was stabbed in the eye with a pencil, so I am currently blind in my right eye.
Q Do you still have to have any type of treatment for your right eye?
A Just standard annual checkups.
Q Checkups. Okey-doke. All right. Excuse me. Have you ever been hospitalized for any reason?
A Yes, sir.
Q Other than childbirth?
A Yes, sir.
Q Okay. What have you been hospitalized for?
A Twice. I've had a back surgery in 2015, December of 2015.
Q Okay.
A I was -- It was just a day surgery. And that was Baptist Hospital in Columbia.
Q Who was the surgeon? Do you remember?
A Dr. Paul deHoll.
Q What did they do for your back? What kind of back surgery did you have?
A I had a discectomy of the L4.

Q Okay. And what other hospital admission have you had?
A I had a hysterectomy.
Q Okey-doke.
A And, if I'm not mistaken, it was December of 2016. And the days -- the dates may be reversed. But a hysterectomy.
Q Okay. Where was that done?
A That was done at Tuomey Hospital.
Q Do you remember who your surgeon was?
A Dr. -- It was Sumter OB-GYN -- Sumter Women's OB-GYN.
Q Okay. All right. Tell me how you ended up with Dr. deHoll with your back.
A He was a referral.
Q Okay. Who referred you over to him?
A Dr. Warrick.
Q Okay.
A And Dr. Warrick is a pain specialist, management.
Q Okay. Where is Dr. Warrick located?
A He's also in Tuomey. And I think it's Todd Warrick.
Q All right. And what led to you ending up having to have a discectomy of your lumbar spine?
A Just some pain in my back, and discomfort, and I

couldn't take it anymore. I didn't know what it was or where it came from.

Q Okay. Did you end up going to see your family doctor first or --

A No. I ended up seeing a chiropractor first, and the chiropractor then referred me to the pain management specialist, and the pain management specialist then referred me to Dr. deHoll.

Q Got you. Alrighty. All right. Have you had to do any follow-up treatment with Dr. deHoll subsequent to the surgery?

A No, sir.

Q Obviously, I think, you did a little bit subsequent to surgery; he had to check you out, make sure everything was okay?

A Correct. Just standard annual checkups. I didn't have any issues with that particular surgery.

Q Okay. All right. And then after the surgery, did you continue to see Dr. deHoll at any point subsequent to that?

A No, sir, not for that.

Q All right. When was the last time you saw Dr. deHoll for any issues related to your spine?

A April and May, if I'm not mistaken.

Q Of this year?

A Definitely April. Yes. But that was for the new condition, not --

Q Okey-doke. When was the last time before April that you had seen him --

A Oh, God.

Q -- for your spine?

A November.

Q And what were you seeing him for in November?

A Because in November I started having some discomfort at that time.

Q When you say November, you're talking about November of 2017?

A Yes, sir.

Q Tell me what kind of problems you were having in November of 2017.

A Just some tightening. I wanted to make sure that any -- This was just a couple of weeks into starting at CW. Just making sure that I had not, like, done anything to my back.

Q Okay.

A So, just some preventative at that point.

Q Okay. All right. Between the surgery being done in, I think you said, 2015, between then and November of 2017, have you seen Dr. deHoll at all?

A No, sir, not at all.

Q Have you seen any other physician for your lumbar --
A No, sir, none at all.
Q -- issues in there at all? Say in 2016 did you go see anybody?
A No, sir.
Q Okay. All right. So, you just saw him the one time in November of 2017?
A Right. Correct. I'm sorry.
Q Okay. And I think deHoll's back in Columbia now, isn't he?
A Yes.
Q Okey-doke. All right. Okay. Have you had to take any kind of medication for your -- for your lumbar issues subsequent to surgery in '15 prior to 2018?
A No, sir.
Q Alrighty. Any other types of issues that you've had to have medical treatment for that were physical -- physical issues that required medical --
A No, sir.
Q -- procedures?
A No, sir.
Q Okey-doke. Alrighty. Have you ever had a workers' compensation claim before with any employer?

A No, sir.
Q Have you ever had any insurance claim of any type with any business, corporation or person for any type of injury to your body?
A No, sir.
Q Okey-doke. Have you ever had a slip-and-fall-type injury anywhere where you've had injuries to your body when you sought any type of insurance claim for any benefits from anybody for an injury to your body?
A No, sir.
Q Have you ever had any automobile accidents where you were injured and sought medical treatment?
A No, sir.
Q Have you ever filed any short-term disability claim with an employer for any type of physical issues?
A Maternity.
Q Okay.
A And that would have been 2004.
Q Okay. Was that with Colonial still?
A That's correct.
Q All right. How about with your back issues in 2015? Did you seek any short-term disability in that time frame?
A No, sir.

Q All right. Have you ever filed a long-term disability claim with anyone?
A No, sir, other than maternity.
Q I got you. Have you ever filed for any Social Security disability benefits?
A I did, but nothing ever -- I think it was dropped. And that was also after maternity leave.
Q Okey-doke. What was the basis of your filing for Social Security disability?
A I had some postpartum depression.
Q Okey-doke. That was after your last baby or --
A Yes.
Q Did you have to receive treatment for your postpartum --
A Yes.
Q Were you hospitalized at all for that?
A Yes.
Q Okay. Where were you hospitalized?
A Richland Springs.
Q Okay. Any other filings for Social Security?
A No, sir.
Q Okay. Alrighty. Have you ever been involved in a lawsuit where you sued someone or someone sued you?
A No, sir.
Q Alrighty. Tell me what went on -- Tell me what

happened to you at CW.

A CW, again, it was a typical night. We are assigned our buildings. I went into my particular building after completing one building, which would have been the Teen Center, and then the next building would have been the Children's Annex building. Went into the Children's Annex building, cleaned the building as normal. At the end of the night, I was emptying the mop bucket. I went into the storage cabinet to empty the bucket, reached over, poured the water out. When I was coming back up from emptying the water bucket, I felt, like, a -- maybe like a burning/pulling sensation. It then started running down the left side of my leg. It did hurt at that particular time. From continuing to pack up the -- the building, the pain increased. I then went over to the next building, which would have been the Daycare Center, which is right next door to the Children's Annex. I walked down the hall. Again, it was hurting a little bit more. At that point, I felt my -- like my toes going numb and some pain going a little further down my leg than like in my buttocks and upper thigh area. At that time, I went to the other side of the building, spoke to the crew leader at that time,

Ms. Crawford, told her that I was hurting, and I tried to kind of adjust, you know, myself or whatever. She then kind of just massaged, like, my butt area to try to relieve some of the pain. And I continued working that night in pain. Went home that -- If I'm not mistaken, it happened on a Thursday. So, this was a Friday. I then -- I did go to work on that Friday, Friday evening.

Q Okay. Then what happened from there?

A I was supposed to report back to work on that Monday. On that Monday, I informed Ms. Vanessa Radcliffe that I needed to take the day off -- or the evening off.

Q Who is she?

A Vanessa -- I'm assuming that she's the supervisor over the program.

Q Okay.

A Advised her that I wasn't feeling well. And that continued kind of throughout the week, going back and forth about me not feeling well. We did several e-mail exchanges in regard to it. I then advised her at that time that I injured myself at work, and this was probably after two weeks in. She advised that I needed to go to Tuomey.

Q Okay.

A Went to Tuomey on a Sunday because I just could not take it anymore. Tuomey then gave me a few days off, three days, if I'm not mistaken, off. Spoke to a Miss Teresa. I'm not quite sure of Miss Teresa's last name or her position. And I'm assuming this would have been a follow-up from the information that Miss Vanessa gave her. She then advised me to go to Doctors Care.

Q Okay.

A Went to Doctors Care, and workman's comp would not authorize a -- them seeing me that particular day. Therefore, I then reached out to my doctor previously, Dr. deHoll, --

Q Okay.

A -- and I've been seeing Dr. deHoll and pain management since then.

Q Okey-doke. How many times have you seen Dr. deHoll?

A Three, if I'm not mistaken.

Q Okay. And where have you been doing pain management?

A Pain management is done at Dr. Warrick's office, and that's Tuomey Pain Management. And I have also seen a physical therapist but could not continue with physical therapy until I got the pain under

control.

Q Okay. That was something that Dr. deHoll sent you to?

A Yes, sir.

Q Okay.

A And my last pain injection was on last Monday.

Q Okay. An ESI? Epidural steroid injection?

A Oh. Yes, sir.

Q Okay. How many of those have you had?

A This is my first one so far.

Q Okay. And who was doing that, Dr. Warrick or Dr. --

A Dr. Warrick.

Q Have they done any MRI or anything of that nature?

A I have had one MRI and one back x-ray.

Q Okay. Where was the MRI done?

A The MRI was done in Columbia. I think it's called Carolina Imaging or something. It's off of Rabon Road.

Q Okay. But it's something Dr. deHoll --

A Off of Farrow Road.

Q -- something Dr. deHoll --

A Yes.

Q -- sent you to?

A Correct.

Q Okay. And the physical therapy he was having you do, where was that?
A Sumter Physical Therapy, and that's here in Sumter off of Wilson Hall Road.
Q Okay. Okay. Any other medical treatment?
A No, sir.
Q Did you go to the chiropractor, as well, during any of this, or this was all -- the chiropractor was all previously?
A The chiropractor was all previous. Nothing with this one.
Q The only two people that you've seen since March has been Dr. deHoll or Dr. Warrick as well as Tuomey, --
A Correct.
Q -- the people there?
A Right.
Q Did you just see Tuomey the one time?
A Yes, sir.
Q And I assume that was just at the emergency room at Tuomey?
A Yes, sir.
Q Okay. Have you continued to be in touch with anybody at CW?
A No, sir.

Q Okay. When was the last time you talked with anyone at CW?
A That was Miss Teresa, and that had to be May, middle of April.
Q Okay. All right. Tell me what sorts of problems you're having currently.
A I currently have numbness of my three toes. I still have numbness in the back of my leg.
Q Which side?
A Left side. I'm sorry. The numbness does go up to the back of my thigh.
Q Okay.
A I have weakness in the left foot and leg. I have severe cramping, especially at night, but they just told me that that's a side effect of -- I guess the body is reacting to it being pinched.
Q Okay.
A My normal activities are affected a lot, like sitting for long periods of time or standing for long periods of time or walking for a long period of time. It's always a -- a achy, dull hurt. But I take medication for that, as well.
Q That was going to be my next question. What type of meds are you taking currently?
A I take gabapentin. I take -- it's V-i-v-o-m-o.

It's a anti-inflammatory. I take Flexeril. I take -- oh, God -- I think it's Tramadol, Tramadol or Trazodone. Tramadol. Tramadol.

Q Okey-doke. All right. Who is -- Which doctor or doctors -- Is it both doctors prescribing or is it one doctor who's doing all the prescriptions for you right now?

A It's one doctor doing all the prescriptions currently.

Q And who is that?

A Dr. deHoll.

Q Dr. deHoll's doing all the scripts?

A Yes, sir.

Q Now, when is your next scheduled appointment with Dr. deHoll? Do you know?

A I do not. Because of the insurance, you have to kind of follow whatever. So, we're going to see what this next injection does.

Q Okay.

A And I have an appointment with Dr. Warrick, which is the pain management, end of July to see how I'm doing.

Q Alrighty. You have ChampVA, but other insurance -- You said it was your supplemental?

A I have -- Yes.

Q What's your primary insurance?
A My primary is UnitedHealthCare, and that's through -- it's postal. That's through my husband's retirement insurance.
Q All right. Do you also have Blue Cross through the state?
A No, sir. I opted out of that because that insurance is great.
Q So, any -- any copays and that type of stuff, CHAMP kicks in and picks up the secondary piece of it?
A Yes, sir.
Q Okay.
A Yeah. I do have to pay for my prescriptions, though.
Q Okey-doke. How much out-of-pocket have you had to pay? Do you know?
A A roundabout figure?
Q Sure.
A $300 maybe.
Q Okay.
A Because I think one of them is like 40-something dollars, so --
Q Okay.
A And may we add to that medical list, because I --
Q Sure. Absolutely. What else?

A Ibuprofen.
Q Okay. Like prescription-type or --
A Mm-mm.
Q -- over-the-counter?
A Just over-the-counter-type so I won't have -- It messes with my stomach.
Q Okay. All right. Give me a sec. Where is your son going to college?
A He is going to NASCAR Tech.
Q Wow.
A He is going to work on those NASCAR engines.
Q Work on the engines. That's fantastic.
A Yes. I am so excited for him.
Q That's pretty cool.
A He's a little fellow with some big engines. I think he's just ready to leave mama.

Mr. Addison: Okay. I think that's all I have. Do you have anything, Dwight?

Mr. Moore: No, sir. That's it.

Mr. Addison: That's it.

(Whereupon the deposition was concluded at 3:53 p.m.)

(Deponent has waived reading and signing.)

State of South Carolina)
)
County of Richland)

Certificate

Be it known that the foregoing deposition of Stara S. McLeod was taken before me;

That I was then and there a Notary Public in and for the State of South Carolina-At-Large;

That by virtue thereof I was duly authorized to administer an oath;

That the witness was by me first duly sworn to testify the truth, the whole truth, and nothing but the truth concerning the matter in controversy aforesaid;

That the foregoing transcript of 46 typewritten pages represents a true, accurate and complete transcription of the testimony so given at the time and place aforesaid to the best of my skill and ability;

That I am not related to nor an employee of any of the parties hereto, nor a relative or employee of any attorney or counsel employed by the parties hereto, nor interested in the outcome of this action.

Signed this 30th day of June 2018.

Barbara P. Scott

Notary Public for South Carolina
My commission expires March 2, 2027.

Note: Recordings are retained for twelve (12) months from date of certification.

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
P.O. Box 1715
Columbia, South Carolina 29202-1715
(803) 737-5739 www.wcc.sc.gov

PRE-HEARING BRIEF
WCC File No.: 1805291

Claimant's Name:	Stara S. McLeod	Employer's Name:	CW Resources, Inc.
Address:	[redacted]	Address:	416 Recreation Street
City:	[redacted] State: [redacted] Zip: [redacted]	City:	Shaw AFB State SC ZIP 29152
Home Phone:	[redacted] Work Phone	Carrier:	PMA Insurance Group
Preparer's Name:	Lee E. Dixon	Preparer's Phone #:	803-727-1215

A claim for workers' compensation benefits is made based on the following grounds:
☒ Injury ☐ Illness ☐ Repetitive Trauma

1. Compensation Rate: $113.28 2. AWW: $169.91 **Date of Injury:** 3/26/2018
3. Type of injury and body part(s): Claimant alleges that she sustained injuries to her back and leg as a result of an alleged work-related accident on March 26, 2018. Defendants dent that Claimant sustained a compensable injury in the course and scope of her employment.
4. Facts in controversy: Whether Claimant sustained a compensable injury by accident; Whether Claimant's need for treatment is causally-related to her employment; if an injury was sustained, the scope and extent thereof and to what benefits is Claimant entitled?
5. Legal issues involved: Same as above, 42-1-160, 42-15-60, waiver, laches, failure to prosecute claim.
6. Unusual aspects: Last known date of alleged related treatment was in August of 2018. Claimant has had intervening treatment for unrelated personal health condition. A Form 19 was filed on 7/6/20 due to failure to prosecute claim. A Form 50 was filed on or about 9/2/20. A hearing was set for 11/11/20 but was cancelled due to Claimant not ready to proceed. See Order dated 1/25/21.
7. Witnesses (designate if expert)*: Claimant, anyone named by Claimant; Dr. P. Douglas deHoll (via deposition); Defendants reserve the right to call further witnesses as required in rebuttal or response to evidence offered by Claimant.
8. Exhibits: Claimant's deposition transcript and Dr. DeHoll's deposition transcript.
9. Medical evidence: (indicate report pursuant to R.67-612; deposition or appearance) See APA submissions
10. Name, address, and specialty, if any, of the treating physician: None.
11. Impairment rating(s); body part(s); physician and date of opinion: None.
12. I am amending my Form 50/51 in the following manner: N/A

☐ **Mediation**
☐a. Mediation is requested to be ordered pursuant to Reg. 67-1801 B
☐b. Mediation is required pursuant to Reg. 67-1802.
☐c. Mediation is requested by consent of the Parties pursuant to Reg. 67-1803.
☐d. Mediation has been conducted by a duly qualified mediator and resulted in impasse.
Questions regarding mediation may be submitted to **mediation@wcc.sc.gov**.

I verify the contents of this Form are accurate and true to the best of my knowledge.
I certify I have served this document pursuant to Reg. 67-211 by delivering a copy to Dwight Moore

Address P.O. Box 1229, Sumter, SC 29151 **on the 11th day of May, 2021, by ☐ first class postage ☐ certified mail ☒ electronic service**

Signature: [signature] Email: ldixon@hedrickgardner.com

Date of Hearing: May 26, 2021 (Comm. Barden) Time needed for hearing: 1 hour

On behalf of ☐ Claimant ☒ Employer

Questions about the use of this form should be directed to the Jurisdictional Commissioner. Refer to Regulations 57-204 through 67-211 and Regulations 67-601 through 67-615; as well as Regulation 67-1801. File this form and proof of service on the opposing party according to R.67-611 and R.67-212. Do not send medical reports. * Commissioners reserve the right to admit expert witnesses at hearings.

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
WCC NO. 1805291

STARA S. MCLEOD, **Claimant,** **vs.** **CW RESOURCES, INC.,** **Employer,** **and** **PMA INSURANCE GROUP,** **Carrier.**	**NOTICE OF WITNESSES AND WRITTEN REPORT(S) PHYSICIAN OR OTHER EVIDENCE TO BE INTRODUCED ON BEHALF OF THE EMPLOYER/CARRIER**

TO: SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION AND DWIGHT C. MOORE, ATTORNEY FOR CLAIMANT:

YOU ARE HEREBY NOTIFIED THAT THE employer/carrier, pursuant to the provisions of the South Carolina Workers' Compensation Act and South Carolina Code §1-23-330 (1976, as amended), herewith submits the following reports/physicians or other evidence on behalf of the employer/carrier, to wit:

TAB	NAME OF PHYSICIAN/OTHER	DATE OF REPORTS	NO.
1	Palmetto Health Tuomey	10/25/16 – 04/23/18	1 – 12
2	Sumter Spine & Pain Center	10/27/16 – 06/18/18	13 – 33
3	Image Care	05/03/18	34 – 35
4	Palmetto Health – USC Orthopaedic Center	01/06/17 – 08/22/18	36 – 88
5	Palmetto Health Baptist	02/01/17	89 – 92
6	Sumter Physical Therapy Clinic	04/30/18 – 08/08/18	93 – 97
7	Encompass Health Rehab	08/19/18	98 – 99

TAB	EXHIBIT	NO.
A	Dr. DeHoll's deposition transcript	100 – 146
B	Claimant's deposition transcript	147 – 193

YOU ARE FURTHER HEREBY NOTIFIED that you have the right to cross-examination; and, should you desire to exercise said right, you are to forthwith schedule the deposition(s) of any of the physicians or other person(s), whose reports are submitted, for the purposes of cross-examination.

YOU ARE FURTHER HEREBY NOTIFIED that the originals of the documents referred herein, or photocopies received from said physicians/others, are being herewith forwarded to the South Carolina Workers' Compensation Commission, for insertion in the file of the South Carolina Workers' Compensation Commission and inclusion into evidence on behalf of the employer/carrier.

YOU ARE FURTHER NOTIFIED that the following witnesses may be called on behalf of the employer/carrier:

Claimant

Anyone named by Claimant

Dr. P. Douglas deHoll (via deposition)

Representative of employer

Lee E. Dixon
Hedrick Gardner Kincheloe & Garofalo LLP
1230 Main Street, Suite 325
Columbia, SC 29201
803-727-1215
Attorneys for Defendant(s)

May 11, 2021

McLeod, Stara S. v. CW Resources

WCC No. : 1805291

DOI: 3/26/2018

APA COVERSHEET

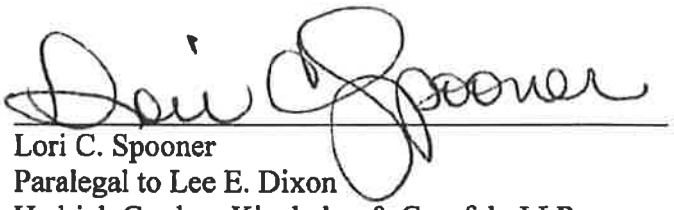
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CERTIFICATE OF SERVICE

This is to certify that a copy of the foregoing Pre-Hearing Brief and Notice of Witnesses and Written Report(s) Physician or Other Evidence to be Introduced on Behalf of the Employer/Carrier has been served upon the following by electronic delivery, addressed as shown below this the 11th day of May, 2021.

Dwight C. Moore
Moore Law Firm, LLC
PO Box 1229
Sumter, SC 29151-1229
moorelawfirm@ftc-i.net



Lori C. Spooner
Paralegal to Lee E. Dixon
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1230 Main Street, Suite 325
Columbia, SC 29201
803-727-1218

Attorneys for Employer/Carrier

PALMETTO HEALTH TUOMEY
129 NORTH WASHINGTON STREET
SUMTER, SC 29150
Phone #: (803)774-9090
Fax: (803)774-9580

Name:	STARA MCLEOD	**Exam Date:**	10/25/2016 10:45 AM
Patient ID:	TUM000443101	**Exam Name:**	MR LUMBAR W/O CONT 0050 | MRI.MR LSPWO
DOB:	[redacted]		
Phone:	803-236-8199	**History:**	
Acc #:	1635138	**Referrer:**	JASON HARKEY

Noncontrasted MR of the lumbar spine demonstrates sagittal and axial T1 and T2-weighted images.

On the coronal scout exam, bilateral renal cysts are noted. The cord demonstrates no intrinsic mass or abnormal signal. The lumbar discs demonstrate from L1-L2 through L4-L5 5. No abnormal protrusion or nerve root impingement. L4-L5 demonstrates a very minimal disc bulge. L5-S1 demonstrates disc space narrowing with an asymmetric protrusion on the left impinging upon the region of the descending left S1 nerve root. Abnormal deformity of the left thecal sac is seen in this region. No acute bony abnormality.

IMPRESSION: Abnormal left L5-S1 disc protrusion deforms the anterior left thecal sac and impinges upon the descending left S1 nerve root.

***** *ABNORMAL* *****

Report Electronically Signed by: GILBERT PARKER JR, MD
Report Electronically Signed on: 10/25/2016 12:10 PM

Patient Name:	STARA MCLEOD	**Exam:**	MR LUMBAR W/O CONT 0050 | MRI.MR LSPWO
Patient ID:	TUM000443101		
Technologist:	ROBERT OCONNOR	**Acc #:**	1635138
Completed Date:	10/25/2016 10:45 AM	**Interpreting Rad:**	GILBERT PARKER JR, MD
Transcribed By:	POWERSCRIBE 360	**Dictated Date:**	10/25/2016 12:01 PM
Transcribed Date:	10/25/2016 12:01 PM	**Finalized Date:**	10/25/2016 12:10 PM

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Chart Copy

ADMISSION RECORD

Patient Name / Address	Account No.	Room / Bed	Type	Location / Service	Medical Rec. No.
MCLEOD,STARA SHANEIQUA [redacted]	A00043924224		ER	ED	M000443101

Phone	Date of Birth	Age	Sex	MarStat	Religion	Ethnicity	Race	Smoker
[redacted]	[redacted]	40	F	M	HOL	NHISLAT	B	

Social Security No. [redacted]
Employer SANTEE WATEREE MENTAL HEA

Guarantor / Address	Person to Notify / Address	Relationship
MCLEOD,STARA SHANEIQUA [redacted]	JOHNSON,ANDRE [redacted]	SPOUSE
Phone [redacted]	Home Phone [redacted]	Other Phone
Relationship Same as Patient	Next of Kin / Address	Relationship
Guarantor Employer SANTEE WATEREE MENTAL H	JOHNSON,ANDRE [redacted]	SPOUSE
Financial Class I	Home Phone [redacted]	Other Phone

Insurance Name	Policy Number	Coverage Number	Subscriber / Insured Name
UNITED HEALTHCARE CHAMPVA	943460441		JOHNSON,ANDRE G MCLEOD,STARA SHANEIQUA

Accident Information	Reason for Visit
ONSET OF SYPTOM	BACK PAIN, LEFT LEG NUMBNESS

Accident Date / Time	Comments	Height / Weight	Arrival Mode
04/23/18			

Admit Date / Time	Admitting Physician	Attending Physician	ED Physician	User
04/23/18 0108		OLSON,DAVID	OLSON,DAVID	NSAYS

Hospital Days	HOME	OMI	SNF	ICF	HH	DIED	AUTOPSY	Surgeon	Consult	Discharge Date / Time
	☐	☐	☐	☐	☐	☐	☐	Anesthesiologist	Consult	

Admitting Diagnosis

Principal Diagnosis — Diagnosis and Procedure Code

Secondary Diagnosis

Procedure

Does pt have Advance Directive (Living Will)? No
Does pt have Health Care Power of Attorney? No
Does patient want info on Advance Directive? No
Are you an organ donor? No

If yes, Living Will copy received?
If yes, Health Care Power of Attorney copy received?

PALMETTO HEALTH TUOMEY
129 North Washington Street
Sumter, South Carolina 29150
Admission Record (Chart Copy)
03000 Rev. 01/01/2004

MCLEOD,STARA SHANEIQUA
Acct: A00043924224 Unit: M000443101
OLSON,DAVID
ER
F B Age: 40
DOS: 04/23/18
DOB: [redacted]

PRESENTING PROBLEM (Mon Apr 23, 2018 01:17 LAH2)
Presenting problems: Leg Injury-Pain-Swelling.
ALLERGY (01:17 LAH2)
NKDA
CURRENT MEDICATIONS
No recorded medications
PRESCRIPTION
No recorded prescriptions
TRIAGE (Mon Apr 23, 2018 01:17 LAH2)
TRIAGE NOTES: Pt to ED with reports of pt emptied mop bucket two weeks ago at work, felt something pop, and now has pain to buttocks, and has numbness to left leg. Pt reports that she has tried heat, ice and OTC medications with no relief. Pt CAOx3. Pt reports "it's more in the bone kind of hurt, not so much muscular." Pt reports that when she sits straight up, it feels like she is sitting on something. (Mon Apr 23, 2018 01:17 LAH2)
PATIENT: NAME: McLeod, Stara S, AGE: 40, GENDER: female, DOB: [redacted], TIME OF GREET: Mon Apr 23, 2018 01:09, PREFERRED LANGUAGE: Pref. Lang. for Rec.Health info: English, RACE: African American, ETHNICITY: Non-Hispanic or Non-Latin, Fall related visit?: No, New onset weakness: No, Pt abuse/neglect?: No, SI/HI Thoughts?: NA, Zip Code: [redacted], KG WEIGHT: 72.57, PHONE: [redacted], MEDICAL RECORD NUMBER: M000443101, ACCOUNT NUMBER: A00043924224, PAYMENT: Insurance, Attending: Saunders, Katherine. (Mon Apr 23, 2018 01:17 LAH2)
ADMISSION: URGENCY: ESI Level 4, TRANSPORT: Walked, BED: LOBBY. (Mon Apr 23, 2018 01:17 LAH2)
VITAL SIGNS: BP: 157/90, MAP: *, Pulse: 84, Resp: 16, Temp: 98.2, Pain: 9, O2 sat: 100 on (RA), End-Tidal CO2: *, Time: 4/23/2018 01:14. (01:14 LAH2)
COMPLAINT: leg pain, numbness. (Mon Apr 23, 2018 01:17 LAH2)
ASSESSMENT: . (Mon Apr 23, 2018 01:17 LAH2)
COLUMBIA SUICIDE SEVERITY RATING A: Patient denies wishing they were dead or wishing they could go to sleep and not wake up in the last month, thoughts of wanting to end one's life/die by suicide. (Mon Apr 23, 2018 01:17 LAH2)
PREVIOUS VISIT ALLERGIES: NKDA. (Mon Apr 23, 2018 01:17 LAH2)
PAST MEDICAL HISTORY (Mon Apr 23, 2018 01:17 LAH2)
MEDICAL HISTORY: No past medical history.
SURGICAL HISTORY FEMALE: Surgical history of hysterectomy, Date of surgery 2015.
PSYCHIATRIC HISTORY: History of depression, Currently under outpatient psychiatric treatment.
SOCIAL HISTORY: Denies alcohol abuse, Denies tobacco abuse, Denies drug abuse, Lives at home with family.
FAMILY HISTORY: Family history is not contributory to this case.
VITAL SIGNS (01:14 LAH2)
VITAL SIGNS: BP: 157/90, MAP: *, Pulse: 84, Resp: 16, Temp: 98.2, Pain: 9, O2 sat: 100 on (RA), Time: 4/23/2018 01:14.
EVENTS (Mon Apr 23, 2018 01:17 LAH2)
TRANSFER: Triage to Emergency Lobby.
GREET (01:09 RRM)
GREET: Greet: Mon Apr 23, 2018 01:09.
NOTES: Patient arrived ambulatory.
ADMIN

CHART VIEW (01:18 LAH2)
XML View. (01:19 MDC)
XML View. (01:38 MDC)
MERGE: Greet Mon Apr 23, 2018 01:09. (Mon Apr 23, 2018 01:17 LAH2)
CHART PRINT (01:17 LAH2)
(01:18 LAH2)
Key:
LAH2=Hudson, RN, Latae MDC=Interface, Ed RRM=Matthews, EDT, Rebecca R.

DIAGNOSIS (06:26 OLSD)
FINAL: PRIMARY: LLE sciatica.
PRESENTING PROBLEM (Mon Apr 23, 2018 01:17 LAH2)
Presenting problems: Leg Injury-Pain-Swelling.
DISPOSITION
PATIENT: Disposition: Home, Disposition Transport: Ambulatory, Condition: Stable. (06:26 OLSD)
Pain Scale: 09, O2 used while in ED?: No, Psych related visit: No, Disposition Transport: Family/Friend Drive, Patient left the department. (07:16 BLF)
ALLERGY (01:17 LAH2)
NKDA
CURRENT MEDICATIONS
No recorded medications
MEDICATION ADMINISTRATION SUMMARY
Drug Name: *Norco, Dose Ordered: 1 tab(s), Route: PO, Status: Given, Time: 07:12 4/23/2018,
Drug Name: Dexamethasone Sodium Phosphate, Dose Ordered: 8 mg, Route: IM, Status: Given, Time: 06:37 4/23/2018, *Additional information available in notes, Detailed record available in Medication Service section.
PRESCRIPTION (06:27 OLSD)
Norco: Tablet : 325 Mg-5 Mg : Oral : Quantity: *** 5 *** Unit: milligram(s) Route: Oral Schedule: every 6 hours as needed Dispense: *** 12 ***
May substitute. Refills: *** No Refills ***
POTENTIAL SEVERE INTERACTION: Dexamethasone Sodium Phosphate (dexamethasone sodium phosphate) [dexamethasone]
Notes: ,
for pain.
Norflex: Tablet, Extended Release : 100 mg : Oral : Quantity: *** 1 *** Unit: tab Route: Oral Schedule: 2 times a day Dispense: *** 15 ***
May substitute. Refills: *** No Refills ***
Notes: ,
for muscle relaxation.
O2SAT INTERPRETATION (06:21 OLSD)
O2SAT: Single pulse oximetry, Oxygen saturation 100%, on room air, Oxygen saturation interpretation: Normal, No intervention required.
INSTRUCTION (06:27 OLSD)
FOLLOWUP: Follow up with Primary Care Physician As Needed.
SPECIAL: Rest, ice until pain resolved
Follow up with your back specialist if symptoms persist.
TRIAGE (Mon Apr 23, 2018 01:17 LAH2)
TRIAGE NOTES: Pt to ED with reports of pt emptied mop bucket two weeks ago at work, felt something pop, and now has pain to buttocks, and has numbness to left leg. Pt reports that she has tried heat, ice and OTC medications with no relief. Pt CAOx3. Pt reports "it's more in the bone kind of hurt, not so much muscular." Pt reports that when she sits straight up, it feels like she is sitting on something. (Mon Apr 23, 2018 01:17 LAH2)
PATIENT: NAME: McLeod, Stara S, AGE: 40, GENDER: female, DOB: [redacted], TIME OF GREET: Mon Apr 23, 2018 01:09, PREFERRED LANGUAGE: Pref. Lang. for Rec.Health info: English, RACE: African

American, ETHNICITY: Non-Hispanic or Non-Latin, Fall related visit?: No, New onset weakness: No, Pt abuse/neglect?: No, SI/HI Thoughts?: NA, Zip Code: [redacted], KG WEIGHT: 72.57, PHONE: [redacted], MEDICAL RECORD NUMBER: M000443101, ACCOUNT NUMBER: A00043924224, PAYMENT: Insurance, Attending: Saunders, Katherine. (Mon Apr 23, 2018 01:17 LAH2)

ADMISSION: URGENCY: ESI Level 4, TRANSPORT: Walked, BED: LOBBY. (Mon Apr 23, 2018 01:17 LAH2)

VITAL SIGNS: BP: 157/90, MAP: *, Pulse: 84, Resp: 16, Temp: 98.2, Pain: 9, O2 sat: 100 on (RA), End-Tidal CO2: *, Time: 4/23/2018 01:14. (01:14 LAH2)

COMPLAINT: leg pain, numbness. (Mon Apr 23, 2018 01:17 LAH2)

ASSESSMENT: . (Mon Apr 23, 2018 01:17 LAH2)

COLUMBIA SUICIDE SEVERITY RATING A: Patient denies wishing they were dead or wishing they could go to sleep and not wake up in the last month, thoughts of wanting to end one's life/die by suicide. (Mon Apr 23, 2018 01:17 LAH2)

PREVIOUS VISIT ALLERGIES: NKDA. (Mon Apr 23, 2018 01:17 LAH2)

HPI BACK (06:29 OLSD)

HISTORY OF PRESENT ILLNESS: 40 y/o female s/p lumbar laminectomy for HNP 1-2 yrs ago dev'd recurrent pain lt LS area with radiation into buttock and post thigh after lifting heavy bucket 2 wks ago. She is followed by Dr. DeHall in Columbia. Mild tenderness and +SLR @ 60 degrees.

CHIEF COMPLAINT: Patient presents for evaluation of pain, Denies swelling, Patient presents for evaluation of tenderness.

HISTORIAN: History provided by patient.

MECHANISM OF INJURY: Mechanism of injury: Body motion, lifting.

LOCATION: Symptoms are localized to the back, to lumbar spine.

QUALITY: Pain is sharp in nature, Described as similar to previous episodes.

SEVERITY: Maximum severity of symptoms moderate, Currently symptoms are moderate.

TIME COURSE: Sudden onset of symptoms, Symptoms are worsening.

ASSOCIATED WITH: No associated problems with urination, Associated with radiation of pain, to the left buttock, Associated with sciatica.

EXACERBATED BY: Patient's condition exacerbated by extension, Patient's condition exacerbated by flexion.

RELIEVED BY: Patient's condition relieved by nothing.

PAST MEDICAL HISTORY (Mon Apr 23, 2018 01:17 LAH2)

MEDICAL HISTORY: No past medical history.

SURGICAL HISTORY FEMALE: Surgical history of hysterectomy, Date of surgery 2015.

PSYCHIATRIC HISTORY: History of depression, Currently under outpatient psychiatric treatment.

SOCIAL HISTORY: Denies alcohol abuse, Denies tobacco abuse, Denies drug abuse, Lives at home with family.

FAMILY HISTORY: Family history is not contributory to this case.

ROS (06:32 OLSD)

CONSTITUTIONAL: Historian denies fever.

EYES: Historian denies eye redness, denies eye discharge, denies vision changes.

ENT: Historian denies epistaxis.

CARDIOVASCULAR: Historian denies chest pain, denies diaphoresis,

denies syncope.
RESPIRATORY: Historian denies cough, denies wheezing.
GI: Historian denies abdominal pain, denies diarrhea, denies vomiting.
GENITOURINARY FEMALE: Historian denies dysuria.
MUSCULOSKELETAL: Historian reports back pain, Historian denies joint swelling.
SKIN: Historian denies rash.
NEUROLOGIC: Historian denies focal weakness, Historian reports paresthesias, sensory changes.
PSYCHIATRIC: Historian denies memory loss.
PHYSICAL EXAM (06:32 OLSD)
CONSTITUTIONAL: Vital signs reviewed, Patient afebrile.
HEAD: normocephalic.
EYES: Pupils equally round and reactive to light, Extraocular muscles intact.
NECK: Neck exam included findings of normal range of motion, no tenderness.
RESPIRATORY CHEST: Respiratory exam included findings of no respiratory distress.
CARDIOVASCULAR: Cardiovascular exam included findings of heart rate regular rate and rhythm.
ABDOMEN FEMALE: no distension.
BACK: Tenderness, paraspinal to the left lower back, Straight leg raise, with pain on the left at 60 degrees, Back exam included findings of normal inspection.
UPPER EXTREMITY: Upper extremity exam included findings of inspection normal, Range of motion normal.
LOWER EXTREMITY: Lower extremity exam included findings of inspection normal, Range of motion normal.
NEURO: Neuro exam findings include patient oriented to person, place and time, no focal motor deficits.
SKIN: Skin exam included findings of skin warm, dry.
PSYCHIATRIC: Psychiatric exam included findings of patient oriented to person place and time.
NURSING PROCEDURE: NURSE NOTES (06:57 BLF)
NURSES NOTES: Patient resting quietly, Assistance offered to patient, Notes: Pt resting on stretcher in POC, resps even, nonlabored, reports no relief from pain at all, discussed d/c instruction and Rx with pt, states understanding, aware this writer to speak with Dr. Olson about further medication prior to d/c.
SAFETY: Side rails up, Cart/Stretcher in lowest position, Call light within reach, Hospital ID band on.
NURSING PROCEDURE: DISCHARGE NOTE (07:12 BLF)
DISCHARGE: Patient discharged to home, ambulating without assistance, friend driving, unaccompanied, Discharge instructions given to patient, Simple or moderate discharge teaching performed, by Barbara Fowler, RN, Prescriptions given and instructions on side effects given, Name of prescription(s) given: norco; norflex, Above person(s) verbalized understanding of discharge instructions and follow-up care, Patient treated and evaluated by physician, Notes: Pt resting on stretcher in POC, resps even, nonlabored. Pt made aware to take all meds as prescribed, to f/u with PMD, call to arrange f/u care. Pt states understanding to all.
BELONGINGS: Belongings remain with patient, Valuables remain with

patient.
SAFETY: Side rails up, Cart/Stretcher in lowest position, Call light within reach, Hospital ID band on.
VITAL SIGNS (01:14 LAH2)
VITAL SIGNS: BP: 157/90, MAP: *, Pulse: 84, Resp: 16, Temp: 98.2, Pain: 9, O2 sat: 100 on (RA), Time: 4/23/2018 01:14.
NURSING ASSESSMENT: EXTREMITY LOWER (06:36 BLF)
CONSTITUTIONAL: History obtained from patient, Patient appears, in distress due to pain, moderate pain distress observed, Patient cooperative, alert. Oriented to person, place and time, Skin warm, Skin dry, Skin normal in color, Mucous membranes pink, moist. Patient is well-groomed.
PAIN: numb pain, sharp pain, to the right upper leg, to the left lower leg, L buttock, Onset of pain 2 weeks ago, constant, on a scale 0-10 patient rates pain as 9.
LEFT LOWER EXTREMITY: Left lower extremity assessment findings include capillary refill less than 2 seconds, Skin color normal, Skin temperature warm, Distal sensation intact, Muscle tone normal.
RIGHT LOWER EXTREMITY: Right lower extremity assessment findings include capillary refill less than 2 seconds, Skin color normal, Skin temperature warm, Distal sensation intact, Muscle tone normal.
NOTES: Patient tolerated procedure well, Notes: Pt reports 2 weeks of pain to L buttock radiating down L leg, now with some numbness, has concerns for something other than sciatica r/t hx of, "a screwed up disc." Pt made aware s/s fit sciatica, to please f/u. with her back doctor, especially if tx recommended today does not help after a few days, pt states understanding to all.
SAFETY: Side rails up, Cart/Stretcher in lowest position, Call light within reach, Hospital ID band on.
EVENTS
TRANSFER: Triage to Emergency Lobby. (Mon Apr 23, 2018 01:17 LAH2)
Emergency Lobby to 2)Main ER 16. (05:02 MER1)
Removed from Emergency 2)Main ER 16. (07:16 BLF)
GREET (01:09 RRM)
GREET: Greet: Mon Apr 23, 2018 01:09.
NOTES: Patient arrived ambulatory.
MEDICATION SERVICE
Dexamethasone Sodium Phosphate: Order: Dexamethasone Sodium Phosphate (dexamethasone sodium phosphate) - Dose: 8 mg : IM
Ordered by: David Olson, MD
Entered by: David Olson, MD Mon Apr 23, 2018 06:26 ,
Acknowledged by: Fowler, RN Barbara Mon Apr 23, 2018 06:34
Documented as given by: Barbara Fowler, RN Mon Apr 23, 2018 06:37
Patient, Medication, Dose, Route, Schedule verified prior to administration., IM medication, Amount given: 8 mg, Medication administered to left buttock, Correct patient, time, route, dose and medication confirmed prior to administration, Patient advised of actions and side-effects prior to administration, Allergies confirmed and medications reviewed prior to administration, Patient tolerated procedure well, Patient in position of comfort, Side rails up, Cart in lowest position, Call light in reach.
Norco: Order: Norco (acetaminophen/hydrocodone bitartrate) - Dose: 1 tab(s) : PO

Notes: per VORB per Dr. Olson received @ 0702
Ordered by: David Olson, MD
Entered by: Barbara Fowler, RN Mon Apr 23, 2018 07:05 ,
Acknowledged by: Fowler, RN Barbara Mon Apr 23, 2018 07:05
Documented as given by: Barbara Fowler, RN Mon Apr 23, 2018 07:12
Patient, Medication, Dose, Route, Schedule verified prior to administration., Verbal order read back and verified, Amount given: 1 tab, , Site: Medication administered P.O., Correct patient, time, route, dose and medication confirmed prior to administration, Patient advised of actions and side-effects prior to administration, Allergies confirmed and medications reviewed prior to administration, Patient tolerated procedure well, Patient in position of comfort, Side rails up, Cart in lowest position, Call light in reach.

ADMIN
CHART VIEW (01:18 LAH2)
XML View. (01:19 MDC)
XML View. (01:38 MDC)
(03:29 RRM)
(04:37 LAH2)
(04:39 LAH2)
(05:32 GMC)
(05:57 BLF)
(06:21 OLSD)
(06:21 OLSD)
XML View. (06:28 MDC)
(06:29 OLSD)
(06:42 BLF)
(06:59 BLF)
(07:15 BLF)
XML View. (07:16 MDC)
(07:16 BLF)
XML View. (07:16 MDC)
(07:17 MAB1)
XML View. (07:18 MDC)
XML View. (19:07 MDC)
MERGE: Greet Mon Apr 23, 2018 01:09. (Mon Apr 23, 2018 01:17 LAH2)
FORM
WORK RELEASE (06:28 OLSD)
Blank (07:11 BLF)
ADMIN
CHART PRINT (01:17 LAH2)
(01:18 LAH2)
Chart sent by text interface. (01:38)
Chart sent by text interface. (01:38)
Chart sent by text interface. (07:16)
Chart sent by text interface. (07:16)
Chart sent by text interface. (07:16)
Chart sent by text interface. (07:16)
CHART FAX: KATHERINE SAUNDERS 8037744626 . (07:16 BLF)
PATIENT DATA CHANGE: Primary Nurse changed from (none) to Barbara Fowler, RN. (05:30 MER1)
Attending changed from (none) to David Olson, MD. (06:04 OLSD)
A08 232046462 by Interface, SSN: [redacted]. (06:28)
A08 232046516 by Interface. (06:31)

DIGITAL SIGNATURE: Fowler, RN, Barbara. (07:15 BLF)
Olson, MD, David. (19:04 OLSD)
Key:
BLF=Fowler, RN, Barbara GMC=Clanton, MD, Garrett LAH2=Hudson, RN, Latae
MAB1=Briley, RN, Tony MDC=Interface, Ed MER1=Russell, RN, Marybeth
OLSD=Olson, MD, David RRM=Matthews, EDT, Rebecca R.

INSTRUCTIONS
* The examination and treatment you received in the emergency department has been rendered on an emergency basis only and is not meant to replace complete care from a personal physician or clinic. *
FINAL DIAGNOSIS LLE sciatica FOLLOWUP CONTACTS SAUNDERS, KATHERINE, PEDIATRICS1278 N LAFAYETTE DRSUMTER SC 29150 Phone: 803-774-4500Follow up with Primary Care Physician As Needed SPECIAL INSTRUCTIONS Rest, ice until pain resolved Follow up with your back specialist if symptoms persist PRESCRIPTIONS (2) Printed (2) Norco : Tablet : 325 Mg-5 Mg : Oral Quantity: 5, Unit: milligram(s), Route: Oral, Schedule: every 6 hours as needed, Dispense: 12 Norflex : Tablet, Extended Release : 100 mg : Oral Quantity: 1, Unit: tab(s), Route: Oral, Schedule: 2 times a day, Dispense: 15_____* X-rays. X-rays are read initially by the emergency physician. The X-ray will be read by a radiology physician specialist within 24 hours. If the radiologist notes any differences, you will be contacted by the emergency department. ** Lab Work. Results of lab testing done in the Emergency Department are available to your private physician. Lab results cannot be given over the Emergency Department phone.* IMPORTANT: If your condition gets worse or you have any concerns and you cannot contact your physician, return promptly to Tuomey Healthcare Systems Emergency Department. (803)774-9111**Disclaimer: Home medications and allergies listed on Patient Medication History Record are as reported by patient/family to Tuomey ED staff.**

DISCHARGE INSTRUCTIONS RECEIPT FINAL DIAGNOSIS LLE sciatica FOLLOWUP CONTACTS SAUNDERS, KATHERINE, PEDIATRICS1278 N LAFAYETTE DRSUMTER SC 29150 Phone: 803-774-4500Follow up with Primary Care Physician As Needed THE FOLLOWING SPECIAL INSTRUCTIONS WERE GIVEN Rest, ice until pain resolved Follow up with your back specialist if symptoms persist THE FOLLOWING PRESCRIPTIONS WERE GIVEN Printed (2) Norco : Tablet : 325 Mg-5 Mg : Oral Quantity: 5, Unit: milligram(s), Route: Oral, Schedule: every 6 hours as needed, Dispense: 12 Norflex : Tablet, Extended Release : 100 mg : Oral Quantity: 1, Unit: tab(s), Route: Oral, Schedule: 2 times a day, Dispense: 15_____

_____Patient Signature

Date/Time_____ ____:____Rn/LPN Ini. TIME

TUOMEY
HEALTHCARE SYSTEM

Name: McLeod, Stara S
Age: 40Y DOB: [redacted]
Gender: F Wt: 72.57 kg Ht:
MedRec: M000443101
AcctNum: A00043924224
Attending: OLSD
Primary RN: BLF
Bed: ED 2-ER 16

TUOMEY HEALTHCARE
DISCHARGE INSTRUCTIONS RECEIPT

FINAL DIAGNOSIS
LLE sciatica

FOLLOWUP CONTACTS

SAUNDERS, KATHERINE, PEDIATRICS
1278 N LAFAYETTE DR
SUMTER SC 29150
Phone: 803-774-4500

Follow up with Primary Care Physician As Needed

THE FOLLOWING SPECIAL INSTRUCTIONS WERE GIVEN
Rest, ice until pain resolved
Follow up with your back specialist if symptoms persist

THE FOLLOWING PRESCRIPTIONS WERE GIVEN

Printed (2)

Norco : Tablet : 325 Mg-5 Mg : Oral
Quantity: 5, Unit: milligram(s), Route: Oral, Schedule: every 6 hours as needed, Dispense: 12

Norflex : Tablet, Extended Release : 100 mg : Oral
Quantity: 1, Unit: tab(s), Route: Oral, Schedule: 2 times a day, Dispense: 15

Stara McLeod 4-23-18
Patient Signature Date/Time

BLP 07:12
Rn/LPN Ini. TIME

Prepared: Mon Apr 23, 2018 06:27 by OLSD 1 of 1

TUOMEY
HEALTHCARE SYSTEM

Name: McLeod, Stara S
Age: 40Y DOB: [redacted]
Gender: F Wt: 72.57 kg Ht:
MedRec: M000443101
AcctNum: A00043924224
Attending: OLSD
Primary RN: BLF
Bed: ED 2–ER 16

TUOMEY HEALTHCARE
WORK RELEASE

EMPLOYER:
RESTRICTIONS:
DIAGNOSIS:
ADDITIONAL INSTRUCTIONS: Ms. McLeod may return to work 27 April 2018.

Signature:

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SUMTER SPINE PAIN CENTER
M. TODD WARRICK, M.D.

100 North Sumter Street, Suite 320
Sumter, SC 29150
Phone: (803) 774-6824
Fax: (803) 774-8977

Name: STARA S MCLEOD **ID: 1219090** **DOB:** [redacted] (38 years)

Date of Encounter: 10/27/2016 09:37 AM

History of Present Illness

Patient words: New patient referred by Harkey. She has pain on the left side of her lower back that radiates into her left hip, leg, and foot. She has numbness and tingling in her left leg and foot. She has been having this pain for about two weeks. She has a MRI report.

The patient is a 38 year old female who presents to the practice today for a transition into care. The patient is transitioning into care from another physician (Harkey) .

Additional reason for visit:

Pain is described as the following:
The pain is described as being located in the lumbar area. The pain radiates to the left hip, left anterior thigh, left posterior thigh, left lateral thigh, left calf and left foot. The onset of the pain has been sudden and has been occurring in a persistent pattern for weeks. The course has been constant. The pain is characterized as sharp, burning, shooting, stabbing, throbbing, tender, cramping, pressure and ache. The symptoms are aggravated by prolonged sitting, lying down, bending, walking and lifting. The symptoms are relieved by lying down.

History

Allergies
No Known Drug Allergies (10/27/2016)

Family History
None (10/27/2016)

Social History
Living Situation
Occupation
No Drug Use
Non Drinker/No Alcohol Use
Tobacco Use

Medication History
Medications Reconciled.

MCLEOD,STARA SHANEIQUA
Acct: A00041464975 Unit: MC00443101
WARRICK,MICHAEL TODD
PAI
F B Age: 38 DOS: 10/27/16
DOB: [redacted]

Review of Systems

General: Not Present- Chills, Fatigue, Fever, Weight Gain and Weight Loss.
HEENT: Not Present- Hearing Loss, Nose Bleed, Difficulty Swallowing and Sore Throat.
Neck: Not Present- Neck Pain and Neck Stiffness.
Respiratory: Not Present- Cough, Difficulty Breathing, Sputum Production and Wheezing.
Cardiovascular: Not Present- Abnormal Blood Pressure, Chest Pain, Palpitations, Shortness of Breath and Swelling of Extremities.
Gastrointestinal: Not Present- Constipation, Diarrhea, Nausea and Rectal Bleeding.
Musculoskeletal: Present- **Back Pain.** Not Present- Difficulty Walking, Joint Pain, **Joint Stiffness** and Muscle Cramps.
Neurological: Present- **Numbness.** Not Present- Confusion, Dizziness, Headaches and Paralysis.
Psychiatric: Not Present- Anxiety, Depression and Suicidal Ideation.
Endocrine: Not Present- Cold Intolerance, Excessive Thirst and Thyroid Problems.
Hematology: Not Present- Anemia, Easy Bruising and Excessive bleeding.
All other systems negative

Vitals

10/27/2016 09:47 AM
Weight: 160 lb **Height:** 64 in
Body Surface Area: 1.81 m² **Body Mass Index:** 27.46 kg/m²
Pain level: 10/10
Pulse: 109 (Regular) **Resp.:** 16 (Unlabored) **P. OX:** 98% (Room air)
BP: 113/76 Manual (Sitting, Left Arm, Standard)

Physical Exam

The physical exam findings are as follows:

General

Mental Status - Alert. **General Appearance** - Cooperative and Well groomed. **Orientation** - Oriented X4. **Build & Nutrition** - Well developed.

Peripheral Vascular

Upper Extremity: Inspection - Left - Normal - No Clubbing, No Cyanosis, No Edema, Pulses Intact. **Right** - Normal - No Clubbing, No Cyanosis, No Edema, Pulses Intact.
Palpation: - All peripheral pulses intact in upper extremities.
Lower Extremity: Inspection - Left - Inspection Normal. **Right** - Inspection Normal.
Palpation: - All peripheral pulses intact in lower extremities.



Neurologic

Sensory:
Light Touch: Intact - Globally.
Proprioception - Bilateral - Normal.
Overall Assessment of Muscle Strength and Tone reveals:
Lower Extremities: Right Iliopsoas - 5/5. **Left Iliopsoas** - 5/5. **Right Quadriceps** - 5/5. **Left Quadriceps** - 5/5. **Right Hamstrings** - 5/5. **Left Hamstrings** - 5/5. **Right Tibialis Anterior** - 5/5. **Left Tibialis Anterior** - 5/5. **Right Gastroc-Soleus** - 5/5. **Left Gastroc-Soleus** - 4/5. **Right EHL** - 5/5. **Left EHL** - 5/5.
General Assessment of Reflexes: **Right Knee** - 2+. **Left Knee** - 2+. **Right Ankle** - 2+. **Left Ankle** - 0. **Plantar Reflexes (L4-S2)** - **Bilateral** - plantar flexion. **Coordination** - Normal. **Gait** - Normal.

Musculoskeletal

Spine/Ribs/Pelvis
Thoracic (Dorsal) Spine:
Inspection and Palpation: Tenderness - None.
ROJM: Normal in flexion/extension/rotation - Normal in flexion/extension/rotation.
Deformities/Malalignments/Discrepancies - None.
Lumbosacral Spine:
Inspection and Palpation: Tenderness - no tenderness to palpation over the spinous processes or paravertebral tissues. **Muscle tone** - no palpable spastic cords or trigger points noted. **Swelling** - none.

ROJM: Testing limited - due to pain.
Functional Testing - Modified Straight Leg Raise positive for sciatic pain. Patrick (FABER) negative for sacroiliac joint pain and Piriformis Stretch Negative for Sciatic Pain.

Assessment & Plan

Intervertebral disc disorders with radiculopathy, lumbosacral region
Acute radicular pain from leftward L5-S1 HNP with S1 displacement and compression. Depressed S1 reflex, weak gastroc. TFESI today, RTC 2 weeks. Consider referral for microdiscectomy.

Plans:
LUMBAR/SACRAL TFESI W/ FLUOROSCOPY(64483) Routine

Unspecified Diagnosis

Plans:
FALL RISK ASSESSMENT (3288F) Routine
SIGN AND SYMPTOM OF ABUSE AND NEGLECT Routine
SCREENING ASSESSMENT OF SUICIDE RISK (3085F) Routine
How to access health information online

I have personally seen and examined this patient. I have fully participated in the care of this patient. I have reviewed the PFSH, ROS, and Vital Signs.

The documentation recorded by the scribe accurately reflects the service I personally performed and the decisions made by me Todd Warrick, M.D.

Entered by Jane Avant, acting as a scribe for Dr. Todd Warrick

MCLEOD,STARA SHANEIQUA
Acct: A00041464975 Unit: M000443101
WARRICK,MICHAEL TODD
PAI DOS: 10/27/16
F B Age: 38 DOB: [redacted]

Procedures

LUMBAR/SACRAL TFESI W/ FLUOROSCOPY(64483) Performed: 10/27/2016 (Final, Reviewed)

- Procedure performed: 1. LEFT-SIDED S1 TRANSFORAMINAL INJECTION (CPT 64483)
- Anesthesia: Local
- Indications for procedure: Intractable pain, poorly responsive to non-invasive therapy.
- Complications: None

PROCEDURE IN DETAIL

- H&P: I have examined the patient and there are no changes in the History and Physical.
- Pre-operative diagnosis: M51.17 disc displacement with radiculopathy, lumbosacral region
- Prep: After the risks outlined in consent form were explained and all patient questions were answered, written informed consent for the procedure was obtained. The patient was taken to the procedure suite and placed in a comfortable position. Noninvasive blood pressure, continuous pulse oximetric and EKG monitoring were placed and baseline readings were recorded. The patient was deemed stable for procedure. The patient's skin was prepped with Chlor Prep and draped in sterile fashion. Using fluoroscopy, the lumbar spine was surveyed.
- Injection level (left): The C - arm was oblique toward the left 20 degrees to a standard view. Under an ipsilateral anterior-oblique view, the skin overlying the neuroforamen at the left S1 was anesthetized with buffered lidocaine 1%.
- Needle (left): At each treated level a 22 gauge, 3.5-inch Quincke needle was advanced into the neuroforamen. Needle tip was verified in AP and lateral views. Radiopaque contrast injected under live fluoroscopy revealed medial, retrograde flow into the epidural space. No intrathecal or intravascular contrast spread was noted. Upon injection, the patient reported no pain or paresthesias. Fluoroscopic images were saved for documentation.
- Medications instilled: A total volume of two milliliter of Depo-Medrol, 40 mg/mL, mixed with one mL of bupivacaine 0.25% was injected after negative aspiration. The needle(s) was flushed and withdrawn. Pressure was held at the needle insertion site for hemostasis, a Band-Aid was applied. The patient was transported to the recovery area and arrived in stable condition.

The patient was monitored for a minimum of fifteen minutes. The patient was neurologically intact. There were no apparent perioperative complications to the procedure. A follow-up appointment was scheduled. The patient was discharged with instructions to contact the Pain Center or present to their nearest emergency center should excessive bleeding, pain, weakness, fever, or other concerning symptom occur.

- Electronically signed by: Jane Avant on behalf of Todd Warrick, M.D.
- Date/Time: 10/27/2016 11:34 AM

FALL RISK ASSESSMENT (3288F) Performed: 10/27/2016 (Final, Reviewed)

- Is patient at risk for fall?: No

SIGN AND SYMPTOM OF ABUSE AND NEGLECT Performed: 10/27/2016 (Final, Reviewed)

- Are sign and symptoms present of abuse and/or neglect?: No

SCREENING ASSESSMENT OF SUICIDE RISK (3085F) Performed: 10/27/2016 (Final, Reviewed)

- Is the patient at risk of harm to themselves and/others?: No

T Warrick, MD

Electronically Signed by Dr. Michael T. Warrick MD

MCLEOD,STARA SHANEIQUA
Acct:A00041464975 Unit: M000443101
WARRICK,MICHAEL TODD
PAI DOS: 10/27/16
F B Age: 38 · DOB: [redacted]

This is a report created on 10/26/16.
Stara McLeod Account#: [None,Z 2095]
06/17/16
Doctor: Provider:Dr. Jason Harkey

SUBJECTIVE:
Stara has a primary complaint of pain, tingling and numbness and soreness at the mid back and lower back radiating to the left leg. The patient describes the problem as severe and frequent (50-75% of the day). The symptoms are exacerbated by sleeping, sitting in one place for too long and bending over.
Onset:
The symptoms have been present since yesterday.
OBJECTIVE:
An exam was performed to determine vertebral subluxation using spinal palpation, observation and orthopedic testing. Ms. McLeod presents with subluxation of the Left Sacroiliac Joint and L5 to the right.
Palpatory Exam:
Palpatory examination indicates spasm, tenderness, edema and tightness of the paralumbar muscles on the right; gluteus maximus muscles on the left; piriformis muscles on the left.
Orthopedic Tests:
Kemp's Test positive bilateral. Lasegue's Test positive left.
Lumbar Range of Motion Exam:
Findings through observation and measurements show that Stara presents with decreased ROM of the Lumbar Spine.
ASSESSMENT:

Assessment of Condition:
There is an exacerbation to the current condition.
Medical Necessity:
Treatment rendered to Ms. McLeod is found to be medically necessary. Care will significantly improve the patient's condition, thus resulting in functional improvement.
PLAN:
Primary treatment today consisted of Spinal Adjustment 1-2 regions (98940) to improve range of motion, circulation, joint integrity and flexibility. Adjustment using flexion distraction and Muscle Stim, Attended (97032) to reduce muscle spasms, reduce inflammation, and enhance soft tissue healing. Stara's goal is to reduce the back pain, so that bending and twisting no longer limit activities of daily living. Eliminating the current limitations will increase Stara's independence and improve quality of life. Decrease painful symptoms (as measured with pain scale) to maximum medical improvement (MMI). Improve range of motion and flexibility without pain to maximum medical improvement (MMI). Stara should return for treatment in 3 days.

Stara McLeod Account#: [None,Z 2095]
06/20/16
Doctor: Provider:Dr. Jason Harkey

MCLEOD,STARA SHANEIQUA
Acct: A00041464975 Unit: M000443101
WARRICK,MICHAEL TODD
PAI DOS: 10/27/16
F 8 Age: 38 DOB: [redacted]

SUBJECTIVE:
The patient has a primary complaint of pain, spasm and soreness at the lower back. On a scale of 0 (no pain) to 10 (severe), the patient describes the pain as 7. Stara states that the symptoms

are a little better as a result of treatment.

TODD ORIGINAL

OBJECTIVE:
An exam was performed to determine vertebral subluxation using spinal palpation and observation. Ms. McLeod presents with subluxation of the lumbar spine and right sacroiliac joint.
Palpatory Exam:
Palpatory examination indicates spasm, tenderness and tightness of the paralumbar muscles bilaterally; gluteus maximus muscles on the right.
ASSESSMENT:

Assessment of Condition:
The symptoms are slowly improving with treatment. The condition is relatively unstable at this time.
Medical Necessity:
Stara is tolerating the treatment plan well, so we will continue visits and treatment as planned.
PLAN:
Primary treatment today consisted of Spinal Adjustment 1-2 regions (98940) to improve range of motion, circulation, joint integrity and flexibility, Muscle Stim, Attended (97032) to reduce muscle spasms, reduce inflammation, and enhance soft tissue healing and Hot/cold packs (97010) to reduce muscle spasm and relieve pain and swelling. Stara should return for treatment in 2 days.

Stara McLeod Account#: [None:Z 2095]
06/22/16
Doctor: Provider:Dr. Jason Harkey

SUBJECTIVE:
The patient complains of pain and soreness at the lower back radiating to the left buttocks. The pain on a scale of 0 (no pain) to 10 (severe) is a 10. Stara states that the symptoms are worse since the last visit.
OBJECTIVE:
An exam was performed to determine vertebral subluxation using spinal palpation and observation. Ms. McLeod presents with subluxation of the left sacroiliac joint and right sacroiliac joint.
Palpatory Exam:
Palpatory examination indicates spasm, tenderness and tightness of the paradorsal muscles on the right; paralumbar muscles on the right; gluteus maximus muscles bilaterally.
ASSESSMENT:

Assessment of Condition:
The symptoms are slowly improving with treatment. The condition is relatively unstable at this time.
PLAN:
Primary treatment today consisted of Spinal Adjustment 1-2 regions (98940) to improve range of motion, circulation, joint integrity and flexibility, Cryotherapy (97010) which reduces inflammation and swelling and Muscle Stim, Attended (97032) to reduce muscle spasms, reduce inflammation, and enhance soft tissue healing.
Visits:
Stara will stay on the regularly scheduled plan for return visits.

MCLEOD,STARA SHANEIQUA
Acct: A00041464975 Unit: M000443101
WARRICK,MICHAEL TODD
PAI DOS: 10/27/16
F B Age: 38 DOB: [redacted]

Stara McLeod Account#: [None,Z 2095]
08/24/16
Doctor: Provider:Dr. Jason Harkey

SUBJECTIVE:
The patient has a primary complaint of pain, sharp pain and spasm at the lower back radiating to the right buttocks. Ms. McLeod describes the symptoms as moderate to severe and frequent (50-75% of the day). The condition is exacerbated by normal movements throughout the day, bending over and driving, especially for a long while.
Onset:
The symptoms have been present for a few days.
OBJECTIVE:
An exam was performed to determine vertebral subluxation using spinal palpation, observation and orthopedic testing. Ms. McLeod presents with subluxation of the Right Sacroiliac Joint and T9 to the right; T12 to the right.
Palpatory Exam:
Palpatory examination indicates spasm, tenderness and tightness of the paradorsal muscles on the right; paralumbar muscles on the right; gluteus maximus muscles on the right.
ASSESSMENT:

Assessment of Condition:
There is an exacerbation to the current condition.
PLAN:
Primary treatment today consisted of Spinal Adjustment 1-2 regions (98940) to improve range of motion, circulation, joint integrity and flexibility, Muscle Stim, Attended (97032) to reduce muscle spasms, reduce inflammation, and enhance soft tissue healing and Hot/cold packs (97010) to reduce muscle spasm and relieve pain and swelling.
Visits:
Stara will stay on the regularly scheduled plan for return visits.

Stara McLeod Account#: [None,Z 2095]
10/20/16
Doctor: Provider:Dr. Jason Harkey

MCLEOD,STARA SHANEIQUA
Acct: A00041464975 Unit: M000443101
WARRICK,MICHAEL TODD
PAI DOS: 10/27/16
F 8 Age: 38 DOB: [redacted]

SUBJECTIVE:
The patient has a primary complaint of pain, sharp pain and spasm at the mid back and lower back. Ms. McLeod describes the symptoms as moderate to severe and frequent (50-75% of the day). The condition is exacerbated by normal movements throughout the day, sleeping and twisting and turning of the hip and midsection.
Onset:
The symptoms have been present for a few weeks.
OBJECTIVE:
An exam was performed to determine vertebral subluxation using spinal palpation and observation. Ms. McLeod presents with subluxation of the Left Sacroiliac Joint, Right Sacroiliac Joint and T10 to the right; L5 to the right.
Palpatory Exam:
Palpatory examination indicates spasm, tenderness and tightness of the paradorsal muscles on the right; paralumbar muscles bilaterally; gluteus maximus muscles bilaterally.

Lumbar Range of Motion Exam:
ROM of the Lumbar Spine is currently within normal limits.
ASSESSMENT:

Assessment of Condition:
The patient's condition appears to be guarded.
Medical Necessity:
Treatment rendered to Ms. McLeod is found to be medically necessary. Care will significantly improve the patient's condition, thus resulting in functional improvement.
PLAN:
Primary treatment today consisted of Spinal Adjustment 3-4 regions (98941) to improve range of motion, circulation, joint integrity and flexibility, Cryotherapy (97010) which reduces inflammation and swelling and Muscle Stim, Attended (97032) to reduce muscle spasms, reduce inflammation, and enhance soft tissue healing. Stara should return for treatment in 3 days.

Stara McLeod Account#: [None,Z 2095]
10/21/16
Doctor: Provider:Dr. Jason Harkey

SUBJECTIVE:
The patient has a primary complaint of pain, sharp pain and spasm at the mid back and lower back radiating to the left leg. Ms: McLeod describes the symptoms as moderate to severe. The condition is exacerbated by standing for long periods of time, sitting in one place for too long and bending over.
OBJECTIVE:
An exam was performed to determine vertebral subluxation using spinal palpation and observation. Ms. McLeod presents with subluxation of the Left Sacroiliac Joint, Right Sacroiliac Joint and T10 to the right.
Palpatory Exam:
Palpatory examination indicates spasm, tenderness and tightness of the paradorsal muscles on the right; paralumbar muscles bilaterally; gluteus maximus muscles on the left.
ASSESSMENT:

Assessment of Condition:
The patient's condition appears to be guarded.
PLAN:
Primary treatment today consisted of Spinal Adjustment 1-2 regions (98940) to improve range of motion, circulation, joint integrity and flexibility, Adjustment using flexion distraction, Cryotherapy (97010) which reduces inflammation and swelling and Muscle Stim, Attended (97032) to reduce muscle spasms, reduce inflammation, and enhance soft tissue healing. Stara's goal is to reduce the back pain, so that bending and twisting no longer limit activities of daily living. Eliminating the current limitations will increase Stara's independence and improve quality of life. Decrease painful symptoms (as measured with pain scale) to maximum medical improvement (MMI). Improve range of motion and flexibility without pain to maximum medical improvement (MMI). Stara should return for treatment in 3 days.

Stara McLeod Account#: [None,Z 2095]
10/24/16
Doctor: Provider:Dr. Jason Harkey

MCLEOD,STARA SHANEIQUA
Acct: A00041464975 Unit: M000443101
WARRICK,MICHAEL TODD
PAI DOS: 10/27/16
F B Age: 38 DOB: [redacted]

SUBJECTIVE:
The patient has a primary complaint of tingling and numbness, soreness and weakness at the lower back radiating to the left leg. The condition is exacerbated by normal movements throughout the day, sitting in one place for too long and twisting and turning of the neck.

OBJECTIVE:
An exam was performed to determine vertebral subluxation using spinal palpation and observation. Ms. McLeod presents with subluxation of the Right Sacroiliac Joint and L3 to the left.

Palpatory Exam:
Palpatory examination indicates spasm, tenderness, edema and tightness of the paradorsal muscles on the right; paralumbar muscles on the left; gluteus maximus muscles on the right.

ASSESSMENT:

Assessment of Condition:
The condition is relatively unstable at this time.

Patient Referral:
Stara is being referred to her primary care physician. Stara is in need of an MRI, and is being referred to a local facility.

PLAN:
Primary treatment today consisted of Spinal Adjustment 1-2 regions (98940) to improve range of motion, circulation, joint integrity and flexibility, Muscle Stim, Attended (97032) to reduce muscle spasms, reduce inflammation, and enhance soft tissue healing and Hot/cold packs (97010) to reduce muscle spasm and relieve pain and swelling. Stara should return for treatment in 2 days.

COPY ORIGINAL



SUMTER SPINE PAIN CENTER
M. TODD WARRICK, M.D.

100 North Sumter Street, Suite 320
Sumter, SC 29150
Phone: (803) 774-6824
Fax: (803) 774-8977

STARA S MCLEOD **Patient #: 1219090** **DOB:** [redacted] (39 years)

Date of Encounter: 11/28/2016 03:13 PM

History of Present Illness

Patient words: Established patient here for follow up TFESI on 10/27. Patient states that she did have 50% relief that lasted 2.5 to 3 weeks. Pt states that pain is now in lower back, the back of her left leg and her left toes with numbness. Pt uses ibuprofen for pain with some relief.

The patient is a 39 year old female

Review of Systems

Musculoskeletal: Present- **Back Pain** and **Difficulty Walking.**
Neurological: Present- **Numbness.**

Allergies
No Known Drug Allergies 10/27/2016

Family History
None (10/27/2016)

Social History
Tobacco Use: Never smoker
Non-Drinker/No Alcohol Use
Living Situation: Married
Occupation: Part-time
No Drug Use

Other Problems
Unspecified Diagnosis
Intervertebral disc disorders with radiculopathy, lumbosacral region (M51.17)

Past Surgical
Hysterectomy: Abdominal

Vital Signs

Date:	11/28/2016 09:28 AM	**Height:**	64 in	**Note:** -
Temperature:		**Weight:**	160 lb	
Pulse:	76	**Waist:**		
Respirations:	16	**BMI:**	27.46 kg/m²	
Peak Flow:		**BSA:**	1.81 m²	
Blood Pressure:	127/80			
Reading Type:	Electronic			

MCLEOD,STARA SHANEIQUA
Acct:A00041466970 Unit: M000443101
WARRICK,MICHAEL TODD
PAI DOS: 11/28/16
F B Age: 38 DOB: [redacted]

Assessment & Plan

Intervertebral disc disorders with radiculopathy, lumbosacral region (M51.17)
Today's' Impression: partial relief, no complications. Repeat today.
Current Plans:

- LUMBAR/SACRAL TFESI W/ FLUOROSCOPY(64483); Routine

Unspecified Diagnosis
Current Plans:

- FALL RISK ASSESSMENT (3288F); Routine
- SIGN AND SYMPTOM OF ABUSE AND NEGLECT; Routine
- SCREENING ASSESSMENT OF SUICIDE RISK (3085F); Routine
- How to access health information online
- I have personally seen and examined this patient. I have fully participated in the care of this patient.
  I have reviewed the PFSH, ROS, and Vital Signs.

- Entered by Jane Avant, acting as a scribe for Dr. Todd Warrick
- The documentation recorded by the scribe accurately reflects the service I personally performed and the decisions made by me Todd Warrick, M.D.



Procedures

LUMBAR/SACRAL TFESI W/ FLUOROSCOPY(64483) Performed: 11/28/2016 (Final, Reviewed)

- Procedure performed: 1. LEFT-SIDED S1 TRANSFORAMINAL INJECTION (CPT 64483)
- Anesthesia: Local
- Indications for procedure: Intractable pain, poorly responsive to non-invasive therapy.
- Complications: None

PROCEDURE IN DETAIL

- H&P: I have examined the patient and there are no changes in the History and Physical.
- Pre-operative diagnosis: M51.17 disc displacement with radiculopathy, lumbosacral region
- Prep: After the risks outlined in consent form were explained and all patient questions were answered, written informed consent for the procedure was obtained. The patient was taken to the procedure suite and placed in a comfortable position. Noninvasive blood pressure, continuous pulse oximetric and EKG monitoring were placed and baseline readings were recorded. The patient was deemed stable for procedure. The patient's skin was prepped with Chlor Prep and draped in sterile fashion. Using fluoroscopy, the lumbar spine was surveyed.
- Injection level (left): The C - arm was oblique toward the left 20 degrees to a standard view. Under an ipsilateral anterior-oblique view, the skin overlying the neuroforamen at the left S1 was anesthetized with buffered lidocaine 1%.
- Needle (left): At each treated level a 22 gauge, 3.5-inch Quincke needle was advanced into the neuroforamen. Needle tip was verified in AP and lateral views. Radiopaque contrast injected under live fluoroscopy revealed medial, retrograde flow into the epidural space. No intrathecal or intravascular contrast spread was noted. Upon injection, the patient reported no pain or paresthesias. Fluoroscopic images were saved for documentation.
- Medications instilled: A total volume of two milliliter of Depo-Medrol, 40 mg/mL, mixed with one mL of bupivacaine 0.25% was injected after negative aspiration. The needle(s) was flushed and withdrawn. Pressure was held at the needle insertion site for hemostasis, a Band-Aid was applied. The patient was transported to the recovery area and arrived in stable condition.

  The patient was monitored for a minimum of fifteen minutes. The patient was neurologically intact. There were no apparent perioperative complications to the procedure. A follow-up appointment was scheduled. The patient was discharged with instructions to contact the Pain Center or present to their nearest emergency center should excessive bleeding, pain, weakness, fever, or other concerning symptom occur.

- Completed by: Jane Avant acting as a scribe for Dr. Michael T. Warrick (The current note replaces the previously documented note.)
- Date/Time: 1/11/2017 3:13 PM

FALL RISK ASSESSMENT (3288F) Performed: 11/28/2016 (Final, Reviewed)

- Is patient at risk for fall?: No

SIGN AND SYMPTOM OF ABUSE AND NEGLECT Performed: 11/28/2016 (Final, Reviewed)

- Are sign and symptoms present of abuse and/or neglect?: No

SCREENING ASSESSMENT OF SUICIDE RISK (3085F) Performed: 11/28/2016 (Final, Reviewed)

- Is the patient at risk of harm to themselves and/others?: No

Chart Review Note *(Dr. Michael T. Warrick, MD; 1/23/2017 1:35:30 PM)*
I have reviewed the history and physical note as well as procedure documentation entered by Jane Avant, acting as scribe, and agree with the findings. I have added the following comments: The documentation recorded by the scribe accurately reflects the services I personally performed and the decisions made by me, Michael T. Warrick, M.D.

T Warrick, MD

MCLEOD,STARA SHANEIQUA
Acct: A00041466970 Unit: M000443101
WARRICK,MICHAEL TODD
PAI
F B Age: 38 DOS: 11/28/16
DOB: [redacted]

Electronically signed by Dr. Michael T. Warrick on 01/23/2017 01:36 PM.

SUMTER SPINE PAIN CENTER
M. TODD WARRICK, M.D

100 North Sumter Street, Suite 320
Sumter, SC 29150
Phone: (803) 774-6824
Fax: (803) 774-8977

STARA S MCLEOD **Patient #: 1219090** **DOB:** [redacted] (39 years)

Date of Encounter: 12/22/2016 10:43 AM

History of Present Illness

Patient words: Patient was seen 11/28/16 and received a Left S1 TFESI. She reports no relief with the injection. She feels like the pain was actually worse after the injection. She continues to have some pain across her lower back that radiates into her left leg and foot. She has numbness in her left leg and foot.

The patient is a 39 year old female

History

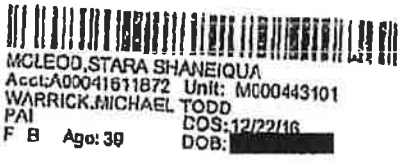
Allergy
No Known Drug Allergies (10/27/2016)
Other Medical History
Intervertebral disc disorders with radiculopathy, lumbosacral region (M51.17)
Unspecified Diagnosis
Unspecified Diagnosis
Social
No Drug Use
Occupation: Part-time
Living Situation: Married
Tobacco Use: Never smoker
Non Drinker/No Alcohol Use
Medications
Medications Reconciled.
Family
None (10/27/2016)
Past Surgical
Hysterectomy; Abdominal

Review of Systems

Musculoskeletal: Present- **Back Pain.**
Neurological: Present- **Numbness.**
All other systems negative

Vital Signs

Date:	12/22/2016 10:50 AM	**Height:**	64 in	**Note:** -
Temperature:		**Weight:**	160 lb	
Pulse:	88	**Waist:**		
Respirations:	16	**BMI:**	27.46 kg/m²	
Peak Flow:		**BSA:**	1.81 m²	
Blood Pressure:	124/69			
Reading Type:	Manual			



Physical Exam
The physical exam findings are as follows:

General
Mental Status - Alert. **General Appearance** - Cooperative and Well groomed. **Orientation** - Oriented X4. **Build & Nutrition** - Well developed.

Peripheral Vascular
Upper Extremity: Inspection - Left - Normal - No Clubbing, No Cyanosis, No Edema, **Pulses Intact. Right** - Normal - No Clubbing, No Cyanosis, No Edema, Pulses Intact.
Palpation: - All peripheral pulses intact in upper extremities.
Lower Extremity: Inspection - Left - Inspection Normal. **Right** - Inspection Normal.
Palpation: - All peripheral pulses intact in lower extremities.

Neurologic
Sensory:
Light Touch: Intact - Globally.
Proprioception - Bilateral - Normal.
Overall Assessment of Muscle Strength and Tone reveals:
Lower Extremities: Right Iliopsoas - 5/5. **Left Iliopsoas** - 5/5. **Right Quadriceps** - 5/5. **Left Quadriceps** - 5/5. **Right Hamstrings** - 5/5. **Left Hamstrings** - 5/5. **Right Tibialis Anterior** - 5/5. **Left Tibialis Anterior** - 5/5. **Right Gastroc-Soleus** - 5/5. **Left Gastroc-Soleus** - 4/5. **Right EHL** - 5/5. **Left EHL** - 5/5.
General Assessment of Reflexes: **Right Knee** - 2+. **Left Knee** - 2+. **Right Ankle** - 2+. **Left Ankle** - 0. **Plantar Reflexes (L4-S2)** - **Bilateral** - plantar flexion. **Coordination** - Normal. **Gait** - Normal.

Musculoskeletal
Spine/Ribs/Pelvis
Thoracic (Dorsal) Spine:
Inspection and Palpation: Tenderness - None.
ROJM: Normal in flexion/extension/rotation - Normal in flexion/extension/rotation.
Deformities/Malalignments/Discrepancies - None.
Lumbosacral Spine:
Inspection and Palpation: Tenderness - no tenderness to palpation over the spinous processes or paravertebral tissues. **Muscle tone** - no palpable spastic cords or trigger points noted. **Swelling** - none.
ROJM: Testing limited - due to pain.
Functional Testing - Modified Straight Leg Raise positive for sciatic pain. Patrick (FABER) negative for sacroiliac joint pain and Piriformis Stretch Negative for Sciatic Pain.


MCLEOD,STARA SHANEIQUA
Acct:A00041611872 Unit: M000443101
WARRICK,MICHAEL TODD
PAI DOS: 12/22/16
F B Age: 39 DOB: [redacted]

Assessment & Plan

Intervertebral disc disorders with radiculopathy, lumbosacral region (M51.17)
Today's' Impression: Continued LLE radicular pain from L5-S1 HNP with S1 root contact / impingement despite TFESI X 2. Refer to deHoll for consideration of microdiscectomy.
Current Plans:

Unspecified Diagnosis
Current Plans:

- FALL RISK ASSESSMENT (3288F); Routine
- SIGN AND SYMPTOM OF ABUSE AND NEGLECT; Routine
- SCREENING ASSESSMENT OF SUICIDE RISK (3085F); Routine
- How to access health information online
- I have personally seen and examined this patient. I have fully participated in the care of this patient.
  I have reviewed the PFSH, ROS, and Vital Signs.
- Entered by Jane Avant, acting as a scribe for Dr. Michael T. Warrick.
- The documentation recorded by the scribe accurately reflects the service I personally performed and the decisions made by me Todd Warrick, M.D.

Procedures

FALL RISK ASSESSMENT (3288F) Performed: 12/22/2016 (Final, Reviewed)
- Is patient at risk for fall?: No

SIGN AND SYMPTOM OF ABUSE AND NEGLECT Performed: 12/22/2016 (Final, Reviewed)
- Are sign and symptoms present of abuse and/or neglect?: No

SCREENING ASSESSMENT OF SUICIDE RISK (3085F) Performed: 12/22/2016 (Final, Reviewed)
- Is the patient at risk of harm to themselves and/others?: No

Chart Review Note *(Dr. Michael T. Warrick, MD; 12/22/2016 11:14:50 AM)*
I was present during the history and physical note performed by Jane Avant and have reviewed the findings.

T Warrick, MD

Electronically signed by Dr. Michael T. Warrick on 12/22/2016 11:16 AM.

MCLEOD,STARA SHANEIQUA
Acct:A00041611872 Unit: M000443101
WARRICK,MICHAEL TODD
PAI DOS: 12/22/16
F B Age: 39 DOB: [redacted]

History & Physical Report #4

STARA S. MCLEOD
5/22/2018 9:11 AM
Location: Sumter Spine & Pain Center
Patient #: 1219090
DOB: [redacted]
Married / Language: English / Race: Black or African American
Female

History of Present Illness (Dr. Michael T. Warrick, MD; 5/22/2018 10:29 AM)

Patient words: Patient was seen on 12/22/16 for an office visit. She was referred to Deholl. She did have the L4 microdiscectomy in December 2016, with good relief She has since been in PT and had a new MRI completed. Dr. Deholl sent her today for a possible SI injection. She is complaining of lower back pain that radiates across the left buttock down to the left knee. She does not have feeling in 3 of the toes on her left foot. She says "I have horrible cramps in my legs at night and alot of weakness on my left side". She has started taking Gabapentin, vimovo, tizanidine, and tramadol since her last visit here. She says that these do help her to rest but her pain is still bad during the day.

The patient is a 40 year old female

Allergies (RN Stacy H Baylor; 5/22/2018 9:17 AM)
No Known Drug Allergies. 10/27/2016

Family History (RN Stacy H Baylor; 5/22/2018 9:17 AM)
None. 10/27/2016

Social History (RN Stacy H Baylor; 5/22/2018 9:17 AM)
Non Drinker / No Alcohol Use
Occupation. Part-time.
No Drug Use
Tobacco Use. Never smoker.
Living Situation. Married.

Medication History (RN Stacy H Baylor; 5/22/2018 9:23 AM)
Medications Reconciled.
TraMADol HCl (50MG Tablet, Oral every 6 hours as needed) Active.
Vimovo (500-20MG Tablet DR, Oral two times daily) Active.
TiZANidine HCl (4MG Capsule, Oral at bedtime) Active.
Gabapentin (600MG Tablet, Oral at bedtime) Active.

Past Surgical History (RN Stacy H Baylor; 5/22/2018 9:17 AM)
Hysterectomy; Abdominal

Other Problems (Dr. Michael T. Warrick, MD; 5/22/2018 10:36 AM)
Intervertebral disc disorders with radiculopathy, lumbosacral region (M51.17)
Unspecified Diagnosis
Unspecified Diagnosis
Unspecified Diagnosis

Review of Systems (Dr. Michael T. Warrick, MD; 5/22/2018 10:29 AM)
Musculoskeletal: Present- **Back Pain** and **Difficulty Walking.**
All other systems negative

Vitals (RN Stacy H Baylor; 5/22/2018 9:20 AM)
5/22/2018 9:19 AM
Weight: 160 lb **Height:** 64 in
Weight was reported by patient.
Height was reported by patient.
Body Surface Area: 1.81 m² **Body Mass Index:** 27.46 kg/m²
Pain Level: 6/10
Pulse: 78 (Regular) **Resp.:** 16 (Unlabored) **P.OX:** 98% (Room air)
BP: 112/76 (Sitting, Left Arm, Standard)

Physical Exam (Dr. Michael T. Warrick, MD; 5/22/2018 10:33 AM)
The physical exam findings are as follows:

General
Mental Status - Alert. **General Appearance** - Cooperative and Well groomed. **Orientation** - Oriented X4. **Build & Nutrition** - Well developed.

Peripheral Vascular
Upper Extremity: Inspection - **Left** - Normal - No Clubbing, No Cyanosis, No Edema, Pulses Intact. **Right** - Normal - No Clubbing, No Cyanosis, No Edema, Pulses Intact.
Palpation: - All peripheral pulses intact in upper extremities.
Lower Extremity: Inspection - **Left** - Inspection Normal. **Right** - Inspection Normal.
Palpation: - All peripheral pulses intact in lower extremities.

Neurologic
Sensory:
Light Touch: Intact - Globally.
Proprioception - Bilateral - Normal.
Overall Assessment of Muscle Strength and Tone reveals:
Lower Extremities: Right Iliopsoas - 5/5. **Left Iliopsoas** - 5/5. **Right Quadriceps** - 5/5. **Left Quadriceps** - 5/5. **Right Hamstrings** - 5/5. **Left Hamstrings** - 5/5. **Right Tibialis Anterior** - 5/5. **Left Tibialis Anterior** - 5/5. **Right Gastroc-Soleus** - 5/5. **Left Gastroc-Soleus** - 4/5. **Right EHL** - 5/5. **Left EHL** - 4/5.
General Assessment of Reflexes: **Right Knee** - 2+. **Left Knee** - 2+. **Right Ankle** - 2+. **Left Ankle** - 0.
Plantar Reflexes (L4-S2) - Bilateral - plantar flexion. **Coordination** - Normal. **Gait** - Normal.

Musculoskeletal
Spine/Ribs/Pelvis
Thoracic (Dorsal) Spine:
Inspection and Palpation: Tenderness - None.
ROJM: Normal in flexion/extension/rotation - Normal in flexion/extension/rotation. **Deformities/Malalignments/Discrepancies** - None.
Lumbosacral Spine:
Inspection and Palpation: Tenderness - no tenderness to palpation over the spinous processes or paravertebral tissues. **Muscle tone** - no palpable spastic cords or trigger points noted. **Swelling** - none.
ROJM: Testing limited - due to pain.
Functional Testing - Modified Straight Leg Raise positive for sciatic pain (mild). Patrick (FABER) negative for sacroiliac joint pain and Piriformis Stretch Negative for Sciatic Pain.

Assessment & Plan (Dr. Michael T. Warrick, MD; 5/22/2018 10:36 AM)

Intervertebral disc disorders with radiculopathy, lumbosacral region (M51.17)
Impression: Patient returns for followup, last seen at end of 2016 for LLE radicular pain associated with L5-S1 HNP. She underwent microdiscectomy with good relief of leg pain for about one year. Gradual progression of axial lumbar pain with now progressive LLE radicular pain / paresthesias. Xrays confirm L5-S1 collapse, MRI was done but not available for review. Neuro exam consistent with S1 radiculopathy, no EMG/NCS done yet. deHoll referred to PT, but she was unable to participate due to pain despite polyanalgesic regimen Rx by deHoll. Seek authorization for left-sided L5-S1 ESI ASAP.

Unspecified Diagnosis
Current Plans
Pt Education - How to access health information online: discussed with patient and provided information.
FALL RISK ASSESSMENT (3288F)
SIGN AND SYMPTOM OF ABUSE AND NEGLECT
SCREENING ASSESSMENT OF SUICIDE RISK (3085F)

I have personally seen and examined this patient. I have fully participated in the care of this patient.

Ihave reviewed the PFSH, ROS, and Vital Signs.

T Warrick, MD

Signed electronically by Dr. Michael T. Warrick, MD (5/22/2018 10:36 AM)

Procedures

FALL RISK ASSESSMENT (3288F) Performed: 05/22/2018 (Final, Reviewed)
- Is patient at risk for fall?: No

SIGN AND SYMPTOM OF ABUSE AND NEGLECT Performed: 05/22/2018 (Final, Reviewed)
- Are sign and symptoms present of abuse and/or neglect?: No

SCREENING ASSESSMENT OF SUICIDE RISK (3085F) Performed: 05/22/2018 (Final, Reviewed)

Ask questions 1 and 2
- 1) Have you wished you were dead or wished you could go to sleep and not wake up?: No
- 2) Have you actually had any thoughts of killing yourself?: No

If YES to 2, ask questions 3, 4, 5 and 6. If NO to 2, go directly to question 6.
- 6) Have you ever done anything, started to do anything, or prepared to do anything to end your life?: No

History & Physical Report #5

STARA S. MCLEOD
6/18/2018 10:53 AM
Location: Sumter Spine & Pain Center
Patient #: 1219090
DOB: [redacted]
Married / Language: English / Race: Black or African American
Female

History of Present Illness (Dr. Michael T. Warrick, MD; 6/18/2018 11:36 AM)

Patient words: Patient is here today for a left sided L5-S1 TFESI after receiving authorization from the insurance company.

The patient is a 40 year old female

Allergies (RN Stacy H Baylor; 6/18/2018 10:55 AM)
No Known Drug Allergies. 10/27/2016

Family History (RN Stacy H Baylor; 6/18/2018 10:55 AM)
None. 10/27/2016

Social History (RN Stacy H Baylor; 6/18/2018 10:55 AM)
Living Situation. Married.
Tobacco Use. Never smoker.
Non Drinker/ No Alcohol Use
No Drug Use
Occupation. Part-time.

Medication History (RN Stacy H Baylor; 6/18/2018 10:55 AM)
TraMADol HCl (50MG Tablet, Oral every 6 hours as needed) Active.
Vimovo (500-20MG Tablet DR, Oral two times daily) Active.
TiZANidine HCl (4MG Capsule, Oral at bedtime) Active.
Gabapentin (600MG Tablet, Oral at bedtime) Active.
Medications Reconciled.

Past Surgical History (RN Stacy H Baylor; 6/18/2018 10:55 AM)
Hysterectomy; Abdominal

Other Problems (Dr. Michael T. Warrick, MD; 6/18/2018 11:37 AM)
Unspecified Diagnosis
Intervertebral disc disorders with radiculopathy, lumbosacral region (M51.17)

Review of Systems (RN Stacy H Baylor; 6/18/2018 10:55 AM)
HEENT: Present- **Wears glasses/contact lenses**.
Musculoskeletal: Present- **Back Pain**.

Vitals (RN Stacy H Baylor; 6/18/2018 11:00 AM)
6/18/2018 10:58 AM
Weight: 160 lb **Height:** 64 in
Weight was reported by patient.
Height was reported by patient.
Body Surface Area: 1.81 m² **Body Mass Index:** 27.46 kg/m²
Pain Level: 7/10
Pulse: 84 (Regular) **Resp.:** 16 (Unlabored) **P.OX:** 98% (Room air)
BP: 127/63 (Sitting, Left Arm, Standard)

Assessment & Plan (Dr. Michael T. Warrick, MD; 6/18/2018 11:37 AM)

Intervertebral disc disorders with radiculopathy, lumbosacral region (M51.17)
Current Plans
| LUMBAR/SACRAL TFESI W/ FLUOROSCOPY(64483)

Unspecified Diagnosis
Current Plans
| Pt Education - How to access health information online: discussed with patient and provided information.
| FALL RISK ASSESSMENT (3288F)
| SIGN AND SYMPTOM OF ABUSE AND NEGLECT
| SCREENING ASSESSMENT OF SUICIDE RISK (3085F)
|

I have personally seen and examined this patient. I have fully participated in the care of this patient.

Ihave reviewed the PFSH, ROS, and Vital Signs.

T Warrick, MD

Signed electronically by Dr. Michael T. Warrick, MD (6/18/2018 11:37 AM)

Procedures

LUMBAR/SACRAL TFESI W/ FLUOROSCOPY(64483) Performed: 06/18/2018 (Final, Reviewed)

- Comments: Left L5-S1 Lumbar/Sacral Transforaminal Epidural Injection

Indication for Procedure: Intractable pain, poorly responsive to non-invasive therapy
Treatment Location: Left L5-S1
Anesthesia: Local
Complications: None

After the risks outlined in consent form were explained and all patient questions were answered, written informed consent for the procedure was obtained. The patient was taken to the procedure suite and placed in a prone position. The skin over the lumbar spine was prepped with chlorhexidine and draped in a sterile fashion. Using fluoroscopy, the lumbar spine was surveyed. Using intermittent ipsilateral oblique fluoroscopy, a needle insertion point was chosen just caudal to the pedicle. The skin was anesthetized with lidocaine 1%. A 22 gauge 5 inch Quincke needle was advanced toward the inferior aspect of the pedicle. The needle was advanced into the neuroforamen under intermittent lateral fluoroscopy. Radiopaque contrast was injected under live anterior/posterior fluoroscopy, which confirmed epidural spread without vascular uptake. The treatment solution was slowly injected without pain or paresthesia into the treated levels for a total dosage of 2cc of Depo-Medrol 40mg/mL and 1cc of bupivacaine 0.25%. The needle(s) were flushed and withdrawn. Pressure was held at the insertion sites for hemostasis, and Band-Aids were applied. A follow-up appointment was scheduled. The patient was discharged with instructions to contact the Pain Center or present to their nearest emergency center should excessive bleeding, pain, weakness, fever or other concerning symptom occur.

FALL RISK ASSESSMENT (3288F) Performed: 06/18/2018 (Final, Reviewed)

- Is patient at risk for fall?: No

SIGN AND SYMPTOM OF ABUSE AND NEGLECT Performed: 06/18/2018 (Final, Reviewed)

- Are sign and symptoms present of abuse and/or neglect?: No

SCREENING ASSESSMENT OF SUICIDE RISK (3085F) Performed: 06/18/2018 (Final, Reviewed)

Ask questions 1 and 2
- 1) Have you wished you were dead or wished you could go to sleep and not wake up?: No
- 2) Have you actually had any thoughts of killing yourself?: No

If YES to 2, ask questions 3, 4, 5 and 6. If NO to 2, go directly to question 6.
- 6) Have you ever done anything, started to do anything, or prepared to do anything to end your life?: No

Encounter #1

History & Physical Report
6/18/2018: Procedure - Intervertebral disc disorders with radiculopathy, lumbosacral region, Unspecified Diagnosis (Michael T. Warrick, MD)

STARA S. MCLEOD
6/18/2018 10:53 AM
Location: Sumter Spine & Pain Center
Patient #: 1219090
DOB: [redacted]
Married / Language: English / Race: Black or African American
Female

History of Present Illness (Michael T. Warrick, MD; 6/18/2018 11:36 AM)

Patient words: Patient is here today for a left sided L5-S1 TFESI after receiving authorization from the insurance company.

The patient is a 40 year old female

Allergies (RN Stacy H. Baylor; 6/18/2018 10:55 AM)
No Known Drug Allergies. 10/27/2016

Family History (RN Stacy H. Baylor; 6/18/2018 10:55 AM)
None. 10/27/2016

Social History (RN Stacy H. Baylor; 6/18/2018 10:55 AM)
Living Situation. Married.
Tobacco Use. Never smoker.
Non Drinker/No Alcohol Use
No Drug Use
Occupation. Part-time.

Medication History (RN Stacy H. Baylor; 6/18/2018 10:55 AM)
TraMADol HCl (50MG Tablet, Oral every 6 hours as needed) Active.
Vimovo (500-20MG Tablet DR, Oral two times daily) Active.
TiZANidine HCl (4MG Capsule, Oral at bedtime) Active.
Gabapentin (600MG Tablet, Oral at bedtime) Active.
Medications Reconciled.

Past Surgical History (RN Stacy H. Baylor; 6/18/2018 10:55 AM)
Hysterectomy; Abdominal

Other Problems (Michael T. Warrick, MD; 6/18/2018 11:37 AM)
Unspecified Diagnosis
Intervertebral disc disorders with radiculopathy, lumbosacral region (M51.17)

Review of Systems (RN Stacy H. Baylor; 6/18/2018 10:55 AM)
HEENT: Present- Wears glasses/contact lenses.
Musculoskeletal: Present- Back Pain.

Vitals (RN Stacy H. Baylor; 6/18/2018 11:00 AM)
6/18/2018 10:58 AM
Weight: 160 lb **Height:** 64 in
Weight was reported by patient.
Height was reported by patient.
Body Surface Area: 1.81 m² **Body Mass Index:** 27.46 kg/m²
Pain Level: 7/10
Pulse: 84 (Regular) **Resp.:** 16 (Unlabored) **P.OX:** 98% (Room air)
BP: 127/63 (Sitting, Left Arm, Standard)

Assessment & Plan (Michael T. Warrick, MD; 6/18/2018 11:37 AM)

Intervertebral disc disorders with radiculopathy, lumbosacral region (M51.17)
Current Plans
- LUMBAR/SACRAL TFESI W/ FLUOROSCOPY(64483)

Unspecified Diagnosis
Current Plans
- Pt Education - How to access health information online: discussed with patient and provided information.
- FALL RISK ASSESSMENT (3288F)
- SIGN AND SYMPTOM OF ABUSE AND NEGLECT
- SCREENING ASSESSMENT OF SUICIDE RISK (3085F)
-

I have personally seen and examined this patient. I have fully participated in the care of this patient.

Ihave reviewed the PFSH, ROS, and Vital Signs.

T Warrick, MD

Signed by Michael T. Warrick, MD (6/18/2018 11:37 AM)

Procedures

LUMBAR/SACRAL TFESI W/ FLUOROSCOPY(64483) Performed: 06/18/2018 (Final, Reviewed)
- Comments: Left L5-S1 Lumbar/Sacral Transforaminal Epidural Injection

Indication for Procedure: Intractable pain, poorly responsive to non-invasive therapy
Treatment Location: Left L5-S1
Anesthesia: Local
Complications: None

After the risks outlined in consent form were explained and all patient questions were answered, written informed consent for the procedure was obtained. The patient was taken to the procedure suite and placed in a prone position. The skin over the lumbar spine was prepped with chlorhexidine and draped in a sterile fashion. Using fluoroscopy, the lumbar spine was surveyed. Using intermittent ipsilateral oblique fluoroscopy, a needle insertion point was chosen just caudal to the pedicle. The skin was anesthetized with lidocaine 1%. A 22 gauge 5 inch Quincke needle was advanced toward the inferior aspect of the pedicle. The needle was advanced into the neuroforamen under intermittent lateral fluoroscopy. Radiopaque contrast was injected under live anterior/posterior fluoroscopy, which confirmed epidural spread without vascular uptake. The treatment solution was slowly injected without pain or paresthesia into the treated levels for a total dosage of 2cc of Depo-Medrol 40mg/mL and 1cc of bupivacaine 0.25%. The needle(s) were flushed and withdrawn. Pressure was held at the insertion sites for hemostasis, and Band-Aids were applied. A follow-up appointment was scheduled. The patient was discharged with instructions to contact the Pain Center or present to their nearest emergency center should excessive bleeding, pain, weakness, fever or other concerning symptom occur.

FALL RISK ASSESSMENT (3288F) Performed: 06/18/2018 (Final, Reviewed)
- Is patient at risk for fall?: No

SIGN AND SYMPTOM OF ABUSE AND NEGLECT Performed: 06/18/2018 (Final, Reviewed)
- Are sign and symptoms present of abuse and/or neglect?: No

SCREENING ASSESSMENT OF SUICIDE RISK (3085F) Performed: 06/18/2018 (Final, Reviewed)

Ask questions 1 and 2
- 1) Have you wished you were dead or wished you could go to sleep and not wake up?: No
- 2) Have you actually had any thoughts of killing yourself?: No

If YES to 2, ask questions 3, 4, 5 and 6. If NO to 2, go directly to question 6.
- 6) Have you ever done anything, started to do anything, or prepared to do anything to end your life?: No

5/3/2018 1:49 PM FAX On behalf of McLeod, Stara 803-295-9999 Page 001 of 004

vox

IMAGECARE, LLC
710 RABON ROAD
COLUMBIA, SC 29203
803-462-3680

Name: McLeod, Stara
Patient ID: 238476
DOB: [redacted]
Acc#: 979845
Patient Phone # [redacted]

Exam Date: 05/03/2018
Exam: MRI L-spine wo contrast
Reason:
Referrer: Dehoff, PDouglas MD

vox

PROCEDURE: Unenhanced MRI scan of the lumbosacral spine

CLINICAL HISTORY: Low back pain since November 2017

COMPARISON: None

TECHNIQUE: 4 mm sagittal and axial FSE T1-weighted images and FSE T2-weighted images were obtained.

FINDINGS: There are 5 nonrib-bearing lumbar vertebral segments with normal anatomic alignment of the lumbosacral and distal 3 thoracic spine segments without fracture deformity, vertebral subluxation, bone destruction, marrow edema, or significant focal or diffuse marrow abnormalities.

A capacious spinal canal is noted without congenital stenosis or segmentation anomalies. There is no significant scoliosis. The intradural and surrounding paraspinal soft tissues, muscles and neural and vascular structures are unremarkable.

Mild L5-S1 disc narrowing with disc desiccation without vacuum phenomenon is noted with a mild diffuse symmetric circumferential bulge of the L5-S1 annulus without focal disc herniation or protrusion or annular fissure. The L5-S1 facets are unremarkable without productive degenerative changes. There is no central or foraminal stenosis at the L5-S1 level.

The L4-5, L3-4, L2-3, L1-2, and distal 3 thoracic discs and adjacent vertebral segments are normal in appearance.

IMPRESSION: (1). Mild L5-S1 disc narrowing with a mild diffuse symmetric circumferential bulge of the annulus is noted without annular fissure, disc protrusion or herniation, spinal stenosis, or productive facet changes.
(2). The proximal 4 lumbar and distal 3 thoracic discs, adjacent vertebral segments, and remainder of the exam are otherwise normal in appearance.

Martin P. Dommers, M.D.
Electronic Signature

MCLEOD, STARA (Id #286433, dob: [redacted]

[redacted]

Date Finalized: 05/03/2018

DD: 05/03/2018 DT:05/03/2018

MCLEOD, STARA (id #286433, dob: [redacted]

MCLEOD, STARA (id #66306, dob: [redacted]

Patient

Name	MCLEOD, STARA (39yo, F) ID# 66306	Appt. Date/Time	01/06/2017 10:40AM
DOB	[redacted]	Service Dept.	Northeast
Provider	PAUL DOUGLAS DEHOLL, MD		
Insurance	Med Primary: UNITED HEALTHCARE Insurance # : 943460441 Policy/Group # : 714081 Med Secondary: [redacted] (CHAMPVA) Insurance #: [redacted] Prescription:		

Chief Complaint

Lumbar spine problem

Patient's Care Team

Referring Provider: TODD WARRICK: 115 N SUMTER ST, SUMTER, SC 29150, Ph (803) 774-6824, Fax (803) 774-5977 NPI: 1952472953

Patient's Pharmacies

WAL-MART NEIGHBORHOOD MARKET 5583 (ERX): 615 BULTMAN DR, SUMTER SC 29150, Ph (803) 305-5104, Fax (803) 305-6197

Vitals

Ht:	5 ft 6 in 01/06/2017 11:31 am	Wt:	140 lbs 01/06/2017 11:31 am	BMI:	22.6 01/06/2017 11:31 am
BP:	120/80 sitting 01/06/2017 11:32 am	Pain Scale:	8 01/06/2017 11:31 am	Pain Scale Type:	Numeric 01/06/2017 11:32 am

Allergies

Reviewed Allergies

NKDA

Medications

Reviewed Medications

Humira 40 mg/0.8 mL subcutaneous syringe kit as directed — 12/05/16 filled

Humira Pen 40 mg/0.8 mL subcutaneous as directed — 02/29/16 filled

Problems

Reviewed Problems

Family History

Reviewed Family History

Social History

Reviewed Social History

Smoking Status: Never smoker

Surgical History

Reviewed Surgical History

GYN History

(not configured)

Obstetric History

Reviewed Obstetric History

Past Medical History

Reviewed Past Medical History

MCLEOD, STARA (Id #286433, dob: [redacted])

MCLEOD, STARA (Id #66306, dob: [redacted])

No Past Medical Problems Reported: Y

Documents for Discussion

N/A

Screening

None recorded.

HPI

This is a 39-year-old female seen at the request of Dr. Warrick for evaluation of sudden onset of left leg pain. The patient reports that she was under the care of Dr. Harkey, a chiropractor back in October where she was experiencing back pain, but no leg pain. She states that she had an adjustment and after that began to experience pain down the left leg with numbness. Her pain radiating got worse. She saw Dr. Harkey who ordered an MRI, apparently found the herniation and send her to Dr. Warrick. Dr. Warrick has tried two epidural injections, which have not helped. She describes 8/10 left leg pain, 6/10 back pain. She has also been treated with physical therapy, deep tissue massage, anti-inflammatories, and narcotics. She has weakness, numbness in the left leg. She has a 10-minute walking tolerance secondary to the above.

ROS

Patient reports arthralgias/joint pain, back pain, and restricted ROM but reports no muscle aches, no muscle weakness, and no swelling in the extremities. She reports weakness, numbness, and tingling but reports no loss of consciousness, no seizures, no dizziness, no migraines, no headaches, and no restless legs. She reports no fever, no night sweats, no significant weight gain, no significant weight loss, and no exercise intolerance. She reports no chest pain, no arm pain on exertion, no shortness of breath, no lightheadedness, no palpitations, and no known heart murmur. She reports no cough, no wheezing, no shortness of breath, no coughing up blood, and no sleep apnea. She reports no abdominal pain, no vomiting, no reflux, no loss of bowel control, and no indigestion. She reports no abnormal mole, no jaundice, no rashes, no skin ulcers, no dry skin, no growths/lesions, no itching, no hives, and no shingles. She reports no swollen glands, no bruising, and no excessive bleeding.

Physical Exam

Patient is a 39-year-old female.

Constitutional: General Appearance: healthy-appearing, NAD, and normal body habitus.

Psychiatric: Orientation: oriented to time, place, and person. Mood and Affect: normal mood and affect and active and alert.

Gait and Station: Appearance: ambulating with no assistive devices, antalgic gait, and pelvis normal.

Cardiovascular System: Arterial Pulses Right: posterior tibialis normal and dorsalis pedis normal. Arterial Pulses Left: posterior tibialis normal and dorsalis pedis normal. Edema Right: none. Edema Left: none. Varicosities Right: no varicosities and capillary refill test normal. Varicosities Left: no varicosities and capillary refill test normal.

Lymph Nodes: Inspection/Palpation Right: no inguinal LAD. Inspection/Palpation Left: no inguinal LAD.

Skin: Lumbosacral Spine: normal skin.

Lumbar Spine: Inspection: no induration or ecchymosis and normal alignment. Bony Palpation of the Lumbar Spine: no tenderness of the spinous process of the sacrum and no step-off. Bony Palpation of the Right Hip: no tenderness of the PSIS, the sciatic notch, the ischial tuberosity, the SI joint, or the greater trochanter. Bony Palpation of the Left Hip: no tenderness of the PSIS, the ischial tuberosity, the SI joint, or the greater trochanter and **tenderness of the sciatic notch**. Soft Tissue Palpation on the Right: no tenderness of the paraspinal region, the gluteus maximus, or the inguinal ligament. Soft Tissue Palpation on the Left: **tenderness of the paraspinal region at L 5 and the gluteus maximus** and no tenderness of the inguinal ligament. Active Range of Motion: **flexion painful, extension painful, lateral flexion to the left painful** and **rotation to the left painful**.

Motor Strength: L1 Motor Strength on the Right: hip flexion iliopsoas 5/5. L1 Motor Strength on the Left: hip flexion iliopsoas 5/5. L2-L4 Motor Strength on the Right: knee extension quadriceps 5/5. L2-L4 Motor Strength on the Left: knee extension quadriceps 5/5. L5 Motor Strength on the Right: ankle dorsiflexion tibialis anterior 5/5 and great toe extension extensor hallucis longus 5/5. L5 Motor Strength on the Left: ankle dorsiflexion tibialis anterior 5/5 and great toe extension extensor hallucis longus 5/5. S1 Motor Strength on the Right: plantar flexion gastrocnemius 5/5. S1 Motor Strength on the Left: plantar flexion gastrocnemius 4/5.

Neurological System: Babinski Reflex Right: plantar reflex absent, Rhomberg's test negative, and tandem gait normal. Babinski Reflex Left: plantar reflex absent. Rhomberg's test negative, and **tandem gait abnormal**. Special Tests: Valsalva's test negative and clonus negative. Ankle Reflex Right: normal (2). Ankle Reflex Left: **diminished (1)**. Knee Reflex Right: normal (2). Knee Reflex Left: normal (2). Sensation on the Right: T12 normal, L1 normal, L2 normal, L3 normal, L4 normal, L5 normal, S1 normal, S2 normal, and normal distal extremities. Sensation on the Left: T12 normal, L1 normal, L2 normal, L3 normal, L4 normal, L5 normal, S2 normal, normal distal extremities, and **decreased sensation on the sole of the foot and the posterior leg (S1)**. Special Tests on the Right: femoral nerve traction test negative, supine straight leg raising test negative, and seated straight leg raising test negative. Special Tests on the Left: supine straight leg raising test positive and seated straight leg raising test positive and femoral nerve traction test negative.

IMAGING
MRI of the lumbar spine reveals a prominent disc extrusion left-side L5-S1.

Assessment / Plan

Ms. McLeod has a loss of ankle reflex. She has motor deficit in that she cannot toe walk with a large herniation that has not improved with epidural. My recommendation has been for a minimally invasive microdiscectomy left side L5-S1. All risks and benefits have been discussed in detail including both short and long term implications associated with surgery. She would like to consider her options prior to proceeding.

1. **Spinal stenosis of lumbar region**
   M48.06: Spinal stenosis, lumbar region
   - SPINAL STENOSIS: CARE INSTRUCTIONS
   - LUMBAR MICROENDOSCOPIC DISCECTOMY

Return to Office
None recorded.

Encounter Sign-Off
Encounter signed-off by Paul Douglas DeHoll, MD, 01/12/2017.

Encounter performed and documented by Paul Douglas DeHoll, MD
Encounter reviewed & signed by Paul Douglas DeHoll, MD on 01/12/2017 at 8:56am

MCLEOD, STARA [redacted]

PALMETTO HEALTH | Orthopedics

*81586830w11770 E-Health-Rx

Patient Name: Stara Mcleod

Primary Care Physician: P. Dahl

Please let us know how you are doing.

1. Overall, how are you feeling: ☒ Better ☐ Worse ☐ Same
2. My back or neck is: ☐ Better ☐ Worse ☒ Same
3. My leg or arm is: ☐ Better ☐ Worse ☒ Same
4. My strength is: ☐ Better ☒ Worse ☐ Same
5. Have you had any new symptoms since your last visit? ☐ Yes ☒ No
   If yes, please explain: _____
6. What treatments have you tried since your last visit?
   ☐ None ☒ Pain Medications ☒ Anti-Inflammatory ☒ Ice ☐ Traction
   ☐ Injections – If so, has it helped? ☐ Yes ☒ Yes, but only for a few minutes or hours ☐ No
   ☐ Physical Therapy – If so, has it helped? ☐ Yes ☒ No
7. New Medications since last visit:
   Percocet / Valium

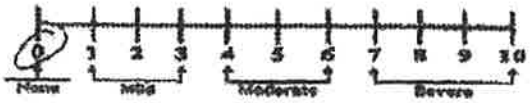
My lower back pain is: (circle number)



My arm/leg pain is: (circle number)



My neck pain is: (circle number)



Patient Signature: Stara Mcleod Date: 1-10-17

MCLEOD, STARA [redacted] 286306

PALMETTO HEALTH | Orthopedics

*5161422w11770 E-HealthPR

Name: Stara S. McLeod Primary Care Physician: _____

Age 39 Occupation: Human Soc. Spec. Who referred you here?: Dr. Todd Wozniak

Is this a work related injury? ☐ Yes ☑ No Date of specific event _____
Is a lawyer involved because of your injury? ☐ Yes ☑ No
Name of lawyer or law office: _____ Phone: _____

SPINAL HISTORY (Please tell us about your current back or leg problems)

1. What is the primary problem or location of pain? Pain back, severe, tired, numb left leg
   When did this problem start? Oct. 2016
   How did your problem start? [redacted] Chiro visit
2. How much of your problem is back pain compared to leg pain?
   ☐ All leg pain ☐ Mostly leg ☑ 50% Back, 50% Leg ☐ Mostly back ☐ All back pain
   Where is your leg pain? ☐ No leg pain ☐ Buttock ☐ Thigh ☑ Lower leg/foot
3. Back pain type: ☐ Aching ☑ Stabbing ☐ Throbbing ☐ Shooting ☑ Dull ☐ Click or Pop
4. Pain Worsened By: ☐ Standing ☑ Walking ☑ Sitting ☑ Lying ☑ Driving ☑ Working ☑ Stairs ☑ Bending forward ☐ Bending backward ☐ Coughing ☐ Sneezing
5. What reduces the pain ☑ Lying Down ☑ Sitting ☐ Standing ☐ Walking ☐ Manipulation ☐ Exercises / therapy ☐ Pain Medications ☐ Injections for pain ☐ Muscle relaxant pills ☐ Anti-inflammatory pills ☐ Nothing ☐ Other _____
6. Do you have numbness or pins & needles sensation in your feet or legs? ☑ Yes ☐ No
   Location? (Buttock) (Thigh back/ side/ front) (Calf) Shin Top of foot (Outside of foot)
   How long has this been present? Since Oct 2016
7. Do you have weakness in your legs or feet? ☑ Yes ☐ No Which side? ☐ Right ☑ Left ☐ Both
   Location? (Entire leg) Thigh/knee (Lifting foot/ankle) Pushing off with foot
   How long has this been present? Since Oct 2016
8. Do you have difficulty walking because of legs feeling tired or weak? ☑ Yes ☐ No
   How far (or how many minutes) can you walk before stopping? 15 min
9. Do you have any bowel or bladder incontinence? ☐ Yes ☑ No
10. Have you been hospitalized for your pain problem? ☐ Yes ☑ No Most recent visit: _____
    Tests/treatments: _____

11. Treatments: Please check all the treatments you have had for this problem.

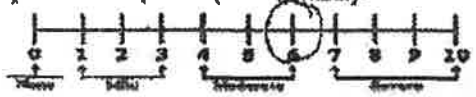
- ☐ Physical therapy
  Dates of treatment Oct 2016
- ☐ Massage
- ☐ Traction
- ☐ Manipulation/Chiropractor
- ☐ TENS Unit
- ☐ Braces
- ☐ Anti-inflammatory medications
- ☐ Narcotic Medication
- ☐ Epidural steroid injections
  How many? 3
  Helped for how long? _____
- ☐ Facet Joint injections
  How many? _____
  Helped for how long? _____
- ☐ Other _____

12. What tests have been done? (Check all that apply & provide dates of most recent test)
☐ MRI Nov 2016 ☐ CT Scan _____ ☐ EMG/nerve study _____ ☐ Other _____

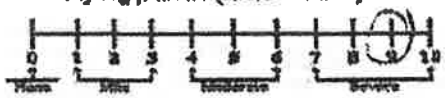
13. Have you ever had back surgery? ☐ Yes ☐ No How many? _____
Procedures: _____
Surgeon name / hospital location _____
Did the surgery relieve the initial problem/pain? ☐ Yes ☐ No ☐ Partially
Did you have any complications? ☐ Yes ☐ No ☐ Spinal Fluid Leak ☐ Infection ☐ Other
Has the pain returned? ☐ Yes ☐ No ☐ My pain is different now

14. Have you ever had MRSA infection (methicillin-resistant staphylococcus aureus)? ☐ Yes ☐ No

My lower back pain is (circle number):

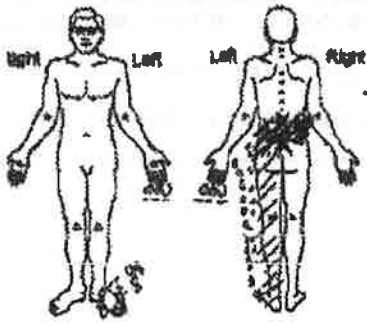


My leg pain is: (circle number):



Please indicate type and location of your pain on the figures below:
Please use the following key to shade in the location of pain on figures.

NUMBNESS	PINS & NEEDLES	ACHE	PAIN
~~	OOOOOO	XXXXXX	//////



BP was → hurtful
right OCT
Leg numb
→ sat
→ back
→ walking
→ legs

sli Comfort

Imaging Results

MCLEOD, STARA (Id #286433, dob: [redacted])

Encounter Sign-Off

Encounter signed-off by Paul Douglas DeHoll, MD, 02/24/2017.

Encounter performed and documented by Paul Douglas DeHoll, MD
Encounter reviewed & signed by Paul Douglas DeHoll, MD on 02/24/2017 at 8:07am

Encounter Date: 02/10/2017

Patient

Name	MCLEOD, STARA (39yo, F) ID# 66306	**Appt. Date/Time**	02/10/2017 02:00PM
DOB	[redacted]	**Service Dept.**	Northeast
Provider	PAUL DOUGLAS DEHOLL, MD		
Insurance	Med Primary: UNITED HEALTHCARE Insurance # : 943460441 Policy/Group # : 714081 Med Secondary: CHAMPVA (CHAMPVA) Insurance # : [redacted] Prescription: OPTUMCOM - Member is eligible. details		

Chief Complaint

Post Op

Patient's Care Team

Referring Provider: TODD WARRICK: 115 N SUMTER ST, SUMTER, SC 29150, Ph (803) 774-6824, Fax (803) 774-6977 NPI: 1952472953

Patient's Pharmacies

WAL-MART NEIGHBORHOOD MARKET 5383 (ERX): 615 BULTMAN DR, SUMTER SC 29150, Ph (803) 305-6194, Fax (803) 305-6197

Vitals

02/10/2017 01:43 pm

Ht: 5 ft 6 in

Allergies

Reviewed Allergies
NKDA

Medications

Reviewed Medications

cyclobenzaprine 10 mg tablet Take 1 tablet(s) 3 times a day by oral route as needed.	02/10/17	prescribed
diazePAM 10 mg tablet Take 1 tablet(s) 3 times a day by oral route as needed.	02/01/17	filled
Humira 40 mg/0.8 mL subcutaneous syringe kit as directed	01/30/17	filled
Humira Pen 40 mg/0.8 mL subcutaneous as directed	02/29/16	filled
HYDROcodone 7.5 mg-acetaminophen 325 mg tablet Take 1 tablet(s) every 6 hours by oral route as needed.	02/01/17	filled
Norco 5 mg-325 mg tablet Take 1-2ablet(s) EVERY 6 HOURS as need for pain	02/10/17	prescribed

Problems

Reviewed Problems

Family History

Reviewed Family History

Social History

MCLEOD, STARA (id #286433, dob: [redacted])

Reviewed Social History
Smoking Status: Never smoker

Surgical History

Reviewed Surgical History

GYN History

(not configured)

Obstetric History

Reviewed Obstetric History

Past Medical History

Reviewed Past Medical History
No Past Medical Problems Reported: Y

Documents for Discussion

N/A

Screening

None recorded.

HPI

Postop followup status post microdiscectomy. Overall the patient states that her leg pain has substantially improved. She, however, is complaining of some continued generalized malaise and back pain. Her spouse indicates that she has a rather low pain threshold.

ROS

Patient reports **arthralgias/joint pain, back pain, and restricted ROM** but reports no muscle aches, no muscle weakness, and no swelling in the extremities. She reports **weakness, numbness, and tingling** but reports no loss of consciousness, no seizures, no dizziness, no migraines, no headaches, and no restless legs. She reports no fever, no night sweats, no significant weight gain, no significant weight loss, and no exercise intolerance. She reports no chest pain, no arm pain on exertion, no shortness of breath, no lightheadedness, no palpitations, and no known heart murmur. She reports no cough, no wheezing, no shortness of breath, no coughing up blood, and no sleep apnea. She reports no abdominal pain, no vomiting, no reflux, no loss of bowel control, and no indigestion. She reports no abnormal mole, no jaundice, no rashes, no skin ulcers, no dry skin, no growths/lesions, no itching, no hives, and no shingles. She reports no swollen glands, no bruising, and no excessive bleeding.

Physical Exam

Patient is a 39-year-old female.

Constitutional: General Appearance: healthy-appearing, NAD, and normal body habitus.

Psychiatric: Orientation: oriented to time, place, and person. Mood and Affect: normal mood and affect and active and alert.

Gait and Station: Appearance: normal gait, no limp, ambulating with no assistive devices, and pelvis normal.

Cardiovascular System: Arterial Pulses Right: posterior tibialis normal and dorsalis pedis normal. Arterial Pulses Left: posterior tibialis normal and dorsalis pedis normal. Edema Right: none. Edema Left: none. Varicosities Right: no varicosities and capillary refill test normal. Varicosities Left: no varicosities and capillary refill test normal.

Lymph Nodes: Inspection/Palpation Right: no inguinal LAD. Inspection/Palpation Left: no inguinal LAD.

Skin: Lumbosacral Spine: scar; healing well.

Lumbar Spine: Inspection: no induration or ecchymosis and normal alignment. Bony Palpation of the Lumbar Spine: no tenderness of the spinous process or the sacrum and no step-off. Bony Palpation of the Right Hip: no tenderness of the PSIS, the sciatic notch, the ischial tuberosity, the SI joint, or the greater trochanter. Bony Palpation of the Left Hip: no tenderness of the PSIS, the sciatic notch, the ischial tuberosity, the SI joint, or the greater trochanter. Soft Tissue Palpation on the Right: no tenderness of the gluteus maximus or the inguinal ligament; tender over incision. Soft Tissue Palpation on the Left: no tenderness of the gluteus maximus or the inguinal ligament; tender over incision. Active Range of Motion: good AROM, full rom not checked.

Motor Strength: L1 Motor Strength on the Right: hip flexion iliopsoas 5/5. L1 Motor Strength on the Left: hip flexion iliopsoas 5/5. L2-L4 Motor Strength on the Right: knee extension quadriceps 5/5. L2-L4 Motor Strength on the Left: knee extension quadriceps 5/5. L5 Motor Strength on the Right: ankle dorsiflexion tibialis anterior 5/5 and great toe extension extensor hallucis longus 5/5. L5 Motor Strength on the Left: ankle dorsiflexion tibialis anterior 5/5 and great toe extension extensor hallucis longus 5/5. S1 Motor Strength on the Right: plantar flexion gastrocnemius 5/5. S1 Motor Strength on the Left: plantar flexion gastrocnemius 5/5.

Neurological System: Babinski Reflex Right: plantar reflex absent. Babinski Reflex Left: plantar reflex absent. Special Tests: Valsalva's test negative and clonus negative. Ankle Reflex Right: normal (2). Ankle Reflex Left: normal (2). Knee Reflex Right: normal (2). Knee Reflex Left: normal (2). Sensation on the Right: T12 normal, L1 normal, L2 normal, L3 normal, L4 normal, L5 normal, S1 normal, S2 normal, and normal distal extremities. Sensation on the Left: T12 normal, L1 normal, L2 normal, L3 normal, L4 normal, L5 normal, S1 normal, S2 normal, and normal distal extremities. Special Tests on the Right: femoral nerve traction test negative, supine

MCLEOD, STARA (id #286433, dob: [redacted])

straight leg raising test negative, and seated straight leg raising test negative. Special Tests on the Left: femoral nerve traction test negative, supine straight leg raising test negative, and seated straight leg raising test negative.

Assessment / Plan

We are going to encourage her to increase her activities to begin to start some gentle low impact exercise. I will see her back in two weeks for final clinical exam.

1. **Spinal stenosis of lumbar region**
   M48.06: Spinal stenosis, lumbar region
   - SPINAL STENOSIS: CARE INSTRUCTIONS
   - Norco 5 mg-325 mg tablet - Take 1-2ablet(s) EVERY 6 HOURS as need for pain Qty: 50 tablet(s) Refills: 0 Pharmacy: WAL-MART NEIGHBORHOOD MARKET 5383
   - cyclobenzaprine 10 mg tablet - Take 1 tablet(s) 3 times a day by oral route as needed. Qty: 60 tablet(s) Refills: 0
   Pharmacy: WAL-MART NEIGHBORHOOD MARKET 5383

Return to Office

- Paul Douglas DeHoll, MD for RE-CHECK at Northeast on 02/24/2017 at 02:10 PM

Encounter Sign-Off

Encounter signed-off by Paul Douglas DeHoll, MD, 02/14/2017.

Encounter performed and documented by Paul Douglas DeHoll, MD
Encounter reviewed & signed by Paul Douglas DeHoll, MD on 02/14/2017 at 10:21am

Encounter Date: 01/06/2017

Patient

Name	MCLEOD, STARA (39yo, F) ID# 66306	**Appt. Date/Time**	01/06/2017 10:40AM
DOB	[redacted]	**Service Dept.**	Northeast
Provider	PAUL DOUGLAS DEHOLL, MD		
Insurance	Med Primary: UNITED HEALTHCARE Insurance # : 943460441 Policy/Group # : 714081 Med Secondary: CHAMPVA (CHAMPVA) Insurance # : [redacted] Prescription: check now		

Chief Complaint

Lumbar spine problem

Patient's Care Team

Referring Provider: TODD WARRICK: 115 N SUMTER ST, SUMTER, SC 29150, Ph (803) 774-6824, Fax (803) 774-8977 NPI: 1952472953

Patient's Pharmacies

WAL-MART NEIGHBORHOOD MARKET 5383 (ERX): 615 BULTMAN DR, SUMTER SC 29150, Ph (803) 305-6194, Fax (803) 305-6197

Vitals

Ht:	5 ft 6 in 01/06/2017 11:31 am	**Wt:**	140 lbs 01/06/2017 11:31 am	**BMI:**	22.6 01/06/2017 11:31 am
BP:	120/80 sitting 01/06/2017 11:32 am	**Pain Scale:**	8 01/06/2017 11:31 am	**Pain Scale Type:**	Numeric 01/06/2017 11:32 am

Allergies

Reviewed Allergies
NKDA

Medications

Reviewed Medications

Humira 40 mg/0.8 mL subcutaneous syringe kit as directed	12/05/16	filled
Humira Pen 40 mg/0.8 mL subcutaneous as directed	02/29/16	filled

MCLEOD, STARA (id #286433, dob: [redacted])

Problems

Reviewed Problems

Family History

Reviewed Family History

Social History

Reviewed Social History
Smoking Status: Never smoker

Surgical History

Reviewed Surgical History

GYN History

(not configured)

Obstetric History

Reviewed Obstetric History

Past Medical History

Reviewed Past Medical History
No Past Medical Problems Reported: Y

Documents for Discussion

N/A

Screening

None recorded.

HPI

This is a 39-year-old female seen at the request of Dr. Warrick for evaluation of sudden onset of left leg pain. The patient reports that she was under the care of Dr. Harkey, a chiropractor back in October where she was experiencing back pain, but no leg pain. She states that she had an adjustment and after that began to experience pain down the left leg with numbness. Her pain radiating got worse. She saw Dr. Harkey who ordered an MRI, apparently found the herniation and send her to Dr. Warrick. Dr. Warrick has tried two epidural injections, which have not helped. She describes 9/10 left leg pain, 6/10 back pain. She has also been treated with physical therapy, deep tissue massage, anti-inflammatories, and narcotics. She has weakness, numbness in the left leg. She has a 10-minute walking tolerance secondary to the above.

ROS

Patient reports **arthralgias/joint pain, back pain, and restricted ROM** but reports no muscle aches, no muscle weakness, and no swelling in the extremities. She reports **weakness, numbness, and tingling** but reports no loss of consciousness, no seizures, no dizziness, no migraines, no headaches, and no restless legs. She reports no fever, no night sweats, no significant weight gain, no significant weight loss, and no exercise intolerance. She reports no chest pain, no arm pain on exertion, no shortness of breath, no lightheadedness, no palpitations, and no known heart murmur. She reports no cough, no wheezing, no shortness of breath, no coughing up blood, and no sleep apnea. She reports no abdominal pain, no vomiting, no reflux, no loss of bowel control, and no indigestion. She reports no abnormal mole, no jaundice, no rashes, no skin ulcers, no dry skin, no growths/lesions, no itching, no hives, and no shingles. She reports no swollen glands, no bruising, and no excessive bleeding.

Physical Exam

Patient is a 39-year-old female.

Constitutional: General Appearance: healthy-appearing, NAD, and normal body habitus.

Psychiatric: Orientation: oriented to time, place, and person. Mood and Affect: normal mood and affect and active and alert.

Gait and Station: Appearance: ambulating with no assistive devices, **antalgic gait**, and pelvis normal.

Cardiovascular System: Arterial Pulses Right: posterior tibialis normal and dorsalis pedis normal. Arterial Pulses Left: posterior tibialis normal and dorsalis pedis normal. Edema Right: none. Edema Left: none. Varicosities Right: no varicosities and capillary refill test normal. Varicosities Left: no varicosities and capillary refill test normal.

Lymph Nodes: Inspection/Palpation Right: no inguinal LAD. Inspection/Palpation Left: no inguinal LAD.

Skin: Lumbosacral Spine: normal skin.

Lumbar Spine: Inspection: no induration or ecchymosis and normal alignment. Bony Palpation of the Lumbar Spine: no tenderness of the spinous process or the sacrum and no step-off. Bony Palpation of the Right Hip: no tenderness of the PSIS, the sciatic notch, the ischial tuberosity, the SI joint, or the greater trochanter. Bony Palpation of the Left Hip: no tenderness of the PSIS, the ischial tuberosity, the SI joint, or the greater trochanter and **tenderness of the sciatic notch**. Soft Tissue Palpation on the Right: no tenderness of the paraspinal region, the gluteus maximus, or the inguinal ligament. Soft Tissue Palpation on the Left: **tenderness of**

MCLEOD, STARA (Id #286433, dob: [redacted])

the paraspinal region at L 5 and the gluteus maximus and no tenderness of the inguinal ligament. Active Range of Motion: flexion painful, extension painful, lateral flexion to the left painful, and rotation to the left painful.

Motor Strength: L1 Motor Strength on the Right: hip flexion iliopsoas 5/5. L1 Motor Strength on the Left: hip flexion iliopsoas 5/5. L2-L4 Motor Strength on the Right: knee extension quadriceps 5/5. L2-L4 Motor Strength on the Left: knee extension quadriceps 5/5. L5 Motor Strength on the Right: ankle dorsiflexion tibialis anterior 5/5 and great toe extension extensor hallucis longus 5/5. L5 Motor Strength on the Left: ankle dorsiflexion tibialis anterior 5/5 and great toe extension extensor hallucis longus 5/5. S1 Motor Strength on the Right: plantar flexion gastrocnemius 5/5. S1 Motor Strength on the Left: **plantar flexion gastrocnemius 4/5.**

Neurological System: Babinski Reflex Right: plantar reflex absent, Rhomberg's test negative, and tandem gait normal. Babinski Reflex Left: plantar reflex absent, Rhomberg's test negative, and **tandem gait abnormal**. Special Tests: Valsalva's test negative and clonus negative. Ankle Reflex Right: normal (2). Ankle Reflex Left: **diminished (1)**. Knee Reflex Right: normal (2). Knee Reflex Left: normal (2). Sensation on the Right: T12 normal, L1 normal, L2 normal, L3 normal, L4 normal, L5 normal, S1 normal, S2 normal, and normal distal extremities. Sensation on the Left: T12 normal, L1 normal, L2 normal, L3 normal, L4 normal, L5 normal, S2 normal, normal distal extremities, and **deceased sensation on the sole of the foot and the posterior leg (S1)** Special Tests on the Right: femoral nerve traction test negative, supine straight leg raising test negative, and seated straight leg raising test negative. Special Tests on the Left: **supine straight leg raising test positive**and **seated straight leg raising test positive**and femoral nerve traction test negative.

IMAGING
MRI of the lumbar spine reveals a prominent disc extrusion left-side L5-S1.

Assessment / Plan

Ms. McLeod has a loss of ankle reflex. She has motor deficit in that she cannot toe walk with a large herniation that has not improved with epidural. My recommendation has been for a minimally invasive microdiscectomy left side L5-S1. All risks and benefits have been discussed in detail including both short and long term implications associated with surgery. She would like to consider her options prior to proceeding.

1. Spinal stenosis of lumbar region
M48.06: Spinal stenosis, lumbar region
- SPINAL STENOSIS: CARE INSTRUCTIONS
- LUMBAR MICROENDOSCOPIC DISCECTOMY

Return to Office
None recorded.

Encounter Sign-Off
Encounter signed-off by Paul Douglas DeHoll, MD, 01/12/2017.

Encounter performed and documented by Paul Douglas DeHoll, MD
Encounter reviewed & signed by Paul Douglas DeHoll, MD on 01/12/2017 at 8:55am

MCLEOD, STARA (Id #286433, dob: [redacted])

Psychiatric: Orientation: oriented to time, place, and person. Mood and Affect: normal mood and affect and active and alert.

Gait and Station: Appearance: normal gait, no limp, ambulating with no assistive devices, and pelvis normal.

Cardiovascular System: Arterial Pulses Right: posterior tibialis normal and dorsalis pedis normal. Arterial Pulses Left: posterior tibialis normal and dorsalis pedis normal. Edema Right: none. Edema Left: none. Varicosities Right: no varicosities and capillary refill test normal. Varicosities Left: no varicosities and capillary refill test normal.

Lymph Nodes: Inspection/Palpation Right: no inguinal LAD. Inspection/Palpation Left: no inguinal LAD.

Skin: Lumbosacral Spine: **scar; healing well.**

Lumbar Spine: Inspection: no induration or ecchymosis and normal alignment. Bony Palpation of the Lumbar Spine: no tenderness of the spinous process or the sacrum and no step-off. Bony Palpation of the Right Hip: no tenderness of the PSIS, the sciatic notch, the ischial tuberosity, the SI joint, or the greater trochanter. Bony Palpation of the Left Hip: no tenderness of the PSIS, the sciatic notch, the ischial tuberosity, the SI joint, or the greater trochanter. Soft Tissue Palpation on the Right: no tenderness of the gluteus maximus or the inguinal ligament; **tender over incision**. Soft Tissue Palpation on the Left: no tenderness of the gluteus maximus or the inguinal ligament; **tender over incision**. Active Range of Motion: **good AROM, full rom not checked**

Motor Strength: L1 Motor Strength on the Right: hip flexion iliopsoas 5/5. L1 Motor Strength on the Left: hip flexion iliopsoas 5/5. L2-L4 Motor Strength on the Right: knee extension quadriceps 5/5. L2-L4 Motor Strength on the Left: knee extension quadriceps 5/5. L5 Motor Strength on the Right: ankle dorsiflexion tibialis anterior 5/5 and great toe extension extensor hallucis longus 5/5. L5 Motor Strength on the Left: **ankle dorsiflexion tibialis anterior 4/5** and **great toe extension extensor hallucis longus 4/5**. S1 Motor Strength on the Right: plantar flexion gastrocnemius 5/5. S1 Motor Strength on the Left: plantar flexion gastrocnemius 5/5.

Neurological System: Babinski Reflex Right: plantar reflex absent. Babinski Reflex Left: plantar reflex absent. Special Tests: Valsalva's test negative and clonus negative. Ankle Reflex Right: normal (2). Ankle Reflex Left: **absent (0)**. Knee Reflex Right: normal (2). Knee Reflex Left: normal (2). Sensation on the Right: T12 normal, L1 normal, L2 normal, L3 normal, L4 normal, L5 normal, S1 normal, S2 normal, and normal distal extremities. Sensation on the Left: T12 normal, L1 normal, L2 normal, L3 normal, L4 normal, L5 normal, S1 normal, S2 normal, and normal distal extremities. Special Tests on the Right: femoral nerve traction test negative, supine straight leg raising test negative, and seated straight leg raising test negative. Special Tests on the Left: femoral nerve traction test negative, supine straight leg raising test negative, and seated straight leg raising test negative.

Assessment / Plan

Ms. McLeod is having mostly back pain more than leg pain. We are going to start her on physical therapy. If not improved, she will call us back and we'll move forward with possible spinal injections.

Attestation:
I, Kayla Andersen, am transcribing this note for Paul deHoll, MD.

1. Spinal stenosis of lumbar region
M48.061: Spinal stenosis, lumbar region without neurogenic claudication
- LUMBAR SPINAL STENOSIS: CARE INSTRUCTIONS
- PHYSICAL THERAPY BACK REFERRAL - Schedule Within: provider's discretion Note to Provider: 2-3x week, 6-8 weeks as needed - personal trainer approach to rehab, establish HEP. Transition to gym, modalities, core strength & stretching, neural glides, McKenzie if appropriate. Postural correction.

Visits per Week: 2- Number of Weeks: 6-8, as needed
3

Return to Office
None recorded.

Encounter Sign-Off
Encounter signed-off by Paul Douglas DeHoll, MD, 12/01/2017.

Encounter performed by Paul Douglas DeHoll, MD
Encounter scribed for Paul Douglas DeHoll, MD by Kayla Andersen
Encounter signed by Kayla Andersen as scribe at 11/30/2017 at 7:42pm
Encounter reviewed & signed by Paul Douglas DeHoll, MD on 12/01/2017 at 7:56am

Encounter Date: 02/23/2017

Patient

Name	MCLEOD, STARA (39yo, F) ID# 66308	**Appt. Date/Time**	02/23/2017 03:10PM
DOB	[redacted]	**Service Dept.**	Northeast
Provider	PAUL DOUGLAS DEHOLL, MD		
Insurance	Med Primary: UNITED HEALTHCARE Insurance # : 943460441 Policy/Group # : 714081 Med Secondary: CHAMPVA (CHAMPVA) Insurance # : [redacted]		

MCLEOD, STARA (id #286433, dob: [redacted])
Prescription: OPTUMCOM - Member is eligible. details

Chief Complaint

Recheck

Patient's Care Team

Referring Provider: TODD WARRICK: 115 N SUMTER ST, SUMTER, SC 29150, Ph (803) 774-6824, Fax (803) 774-8977 NPI: 1952472953

Patient's Pharmacies

WAL-MART NEIGHBORHOOD MARKET 5383 (ERX): 615 BULTMAN DR, SUMTER SC 29150, Ph (803) 305-6194, Fax (803) 305-6197

Vitals

02/23/2017 02:43 pm

Ht: 5 ft 6 in

Allergies

Reviewed Allergies
NKDA

Medications

Reviewed Medications

cyclobenzaprine 10 mg tablet Take 1 tablet(s) 3 times a day by oral route as needed.	02/10/17 filled
diazePAM 10 mg tablet Take 1 tablet(s) 3 times a day by oral route as needed.	02/01/17 filled
Humira 40 mg/0.8 mL subcutaneous syringe kit as directed	01/30/17 filled
Humira Pen 40 mg/0.8 mL subcutaneous as directed	02/29/16 filled
HYDROcodone 5 mg-acetaminophen 325 mg tablet Take 1-2ablet(s) EVERY 6 HOURS as need for pain	02/13/17 filled
HYDROcodone 7.5 mg-acetaminophen 325 mg tablet Take 1 tablet(s) every 6 hours by oral route as needed.	02/01/17 filled

Problems

Reviewed Problems

Family History

Reviewed Family History

Social History

Reviewed Social History
Smoking Status: Never smoker

Surgical History

Reviewed Surgical History

GYN History

(not configured)

Obstetric History

Reviewed Obstetric History

Past Medical History

Reviewed Past Medical History
No Past Medical Problems Reported

MCLEOD, STARA (Id #286433, dob: [redacted])

Documents for Discussion

N/A

Screening

None recorded.

HPI

Postop followup status post microdiscectomy. Leg pain has largely resolved. Having a little bit of numbness. Overall, she feels a little bit achy, but otherwise is doing very well.

ROS

Patient reports **arthralgias/joint pain, back pain, and restricted ROM** but reports no muscle aches, no muscle weakness, and no swelling in the extremities. She reports **weakness, numbness, and tingling** but reports no loss of consciousness, no seizures, no dizziness, no migraines, no headaches, and no restless legs. She reports no fever, no night sweats, no significant weight gain, no significant weight loss, and no exercise intolerance. She reports no chest pain, no arm pain on exertion, no shortness of breath, no lightheadedness, no palpitations, and no known heart murmur. She reports no cough, no wheezing, no shortness of breath, no coughing up blood, and no sleep apnea. She reports no abdominal pain, no vomiting, no reflux, no loss of bowel control, and no indigestion. She reports no abnormal mole, no jaundice, no rashes, no skin ulcers, no dry skin, no growths/lesions, no itching, no hives, and no shingles. She reports no swollen glands, no bruising, and no excessive bleeding.

Physical Exam

Patient is a 39-year-old female.

Constitutional: General Appearance: healthy-appearing, NAD, and normal body habitus.

Psychiatric: Orientation: oriented to time, place, and person. Mood and Affect: normal mood and affect and active and alert.

Gait and Station: Appearance: normal gait, no limp, ambulating with no assistive devices, and pelvis normal.

Cardiovascular System: Arterial Pulses Right: posterior tibialis normal and dorsalis pedis normal. Arterial Pulses Left: posterior tibialis normal and dorsalis pedis normal. Edema Right: none. Edema Left: none. Varicosities Right: no varicosities and capillary refill test normal. Varicosities Left: no varicosities and capillary refill test normal.

Lymph Nodes: Inspection/Palpation Right: no inguinal LAD. Inspection/Palpation Left: no inguinal LAD.

Skin: Lumbosacral Spine: **scar; healing well.**

Lumbar Spine: Inspection: no induration or ecchymosis and normal alignment. Bony Palpation of the Lumbar Spine: no tenderness of the spinous process or the sacrum and no step-off. Bony Palpation of the Right Hip: no tenderness of the PSIS, the sciatic notch, the ischial tuberosity, the SI joint, or the greater trochanter. Bony Palpation of the Left Hip: no tenderness of the PSIS, the sciatic notch, the ischial tuberosity, the SI joint, or the greater trochanter. Soft Tissue Palpation on the Right: no tenderness of the gluteus maximus or the inguinal ligament; **tender over incision.** Soft Tissue Palpation on the Left: no tenderness of the gluteus maximus or the inguinal ligament; **tender over incision.** Active Range of Motion: **good AROM, full rom not checked.**

Motor Strength: L1 Motor Strength on the Right: hip flexion iliopsoas 5/5. L1 Motor Strength on the Left: hip flexion iliopsoas 5/5. L2-L4 Motor Strength on the Right: knee extension quadriceps 5/5. L2-L4 Motor Strength on the Left: knee extension quadriceps 5/5. L5 Motor Strength on the Right: ankle dorsiflexion tibialis anterior 5/5 and great toe extension extensor hallucis longus 5/5. L5 Motor Strength on the Left: ankle dorsiflexion tibialis anterior 5/5 and great toe extension extensor hallucis longus 5/5. S1 Motor Strength on the Right: plantar flexion gastrocnemius 5/5. S1 Motor Strength on the Left: plantar flexion gastrocnemius 5/5.

Neurological System: Babinski Reflex Right: plantar reflex absent. Babinski Reflex Left: plantar reflex absent. Special Tests: Valsalva's test negative and clonus negative. Ankle Reflex Right: normal (2). Ankle Reflex Left: normal (2). Knee Reflex Right: normal (2). Knee Reflex Left: normal (2). Sensation on the Right: T12 normal, L1 normal, L2 normal, L3 normal, L4 normal, L5 normal, S1 normal, S2 normal, and normal distal extremities. Sensation on the Left: T12 normal, L1 normal, L2 normal, L3 normal, L4 normal, L5 normal, S1 normal, S2 normal, and normal distal extremities. Special Tests on the Right: femoral nerve traction test negative, supine straight leg raising test negative, and seated straight leg raising test negative. Special Tests on the Left: femoral nerve traction test negative, supine straight leg raising test negative, and seated straight leg raising test negative.

Assessment / Plan

Ms. McLeod, as we have discussed openly has a rather low pain threshold. We are going to let her get back to work where she has no lifting requirements. I will see her back in two to three weeks for final recheck.

1. Spinal stenosis of lumbar region
M48.06: Spinal stenosis, lumbar region
- SPINAL STENOSIS: CARE INSTRUCTIONS

Return to Office

- Paul Douglas DeHoll, MD for POST OP GLOBAL at Northeast on 03/23/2017 at 01:10 PM

MCLEOD, STARA (id #286433, dob: [redacted])
None recorded

Sincerely,



Electronically Signed by: PAUL DOUGLAS DEHOLL, MD

PALMETTO HEALTH | Orthopedics

Palmetto Health Orthopedics
101 Business Park Blvd
COLUMBIA, SC 29223-8401
Phone: (803) 296-9200, Fax: (803) 296-9699

RETURN TO WORK / SCHOOL

Patient: McLeod, Stara
DOB: [redacted]
Address: [redacted]

Date: 02/23/2017
Patient ID: 66306

Note to Patient:

_x_ Was Seen in my office on: 2/23/17

_x_ May return to work/school on: 2/27/17

___ May Not return to work/school on: _____

___ Work limitations: _____

___ May Not participate in physical education: _____

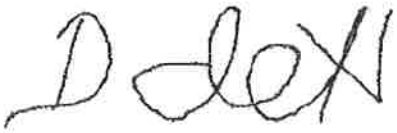
___ May return to physical education: _____

___ Limitations for physical education: _____

MCLEOD, STARA (id #286433, dob: [redacted])

___ May Not participate in jury duty:_____

Electronically Signed by: PAUL DOUGLAS DEHOLL, MD



MCLEOD, STARA (id #66306, dob: [redacted])

PALMETTO HEALTH | Orthopedics

Palmetto Health Orthopedics
101 Business Park Blvd
COLUMBIA, SC 29223-8401
Phone: (803) 296-9200, Fax: (803) 296-9699

Date: 02/24/2017

Dear Stara McLeod,

The following is a summary of your visit today. If you have any questions, please contact our office.

Sincerely,

Electronically Signed by: PAUL DOUGLAS DEHOLL, MD



Patient Care Summary for Stara McLeod

Most Recent Encounter

02/23/2017 Paul Deholl: 101 Business Park Blvd, Columbia, SC 29223-8401, Ph. tel:+1-803-2969200

Reason for Visit

PALMETTO HEALTH | **Orthopedics**

MCLEOD, STARA [redacted] #56306

*4171927w11770 E-HealthHx

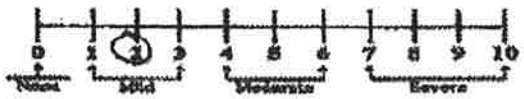
Patient Name: Stara McLeod

Primary Care Physician: _____

Please let us know how you are doing.

1. Overall, how are you feeling: ☑ Better ☐ Worse ☐ Same
2. My back or neck is: ☑ Better ☐ Worse ☐ Same
3. My leg or arm is: ☑ Better ☐ Worse ☐ Same
4. My strength is: ☐ Better ☐ Worse ☑ Same
5. Have you had any new symptoms since your last visit? ☐ Yes ☑ No
   If yes, please explain: _____
6. What treatments have you tried since your last visit?
   ☐ None ☑ Pain Medications ☐ Anti-Inflammatory ☐ Ice ☐ Traction
   ☐ Injections – If so, has it helped? ☐ Yes ☐ Yes, but only for a few minutes or hours ☐ No
   ☐ Physical Therapy – If so, has it helped? ☐ Yes ☐ No
7. New Medications since last visit:

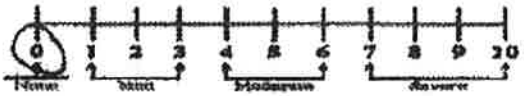
My lower back pain is: (circle number)



My arm/leg pain is: (circle number)



My neck pain is: (circle number)



Patient Signature: Stara McLeod Date: 2-24

MCLEOD, STARA (Id #286433, dob: [redacted]
DND

1. Spinal stenosis of lumbar region
M48.061: Spinal stenosis, lumbar region without neurogenic claudication
- XR, LUMBAR SPINE
- LUMBAR SPINAL STENOSIS: CARE INSTRUCTIONS
- PHYSICAL THERAPY BACK REFERRAL - Schedule Within: provider's discretion Note to Provider: 2-3x week, 6-8 weeks as needed - personal trainer approach to rehab, establish HEP. Transition to gym, modalities, core strength & stretching, neural glides, McKenzie if appropriate. Postural correction.

Visits per Week: 2- Number of Weeks: 6-8, as needed
3

- tramadol 50 mg tablet - Take 1 tablet(s) every 6 hours by oral route as needed. Qty: 50 tablet(s) Refills: 0 Pharmacy: WALMART NEIGHBORHOOD MARKET 5383
- Vimovo 500 mg-20 mg tablet,immediate and delay release - Take 1 tablet(s) twice a day by oral route. Qty: 60 tablet(s) Refills: 0 Pharmacy: PINE RIDGE PHARMACY- WEST COLUMBIA,
- Zanaflex 4 mg capsule - Take 1 capsule(s) every day by oral route at bedtime. Qty: 50 capsule(s) Refills: 0 Pharmacy: WALMART NEIGHBORHOOD MARKET 5383

XR, LUMBAR SPINE

Review of xr, lumbar spine taken on 04/13/2018 at IN-OFFICE ORDER shows:
Views:
Taken: 4-5 views.
Views taken: A/P, Lateral, Flexion, and Extension.

Return to Office
- Paul Douglas DeHoll, MD for RE-CHECK at 101 Business Park NE on 06/07/2018 at 01:10 PM

Encounter Sign-Off
Encounter signed-off by Douglas Dow, PA, 04/13/2018.

Encounter performed and documented by Paul Douglas DeHoll, MD
Encounter reviewed & signed by Douglas Dow, PA on 04/13/2018 at 9:04pm

Encounter Date: 11/30/2017

Patient

Name	MCLEOD, STARA (40yo, F) ID# 66306	**Appt. Date/Time**	11/30/2017 09:30AM
DOB	[redacted]	**Service Dept.**	Northeast
Provider	PAUL DOUGLAS DEHOLL, MD		
Insurance	Med Primary: UNITED HEALTHCARE Insurance # : 943460441 Policy/Group # : 714081 Med Secondary: CHAMPVA (CHAMPVA) Insurance # : [redacted] Prescription: OPTUMCOM - Member is eligible. details		

Chief Complaint
Recheck

Patient's Care Team
Referring Provider: TODD WARRICK: 115 N SUMTER ST, SUMTER, SC 29150, Ph (803) 774-6824, Fax (803) 774-6977 NPI: 1952472953

Patient's Pharmacies
WAL-MART NEIGHBORHOOD MARKET 5383 (ERX): 615 BULTMAN DR, SUMTER SC 29150, Ph (803) 305-6194, Fax (803) 305-6197

Vitals
11/30/2017 09:26 am

Ht:	5 ft 6 in	**Wt:**	140 lbs	**BMI:**	22.6
BP:	120/80 sitting	**Pain Scale:**	8	**Pain Scale Type:**	Numeric

Allergies
Reviewed Allergies
NKDA

Medications

MCLEOD, STARA (Id #286433, dob: [redacted])
Reviewed Medications

ARIPiprazole 5 mg tablet Take 1 tablet(s) as needed by oral route for 30 days.	07/31/17	filled
cyclobenzaprine 10 mg tablet Take 1 tablet(s) 3 times a day by oral route as needed.	02/10/17	filled
desvenlafaxine succinate ER 50 mg tablet,extended release 24 hr Take 1 tablet(s) as needed by oral route for 30 days.	08/03/17	filled
Humira 40 mg/0.8 mL subcutaneous syringe kit as directed	11/09/17	filled
Humira Pen 40 mg/0.8 mL subcutaneous as directed	02/29/16	filled

Problems

Reviewed Problems
No known problems

Family History

Reviewed Family History

Social History

Reviewed Social History
Smoking Status: Never smoker

Surgical History

Reviewed Surgical History

GYN History

(not configured)

Obstetric History

Obstetric History not reviewed (last reviewed 02/23/2017)

Past Medical History

Reviewed Past Medical History
No Past Medical Problems Reported: Y

Documents for Discussion

N/A

Screening

None recorded.

HPI

This is a 40-year-old female who presents to clinic today for recheck. She was last seen in 02/2017 with minimal pain. Her pain has since worsened. She reports intermittent pain radiating into her left leg, as well as minimal numbness and tingling in her toes.

ROS

Patient reports **muscle aches, arthralgias/joint pain, back pain, and restricted ROM** but reports no swelling in the extremities. She reports **numbness and tingling** but reports no loss of consciousness, no seizures, no dizziness, no migraines, no headaches, and no restless legs. She reports no fever, no night sweats, no significant weight gain, no significant weight loss, and no exercise intolerance. She reports no chest pain, no arm pain on exertion, no shortness of breath, no lightheadedness, no palpitations, and no known heart murmur. She reports no cough, no wheezing, no shortness of breath, no coughing up blood, and no sleep apnea. She reports no abdominal pain, no vomiting, no reflux, no loss of bowel control, and no indigestion. She reports no abnormal mole, no jaundice, no rashes, no skin ulcers, no dry skin, no growths/lesions, no itching, no hives, and no shingles. She reports no swollen glands, no bruising, and no excessive bleeding.
ROS as noted in the HPI

Physical Exam

Patient is a 40-year-old female.

Constitutional: General Appearance: **healthy-appearing, NAD, and normal body habitus.**

MCLEOD, STARA (Id #286433, dob: [redacted]

Referral Order

11/30/2017

To Provider	From Provider
SUMTER PHYSICAL THERAPY 1185 WILSON HALL RD SUMTER, SC 29150 Phone: Phone: (803) 469-3213 Fax: Fax: (803) 469-3233	PAUL DOUGLAS DEHOLL, MD NPI: 1124029103 Northeast 101 Business Park Blvd COLUMBIA, SC 29223-8401 Phone: (803) 296-9200 Fax: (803) 296-9699

Referral Order Information

Diagnosis	Spinal stenosis of lumbar region ICD-10: M48.061: Spinal stenosis, lumbar region without neurogenic claudication
Order Name	Orders Included: 1 Spinal stenosis of lumbar region ICD-10: M48.061: Spinal stenosis, lumbar region without neurogenic claudication • PHYSICAL THERAPY BACK REFERRAL Schedule Within: provider's discretion Note to Provider: 2-3x week, 6-8 weeks as needed - personal trainer approach to rehab, establish HEP. Transition to gym, modalities, core strength & stretching, neural glides, McKenzie if appropriate. Postural correction. Visits per Week: 2-3 Number of Weeks: 6-8, as needed
Notes	2-3x week, 6-8 weeks as needed - personal trainer approach to rehab, establish HEP. Transition to gym, modalities, core strength & stretching, neural glides, McKenzie if appropriate. Postural correction.

Patient Information

Patient Name	MCLEOD, STARA
Sex - DOB - Age	F [redacted] 40yo
Address	[redacted]
Phone	H: [redacted] W: [redacted] M: [redacted]
Primary Insurance	United Healthcare ID: 943460441 Group: 714081 Policy Holder: JOHNSON, ANDRE G
Secondary Insurance	CHAMPVA (CHAMPVA) ID: [redacted] Policy Holder: MCLEOD-JOHNSON, STARA S

Electronically Signed by: PAUL DOUGLAS DEHOLL, MD

PAUL DOUGLAS DEHOLL, MD

MCLEOD, STARA (id #286433, dob: [redacted]

the ischial tuberosity, the SI joint, or the greater trochanter. Bony Palpation of the Left Hip: no tenderness of the PSIS, the ischial tuberosity, or the greater trochanter and **tenderness of the sciatic notch** and **the SI joint**. Soft Tissue Palpation on the Right: no tenderness of the paraspinal region, the gluteus maximus, or the inguinal ligament; **tender over incision**. Soft Tissue Palpation on the Left: **tenderness of the paraspinal region at L 5** and **the gluteus maximus** and no tenderness of the inguinal ligament; **tender over incision**. Active Range of Motion: **flexion painful, extension painful, lateral flexion to the left painful**, and **rotation to the left painful; good AROM, full rom not checked**.

Motor Strength: L1 Motor Strength on the Right: hip flexion iliopsoas 5/5. L1 Motor Strength on the Left: hip flexion iliopsoas 5/5. L2-L4 Motor Strength on the Right: knee extension quadriceps 5/5. L2-L4 Motor Strength on the Left: **knee extension quadriceps 4/5**. L5 Motor Strength on the Right: ankle dorsiflexion tibialis anterior 5/5 and great toe extension extensor hallucis longus 5/5. L5 Motor Strength on the Left: **ankle dorsiflexion tibialis anterior 4/5** and **great toe extension extensor hallucis longus 4/5**. S1 Motor Strength on the Right: plantar flexion gastrocnemius 5/5. S1 Motor Strength on the Left: **plantar flexion gastrocnemius 4/5**.

Neurological System: Babinski Reflex Right: plantar reflex absent, **Rhomberg's test negative**, and tandem gait normal. Babinski Reflex Left: plantar reflex absent, Rhomberg's test negative, and **tandem gait abnormal**. Special Tests: Valsalva's test negative and clonus negative. Ankle Reflex Right: normal (2). Ankle Reflex Left: **diminished (1)**. Knee Reflex Right: normal (2). Knee Reflex Left: normal (2). Sensation on the Right: T12 normal, L1 normal, L2 normal, L3 normal, L4 normal, L5 normal, S1 normal, S2 normal, and normal distal extremities. Sensation on the Left: **decreased sensation of the knee and medial leg (L4)** and **on the lateral leg and dorsum of the foot (L5)**; **dereased sensation on the sole of the foot and the posterior leg (S1)** and T12 normal, L1 normal, L2 normal, L3 normal, S2 normal, and normal distal extremities. Special Tests on the Right: femoral nerve traction test negative, supine straight leg raising test negative, and seated straight leg raising test negative. Special Tests on the Left: **Patrick-Fabere test positive, supine straight leg raising test positive** and **seated straight leg raising test positive** and femoral nerve traction test negative; **Positive Forton's, positive Gaensien's.**

Images reviewed of AP and Lat radiographs taken today in clinic. There is a loss of disc height at L5-S1 with anterior osteophyte at that level. There is arthritis noted and the facets from L3 to S1. All other vertebral bodies and disc heights are well maintained at this time. There is no listhesis no acute fractures noted.

Assessment / Plan

Concerned that with the increased pain and the decrease in strength of her left leg as well as a previous microdiscectomy we will need a new MRI at this time. We will need to see her after she gets her MRI. Reviewed the modalities of heat, ice and stretching.

1. Spinal stenosis of lumbar region

M48.061: Spinal stenosis, lumbar region without neurogenic claudication

- LUMBAR SPINAL STENOSIS: CARE INSTRUCTIONS
- MRI, LUMBAR SPINE, W/O CONTRAST - Note to Imaging Facility: Please provide disc to patient

Metal in body?: N	Pacemaker or defibrillator?: N
Patient claustrophobic?: N	Authorization #: CC04650377
Authorization Notes: 46 days	Appointment Date: 05/03/2018

Return to Office

- Paul Douglas DeHoll, MD for MRI FOLLOW-UP at 101 Business Park NE on 05/03/2018 at 01:50 PM
- Paul Douglas DeHoll, MD for RE-CHECK at 101 Business Park NE on 06/07/2018 at 01:10 PM

Encounter Sign-Off

Encounter signed-off by Douglas Dow, PA, 04/27/2018.

Encounter performed and documented by Douglas Dow, PA
Encounter reviewed & signed by Douglas Dow, PA on 04/27/2018 at 11:55am

Encounter Date: 04/13/2018

Patient

Name	MCLEOD, STARA (40yo, F) ID# 286433	**Appt. Date/Time**	04/13/2018 03:20PM
DOB	[redacted]	**Service Dept.**	101 Business Park NE
Provider	PAUL DOUGLAS DEHOLL, MD		
Insurance	Med Primary: UNITED HEALTHCARE Insurance # : 943460441 Policy/Group # : 714081 Med Secondary: CHAMPVA (CHAMPVA) Insurance # : [redacted] Prescription: OPTUMCOM - Member is eligible. details		

Chief Complaint

None recorded.

Patient's Care Team

Referring Provider: TODD WARRICK: 115 N SUMTER ST, SUMTER, SC 29150, Ph (803) 774-6824, Fax (803) 774-6977 NPI: 1952472953

MCLEOD, STARA (Id #286433, dob: [redacted])

Patient's Pharmacies

WALMART NEIGHBORHOOD MARKET 5383 (ERX): 615 BULTMAN DR, SUMTER SC 29150, Ph (803) 305-6194, Fax (803) 305-6197

Vitals

04/13/2018 03:17 pm

Ht: 5 ft 6 in	**Wt:** 140 lbs	**BMI:** 22.6
BP: 120/80 sitting	**Pain Scale:** 8	**Pain Scale Type:** Numeric

Allergies

Reviewed Allergies
NKDA

Medications

Reviewed Medications

cyclobenzaprine 10 mg tablet Take 1 tablet(s) 3 times a day by oral route as needed.	02/10/17	filled
desvenlafaxine succinate ER 50 mg tablet,extended release 24 hr Take 1 tablet(s) as needed by oral route for 30 days.	02/23/18	filled
Humira 40 mg/0.8 mL subcutaneous syringe kit as directed	02/21/18	filled
traMADol 50 mg tablet Take 1 tablet(s) every 6 hours by oral route as needed.	04/13/18	prescribed
Vimovo 500 mg-20 mg tablet,immediate and delay release Take 1 tablet(s) twice a day by oral route.	04/13/18	prescribed
Zanaflex 4 mg capsule Take 1 capsule(s) every day by oral route at bedtime.	04/13/18	prescribed

Problems

Reviewed Problems
No known problems

Family History

Reviewed Family History

Social History

Reviewed Social History
Smoking Status: Never smoker

Surgical History

Reviewed Surgical History
Patient indicated no previous surgeries on (04/13/2018)

GYN History

(not configured)

Obstetric History

Obstetric History not reviewed (last reviewed 02/23/2017)

Past Medical History

Reviewed Past Medical History
No Past Medical Problems Reported: Y

Documents for Discussion

N/A

Screening

MCLEOD, STARA (id #286433, dob: [redacted])

None recorded.

HPI

This is a 40-year-old female who presents to clinic today for recheck. She was last seen in 11/2017 with minimal pain. Her pain has since worsened. She reports intermittent pain radiating into her left leg, as well as minimal numbness and tingling in her toes. Patient states that she's been doing PT since November 2017. She denies any injections recently, has had 2 in the past that she states didn't help. Pain medication has consisted of over-the-counter Aleve that she states wears off by about 4:00 in the afternoon. She's tried gabapentin in the past without any help and tramadol the past without help. She states she uses both heat and ice that helped but do not relieve her symptoms.

ROS

Patient reports **muscle aches, arthralgias/joint pain, back pain, and restricted ROM** but reports no swelling in the extremities. She reports **numbness and tingling** but reports no loss of consciousness, no seizures, no dizziness, no migraines, no headaches, and no restless legs. She reports no fever, no night sweats, no significant weight gain, no significant weight loss, and no exercise intolerance. She reports no chest pain, no arm pain on exertion, no shortness of breath, no lightheadedness, no palpitations, and no known heart murmur. She reports no cough, no wheezing, no shortness of breath, no coughing up blood, and no sleep apnea. She reports no abdominal pain, no vomiting, no reflux, no loss of bowel control, and no indigestion. She reports no abnormal mole, no jaundice, no rashes, no skin ulcers, no dry skin, no growths/lesions, no itching, no hives, and no shingles. She reports no swollen glands, no bruising, and no excessive bleeding.
ROS as noted in the HPI

Physical Exam

Patient is a 40-year-old female.

Constitutional: General Appearance: healthy-appearing, NAD, and normal body habitus.

Psychiatric: Orientation: oriented to time, place, and person. Mood and Affect: normal mood and affect and active and alert.

Gait and Station: Appearance: normal gait, no limp, ambulating with no assistive devices, and pelvis normal.

Cardiovascular System: Arterial Pulses Right: posterior tibialis normal and dorsalis pedis normal. Arterial Pulses Left: posterior tibialis normal and dorsalis pedis normal. Edema Right: none. Edema Left: none. Varicosities Right: no varicosities and capillary refill test normal. Varicosities Left: no varicosities and capillary refill test normal.

Lymph Nodes: Inspection/Palpation Right: no inguinal LAD. Inspection/Palpation Left: no inguinal LAD.

Skin: Lumbosacral Spine: **scar; healing well.**

Lumbar Spine: Inspection: no induration or ecchymosis and normal alignment. Bony Palpation of the Lumbar Spine: no tenderness of the spinous process or the sacrum and no step-off. Bony Palpation of the Right Hip: no tenderness of the PSIS, the sciatic notch, the ischial tuberosity, the SI joint, or the greater trochanter. Bony Palpation of the Left Hip: no tenderness of the PSIS, the ischial tuberosity, or the greater trochanter and **tenderness of the sciatic notch** and **the SI joint**. Soft Tissue Palpation on the Right: no tenderness of the gluteus maximus or the inguinal ligament; **tender over incision**. Soft Tissue Palpation on the Left:**tenderness of the paraspinal region at L 5** and **the gluteus maximus** and no tenderness of the inguinal ligament;**tender over incision**. Active Range of Motion: **good AROM, full rom not checked**.

Motor Strength: L1 Motor Strength on the Right: hip flexion iliopsoas 5/5. L1 Motor Strength on the Left: hip flexion iliopsoas 5/5. L2-L4 Motor Strength on the Right: knee extension quadriceps 5/5. L2-L4 Motor Strength on the Left: knee extension quadriceps 5/5. L5 Motor Strength on the Right: ankle dorsiflexion tibialis anterior 5/5 and great toe extension extensor hallucis longus 5/5. L5 Motor Strength on the Left: **ankle dorsiflexion tibialis anterior 4/5** and **great toe extension extensor hallucis longus 4/5**. S1 Motor Strength on the Right: plantar flexion gastrocnemius 5/5. S1 Motor Strength on the Left: plantar flexion gastrocnemius 5/5.

Neurological System: Babinski Reflex Right: plantar reflex absent. Babinski Reflex Left: plantar reflex absent. Special Tests: Valsalva's test negative and clonus negative. Ankle Reflex Right: normal (2). Ankle Reflex Left: **absent (0)**. Knee Reflex Right: normal (2). Knee Reflex Left: **diminished (1)**. Sensation on the Right: T12 normal, L1 normal, L2 normal, L3 normal, L4 normal, L5 normal, S1 normal, S2 normal, and normal distal extremities. Sensation on the Left: T12 normal, L1 normal, L2 normal, L3 normal, L5 normal, S1 normal, S2 normal, normal distal extremities, and **decreased sensation of the knee and medial leg (L4)** Special Tests on the Right: femoral nerve traction test negative, supine straight leg raising test negative, and seated straight leg raising test negative. Special Tests on the Left: **Patrick-Fabere test positive, supine straight leg raising test positive**, and **seated straight leg raising test positive** and femoral nerve traction test negative;**Positive Forton's, positive Gaenslen's.**

Images reviewed of AP and Lat radiographs taken today in clinic. There is a loss of disc height at L5-S1 with anterior osteophyte at that level. There is arthritis noted and the facets from L3 to S1. All the vertebral bodies and disc heights are well maintained at this time. There is no listhesis no acute fractures noted.

Assessment / Plan

Discussed with her that her first course of action would be PT will provide some medication as well. Reviewed the modalities of heat ice and stretching. We will need to see her back after she's completed PT if there is no improvement.

MCLEOD, STARA (Id #286433, dob: [redacted])

Referral Order

04/13/2018

To Provider	From Provider
SUMTER PHYSICAL THERAPY 1185 WILSON HALL RD SUMTER, SC 29150 Phone: Phone: (803) 469-3213 Fax: Fax: (803) 469-3233	PAUL DOUGLAS DEHOLL, MD NPI: 1124029103 101 Business Park NE 101 Business Park Blvd COLUMBIA, SC 29223-8401 Phone: (803) 296-7846 Fax: (803) 296-9699

Referral Order Information

Diagnosis	Spinal stenosis of lumbar region ICD-10: M48.061: Spinal stenosis, lumbar region without neurogenic claudication
Order Name	Orders Included: 1 Spinal stenosis of lumbar region ICD-10: M48.061: Spinal stenosis, lumbar region without neurogenic claudication • PHYSICAL THERAPY BACK REFERRAL Schedule Within: provider's discretion Note to Provider: 2-3x week, 6-8 weeks as needed - personal trainer approach to rehab, establish HEP. Transition to gym, modalities, core strength & stretching, neural glides, McKenzie if appropriate. Postural correction. Visits per Week: 2-3 Number of Weeks: 6-8, as needed
Notes	2-3x week, 6-8 weeks as needed - personal trainer approach to rehab, establish HEP. Transition to gym, modalities, core strength & stretching, neural glides, McKenzie if appropriate. Postural correction.

Patient Information

Patient Name	MCLEOD, STARA
Sex - DOB - Age	F [redacted] 40yo
Address	[redacted]
Phone	H: [redacted] W [redacted] M: [redacted]
Primary Insurance	United Healthcare ID: 943460441 Group: 714081 Policy Holder: JOHNSON, ANDRE G
Secondary Insurance	CHAMPVA (CHAMPVA) ID: [redacted] Policy Holder: MCLEOD-JOHNSON, STARA S

Electronically Signed by: PAUL DOUGLAS DEHOLL, MD

D Deholl

PAUL DOUGLAS DEHOLL, MD

MCLEOD, STARA (Id #286433, dob: [redacted])



DOUGLAS DOW, PA

Imaging Order

04/13/2018

To Provider	From Provider
IN-OFFICE ORDER INTERNAL USE ONLY DO NOT ATTACH COMPENDIUM , MA 00000 Phone: Fax:	PAUL DOUGLAS DEHOLL, MD 101 Business Park NE 101 Business Park Blvd COLUMBIA, SC 29223-8401 Phone: (803) 296-7846 Fax: (803) 296-9699

Imaging Order Information

Diagnosis	Spinal stenosis of lumbar region ICD-10: M48.061: Spinal stenosis, lumbar region without neurogenic claudication
Order Name	Orders Included: 1 Spinal stenosis of lumbar region | ICD-10: M48.061: Spinal stenosis, lumbar region without neurogenic claudication • XR, LUMBAR SPINE
Notes	

Patient Information

Patient Name	MCLEOD, STARA
Sex - DOB - Age	F [redacted] 40yo
Address	[redacted]
Phone	H: [redacted] W: M:
Primary Insurance	United Healthcare ID: 943460441 Group: 714081 Policy Holder: JOHNSON, ANDRE G Eligibility: Member is eligible. (Verified 05/01/2018)
Secondary Insurance	CHAMPVA (CHAMPVA) ID: [redacted] Policy Holder: MCLEOD-JOHNSON, STARA S Eligibility: Member is eligible. (Verified 05/01/2018)

Electronically Signed by: PAUL DOUGLAS DEHOLL, MD

MCLEOD, STARA (Id #286433, dob: [redacted])

Return to Office

- **Paul Douglas DeHoll, MD for RE-CHECK at 101 Business Park NE on 07/19/2018 at 02:00 PM**

Encounter Sign-Off

Encounter signed-off by Paul Douglas DeHoll, MD, 05/04/2018.

Encounter performed by Paul Douglas DeHoll, MD
Encounter scribed for Paul Douglas DeHoll, MD by Kayla Andersen
Encounter signed by Kayla Andersen as scribe at 05/04/2018 at 8:26am
Encounter reviewed & signed by Paul Douglas DeHoll, MD on 05/04/2018 at 5:52pm

Encounter Date: 04/27/2018

Patient

Name	MCLEOD, STARA (40yo, F) ID# 286433	**Appt. Date/Time**	04/27/2018 08:40AM
DOB	[redacted]	**Service Dept.**	101 Business Park NE
Provider	DOUGLAS DOW, PA		
Insurance	**Med Primary: UNITED HEALTHCARE** **Insurance # : 943460441** **Policy/Group # : 714081** Med Secondary: CHAMPVA (CHAMPVA) Insurance # : [redacted] Prescription: ESI1 - Member is eligible. details Prescription: OPTUMCOM - Member is eligible. **details**		

Chief Complaint

Lumbar spine problem

Patient's Care Team

Referring Provider: TODD WARRICK: 115 N SUMTER ST, SUMTER, SC 29150, Ph (803) 774-6824, Fax (803) 774-6977 NPI: 1952472953

Patient's Pharmacies

WALMART NEIGHBORHOOD MARKET 5383 (ERX): 615 BULTMAN DR, SUMTER SC 29150, Ph (803) 305-6194, Fax (803) 305-6197

Vitals

Ht:	5 ft 6 in 04/27/2018 08:21 am	**Wt:**	140 lbs 04/27/2018 08:22 am	**BMI:**	22.6 04/27/2018 08:22 am
BP:	120/80 sitting 04/27/2018 08:22 am	**Pain Scale:**	8 04/27/2018 08:22 am	**Pain Scale Type:**	Numeric 04/27/2018 08:22 am

Allergies

Reviewed Allergies
NKDA

Medications

Reviewed Medications

cyclobenzaprine 10 mg tablet Take 1 tablet(s) 3 times a day by oral route as needed.	02/10/17	filled
desvenlafaxine succinate ER 50 mg tablet,extended release 24 hr Take 1 tablet(s) as needed by oral route for 30 days.	02/23/18	filled
Humira 40 mg/0.8 mL subcutaneous syringe kit as directed	02/21/18	filled
tiZANidine 4 mg capsule Take 1 capsule(s) every day by oral route at bedtime.	04/13/18	filled
traMADol 50 mg tablet Take 1 tablet(s) every 6 hours by oral route as needed.	04/13/18	prescribed

MCLEOD, STARA (id #286433, dob: [redacted])

Vimovo 500 mg-20 mg tablet,immediate and delay release 04/13/18 prescribed
Take 1 tablet(s) twice a day by oral route.

Problems

Reviewed Problems
No known problems

Family History

Reviewed Family History

Social History

Reviewed Social History
Smoking Status: Never smoker

Surgical History

Reviewed Surgical History
Patient indicated no previous surgeries on (04/13/2018)

GYN History

(not configured)

Obstetric History

Obstetric History not reviewed (last reviewed 02/23/2017)

Past Medical History

Reviewed Past Medical History
No Past Medical Problems Reported: Y

Documents for Discussion

N/A

Screening

None recorded.

HPI

Patient is a 40-year-old woman with continued lower back pain for the past couple years she had a previous surgery beginning of 2017 for a microdiscectomy. Recently she's had an increase in pressure in her tailbone and increased pressure and pain in her left leg with numbness and tingling radiating down to her foot. Recently we had tried to get her into physical therapy, pain has increased the point where she is unable to do so. She had an injection done at the ER which she states did not help but made her leg ache more. She's had a significant increase in pain every time she sneezes. She states she's had decreased strength in the left leg. She's been taking NSAIDs since December without any relief in her pain or symptoms.

ROS

Patient reports **muscle aches, arthralgias/joint pain, back pain, and restricted ROM** but reports no swelling in the extremities. She reports **numbness and tingling** but reports no loss of consciousness, no seizures, no dizziness, no migraines, no headaches, and no restless legs. She reports no fever, no night sweats, no significant weight gain, no significant weight loss, and no exercise intolerance. She reports no chest pain, no arm pain on exertion, no shortness of breath, no lightheadedness, no palpitations, and no known heart murmur. She reports no cough, no wheezing, no shortness of breath, no coughing up blood, and no sleep apnea. She reports no abdominal pain, no vomiting, no reflux, no loss of bowel control, and no indigestion. She reports no abnormal mole, no jaundice, no rashes, no skin ulcers, no dry skin, no growths/lesions, no itching, no hives, and no shingles. She reports no swollen glands, no bruising, and no excessive bleeding.

Physical Exam

Patient is a 40-year-old female.

Constitutional: General Appearance: **healthy-appearing, NAD,** and normal body habitus.

Psychiatric: Orientation: **oriented to time, place, and person.** Mood and Affect: **normal mood and affect and active and alert.**

Gait and Station: Appearance: **ambulating with no assistive devices, antalgic gait,** and **pelvis** normal.

Cardiovascular System: Arterial Pulses Right: posterior tibialis normal and dorsalis pedis normal. Arterial Pulses Left: posterior tibialis normal and dorsalis pedis normal. Edema Right: none. Edema Left: none. Varicosities Right: no varicosities and capillary refill test normal. Varicosities Left: no varicosities and capillary refill test normal.

Lymph Nodes: Inspection/Palpation Right: no inguinal LAD. Inspection/Palpation Left: no inguinal LAD.

Skin: Lumbosacral Spine: **scar; healing well.**

Lumbar Spine: Inspection: no induration or ecchymosis and normal alignment. Bony Palpation of the Lumbar Spine: no tenderness of the spinous process or the sacrum and no step-off. Bony Palpation of the Right Hip: no tenderness of the PSIS, the sciatic notch,

MCLEOD, STARA (id #286433, dob: [redacted])

Imaging Orders

Imaging Order

04/27/2018

To Provider	From Provider
IMAGE CARE 710 RABON RD STE 100 COLUMBIA, SC 29203 Phone: Phone: (803) 462-3680 Fax: Fax: (803) 462-3690	DOUGLAS DOW, PA 101 Business Park NE 101 Business Park Blvd COLUMBIA, SC 29223-8401 Phone: (803) 296-7846 Fax: (803) 296-9699

Imaging Order Information

Diagnosis	Spinal stenosis of lumbar region ICD-10: M48.061: Spinal stenosis, lumbar region without neurogenic claudication
Order Name	Orders included: 1 Spinal stenosis of lumbar region | ICD-10: M48.061: Spinal stenosis, lumbar region without neurogenic claudication • MRI, LUMBAR SPINE, W/O CONTRAST NOTE TO IMAGING FACILITY: Please provide disc to patient Metal in body?: N Pacemaker or defibrillator?: N Patient claustrophobic?: N Authorization #: CC04850377 Authorization Notes: 46 days Appointment Date: 05/03/2018
Notes	

Patient Information

Patient Name	MCLEOD, STARA
Sex - DOB - Age	F [redacted] 40yo
Address	[redacted]
Phone	[redacted]
Primary Insurance	United Healthcare ID: 943460441 Group: 714081 Policy Holder: JOHNSON, ANDRE G Eligibility: Member is eligible. (Verified 05/01/2018)
Secondary Insurance	CHAMPVA (CHAMPVA) ID: [redacted] Policy Holder: MCLEOD-JOHNSON, STARA S Eligibility: Member is eligible. (Verified 05/01/2018)

Electronically Signed by: DOUGLAS DOW, PA, PASUP

MCLEOD, STARA (id #286433, dob [redacted]
Insurance # : 943460441
Policy/Group # : 714081
Med Secondary: CHAMPVA (CHAMPVA)
Insurance # : [redacted]
Prescription: ESI1 - Member is eligible. details
Prescription: OPTUMCOM - Member is eligible. details

Chief Complaint

MRI Followup

Patient's Care Team

Referring Provider: TODD WARRICK: 115 N SUMTER ST, SUMTER, SC 29150, Ph (803) 774-6824, Fax (803) 774-8977 NPI: 1952472953

Patient's Pharmacies

WALMART NEIGHBORHOOD MARKET 5383 (ERX): 615 BULTMAN DR, SUMTER SC 29150, Ph (803) 305-6194, Fax (803) 305-6197

Vitals

05/03/2018 02:03 pm

Ht: 5 ft 6 in	**Wt:** 140 lbs	**BMI:** 22.6
BP: 120/80 sitting	**Pain Scale:** 8	**Pain Scale Type:** Numeric

Allergies

Reviewed Allergies
NKDA

Medications

Reviewed Medications

cyclobenzaprine 10 mg tablet Take 1 tablet(s) 3 times a day by oral route as needed.	02/10/17	filled
desvenlafaxine succinate ER 50 mg tablet,extended release 24 hr Take 1 tablet(s) as needed by oral route for 30 days.	02/23/18	filled
Humira 40 mg/0.8 mL subcutaneous syringe kit as directed	02/21/18	filled
tiZANidine 4 mg capsule Take 1 capsule(s) every day by oral route at bedtime.	04/13/18	filled
traMADol 50 mg tablet Take 1 tablet(s) every 6 hours by oral route as needed.	04/13/18	prescribed
Vimovo 500 mg-20 mg tablet,immediate and delay release Take 1 tablet(s) twice a day by oral route.	04/13/18	prescribed

Problems

Reviewed Problems
No known problems

Family History

Reviewed Family History

Social History

Reviewed Social History
Smoking Status: Never smoker

Surgical History

Reviewed Surgical History
Patient indicated no previous surgeries on (04/13/2018)

GYN History

MCLEOD, STARA (id #286433, dob: [redacted])

(not configured)

Obstetric History

Obstetric History not reviewed (last reviewed 02/23/2017)

Past Medical History

Reviewed Past Medical History
No Past Medical Problems Reported: Y

Documents for Discussion

N/A

Screening

None recorded.

HPI

This is a 40-year-old female who presents to clinic for MRI follow-up. The patient was initially evaluated by Doug Dow, PA-C for low back pain with associated numbness and tingling in her left leg. She was given medications and sent to physical therapy. Therapy was unable to do anything, so she went to the emergency department secondary to severe pain where an MRI was ordered.

ROS

Patient reports **muscle aches, arthralgias/joint pain, back pain, and restricted ROM** but reports no swelling in the extremities. She reports **numbness and tingling** but reports no loss of consciousness, no seizures, no dizziness, no migraines, no headaches, and no restless legs. She reports no fever, no night sweats, no significant weight gain, no significant weight loss, and no exercise intolerance. She reports no chest pain, no arm pain on exertion, no shortness of breath, no lightheadedness, no palpitations, and no known heart murmur. She reports no cough, no wheezing, no shortness of breath, no coughing up blood, and no sleep apnea. She reports no abdominal pain, no vomiting, no reflux, no loss of bowel control, and no indigestion. She reports no abnormal mole, no jaundice, no rashes, no skin ulcers, no dry skin, no growths/lesions, no itching, no hives, and no shingles. She reports no swollen glands, no bruising, and no excessive bleeding.
ROS as noted in the HPI

Physical Exam

Patient is a 40-year-old female.

Constitutional: General Appearance: healthy-appearing, NAD, and normal body habitus.

Psychiatric: Orientation: oriented to time, place, and person. Mood and Affect: normal mood and affect and active and alert.

Gait and Station: Appearance: normal gait, no limp, ambulating with no assistive devices, and pelvis normal.

Cardiovascular System: Arterial Pulses Right: posterior tibialis normal and dorsalis pedis normal. Arterial Pulses Left: posterior tibialis normal and dorsalis pedis normal. Edema Right: none. Edema Left: none. Varicosities Right: no varicosities and capillary refill test normal. Varicosities Left: no varicosities and capillary refill test normal.

Lymph Nodes: Inspection/Palpation Right: no inguinal LAD. Inspection/Palpation Left: no inguinal LAD.

Skin: Lumbosacral Spine: normal skin.

Lumbar Spine: Inspection: normal alignment and no ecchymosis. Bony Palpation of the Lumbar Spine: no tenderness of the spinous process or the sacrum and no step-off. Bony Palpation of the Right Hip: no tenderness of the sciatic notch, the SI joint, or the greater trochanter. Bony Palpation of the Left Hip: no tenderness of the sciatic notch or the greater trochanter and **tenderness of the SI joint**. Soft Tissue Palpation on the Right: no tenderness of the gluteus maximus and **tenderness of the paraspinal region at L 5**. Soft Tissue Palpation on the Left: no tenderness of the gluteus maximus and **tenderness of the paraspinal region at L 5**. Active Range of Motion: **flexion painful (mild)**, **extension painful (mild)**, and **pain with motion**.

Motor Strength: L1 Motor Strength on the Right: hip flexion iliopsoas 5/5. L1 Motor Strength on the Left: hip flexion iliopsoas 5/5. L2-L4 Motor Strength on the Right: knee extension quadriceps 5/5. L2-L4 Motor Strength on the Left: knee extension quadriceps 5/5. L5 Motor Strength on the Right: ankle dorsiflexion tibialis anterior 5/5 and great toe extension extensor hallucis longus 5/5. L5 Motor Strength on the Left: ankle dorsiflexion tibialis anterior 5/5 and great toe extension extensor hallucis longus 5/5. S1 Motor Strength on the Right: plantar flexion gastrocnemius 5/5. S1 Motor Strength on the Left: plantar flexion gastrocnemius 5/5.

Neurological System: Babinski Reflex Right: plantar reflex absent, Rhomberg's test negative, and tandem gait normal. Babinski Reflex Left: plantar reflex absent, Rhomberg's test negative, and tandem gait normal. Special Tests: Valsalva's test negative and clonus negative. Ankle Reflex Right: normal (2). Ankle Reflex Left: normal (2). Knee Reflex Right: normal (2). Knee Reflex Left: normal (2). Sensation on the Right: T12 normal, L1 normal, L2 normal, L3 normal, L4 normal, L5 normal, S1 normal, S2 normal, and normal distal extremities. Sensation on the Left: T12 normal, L1 normal, L2 normal, L3 normal, L4 normal, L5 normal, S1 normal, S2 normal, and normal distal extremities. Special Tests on the Right: femoral nerve traction test negative, supine straight leg raising test negative, and seated straight leg raising test negative. Special Tests on the Left: femoral nerve traction test negative, supine straight leg raising test negative, seated straight leg raising test negative, and **Patrick-Fabere test positive**; **positive Fortin's finger sign**.

Imaging Studies:

MCLEOD, STARA (id #286433, dob: [redacted])

MRI of the lumbar spine from ImageCare reveals severe discogenic collapse at L5-S1 with mild modic endplate changes. There is minimal bulging and evidence of a prior left hemilaminotomy, but no recurrent disc herniation.

Assessment / Plan

The patient definitely has discogenic changes at L5-S1. We have discussed that we would very much like to avoid surgery, albeit an L5-S1 anterior fusion for her discogenic issues. She does have pain over her left SI joint. In an attempt to avoid consideration of an ALIF, we are going to try a left-sided SI injection, and I will see her back after to discuss.

Attestation:
I, Kayla Andersen, am transcribing this note for Paul deHoll, MD.

1. Spinal stenosis of lumbar region
M48.061: Spinal stenosis, lumbar region without neurogenic claudication
- LUMBAR SPINAL STENOSIS: CARE INSTRUCTIONS
- SACROILIAC JOINT INJECTION (PROC) - Note to Provider: left SI joint injection

Return to Office
- Paul Douglas DeHoll, MD for RE-CHECK at 101 Business Park NE on 07/19/2018 at 02:00 PM

Encounter Sign-Off
Encounter signed-off by Paul Douglas DeHoll, MD, 05/04/2018.

Encounter performed by Paul Douglas DeHoll, MD
Encounter scribed for Paul Douglas DeHoll, MD by Kayla Andersen
Encounter signed by Kayla Andersen as scribe at 05/04/2018 at 8:26am
Encounter reviewed & signed by Paul Douglas DeHoll, MD on 05/04/2018 at 5:52pm

Imaging Results

MCLEOD, STARA (id #286433, dob: [redacted])

Stroke
Diabetes
Heart disease
History of anesthesia problem
High Cholesterol
Hypertensive disorder
Joint problem
Cancer
Multiple fractures
Osteoporosis
Blood Clot
Rheumatoid arthritis
Scoliosis deformity of spine
No current problems or disability

Allergies

Medications

Abilify 5 mg tablet	Stop Date: 01/06/2017
prednisone 10 mg tablet	Stop Date: 01/06/2017
sulfamethoxazole 800 mg-trimethoprim 160 mg tablet	Stop Date: 01/06/2017
venlafaxine 75 mg tablet	Stop Date: 01/06/2017
minocycline 100 mg capsule	Stop Date: 01/06/2017
tretinoin 0.05 % topical gel	Stop Date: 01/06/2017
Humira Pen 40 mg/0.8 mL subcutaneous	No additional information
metronidazole 500 mg tablet	Stop Date: 01/06/2017
nitrofurantoin monohydrate/macrocrystals 100 mg capsule	Stop Date: 01/06/2017
Ventolin HFA 90 mcg/actuation aerosol inhaler	Stop Date: 01/06/2017
Humira 40 mg/0.8 mL subcutaneous syringe kit	No additional information
clindamycin 1 % topical gel	Stop Date: 01/06/2017

Encounters and Procedures

Clinical Encounter Summaries
Encounter Date: 05/03/2018

Patient

Name	MCLEOD, STARA (40yo, F) ID# 286433	**Appt. Date/Time**	05/03/2018 01:50PM
DOB	[redacted]	**Service Dept.**	101 Business Park NE
Provider	PAUL DOUGLAS DEHOLL, MD		
Insurance	Med Primary: UNITED HEALTHCARE Insurance # : 943460441 Policy/Group # : 714081 Med Secondary: CHAMPVA (CHAMPVA) Insurance # : [redacted] Prescription: ESI1 - Member is eligible. details Prescription: OPTUMCOM - Member is eligible. details		

Chief Complaint

MRI Followup

Patient's Care Team

Referring Provider: TODD WARRICK: 115 N SUMTER ST, SUMTER, SC 29150, Ph (803) 774-6824, Fax (803) 774-8977 NPI: 1952472953

Patient's Pharmacies

MCLEOD, STARA (Id #286433, dob: [redacted])

WALMART NEIGHBORHOOD MARKET 5383 (ERX): 615 BULTMAN DR, SUMTER SC 29150, Ph (803) 305-6194, Fax (803) 305-6197

Vitals

05/03/2018 02:03 pm

Ht: 5 ft 6 in	**Wt:** 140 lbs	**BMI:** 22.6
BP: 120/80 sitting	**Pain Scale:** 8	**Pain Scale Type:** Numeric

Allergies

Reviewed Allergies
NKDA

Medications

Reviewed Medications

cyclobenzaprine 10 mg tablet Take 1 tablet(s) 3 times a day by oral route as needed.	02/10/17	filled
desvenlafaxine succinate ER 50 mg tablet,extended release 24 hr Take 1 tablet(s) as needed by oral route for 30 days.	02/23/18	filled
Humira 40 mg/0.8 mL subcutaneous syringe kit as directed	02/21/18	filled
tiZANidine 4 mg capsule Take 1 capsule(s) every day by oral route at bedtime.	04/13/18	filled
traMADol 50 mg tablet Take 1 tablet(s) every 6 hours by oral route as needed.	04/13/18	prescribed
Vimovo 500 mg-20 mg tablet,immediate and delay release Take 1 tablet(s) twice a day by oral route.	04/13/18	prescribed

Problems

Reviewed Problems
No known problems

Family History

Reviewed Family History

Social History

Reviewed Social History
Smoking Status: Never smoker

Surgical History

Reviewed Surgical History
Patient indicated no previous surgeries on (04/13/2018)

GYN History

(not configured)

Obstetric History

Obstetric History not reviewed (last reviewed 02/23/2017)

Past Medical History

Reviewed Past Medical History
No Past Medical Problems Reported: Y

Documents for Discussion

N/A

Screening

None recorded.

MCLEOD, STARA (Id #286433, dob: [redacted])

HPI

This is a 40-year-old female who presents to clinic for MRI follow-up. The patient was initially evaluated by Doug Dow, PA-C for low back pain with associated numbness and tingling in her left leg. She was given medications and sent to physical therapy. Therapy was unable to do anything, so she went to the emergency department secondary to severe pain where an MRI was ordered.

ROS

Patient reports **muscle aches, arthralgias/joint pain, back pain, and restricted ROM** but reports no swelling in the extremities. She reports **numbness and tingling** but reports no loss of consciousness, no seizures, no dizziness, no migraines, no headaches, and no restless legs. She reports no fever, no night sweats, no significant weight gain, no significant weight loss, and no exercise intolerance. She reports no chest pain, no arm pain on exertion, no shortness of breath, no lightheadedness, no palpitations, and no known heart murmur. She reports no cough, no wheezing, no shortness of breath, no coughing up blood, and no sleep apnea. She reports no abdominal pain, no vomiting, no reflux, no loss of bowel control, and no indigestion. She reports no abnormal mole, no jaundice, no rashes, no skin ulcers, no dry skin, no growths/lesions, no itching, no hives, and no shingles. She reports no swollen glands, no bruising, and no excessive bleeding.
ROS as noted in the HPI

Physical Exam

Patient is a 40-year-old female.

Constitutional: General Appearance: healthy-appearing, NAD, and normal body habitus.

Psychiatric: Orientation: oriented to time, place, and person. Mood and Affect: normal mood and affect and active and alert.

Gait and Station: Appearance: normal gait, no limp, ambulating with no assistive devices, and pelvis normal.

Cardiovascular System: Arterial Pulses Right: posterior tibialis normal and dorsalis pedis normal. Arterial Pulses Left: posterior tibialis normal and dorsalis pedis normal. Edema Right: none. Edema Left: none. Varicosities Right: no varicosities and capillary refill test normal. Varicosities Left: no varicosities and capillary refill test normal.

Lymph Nodes: Inspection/Palpation Right: no inguinal LAD. Inspection/Palpation Left: no inguinal LAD.

Skin: Lumbosacral Spine: normal skin.

Lumbar Spine: Inspection: normal alignment and no ecchymosis. Bony Palpation of the Lumbar Spine: no tenderness of the spinous process or the sacrum and no step-off. Bony Palpation of the Right Hip: no tenderness of the sciatic notch, the SI joint, or the greater trochanter. Bony Palpation of the Left Hip: no tenderness of the sciatic notch or the greater trochanter and **tenderness of the SI joint**. Soft Tissue Palpation on the Right: no tenderness of the gluteus maximus and **tenderness of the paraspinal region at L 5**. Soft Tissue Palpation on the Left: no tenderness of the gluteus maximus and **tenderness of the paraspinal region at L 5**. Active Range of Motion: **flexion painful (mild), extension painful (mild),** and **pain with motion.**

Motor Strength: L1 Motor Strength on the Right: hip flexion iliopsoas 5/5. L1 Motor Strength on the Left: hip flexion iliopsoas 5/5. L2-L4 Motor Strength on the Right: knee extension quadriceps 5/5. L2-L4 Motor Strength on the Left: knee extension quadriceps 5/5. L5 Motor Strength on the Right: ankle dorsiflexion tibialis anterior 5/5 and great toe extension extensor hallucis longus 5/5. L5 Motor Strength on the Left: ankle dorsiflexion tibialis anterior 5/5 and great toe extension extensor hallucis longus 5/5. S1 Motor Strength on the Right: plantar flexion gastrocnemius 5/5. S1 Motor Strength on the Left: plantar flexion gastrocnemius 5/5.

Neurological System: Babinski Reflex Right: plantar reflex absent, Rhomberg's test negative, and tandem gait normal. Babinski Reflex Left: plantar reflex absent, Rhomberg's test negative, and tandem gait normal. Special Tests: Valsalva's test negative and clonus negative. Ankle Reflex Right: normal (2). Ankle Reflex Left: normal (2). Knee Reflex Right: normal (2). Knee Reflex Left: normal (2). Sensation on the Right: T12 normal, L1 normal, L2 normal, L3 normal, L4 normal, L5 normal, S1 normal, S2 normal, and normal distal extremities. Sensation on the Left: T12 normal, L1 normal, L2 normal, L3 normal, L4 normal, L5 normal, S1 normal, S2 normal, and normal distal extremities. Special Tests on the Right: femoral nerve traction test negative, supine straight leg raising test negative, and seated straight leg raising test negative. Special Tests on the Left: femoral nerve traction test negative, supine straight leg raising test negative, seated straight leg raising test negative, and **Patrick-Fabere test positive; positive Fortin's finger sign**.

Imaging Studies:
MRI of the lumbar spine from ImageCare reveals severe discogenic collapse at L5-S1 with mild modic endplate changes. There is minimal bulging and evidence of a prior left hemilaminotomy, but no recurrent disc herniation.

Assessment / Plan

The patient definitely has discogenic changes at L5-S1. We have discussed that we would very much like to avoid surgery, albeit an L5-S1 anterior fusion for her discogenic issues. She does have pain over her left SI joint. In an attempt to avoid consideration of an ALIF, we are going to try a left-sided SI injection, and I will see her back after to discuss.

Attestation:
I, Kayla Andersen, am transcribing this note for Paul deHoll, MD.

1. Spinal stenosis of lumbar region
M48.061: Spinal stenosis, lumbar region without neurogenic claudication
- LUMBAR SPINAL STENOSIS: CARE INSTRUCTIONS
- SACROILIAC JOINT INJECTION (PROC) - Note to Provider: left SI joint injection

Palmetto Health USC Orthopedic Center • 101 Bypass Park Blvd, (D) LMHA SC 29223-8401
MCLEOD, STARA (id #286433, dob: [redacted])

Surgery Order

05/03/2016

From Provider	To Provider
Ordering Provider: PAUL DOUGLAS DEHOLL, MD Palmetto Health USC Orthopedic Center 14 Richland Medical Park COLUMBIA, SC 29203-6802 Phone: (803) 296-7540 Fax: (803) 296-9695	TODD WARRICK 118 N SUMTER ST SUMTER, SC 29150 Phone: (803) 774-6824 Fax: (803) 774-6877

Patient	NAME: MCLEOD, STARA PATIENT ID: 286433 PATIENT SSN: [redacted] Gender: F DOB: [redacted] AGE: 40yo	
Address	3525 DELAWARE DR, DALZELL, SC 29040	
Phone	H: [redacted] W M	
Primary Ins.	United Healthcare ID: 943660641 Group: 714081 Policy Holder: JOHNSON, ANDRE G	Claim Case#: Case Injury Date: Case Worker's Name:
Secondary Ins.	CHAMPVA (CHAMPVA) ID: [redacted] Policy Holder: MCLEOD-JOHNSON, STARA S	

Diagnosis	Spinal stenosis of lumbar region ICD-10: M48.061: Spinal stenosis, lumbar region without neurogenic claudication
Order Name	Orders Included: 1 Spinal stenosis of lumbar region ICD-10: M48.061: Spinal stenosis, lumbar region without neurogenic claudication • SACROILIAC JOINT INJECTION (PROC) Note to Provider: left SI joint injection

Electronically Signed by: PAUL DOUGLAS DEHOLL, MD

D Deholl

ON: 05/03/2016 11:54 AM

MCLEOD, STARA (id #286433, dob: [redacted]

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500 • Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737-5675
www.wcc.sc.gov

Physician's Statement

Claimant's Name:	Stara McLeod	Employer's Name:	CW Group Inc CW Resources
Physician's Name:	Dr. Paul Douglas DeHoff	Insurance Carrier:	PA Manufacturers Assn. Ins. Co.
Practice/Clinic:	Palmetto Health USC Orthopedic Center	SCWCC File No:	1805291
Preparer's Name:		Phone:	

The undersigned physician has been authorized to evaluate or treat the Claimant for his or her work injury or illness pursuant to *South Carolina Code Sections* 42-15-60, 42-15-80, 42-1-172, or 42-11-10.

Date of injury: 03/28/2018 Date of first office visit: 1/10/2017 Date of last office visit: 5/3/2018

The medical opinions below are stated to a reasonable degree of medical certainty.

Diagnosis or nature of injury or illness: M48.061-Spinal Stenosis

Body part(s) injured: Lumbar Spine Body part(s) affected: Lumbar Spine

Date of maximum medical improvement: 5/3/2018

Has the Claimant sustained permanent physical impairment as a result of the work injury? ____ Yes X No

If so, the permanent physical impairment is: ____ % medical impairment to the _____ (injured body part).

If there is a permanent physical impairment to other body part(s) as a result of the work injury, please indicate below:
____ % medical impairment to the _____ (additional body part injured or affected).

The impairment rating(s) above are based upon the following:

X The AMA's *Guides to the Evaluation of Permanent Impairment* ____ Edition; or
____ Other medical treatise: _____ or
____ Other: _____

Does the Claimant have permanent physical limitations as a result of the injury? ____ Yes X No

If so, the permanent physical limitations are: _____

Does the Claimant possess retained hardware as a result of the injury? X Yes ____ No

If so, the retained hardware is: Lumbar Microdiscectomy 5/1 Date: 2/1/17

Is there medical, surgical, hospital or other treatment that the Claimant needs as a result of the injury for an additional time that will tend to lessen the period of disability or maintain the current level of function: X Yes ____ No

If so, the medical care and treatment that is needed is/are:

Sacroiliac joint Injection - left SI joint

*An indication or statement that future medical care "may be necessary" or "might be necessary" is not sufficient and will require further clarification.

I certify that I am a physician or other licensed healthcare provider, I have personally read and prepared this document, and the opinions reflected above are mine.

D. DeHoff M.D.

Treating or Evaluating Physician

10/23/2018
Date

MCLEOD, STARA (id #286433, dob: [redacted])

Encounters and Procedures

Clinical Encounter Summaries

Encounter Date: 07/19/2018

Patient

Name	MCLEOD, STARA (40yo, F) ID# 286433	**Appt. Date/Time**	07/19/2018 02:00PM
DOB	[redacted]	**Service Dept.**	101 Business Park NE
Provider	PAUL DOUGLAS DEHOLL, MD		
Insurance	Med Primary: UNITED HEALTHCARE Insurance # : 943460441 Policy/Group # : 714081 Med Secondary: CHAMPVA (CHAMPVA) Insurance # : [redacted] Prescription: OPTUMCOM - Member is eligible. details		

Chief Complaint

Lumbar spine problem

Patient's Care Team

Referring Provider: TODD WARRICK: 115 N SUMTER ST, SUMTER, SC 29150, Ph (803) 774-6824, Fax (803) 774-8977 NPI: 1952472953

Patient's Pharmacies

WALMART NEIGHBORHOOD MARKET 5383 (ERX): 615 BULTMAN DR, SUMTER SC 29150, Ph (803) 305-6194, Fax (803) 305-6197

Vitals

Ht:	5 ft 6 in 07/19/2018 02:11 pm	**Wt:**	140 lbs 07/19/2018 02:11 pm	**BMI:**	22.6 07/19/2018 02:11 pm
BP:	120/80 07/19/2018 02:12 pm				

Allergies

Reviewed Allergies

NKDA

Medications

Reviewed Medications

clindamycin HCl 300 mg capsule 1 tab po daily	05/09/18	filled
cyclobenzaprine 10 mg tablet Take 1 tablet(s) 3 times a day by oral route as needed.	02/10/17	filled
desvenlafaxine succinate ER 50 mg tablet,extended release 24 hr Take 1 tablet(s) as needed by oral route for 30 days.	06/18/18	filled
Humira 40 mg/0.8 mL subcutaneous syringe kit as directed	02/21/18	filled
predniSONE 20 mg tablet 1 tab po daily	05/09/18	filled
tiZANidine 4 mg capsule Take 1 capsule(s) every day by oral route at bedtime.	04/13/18	filled
tobramycin 0.3 %-dexamethasone 0.1 % eye drops,suspension	05/07/18	filled
traMADol 50 mg tablet Take 1 tablet(s) every 6 hours by oral route as needed.	04/13/18	prescribed

MCLEOD, STARA (id #286433, dob: [redacted])

Vimovo 500 mg-20 mg **tablet,immediate and delay release** 04/13/18 prescribed
Take 1 tablet(s) twice a day by oral route.

Problems

Reviewed Problems
No known problems

Family History

Reviewed Family History

Social History

Reviewed Social History
Smoking Status: Never smoker

Surgical History

Reviewed Surgical History
Patient indicated no previous surgeries on (07/19/2018)

GYN History

(not configured)

Obstetric History

Obstetric History not reviewed (last reviewed 02/23/2017)

Past Medical History

Reviewed Past Medical History
No Past Medical Problems Reported: **Y**

Documents for Discussion

N/A

Screening

None recorded.

HPI

This is a 40-year-old female **who presents to clinic for recheck. She was referred for an SI joint injection at her last visit, but this only worsened her pain. She did physical therapy in 04/2018 without any improvement.**

ROS

Patient reports **muscle aches, arthralgias/joint pain, back pain, and restricted ROM**but reports no swelling in the extremities. She reports **numbness and tingling** but reports no loss of consciousness, no seizures, no dizziness, no migraines, no headaches, and no restless legs. She reports no fever, no night sweats, no significant weight gain, no significant weight loss, and no exercise intolerance. She reports no chest pain, no arm pain on exertion, no shortness of breath, no lightheadedness, no palpitations, and no known heart murmur. She reports no cough, no wheezing, no shortness of breath, no coughing up blood, and no sleep apnea. She reports no abdominal pain, no vomiting, no reflux, no loss of bowel control, and no indigestion. She reports no abnormal mole, no jaundice, no rashes, no skin ulcers, no dry skin, no growths/lesions, no itching, no hives, and no shingles. She reports no swollen glands, no bruising, and no excessive bleeding.
ROS as noted in the HPI

Physical Exam

Patient is a 40-year-old female.

Constitutional: General Appearance: healthy-appearing, NAD, and normal body habitus.

Psychiatric: Orientation: oriented to time, place, and person. Mood and Affect: normal mood and affect and active and alert.

Gait and Station: Appearance: normal gait, no limp, ambulating with no assistive devices, and pelvis normal.

Cardiovascular System: Arterial Pulses Right: posterior tibialis normal and dorsalis pedis normal. Arterial Pulses Left: posterior tibialis normal and dorsalis pedis normal. Edema Right: none. Edema Left: none. Varicosities Right: no varicosities and capillary refill test normal. Varicosities Left: no varicosities and capillary refill test normal.

Lymph Nodes: Inspection/Palpation Right: no inguinal LAD. Inspection/Palpation Left: no inguinal LAD.

Skin: Lumbosacral Spine: **scar (well-healed surgical scar, lumbar spine).**

Lumbar Spine: Inspection: normal alignment and no ecchymosis. Bony Palpation of the Lumbar Spine: no tenderness of the spinous process or the sacrum and no step-off. Bony Palpation of the Right Hip: no tenderness of the sciatic notch, the SI joint, or the greater trochanter. Bony Palpation of the Left Hip: no tenderness of the sciatic notch, the SI joint, or the greater trochanter. Soft Tissue Palpation on the Right: no tenderness of the gluteus maximus and **[illegible]erness of the paraspinal region at L 5** Soft Tissue

MCLEOD, STARA (id #286433, dob: [redacted])

Palpation on the Left: no tenderness of the gl[redacted] and **tenderness of the paraspinal region at L 5.** Active Range of Motion: **flexion painful (mild), extension painful (mild), and pain with motion.**

Motor Strength: L1 Motor Strength on the Right: hip flexion iliopsoas 5/5. L1 Motor Strength on the Left: hip flexion iliopsoas 5/5. L2-L4 Motor Strength on the Right: knee extension quadriceps 5/5. L2-L4 Motor Strength on the Left: knee extension quadriceps 5/5. L5 Motor Strength on the Right: ankle dorsiflexion tibialis anterior 5/5 and great toe extension extensor hallucis longus 5/5. L5 Motor Strength on the Left: ankle dorsiflexion tibialis anterior 5/5 and great toe extension extensor hallucis longus 5/5. S1 Motor Strength on the Right: plantar flexion gastrocnemius 5/5. S1 Motor Strength on the Left: plantar flexion gastrocnemius 5/5.

Neurological System: Babinski Reflex Right: plantar reflex absent, Rhomberg's test negative, and tandem gait normal. Babinski Reflex Left: plantar reflex absent, Rhomberg's test negative, and tandem gait normal. Special Tests: Valsalva's test negative and clonus negative. Ankle Reflex Right: normal (2). Ankle Reflex Left: normal (2). Knee Reflex Right: normal (2). Knee Reflex Left: normal (2). Sensation on the Right: T12 normal, L1 normal, L2 normal, L3 normal, L4 normal, L5 normal, S1 normal, S2 normal, and normal distal extremities. Sensation on the Left: T12 normal, L1 normal, L2 normal, L3 normal, L4 normal, L5 normal, S1 normal, S2 normal, and normal distal extremities. Special Tests on the Right: femoral nerve traction test negative, supine straight leg raising test negative, and seated straight leg raising test negative. Special Tests on the Left: femoral nerve traction test negative, supine straight leg raising test negative, and seated straight leg raising test negative.

Assessment / Plan

The patient has had a prior microdiscectomy. Per her MRI, her disc herniation is gone, but she has significant discogenic collapse with modic changes at L5-S1, which is somewhat in line with her primary complaints of back pain and the leg pain is definitely a secondary issue. I discussed with her the possibility that she may end up with an ALIF at L5-S1, which would be my surgical recommendation, but she would like to avoid that. It sounds as though Dr. Warrick has injected her and said he would inject her a second time, but that is all he has to offer, which is not the comprehensive pain management I was hoping for. I will get her in to see Dr. Koranloo to see what other ideas he has to try to improve her without another surgical procedure.

Attestation:
I, Kayla Andersen, am transcribing this note for Paul deHoll, MD.

1. Spinal stenosis of lumbar region
M48.061: Spinal stenosis, lumbar region without neurogenic claudication
- LUMBAR SPINAL STENOSIS: CARE INSTRUCTIONS

Return to Office
None recorded.

Encounter Sign-Off
Encounter signed-off by Paul Douglas DeHoll, MD, 07/21/2018.

Encounter performed by Paul Douglas DeHoll, MD
Encounter scribed for Paul Douglas DeHoll, MD by Kayla Andersen
Encounter signed by Kayla Andersen as scribe at 07/19/2018 at 7:47pm
Encounter reviewed & signed by Paul Douglas DeHoll, MD on 07/21/2018 at 10:35am
Encounter Date: 05/03/2018

Patient

Name	MCLEOD, STARA (40yo, F) ID# 286433	**Appt. Date/Time**	05/03/2018 01:50PM
DOB	[redacted]	**Service Dept.**	101 Business Park NE
Provider	PAUL DOUGLAS DEHOLL, MD		
Insurance	Med Primary: UNITED HEALTHCARE Insurance # : 943460441 Policy/Group # : 714081 Med Secondary: CHAMPVA (CHAMPVA) Insurance # : [redacted] Prescription: ESI1 - Member is eligible. details Prescription: OPTUMCOM - Member is eligible. details		

Chief Complaint
MRI Followup

Patient's Care Team
Referring Provider: TODD WARRICK: 115 N SUMTER ST, SUMTER, SC 29150, Ph (803) 774-6824, Fax (803) 774-8977 NPI: 1952472953

Patient's Pharmacies
WALMART NEIGHBORHOOD MARKET 5383 (ERX): 615 BULTMAN DR, SUMTER SC 29150, Ph (803) 305-6194, Fax (803) 305-6197

Vitals
05/03/2018 02:03 pm

MCLEOD, STARA (id #286433, dob: [redacted])

Encounter Date: 08/07/2018

Patient

Name	MCLEOD, STARA (40yo, F) ID# 286433	**Appt. Date/Time**	08/07/2018 01:30PM
DOB	[redacted]	**Service Dept.**	101 Business Park NE
Provider	KAMRAN ZARGHAM-KORANLOO, MD		
Insurance	Med Primary: UNITED HEALTHCARE Insurance # : 943460441 Policy/Group # : 714081 Med Secondary: [redacted]MPVA) Insurance # [redacted] Prescription: OPTUMCOM - Member is eligible. details		

Chief Complaint

None recorded.

Patient's Care Team

Referring Provider: TODD WARRICK: 115 N SUMTER ST, SUMTER, SC 29150, Ph (803) 774-6824, Fax (803) 774-8977 NPI: 1952472953

Patient's Pharmacies

WALMART NEIGHBORHOOD MARKET 5383 (ERX): 615 BULTMAN DR, SUMTER SC 29150, Ph (803) 305-6194, Fax (803) 305-6197

Vitals

Ht:	5 ft 6 in 08/07/2018 01:11 pm	**Wt:**	162.6 lbs 08/07/2018 01:12 pm	**BMI:**	26.2 08/07/2018 01:12 pm
BP:	119/79 sitting 08/07/2018 01:13 pm	**Pain Scale:**	7 08/07/2018 01:12 pm	**Pain Scale Type:**	Numeric 08/07/2018 01:12 pm

Allergies

Reviewed Allergies

NKDA

Medications

Reviewed Medications

ARIPiprazole 10 mg tablet	07/31/18	filled
clindamycin HCl 300 mg capsule 1 tab po daily	05/09/18	filled
cyclobenzaprine 10 mg tablet Take 1 tablet(s) 3 times a day by oral route as needed.	02/10/17	filled
desvenlafaxine succinate ER 50 mg tablet,extended release 24 hr Take 1 tablet(s) as needed by oral route for 30 days.	07/31/18	filled
gabapentin 300 mg capsule	07/31/18	filled
Humira 40 mg/0.8 mL subcutaneous syringe kit as directed	02/21/18	filled
tiZANidine 4 mg capsule Take 1 capsule(s) every day by oral route at bedtime.	04/13/18	filled
tobramycin 0.3 %-dexamethasone 0.1 % eye drops,suspension	05/07/18	filled
traMADol 50 mg tablet Take 1 tablet(s) every 6 hours by oral route as needed.	04/13/18	prescribed
Vimovo 500 mg-20 mg tablet,immediate and delay release	04/13/18	prescribed

MCLEOD, STARA (id #286433, dob: [redacted])

Take 1 tablet(s) twice a day by oral route.

Problems

Reviewed Problems
No known problems

Family History

Reviewed Family History

Social History

Reviewed Social History
Smoking Status: Never smoker

Surgical History

Reviewed Surgical History
Patient indicated no previous surgeries on (07/19/2018)

GYN History

(not configured)

Obstetric History

Obstetric History not reviewed (last reviewed 02/23/2017)

Past Medical History

Reviewed Past Medical History
No Past Medical Problems Reported: Y

Documents for Discussion

N/A

Screening

None recorded.

HPI

Patient is a pleasant 40-year-old lady kindly referred by Dr. de Holl for evaluation and management of her left-sided lumbar radiculopathy. Her low back pain started gradually in 2016 radiating down the left leg. She underwent L5-S1 microdiscectomy in December 2016 and did very well after surgery. In April of this year, after she emptied several buckets of water she felt a sudden severe left-sided low back pain radiating down the left posterior leg all the way down to the bottom of the foot. She felt warm and burning sensation for the first time. Pain radiates all the toes except for the first one. She has numbness and tingling. She has weakness in the left leg and stumbles all the time. She received LESI in May but she reports that increased her pain intensity. She has noticed some urinary dysfunction since the beginning of recent episode of radiculopathy. Her pain is constant and is worse with standing and walking. Sneezing and coughing severely increases the pain. Pain disrupts her sleep at night. She takes gabapentin 300 mg daily at bedtime, OTC NSAIDs and muscle relaxants.

ROS

Patient reports **muscle aches, muscle weakness, and back pain** but reports no arthralgias/joint pain, no swelling in the extremities, and normal ROM; **pain in the left leg.** She reports **numbness and tingling** but reports no loss of consciousness, no weakness, no seizures, no dizziness, no migraines, no headaches, and no restless legs; **left foot/toes and calf.**
ROS as noted in the HPI

Physical Exam

Patient is a 40-year-old female.

She is in no apparent distress. Peripheral pulses are 2+ and present. On neurological exam: Affect is normal. Gait is antalgic. There is neurogenic claudication. She is unable to stand on the left leg with stability. Standing on the left heel is unsteady. Motor is 4/5 in all muscle groups in the left and 5/5 in all muscle groups in the right leg. There is decreased dorsiflexion of the left ankle. Sensory is grossly intact to light touch. DTRs are 2+ and present symmetrically. On lumbar spine examination there is no gross abnormalities. Flexion is 60°. Extension is 10°. There is tenderness in the left paravertebral area in the lumbosacral region. SLR is positive at 20° on the left.

Lumbar spine MRI dated 05/03/2018 without contrast shows mild posterior bulging disks at L5-S1 otherwise unremarkable.

Assessment / Plan

Recurrence of left-sided lumbar radiculopathy with weakness. My recommendation is to:

1. Refer patient for EMG/NCV of the left lower extremity to determine the site and extent of nerve root injury

MCLEOD, STARA (id #286433, dob: [redacted])

2.try left L5-S1 transforaminal ESI to help relieve the pain

Patient is agreeable with the plan and I will see her tomorrow for her injection. We also discussed possibility of L5-S1 fusion if she does not benefit from injection.

1. Lumbar radiculopathy

M54.16: Radiculopathy, lumbar region

- EPIDURAL STEROID INJECTION, LUMBAR TRANSFORAMINAL (PROC) - Note to Provider: Scheduled 8/8/18 w/ KZK

  Location: L5-S1 Side: LEFT

- NERVE CONDUCTION STUDY/EMG, LOWER EXTREMITY (PROC) - Note to Provider: Left lower extremity EMG/NCS

Return to Office

- Kamran Zargham-Koranloo, MD for ESI-15 at 101 Business Park NE on 08/08/2018 at 02:30 PM

Encounter Sign-Off

Encounter signed-off by Kamran Zargham-Koranloo, MD, 08/07/2018.

Encounter performed and documented by Kamran Zargham-Koranloo, MD
Encounter reviewed & signed by Kamran Zargham-Koranloo, MD on 08/07/2018 at 2:23pm

Encounter Date: 07/19/2018

Patient

Name	MCLEOD, STARA (40yo, F) ID# 286433	**Appt. Date/Time**	07/19/2018 02:00PM
DOB	[redacted]	**Service Dept.**	101 Business Park NE
Provider	PAUL DOUGLAS DEHOLL, MD		
Insurance	Med Primary: UNITED HEALTHCARE Insurance # : 943460441 Policy/Group # : 714081 Med Secondary: CHAMPVA (CHAMPVA) Insurance # : [redacted] Prescription: OPTUMCOM - Member is eligible. details		

Chief Complaint

Lumbar spine problem

Patient's Care Team

Referring Provider: TODD WARRICK: 115 N SUMTER ST, SUMTER, SC 29150, Ph (803) 774-6824, Fax (803) 774-8977 NPI: 1952472953

Patient's Pharmacies

WALMART NEIGHBORHOOD MARKET 5383 (ERX): 615 BULTMAN DR, SUMTER SC 29150, Ph (803) 305-6194, Fax (803) 305-6197

Vitals

Ht:	5 ft 8 in 07/19/2018 02:11 pm	**Wt:**	140 lbs 07/19/2018 02:11 pm	**BMI:**	22.6 07/19/2018 02:11 pm
BP:	120/80 07/19/2018 02:12 pm				

Allergies

Reviewed Allergies
NKDA

Medications

Reviewed Medications

clindamycin HCl 300 mg capsule 1 tab po daily	05/09/18	filled
cyclobenzaprine 10 mg tablet Take 1 tablet(s) 3 times a day by oral route as needed.	02/10/17	filled
desvenlafaxine succinate ER 50 mg tablet,extended release 24 hr Take 1 tablet(s) as needed by oral route for 30 days.	06/18/18	filled

MCLEOD, STARA (id #286433, dob: [redacted])

Humira 40 mg/0.8 mL subcutaneous syringe kit as directed	02/21/18	filled
predniSONE 20 mg tablet 1 tab po daily	05/09/18	filled
tiZANidine 4 mg capsule Take 1 capsule(s) every day by oral route at bedtime.	04/13/18	filled
tobramycin 0.3 %-dexamethasone 0.1 % eye drops,suspension	05/07/18	filled
traMADol 50 mg tablet Take 1 tablet(s) every 6 hours by oral route as needed.	04/13/18	prescribed
Vimovo 500 mg-20 mg tablet,immediate and delay release Take 1 tablet(s) twice a day by oral route.	04/13/18	prescribed

Problems

Reviewed Problems
No known problems

Family History

Reviewed Family History

Social History

Reviewed Social History
Smoking Status: Never smoker

Surgical History

Reviewed Surgical History
Patient indicated no previous surgeries on (07/19/2018)

GYN History

(not configured)

Obstetric History

Obstetric History not reviewed (last reviewed 02/23/2017)

Past Medical History

Reviewed Past Medical History
No Past Medical Problems Reported: Y

Documents for Discussion

N/A

Screening

None recorded.

HPI

This is a 40-year-old female who presents to clinic for recheck. She was referred for an SI joint injection at her last visit, but this only worsened her pain. She did physical therapy in 04/2018 without any improvement.

ROS

Patient reports **muscle aches, arthralgias/joint pain, back pain, and restricted ROM**but reports no swelling in the extremities. She reports **numbness and tingling** but reports no loss of consciousness, no seizures, no dizziness, no migraines, no headaches, and no restless legs. She reports no fever, no night sweats, no significant weight gain, no significant weight loss, and no exercise intolerance. She reports no chest pain, no arm pain on exertion, no shortness of breath, no lightheadedness, no palpitations, and no known heart murmur. She reports no cough, no wheezing, no shortness of breath, no coughing up blood, and no sleep apnea. She reports no abdominal pain, no vomiting, no reflux, no loss of bowel control, and no indigestion. She reports no abnormal mole, no jaundice, no rashes, no skin ulcers, no dry skin, no growths/lesions, no itching, no hives, and no shingles. She reports no swollen glands, no bruising, and no excessive bleeding.
ROS as noted in the HPI

Physical Exam

MCLEOD, STARA (id #286433, dob: [redacted])

Patient is a 40-year-old female.

Constitutional: General Appearance: healthy-appearing, NAD, and normal body habitus.

Psychiatric: Orientation: oriented to time, place, and person. Mood and Affect: normal mood and affect and active and alert.

Gait and Station: Appearance: normal gait, no limp, ambulating with no assistive devices, and pelvis normal.

Cardiovascular System: Arterial Pulses Right: posterior tibialis normal and dorsalis pedis normal. Arterial Pulses Left: posterior tibialis normal and dorsalis pedis normal. Edema Right: none. Edema Left: none. Varicosities Right: no varicosities and capillary refill test normal. Varicosities Left: no varicosities and capillary refill test normal.

Lymph Nodes: Inspection/Palpation Right: no inguinal LAD. Inspection/Palpation Left: no inguinal LAD.

Skin: Lumbosacral Spine: **scar (well-healed surgical scar, lumbar spine).**

Lumbar Spine: Inspection: normal alignment and no ecchymosis. Bony Palpation of the Lumbar Spine: no tenderness of the spinous process or the sacrum and no step-off. Bony Palpation of the Right Hip: no tenderness of the sciatic notch, the SI joint, or the greater trochanter. Bony Palpation of the Left Hip: no tenderness of the sciatic notch, the SI joint, or the greater trochanter. Soft Tissue Palpation on the Right: no tenderness of the gluteus maximus and **tenderness of the paraspinal region at L 5.** Soft Tissue Palpation on the Left: no tenderness of the gluteus maximus and **tenderness of the paraspinal region at L 5.** Active Range of Motion: **flexion painful (mild), extension painful (mild),** and **pain with motion.**

Motor Strength: L1 Motor Strength on the Right: hip flexion iliopsoas 5/5. L1 Motor Strength on the Left: hip flexion iliopsoas 5/5. L2-L4 Motor Strength on the Right: knee extension quadriceps 5/5. L2-L4 Motor Strength on the Left: knee extension quadriceps 5/5. L5 Motor Strength on the Right: ankle dorsiflexion tibialis anterior 5/5 and great toe extension extensor hallucis longus 5/5. L5 Motor Strength on the Left: ankle dorsiflexion tibialis anterior 5/5 and great toe extension extensor hallucis longus 5/5. S1 Motor Strength on the Right: plantar flexion gastrocnemius 5/5. S1 Motor Strength on the Left: plantar flexion gastrocnemius 5/5.

Neurological System: Babinski Reflex Right: plantar reflex absent, Rhomberg's test negative, and tandem gait normal. Babinski Reflex Left: plantar reflex absent, Rhomberg's test negative, and tandem gait normal. Special Tests: Valsalva's test negative and clonus negative. Ankle Reflex Right: normal (2). Ankle Reflex Left: normal (2). Knee Reflex Right: normal (2). Knee Reflex Left: normal (2). Sensation on the Right: T12 normal, L1 normal, L2 normal, L3 normal, L4 normal, L5 normal, S1 normal, S2 normal, and normal distal extremities. Sensation on the Left: T12 normal, L1 normal, L2 normal, L3 normal, L4 normal, L5 normal, S1 normal, S2 normal, and normal distal extremities. Special Tests on the Right: femoral nerve traction test negative, supine straight leg raising test negative, and seated straight leg raising test negative. Special Tests on the Left: femoral nerve traction test negative, supine straight leg raising test negative, and seated straight leg raising test negative.

Assessment / Plan

The patient has had a prior microdiscectomy. Per her MRI, her disc herniation is gone, but she has significant discogenic collapse with modic changes at L5-S1, which is somewhat in line with her primary complaints of back pain and the leg pain is definitely a secondary issue. I discussed with her the possibility that she may end up with an ALIF at L5-S1, which would be my surgical recommendation, but she would like to avoid that. It sounds as though Dr. Warrick has injected her and said he would inject her a second time, but that is all he has to offer, which is not the comprehensive pain management I was hoping for. I will get her in to see Dr. Koranloo to see what other ideas he has to try to improve her without another surgical procedure.

Attestation:
I, Kayla Andersen, am transcribing this note for Paul deHoll, MD.

1. **Spinal stenosis of lumbar region**
   M48.061: Spinal stenosis, lumbar region without neurogenic claudication
   - LUMBAR SPINAL STENOSIS: CARE INSTRUCTIONS

Return to Office

None recorded.

Encounter Sign-Off

Encounter signed-off by Paul Douglas DeHoll, MD, 07/21/2018.

Encounter performed by Paul Douglas DeHoll, MD
Encounter scribed for Paul Douglas DeHoll, MD by Kayla Andersen
Encounter signed by Kayla Andersen as scribe at 07/19/2018 at 7:47pm
Encounter reviewed & signed by Paul Douglas DeHoll, MD on 07/21/2018 at 10:35am

Encounter Date: 05/03/2018

Patient

Name	MCLEOD, STARA (40yo, F) ID# 286433	**Appt. Date/Time**	05/03/2018 01:50PM
DOB	[redacted]	**Service Dept**	101 Business Park NE
Provider	PAUL DOUGLAS DEHOLL, MD		
Insurance	Med Primary: UNITED HEALTHCARE		

MCLEOD, STARA (Id #286433, dob: [redacted])

Surgery Order

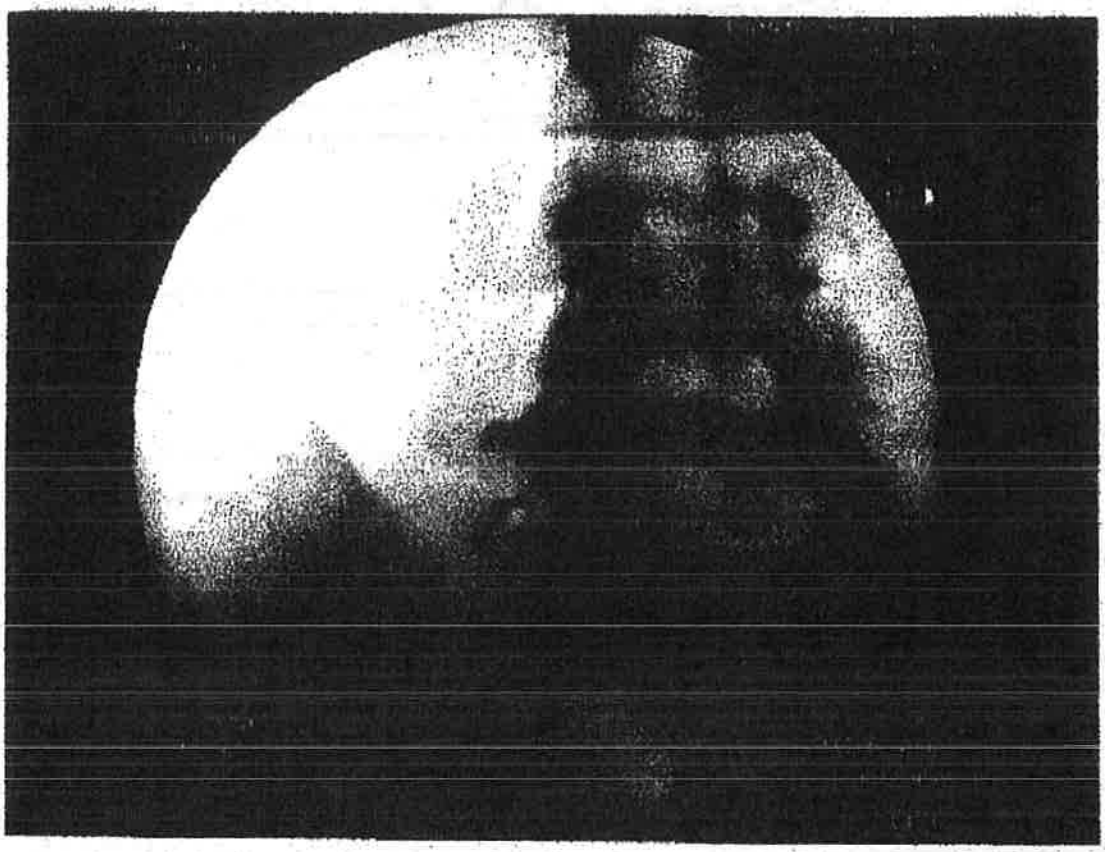
08/07/2018

From Provider	To Provider
Ordering Provider: KAMRAN ZARGHAM-KORANLOO, MD Palmetto Health USC Orthopedic Center 14 Richland Medical Park COLUMBIA, SC 29203-6882 Phone: (803) 296-7846 Fax: (803) 296-9699	

Patient	NAME: MCLEOD, STARA PATIENT ID: 286433 PATIENT SSN: [redacted] Gender: F DOB: [redacted] AGE: 40yo
Address	[redacted]
Phone	H: [redacted] W: M:
Primary Ins.	United Healthcare ID: 943480441 Group: 714081 Policy Holder: JOHNSON, ANDRE G Claim Case#: Case Injury Date: Case Worker's Name:
Secondary Ins.	CHAMPVA (CHAMPVA) ID: [redacted] Policy Holder: MCLEOD-JOHNSON, STARA B
Diagnosis	Lumber radiculopathy ICD-10: M54.16: Radiculopathy, lumbar region
Order Name	Orders included: 1 Lumbar radiculopathy ICD-10: M54.16: Radiculopathy, lumbar region • NERVE CONDUCTION STUDY/EMG, LOWER EXTREMITY (PROC) Note to Provider: Left lower extremity EMG/NCS - prior lumbar discectomy

Electronically Signed by: KAMRAN ZARGHAM-KORANLOO, MD

ON: 08/07/2018 03:30 PM



MCLEOD, STARA (id #286433, dob: [redacted])

ELECTROMYOGRAM + NERVE CONDUCTION STUDY

(#6147438, 08/16/2018 12:00am)

F. 296-9699

Devin Troyer MD
2935 Colonial Dr.
Columbia, SC 29203

RGS

Test Date: 8/16/2018

Patient:	Stara McLeod	**DOB:**	[redacted]	**Physician:**	Troyer
Sex:	Female	**Height:**	cm	**Ref Phys:**	Koranloo
ID#:		**Weight:**	lbs.	**Technician:**	

Patient Complaints:
Patient is a 40-year-old female who presents with back pain and numbness, tingling, weakness, and pain in the left lower extremity. She had a discectomy at L4 in 2016 with improvements. The symptoms have been present for several months since April.

Nerve Conduction Studies

Anti Sensory Summary Table

Site Site	NR	Peak (ms)	Norm Peak (ms)	P-T Amp (µV)	Norm P-T Amp	Site1	Site2	Delta-P (ms)	Dist (cm)	Vel (m/s)	Norm Vel (m/s)
Left Sup Fibular Anti Sensory (Ant Lat Mall)											
ant. tib	3.4	<3.8		18.7	>5.0	ant. tib	Ant Lat Mall	3.4	12.0	35	>32
Left Sural Anti Sensory (Lat Mall)											
Calf	3.1	<3.8		13.0	>5.0	Calf	Lat Mall	3.1	12.0	39	>35

Motor Summary Table

Site Site	NR	Onset (ms)	Norm Onset (ms)	O-P Amp (mV)	Norm O-P Amp	Site1	Site2	Delta-0 (ms)	Dist (cm)	Vel (m/s)	Norm Vel (m/s)
Left Fibular Motor (Ext Dig Brev)											
Ankle	3.7	<6.1		5.7	>2.5	B Fib	Ankle	7.2	37.0	51	>38
B Fib	10.9			5.3							
Left Tibial Motor (Abd Hall Brev)											
Ankle	4.5	<6.1		8.7	>3.0						

Mixed Summary Table

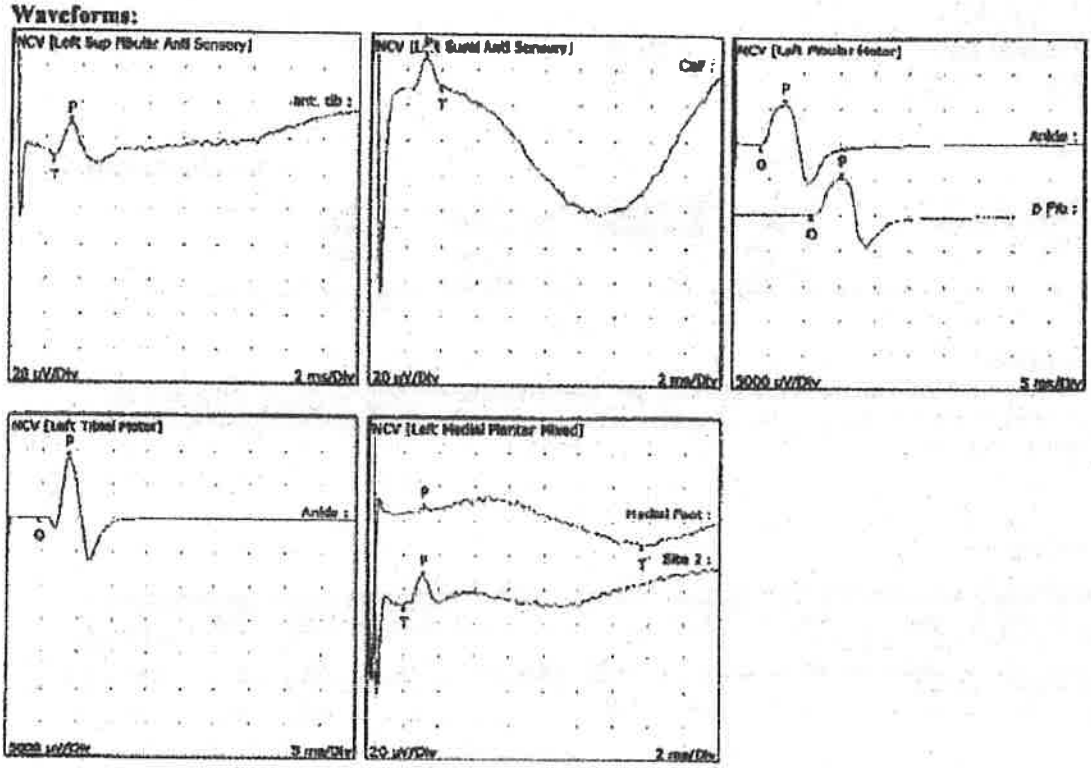
Site Site	NR	Peak (ms)	Norm Peak (ms)	P-T Amp (µV)	Norm P-T Amp	Site1	Site2	Delta-P (ms)	Dist (cm)	Vel (m/s)	Norm Vel (m/s)
Left Medial Plantar Mixed (Med Malleolus)											
Medial Foot	3.1	<3.7		20.8	>10						
Site 2	3.1			17.7							

EMG

Side	Muscle	Nerve	Root	MotAmp	Fibs	Recrt	Amp	Durat	Poly	Recrt	IntPat	Comments
Left	AntTibialis	Dp Br Fibular	L4-5	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	
Left	Gastroc	Tibial	S1-2	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	
Left	Fibularis Long	Sup Br Fibular	L5-S1	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	
Left	VastusMed	Femoral	L2-4	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	
Left	FDI	Med Plantar	S1-2	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	

Patient: McLeod, Stara **Test Date: 8/16/2018** **Page 2**

Waveforms:



Patient History / Exam:
Past medical history is not significant. Manual muscle testing revealed 5/5 in bilateral lower extremities except for 4/5 in the left ankle dorsiflexors and EHL and toe flexors. Muscle stretch reflexes revealed 2+ in bilateral quadriceps and in the right gastroc-soleus and 0 in the left gastroc.

Impression:
This is a normal electrical study. There is no evidence of peripheral nerve entrapment. There is no evidence of peripheral polyneuropathy EMG reveals no evidence of radiculopathy or myopathy.

Her physical exam is certainly suspicious for radiculopathy with absent ankle reflex and distal weakness but no electrical changes were seen on EMG today.

Recommendations:
1. Follow-up with referring physician.
2. Continue current management of symptoms.
3. Today's results were discussed with the patient.

Devin Troyer MD.

MCLEOD, STARA (id #286433, dob: [redacted])

Encounters and Procedures

Clinical Encounter Summaries
Encounter Date: 08/22/2018

Patient

Name	MCLEOD, STARA (40yo, F) ID# 286433	**Appt. Date/Time**	08/22/2018 11:00AM
DOB	[redacted]	**Service Dept.**	101 Business Park NE
Provider	KAMRAN ZARGHAM-KORANLOO, MD		
Insurance	Med Primary: UNITED HEALTHCARE Insurance # : 943460441 Policy/Group # : 714081 Med Secondary: CHAMPVA (CHAMPVA) Insurance # : [redacted] Prescription: OPTUMCOM - Member is eligible. details		

Chief Complaint

Injection Followup

Patient's Care Team

Referring Provider: TODD WARRICK: 115 N SUMTER ST, SUMTER, SC 29150, Ph (803) 774-6824, Fax (803) 774-8977 NPI: 1952472953
Primary Care Provider: SUMTER FAMILY HEALTH CENTER (OFFICE): 1278 N LAFAYETTE DR, SUMTER, SC 29150-2984, Ph (803) 774-4500, Fax (803) 774-4627 NPI: 1386630192

Patient's Pharmacies

WALMART NEIGHBORHOOD MARKET 5383 (ERX): 615 BULTMAN DR, SUMTER SC 29150, Ph (803) 305-6194, Fax (803) 305-6197

Vitals

Ht:	5 ft 6 in 08/22/2018 11:02 am	**Wt:**	162 lbs 08/22/2018 11:03 am	**BMI:**	26.1 08/22/2018 11:03 am
BP:	124/87 sitting 08/22/2018 11:04 am	**Pain Scale:**	6 08/22/2018 11:04 am	**Pain Scale Type:**	Numeric 08/22/2018 11:04 am

Allergies

Reviewed Allergies
NKDA

Medications

Reviewed Medications

clindamycin HCl 300 mg capsule 1 tab po daily pm	05/09/18	filled
cyclobenzaprine 10 mg tablet Take 1 tablet(s) 3 times a day by oral route as needed.	02/10/17	filled
gabapentin 300 mg capsule	07/31/18	filled
tiZANidine 4 mg capsule Take 1 capsule(s) every day by oral route at bedtime.	04/13/18	filled
traMADol 50 mg tablet Take 1 tablet(s) every 6 hours by oral route as needed.	04/13/18	prescribed
Vimovo 500 mg-20 mg tablet,immediate and delay release Take 1 tablet(s) twice a day by oral route.	04/13/18	prescribed

Problems

Reviewed Problems
No known problems

Family History

MCLEOD, STARA (id #286433, dob: [redacted])

Reviewed Family History

Social History

Reviewed Social History
Smoking Status: Never smoker

Surgical History

Reviewed Surgical History
Patient Indicated no previous surgeries on (07/19/2018)

GYN History

(not configured)

Obstetric History

Obstetric History not reviewed (last reviewed 02/23/2017)

Past Medical History

Reviewed Past Medical History
No Past Medical Problems Reported: Y

Documents for Discussion

N/A

Screening

None recorded.

HPI

Patient is here for follow-up after left L5-S1 transforaminal ESI 2 weeks ago. She reports that compared to how she felt before the injection she is experiencing 2 or 3 good days in a week. She continues feeling abnormal in the left leg especially with walking.

EMG/NCV does not reveal any chronic nerve root injury.

ROS

Patient reports **muscle aches, muscle weakness, arthralgias/joint pain, and back pain** She reports **numbness and tingling**
Additionally reports: Reports no side effects or complications from the injection.

Physical Exam

Patient is a 40-year-old female.

Affect is normal. Gait is antalgic. Dorsiflexion of the left leg seems to have improved since the initial evaluation. Motor is 4/5 in all muscle groups in the left leg.

Assessment / Plan

Status post L5-S1 discectomy now with recurrence of symptomatology since overexertion injury in April. Minimal response to injections. I had a thorough discussion with the patient with regard to the best next course of action. She will follow-up with Dr. de Holl with regard to discussing fusion. I will be available to Dr. de Holl and the patient if I can be of any further assistance.

Return to Office

None recorded.

Encounter Sign-Off

Encounter signed-off by Kamran Zargham-Koranloo, MD, 08/22/2018.

Encounter performed and documented by Kamran Zargham-Koranloo, MD
Encounter reviewed & signed by Kamran Zargham-Koranloo, MD on 08/22/2018 at 12:36pm

Encounter Date: 08/08/2018

Patient

Name	MCLEOD, STARA (40yo, F) ID# 286433	**Appt. Date/Time**	08/08/2018 02:30PM
DOB	[redacted]	**Service Dept.**	101 Business Park NE
Provider	KAMRAN ZARGHAM-KORANLOO, MD		
Insurance	Med Primary: UNITED HEALTHCARE Insurance # : 943460441 Policy/Group # : 714081 Med Secondary: CHAMPVA (CHAMPVA) Insurance # : [redacted] Prescription: OPTUMCOM - Member is eligible. details		

MCLEOD, STARA (id #286433, dob: [redacted])

Chief Complaint

Injection

Patient's Care Team

Referring Provider: TODD WARRICK: 115 N SUMTER ST, SUMTER, SC 29150, Ph (803) 774-6824, Fax (803) 774-8977 NPI: 1952472953

Patient's Pharmacies

WALMART NEIGHBORHOOD MARKET 5383 (ERX): 615 BULTMAN DR, SUMTER SC 29150, Ph (803) 305-6194, Fax (803) 305-6197

Vitals

08/08/2018 02:29 pm

Ht: 5 ft 6 in **Wt:** 162.6 lbs **BMI:** 26.2

Pain Scale: 5

Allergies

Reviewed Allergies
NKDA

Medications

Reviewed Medications

ARIPiprazole 10 mg tablet	07/31/18	filled
clindamycin HCl 300 mg capsule 1 tab po daily	05/09/18	filled
cyclobenzaprine 10 mg tablet Take 1 tablet(s) 3 times a day by oral route as needed.	02/10/17	filled
desvenlafaxine succinate ER 50 mg tablet,extended release 24 hr Take 1 tablet(s) as needed by oral route for 30 days.	07/31/18	filled
gabapentin 300 mg capsule	07/31/18	filled
Humira 40 mg/0.8 mL subcutaneous syringe kit as directed	02/21/18	filled
tiZANidine 4 mg capsule Take 1 capsule(s) every day by oral route at bedtime.	04/13/18	filled
tobramycin 0.3 %-dexamethasone 0.1 % eye drops,suspension	05/07/18	filled
traMADol 50 mg tablet Take 1 tablet(s) every 6 hours by oral route as needed.	04/13/18	prescribed
Vimovo 500 mg-20 mg tablet,immediate and delay release Take 1 tablet(s) twice a day by oral route.	04/13/18	prescribed

Problems

Reviewed Problems
No known problems

Family History

Reviewed Family History

Social History

Reviewed Social History
Smoking Status: Never smoker

Surgical History

MCLEOD, STARA (id #286433, dob: [redacted])

Reviewed Surgical History
Patient indicated no previous surgeries on (07/19/2018)

GYN History

(not configured)

Obstetric History

Obstetric History not reviewed (last reviewed 02/23/2017)

Past Medical History

Reviewed Past Medical History
No Past Medical Problems Reported: Y

Documents for Discussion

N/A

Screening

None recorded.

ROS

Patient reports **muscle aches, muscle weakness, back pain, and restricted ROM** but reports no arthralgias/joint pain and no swelling in the extremities. She reports **weakness, numbness, and tingling** but reports no loss of consciousness, no seizures, no dizziness, no migraines, no headaches, and no restless legs. She reports no fever, no night sweats, no significant weight gain, no significant weight loss, and no exercise intolerance. She reports no chest pain, no arm pain on exertion, no shortness of breath, no lightheadedness, no palpitations, and no known heart murmur. She reports no cough, no wheezing, no shortness of breath, no coughing up blood, and no sleep apnea. She reports no abdominal pain, no vomiting, no reflux, no loss of bowel control, and no indigestion. She reports no abnormal mole, no jaundice, no rashes, no skin ulcers, no dry skin, no growths/lesions, no itching, no hives, and no shingles. She reports no swollen glands, no bruising, and no excessive bleeding.

Physical Exam

None recorded.

Procedure Documentation

kzk TF ESI left L5/S1:

Procedure: Transforaminal Epidural Steroid Injection, left L5/S1

Patient returned to our office for his transforaminal epidural steroid injection for the lo back/leg pain. The procedure and its possible risks were explained and informed consent was obtained from the patient. The patient was placed in the prone position on the fluoroscopy table and the correct interspace was identified by the aid of fluoroscopy. Fluoroscope was adjusted to sharpen the endplates. The back of the patient was prepped and draped in sterile fashion. Skin and subcutaneous tissues were anesthetized with local infiltration of 1% lidocaine. A 22g chiba needle was introduced and directed in an oblique angle targeting the 6 o'clock position on the pedicle (junction of transverse process and vertebral body). Mild paresthesia elicited. 1ml contrast was injected after negative aspiration for blood and CSF was noted. A satisfactory epidurogram/nerve root sleeve was appreciated. 60mg of triamcinolone mixed with 1cc of sterile water was slowly injected into the foramen on the left side without difficulty. Patient tolerated the procedure well and was discharged in stable condition with an escort. She will return to our office in two weeks for follow-up. Kamran Koranloo, MD

Assessment / Plan

Lumbar spondylosis. Left-sided radiculopathy. Follow-up in 2 weeks to assess the results of injection.

Return to Office

- Kamran Zargham-Koranloo, MD for RE-CHECK at 101 Business Park NE on 08/22/2018 at 11:00 AM

Encounter Sign-Off

Encounter signed-off by Kamran Zargham-Koranloo, MD, 08/08/2018.

Encounter performed and documented by Kamran Zargham-Koranloo, MD
Encounter reviewed & signed by Kamran Zargham-Koranloo, MD on 08/08/2018 at 2:38pm

MCLEOD, STARA (id #286433, dob: [redacted])

Encounters and Procedures

Clinical Encounter Summaries
Encounter Date: 08/22/2018

Patient

Name	MCLEOD, STARA (40yo, F) ID# 286433	**Appt. Date/Time**	08/22/2018 11:00AM
DOB	[redacted]	**Service Dept.**	101 Business Park NE
Provider	KAMRAN ZARGHAM-KORANLOO, MD		
Insurance	Med Primary: UNITED HEALTHCARE Insurance # : 943460441 Policy/Group # : 714081 Med Secondary: CHAMPVA (CHAMPVA) Insurance # : [redacted] Prescription: OPTUMCOM - Member is eligible. details		

Chief Complaint

Injection Followup

Patient's Care Team

Referring Provider: TODD WARRICK: 115 N SUMTER ST, SUMTER, SC 29150, Ph (803) 774-6924, Fax (803) 774-8977 NPI: 1952472953
Primary Care Provider: SUMTER FAMILY HEALTH CENTER (OFFICE): 1278 N LAFAYETTE DR, SUMTER, SC 29150-2984, Ph (803) 774-4500, Fax (803) 774-4627 NPI: 1386630192

Patient's Pharmacies

WALMART NEIGHBORHOOD MARKET 5383 (ERX): 615 BULTMAN DR, SUMTER SC 29150, Ph (803) 305-6194, Fax (803) 305-6197

Vitals

Ht:	5 ft 6 in 08/22/2018 11:02 am	**Wt:**	162 lbs 08/22/2018 11:03 am	**BMI:**	26.1 08/22/2018 11:03 am
BP:	124/87 sitting 08/22/2018 11:04 am	**Pain Scale:**	6 08/22/2018 11:04 am	**Pain Scale Type:**	Numeric 08/22/2018 11:04 am

Allergies

Reviewed Allergies
NKDA

Medications

Reviewed Medications

clindamycin HCl 300 mg capsule 1 tab po daily pm	05/09/18	filled
cyclobenzaprine 10 mg tablet Take 1 tablet(s) 3 times a day by oral route as needed.	02/10/17	filled
gabapentin 300 mg capsule	07/31/18	filled
tiZANidine 4 mg capsule Take 1 capsule(s) every day by oral route at bedtime.	04/13/18	filled
traMADol 50 mg tablet Take 1 tablet(s) every 6 hours by oral route as needed.	04/13/18	prescribed
Vimovo 500 mg-20 mg tablet,immediate and delay release Take 1 tablet(s) twice a day by oral route.	04/13/18	prescribed

Problems

Reviewed Problems
No known problems

Family History

MCLEOD, STARA (id #286433, dob: [redacted])

Reviewed Family History

Social History

Reviewed Social History
Smoking Status: Never smoker

Surgical History

Reviewed Surgical History
Patient indicated no previous surgeries on (07/19/2018)

GYN History

(not configured)

Obstetric History

Obstetric History not reviewed (last reviewed 02/23/2017)

Past Medical History

Reviewed Past Medical History
No Past Medical Problems Reported: Y

Documents for Discussion

N/A

Screening

None recorded.

HPI

Patient is here for follow-up after left L5-S1 transforaminal ESI 2 weeks ago. She reports that compared to how she felt before the injection she is experiencing 2 or 3 good days in a week. She continues feeling abnormal in the left leg especially with walking.

EMG/NCV does not reveal any chronic nerve root injury.

ROS

Patient reports **muscle aches, muscle weakness, arthralgias/joint pain, and back pain** She reports **numbness and tingling.**
Additionally reports: Reports no side effects or complications from the injection.

Physical Exam

Patient is a 40-year-old female.

Affect is normal. Gait is antalgic. Dorsiflexion of the left leg seems to have improved since the initial evaluation. Motor is 4/5 in all muscle groups in the left leg.

Assessment / Plan

Status post L5-S1 discectomy now with recurrence of symptomatology since overexertion injury in April. Minimal response to injections. I had a thorough discussion with the patient with regard to the best next course of action. She will follow-up with Dr. de Holl with regard to discussing fusion. I will be available to Dr. de Holl and the patient if I can be of any further assistance.

Return to Office

None recorded.

Encounter Sign-Off

Encounter signed-off by Kamran Zargham-Koranloo, MD, 08/22/2018.

Encounter performed and documented by Kamran Zargham-Koranloo, MD
Encounter reviewed & signed by Kamran Zargham-Koranloo, MD on 08/22/2018 at 12:36pm

Encounter Date: 08/08/2018

Patient

Name	MCLEOD, STARA (40yo, F) ID# 286433	**Appt. Date/Time**	08/08/2018 02:30PM
DOB	[redacted]	**Service Dept.**	101 Business Park NE
Provider	KAMRAN ZARGHAM-KORANLOO, MD		
Insurance	Med Primary: UNITED HEALTHCARE Insurance # : 943460441 Policy/Group # : 714081 Med Secondary: CHAMPVA (CHAMPVA) Insurance # : [redacted] Prescription: OPTUMCOM - Member is eligible. details		

MCLEOD, STARA (id #286433, dob: [redacted])

Chief Complaint

Injection

Patient's Care Team

Referring Provider: TODD WARRICK: 115 N SUMTER ST, SUMTER, SC 29150, Ph (803) 774-6824, Fax (803) 774-8977 NPI: 1952472953

Patient's Pharmacies

WALMART NEIGHBORHOOD MARKET 5383 (ERX): 615 BULTMAN DR, SUMTER SC 29150, Ph (803) 305-6194, Fax (803) 305-6197

Vitals

08/08/2018 02:29 pm

Ht: 5 ft 6 in **Wt:** 162.6 lbs **BMI:** 26.2

Pain Scale: 5

Allergies

Reviewed Allergies
NKDA

Medications

Reviewed Medications

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desvenlafaxine succinate ER 50 mg tablet,extended release 24 hr Take 1 tablet(s) as needed by oral route for 30 days.	07/31/18	filled
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Vimovo 500 mg-20 mg tablet,immediate and delay release Take 1 tablet(s) twice a day by oral route.	04/13/18	prescribed

Problems

Reviewed Problems
No known problems

Family History

Reviewed Family History

Social History

Reviewed Social History
Smoking Status: Never smoker

Surgical History

MCLEOD, STARA (id #286433, dob: [redacted]

Reviewed Surgical History
Patient indicated no previous surgeries on (07/19/2018)

GYN History

(not configured)

Obstetric History

Obstetric History not reviewed (last reviewed 02/23/2017)

Past Medical History

Reviewed Past Medical History
No Past Medical Problems Reported: Y

Documents for Discussion

N/A

Screening

None recorded.

ROS

Patient reports **muscle aches, muscle weakness, back pain, and restricted ROM** but reports no arthralgias/joint pain and no swelling in the extremities. She reports **weakness, numbness, and tingling** but reports no loss of consciousness, no seizures, no dizziness, no migraines, no headaches, and no restless legs. She reports no fever, no night sweats, no significant weight gain, no significant weight loss, and no exercise intolerance. She reports no chest pain, no arm pain on exertion, no shortness of breath, no lightheadedness, no palpitations, and no known heart murmur. She reports no cough, no wheezing, no shortness of breath, no coughing up blood, and no sleep apnea. She reports no abdominal pain, no vomiting, no reflux, no loss of bowel control, and no indigestion. She reports no abnormal mole, no jaundice, no rashes, no skin ulcers, no dry skin, no growths/lesions, no itching, no hives, and no shingles. She reports no swollen glands, no bruising, and no excessive bleeding.

Physical Exam

None recorded.

Procedure Documentation

kzk TF ESI left L5/S1:

Procedure: Transforaminal Epidural Steroid Injection, left L5/S1

Patient returned to our office for his transforaminal epidural steroid injection for the lo back/leg pain. The procedure and its possible risks were explained and informed consent was obtained from the patient. The patient was placed in the prone position on the fluoroscopy table and the correct interspace was identified by the aid of fluoroscopy. Fluoroscope was adjusted to sharpen the endplates. The back of the patient was prepped and draped in sterile fashion. Skin and subcutaneous tissues were anesthetized with local infiltration of 1% lidocaine. A 22g chiba needle was introduced and directed in an oblique angle targeting the 6 o'clock position on the pedicle (junction of transverse process and vertebral body). Mild paresthesia elicited. 1ml contrast was injected after negative aspiration for blood and CSF was noted. A satisfactory epidurogram/nerve root sleeve was appreciated. 60mg of triamcinolone mixed with 1cc of sterile water was slowly injected into the foramen on the left side without difficulty. Patient tolerated the procedure well and was discharged in stable condition with an escort. She will return to our office in two weeks for follow-up. Kamran Koranloo, MD

Assessment / Plan

Lumbar spondylosis. Left-sided radiculopathy. Follow-up in 2 weeks to assess the results of injection.

Return to Office

- Kamran Zargham-Koranloo, MD for RE-CHECK at 101 Business Park NE on 08/22/2018 at 11:00 AM

Encounter Sign-Off

Encounter signed-off by Kamran Zargham-Koranloo, MD, 08/08/2018.

Encounter performed and documented by Kamran Zargham-Koranloo, MD
Encounter reviewed & signed by Kamran Zargham-Koranloo, MD on 08/08/2018 at 2:38pm

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500 • Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737-5675
www.wcc.sc.gov

Physician's Statement

Claimant's Name: Stark McLeod
Employer's Name: CW Group Inc CW Resources
Physician's Name: Dr. Paul Douglas DeHoll
Insurance Carrier: PA Manufacturers Assn. Ins. Co.
Practice/Clinic: Palmetto Health USC Orthopedic Center
SCWCC File No: 1805291
Preparer's Name:
Phone:

The undersigned physician has been authorized to evaluate or treat this Claimant for his or her work injury or illness pursuant to *South Carolina Code Sections* 42-15-60, 42-15-80, 42-1-172, or 42-11-10.

Date of Injury: 03/26/2018 Date of first office visit: _____ Date of last office visit: _____

The medical opinions below are stated to a reasonable degree of medical certainty.

No knowledge of a mark

Diagnosis or nature of injury or illness: _____

Body part(s) injured: _____ Body part(s) affected: _____

Date of maximum medical improvement: _____

Has the Claimant sustained permanent physical impairment as a result of the work injury? ____ Yes ____ No related

If so, the permanent physical impairment is: _____ % medical impairment to the _____ (injured body part).

If there is a permanent physical impairment to other body part(s) as a result of the work injury, please indicate below:
_____ % medical impairment to the _____ (additional body part injured or affected).

The impairment rating(s) above are based upon the following:

injury in

_____ The AMA's *Guides to the Evaluation of Permanent Impairment* _____ Edition; or
_____ Other medical treatise: _____ or
_____ Other: _____

Does the Claimant have permanent physical limitations as a result of the injury? ____ Yes ____ No of

If so, the permanent physical limitations are: _____

Does the Claimant possess retained hardware as a result of the injury? ____ Yes ____ No this is it

If so, the retained hardware is: _____

Is there medical, surgical, hospital or other treatment that the Claimant needs as a result of the injury for an additional time that will tend to lessen the period of disability or maintain the current level of function: ____ Yes ____ No

If so, the medical care and treatment that is needed is/are:

*An indication or statement that future medical care "may be necessary" or "might be necessary" is not sufficient and will require further clarification.

I certify that I am a physician or other licensed healthcare provider, I have personally read and prepared this document, and the opinions reflected above are mine.

Treating or Evaluating Physician Date

Surgical Documentation

Pain Evaluation
Primary Pain Location : Leg
Laterality : Left
Quality : Aching, Sharp, Shooting
Primary Pain Time Pattern : Constant
Self Report Pain Tool . Numeric rating scale

Clark RN, Miriam A - 01/26/2017 10:02

Numeric/FACES Pain Scale
Numeric Pain Scale : 7
Numeric Pain Score : 7

Clark RN, Miriam A - 01/26/2017 10:02

Image 1 - Images currently included in the form version of this document have not been included in the text rendition version of the form.

DOCUMENT NAME:	Operative Report
SERVICE DATE/TIME:	2/1/2017 16:50 EST
RESULT STATUS:	Auth (Verified)
PERFORM INFORMATION:	DeHoll MD,Paul Douglas (2/1/2017 16:51 EST)
ELECTRONICALLY SIGNED BY:	DeHoll MD,Paul Douglas (2/1/2017 16:51 EST)

CC: Lumbar disk herniation

Patient: **MCLEOD, STARA S** **MRN: B001000884** **FIN: B1702600781**
Age: 39 years Sex: Female DOB: [redacted]
Associated Diagnoses: **Lumbar disc prolapse with radiculopathy**
Author **DeHoll MD, Paul Douglas**

Procedure
Lumbar microdiscectomy _ - 63030
Utilization and interpretation of intraoperative fluoroscopy for greater than 1 hour- 76001

Postoperative Information
Preoperative Diagnosis: Lumbar disc prolapse with radiculopathy (ICD10-CM M51.16, Discharge, Medical).
Postoperative Diagnosis: Lumbar disc prolapse with radiculopathy (ICD10-CM M51.16, Discharge, Medical).
Performed by. DeHoll MD, Paul Douglas.
Findings disc herniation
Specimens Removed: lumbar disc.
Estimated Blood Loss. minimal.
Complications: None.
Anesthetic utilized: General

Procedure
Procedure
Confirmed: patient, procedure, side, site, safety procedures followed.
Type of procedure: lumbar microdiscectomy

Informed consent: signed by patient.
Indication: patient presents with lumbar disc herniation that has failed conservative treatment. Patient was counseled on the option of surgery. Informed the risks of surgery to include but not limited to the risk of pain,scar, bleeding, infection, intraoperative or postoperative nerve or vascular injury. Failure to alleviate symptoms in spite of a technically successful procedure Recurrent herniation. Need for further surgery Blood clots in the legs and lungs heart attack stroke and death. Patient understood these risks and elects to proceed..

SUMTER
PHYSICAL THERAPY CLINIC
1185 WILSON HALL ROAD • SUMTER, SC 29150
PHONE (803) 469-3213 • FAX (803) 469-3233

PLAN OF CARE

Physical Therapy ✓ Occupational Therapy _____

1. Patient McLeod, Johnson, Stasa (DOB: [redacted]) Date 4.30.18
2. Diagnosis and Date of Onset ~4 wk hx LBP c radiculopathy (L)
3. Functional Limitations Prior to Injury or Onset of Condition L4 discectomy Feb 17
4. Contraindications: Estim Wound Care Precautions THA Precautions Other: neuro
5. Treatment Plan Effective From 4.30.18 To 6.30.18
   Rehab Potential: _____ Poor ___X___ Good _____ Excellent 2° severity of neurological symptoms
6. ST Goals: (1) Independent in home program for back
   (2) Increase strength 1/2 grade in R/(L) UE/LE/Other hip
   (3) Increase ROM to WFL/Other _____ in R/(L) UE/LE/Other hip flex angle = 60°
   (4) Decrease pain and swelling to none/(minimal level) 2 to 6/10 89
   5) Other: _____
   6) Other: _____
7. LT Goals: (1) Independent in home program for back
   (2) Increase strength 1 grade in R/(L) UE/LE/Other hip
   (3) Increase ROM to WNL/Other _____ in R/(L) UE/LE/Other hip flex angle = 90°
   (4) Decrease pain and swelling to none/(minimal level) 2 to 4/10 89
   (5) Other: Improve Back Indx to 20/50
   6) Other: _____

Treatment: (Moist heat); (ultrasound); UE/LE (ROM); UE/LE strengthening; balance/proprioception exercises; UE/LE (flexibility) exercises; (manual ROM exercises); iontophoresis; phonophoresis; (interferential E-stim); Russian E-stim; (cold pack); cervical/low back ROM; cervical/low back strengthening; (core strengthening); general conditioning; gait training;
Other: _____

Physical Therapy 2-3x / Week For 1-2 Months Carol O P.T.
Occupational Therapy _____ / Week For _____ Months _____ O.T.
Date 5-8-18 Referring Physician deNell M.D.

9:10- 10:00 ocul (30') ortho (15') neuro

Sumter Physical Therapy Clinic
1185 Wilson Hall Rd, Sumter, SC; Phone: (803)469-3213 Fax: (803)469-3233

PATIENT: McLeod-Johnson, Stasia AGE: 40 DATE: 4-30-18
DIAGNOSIS: LBP c radiculopathy
PRECAUTIONS: neuro
SUBJECTIVE: MRI Scheduled 5-3-18
"MD says he thinks my disc is blown". Likely surgical candidate
History of injury/complaint: ~4 wks ago pt lt was leaning forward to empty mop bucket - felt warmth in LB pain went to (L) glut, ant thigh
PMHX: L4 discectomy Feb '17

MEDS: tramadol, Vimovo, ?another, Humira, cyclobenzaprine, dexamet.
WORK/ACTIVITY: works on base - part time custodial work; full time counseling
PAIN: Current: 8 /10 At worst: 10/10 At best: 6/10 Location/description: (L) LB → (L) glut → ant thigh → calf
DIAGNOSTIC TESTING: X-ray: loss of disc height at L5-S1; at thoracic levels L3-5
ROM extremities: PAP angle (R) 40° (L) 80°, hip flex (R) 95° (L) 85°
hip ER (R) 50° (L) 25° IR (R) 30° (L) 25°

Trunk ROM		Cervical ROM	
lex: 50°/0		Flex:	
xt: 40°/0		Ext:	
3 (R) 90°/0	(L) 80°/0	SB (R)	(L)
ot (R)	(L)	Rot (R)	(L)

ENSATION: numbness toes, plantar surface (L)

Trunk flex: /5	Hip Flex (R) 4+/5 (L) 2+/5	Shoulder	LowTrap (R) /5 (L) /5
Trunk ext: /5	Ext (R) 4+/5 (L) 2 /5	Flex (R) /5 (L) /5	Elbow flex (R) /5 (L) /5
DF (R) 4+/5 (L) 3+/5	Abd (R) 4/5 (L) 2-/5	ER (R) /5 (L) /5	Elbow ext (R) /5 (L) /5
EV (R) 4+/5 (L) 3+/5	Grtoe ext (R) /5 (L) /5	IR (R) /5 (L) /5	Wrist ext (R) /5 (L) /5
Knee ext (R) 4+/5 (L) 4/5		MidTrap (R) /5 (L) /5	Grip (R) lb (L) lb
Flex (R) 4+/5 (L) 3+/5		Lats (R) /5 (L) /5	

STURE: Lumbar lordosis ↓ Thoracic kyphosis
ervical lordosis Scoliosis
ead/Shoulders Leg Length
T: Amb S adl, ↓ trunk rot noted, Trendelenburg lean c (L) knee
CIAL TESTS: (+) (B) SLR
PATION: Tender (B) QL, ms lumbar, (L) > (R) SI
L) > (R) piriformis
EXES: Back/Neck Index 37/50
SSMENT: unable to relieve radicular symptoms
ATMENT: attempted wall leans S success, prone c 2 pillows under c CPA flexion x15; (L) piriformis (L) hip flexor IDD release
lan of Care for goals and prognosis THERAPIST:

095

Back Index

Form BI100

rev 3/27/2003

Patient Name McLeod-Johnson, Stara **Date** 4-30-18

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is very severe.
5. The pain is very severe and does not vary much.

Personal Care

0. I do not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increases the pain but I manage not to change my way of doing it.
3. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
4. Because of the pain I am unable to do some washing and dressing without help.
5. Because of the pain I am unable to do any washing and dressing without help.

Sleeping

0. I get no pain in bed.
1. I get pain in bed but it does not prevent me from sleeping well.
2. Because of pain my normal sleep is reduced by less than 25%.
3. Because of pain my normal sleep is reduced by less than 50%.
4. Because of pain my normal sleep is reduced by less than 75%.
5. Pain prevents me from sleeping at all.

Lifting

0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it causes extra pain.
2. Pain prevents me from lifting heavy weights off the floor.
3. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
4. Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights.

Sitting

0. I can sit in any chair as long as I like.
1. I can only sit in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than 1/2 hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

Traveling

0. I get no pain while traveling.
1. I get some pain while traveling but none of my usual forms of travel make it worse.
2. I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
3. I get extra pain while traveling which causes me to seek alternate forms of travel.
4. Pain restricts all forms of travel except that done while lying down.
5. Pain restricts all forms of travel.

Standing

0. I can stand as long as I want without pain.
1. I have some pain while standing but it does not increase with time.
2. I cannot stand for longer than 1 hour without increasing pain.
3. I cannot stand for longer than 1/2 hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing because it increases pain immediately.

Social Life

0. My social life is normal and gives me no extra pain.
1. My social life is normal but increases the degree of pain.
2. Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of the pain.

Walking

0. I have no pain while walking.
1. I have some pain while walking but it doesn't increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than 1/2 mile without increasing pain.
4. I cannot walk more than 1/4 mile without increasing pain.
5. I cannot walk at all without increasing pain.

Changing degree of pain

0. My pain is rapidly getting better.
1. My pain fluctuates but overall is definitely getting better.
2. My pain seems to be getting better but improvement is slow.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score 37

1)/c

PROGRESS REPORT

SUMTER
PHYSICAL THERAPY CLINIC
1185 WILSON HALL ROAD · SUMTER, SC 29150
PHONE 803-469-3213 · FAX 803-469-3233

Patient's Name: Mcleod-Johnson, Sara

MD: dcHoll

Date of Initial Visit: 4-30-18

Today's Date: 8.8.18

Total Visits: 1

Chief Complaint:

Initially: ~4 wk hx LBP i (L) radiculopathy

Currently: ___ Improving ___ Same ___ Worse

Objective: CPc IFCestim x15' prone c 2 pillows under chest; (L) manual MCitorms, hip flexor/QL release, attempted SLR, ~

EXERCISE	INSTRUCTION	MODALITIES	OTHER
___ conditioning	___ body mechanics	___ heat/ice	___ manual therapy
___ flexibility	___ home program	___ ultrasound	___ monitoring:
___ stabilization	___ lifting techniques	___ phono/ionto	___ swelling
___ strengthening	___ postural awareness	___ elec stim	___ cardiovascular
___ work hardening	___ self treatment	___ C/LB traction	___ relax techniques
		___ Whirlpool	

Progress Summary: Pt seen for I.E. - unable to relieve radicular symptoms; pt no showed next appt and did not return to PT

☒ **Physical Therapy Goals:**

☐ **Occupational Therapy Goals:**

Recommendations:

___ being met
X unable to meet
___ met

___ Continue therapy
___ Per M.D.'s instructions
X Discharge from therapy

Thank you.

Signature

8.8.18
Date

ALP106-S

097

336

F: 296·96999
8/16/18

Devin Troyer MD
2935 Colonial Dr.
Columbia, SC 29203

RGS

Test Date: 8/16/2018

Patient:	Stara McLeod	**DOB:**	[redacted]	**Physician:**	Troyer
Sex:	Female	**Height:**	cm	**Ref Phys:**	Koranloo
ID#:		**Weight:**	lbs.	**Technician:**	

Patient Complaints:
Patient is a 40-year-old female who presents with back pain and numbness, tingling, weakness, and pain in the left lower extremity. She had a discectomy at L4 in 2016 with improvements. The symptoms have been present for several months since April.

Nerve Conduction Studies

Anti Sensory Summary Table

Stim Site	NR	Peak (ms)	Norm Peak (ms)	P-T Amp (µV)	Norm P-T Amp	Site1	Site2	Delta-P (ms)	Dist (cm)	Vel (m/s)	Norm Vel (m/s)
Left Sup Fibular Anti Sensory (Ant Lat Mall)											
ant. tib		3.4	<3.8	18.7	>5.0	ant. tib	Ant Lat Mall	3.4	12.0	35	>32
Left Sural Anti Sensory (Lat Mall)											
Calf		3.1	<3.8	15.0	>5.0	Calf	Lat Mall	3.1	12.0	39	>35

Motor Summary Table

Stim Site	NR	Onset (ms)	Norm Onset (ms)	O-P Amp (mV)	Norm O-P Amp	Site1	Site2	Delta-0 (ms)	Dist (cm)	Vel (m/s)	Norm Vel (m/s)
Left Fibular Motor (Ext Dig Brev)											
Ankle		3.7	<6.1	5.7	>2.5	B Fib	Ankle	7.2	37.0	51	>38
B Fib		10.9		5.3							
Left Tibial Motor (Abd Hall Brev)											
Ankle		4.5	<6.1	8.7	>3.0						

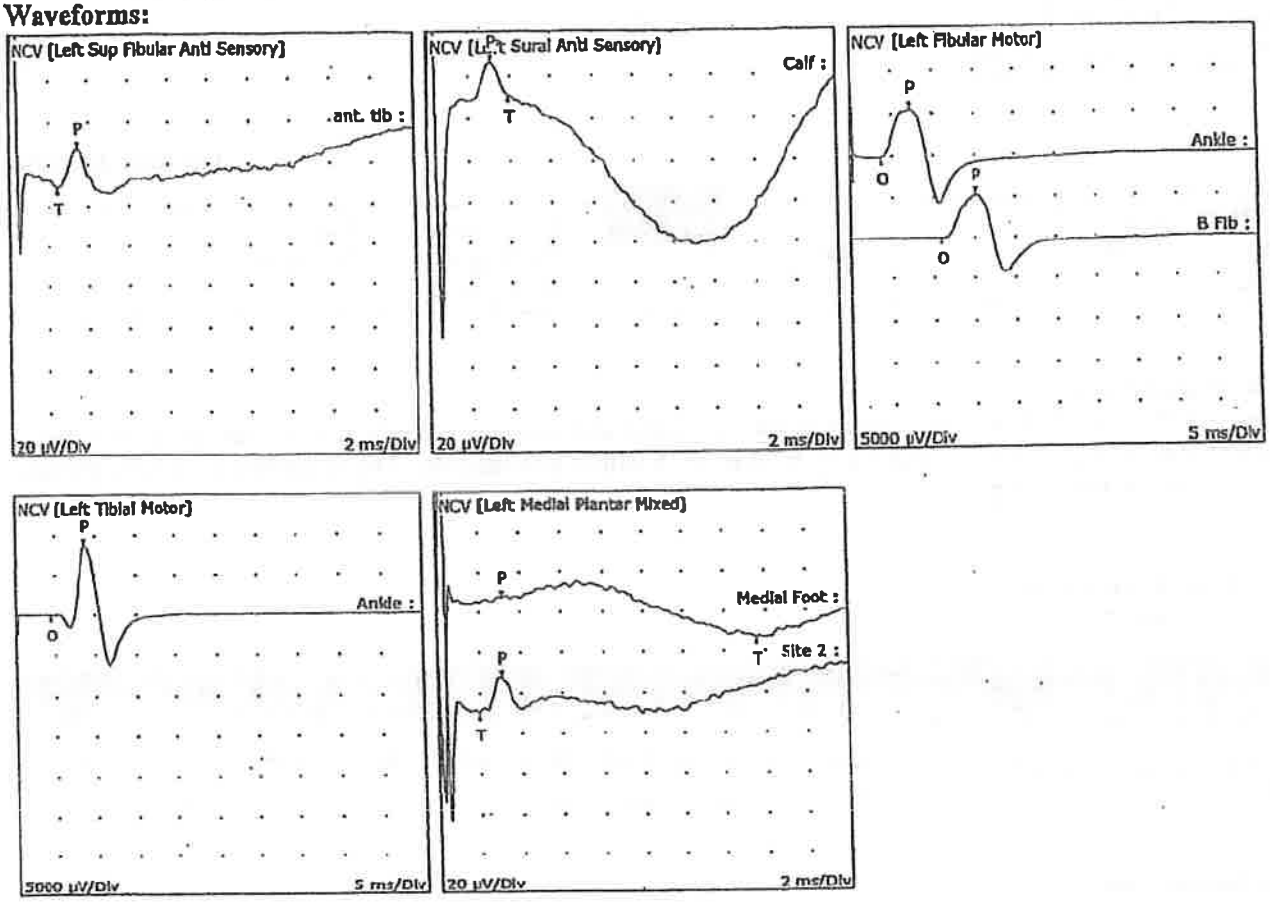
Mixed Summary Table

Stim Site	NR	Peak (ms)	Norm Peak (ms)	P-T Amp (µV)	Norm P-T Amp	Site1	Site2	Delta-P (ms)	Dist (cm)	Vel (m/s)	Norm Vel (m/s)
Left Medial Plantar Mixed (Med Malleolus)											
Medial Foot		3.1	<3.7	20.8	>10						
Site 2		3.1		17.7							

EMG

Sides	Muscle	Nerve	Root	Ins Act	Fibs	PSW	Amp	Dur	Poly	Recrt	Int Pat	Comment
Left	AntTibialis	Dp Br Fibular	L4-5	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	
Left	Gastroc	Tibial	S1-2	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	
Left	Fibularis Long	Sup Br Fibular	L5-S1	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	
Left	VastusMed	Femoral	L2-4	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	
Left	FDI	Med Plantar	S1-2	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	

Waveforms:



Patient History / Exam:
Past medical history is not significant. Manual muscle testing revealed 5/5 in bilateral lower extremities except for 4/5 in the left ankle dorsiflexors and EHL and toe flexors. Muscle stretch reflexes revealed 2+ in bilateral quadriceps and in the right gastroc-soleus and 0 in the left gastroc.

Impression:
This is a normal electrical study. There is no evidence of peripheral nerve entrapment. There is no evidence of peripheral polyneuropathy EMG reveals no evidence of radiculopathy or myopathy.

Her physical exam is certainly suspicious for radiculopathy with absent ankle reflex and distal weakness but no electrical changes were seen on EMG today.

Recommendations:
1. Follow-up with referring physician.
2. Continue current management of symptoms.
3. Today's results were discussed with the patient.

Devin Troyer MD.

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
(803) 737-5675 www.wcc.sc.gov

PRE-HEARING BRIEF
WCC File No: 1805291

Claimant's Name: Stara S. McLeod
Address: [redacted]
City: [redacted] State: [redacted] Zip: [redacted]
Home Phone: [redacted] Work Phone:

Employer's Name: CW Resources Inc.
Address: 416 Recreation Street
City: Shaw AFB State: SC Zip: 29152
Carrier: PA Manufacturers Assn. Ins. Co.

Preparer's Name: Dwight C. Moore
Preparer's Phone #: (803) 778-6520

A claim for workers' compensation benefits is made based on the following grounds:
☑ Injury ☐ Illness ☐ Repetitive Trauma

1. Compensation Rate: $194.01 2. AWW: $ 291.00 **Date of Injury:** 3/26/2018
3. Type of injury and body part(s): Lower back and leg
4. Facts in controversy:
   Whether claimant sustained an injury to the lower back and leg within the scope of employment.
5. Legal issues involved:
   S.C. Code Ann. Sections 42-1-160, 42-9-30, 42-15-60 and other applicable statuses, regulations and case law.
6. Unusual aspects:
7. Witnesses (designate if expert):*
8. Exhibits:
   Deposition and Personnel File
9. Medical evidence (indicate report pursuant to R.67-612; deposition or appearance):
10. Name, address, and specialty, if any, of the treating physician:
    Palmetto Health USC Spine 101 Business Park Blvd Columbia, Palmetto Health Tuomey 129 N Washington St Sumter, Sumter Spine Pain Center 100 North Sumter St, Suite 320 Sumter, Sumter Physical Therapy
11. Impairment rating(s); body part(s); physician and date of opinion:
12. I am amending my Form 50/51 in the following manner:

☐ **Mediation**
- ☐ a. Mediation is requested to be ordered pursuant to Reg. 67-1801 B.
- ☐ b. Mediation is required pursuant to Reg. 67-1802.
- ☐ c. Mediation is requested by consent of the Parties pursuant to Reg. 67-1803.
- ☐ d. Mediation has been conducted by a duly qualified mediator and resulted in an impasse.

Questions regarding mediation may be submitted to mediation@wcc.sc.gov.

I certify I have served this document pursuant to Reg. 67-211 by delivering a copy to Hedrick Gardner Kincheloe & Garofalo, LLP **address** 1230 Main Street, Suite 325 Columbia, SC 29201 **on the** 14 **day of** May **20** 21,
by ☐ **first class postage** ☐ **certified mail** ☐ **personal service** ☑ **electronic service**

I verify the contents of this form are accurate and true to the best of my knowledge.

Signature: [signature] Email: moorelawfirm@ftc-i.net

Date of hearing: May 26, 2021 Time needed for hearing: 30 Minutes

Questions about the use of this form should be directed to the Jurisdictional Commissioner. Refer to Regulations 67-204 through 67-211 and Regulations 67-601 through 67-615; as well as Regulation 67- 1801. File this form and proof of service on the opposing party according to R.67-611 and R.67-212. Do not send medical reports. * Commissioners reserve the right to admit expert witnesses at hearings.

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
WCC FILE NO.: 1805291

Stara McLeod, **Claimant,**	)	
vs	)	**NOTICE OF WITNESSES AND WRITTEN MEDICAL REPORTS TO BE INTRODUCED AS DIRECT EVIDENCE ON BEHALF OF THE CLAIMANT**
CW Group Inc., **Employer,**	)	
and	)	
PA Manufacturers Assn. Ins. Co., **Carrier,**	)	
Defendants	)	

TO: COMMISSIONER SUSAN S.BARDEN, SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION AND LEE DIXON, ESQUIRE:

YOU ARE HEREBY NOTIFIED THAT the Claimant, pursuant to the provision of the South Carolina Workers' Compensation Act and South Carolina Code Section 1-23-330, (1976) as amended, herewith submits the following medical reports as direct evidence on behalf of the Claimant, to wit:

MEDICAL RECORDS

NAME OF DOCTORS	DATES	PAGES
Palmetto Health USC Orthopedic	04/13/18 – 8/8/18	1-18
Palmetto Health Tuomey	04/23/18	19-27
Sumter Physical Therapy	04/30/18 and 8/8/18	28-30
Image Care	05/03/18	31-33
Encompass Health Rehab.	8/16/18	34-35
Southeastern Spine Institute	8/23/18	36-37
Sumter Pain and Spine Center	3/1/18-10/30/20	38-53

EXHIBITS

A.	Deposition	1-57
B.	Personnel File	1-21
C.	Deposition of Dr. P. Douglas deHoll	1-15

YOU ARE FURTHER HEREBY NOTIFIED that you have the right to cross-examination, and, should, you desire to exercise said right, you are forthwith schedule the deposition of any of the physicians, whose reports are submitted, for purpose of cross-examination.

YOU ARE FURTHER HEREBY NOTIFIED that the originals of the documents referred to herein or photocopies received from said physicians/others will be moved into Commission, for insertion in the file of the South Carolina Workers' Compensation Commission and inclusion into evidence on behalf of the claimant.

Respectfully Submitted

Dwight C. Moore, Bar No.: SC 63008
26 North Main Street
Post Office Box 1229
Sumter, South Carolina 29150
Telephone (803) 778-6520
Facsimile (803) 775-6365
ATTORNEY FOR CLAIMANT

May 14, 2021
Sumter, South Carolina

MCLEOD, STARA (id #286433, dob: [redacted])

Patient

Name	MCLEOD, STARA (40yo, F) ID# 286433	**Appt. Date/Time**	04/13/2018 03:20PM
DOB	[redacted]	**Service Dept.**	101 Business Park NE
Provider	PAUL DOUGLAS DEHOLL, MD		
Insurance	Med Primary: UNITED HEALTHCARE Insurance # : 943460441 Policy/Group # : 714081 Med Secondary: CHAMPVA (CHAMPVA) Insurance # : [redacted] Prescription: OPTUMCOM - Member is eligible.		

Chief Complaint

None recorded.

Patient's Care Team

Referring Provider: TODD WARRICK: 115 N SUMTER ST, SUMTER, SC 29150, Ph (803) 774-6824, Fax (803) 774-8977 NPI: 1952472953

Patient's Pharmacies

WALMART NEIGHBORHOOD MARKET 5383 (ERX): 615 BULTMAN DR, SUMTER SC 29150, Ph (803) 305-6194, Fax (803) 305-6197

Vitals

04/13/2018 03:17 pm

Ht:	5 ft 6 in	**Wt:**	140 lbs	**BMI:**	22.6
BP:	120/80 sitting	**Pain Scale:**	8	**Pain Scale Type:**	Numeric

Allergies

Reviewed Allergies
NKDA

Medications

Reviewed Medications

cyclobenzaprine 10 mg tablet Take 1 tablet(s) 3 times a day by oral route as needed.	02/10/17	filled
desvenlafaxine succinate ER 50 mg tablet,extended release 24 hr Take 1 tablet(s) as needed by oral route for 30 days.	02/23/18	filled
Humira 40 mg/0.8 mL subcutaneous syringe kit as directed	02/21/18	filled
traMADol 50 mg tablet Take 1 tablet(s) every 6 hours by oral route as needed.	04/13/18	prescribed
Vimovo 500 mg-20 mg tablet,immediate and delay release Take 1 tablet(s) twice a day by oral route.	04/13/18	prescribed
Zanaflex 4 mg capsule Take 1 capsule(s) every day by oral route at bedtime.	04/13/18	prescribed

Problems

Reviewed Problems
No known problems

Family History

Reviewed Family History

MCLEOD, STARA (id #286433, dob: [redacted])

Social History

Reviewed Social History
Smoking Status: Never smoker

Surgical History

Reviewed Surgical History
Patient indicated no previous surgeries on (04/13/2018)

GYN History

(not configured)

Obstetric History

Obstetric History not reviewed (last reviewed 02/23/2017)

Past Medical History

Reviewed Past Medical History
No Past Medical Problems Reported: Y

Documents for Discussion

N/A

Screening

None recorded.

HPI

This is a 40-year-old female who presents to clinic today for recheck. She was last seen in 11/2017 with minimal pain. Her pain has since worsened. She reports intermittent pain radiating into her left leg, as well as minimal numbness and tingling in her toes. Patient states that she's been doing PT since November 2017. She denies any injections recently, has had 2 in the past that she states didn't help. Pain medication has consisted of over-the-counter Aleve that she states wears off by about 4:00 in the afternoon. She's tried gabapentin in the past without any help and tramadol the past without help. She states she uses both heat and ice that helped but do not relieve her symptoms.

ROS

Patient reports **muscle aches, arthralgias/joint pain, back pain, and restricted ROM** but reports no swelling in the extremities. She reports **numbness and tingling** but reports no loss of consciousness, no seizures, no dizziness, no migraines, no headaches, and no restless legs. She reports no fever, no night sweats, no significant weight gain, no significant weight loss, and no exercise intolerance. She reports no chest pain, no arm pain on exertion, no shortness of breath, no lightheadedness, no palpitations, and no known heart murmur. She reports no cough, no wheezing, no shortness of breath, no coughing up blood, and no sleep apnea. She reports no abdominal pain, no vomiting, no reflux, no loss of bowel control, and no indigestion. She reports no abnormal mole, no jaundice, no rashes, no skin ulcers, no dry skin, no growths/lesions, no itching, no hives, and no shingles. She reports no swollen glands, no bruising, and no excessive bleeding.
ROS as noted in the HPI

Physical Exam

Patient is a 40-year-old female.

Constitutional: General Appearance: healthy-appearing, NAD, and normal body habitus.

Psychiatric: Orientation: oriented to time, place, and person. Mood and Affect: normal mood and affect and active and alert.

Gait and Station: Appearance: normal gait, no limp, ambulating with no assistive devices, and pelvis normal.

Cardiovascular System: Arterial Pulses Right: posterior tibialis normal and dorsalis pedis normal. Arterial Pulses Left: posterior tibialis normal and dorsalis pedis normal. Edema Right: none. Edema Left: none. Varicosities Right: no varicosities and capillary refill test normal. Varicosities Left: no varicosities and capillary refill test normal.

Lymph Nodes: Inspection/Palpation Right: no inguinal LAD. Inspection/Palpation Left: no inguinal LAD.

Skin: Lumbosacral Spine: **scar; healing well.**

Lumbar Spine: Inspection: no induration or ecchymosis and normal alignment. Bony Palpation of the Lumbar Spine: no tenderness of the spinous process or the sacrum and no step-off. Bony Palpation of the Right Hip: no tenderness of the PSIS, the sciatic notch, the ischial tuberosity, the SI joint, or the greater trochanter. Bony Palpation of the Left Hip: no tenderness of the PSIS, the ischial tuberosity, or the greater trochanter and **tenderness of the sciatic notch and the SI joint**. Soft Tissue Palpation on the Right: no tenderness of the gluteus maximus or the inguinal ligament; **tender over incision**. Soft Tissue Palpation on the Left: **tenderness of the paraspinal region at L 5 and the gluteus maximus** and no tenderness of the inguinal ligament; **tender over incision**. Active Range of Motion: **good AROM, full rom not checked**.

MCLEOD, STARA (id #286433, dob: [redacted]

Motor Strength: L1 Motor Strength on the Right: hip flexion iliopsoas 5/5. L1 Motor Strength on the Left: hip flexion iliopsoas 5/5. L2-L4 Motor Strength on the Right: knee extension quadriceps 5/5. L2-L4 Motor Strength on the Left: knee extension quadriceps 5/5. L5 Motor Strength on the Right: ankle dorsiflexion tibialis anterior 5/5 and great toe extension extensor hallucis longus 5/5. L5 Motor Strength on the Left: **ankle dorsiflexion tibialis anterior 4/5** and **great toe extension extensor hallucis longus 4/5.** S1 Motor Strength on the Right: plantar flexion gastrocnemius 5/5. S1 Motor Strength on the Left: plantar flexion gastrocnemius 5/5.

Neurological System: Babinski Reflex Right: plantar reflex absent. Babinski Reflex Left: plantar reflex absent. Special Tests: Valsalva's test negative and clonus negative. Ankle Reflex Right: normal (2). Ankle Reflex Left: **absent (0).** Knee Reflex Right: normal (2). Knee Reflex Left: **diminished (1).** Sensation on the Right: T12 normal, L1 normal, L2 normal, L3 normal, L4 normal, L5 normal, S1 normal, S2 normal, and normal distal extremities. Sensation on the Left: T12 normal, L1 normal, L2 normal, L3 normal, L5 normal, S1 normal, S2 normal, normal distal extremities, and **decreased sensation of the knee and medial leg (L4).** Special Tests on the Right: femoral nerve traction test negative, supine straight leg raising test negative, and seated straight leg raising test negative. Special Tests on the Left: **Patrick-Fabere test positive, supine straight leg raising test positive, and seated straight leg raising test positive**and femoral nerve traction test negative;**Positive Forton's, positive Gaenslen's.**.

Images reviewed of AP and Lat radiographs taken today in clinic. There is a loss of disc height at L5-S1 with anterior osteophyte at that level. There is arthritis noted and the facets from L3 to S1. All the vertebral bodies and disc heights are well maintained at this time. There is no listhesis no acute fractures noted.

Assessment / Plan

Discussed with her that her first course of action would be PT will provide some medication as well. Reviewed the modalities of heat ice and stretching. We will need to see her back after she's completed PT if there is no improvement.

DND

1. Spinal stenosis of lumbar region
M48.061: Spinal stenosis, lumbar region without neurogenic claudication

- XR, LUMBAR SPINE
- LUMBAR SPINAL STENOSIS: CARE INSTRUCTIONS
- PHYSICAL THERAPY BACK REFERRAL - Schedule Within: provider's discretion Note to Provider: 2-3x week, 6-8 weeks as needed - personal trainer approach to rehab, establish HEP. Transition to gym, modalities, core strength & stretching, neural glides, McKenzie if appropriate. Postural correction.
  Visits per Week: 2- Number of Weeks: 6-8, as needed
  3
- tramadol 50 mg tablet - Take 1 tablet(s) every 6 hours by oral route as needed. Qty: 50 tablet(s) Refills: 0
  Pharmacy: WALMART NEIGHBORHOOD MARKET 5383
- Vimovo 500 mg-20 mg tablet,immediate and delay release - Take 1 tablet(s) twice a day by oral route. Qty: 60 tablet(s)
  Refills: 0 Pharmacy: PINE RIDGE PHARMACY- WEST COLUMBIA,
- Zanaflex 4 mg capsule - Take 1 capsule(s) every day by oral route at bedtime. Qty: 50 capsule(s) Refills: 0
  Pharmacy: WALMART NEIGHBORHOOD MARKET 5383

XR, LUMBAR SPINE

Review of xr, lumbar spine taken on 04/13/2018 at IN-OFFICE ORDER shows:
Views:
Taken: 4-5 views.
Views taken: A/P, Lateral, Flexion, and Extension.

Return to Office

- Paul Douglas DeHoll, MD for RE-CHECK at 101 Business Park NE on 06/07/2018 at 01:10 PM

Encounter Sign-Off

Encounter signed-off by Douglas Dow, PA, 04/13/2018.

Encounter performed and documented by Paul Douglas DeHoll, MD
Encounter reviewed & signed by Douglas Dow, PA on 04/13/2018 at 9:04pm

MCLEOD, STARA (id #286433, dob: [redacted])

MRI of the lumbar spine from ImageCare reveals severe discogenic collapse at L5-S1 with mild modic endplate changes. There is minimal bulging and evidence of a prior left hemilaminotomy, but no recurrent disc herniation.

Assessment / Plan

The patient definitely has discogenic changes at L5-S1. We have discussed that we would very much like to avoid surgery, albeit an L5-S1 anterior fusion for her discogenic issues. She does have pain over her left SI joint. In an attempt to avoid consideration of an ALIF, we are going to try a left-sided SI injection, and I will see her back after to discuss.

Attestation:
I, Kayla Andersen, am transcribing this note for Paul deHoll, MD.

1. Spinal stenosis of lumbar region
M48.061: Spinal stenosis, lumbar region without neurogenic claudication
- LUMBAR SPINAL STENOSIS: CARE INSTRUCTIONS
- SACROILIAC JOINT INJECTION (PROC) - Note to Provider: left SI joint injection

Return to Office
- Paul Douglas DeHoll, MD for RE-CHECK at 101 Business Park NE on 07/19/2018 at 02:00 PM

Encounter Sign-Off
Encounter signed-off by Paul Douglas DeHoll, MD, 05/04/2018.

Encounter performed by Paul Douglas DeHoll, MD
Encounter scribed for Paul Douglas DeHoll, MD by Kayla Andersen
Encounter signed by Kayla Andersen as scribe at 05/04/2018 at 8:26am
Encounter reviewed & signed by Paul Douglas DeHoll, MD on 05/04/2018 at 5:52pm

Encounter Date: 04/27/2018

Patient

Name	MCLEOD, STARA (40yo, F) ID# 286433	**Appt. Date/Time**	04/27/2018 08:40AM
DOB	[redacted]	**Service Dept.**	101 Business Park NE
Provider	DOUGLAS DOW, PA		
Insurance	Med Primary: UNITED HEALTHCARE Insurance # : 943460441 Policy/Group # : 714081 Med Secondary: CHAMPVA (CHAMPVA) Insurance # : [redacted] Prescription: ESI1 - Member is eligible. details Prescription: OPTUMCOM - Member is eligible. details		

Chief Complaint
Lumbar spine problem

Patient's Care Team
Referring Provider: TODD WARRICK: 115 N SUMTER ST, SUMTER, SC 29150, Ph (803) 774-6824, Fax (803) 774-8977 NPI: 1952472953

Patient's Pharmacies
WALMART NEIGHBORHOOD MARKET 5383 (ERX): 615 BULTMAN DR, SUMTER SC 29150, Ph (803) 305-6194, Fax (803) 305-6197

Vitals

Ht:	5 ft 6 in 04/27/2018 08:21 am	**Wt:**	140 lbs 04/27/2018 08:22 am	**BMI:**	22.6 04/27/2018 08:22 am
BP:	120/80 sitting 04/27/2018 08:22 am	**Pain Scale:**	8 04/27/2018 08:22 am	**Pain Scale Type:**	Numeric 04/27/2018 08:22 am

Allergies
Reviewed Allergies
NKDA

Medications
Reviewed Medications

cyclobenzaprine 10 mg tablet
Take 1 tablet(s) 3 times a day by oral route as needed. 02/10/17 filled

MCLEOD, STARA (id #286433, dob: [redacted]

desvenlafaxine succinate ER 50 mg tablet,extended release 24 hr 02/23/18 filled
Take 1 tablet(s) as needed by oral route for 30 days.

Humira 40 mg/0.8 mL subcutaneous syringe kit 02/21/18 filled
as directed

tiZANidine 4 mg capsule 04/13/18 filled
Take 1 capsule(s) every day by oral route at bedtime.

traMADol 50 mg tablet 04/13/18 prescribed
Take 1 tablet(s) every 6 hours by oral route as needed.

Vimovo 500 mg-20 mg tablet,immediate and delay release 04/13/18 prescribed
Take 1 tablet(s) twice a day by oral route.

Problems

Reviewed Problems
No known problems

Family History

Reviewed Family History

Social History

Reviewed Social History
Smoking Status: Never smoker

Surgical History

Reviewed Surgical History
Patient indicated no previous surgeries on (04/13/2018)

GYN History

ıot configured)

Obstetric History

Obstetric History not reviewed (last reviewed 02/23/2017)

Past Medical History

Reviewed Past Medical History
No Past Medical Problems Reported: Y

Documents for Discussion

N/A

Screening

None recorded.

HPI

Patient is a 40-year-old woman with continued lower back pain for the past couple years she had a previous surgery beginning of 2017 for a microdiscectomy. Recently she's had an increase in pressure in her tailbone and increased pressure and pain in her left leg with numbness and tingling radiating down to her foot. Recently we had tried to get her into physical therapy, pain has increased the point where she is unable to do so. She had an injection done at the ER which she states did not help but made her leg ache more. She's had a significant increase in pain every time she sneezes. She states she's had decreased strength in the left leg. She's been taking NSAIDs since December without any relief in her pain or symptoms.

ROS

Patient reports muscle aches, arthralgias/joint pain, back pain, and restricted ROMbut reports no swelling in the extremities. She reports numbness and tingling but reports no loss of consciousness, no seizures, no dizziness, no migraines, no headaches, and no restless legs. She reports no fever, no night sweats, no significant weight gain, no significant weight loss, and no exercise intolerance. She reports no chest pain, no arm pain on exertion, no shortness of breath, no lightheadedness, no palpitations, and no known heart murmur. She reports no cough, no wheezing, no shortness of breath, no coughing up blood, and no sleep apnea. She orts no abdominal pain, no vomiting, no reflux, no loss of bowel control, and no indigestion. She reports no abnormal mole, no ndice, no rashes, no skin ulcers, no dry skin, no growths/lesions, no itching, no hives, and no shingles. She reports no swollen glands, no bruising, and no excessive bleeding.

Physical Exam

Patient is a 40-year-old female.

MCLEOD, STARA (id #286433, dob: [redacted])

Constitutional: General Appearance: healthy-appearing, NAD, and normal body habitus.

Psychiatric: Orientation: oriented to time, place, and person. Mood and Affect: normal mood and affect and active and alert.

Gait and Station: Appearance: ambulating with no assistive devices, **antalgic gait**, and pelvis normal.

Cardiovascular System: Arterial Pulses Right: posterior tibialis normal and dorsalis pedis normal. Arterial Pulses Left: posterior tibialis normal and dorsalis pedis normal. Edema Right: none. Edema Left: none. Varicosities Right: no varicosities and capillary refill test normal. Varicosities Left: no varicosities and capillary refill test normal.

Lymph Nodes: Inspection/Palpation Right: no inguinal LAD. Inspection/Palpation Left: no inguinal LAD.

Skin: Lumbosacral Spine: **scar; healing well.**

Lumbar Spine: Inspection: no induration or ecchymosis and normal alignment. Bony Palpation of the Lumbar Spine: no tenderness of the spinous process or the sacrum and no step-off. Bony Palpation of the Right Hip: no tenderness of the PSIS, the sciatic notch, the ischial tuberosity, the SI joint, or the greater trochanter. Bony Palpation of the Left Hip: no tenderness of the PSIS, the ischial tuberosity, or the greater trochanter and **tenderness of the sciatic notch and the SI joint**. Soft Tissue Palpation on the Right: no tenderness of the paraspinal region, the gluteus maximus, or the inguinal ligament; **tender over incision**. Soft Tissue Palpation on the Left: **tenderness of the paraspinal region at L 5 and the gluteus maximus** and no tenderness of the inguinal ligament; **tender over incision**. Active Range of Motion: **flexion painful, extension painful, lateral flexion to the left painful** and **rotation to the left painful; good AROM, full rom not checked**.

Motor Strength: L1 Motor Strength on the Right: hip flexion iliopsoas 5/5. L1 Motor Strength on the Left: hip flexion iliopsoas 5/5. L2-L4 Motor Strength on the Right: knee extension quadriceps 5/5. L2-L4 Motor Strength on the Left: **knee extension quadriceps 4/5**. L5 Motor Strength on the Right: ankle dorsiflexion tibialis anterior 5/5 and great toe extension extensor hallucis longus 5/5. L5 Motor Strength on the Left: **ankle dorsiflexion tibialis anterior 4/5 and great toe extension extensor hallucis longus 4/5**. S1 Motor Strength on the Right: plantar flexion gastrocnemius 5/5. S1 Motor Strength on the Left: **plantar flexion gastrocnemius 4/5**.

Neurological System: Babinski Reflex Right: plantar reflex absent, Rhomberg's test negative, and tandem gait normal. Babinski Reflex Left: plantar reflex absent, Rhomberg's test negative, and **tandem gait abnormal**. Special Tests: Valsalva's test negative and clonus negative. Ankle Reflex Right: normal (2). Ankle Reflex Left: **diminished (1)**. Knee Reflex Right: normal (2). Knee Reflex Left: normal (2). Sensation on the Right: T12 normal, L1 normal, L2 normal, L3 normal, L4 normal, L5 normal, S1 normal, S2 normal, and normal distal extremities. Sensation on the Left: **decreased sensation of the knee and medial leg (L4) and on the lateral leg and dorsum of the foot (L5); dereased sensation on the sole of the foot and the posterior leg (S1)** and T12 normal, L1 normal, L2 normal, L3 normal, S2 normal, and normal distal extremities. Special Tests on the Right: femoral nerve traction test negative, supine straight leg raising test negative, and seated straight leg raising test negative. Special Tests on the Left: **Patrick-Fabere test positive, supine straight leg raising test positive**, and **seated straight leg raising test positive** and femoral nerve traction test negative; **Positive Forton's, positive Gaenslen's.**.

Images reviewed of AP and Lat radiographs taken today in clinic. There is a loss of disc height at L5-S1 with anterior osteophyte at that level. There is arthritis noted and the facets from L3 to S1. All other vertebral bodies and disc heights are well maintained at this time. There is no listhesis no acute fractures noted.

Assessment / Plan

Concerned that with the increased pain and the decrease in strength of her left leg as well as a previous microdiscectomy we will need a new MRI at this time. We will need to see her after she gets her MRI. Reviewed the modalities of heat, ice and stretching.

1. Spinal stenosis of lumbar region

M48.061: Spinal stenosis, lumbar region without neurogenic claudication

- LUMBAR SPINAL STENOSIS: CARE INSTRUCTIONS
- MRI, LUMBAR SPINE, W/O CONTRAST - Note to Imaging Facility: Please provide disc to patient

Metal in body?: N	Pacemaker or defibrillator?: N
Patient claustrophobic?: N	Authorization #: CC04850377
Authorization Notes: 46 days	Appointment Date: 05/03/2018

Return to Office

- Paul Douglas DeHoll, MD for MRI FOLLOW-UP at 101 Business Park NE on 05/03/2018 at 01:50 PM
- Paul Douglas DeHoll, MD for RE-CHECK at 101 Business Park NE on 06/07/2018 at 01:10 PM

Encounter Sign-Off

Encounter signed-off by Douglas Dow, PA, 04/27/2018.

Encounter performed and documented by Douglas Dow, PA
Encounter reviewed & signed by Douglas Dow, PA on 04/27/2018 at 11:55am

Encounter Date: 04/13/2018

Patient

Name MCLEOD, STARA (40yo, F) ID# 286433 **Appt. Date/Time** 04/13/2018 03:20PM

MCLEOD, STARA (id #66306, dob: [redacted]

Encounters and Procedures

Clinical Encounter Summaries

Encounter Date: 05/03/2018

Patient

Name	MCLEOD, STARA (40yo, F) ID# 286433	**Appt. Date/Time**	05/03/2018 01:50PM
DOB	[redacted]	**Service Dept.**	101 Business Park NE
Provider	PAUL DOUGLAS DEHOLL, MD		
Insurance	Med Primary: UNITED HEALTHCARE Insurance # : 943460441 Policy/Group # : 714081 Med Secondary: CHAMPVA (CHAMPVA) Insurance # : [redacted] Prescription: ESI1 - Member is eligible. details Prescription: OPTUMCOM - Member is eligible. details		

Chief Complaint

MRI Followup

Patient's Care Team

Referring Provider: TODD WARRICK: 115 N SUMTER ST, SUMTER, SC 29150, Ph (803) 774-6824, Fax (803) 774-8977 NPI: 1952472953

Patient's Pharmacies

WALMART NEIGHBORHOOD MARKET 5383 (ERX): 615 BULTMAN DR, SUMTER SC 29150, Ph (803) 305-6194, Fax (803) 305-6197

Vitals

05/03/2018 02:03 pm

Ht:	5 ft 6 in	**Wt:**	140 lbs	**BMI:**	22.6
BP:	120/80 sitting	**Pain Scale:**	8	**Pain Scale Type:**	Numeric

Allergies

Reviewed Allergies

NKDA

Medications

Reviewed Medications

cyclobenzaprine 10 mg tablet Take 1 tablet(s) 3 times a day by oral route as needed.	02/10/17	filled
desvenlafaxine succinate ER 50 mg tablet,extended release 24 hr Take 1 tablet(s) as needed by oral route for 30 days.	02/23/18	filled
Humira 40 mg/0.8 mL subcutaneous syringe kit as directed	02/21/18	filled
tiZANidine 4 mg capsule Take 1 capsule(s) every day by oral route at bedtime.	04/13/18	filled
traMADol 50 mg tablet Take 1 tablet(s) every 6 hours by oral route as needed.	04/13/18	prescribed
Vimovo 500 mg-20 mg tablet,immediate and delay release Take 1 tablet(s) twice a day by oral route.	04/13/18	prescribed

Problems

Reviewed Problems

No known problems

Family History

Reviewed Family History

MCLEOD, STARA (id #66306, dob: [redacted])

Social History

Reviewed Social History
Smoking Status: Never smoker

Surgical History

Reviewed Surgical History
Patient indicated no previous surgeries on (04/13/2018)

GYN History

(not configured)

Obstetric History

Obstetric History not reviewed (last reviewed 02/23/2017)

Past Medical History

Reviewed Past Medical History
No Past Medical Problems Reported: Y

Documents for Discussion

N/A

Screening

None recorded.

HPI

This is a 40-year-old female who presents to clinic for MRI follow-up. The patient was initially evaluated by Doug Dow, PA-C for low back pain with associated numbness and tingling in her left leg. She was given medications and sent to physical therapy. Therapy was unable to do anything, so she went to the emergency department secondary to severe pain where an MRI was ordered.

ROS

Patient reports **muscle aches, arthralgias/joint pain, back pain, and restricted ROM**but reports no swelling in the extremities. She reports **numbness and tingling** but reports no loss of consciousness, no seizures, no dizziness, no migraines, no headaches, and no restless legs. She reports no fever, no night sweats, no significant weight gain, no significant weight loss, and no exercise intolerance. She reports no chest pain, no arm pain on exertion, no shortness of breath, no lightheadedness, no palpitations, and no known heart murmur. She reports no cough, no wheezing, no shortness of breath, no coughing up blood, and no sleep apnea. She reports no abdominal pain, no vomiting, no reflux, no loss of bowel control, and no indigestion. She reports no abnormal mole, no jaundice, no rashes, no skin ulcers, no dry skin, no growths/lesions, no itching, no hives, and no shingles. She reports no swollen glands, no bruising, and no excessive bleeding.
ROS as noted in the HPI

Physical Exam

Patient is a 40-year-old female.

Constitutional: General Appearance: healthy-appearing, NAD, and normal body habitus.

Psychiatric: Orientation: oriented to time, place, and person. Mood and Affect: normal mood and affect and active and alert.

Gait and Station: Appearance: normal gait, no limp, ambulating with no assistive devices, and pelvis normal.

Cardiovascular System: Arterial Pulses Right: posterior tibialis normal and dorsalis pedis normal. Arterial Pulses Left: posterior tibialis normal and dorsalis pedis normal. Edema Right: none. Edema Left: none. Varicosities Right: no varicosities and capillary refill test normal. Varicosities Left: no varicosities and capillary refill test normal.

Lymph Nodes: Inspection/Palpation Right: no inguinal LAD. Inspection/Palpation Left: no inguinal LAD.

Skin: Lumbosacral Spine: normal skin.

Lumbar Spine: Inspection: normal alignment and no ecchymosis. Bony Palpation of the Lumbar Spine: no tenderness of the spinous process or the sacrum and no step-off. Bony Palpation of the Right Hip: no tenderness of the sciatic notch, the SI joint, or the greater trochanter. Bony Palpation of the Left Hip: no tenderness of the sciatic notch or the greater trochanter and **tenderness of the SI joint.** Soft Tissue Palpation on the Right: no tenderness of the gluteus maximus and**tenderness of the paraspinal region at L 5.** Soft Tissue Palpation on the Left: no tenderness of the gluteus maximus and **tenderness of the paraspinal region at L 5.** Active Range of Motion: **flexion painful (mild), extension painful (mild),** and **pain with motion.**

Motor Strength: L1 Motor Strength on the Right: hip flexion iliopsoas 5/5. L1 Motor Strength on the Left: hip flexion iliopsoas 5/5. L2-4 Motor Strength on the Right: knee extension quadriceps 5/5. L2-L4 Motor Strength on the Left: knee extension quadriceps 5/5. L5 Motor Strength on the Right: ankle dorsiflexion tibialis anterior 5/5 and great toe extension extensor hallucis longus 5/5. L5 Motor Strength on the Left: ankle dorsiflexion tibialis anterior 5/5 and great toe extension extensor hallucis longus 5/5. S1 Motor Strength on the Right: plantar flexion gastrocnemius 5/5. S1 Motor Strength on the Left: plantar flexion gastrocnemius 5/5.

MCLEOD, STARA (id #66306, dob: [redacted])

Neurological System: Babinski Reflex Right: plantar reflex absent, Rhomberg's test negative, and tandem gait normal. Babinski Reflex Left: plantar reflex absent, Rhomberg's test negative, and tandem gait normal. Special Tests: Valsalva's test negative and clonus negative. Ankle Reflex Right: normal (2). Ankle Reflex Left: normal (2). Knee Reflex Right: normal (2). Knee Reflex Left: normal (2). Sensation on the Right: T12 normal, L1 normal, L2 normal, L3 normal, L4 normal, L5 normal, S1 normal, S2 normal, and normal distal extremities. Sensation on the Left: T12 normal, L1 normal, L2 normal, L3 normal, L4 normal, L5 normal, S1 normal, S2 normal, and normal distal extremities. Special Tests on the Right: femoral nerve traction test negative, supine straight leg raising test negative, and seated straight leg raising test negative. Special Tests on the Left: femoral nerve traction test negative, supine straight leg raising test negative, seated straight leg raising test negative, and **Patrick-Fabere test positive; positive Fortin's finger sign**

Imaging Studies:
MRI of the lumbar spine from ImageCare reveals severe discogenic collapse at L5-S1 with mild modic endplate changes. There is minimal bulging and evidence of a prior left hemilaminotomy, but no recurrent disc herniation.

Assessment / Plan

The patient definitely has discogenic changes at L5-S1. We have discussed that we would very much like to avoid surgery, albeit an L5-S1 anterior fusion for her discogenic issues. She does have pain over her left SI joint. In an attempt to avoid consideration of an ALIF, we are going to try a left-sided SI injection, and I will see her back after to discuss.

Attestation:
I, Kayla Andersen, am transcribing this note for Paul deHoll, MD.

1. Spinal stenosis of lumbar region
M48.061: Spinal stenosis, lumbar region without neurogenic claudication
- LUMBAR SPINAL STENOSIS: CARE INSTRUCTIONS
- SACROILIAC JOINT INJECTION (PROC) - Note to Provider: left SI joint injection

Return to Office
- Paul Douglas DeHoll, MD for RE-CHECK at 101 Business Park NE on 07/19/2018 at 02:00 PM

Encounter Sign-Off
Encounter signed-off by Paul Douglas DeHoll, MD, 05/04/2018.

Encounter performed by Paul Douglas DeHoll, MD
Encounter scribed for Paul Douglas DeHoll, MD by Kayla Andersen
Encounter signed by Kayla Andersen as scribe at 05/04/2018 at 8:26am
Encounter reviewed & signed by Paul Douglas DeHoll, MD on 05/04/2018 at 5:52pm

Encounter Date: 04/13/2018

Patient

Name	MCLEOD, STARA (40yo, F) ID# 286433	**Appt. Date/Time**	04/13/2018 03:20PM
DOB	[redacted]	**Service Dept.**	101 Business Park NE
Provider	PAUL DOUGLAS DEHOLL, MD		
Insurance	Med Primary: UNITED HEALTHCARE Insurance # : 943460441 Policy/Group # : 714081 Med Secondary: CHAMPVA (CHAMPVA) Insurance # : [redacted] Prescription: OPTUMCOM - Member is eligible. details		

Chief Complaint
None recorded.

Patient's Care Team
Referring Provider: TODD WARRICK: 115 N SUMTER ST, SUMTER, SC 29150, Ph (803) 774-6824, Fax (803) 774-8977 NPI: 1952472953

Patient's Pharmacies
WALMART NEIGHBORHOOD MARKET 5383 (ERX): 615 BULTMAN DR, SUMTER SC 29150, Ph (803) 305-6194, Fax (803) 305-6197

Vitals
04/13/2018 03:17 pm

Ht: 5 ft 6 in	**Wt:** 140 lbs	**BMI:** 22.6
BP: 120/80 sitting	**Pain Scale:** 8	**Pain Scale Type:** Numeric

Allergies
Reviewed Allergies

MCLEOD, STARA (id #66306, dob: [redacted]
NKDA

Medications

Reviewed Medications

cyclobenzaprine 10 mg tablet Take 1 tablet(s) 3 times a day by oral route as needed.	02/10/17	filled
desvenlafaxine succinate ER 50 mg tablet,extended release 24 hr Take 1 tablet(s) as needed by oral route for 30 days.	02/23/18	filled
Humira 40 mg/0.8 mL subcutaneous syringe kit as directed	02/21/18	filled
traMADol 50 mg tablet Take 1 tablet(s) every 6 hours by oral route as needed.	04/13/18	prescribed
Vimovo 500 mg-20 mg tablet,immediate and delay release Take 1 tablet(s) twice a day by oral route.	04/13/18	prescribed
Zanaflex 4 mg capsule Take 1 capsule(s) every day by oral route at bedtime.	04/13/18	prescribed

Problems

Reviewed Problems
No known problems

Family History

Reviewed Family History

Social History

Reviewed Social History
Smoking Status: Never smoker

Surgical History

Reviewed Surgical History
Patient indicated no previous surgeries on (04/13/2018)

GYN History

(not configured)

Obstetric History

Obstetric History not reviewed (last reviewed 02/23/2017)

Past Medical History

Reviewed Past Medical History
No Past Medical Problems Reported: Y

Documents for Discussion

N/A

Screening

None recorded.

HPI

This is a 40-year-old female who presents to clinic today for recheck. She was last seen in 11/2017 with minimal pain. Her pain has since worsened. She reports intermittent pain radiating into her left leg, as well as minimal numbness and tingling in her toes. Patient states that she's been doing PT since November 2017. She denies any injections recently, has had 2 in the past that she states didn't help. Pain medication has consisted of over-the-counter Aleve that she states wears off by about 4:00 in the afternoon. She's tried gabapentin in the past without any help and tramadol the past without help. She states she uses both heat and ice that helped but do not relieve her symptoms.

OS

Patient reports **muscle aches, arthralgias/joint pain, back pain, and restricted ROM**but reports no swelling in the extremities. She reports **numbness and tingling** but reports no loss of consciousness, no seizures, no dizziness, no migraines, no headaches, and no restless legs. She reports no fever, no night sweats, no significant weight gain, no significant weight loss, and no exercise

MCLEOD, STARA (id #66306, dob: [redacted]

intolerance. She reports no chest pain, no arm pain on exertion, no shortness of breath, no lightheadedness, no palpitations, and no known heart murmur. She reports no cough, no wheezing, no shortness of breath, no coughing up blood, and no sleep apnea. She reports no abdominal pain, no vomiting, no reflux, no loss of bowel control, and no indigestion. She reports no abnormal mole, no jaundice, no rashes, no skin ulcers, no dry skin, no growths/lesions, no itching, no hives, and no shingles. She reports no swollen glands, no bruising, and no excessive bleeding.
ROS as noted in the HPI

Physical Exam

Patient is a 40-year-old female.

Constitutional: General Appearance: healthy-appearing, NAD, and normal body habitus.

Psychiatric: Orientation: oriented to time, place, and person. Mood and Affect: normal mood and affect and active and alert.

Gait and Station: Appearance: normal gait, no limp, ambulating with no assistive devices, and pelvis normal.

Cardiovascular System: Arterial Pulses Right: posterior tibialis normal and dorsalis pedis normal. Arterial Pulses Left: posterior tibialis normal and dorsalis pedis normal. Edema Right: none. Edema Left: none. Varicosities Right: no varicosities and capillary refill test normal. Varicosities Left: no varicosities and capillary refill test normal.

Lymph Nodes: Inspection/Palpation Right: no inguinal LAD. Inspection/Palpation Left: no inguinal LAD.

Skin: Lumbosacral Spine: **scar; healing well.**

Lumbar Spine: Inspection: no induration or ecchymosis and normal alignment. Bony Palpation of the Lumbar Spine: no tenderness of the spinous process or the sacrum and no step-off. Bony Palpation of the Right Hip: no tenderness of the PSIS, the sciatic notch, the ischial tuberosity, the SI joint, or the greater trochanter. Bony Palpation of the Left Hip: no tenderness of the PSIS, the ischial tuberosity, or the greater trochanter and **tenderness of the sciatic notch** and **the SI joint**. Soft Tissue Palpation on the Right: no tenderness of the gluteus maximus or the inguinal ligament; **tender over incision**. Soft Tissue Palpation on the Left:**tenderness of the paraspinal region at L 5** and **the gluteus maximus** and no tenderness of the inguinal ligament;**tender over incision**. Active Range of Motion: **good AROM, full rom not checked**.

Motor Strength: L1 Motor Strength on the Right: hip flexion iliopsoas 5/5. L1 Motor Strength on the Left: hip flexion iliopsoas 5/5. L2-L4 Motor Strength on the Right: knee extension quadriceps 5/5. L2-L4 Motor Strength on the Left: knee extension quadriceps 5/5. L5 Motor Strength on the Right: ankle dorsiflexion tibialis anterior 5/5 and great toe extension extensor hallucis longus 5/5. L5 Motor Strength on the Left: **ankle dorsiflexion tibialis anterior 4/5** and **great toe extension extensor hallucis longus 4/5**. S1 Motor Strength on the Right: plantar flexion gastrocnemius 5/5. S1 Motor Strength on the Left: plantar flexion gastrocnemius 5/5.

Neurological System: Babinski Reflex Right: plantar reflex absent. Babinski Reflex Left: plantar reflex absent. Special Tests: Valsalva's test negative and clonus negative. Ankle Reflex Right: normal (2). Ankle Reflex Left: **absent (0)**. Knee Reflex Right: normal (2). Knee Reflex Left: **diminished (1)**. Sensation on the Right: T12 normal, L1 normal, L2 normal, L3 normal, L4 normal, L5 normal, S1 normal, S2 normal, and normal distal extremities. Sensation on the Left: T12 normal, L1 normal, L2 normal, L3 normal, L5 normal, S1 normal, S2 normal, normal distal extremities, and **decreased sensation of the knee and medial leg (L4)** Special Tests on the Right: femoral nerve traction test negative, supine straight leg raising test negative, and seated straight leg raising test negative. Special Tests on the Left: **Patrick-Fabere test positive, supine straight leg raising test positive**, and **seated straight leg raising test positive** and femoral nerve traction test negative;**Positive Forton's, positive Gaenslen's.**

Images reviewed of AP and Lat radiographs taken today in clinic. There is a loss of disc height at L5-S1 with anterior osteophyte at that level. There is arthritis noted and the facets from L3 to S1. All the vertebral bodies and disc heights are well maintained at this time. There is no listhesis no acute fractures noted.

Assessment / Plan

Discussed with her that her first course of action would be PT will provide some medication as well. Reviewed the modalities of heat ice and stretching. We will need to see her back after she's completed PT if there is no improvement.

DND

1. Spinal stenosis of lumbar region
M48.061: Spinal stenosis, lumbar region without neurogenic claudication
- XR, LUMBAR SPINE
- LUMBAR SPINAL STENOSIS: CARE INSTRUCTIONS
- PHYSICAL THERAPY BACK REFERRAL - Schedule Within: provider's discretion Note to Provider: 2-3x week, 6-8 weeks as needed - personal trainer approach to rehab, establish HEP. Transition to gym, modalities, core strength & stretching, neural glides, McKenzie if appropriate. Postural correction.

Visits per Week: 2- Number of Weeks: 6-8, as needed
3

- tramadol 50 mg tablet - Take 1 tablet(s) every 6 hours by oral route as needed. Qty: 50 tablet(s) Refills: 0 Pharmacy: WALMART NEIGHBORHOOD MARKET 5383

MCLEOD, STARA (id #66306, dob: [redacted]

- Vimovo 500 mg-20 mg tablet,immedia[redacted]ease - Take 1 tablet(s) twice a day by oral route. Qty: 60 tablet(s) Refills: 0 Pharmacy: PINE RIDGE PHARMACY- WEST COLUMBIA,
- Zanaflex 4 mg capsule - Take 1 capsule(s) every day by oral route at bedtime. Qty: 50 capsule(s) Refills: 0 Pharmacy: WALMART NEIGHBORHOOD MARKET 5383

XR, LUMBAR SPINE

Review of xr, lumbar spine taken on 04/13/2018 at IN-OFFICE ORDER shows:
Views:
Taken: 4-5 views.
Views taken: A/P, Lateral, Flexion, and Extension.

Return to Office

- Paul Douglas DeHoll, MD for RE-CHECK at 101 Business Park NE on 06/07/2018 at 01:10 PM

Encounter Sign-Off
Encounter signed-off by Douglas Dow, PA, 04/13/2018.

Encounter performed and documented by Paul Douglas DeHoll, MD
Encounter reviewed & signed by Douglas Dow, PA on 04/13/2018 at 9:04pm

Imaging Results

MCLEOD, STARA (id #286433, dob: [redacted])

Encounters and Procedures

Clinical Encounter Summaries

Encounter Date: 07/19/2018

Patient

Name	MCLEOD, STARA (40yo, F) ID# 286433	**Appt. Date/Time**	07/19/2018 02:00PM
DOB	[redacted]	**Service Dept.**	101 Business Park NE
Provider	PAUL DOUGLAS DEHOLL, MD		
Insurance	Med Primary: UNITED HEALTHCARE Insurance # : 943460441 Policy/Group # : 714081 Med Secondary: CHAMPVA (CHAMPVA) Insurance # : [redacted] Prescription: OPTUMCOM - Member is eligible. details		

Chief Complaint

Lumbar spine problem

Patient's Care Team

Referring Provider: TODD WARRICK: 115 N SUMTER ST, SUMTER, SC 29150, Ph (803) 774-6824, Fax (803) 774-8977 NPI: 1952472953

Patient's Pharmacies

WALMART NEIGHBORHOOD MARKET 5383 (ERX): 615 BULTMAN DR, SUMTER SC 29150, Ph (803) 305-6194, Fax (803) 305-6197

Vitals

Ht:	5 ft 6 in 07/19/2018 02:11 pm	**Wt:**	140 lbs 07/19/2018 02:11 pm	**BMI:**	22.6 07/19/2018 02:11 pm
BP:	120/80 07/19/2018 02:12 pm				

Allergies

Reviewed Allergies

NKDA

Medications

Reviewed Medications

clindamycin HCl 300 mg capsule 1 tab po daily	05/09/18	filled
cyclobenzaprine 10 mg tablet Take 1 tablet(s) 3 times a day by oral route as needed.	02/10/17	filled
desvenlafaxine succinate ER 50 mg tablet,extended release 24 hr Take 1 tablet(s) as needed by oral route for 30 days.	06/18/18	filled
Humira 40 mg/0.8 mL subcutaneous syringe kit as directed	02/21/18	filled
predniSONE 20 mg tablet 1 tab po daily	05/09/18	filled
tiZANidine 4 mg capsule Take 1 capsule(s) every day by oral route at bedtime.	04/13/18	filled
tobramycin 0.3 %-dexamethasone 0.1 % eye drops,suspension	05/07/18	filled
traMADol 50 mg tablet Take 1 tablet(s) every 6 hours by oral route as needed.	04/13/18	prescribed

MCLEOD, STARA (id #286433, dob: [redacted]

Vimovo 500 mg-20 mg tablet,immediate and delay release 04/13/18 prescribed
Take 1 tablet(s) twice a day by oral route.

Problems

Reviewed Problems
No known problems

Family History

Reviewed Family History

Social History

Reviewed Social History
Smoking Status: Never smoker

Surgical History

Reviewed Surgical History
Patient indicated no previous surgeries on (07/19/2018)

GYN History

(not configured)

Obstetric History

Obstetric History not reviewed (last reviewed 02/23/2017)

Past Medical History

Reviewed Past Medical History
No Past Medical Problems Reported: Y

Documents for Discussion

N/A

Screening

None recorded.

HPI

This is a 40-year-old female who presents to clinic for recheck. She was referred for an SI joint injection at her last visit, but this only worsened her pain. She did physical therapy in 04/2018 without any improvement.

ROS

Patient reports **muscle aches, arthralgias/joint pain, back pain, and restricted ROM**but reports no swelling in the extremities. She reports **numbness and tingling** but reports no loss of consciousness, no seizures, no dizziness, no migraines, no headaches, and no restless legs. She reports no fever, no night sweats, no significant weight gain, no significant weight loss, and no exercise intolerance. She reports no chest pain, no arm pain on exertion, no shortness of breath, no lightheadedness, no palpitations, and no known heart murmur. She reports no cough, no wheezing, no shortness of breath, no coughing up blood, and no sleep apnea. She reports no abdominal pain, no vomiting, no reflux, no loss of bowel control, and no indigestion. She reports no abnormal mole, no jaundice, no rashes, no skin ulcers, no dry skin, no growths/lesions, no itching, no hives, and no shingles. She reports no swollen glands, no bruising, and no excessive bleeding.
ROS as noted in the HPI

Physical Exam

Patient is a 40-year-old female.

Constitutional: General Appearance: healthy-appearing, NAD, and normal body habitus.

Psychiatric: Orientation: oriented to time, place, and person. Mood and Affect: normal mood and affect and active and alert.

Gait and Station: Appearance: normal gait, no limp, ambulating with no assistive devices, and pelvis normal.

Cardiovascular System: Arterial Pulses Right: posterior tibialis normal and dorsalis pedis normal. Arterial Pulses Left: posterior tibialis normal and dorsalis pedis normal. Edema Right: none. Edema Left: none. Varicosities Right: no varicosities and capillary refill test normal. Varicosities Left: no varicosities and capillary refill test normal.

Lymph Nodes: Inspection/Palpation Right: no inguinal LAD. Inspection/Palpation Left: no inguinal LAD.

Skin: Lumbosacral Spine: **scar (well-healed surgical scar, lumbar spine).**

Lumbar Spine: Inspection: normal alignment and no ecchymosis. Bony Palpation of the Lumbar Spine: no tenderness of the spinous process or the sacrum and no step-off. Bony Palpation of the Right Hip: no tenderness of the sciatic notch, the SI joint, or the greater trochanter. Bony Palpation of the Left Hip: no tenderness of the sciatic notch, the SI joint, or the greater trochanter. Soft Tissue Palpation on the Right: no tenderness of the gluteus maximus and **[illegible]erness of the paraspinal region at L 5** Soft Tissue

MCLEOD, STARA (id #286433, dob: [redacted])

Palpation on the Left: no tenderness of the gluteus maximus and **tenderness of the paraspinal region at L 5.** Active Range of Motion: **flexion painful (mild), extension painful (mild),** and **pain with motion.**

Motor Strength: L1 Motor Strength on the Right: hip flexion iliopsoas 5/5. L1 Motor Strength on the Left: hip flexion iliopsoas 5/5. L2-L4 Motor Strength on the Right: knee extension quadriceps 5/5. L2-L4 Motor Strength on the Left: knee extension quadriceps 5/5. L5 Motor Strength on the Right: ankle dorsiflexion tibialis anterior 5/5 and great toe extension extensor hallucis longus 5/5. L5 Motor Strength on the Left: ankle dorsiflexion tibialis anterior 5/5 and great toe extension extensor hallucis longus 5/5. S1 Motor Strength on the Right: plantar flexion gastrocnemius 5/5. S1 Motor Strength on the Left: plantar flexion gastrocnemius 5/5.

Neurological System: Babinski Reflex Right: plantar reflex absent, Rhomberg's test negative, and tandem gait normal. Babinski Reflex Left: plantar reflex absent, Rhomberg's test negative, and tandem gait normal. Special Tests: Valsalva's test negative and clonus negative. Ankle Reflex Right: normal (2). Ankle Reflex Left: normal (2). Knee Reflex Right: normal (2). Knee Reflex Left: normal (2). Sensation on the Right: T12 normal, L1 normal, L2 normal, L3 normal, L4 normal, L5 normal, S1 normal, S2 normal, and normal distal extremities. Sensation on the Left: T12 normal, L1 normal, L2 normal, L3 normal, L4 normal, L5 normal, S1 normal, S2 normal, and normal distal extremities. Special Tests on the Right: femoral nerve traction test negative, supine straight leg raising test negative, and seated straight leg raising test negative. Special Tests on the Left: femoral nerve traction test negative, supine straight leg raising test negative, and seated straight leg raising test negative.

Assessment / Plan

The patient has had a prior microdiscectomy. Per her MRI, her disc herniation is gone, but she has significant discogenic collapse with modic changes at L5-S1, which is somewhat in line with her primary complaints of back pain and the leg pain is definitely a secondary issue. I discussed with her the possibility that she may end up with an ALIF at L5-S1, which would be my surgical recommendation, but she would like to avoid that. It sounds as though Dr. Warrick has injected her and said he would inject her a second time, but that is all he has to offer, which is not the comprehensive pain management I was hoping for. I will get her in to see Dr. Koranloo to see what other ideas he has to try to improve her without another surgical procedure.

Attestation:
I, Kayla Andersen, am transcribing this note for Paul deHoll, MD.

1. Spinal stenosis of lumbar region
M48.061: Spinal stenosis, lumbar region without neurogenic claudication
- LUMBAR SPINAL STENOSIS: CARE INSTRUCTIONS

Return to Office
None recorded.

Encounter Sign-Off
Encounter signed-off by Paul Douglas DeHoll, MD, 07/21/2018.

Encounter performed by Paul Douglas DeHoll, MD
Encounter scribed for Paul Douglas DeHoll, MD by Kayla Andersen
Encounter signed by Kayla Andersen as scribe at 07/19/2018 at 7:47pm
Encounter reviewed & signed by Paul Douglas DeHoll, MD on 07/21/2018 at 10:35am

Encounter Date: 05/03/2018

Patient

Name	MCLEOD, STARA (40yo, F) ID# 286433	**Appt. Date/Time**	05/03/2018 01:50PM
DOB	11/04/1977	**Service Dept.**	101 Business Park NE
Provider	PAUL DOUGLAS DEHOLL, MD		
Insurance	Med Primary: UNITED HEALTHCARE Insurance # : 943460441 Policy/Group # : 714081 Med Secondary: CHAMPVA (CHAMPVA) Insurance # : [redacted] Prescription: ESI1 - Member is eligible. details Prescription: OPTUMCOM - Member is eligible. details		

Chief Complaint
MRI Followup

Patient's Care Team
Referring Provider: TODD WARRICK: 115 N SUMTER ST, SUMTER, SC 29150, Ph (803) 774-6824, Fax (803) 774-8977 NPI: 1952472953

Patient's Pharmacies
WALMART NEIGHBORHOOD MARKET 5383 (ERX): 615 BULTMAN DR, SUMTER SC 29150, Ph (803) 305-6194, Fax (803) 305-6197

Vitals
05/03/2018 02:03 pm

MCLEOD, STARA (Id #286433, dob: [redacted]

Encounters and Procedures

Clinical Encounter Summaries

:ounter Date: 08/07/2018

tient

.ne	MCLEOD, STARA (40yo, F) ID# 286433	Appt. Date/Time	08/07/2018 01:30PM
DOB	[redacted]	Service Dept.	101 Business Park NE
Provider	KAMRAN ZARGHAM-KORANLOO, MD		
Insurance	Med Primary: UNITED HEALTHCARE Insurance # : 943460441 Policy/Group # : 714081 Med Secondary: CHAMPVA (CHAMPVA) Insurance # : [redacted] Prescription: OPTUMCOM - Member is eligible. details		

Chief Complaint

None recorded.

Patient's Care Team

Referring Provider: TODD WARRICK: 115 N SUMTER ST, SUMTER, SC 29150, Ph (803) 774-6824, Fax (803) 774-8977 NPI: 1952472953

Patient's Pharmacies

WALMART NEIGHBORHOOD MARKET 5383 (ERX): 615 BULTMAN DR, SUMTER SC 29150, Ph (803) 305-6194, Fax (803) 305-6197

Vitals

Ht:	5 ft 6 in 08/07/2018 01:11 pm	Wt:	162.6 lbs 08/07/2018 01:12 pm	BMI:	26.2 08/07/2018 01:12 pm
BP:	119/79 sitting 08/07/2018 01:13 pm	Pain Scale:	7 08/07/2018 01:12 pm	Pain Scale Type:	Numeric 08/07/2018 01:12 pm

rgies

Reviewed Allergies

NKDA

Medications

Revlewed Medications

ARIPiprazole 10 mg tablet	07/31/18	filled
clindamycin HCl 300 mg capsule 1 tab po daily	05/09/18	filled
cyclobenzaprine 10 mg tablet Take 1 tablet(s) 3 times a day by oral route as needed.	02/10/17	filled
desvenlafaxine succinate ER 50 mg tablet,extended release 24 hr Take 1 tablet(s) as needed by oral route for 30 days.	07/31/18	filled
gabapentin 300 mg capsule	07/31/18	filled
Humira 40 mg/0.8 mL subcutaneous syringe kit as directed	02/21/18	filled
\Nidine 4 mg capsule ‹e 1 capsule(s) every day by oral route at bedtime.	04/13/18	filled
tobramycin 0.3 %-dexamethasone 0.1 % eye drops,suspension	05/07/18	filled
traMADol 50 mg tablet Take 1 tablet(s) every 6 hours by oral route as needed.	04/13/18	prescribed

MCLEOD, STARA (id #286433, dob: [redacted]

Vimovo 500 mg-20 mg tablet,immediate and delay release
Take 1 tablet(s) twice a day by oral route. 04/13/18 prescribed

blems

Reviewed Problems
No known problems

Family History

Reviewed Family History

Social History

Reviewed Social History
Smoking Status: Never smoker

Surgical History

Reviewed Surgical History
Patient indicated no previous surgeries on (07/19/2018)

GYN History

(not configured)

Obstetric History

Obstetric History not reviewed (last reviewed 02/23/2017)

Past Medical History

Reviewed Past Medical History
No Past Medical Problems Reported: Y

Documents for Discussion

N/A

eening

ıe recorded.

HPI

Patient is a pleasant 40-year-old lady kindly referred by Dr. de Holl for evaluation and management of her left-sided lumbar radiculopathy. Her low back pain started gradually in 2016 radiating down the left leg. She underwent L5-S1 microdiscectomy in December 2016 and did very well after surgery. In April of this year, after she emptied several buckets of water she felt a sudden severe left-sided low back pain radiating down the left posterior leg all the way down to the bottom of the foot. She felt warm and burning sensation for the first time. Pain radiates all the toes except for the first one. She has numbness and tingling. She has weakness in the left leg and stumbles all the time. She received LESI in May but she reports that increased her pain intensity. She has noticed some urinary dysfunction since the beginning of recent episode of radiculopathy. Her pain is constant and is worse with standing and walking. Sneezing and coughing severely increases the pain. Pain disrupts her sleep at night. She takes gabapentin 300 mg daily at bedtime, OTC NSAIDs and muscle relaxants.

ROS

Patient reports **muscle aches, muscle weakness, and back pain**but reports no arthralgias/joint pain, no swelling in the extremities, and normal ROM; **pain in the left leg.** She reports **numbness and tingling** but reports no loss of consciousness, no weakness, no seizures, no dizziness, no migraines, no headaches, and no restless legs; **left foot/toes and calf.**
ROS as noted in the HPI

Physical Exam

Patient is a 40-year-old female.

She is in no apparent distress. Peripheral pulses are 2+ and present. On neurological exam: Affect is normal. Gait is antalgic. There is neurogenic claudication. She is unable to stand on the left leg with stability. Standing on the left heel is unsteady. Motor is 4/5 in all muscle groups in the left and 5/5 in all muscle groups in the right leg. There is decreased dorsiflexion of the left ankle. Sensory is grossly intact to light touch. DTRs are 2+ and present symmetrically. On lumbar spine examination there is no gross abnormalities. Flexion is 60°. Extension is 10°. There is tenderness in the left paravertebral area in the lumbosacral region. SLR is positive at 20° he left.

ıbar spine MRI dated 05/03/2018 without contrast shows mild posterior bulging disks at L5-S1 otherwise unremarkable.

Assessment / Plan

Recurrence of left-sided lumbar radiculopathy with weakness. My recommendation is to:

MCLEOD, STARA (id #286433, dob: [redacted])

1. Refer patient for EMG/NCV of the left lower extremity to determine the site and extent of nerve root injury

2.try left L5-S1 transforaminal ESI to help relieve the pain

atient is agreeable with the plan and I will see her tomorrow for her injection. We also discussed possibility of L5-S1 fusion if she es not benefit from injection.

1. Lumbar radiculopathy
   M54.16: Radiculopathy, lumbar region
   - EPIDURAL STEROID INJECTION, LUMBAR TRANSFORAMINAL (PROC) - Note to Provider: Scheduled 8/8/18 w/ KZK

   Location: L5-S1 Side: LEFT
   - NERVE CONDUCTION STUDY/EMG, LOWER EXTREMITY (PROC) - Note to Provider: Left lower extremity EMG/NCS

Return to Office
- Kamran Zargham-Koranloo, MD for ESI-15 at 101 Business Park NE on 08/08/2018 at 02:30 PM

Encounter Sign-Off
Encounter signed-off by Kamran Zargham-Koranloo, MD, 08/07/2018.

Encounter performed and documented by Kamran Zargham-Koranloo, MD
Encounter reviewed & signed by Kamran Zargham-Koranloo, MD on 08/07/2018 at 2:23pm
Encounter Date: 07/19/2018

Patient

Name	MCLEOD, STARA (40yo, F) ID# 286433	**Appt. Date/Time**	07/19/2018 02:00PM
DOB	[redacted]	**Service Dept.**	101 Business Park NE
Provider	PAUL DOUGLAS DEHOLL, MD		
Insurance	Med Primary: UNITED HEALTHCARE Insurance # : 943460441 Policy/Group # : 714081 Med Secondary: CHAMPVA (CHAMPVA) Insurance # : [redacted] Prescription: OPTUMCOM - Member is eligible. details		

Chief Complaint
Lumbar spine problem

Patient's Care Team
Referring Provider: TODD WARRICK: 115 N SUMTER ST, SUMTER, SC 29150, Ph (803) 774-6824, Fax (803) 774-8977 NPI: 1952472953

Patient's Pharmacies
WALMART NEIGHBORHOOD MARKET 5383 (ERX): 615 BULTMAN DR, SUMTER SC 29150, Ph (803) 305-6194, Fax (803) 305-6197

Vitals

Ht:	5 ft 6 in 07/19/2018 02:11 pm	**Wt:**	140 lbs 07/19/2018 02:11 pm	**BMI:**	22.6 07/19/2018 02:11 pm
BP:	120/80 07/19/2018 02:12 pm				

Allergies
Reviewed Allergies
NKDA

Medications
Reviewed Medications

ndamycin HCl 300 mg capsule .ab po daily	05/09/18	filled
cyclobenzaprine 10 mg tablet Take 1 tablet(s) 3 times a day by oral route as needed.	02/10/17	filled

Chart Copy

ADMISSION RECORD

Patient Name / Address	Account No.	Room / Bed	Type	Location / Service	Medical Rec. No.
MCLEOD,STARA SHANEIQUA [redacted] Phone [redacted] Social Security No. [redacted] Employer SANTEE WATEREE MENTAL HEA	A00043924224		ER	ED	M000443101

Date of Birth	Age	Sex	MarStat	Religion	Ethnicity	Race	Smoker
11/04/1977	40	F	M	HOL	NHISLAT	B	

Guarantor / Address	Person to Notify / Address	Relationship
MCLEOD,STARA SHANEIQUA [redacted] Phone [redacted] Relationship Same as Patient Guarantor Employer SANTEE WATEREE MENTAL H	JOHNSON,ANDRE 3525 DELAWARE DR DALZELL,SC 29040 Home Phone 803-565-0665 Other Phone	SPOUSE

Financial Class	Next of Kin / Address	Relationship
	JOHNSON,ANDRE 3525 DELAWARE DR DALZELL,SC 29040 Home Phone 803-565-0665 Other Phone	SPOUSE

Insurance Name	Policy Number	Coverage Number	Subscriber / Insured Name
UNITED HEALTHCARE CHAMPVA	[redacted]		JOHNSON,ANDRE G MCLEOD,STARA SHANEIQUA

Accident Information	Reason for Visit
ONSET OF SYPTOM	BACK PAIN, LEFT LEG NUMBNESS

Accident Date / Time	Comments	Height / Weight	Arrival Mode
04/23/18			

Admit Date / Time	Admitting Physician	Attending Physician	ED Physician	User
04/23/18 0108		OLSON,DAVID	OLSON,DAVID	NSAYS

Hospital Days	HOME	OMI	SNF	ICF	HH	DIED	AUTOPSY	Surgeon	Consult	Discharge Date / Time
	☐	☐	☐	☐	☐	☐	☐			
								Anesthesiologist	Consult	

Admitting Diagnosis

Principal Diagnosis — Diagnosis and Procedure Code

Secondary Diagnosis

Procedure

Does pt have Advance Directive (Living Will)? No
Does pt have Health Care Power of Attorney? No
Does patient want info on Advance Directive? No
Are you an organ donor? No

If yes, Living Will copy received?
If yes, Health Care Power of Attorney copy received?

PALMETTO HEALTH TUOMEY
129 North Washington Street
Sumter, South Carolina 29150

Admission Record (Chart Copy)

CD000 Rev. 01/01/2004

MCLEOD,STARA SHANEIQUA
Acct: A00043924224 Unit: M000443101
OLSON,DAVID
ER
F B Age: 40
DOS: 04/23/18
DOB: [redacted]

DIAGNOSIS (06:26 OLSD)
FINAL: PRIMARY: LLE sciatica.
PRESENTING PROBLEM (Mon Apr 23, 2018 01:17 LAH2)
Presenting problems: Leg Injury-Pain-Swelling.
DISPOSITION
PATIENT: Disposition: Home, Disposition Transport: Ambulatory, Condition: Stable. (06:26 OLSD)
Pain Scale: 09, O2 used while in ED?: No, Psych related visit: No, Disposition Transport: Family/Friend Drive, Patient left the department. (07:16 BLF)
ALLERGY (01:17 LAH2)
NKDA
CURRENT MEDICATIONS
No recorded medications
MEDICATION ADMINISTRATION SUMMARY
Drug Name: *Norco, Dose Ordered: 1 tab(s), Route: PO, Status: Given, Time: 07:12 4/23/2018,
Drug Name: Dexamethasone Sodium Phosphate, Dose Ordered: 8 mg, Route: IM, Status: Given, Time: 06:37 4/23/2018, *Additional information available in notes, Detailed record available in Medication Service section.
PRESCRIPTION (06:27 OLSD)
Norco: Tablet : 325 Mg-5 Mg : Oral : Quantity: *** 5 *** Unit: milligram(s) Route: Oral Schedule: every 6 hours as needed Dispense: *** 12 ***
May substitute. Refills: *** No Refills ***
POTENTIAL SEVERE INTERACTION: Dexamethasone Sodium Phosphate (dexamethasone sodium phosphate) [dexamethasone]
Notes: ,
for pain.
Norflex: Tablet, Extended Release : 100 mg : Oral : Quantity: *** 1 *** Unit: tab Route: Oral Schedule: 2 times a day Dispense: *** 15 ***
May substitute. Refills: *** No Refills ***
Notes: ,
for muscle relaxation.
O2SAT INTERPRETATION (06:21 OLSD)
O2SAT: Single pulse oximetry, Oxygen saturation 100%, on room air, Oxygen saturation interpretation: Normal, No intervention required.
INSTRUCTION (06:27 OLSD)
FOLLOWUP: Follow up with Primary Care Physician As Needed.
SPECIAL: Rest, ice until pain resolved
Follow up with your back specialist if symptoms persist.
TRIAGE (Mon Apr 23, 2018 01:17 LAH2)
TRIAGE NOTES: Pt to ED with reports of pt emptied mop bucket two weeks ago at work, felt something pop, and now has pain to buttocks, and has numbness to left leg. Pt reports that she has tried heat, ice and OTC medications with no relief. Pt CAOx3. Pt reports "it's more in the bone kind of hurt, not so much muscular." Pt reports that when she sits straight up, it feels like she is sitting on something. (Mon Apr 23, 2018 01:17 LAH2)
PATIENT: NAME: McLeod, Stara S, AGE: 40, GENDER: female, DOB: [redacted] TIME OF GREET: Mon Apr 23, 2018 01:09, PREFERRED LANGUAGE: Pref. Lang. for Rec.Health info: English, RACE: African

American, ETHNICITY: Non-Hispanic or Non-Latin, Fall related visit?: No, New onset weakness: No, Pt abuse/neglect?: No, SI/HI Thoughts?: NA, Zip Code: [redacted], KG WEIGHT: 72.57, PHONE: [redacted], MEDICAL RECORD NUMBER: M000443101, ACCOUNT NUMBER: A00043924224, PAYMENT: Insurance, Attending: Saunders, Katherine. (Mon Apr 23, 2018 01:17 LAH2)

ADMISSION: URGENCY: ESI Level 4, TRANSPORT: Walked, BED: LOBBY. (Mon Apr 23, 2018 01:17 LAH2)

VITAL SIGNS: BP: 157/90, MAP: *, Pulse: 84, Resp: 16, Temp: 98.2, Pain: 9, O2 sat: 100 on (RA), End-Tidal CO2: *, Time: 4/23/2018 01:14. (01:14 LAH2)

COMPLAINT: leg pain, numbness. (Mon Apr 23, 2018 01:17 LAH2)

ASSESSMENT: . (Mon Apr 23, 2018 01:17 LAH2)

COLUMBIA SUICIDE SEVERITY RATING A: Patient denies wishing they were dead or wishing they could go to sleep and not wake up in the last month, thoughts of wanting to end one's life/die by suicide. (Mon Apr 23, 2018 01:17 LAH2)

PREVIOUS VISIT ALLERGIES: NKDA. (Mon Apr 23, 2018 01:17 LAH2)

HPI BACK (06:29 OLSD)

HISTORY OF PRESENT ILLNESS: 40 y/o female s/p lumbar laminectomy for HNP 1-2 yrs ago dev'd recurrent pain lt LS area with radiation into buttock and post thigh after lifting heavy bucket 2 wks ago. She is followed by Dr. DeHall in Columbia. Mild tenderness and +SLR @ 60 degrees.

CHIEF COMPLAINT: Patient presents for evaluation of pain, Denies swelling, Patient presents for evaluation of tenderness.

HISTORIAN: History provided by patient.

MECHANISM OF INJURY: Mechanism of injury: Body motion, lifting.

ATION: Symptoms are localized to the back, to lumbar spine.

LITY: Pain is sharp in nature, Described as similar to previous episodes.

SEVERITY: Maximum severity of symptoms moderate, Currently symptoms are moderate.

TIME COURSE: Sudden onset of symptoms, Symptoms are worsening.

ASSOCIATED WITH: No associated problems with urination, Associated with radiation of pain, to the left buttock, Associated with sciatica.

EXACERBATED BY: Patient's condition exacerbated by extension, Patient's condition exacerbated by flexion.

RELIEVED BY: Patient's condition relieved by nothing.

PAST MEDICAL HISTORY (Mon Apr 23, 2018 01:17 LAH2)

MEDICAL HISTORY: No past medical history.

SURGICAL HISTORY FEMALE: Surgical history of hysterectomy, Date of surgery 2015.

PSYCHIATRIC HISTORY: History of depression, Currently under outpatient psychiatric treatment.

SOCIAL HISTORY: Denies alcohol abuse, Denies tobacco abuse, Denies drug abuse, Lives at home with family.

FAMILY HISTORY: Family history is not contributory to this case.

ROS (06:32 OLSD)

CONSTITUTIONAL: Historian denies fever.

EYES: Historian denies eye redness, denies eye discharge, denies vision changes.

F[illegible]: Historian denies epistaxis.

DIOVASCULAR: Historian denies chest pain, denies diaphoresis,

denies syncope.
RESPIRATORY: Historian denies cough, denies wheezing.
GI: Historian denies abdominal pain, denies diarrhea, denies vomiting.
GENITOURINARY FEMALE: Historian denies dysuria.
MUSCULOSKELETAL: Historian reports back pain, Historian denies joint swelling.
SKIN: Historian denies rash.
NEUROLOGIC: Historian denies focal weakness, Historian reports paresthesias, sensory changes.
PSYCHIATRIC: Historian denies memory loss.
PHYSICAL EXAM (06:32 OLSD)
CONSTITUTIONAL: Vital signs reviewed, Patient afebrile.
HEAD: normocephalic.
EYES: Pupils equally round and reactive to light, Extraocular muscles intact.
NECK: Neck exam included findings of normal range of motion, no tenderness.
RESPIRATORY CHEST: Respiratory exam included findings of no respiratory distress.
CARDIOVASCULAR: Cardiovascular exam included findings of heart rate regular rate and rhythm.
ABDOMEN FEMALE: no distension.
BACK: Tenderness, paraspinal to the left lower back, Straight leg raise, with pain on the left at 60 degrees, Back exam included findings of normal inspection.
UPPER EXTREMITY: Upper extremity exam included findings of inspection normal, Range of motion normal.
LOWER EXTREMITY: Lower extremity exam included findings of inspection normal, Range of motion normal.
NEURO: Neuro exam findings include patient oriented to person, place and time, no focal motor deficits.
SKIN: Skin exam included findings of skin warm, dry.
PSYCHIATRIC: Psychiatric exam included findings of patient oriented to person place and time.
NURSING PROCEDURE: NURSE NOTES (06:57 BLF)
NURSES NOTES: Patient resting quietly, Assistance offered to patient, Notes: Pt resting on stretcher in POC, resps even, nonlabored, reports no relief from pain at all, discussed d/c instruction and Rx with pt, states understanding, aware this writer to speak with Dr. Olson about further medication prior to d/c.
SAFETY: Side rails up, Cart/Stretcher in lowest position, Call light within reach, Hospital ID band on.
NURSING PROCEDURE: DISCHARGE NOTE (07:12 BLF)
DISCHARGE: Patient discharged to home, ambulating without assistance, friend driving, unaccompanied, Discharge instructions given to patient, Simple or moderate discharge teaching performed, by Barbara Fowler, RN, Prescriptions given and instructions on side effects given, Name of prescription(s) given: norco; norflex, Above person(s) verbalized understanding of discharge instructions and follow-up care, Patient treated and evaluated by physician, Notes: Pt resting on stretcher in POC, resps even, nonlabored. Pt made aware to take all meds as prescribed, to f/u with PMD, call to arrange f/u care. Pt states understanding to all.
BELONGINGS: Belongings remain with patient, Valuables remain with

patient.
SAFETY: Side rails up, Cart/Stretcher in lowest position, Call light within reach, Hospital ID band on.
TAL SIGNS (01:14 LAH2)
AL SIGNS: BP: 157/90, MAP: *, Pulse: 84, Resp: 16, Temp: 98.2, Pain: 9, O2 sat: 100 on (RA), Time: 4/23/2018 01:14.
NURSING ASSESSMENT: EXTREMITY LOWER (06:36 BLF)
CONSTITUTIONAL: History obtained from patient, Patient appears, in distress due to pain, moderate pain distress observed, Patient cooperative, alert. Oriented to person, place and time, Skin warm, Skin dry, Skin normal in color, Mucous membranes pink, moist. Patient is well-groomed.
PAIN: numb pain, sharp pain, to the right upper leg, to the left lower leg, L buttock, Onset of pain 2 weeks ago, constant, on a scale 0-10 patient rates pain as 9.
LEFT LOWER EXTREMITY: Left lower extremity assessment findings include capillary refill less than 2 seconds, Skin color normal, Skin temperature warm, Distal sensation intact, Muscle tone normal.
RIGHT LOWER EXTREMITY: Right lower extremity assessment findings include capillary refill less than 2 seconds, Skin color normal, Skin temperature warm, Distal sensation intact, Muscle tone normal.
NOTES: Patient tolerated procedure well, Notes: Pt reports 2 weeks of pain to L buttock radiating down L leg, now with some numbness, has concerns for something other than sciatica r/t hx of, "a screwed up disc." Pt made aware s/s fit sciatica, to please f/u. with her back doctor, especially if tx recommended today does not help after a few days, pt states understanding to all.
SAFETY: Side rails up, Cart/Stretcher in lowest position, Call light within reach, Hospital ID band on.
NTS
NSFER: Triage to Emergency Lobby. (Mon Apr 23, 2018 01:17 LAH2)
Emergency Lobby to 2)Main ER 16. (05:02 MER1)
Removed from Emergency 2)Main ER 16. (07:16 BLF)
GREET (01:09 RRM)
GREET: Greet: Mon Apr 23, 2018 01:09.
NOTES: Patient arrived ambulatory.
MEDICATION SERVICE
Dexamethasone Sodium Phosphate: Order: Dexamethasone Sodium Phosphate (dexamethasone sodium phosphate) - Dose: 8 mg : IM
Ordered by: David Olson, MD
Entered by: David Olson, MD Mon Apr 23, 2018 06:26 ,
Acknowledged by: Fowler, RN Barbara Mon Apr 23, 2018 06:34
Documented as given by: Barbara Fowler, RN Mon Apr 23, 2018 06:37
Patient, Medication, Dose, Route, Schedule verified prior to administration., IM medication, Amount given: 8 mg, Medication administered to left buttock, Correct patient, time, route, dose and medication confirmed prior to administration, Patient advised of actions and side-effects prior to administration, Allergies confirmed and medications reviewed prior to administration, Patient tolerated procedure well, Patient in position of comfort, Side rails up, Cart in lowest position, Call light in reach.
Norco: Order: Norco (acetaminophen/hydrocodone bitartrate) - Dose: 1 tab(s) : PO

Notes: per VORB per Dr. Olson received @ 0702
Ordered by: David Olson, MD
Entered by: Barbara Fowler, RN Mon Apr 23, 2018 07:05 ,
Acknowledged by: Fowler, RN Barbara Mon Apr 23, 2018 07:05
Documented as given by: Barbara Fowler, RN Mon Apr 23, 2018 07:12
Patient, Medication, Dose, Route, Schedule verified prior to administration., Verbal order read back and verified, Amount given: 1 tab, , Site: Medication administered P.O., Correct patient, time, route, dose and medication confirmed prior to administration, Patient advised of actions and side-effects prior to administration, Allergies confirmed and medications reviewed prior to administration, Patient tolerated procedure well, Patient in position of comfort, Side rails up, Cart in lowest position, Call light in reach.

ADMIN

CHART VIEW (01:18 LAH2)

XML View. (01:19 MDC)

XML View. (01:38 MDC)

(03:29 RRM)

(04:37 LAH2)

(04:39 LAH2)

(05:32 GMC)

(05:57 BLF)

(06:21 OLSD)

(06:21 OLSD)

XML View. (06:28 MDC)

(06:29 OLSD)

(06:42 BLF)

(06:59 BLF)

(07:15 BLF)

XML View. (07:16 MDC)

(07:16 BLF)

XML View. (07:16 MDC)

(07:17 MAB1)

XML View. (07:18 MDC)

XML View. (19:07 MDC)

MERGE: Greet Mon Apr 23, 2018 01:09. (Mon Apr 23, 2018 01:17 LAH2)

FORM

WORK RELEASE (06:28 OLSD)

Blank (07:11 BLF)

ADMIN

CHART PRINT (01:17 LAH2)

(01:18 LAH2)

Chart sent by text interface. (01:38)

Chart sent by text interface. (01:38)

Chart sent by text interface. (07:16)

Chart sent by text interface. (07:16)

Chart sent by text interface. (07:16)

Chart sent by text interface. (07:16)

CHART FAX: KATHERINE SAUNDERS 8037744626 . (07:16 BLF)

PATIENT DATA CHANGE: Primary Nurse changed from (none) to Barbara Fowler, RN. (05:30 MER1)

Attending changed from (none) to David Olson, MD. (06:04 OLSD)

A08 232046462 by Interface, SSN: 251377085. (06:28)

A08 232046516 by Interface. (06:31)

DIGITAL SIGNATURE: Fowler, RN, Barbara. (07:15 BLF)
Olson, MD, David. (19:04 OLSD)
Key:
BLF=Fowler, RN, Barbara GMC=Clanton, MD, Garrett LAH2=Hudson, RN, Latae
ABl=Briley, RN, Tony MDC=Interface, Ed MER1=Russell, RN, Marybeth
OLSD=Olson, MD, David RRM=Matthews, EDT, Rebecca R.

INSTRUCTIONS
* The examination and treatment you received in the emergency department has been rendered on an emergency basis only and is not meant to replace complete care from a personal physician or clinic. *
FINAL DIAGNOSIS LLE sciatica FOLLOWUP CONTACTS SAUNDERS, KATHERINE, PEDIATRICS1278 N LAFAYETTE DRSUMTER SC 29150 Phone: 803-774-4500Follow up with Primary Care Physician As Needed SPECIAL INSTRUCTIONS Rest, ice until pain resolved Follow up with your back specialist if symptoms persist PRESCRIPTIONS (2) Printed (2) Norco : Tablet : 325 Mg-5 Mg : Oral Quantity: 5, Unit: milligram(s), Route: Oral, Schedule: every 6 hours as needed, Dispense: 12 Norflex : Tablet, Extended Release : 100 mg : Oral Quantity: 1, Unit: tab(s), Route: Oral, Schedule: 2 times a day, Dispense: 15_____* X-rays. X-rays are read initially by the emergency physician. The X-ray will be read by a radiology physician specialist within 24 hours. If the radiologist notes any differences, you will be contacted by the emergency department. ** Lab Work. Results of lab testing done in the Emergency Department are available to your private physician. Lab results cannot be given over the Emergency Department phone.* IMPORTANT: If your condition gets worse or you have any concerns and you cannot contact your physician, eturn promptly to Tuomey Healthcare Systems Emergency Department. 803)774-9111**Disclaimer: Home medications and allergies listed on Patient Medication History Record are as reported by patient/family to Tuomey ED staff.**

DISCHARGE INSTRUCTIONS RECEIPT FINAL DIAGNOSIS LLE sciatica FOLLOWUP CONTACTS SAUNDERS, KATHERINE, PEDIATRICS1278 N LAFAYETTE DRSUMTER SC 29150 Phone: 803-774-4500Follow up with Primary Care Physician As Needed THE FOLLOWING SPECIAL INSTRUCTIONS WERE GIVEN Rest, ice until pain resolved Follow up with your back specialist if symptoms persist THE FOLLOWING PRESCRIPTIONS WERE GIVEN Printed (2) Norco : Tablet : 325 Mg-5 Mg : Oral Quantity: 5, Unit: milligram(s), Route: Oral, Schedule: every 6 hours as needed, Dispense: 12 Norflex : Tablet, Extended Release : 100 mg : Oral Quantity: 1, Unit: tab(s), Route: Oral, Schedule: 2 times a day, Dispense: 15_____

_____Patient Signature
Date/Time_____ ____:____Rn/LPN Ini. TIME

PRESENTING PROBLEM (Mon Apr 23, 2018 01:17 LAH2)
Presenting problems: Leg Injury-Pain-Swelling.
ALLERGY (01:17 LAH2)
DA
RRENT MEDICATIONS
No recorded medications
PRESCRIPTION
No recorded prescriptions
TRIAGE (Mon Apr 23, 2018 01:17 LAH2)
TRIAGE NOTES: Pt to ED with reports of pt emptied mop bucket two weeks ago at work, felt something pop, and now has pain to buttocks, and has numbness to left leg. Pt reports that she has tried heat, ice and OTC medications with no relief. Pt CAOx3. Pt reports "it's more in the bone kind of hurt, not so much muscular." Pt reports that when she sits straight up, it feels like she is sitting on something. (Mon Apr 23, 2018 01:17 LAH2)
PATIENT: NAME: McLeod, Stara S, AGE: 40, GENDER: female, DOB: [redacted], TIME OF GREET: Mon Apr 23, 2018 01:09, PREFERRED LANGUAGE: Pref. Lang. for Rec.Health info: English, RACE: African American, ETHNICITY: Non-Hispanic or Non-Latin, Fall related visit?: No, New onset weakness: No, Pt abuse/neglect?: No, SI/HI Thoughts?: NA, Zip Code: [redacted], KG WEIGHT: 72.57, PHONE: [redacted] MEDICAL RECORD NUMBER: M000443101, ACCOUNT NUMBER: A00043924224, PAYMENT: Insurance, Attending: Saunders, Katherine. (Mon Apr 23, 2018 01:17 LAH2)
ADMISSION: URGENCY: ESI Level 4, TRANSPORT: Walked, BED: LOBBY. (Mon Apr 23, 2018 01:17 LAH2)
VITAL SIGNS: BP: 157/90, MAP: *, Pulse: 84, Resp: 16, Temp: 98.2, Pain: 9, O2 sat: 100 on (RA), End-Tidal CO2: *, Time: 4/23/2018 01:14. (01:14 LAH2)
COMPLAINT: leg pain, numbness. (Mon Apr 23, 2018 01:17 LAH2)
ASSESSMENT: . (Mon Apr 23, 2018 01:17 LAH2)
COLUMBIA SUICIDE SEVERITY RATING A: Patient denies wishing they were dead or wishing they could go to sleep and not wake up in the last month, thoughts of wanting to end one's life/die by suicide. (Mon Apr 23, 2018 01:17 LAH2)
PREVIOUS VISIT ALLERGIES: NKDA. (Mon Apr 23, 2018 01:17 LAH2)
PAST MEDICAL HISTORY (Mon Apr 23, 2018 01:17 LAH2)
MEDICAL HISTORY: No past medical history.
SURGICAL HISTORY FEMALE: Surgical history of hysterectomy, Date of surgery 2015.
PSYCHIATRIC HISTORY: History of depression, Currently under outpatient psychiatric treatment.
SOCIAL HISTORY: Denies alcohol abuse, Denies tobacco abuse, Denies drug abuse, Lives at home with family.
FAMILY HISTORY: Family history is not contributory to this case.
VITAL SIGNS (01:14 LAH2)
VITAL SIGNS: BP: 157/90, MAP: *, Pulse: 84, Resp: 16, Temp: 98.2, Pain: 9, O2 sat: 100 on (RA), Time: 4/23/2018 01:14.
EVENTS (Mon Apr 23, 2018 01:17 LAH2)
TRANSFER: Triage to Emergency Lobby.
GREET (01:09 RRM)
GREET: Greet: Mon Apr 23, 2018 01:09.
NOTES: Patient arrived ambulatory.
IN

CHART VIEW (01:18 LAH2)
XML View. (01:19 MDC)
XML View. (01:38 MDC)
RGE: Greet Mon Apr 23, 2018 01:09. (Mon Apr 23, 2018 01:17 LAH2)
CHART PRINT (01:17 LAH2)
(01:18 LAH2)
Key:
LAH2=Hudson, RN, Latae MDC=Interface, Ed RRM=Matthews, EDT, Rebecca R.

SUMTER
PHYSICAL THERAPY CLINIC
1185 WILSON HALL ROAD • SUMTER, SC 29150
PHONE (803) 469-3213 • FAX (803) 469-3233

PLAN OF CARE

Physical Therapy ✓ Occupational Therapy _____

1. Patient McLeod, Johnson, Stara (DOB: [redacted]) (L) Date 4.30.18
2. Diagnosis and Date of Onset ~4 wk hx LBP c radiculopathy
3. Functional Limitations Prior to Injury or Onset of Condition L4 discectomy Feb 17
4. Contraindications: Estim Wound Care Precautions THA Precautions Other: Neuro
5. Treatment Plan Effective From 4.30.18 To 6.30.18
   Rehab Potential: _____ Poor ___X___ Good _____ Excellent 20 severity of neuro symptoms
6. ST Goals:
   (1) Independent in home program for back
   (2) Increase strength 1/2 grade in R/L UE/LE/Other hip
   (3) Increase ROM to WFL/Other _____ in R/L UE/LE/Other hip angle - 60°
   (4) Decrease pain and swelling to none/minimal level 1 to 10 pain
   5) Other: _____
   6) Other: _____
7. LT Goals:
   (1) Independent in home program for back
   (2) Increase strength 1 grade in R/L UE/LE/Other hip
   (3) Increase ROM to WNL/Other _____ in R/L UE/LE/Other hip angle = 45°
   (4) Decrease pain and swelling to none/minimal level 1 to 0/10 pain
   (5) Other: Improve Back Index to 20/50
   6) Other: _____

Treatment: Moist heat; ultrasound; UE/LE ROM; UE/LE strengthening; balance/proprioception exercises; UE/LE flexibility exercises; manual ROM exercises; iontophoresis; phonophoresis; interferential E-stim; Russian E-stim; cold pack; cervical/low back ROM; cervical/low back strengthening; core strengthening; general conditioning; gait training;
Other: _____

Physical Therapy 2.3x / Week For 1-2 Months _____ P.T.

Occupational Therapy _____ / Week For _____ Months _____ O.T.

Date 5-8-18 Referring Physician deHoll M.D.

910- ocul (30')
10th optim (15')
rem 15

Sumter Physical Therapy Clinic
1185 Wilson Hall Rd, Sumter, SC; Phone: (803)469-3213 Fax: (803)469-3233

PATIENT: McLeod-Johnson, Stasia AGE: 40 DATE: 4-30-18
DIAGNOSIS: LBP c radiculopathy
PRECAUTIONS: none
SUBJECTIVE: MRI scheduled 5-3-18
"MD says he thinks my disc is blown" - likely surgical candidate
History of injury/complaint: ~4 wks ago pt felt was leaning back to empty mop bucket - felt warmth in LB then went to (L) glut, ant thigh
PMHX: L4 discectomy Feb '17

MEDS: Tramadol, Vicodin, Zanaflex, Humira, cyclobenzaprine, dexamethasone
WORK/ACTIVITY: works on base - part time custodial work; full time counseling
PAIN: Current: 8 /10 At worst: 10/10 At best: 6/10 Location/description: (L) LB → (L) glut → ant thigh → calf
DIAGNOSTIC TESTING: X-ray: loss of disc height at L5-S1; arthritis facets L3-S1
ROM extremities: POP angle (R) 40° (L) 80°, hip flex (R) 95° (L) 85°
ER (R) 50° (L) 25° IR (R) 30° (L) 25°

Trunk ROM		Cervical ROM	
Flex: 50°/10		Flex:	
Ext: 40°/10		Ext:	
SB (R) 20°/10	(L) 30°/10	SB (R)	(L)
Rot (R)	(L)	Rot (R)	(L)

SENSATION: numbness toes, plantar surface (L)

MMT				
Trunk flex: /5	Hip Flex (R) 4+/5 (L) 2+/5	Shoulder	LowTrap (R) /5 (L) /5	
Trunk ext: /5	Ext (R) 4+/5 (L) 2 /5	Flex (R) /5 (L) /5	Elbow flex (R) /5 (L) /5	
DF (R) 4+/5 (L) 3+/5	Abd (R) 4 /5 (L) 2- /5	ER (R) /5 (L) /5	Elbow ext (R) /5 (L) /5	
EV (R) 4+/5 (L) 3+ /5	Grtoe ext (R) /5 (L) /5	IR (R) /5 (L) /5	Wrist ext (R) /5 (L) /5	
Knee ext (R) 4+/5 (L) 4 /5		MidTrap (R) /5 (L) /5	Grip (R) lb (L) lb	
Flex (R) 4+/5 (L) 3+ /5		Lats (R) /5 (L) /5		

POSTURE: Lumbar lordosis ↓ Thoracic kyphosis
Cervical lordosis Scoliosis
Head/Shoulders Leg Length
GAIT: Amb 5 a/d, ↓ trunk rot noted, Trendelenberg lean c (L) stance
SPECIAL TESTS: (+) (R) SLR
PALPATION: Tender (R) QL, p/s lumbar, (L) > (R) SI
(L) > (R) piriformis
EXES:
Back/Neck Index 37/50
ASSESSMENT: Unable to relieve back/radicular symptoms
TREATMENT: attempted well leg SS, prone c 2 pillows under ABD/FEMUR mx 15', (L) piriformis, hip flexor IDY release
P. 29
ee Plan of Care for goals and prognosis THERAPIST:

D/C

~~PROGRESS~~ REPORT

SUMTER
PHYSICAL THERAPY CLINIC
1185 WILSON HALL ROAD · SUMTER, SC 29150
PHONE 803-469-3213 · FAX 803-469-3233

Patient's Name: Mcleod Johnson, Stara

MD: dr Hall

Date of Initial Visit: 4-30-18

Today's Date: 8.8.18

Total Visits: 1

Chief Complaint:

Initially: ~4 wk h/o LBP c (L) radiculopathy.

Currently: ____ Improving ____ Same ____ Worse

Objective: CPC IFC stim x 15' prone c 2 pillows under chest; (L) manual rectalmis, hip flexor/QL release, attempted SLR 45

EXERCISE	INSTRUCTION	MODALITIES	OTHER
___ conditioning	___ body mechanics	___ heat/ice	___ manual therapy
___ flexibility	___ home program	___ ultrasound	___ monitoring:
___ stabilization	___ lifting techniques	___ phono/ionto	___ swelling
___ strengthening	___ postural awareness	___ elec stim	___ cardiovascular
___ work hardening	___ self treatment	___ C/LB traction	___ relax techniques
		___ Whirlpool	

Progress Summary: Pt seen for I.E. - unable to relieve radicular symptoms; pt no showed next appt and did not return to PT

☒ **Physical Therapy Goals:**

☐ **Occupational Therapy Goals:**

Recommendations:

_____ being met	_____ Continue therapy
___X___ unable to meet	_____ Per M.D.'s instructions
_____ met	___X___ Discharge from therapy

Thank you.

EP. 30

8.8.18

***

IMAGECARE, LLC

710 RABON ROAD
COLUMBIA, SC 29203
803-462-3680

Name: McLeod, Stara
Patient ID: 230476
DOB: [redacted]
Acc#: 979845
Patient Phone #: [redacted]
***

Exam Date: 05/03/2018
Exam: MRI L-spine wo contrast
Reason:
Referrer: Deholl, PDouglas MD

PROCEDURE: Unenhanced MRI scan of the lumbosacral spine

CLINICAL HISTORY: Low back pain since November 2017

COMPARISON: None

TECHNIQUE: 4 mm sagittal and axial FSE T1-weighted images and FSE T2-weighted images were obtained.

FINDINGS: There are 5 nonrib-bearing lumbar vertebral segments with normal anatomic alignment of the lumbosacral and distal 3 thoracic spine segments without fracture deformity, vertebral subluxation, bone destruction, marrow edema, or significant focal or diffuse marrow abnormalities.

A capacious spinal canal is noted without congenital stenosis or segmentation anomalies. There is no significant scoliosis. The intradural and surrounding paraspinal soft tissues, muscles and neural and vascular structures are unremarkable.

Mild L5-S1 disc narrowing with disc desiccation without vacuum phenomenon is noted with a mild diffuse symmetric circumferential bulge of the L5-S1 annulus without focal disc herniation or protrusion or annular fissure. The L5-S1 facets are unremarkable without productive degenerative changes. There is no central or foraminal stenosis at the L5-S1 level.

The L4-5, L3-4, L2-3, L1-2, and distal 3 thoracic discs and adjacent vertebral segments are normal in appearance.

IMPRESSION: **(1). Mild L5-S1 disc narrowing with a mild diffuse symmetric circumferential bulge of the annulus is noted without annular fissure, disc protrusion or herniation, spinal stenosis, or productive facet changes.**

(2). The proximal 4 lumbar and distal 3 thoracic discs, adjacent vertebral segments, and remainder of the exam are otherwise normal in appearance.

Martin P. Dommers, M.D.
Electronic Signature

Date Finalized: 05/03/2018

DD: 05/03/2018 DT:05/03/2018

MCLEOD, STARA (id #286433, dob: [redacted])

XR, LUMBAR SPINE 04/13/2018 (#5279221)

rpretation	Review of xr, lumbar spine taken on 04/13/2018 at IN-OFFICE ORDER shows: Views: # Taken: 4-5 views. Views taken: A/P, Lateral, Flexion, and Extension.

f: 296·96999
8116118

Devin Troyer MD
2935 Colonial Dr.
Columbia, SC 29203

RGS

Test Date: 8/16/2018

Patient:	Stara McLeod	**DOB:**	11/4/1977	**Physician:**	Troyer
Sex:	Female	**Height:**	cm	**Ref Phys:**	Koranloo
ID#:		**Weight:**	lbs.	**Technician:**	

Patient Complaints:
Patient is a 40-year-old female who presents with back pain and numbness, tingling, weakness, and pain in the left lower extremity. She had a discectomy at L4 in 2016 with improvements. The symptoms have been present for several months since April.

Nerve Conduction Studies

Anti Sensory Summary Table

Stim Site	NR	Peak (ms)	Norm Peak (ms)	P-T Amp (µV)	Norm P-T Amp	Site1	Site2	Delta-P (ms)	Dist (cm)	Vel (m/s)	Norm Vel (m/s)
Left Sup Fibular Anti Sensory (Ant Lat Mall)											
ant. tib		3.4	<3.8	18.7	>5.0	ant. tib	Ant Lat Mall	3.4	12.0	35	>32
Left Sural Anti Sensory (Lat Mall)											
Calf		3.1	<3.8	15.0	>5.0	Calf	Lat Mall	3.1	12.0	39	>35

Motor Summary Table

Stim Site	NR	Onset (ms)	Norm Onset (ms)	C-P Amp (mV)	Norm C-P Amp	Site1	Site2	Delta-0 (ms)	Dist (cm)	Vel (m/s)	Norm Vel (m/s)
Left Fibular Motor (Ext Dig Brev)											
Ankle		3.7	<6.1	5.7	>2.5	B Fib	Ankle	7.2	37.0	51	>38
B Fib		10.9		5.3							
Left Tibial Motor (Abd Hall Brev)											
Ankle		4.5	<6.1	8.7	>3.0						

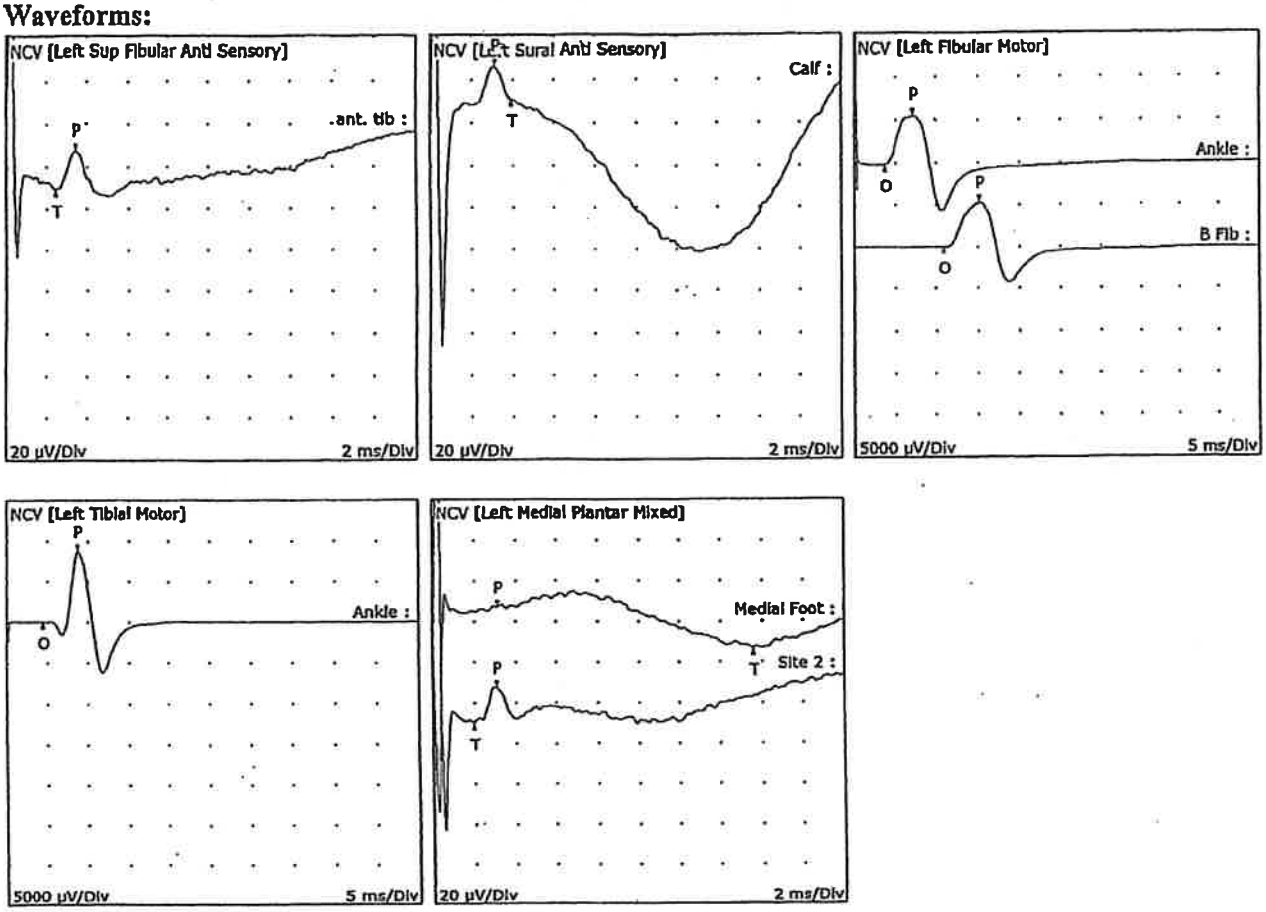
Mixed Summary Table

Stim Site	NR	Peak (ms)	Norm Peak (ms)	P-T Amp (µV)	Norm P-T Amp	Site1	Site2	Delta-P (ms)	Dist (cm)	Vel (m/s)	Norm Vel (m/s)
Left Medial Plantar Mixed (Med Malleolus)											
Medial Foot		3.1	<3.7	20.8	>10						
Site 2		3.1		17.7							

EMG

Sides	Muscle	Nerve	Root	Ins Act	Fibs	Psw	Amp	Dur	Poly	Recrt	Int Pat	Comment
Left	AntTibialis	Dp Br Fibular	L4-5	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	
Left	Gastroc	Tibial	S1-2	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	
Left	Fibularis Long	Sup Br Fibular	L5-S1	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	
Left	VastusMed	Femoral	L2-4	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	
Left	FDI	Med Plantar	S1-2	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	

Waveforms:



Patient History / Exam:
Past medical history is not significant. Manual muscle testing revealed 5/5 in bilateral lower extremities except for 4/5 in the left ankle dorsiflexors and EHL and toe flexors. Muscle stretch reflexes revealed 2+ in bilateral quadriceps and in the right gastroc-soleus and 0 in the left gastroc.

Impression:
This is a normal electrical study. There is no evidence of peripheral nerve entrapment. There is no evidence of peripheral polyneuropathy EMG reveals no evidence of radiculopathy or myopathy.

Her physical exam is certainly suspicious for radiculopathy with absent ankle reflex and distal weakness but no electrical changes were seen on EMG today.

Recommendations:
1. Follow-up with referring physician.
2. Continue current management of symptoms.
3. Today's results were discussed with the patient.

Devin Troyer MD.

SOUTHEASTERN SPINE INSTITUTE
1106 Chuck Dawley Blvd., Suite 200 ■ Mt. Pleasant, SC 29464

Patient Name: Stara Mcleod Encounter Date: 8/23/2018 Date of Birth: [redacted]
Account Number: 1083010

Chief Complaint: Low back pain with radiating left buttock and leg pain.

History of Present Illness: This patient is a 40 year old from Dalzell, South Carolina. He is referred by his attorney for an independent medical evaluation. He is status post date of injury 03-26-18. He has pain at 7 out of 10 particularly in the low back with radiation to the left buttock and left leg. He has 50% back 50% leg pain. He is seeing Dr. Todd Warrick and had to epidural injections with a third injection done elsewhere which did not help. Additionally, the patient has been through physical therapy.

The patient states she has talked with Dr. DeHoll and surgical intervention has been discussed. Past back history includes status post discectomy done January 2016 by Dr. Douglas DeHoll; surgery was an L5-S1 laminectomy on the left side. Patient did well from the surgery and was able to return to all activities. Pain is made better only by lying on her back.

Past Medical History: No known medical conditions.

Current Medications: desvenlafaxine succinate ER 50 mg tablet, extended release 24 hr Tb24 Oral, prednisone 20 mg tablet oral, clindamycin 300 mg capsule Oral, tobramycin-dexamethasone 0.3 %-0.1 % Eye Drops, Susp DrpS Opht

Drug Allergies: No known allergies.

Personal and Social History: She does not smoke cigarettes. She is employed at South Carolina Department of Mental Health.

Physical Examination: The patient is quite painful today. She is 5 feet 4 inches and weighs 164 pounds. She has a provocative straight leg raise on the left. She is tender in the left sciatic notch. Her gait is antalgic. She has pain with forward flexion and has an extensor lag. She is grossly neurologically intact.

Imaging Findings: The patient is accompanied by past medical records that I have reviewed. These have included notes from Dr. Douglas DeHoll and the most recent I have is dated 08-07-18. It was recommended the patient have an L5-S1 injection which she states she has done x3. Additionally, there is a discussion in regards to an L5-S1 fusion with this patient if she did not improve with nonoperative treatment.

I reviewed the patient's MRI scan. She does not have a large recurrent disc herniation. She has significant disc space collapse with Modic changes in the end plates. Levels above actually look quit good. Patient has expected postoperative

scar tissue on the left at L5-S1. The right side is not involved.

I reviewed Dr. DeHoll's note of 07-19-18 who stated at that time he did discuss "the possibility the patient may end up with an anterior lumbar interbody fusion at L5-S1."

Diagnosis Codes:
M54.5 Low back pain

Impression:
1. Low back pain with radiating left buttock and left leg pain.
2. Disc space collapse with foraminal stenosis L5-S1.
3. Status post laminectomy L5-S1 left January 2016.

Treatment Plan: I feel the patient has not reached maximum medical improvement. In my opinion, she would be a good candidate for an anterior lumbar interbody fusion at L5-S1.

Most probable to a reasonable degree of medical certainty the patient's current symptoms are causally related to her work injury of 03-26-18 by way of an exacerbation of a symptomatic exacerbation of a pre-existing asymptomatic condition.

I agree with Dr. DeHoll she would be a candidate for an anterior lumbar interbody fusion. We discussed the surgery at length and the importance of the vascular surgeon. Patient feels she cannot live with the situation as it is. Again, I feel she has not reached maximum medical improvement. She has maximized nonoperative treatment.

All opinions given above are most probable to a reasonable degree of medical certainty.

A vascular consultation was requested for evaluation and treatment. The patient is instructed to return if pain or symptoms arise.

Donald R. Johnson, II, MD

DRJ/jbe

cc: Dwight C. Moore, Esquire

ELECTRONICALLY SIGNED BY: Donald R. Johnson, II, MD
9/8/2018

Encounters

Encounter 2 Date 05/18/2018
Diagnosis Intervertebral disc disorders with radiculopathy, lumbosacral region, Unspecified Diagnosis

Encounter 1 Date 05/22/2018
Diagnosis Intervertebral disc disorders with radiculopathy, lumbosacral region, Unspecified Diagnosis

Encounter #1

History & Physical Report
5/22/2018: Office Visit - Intervertebral disc disorders with radiculopathy, lumbosacral region, Unspecified Diagnosis (Michael T. Warrick, MD)

STARA S. MCLEOD
5/22/2018 9:11 AM
Location: Sumter Spine & Pain Center
Patient #: 121 9090
DOB: [redacted]
Married / Language: English / Race: Black or African American
Female

History of Present Illness (Michael T. Warrick, MD; 5/22/2018 10:29 AM)

Patient words: Patient was seen on 12/22/16 for an office visit. She was referred to Deholl. She did have the L4 microdiscectomy in December 2016, with good relief. She has since been in PT and had a new MRI completed. Dr. Deholl sent her today for a possible SI injection. She is complaining of lower back pain that radiates across the left buttock down to the left knee. She does not have feeling in 3 of the toes on her left foot. She says "I have horrible cramps in my legs at night and alot of weakness on my left side". She has started taking Gabapentin, vimovo, tizanidine, and tramadol since her last visit here. She says that these do help her to rest but her pain is still bad during the day.

The patient is a 40 year old female

Allergies (RN Stacy H. Baylor; 5/22/2018 9:17 AM)
No Known Drug Allergies. 10/27/2016

Family History (RN Stacy H. Baylor; 5/22/2018 9:17 AM)
None. 10/27/2016

Social History (RN Stacy H. Baylor; 5/22/2018 9:17 AM)
Non Drinker/No Alcohol Use
Occupation. Part-time.
No Drug Use
Tobacco Use. Never smoker.
Living Situation. Married.

Medication History (RN Stacy H. Baylor; 5/22/2018 9:23 AM)
Medications Reconciled.
TraMADol HCl (50MG Tablet, Oral every 6 hours as needed) Active.
Vimovo (500-20MG Tablet DR, Oral two times daily) Active.
TiZANidine HCl (4MG Capsule, Oral at bedtime) Active.
Gabapentin (600MG Tablet, Oral at bedtime) Active.

Past Surgical History (RN Stacy H. Baylor; 5/22/2018 9:17 AM)
Hysterectomy; Abdominal

Other Problems (Michael T. Warrick, MD; 5/22/2018 10:36 AM)
Intervertebral disc disorders with radiculopathy, lumbosacral region (M51.17)
Unspecified Diagnosis
Unspecified Diagnosis
Unspecified Diagnosis

Review of Systems (Michael T. Warrick, MD; 5/22/2018 10:29 AM)
Musculoskeletal: Present - Back Pain and Difficulty Walking.
All other systems negative

Vitals (RN Stacy H. Baylor; 5/22/2018 9:20 AM)
5/22/2018 9:19 AM
Weight: 160 lb **Height:** 64 in
Weight was reported by patient.
Height was reported by patient.
Body Surface Area: 1.81 m² **Body Mass Index:** 27.46 kg/m²

Pain Level: 6/10
Pulse: 78 (Regular) **Resp.:** 16 (Unlabored) **P.OX:** 98% (Room air)
BP: 112/76 (Sitting, Left Arm, Standard)

Physical Exam (Michael T Warrick, MD; 5/22/2018 10:33 AM)
The physical exam findings are as follows:

General
Mental Status - Alert. **General Appearance** - Cooperative and Well groomed. **Orientation** - Oriented X4. **Build & Nutrition** - Well developed.

Peripheral Vascular
Upper Extremity: Inspection - Left - Normal - No Clubbing, No Cyanosis, No Edema, Pulses Intact. **Right** - Normal - No Clubbing, No Cyanosis, No Edema, Pulses Intact
Palpation: - All peripheral pulses intact in upper extremities.
Lower Extremity: Inspection - Left - Inspection Normal. **Right** - Inspection Normal.
Palpation: - All peripheral pulses intact in lower extremities.

Neurologic
Sensory:
Light Touch: Intact - Globally.
Proprioception - **Bilateral** - Normal.
Overall Assessment of Muscle Strength and Tone reveals:
Lower Extremities: Right Iliopsoas - 5/5. **Left Iliopsoas** - 5/5. **Right Quadriceps** - 5/5. **Left Quadriceps** - 5/5. **Right Hamstrings** - 5/5. **Left Hamstrings** - 5/5. **Right Tibialis Anterior** - 5/5. **Left Tibialis Anterior** - 5/5. **Right Gastroc-Soleus** - 5/5. **Left Gastroc-Soleus** - 4/5. **Right EHL** - 5/5 **Left EHL** - 4/5.
General Assessment of Reflexes: **Right Knee** - 2+. **Left Knee** - 2+. **Right Ankle** - 2+. **Left Ankle** - 0.
Plantar Reflexes (L4-S2) - **Bilateral** - plantar flexion. **Coordination** - Normal. **Gait** - Normal.

Musculoskeletal
Spine/Ribs/Pelvis
Thoracic (Dorsal) Spine:
Inspection and Palpation: Tenderness - None.
ROJM: Normal in flexion/extension/rotation - Normal in flexion/extension/rotation.
Deformities/Malalignments/Discrepancies - None.
Lumbosacral Spine:
Inspection and Palpation: Tenderness - no tenderness to palpation over the spinous processes or paravertebral tissues
Muscle tone - no palpable spastic cords or trigger points noted. **Swelling** - none.
ROJM: Testing limited - due to pain
Functional Testing - Modified Straight Leg Raise positive for sciatic pain (mild). Patrick (FABER) negative for sacroiliac joint pain and Piriformis Stretch Negative for Sciatic Pain.

Assessment & Plan (Michael T. Warrick, MD; 5/22/2018 10:36 AM)
Intervertebral disc disorders with radiculopathy, lumbosacral region (M51.17)
Impression: Patient returns for followup, last seen at end of 2016 for L E radicular pain associated with L5-S1 HNP. She underwent microdiscectomy with good relief of leg pain for about one year. Gradual progression of axial lumbar pain with now progressive L-E radicular pain / paresthesias. Xrays confirm L5-S1 collapse, MRI was done but not available for review. Neuro exam consistent with S1 radiculopathy, no EMG/NCS done yet. deHoll referred to PT, but she was unable to participate due to pain despite polyanalgesic regimen Rx by deHoll. Seek authorization for left-sided L5-S1 ESI ASAP.

Unspecified Diagnosis
Current Plans
- Pt Education - How to access health information online: discussed with patient and provided information.
- FALL RISK ASSESSMENT (3288F)
- SIGN AND SYMPTOM OF ABUSE AND NEGLECT
- SCREENING ASSESSMENT OF SUICIDE RISK (3085F)
-

I have personally seen and examined this patient. I have fully participated in the care of this patient.

I have reviewed the PFSH, ROS, and Vital Signs.

T Warrick, MD

Signed by Michael T. Warrick, MD (5/22/2018 10:36 AM)

Encounter #2

History & Physical Report
6/18/2018: Procedure - Intervertebral disc disorders with radiculopathy, lumbosacral region, Unspecified Diagnosis (Michael T. Warrick, MD)

STARA S. MCLEOD
6/18/2018 10:53 AM
Location: Sumter Spine & Pain Center
Patient #: 121 9090
DOB: [redacted]
Married / Language: English / Race: Black or African American
Female

History of Present Illness (Michael T. Warrick, MD; 6/18/2018 11:36 AM)

Patient words: Patient is here today for a left sided LS-S1 TFESI after receiving authorization from the insurance company

The patient is a 40 year old female

Allergies (RN Stacy H. Baylor; 6/18/2018 10:55 AM)
No Known Drug Allergies. 10/27/2016

Family History (RN Stacy H. Baylor; 6/18/2018 10:55 AM)
None. 10/27/2016

Social History (RN Stacy H. Baylor; 6/18/2018 10:55 AM)
Living Situation. Married.
Tobacco Use. Never smoker.
Non Drinker/No Alcohol Use
No Drug Use
Occupation. Part-time.

Medication History (RN Stacy H. Baylor; 6/18/2018 10:55 AM)
TraMADol HCl (50MG Tablet, Oral every 6 hours as needed) Active.
Vimovo (500-20MG Tablet DR, Oral two times daily) Active.
TiZANidine HCl (4MG Capsule, Oral at bedtime) Active.
Gabapentin (600MG Tablet, Oral at bedtime) Active.
Medications Reconciled.

Past Surgical History (RN Stacy H. Baylor; 6/18/2018 10:55 AM)
Hysterectomy; Abdominal

Other Problems (Michael T. Warrick, MD; 6/18/2018 11:37 AM)
Unspecified Diagnosis
Intervertebral disc disorders with radiculopathy, lumbosacral region (M51.17)

Review of Systems (RN Stacy H. Baylor; 6/18/2018 10:55 AM)
HEENT: Present- **Wears glasses/contact lenses.**
Musculoskeletal: Present- **Back Pain.**

Vitals (RN Stacy H. Baylor; 6/18/2018 11:00 AM)
6/18/2018 10:58 AM
Weight: 160 lb **Height:** 64 in
Weight was reported by patient.
Height was reported by patient.
Body Surface Area: 1.81 m² **Body Mass Index:** 27.46 kg/m²
Pain Level: 7/10
Pulse: 84 (Regular) **Resp.:** 16 (Unlabored) **P.OX:** 98% (Room air)
BP: 127/63 (Sitting, Left Arm, Standard)

Assessment & Plan (Michael T. Warrick, MD; 6/18/2018 11:37 AM)

Intervertebral disc disorders with radiculopathy, lumbosacral region (M51.17)
Current Plans
- LUMBAR/SACRA. TFESI W/ FLUOROSCOPY(64483)

Unspecified Diagnosis
Current Plans
- Pt Education - How to access health information online: discussed with patient and provided information.
- FALL RISK ASSESSMENT (3288F)
- SIGN AND SYMPTOM OF ABUSE AND NEGLECT
- SCREENING ASSESSMENT OF SUICIDE RISK (3085F)
-

I have personally seen and examined this patient. I have fully participated in the care of this patient.

I have reviewed the PFSH, ROS, and Vital Signs

T Warrick, MD

Signed by Michael T. Warrick, MD (6/18/2018 11:37 AM)

Procedures

LUMBAR/SACRAL TFESI W/ FLUOROSCOPY(64483) Performed: 06/18/2018 (Final, Reviewed)
- Comments: Left L5-S1 Lumbar/Sacral Transforaminal Epidural Injection

Indication for Procedure: Intractable pain, poorly responsive to non-invasive therapy
Treatment Location: Left L5-S1
Anesthesia: Local
Complications: None

After the risks outlined in consent form were explained and all patient questions were answered, written informed consent for the procedure was obtained. The patient was taken to the procedure suite and placed in a prone position. The skin over the lumbar spine was prepped with chlorhexidine and draped in a sterile fashion. Using fluoroscopy, the lumbar spine was surveyed. Using intermittent ipsilateral oblique fluoroscopy, a needle insertion point was chosen just caudal to the pedicle. The skin was anesthetized with lidocaine 1%. A 22 gauge 5 inch Quincke needle was advanced toward the inferior aspect of the pedicle. The needle was advanced into the neuroforamen under intermittent lateral fluoroscopy. Radiopaque contrast was injected under live anterior/posterior fluoroscopy, which confirmed epidural spread without vascular uptake. The treatment solution was slowly injected without pain or paresthesia into the treated levels for a total dosage of 2cc of Depo-Medrol 40mg/ml and 1cc of bupivacaine 0.25%. The needle(s) were flushed and withdrawn. Pressure was held at the insertion sites for hemostasis, and Band-Aids were applied. A follow-up appointment was scheduled. The patient was discharged with instructions to contact the Pain Center or present to their nearest emergency center should excessive bleeding, pain, weakness, fever or other concerning symptom occur.

FALL RISK ASSESSMENT (3288F) Performed: 06/18/2018 (Final, Reviewed)
- Is patient at risk for fall?: No

SIGN AND SYMPTOM OF ABUSE AND NEGLECT Performed: 06/18/2018 (Final, Reviewed)
- Are sign and symptoms present of abuse and/or neglect?: No

SCREENING ASSESSMENT OF SUICIDE RISK (3085F) Performed: 06/18/2018 (Final, Reviewed)

Ask questions 1 and 2
- 1) Have you wished you were dead or wished you could go to sleep and not wake up?: No
- 2) Have you actually had any thoughts of killing yourself?: No

If YES to 2, ask questions 3, 4, 5 and 6. If NO to 2, go directly to question 6.
- 6) Have you ever done anything, started to do anything, or prepared to do anything to end your life?: No

Procedures

FALL RISK ASSESSMENT (3288F) Performed: 05/22/2018 (Final, Reviewed)
- Is patient at risk for fall?: No

SIGN AND SYMPTOM OF ABUSE AND NEGLECT Performed: 05/22/2018 (Final, Reviewed)
- Are sign and symptoms present of abuse and/or neglect?: No

SCREENING ASSESSMENT OF SUICIDE RISK (3085F) Performed: 05/22/2018 (Final, Reviewed)

Ask questions 1 and 2
- 1) Have you wished you were dead or wished you could go to sleep and not wake up?: No
- 2) Have you actually had any thoughts of killing yourself?: No

If YES to 2, ask questions 3, 4, 5 and 6. If NO to 2, go directly to question 6
- 6) Have you ever done anything, started to do anything, or prepared to do anything to end your life?: No

ACCOUNT CHARGE ACTIVITY DETAIL
10/30/2020

CLINIC:
NAME PALMETTO HEALTH
ADDRESS PO BOX 402145
ATLANTA, GA 303842145

803-296-7320

GUARANTOR:
5-37-03484 FC: MA
NAME JOHNSON, ANDRE G
ADDRESS [redacted]

DATA SELECTION CRITERIA:
CUSTOMER: 10513
FIN CLASS:

PHYSICIAN:
SITE:
AGC:
DEPARTMENT: SPSCTR
LOCATION:
PRINT: Detail
DATE SELECTION: Post date
DATE FROM: 03/26/2018
DATE TO: 10/30/2020
PROC CODE FROM:
PROC CODE TO:
RESPONSIBLE: All
CHARGE STATUS: Both

PATIENT RESPONSIBLE:	22.42
INSURANCE RESPONSIBLE:	42.82
PREPAYMENTS:	0.00
INSURANCE UNAPPLIED PAYMENTS:	0.00
PERSONAL UNAPPLIED PAYMENTS:	0.00
LINKED PAYMENTS:	0.00

SORT BY:
PRIMARY: Posting date
SECONDARY:
TERTIARY:

PAGE: 1

OPERATOR: CPRESSL3

GUARANTOR: 5-37-03484 JOHNSON, ANDRE G
PATIENT:

ACCOUNT CHARGE ACTIVITY DETAIL

DOS	CODE / DESCRIPTION	BILL AMOUNT	INS RESP	INS PAID	PATIENT INS ADJ	PHYSICIAN PAT RESP	PAT PAID	PAT ADJ	OPEN BAL
05/22/2018	99214 OFFICE/OUTPATIENT VISIT EST	162.00	162.00	81.14- STAR	66.54- MCLEOD	WARRICK, MICHAEL T 0.00	0.00	0.00	14.32
	ICD-10 DX: M5117								
	ICD-9 DX:								
	05/29/2018 Filed to UHCMCRPPO			162.00 CHAMPVA	Claim: 5093025	FC: MA			
	07/30/2018 MEDICARE ADVANTAGE PAYMENT			81.14-		FC: MA			
	07/30/2018 MEDICARE ADVANTAGE DISALLOW			66.54-		FC: MA			
06/18/2018	64483 INJ FORAMEN EPIDURAL L/S	684.00	684.00	161.53- STAR	493.97- MCLEOD	WARRICK, MICHAEL T 0.00	0.00	0.00	28.50
	ICD-10 DX: M5117								
	ICD-9 DX:								
	06/25/2018 Filed to UHCMCRPPO			684.00 CHAMPVA	Claim: 5114664	FC: MA			
	07/30/2018 MEDICARE ADVANTAGE PAYMENT			161.53-		FC: MA			
	07/30/2018 MEDICARE ADVANTAGE DISALLOW			493.97-		FC: MA			
		846.00	846.00	242.67-	560.51-	0.00	0.00	0.00	42.82

PATIENT BALANCE	0.00
INSURANCE BALANCE	42.82
NONCOLLECTIBLE BALANCE	0.00

OPERATOR: CPRESSL3

BENEFITS ASSIGNED TO Prisma Health Tuomey

PRISMA HEALTH.

REMIT TO:
Prisma Health Tuomey
P.O. Box 602129
Charlotte, NC 28260-2129

AMOUNT ENCLOSED	TYPE

PLEASE DETACH AT PERFORATION AND RETURN WITH YOUR REMITTANCE

PATIENT NAME	PATIENT ACCOUNT NUMBER	ADMISSION DATE	DISCHARGE DATE	BILLING DATE
MCLEOD,STARA SHANEIQUA	A00043924224	04/23/18	04/23/18	04/28/18

GUARANTOR
MCLEOD,STARA SHANEIQUA
[redacted]

INSURANCE COVERAGE
UNITED HEALTHCARE 943460441
CHAMPVA [redacted]

POLICY NUMBER

SERVICE DATE		DESCRIPTION	QTY.	AMOUNT
	***	0450 EMERGENCY ROOM ***		
04/23/18	78102503	ER LEVEL 3 9928325; ER LEVEL 3 9928325	1	897.00
04/23/18	78190772	INJ IM/SC DIAG/PROPH ER; INJ IM/SC DIAG/PROPH ER	1	500.00
				1397.00
	***	0636 DRUGS REQ DETAIL CODING ***		
04/23/18	88208608	DEXAMETHASONE 1MG INJ; Dexamethasone Sod Phos 4 MG/ML VIAL	2	12.00
				12.00
	***	0637 DRUGS - SELF ADMINISTERED ***		
04/23/18	88231622	HYDROCODONE 5 MG/APAP 325 MG; HYDROcodone/APAP 5/325 MG TAB	1	3.00
				3.00
	***	RECEIPTS, ADJUSTMENTS, ETC. ***		
07/24/18	AUNIHEAG1	UNITED HEALTHCARE; COM ADJ	1	-228.00
07/24/18	PUNIHEAG1	UNITED HEALTHCARE; COM RCP	1	-1006.40
07/24/18	PCHMPVA	CHAMPVA; COM RCP	1	0
08/24/18	PCHMPVA	CHAMPVA; TRI RCP	1	-177.60
				-1412.00

A00043924224

PATIENT ACCOUNT NO.

Prisma Health Tuomey
129 N. WASHINGTON ST. SUMTER, SC 29150-4983

THIS IS THE ONLY COPY OF THIS BILL YOU WILL RECEIVE. PLEASE SAVE FOR ANY MAJOR MEDICAL BILLING AND TAX RECORDS.

TOTAL: 1412.00
TOTAL CREDITS: -1412.00
TOTAL DUE: 0.00
ESTIMATED INSURANCE COVERAGE: 0.00
ESTIMATED PATIENT DUE: 0.00

BENEFITS ASSIGNED TO Prisma Health Tuomey

PRISMA HEALTH

REMIT TO:
Prisma Health Tuomey
P.O. Box 602129
Charlotte, NC 28260-2129

AMOUNT ENCLOSED	TYPE

PLEASE DETACH AT PERFORATION AND RETURN WITH YOUR REMITTANCE

PATIENT NAME	PATIENT ACCOUNT NUMBER	ADMISSION DATE	DISCHARGE DATE	BILLING DATE
MCLEOD,STARA SHANEIQUA	A00044053536	05/22/18	05/22/18	05/30/18

GUARANTOR
MCLEOD,STARA SHANEIQUA
[redacted]

INSURANCE COVERAGE / POLICY NUMBER
UNITED HEALTHCARE 943460441
CHAMPVA [redacted]

SERVICE DATE		DESCRIPTION	QTY.	AMOUNT
	***	0S10 CLINIC ***		
05/22/18	61099211	E&M EST PT LEVEL 1 99211	1	95.00
				95.00
	***	RECEIPTS, ADJUSTMENTS, ETC. ***		
07/24/18	AUNIHEAG1	UNITED HEALTHCARE; COM ADJ	1	-19.76
07/24/18	PUNIHEAG1	UNITED HEALTHCARE; COM RCP	1	-63.95
07/24/18	PCHMPVA	CHAMPVA; COM RCP	1	0
07/26/18	ACHMPVA	CHAMPVA	1	-11.29
09/05/18	PCHMPVA	CHAMPVA; TRI RCP	1	-11.29
09/11/18	ACHMPVA	CHAMPVA	-1	11.29
				-95.00

A00044053536
PATIENT ACCOUNT NO.

Prisma Health Tuomey
129 N. WASHINGTON ST. SUMTER, SC 29150-4983

THIS IS THE ONLY COPY OF THIS BILL YOU WILL RECEIVE. PLEASE SAVE FOR ANY MAJOR MEDICAL BILLING AND TAX RECORDS.

TOTAL: 95.00
TOTAL CREDITS: -95.00
TOTAL DUE: 0.00
ESTIMATED INSURANCE COVERAGE: 0.00
ESTIMATED PATIENT DUE: 0.00

BENEFITS ASSIGNED TO Prisma Health Tuomey

PRISMA HEALTH.

REMIT TO:
Prisma Health Tuomey
P.O. Box 602129
Charlotte, NC 28260-2129

AMOUNT ENCLOSED	TYPE

PLEASE DETACH AT PERFORATION AND RETURN WITH YOUR REMITTANCE

PATIENT NAME	PATIENT ACCOUNT NUMBER	ADMISSION DATE	DISCHARGE DATE	BILLING DATE
MCLEOD,STARA SHANEIQUA	AC0044170587	06/18/18	06/18/18	06/30/18

GUARANTOR
MCLEOD,STARA SHANEIQUA
[redacted]

INSURANCE COVERAGE
UNITED HEALTHCARE CHAMPVA

POLICY NUMBER
943460441
[redacted]

SERVICE DATE		DESCRIPTION	QTY.	AMOUNT
	***	0250 PHARMACY ***		
06/18/18	88261377	BUPIVACAINE 0.25% PF 10ML VIAL; Bupivacaine 0.25% PF 10 ML VIAL	1	9.00
				9.00
	***	0510 CLINIC ***		
06/18/18	61020644	INJ LUMBAR EPID W/CONT 64483LT	1	1837.00
				1837.00
	***	0636 DRUGS REQ DETAIL CODING ***		
06/18/18	88209200	METHYLPREDNISO.ACETATE 40MG; methylPREDNISolone Acetate 40 MG/ML	2	54.00
06/18/18	88261640	LIDOCAINE 300 MG/30 ML VIAL; Lidocaine 1% (Local Anesth.) 1 VIAL	1	8.00
				62.00
	***	RECEIPTS, ADJUSTMENTS, ETC. ***		
07/24/18	PUNIHEAG1	UNITED HEALTHCARE; COM RCP	1	-1621.80
07/24/18	PCHMPVA	CHAMPVA; COM RCP	1	0
07/26/18	ACHMPVA	CHAMPVA	1	-286.20
				-1908.00

A00044170587

PATIENT ACCOUNT NO.

Prisma Health Tuomey
129 N. WASHINGTON ST. SUMTER, SC 29150-4983

THIS IS THE ONLY COPY OF THIS BILL YOU WILL RECEIVE. PLEASE SAVE FOR ANY MAJOR MEDICAL BILLING AND TAX RECORDS.

TOTAL: 1908.00
TOTAL CREDITS: -1908.00
TOTAL DUE: 0.00
ESTIMATED INSURANCE COVERAGE: 0.00
ESTIMATED PATIENT DUE: 0.00

BENEFITS ASSIGNED TO Prisma Health Tuomey

PRISMA HEALTH.

REMIT TO:
Prisma Health Tuomey
P.O. Box 602129
Charlotte, NC 28260-2129

PAGE: 1

AMOUNT ENCLOSED	TYPE

PLEASE DETACH AT PERFORATION AND RETURN WITH YOUR REMITTANCE

PATIENT NAME	PATIENT ACCOUNT NUMBER	ADMISSION DATE	DISCHARGE DATE	BILLING DATE
MCLEOD,STARA SHANEIQUA	A00044816411	11/06/18	11/06/18	11/15/18

GUARANTOR	INSURANCE COVERAGE	POLICY NUMBER
MCLEOD,STARA SHANEIQUA [redacted]	UNITED HEALTHCARE CHAMPVA	943460441 [redacted]

SERVICE DATE		DESCRIPTION	QTY.	AMOUNT
	***	0401 MAMMOGRAMS/DIAGNOSTIC ***		
11/06/18	84706652	MAM DX BIL AND CAD *	1	261.00
				261.00
	***	0402 ULTRASOUND ***		
11/06/18	84776642	MAMMO U/S RT BREAST LIMITED	1	260.00
				260.00
	***	RECEIPTS, ADJUSTMENTS, ETC. ***		
11/27/18	PCHMPVA	CHAMPVA; COM RCP	1	0
11/27/18	AUNIHEAG1	UNITED HEALTHCARE; COM ADJ	1	-108.37
11/27/18	PUNIHEAG1	UNITED HEALTHCARE; COM RCP	1	-350.73
01/07/19	PCHMPVA	CHAMPVA; TRI RCP	1	-61.90
				-521.00

A00044816411

PATIENT ACCOUNT NO.

Prisma Health Tuomey
129 N. WASHINGTON ST. SUMTER, SC 29150-4983

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TOTAL: 521.00
TOTAL CREDITS: -521.00
TOTAL DUE: 0.00
ESTIMATED INSURANCE COVERAGE: 0.00
ESTIMATED PATIENT DUE: 0.00

BENEFITS ASSIGNED TO Prisma Health Tuomey

PRISMA HEALTH

REMIT TO:
Prisma Health Tuomey
P.O. Box 602129
Charlotte, NC 28260-2129

AMOUNT ENCLOSED	TYPE

PLEASE DETACH AT PERFORATION AND RETURN WITH YOUR REMITTANCE

PATIENT NAME	PATIENT ACCOUNT NUMBER	ADMISSION DATE	DISCHARGE DATE	BILLING DATE
MCLEOD,STARA SHANEIQUA	A00044978468	12/18/18	12/18/18	01/12/19

GUARANTOR	INSURANCE COVERAGE	POLICY NUMBER
MCLEOD,STARA SHANEIQUA [redacted]	UNITED HEALTHCARE CHAMPVA	943460441 [redacted]

SERVICE DATE		DESCRIPTION	QTY.	AMOUNT
	***	0610 MRI-GEN CLASSIFICATION ***		
12/18/18	83000204	MRI CAD FOR BREAST *	1	37.00
12/18/18	83000206	MRI BREAST CAD BIL W/WO CONT	1	5288.00
				5325.00
	***	0636 DRUGS REQ DETAIL CODING ***		
12/18/18	83000184	PER ML; MR Gadavist 10ml	8	0.00
				0
	***	RECEIPTS, ADJUSTMENTS, ETC. ***		
01/23/19	AUNIHEAG1	UNITED HEALTHCARE; COM ADJ	1	-2393.00
01/23/19	PUNIHEAG1	UNITED HEALTHCARE; COM RCP	1	-2460.75
01/23/19	PCHMPVA	CHAMPVA; COM RCP	1	-434.25
06/25/19	PSP	PATIENT PAYMENT SELF PAY	1	-37.00
				-5325.00

A00044978468

PATIENT ACCOUNT NO.

Prisma Health Tuomey
129 N. WASHINGTON ST. SUMTER, SC 29150-4983

THIS IS THE ONLY COPY OF THIS BILL YOU WILL RECEIVE. PLEASE SAVE FOR ANY MAJOR MEDICAL BILLING AND TAX RECORDS.

TOTAL: 5325.00
TOTAL CREDITS: -5325.00
TOTAL DUE: 0.00
ESTIMATED INSURANCE COVERAGE: 0.00
ESTIMATED PATIENT DUE: 0.00

BENEFITS ASSIGNED TO Prisma Health Tuomey

PRISMA HEALTH.

REMIT TO:
Prisma Health Tuomey
P.O. Box 602129
Charlotte, NC 28260-2129

AMOUNT ENCLOSED	TYPE

PLEASE DETACH AT PERFORATION AND RETURN WITH YOUR REMITTANCE

PATIENT NAME	PATIENT ACCOUNT NUMBER	ADMISSION DATE	DISCHARGE DATE	BILLING DATE
MCLEOD,STARA SHANEIQUA	A00045038627	01/07/19	01/07/19	01/15/19

GUARANTOR	INSURANCE COVERAGE	POLICY NUMBER
MCLEOD,STARA SHANEIQUA [redacted]	UNITED HEALTHCARE CHAMPVA	943460441 [redacted]

SERVICE DATE		DESCRIPTION	QTY.	AMOUNT
	***	0312 HISTOLOGY ***		
01/07/19	80803954	SURG PATH LEVEL IV 88305	1	145.00
				145.00
	***	0361 OR/MINOR ***		
01/07/19	84719083	US BX BREAST 1ST LESION IMAG	1	1926.00
				1926.00
	***	0401 MAMMOGRAMS/DIAGNOSTIC ***		
01/07/19	84703206	MAMMO DIAG UNILAT DIGITAL	1	204.00
				204.00
	***	RECEIPTS, ADJUSTMENTS, ETC. ***		
01/23/19	PUNIHEAG1	UNITED HEALTHCARE; COM RCP	1	-465.37
01/29/19	PCHMPVA	CHAMPVA; COM RCP	1	-1588.06
03/04/19	PCHMPVA	CHAMPVA; TRI RCP	1	-894.00
03/11/20	ACHMPVA	CHAMPVA	-1	672.43
				-2275.00

A00045038627

PATIENT ACCOUNT NO.

Prisma Health Tuomey
129 N. WASHINGTON ST. SUMTER, SC 29150-4983

THIS IS THE ONLY COPY OF THIS BILL YOU WILL RECEIVE. PLEASE SAVE FOR ANY MAJOR MEDICAL BILLING AND TAX RECORDS.

TOTAL: 2275.00
TOTAL CREDITS: -2275.00
TOTAL DUE: 0.00
ESTIMATED INSURANCE COVERAGE: 0.00
ESTIMATED PATIENT DUE: 0.00

BENEFITS ASSIGNED TO Prisma Health Tuomey

PRISMA HEALTH

REMIT TO:
Prisma Health Tuomey
P.O. Box 602129
Charlotte, NC 28260-2129

PAGE: 1

AMOUNT ENCLOSED	TYPE

PLEASE DETACH AT PERFORATION AND RETURN WITH YOUR REMITTANCE

PATIENT NAME	PATIENT ACCOUNT NUMBER	ADMISSION DATE	DISCHARGE DATE	BILLING DATE
MCLEOD,STARA SHANEIQUA	A00045070919	01/10/19	01/10/19	01/17/19

GUARANTOR
MCLEOD,STARA SHANEIQUA
[redacted]

INSURANCE COVERAGE
UNITED HEALTHCARE 943460441
CHAMPVA [redacted]

POLICY NUMBER

SERVICE DATE		DESCRIPTION	QTY.	AMOUNT
	***	0402 ULTRASOUND ***		
01/10/19	85704500	76700 U/S ABDOMEN	1	409.00
				409.00
	***	RECEIPTS, ADJUSTMENTS, ETC. ***		
01/29/19	PCHMPVA	CHAMPVA; COM RCP	1	0
01/29/19	AUNIHEAG1	UNITED HEALTHCARE; COM ADJ	1	-85.07
01/29/19	PUNIHEAG1	UNITED HEALTHCARE; COM RCP	1	-275.34
03/07/19	PCHMPVA	CHAMPVA; TRI RCP	1	-48.59
				-409.00

A00045070919
PATIENT ACCOUNT NO.

Prisma Health Tuomey
129 N. WASHINGTON ST. SUMTER, SC 29150-4983

THIS IS THE ONLY COPY OF THIS BILL YOU WILL RECEIVE, PLEASE SAVE FOR ANY MAJOR MEDICAL BILLING AND TAX RECORDS.

TOTAL: 409.00
TOTAL CREDITS: -409.00
TOTAL DUE: 0.00
ESTIMATED INSURANCE COVERAGE: 0.00
ESTIMATED PATIENT DUE: 0.00

BENEFITS ASSIGNED TO Prisma Health Tuomey

PRISMA HEALTH

REMIT TO:
Prisma Health Tuomey
P.O. Box 602129
Charlotte, NC 28260-2129

AMOUNT ENCLOSED	TYPE

PLEASE DETACH AT PERFORATION AND RETURN WITH YOUR REMITTANCE

PATIENT NAME	PATIENT ACCOUNT NUMBER	ADMISSION DATE	DISCHARGE DATE	BILLING DATE
MCLEOD,STARA SHANEIQUA	A00045300720	02/27/19	02/28/19	03/21/19

GUARANTOR
MCLEOD,STARA SHANEIQUA
[redacted]

INSURANCE COVERAGE
UNITED HEALTHCARE 943460441
CHAMPVA [redacted]

POLICY NUMBER

SERVICE DATE	DESCRIPTION		QTY.	AMOUNT
	***	0420 PHYSICAL THERAPY ***		
02/27/19	PT92046194	PT MODERATE COMPLEXITY EVAL; PT MODERATE COMPLEXITY EVAL	1	389.00
				389.00
	***	RECEIPTS, ADJUSTMENTS, ETC. ***		
04/02/19	PUNIHEAG1	UNITED HEALTHCARE; COM RCP	1	-389.00
05/14/19	PCHMPVA	CHAMPVA; COM RCP	1	0
05/14/19	PUNIHEAG1	UNITED HEALTHCARE; COM RCP	-1	389.00
05/14/19	AUNIHEAG1	UNITED HEALTHCARE; COM ADJ	1	-60.00
05/14/19	PUNIHEAG1	UNITED HEALTHCARE; COM RCP	1	-279.65
05/15/19	PUNIHEAG1	UNITED HEALTHCARE	1	-109.35
05/20/19	AUNIHEAG1	UNITED HEALTHCARE	-1	60.00
07/03/19	PUNIHEAG1	UNITED HEALTHCARE	-1	109.35
06/10/20	PRSI	RSI	1	-25.00
				-304.65

A00045300720
PATIENT ACCOUNT NO.

Prisma Health Tuomey
129 N. WASHINGTON ST. SUMTER, SC 29150-4983

THIS IS THE ONLY COPY OF THIS BILL YOU WILL RECEIVE. PLEASE SAVE FOR ANY MAJOR MEDICAL BILLING AND TAX RECORDS.

TOTAL: 389.00
TOTAL CREDITS: -304.65
TOTAL DUE: 84.35
ESTIMATED INSURANCE COVERAGE: 0.00
ESTIMATED PATIENT DUE: 84.35

Routing Sheet

Site: SC

RESOURCES x

(KI,SM,NH only) ENTERPRISE

Name: Starra McLeod

Program SC Cost Center 456 Task Code 72

	Circle What Applies	
Is This Person Time Studied?	YES	(NO)
Is This Person JWOD?	(YES)	NO
If Yes Agency Name	State of South Carolina Department of Mental Health	
Is This Person A Veteran?	YES	(NO)

New Hire ✓ Re-Hire ____ Driver ✓

Full Time ____ Part Time ✓ Activity Code 710

Building N/A (NW ONLY) Department ____ (UN - US - JA - JP) Indirect Labor % ____ (OTHER ONLY)

Vacation ✓ Standard Hours ____ (HD and FL) Sick Mandate State ____ (CA-CT-DC-MA-NY (90 Days From Start Date))

FCE Insurance:

Yes x No ____ (NW OR Per Mr. Green)

Previously Held By: Roberta Goodman

Description/ Job Title: Janitor

Site Application Check OFF

INTAKE (If applicable)	Ø	Intake Eligibility Form
	Ø	Informed Consent Release — Orientation Date ____
	Ø	Informed Consent Letter
PART 1	Ø	Job Application
	Ø	Disclosure and Authorization Form (2 pages)
	Ø	Items to bring to Orientation (give to prospective employee)
PART 2	O	Orientation Checklist
	O	I9
	O	W4
	O	Direct Deposit or Money Network Card Authorization Form
	O	Employee Data Sheet
	O	Invitation to Self-Identify - PM Must Complete if Employee Doesn't
	O	8850 the Work Opportunity Credit
	O	FCE Benefits Enrollment Form (MUST be completed even if Waiving)
	O	Waiver of Medical Benefits (Complete ONLY if Waiving Medical)
	O	Class IV Dependent Option (Complete ONLY if Full Time (30+ hrs per wk))
Additional Forms (If applicable)	O	
	O	
	O	
	O	

ABOVE MUST BE COMPLETED

OK WS

OFFICE USE ONLY
NISH %: 77.10%

ID # 39703

Chrys

Clerk Routing Sheet

NATIONAL

CONNECTICUT

Ran Background: 10/16-17 Pass Hit

Ran Driver Authorization: _____ Pass Hit
Susan - Rosita

Submitted CT DMR: _____ Pass Hit
Rosita

Drug Test: _____ Pass Hit
MC - SE

Submitted for Approval: _____ Approved: _____

Doc of Dis

Diagnosis MIm/ADHD/OCD

Limitations ✓

Signature ✓

Approval CC
Limary - Christa

INTERACT

Interact ✓ Interact Import _____ Audit List ✓

File Scanned ✓ Made File ✓ Pink File ✓

Sent Packet to Accounting: ✓
Katherine

Email FCE Form: _____
Tammy Osden

Sent to JenG. NA
HD - NP - NO - NW - HL - IN

Indirect Labor % N/A

MITC

Home Job _____ Manager _____ Check off Holiday _____

Title _____ Holiday Pay Table _____ Activity Code _____
Clock ONLY (NOT COMM.)

Break Time & Break After _____
FJ - SW - WR

Usual Rate _____
FL - HD

Hire Date _____ Anniv Date _____

START DATE

Start Date I-9 _____ I-9 _____ Audit List _____

Interact Short Entry/Status Tracking _____ Interact Eligible Leave _____

Tammy & Katherine _____ IAS Auto Assign Leave _____

Apr-17

CC

INTAKE ELIGIBILITY FORM

Date 10/11/17

Last Name Mcleod [redacted] First Name Staro

Street [redacted] Apt or Unit #

City [redacted] State [redacted]

Zip code [redacted] plus 4

Home Phone [redacted] Cell Phone [redacted]

Email Address [redacted]

Are you affiliated with an Agency? (Circle One) YES NO

If Yes, please enter:

Agency Name Santee Wateree

Address 215 N. Magnolia St.

Phone 803-934-4099

What is your main Disability and how does it impact your ability to obtain a job?

Bipolar disorder. because of my mood swings I get frustrated with myself for not believing in myself.

Physical Limitations none

Education High school Diploma

Medications Abilify, Prozac, Trazodone, Gabapentin

Last Employment Santee Wateree DMH

Transportation Personal Vehicle

Most Recent Documentation of Disability attached? (Circle One) YES NO

Informed Consent Release form attached? (Circle One) YES NO

Star Mcleod

Signature

HEADQUARTERS
200 Myrtle Street, New Britain, CT 06051
Telephone (860) 229-7700 Fax (860) 229-68-17
www.cwresources.org

A CW GROUP COMPANY

Job Application

Last	First	MI	Email
Mcleod	Stara		star.mcleod@SCDMH.org
[redacted]			Home Phone [redacted]

Are you authorized to work in the United States? ☒ Yes ☐ No	Are you 18 or older? ☒ Yes ☐ No	Expected Hourly Rate	minimum wage
Have you been convicted of a felony in the past seven years? ☐ Yes ☒ No	If yes, please explain:		
Military Service? ☐ Yes ☒ No Branch:	Are you a veteran? ☐ Yes ☒ No		
What position are you applying for?	How did you hear about this position?		
Cook 1	employer		
Do you have a Security Clearance? ☒ Yes ☐ No Type:	Investigation Date:	Date Available	October 11th

	Current or Most Recent	Prior	Prior
Employer	SCDMH		
Telephone	803-934-4099		
Name of Immediate Supervisor	Roslyn Sanders		
Dates of Employment	From 2015 To 10-2014	From To	From To
Position/Job Title	Peer Support		
Pay	11.55		
Reason for Leaving	current		
May We Contact	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

	Name/Location	Last Year Complete	Degree	Major or Emphasis
High School	Sumter High	9 10 11 (12)	Diploma	General
College/University		1 2 3 4		
Trade School				
Other				
List any applicable special skills, training or proficiencies.				

CW Resources, Inc. provides equal employment opportunities (EEO) to all employees and applicants for employment without regard to race, color, religion, sex, national origin, age, disability or genetics. In addition to federal law requirements, CW Resources, Inc. complies with applicable state and local laws governing nondiscrimination in employment in every location in which the company has facilities. This policy applies to all terms and conditions of employment, including recruiting, hiring, placement, promotion, termination, layoff, recall, transfer, leaves of absence, compensation and training.

Disclaimer - By signing, I hereby certify that the above information, to the best of my knowledge, is correct. I understand that falsification of this information may prevent me from being hired or lead to my dismissal if hired. I also provide consent for former employers to be contacted regarding work records.	Signature	Date
	Star Mcleod	10-11-14

AUTHORIZATION

I have carefully read and understand this Disclosure and Authorization form and the attached summary of rights under the Fair Credit Reporting Act. **By my signature below**, I consent to the release of consumer reports and investigative consumer reports prepared by a consumer reporting agency, such as HireRight, Inc., to the Company and its designated representatives and agents. I understand that if the Company hires me, my consent will apply, and the Company may obtain reports, throughout my employment.

I also understand that information contained in my job application or otherwise disclosed by me before or during my employment, if any, may be used for the purpose of obtaining consumer reports and/or investigative consumer reports.

By my signature below, I authorize law enforcement agencies, learning institutions (including public and private schools and universities), information service bureaus, credit bureaus, record/data repositories, courts (federal, state and local), motor vehicle records agencies, my past or present employers, the military, and other individuals and sources to furnish any and all information on me that is requested by the consumer reporting agency.

By my signature below, I certify the information I provided on this form is true and correct. I agree that this Disclosure and Authorization form in original, faxed, photocopied or electronic (including electronically signed) form, will be valid for any reports that may be requested by or on behalf of the Company.

California, Minnesota or Oklahoma applicants only – You will be provided with a free copy of any consumer reports or investigative consumer reports obtained on you if you check the box below.

☐ I wish to receive a free copy of the report.

MUST BE LEGIBLE

Applicant Last Name Mcleod First Stara Middle S

Social Security No.* [redacted] Date of Birth* [redacted]

Birth City: Sumter Birth State: SC

Present Address [redacted]

City/State/Zip [redacted]

Prior Addresses Same above From: 2008 To: present

From: To:

From: To:

WILL THIS PERSON BE A DRIVER? Yes or NO

If yes, please complete:

Driver's License # [redacted] State: South Carolina

Applicant Signature Stara Mcleod **Date** 10-16-2017

* This information will be used only for background screening purposes and will not be taken into consideration in any employment decisions.

HireRight. Intelligence to move forward

STARA S MCLEOD

Complete Report

Social Security Number: ***-**-[redacted]
DOB: **/**/****

Prepared By:
HireRight
3349 Michelson Dr. Suite 150
Irvine, CA 92612
Phone: 866-521-6995
Fax: 877-797-3442
customerservice@hireright.com

Request #: HE-101617-BD26H
Turnaround time: 1.5 business days
Package: CW Resources Economy Package

Date Request Submitted: October 16, 2017 12:59 PM PDT
Request Completion Date: October 18, 2017 2:50 AM PDT
Hiring Manager: ccarkner@cwresources.org

Requested By:
Christa Carkner
CW Resources
200 Myrtle st
New Britain, CT 06053
Phone: (860) 229-7700
E-mail: ccarkner@cwresources.org

STARA MCLEOD, ***-**-7085

Widescreen Plus National Criminal Search

Widescreen Plus National Criminal Search
Result: **Completed**

Time Completed: October 16, 2017 10:01 PM PDT

⊞ Jurisdictions Searched:

STARA MCLEOD, ***-**[redacted]

Court Records

3 subrequests

1. **Criminal Felony & Misdemeanor (Past 7 Years Search)** — **Complete - No Court Record Found**
   MCLEOD, STARA S
   Address(es): Clarendon County, SC, USA
   Location Searched: Clarendon County, SC
   Time Completed: October 17, 2017 1:15 AM PDT
   Verified by: QA-434
   ⊟ **HireRight comments**
   October 16, 2017 10:01 PM PDT - Note:
   -------Reason: Clarendon County, SC - Average court turnaround time is currently 3 business days.

2. **Criminal Felony & Misdemeanor (Past 7 Years Search)** — **Complete - Court Record Found**
   MCLEOD, STARA S
   Address(es): Richland County, SC, USA
   Location Searched: Richland County, SC
   Time Completed: October 17, 2017 2:57 PM PDT
   Verified by: QA-23271
   ⊟ **HireRight comments**

October 16, 2017 10:01 PM PDT - Note:
-------Reason: Richland County, SC - Average court turnaround time is currently 3 business days.

1.) Case Nbr.: H009304 (RICHLAND COUNTY)
Comments:
Identifiers: Confirmation: Partial Name, Address, Other ID. Mcleod, Stara Shaniqua; Year of Birth

Count: 1
Offense Date: July 25, 2014
Offense: Traffic / Expired Vehicle License
Disposition: Guilty
Sentence: Jail time 10 days or fine/costs: $237.50 paid
Severity: Misdemeanor
Disp. Date: July 31, 2014

2.) Case Nbr.: H009303 (Richland County)
Comments:
Identifiers: Confirmation: Partial Name, Address, Other ID. Mcleod, Stara Shaniqua; Year of Birth

Count: 1
Offense Date: July 25, 2014
Offense: Traffic / Seatbelt Violation - Non-Criminal
Disposition: Guilty
Sentence: Fine/costs: $25.00 paid
Severity: Misdemeanor
Disp. Date: July 31, 2014

---

3. Criminal Felony & Misdemeanor (Past 7 Years Search) Complete - Court Record Found
MCLEOD, STARA S
Address(es): Sumter County, SC, USA
Location Searched: Sumter County, SC
Time Completed: October 18, 2017 2:50 AM PDT
Verified by: QA-56825

⊟ HireRight comments
October 16, 2017 10:01 PM PDT - Note:
-------Reason: Sumter County, SC - Average court turnaround time is currently 3 business days.

1.) Case Nbr.: 83392FW (Sumter County)
Comments:
Identifiers: Confirmation: Name, Partial Date Of Birth, Address. NAME ON FILE : Mcleod, Stara Shaneiqua Middle name on record confirmed to belong to the candidate

Count: 1
Offense Date: May 16, 2012
Offense: Traffic / Speeding, 10 Miles Per Hour Or Less Over The Speed Limit
Disposition: Guilty
Sentence: Fine/costs: $81.88 paid
Severity: Misdemeanor
Disp. Date: June 28, 2012

STARA MCLEOD, *** [redacted]

SSN Validation

SSN Validation

Result: **Complete - SSN has been issued by the SSA [1]**

Time Completed: October 16, 2017 12:59 PM PDT

SSN ***-**[redacted] was issued in 1978 in SOUTH CAROLINA. SSN is not in the death index.

Activity Log

Activity	Date/Time	Performed By	Recipient	Result
Report Submitted	October 16, 2017 12:59 PM PDT	CW Resources		

[1] "Complete" indicates that this request has been processed to conclusion. Please review the report details in their entirety to evaluate any potential discrepancies or records related to this request.

All times listed in America/Los_Angeles timezone

The Activity Log above may reflect activity for this screening report. E-mail notifications, if configured by the company that requested the report, may have been sent by or through HireRight to an authorized company-user (shown as the "Recipient"). Some adjudication history entries and related e-mail notifications, if any, indicate whether an initial determination was made regarding whether the report satisfied the company's hiring criteria (shown in the "Result" column), including any preliminary status Result of "Meets" or "Does Not Meet" company standards. Sometimes a company's final adjudication determination may change from its initial determination. Questions about the company's hiring decisions should be directed to the company.

LEGAL NOTES:
The information provided herein is a consumer report as defined in the federal Fair Credit Reporting Act [15 USC 1681 et.seq.] It contains confidential information on the individual named. It is submitted subject to the express conditions contained in your Subscriber Agreement with HireRight, and may be used solely for legally permissible employment purposes (i.e., as a factor in evaluating the named individual for employment, promotion, reassignment or retention as an employee). Proper use of the content of this report and final verification of the named individual's identity is your sole responsibility.

HEADQUARTERS
200 Myrtle Street, New Britain CT 06053
Telephone (860) 229-7700 Fax (860) 229-6047
www.cwresources.org

A CW Group Company

Employee Data Sheet

EMPLOYEE INFORMATION

Name: Stara Mcleod
Birth Date: [redacted]
Address: [redacted]
SSN: [redacted]
Marital Status: married
Sex: female
Home #: [redacted]
Cell #:
Email: star.mcleod@SCDMH.org
Case Worker: Tara Trammell
Agency: S. Conn. Interstate Mental Health
Phone: 203-775-9364
Email: tyt@SCImh.org

EMERGENCY CONTACT INFORMATION

Name: Andre Johnson
Relationship: husband
Address: [redacted]
Phone: [redacted]

Disability

MR/DD Mild – Moderate – Profound - Severe
Autism Spectrum Disorders
Borderline Intellectual Function
Cerebral Palsy
Other Developmental Disability
Endocrine, Nutritional, Metabolic, Incl. Diabetes & Immune System
Other Physical Disorder
Substance Abuse/ Alcoholism
Traumatic Brain Injury
Hearing Impairment
Legal Blindness
Visual Impairment other than Legal Blindness
Mental Illness – Mood – Affective - Schizophrenia
Mental Illness – Other
Musculoskeletal System and Connective Tissue, incl Arthritis
Other Disability, Not Meeting Standard for Severe
Other Neurological Impairments
Other Sever Disability
No Disability

INSTRUCTIONS

PLEASE READ ALL INSTRUCTIONS CAREFULLY BEFORE COMPLETING THIS FORM

Anti-Discrimination Notice. It is an unlawful employment practice for an employer to fail or refuse to hire or discharge any individual, or otherwise to discriminate against any individual with respect to that individual's terms and conditions of employment, because of such individual's race, color, religion, sex, or national origin.

This employer is subject to certain nondiscrimination and affirmative action recordkeeping and reporting requirements, which require the employer to invite employees to voluntarily self-identify their race/ethnicity. Submission of this information is voluntary and refusal to provide it will not subject you to any adverse treatment. The information obtained will be kept confidential and may only be used in accordance with the provisions of applicable federal laws, executive orders, and regulations, including those that require the information to be summarized and reported to the Federal Government for civil rights enforcement purposes.

If you choose not to self-identify your race/ethnicity at this time, the federal government requires this employer to determine this information by visual survey and/or other available information.

For civil rights monitoring and enforcement purposes only, all race/ethnicity information will be collected and reported in the seven categories identified below. The definitions for each category have been established by the federal government. If you choose to voluntarily self-identify, you may mark only one of the boxes presented below.

INVITATION TO SELF-IDENTIFY

PLEASE ANSWER THE FOLLOWING QUESTION

What is your race/ethnicity? Please mark the one box that describes the race/ethnicity category with which you primarily identify.

Hispanic or Latino: a person of Cuban, Mexican, Chicano, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

White: a person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Black or African American: a person having origins in any of the black racial groups of Africa.

Asian: a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Native Hawaiian or Other Pacific Islander: a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

American Indian or Alaska Native: a person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

Two or More Races: a person who primarily identifies with two or more of the above race/ethnicity categories.

HEADQUARTERS
200 Myrtle Street, New Britain CT 06053
Telephone (800) 229-7700 Fax (860) 229-6647
www.cwresources.org

A CW Group Company

I hereby certify that I am not a relative or friend and that I have no outside relationship with the applicant in question. I understand that hiring family and friends creates the possibility or the perception of favoritism, brings down morale, and can create unfavorable working conditions for other employees.

Luisa M. Ratcliff
Name

23 Oct 2017
Date

Luisa M. Ratcliff
Signature

Project Mgr.
Position/Title

I do know the individual in question outside of work but, if hired, I will not be directly supervising.

Your position: _____

Relationship to you: _____

_____
Name

_____
Date

_____
Signature

_____
Position/Title

Form **8850** (Rev. January 2012)
Department of the Treasury
Internal Revenue Service

Pre-Screening Notice and Certification Request for the Work Opportunity Credit

▶ See separate instructions.

OMB No. 1545-1500

Job applicant: Fill in the lines below and check any boxes that apply. Complete only this side.

Your name Staray Mcleod Social security number ▶ [redacted]

Street address where you live [redacted]

City or town, state, and ZIP code [redacted]

County _____ Telephone nu [redacted]

If you are under age 40, enter your date of birth (month, day, year) 11-04-M

1 ☐ Check here if you received a conditional certification from the state workforce agency (SWA) or a participating local agency for the work opportunity credit.

2 ☒ Check here if any of the following statements apply to you.
- I am a member of a family that has received assistance from Temporary Assistance for Needy Families (TANF) for any 9 months during the past 18 months.
- I am a veteran and a member of a family that received Supplemental Nutrition Assistance Program (SNAP) benefits (food stamps) for at least a 3-month period during the past 15 months.
- I was referred here by a rehabilitation agency approved by the state, an employment network under the Ticket to Work program, or the Department of Veterans Affairs.
- I am at least age 18 but not age 40 or older and I am a member of a family that:
  a Received SNAP benefits (food stamps) for the past 6 months, or
  b Received SNAP benefits (food stamps) for at least 3 of the past 5 months, but is no longer eligible to receive them.
- During the past year, I was convicted of a felony or released from prison for a felony.
- I received supplemental security income (SSI) benefits for any month ending during the past 60 days.
- I am a veteran and I was unemployed for a period or periods totaling at least 4 weeks but less than 6 months during the past year.

3 ☐ Check here if you are a veteran and you were unemployed for a period or periods totaling at least 6 months during the past year.

4 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were discharged or released from active duty in the U.S. Armed Forces during the past year.

5 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were unemployed for a period or periods totaling at least 6 months during the past year.

6 ☐ Check here if you are a member of a family that:
- Received TANF payments for at least the past 18 months, or
- Received TANF payments for any 18 months beginning after August 5, 1997, and the earliest 18-month period beginning after August 5, 1997, ended during the past 2 years, or
- Stopped being eligible for TANF payments during the past 2 years because federal or state law limited the maximum time those payments could be made.

Signature—All Applicants Must Sign

Under penalties of perjury, I declare that I gave the above information to the employer on or before the day I was offered a job, and it is, to the best of my knowledge, true, correct, and complete.

Job applicant's signature ▶ Staray Mcleod Date 10-11-M

For Privacy Act and Paperwork Reduction Act Notice, see page 2. Cat. No. 22051L Form 8850 (Rev. 1-2012)

For Employer's Use Only

Employer's name _____ Telephone no. _____ EIN ▶ _____

Street address _____

City or town, state, and ZIP code _____

Person to contact, if different from above _____ Telephone no. _____

Street address _____

City or town, state, and ZIP code _____

If, based on the individual's age and home address, he or she is a member of group 4 or 6 (as described under Members of Targeted Groups in the separate instructions), enter that group number (4 or 6) . . . . . ▶ _____

Date applicant:

Gave information _____ Was offered job _____ Was hired _____ Started job _____

Under penalties of perjury, I declare that the applicant provided the information on this form on or before the day a job was offered to the applicant and that the information I have furnished is, to the best of my knowledge, true, correct, and complete. Based on the information the job applicant furnished on page 1, I believe the individual is a member of a targeted group. I hereby request a certification that the individual is a member of a targeted group.

Employer's signature ▶ Title Date

Privacy Act and Paperwork Reduction Act Notice

Section references are to the Internal Revenue Code.

Section 51(d)(13) permits a prospective employer to request the applicant to complete this form and give it to the prospective employer. The information will be used by the employer to complete the employer's federal tax return. Completion of this form is voluntary and may assist members of targeted groups in securing employment. Routine uses of this form include giving it to the state workforce agency (SWA), which will contact appropriate sources to confirm that the applicant is a member of a targeted group. This form may also be given to the Internal Revenue Service for administration of the Internal Revenue laws, to the Department of Justice for civil and criminal litigation, to the Department of Labor for oversight of the certifications performed by the SWA, and to cities, states, and the District of Columbia for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The time needed to complete and file this form will vary depending on individual circumstances. The estimated average time is:

Recordkeeping . . 6 hr., 27 min.

Learning about the law or the form . . . . . 30 min.

Preparing and sending this form to the SWA . . . . . 37 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making this form simpler, we would be happy to hear from you. You can write to the Internal Revenue Service, Tax Products Coordinating Committee, SE:W:CAR:MP:T:M:S, 1111 Constitution Ave. NW, IR-6526, Washington, DC 20224.

Do not send this form to this address. Instead, see *When and Where To File* in the separate instructions.

Site Code SC-456

MANAGER must sign either TOP or BOTTOM section Employee/Staff LM Initial SM

AUTHORIZATION TO REQUEST MOTOR VEHICLE REPORT

Employee should complete ONLY If being hired to drive.

Individuals employed by CW Group who are required to operate company owned vehicles are subject to a motor vehicle report review.

For this purpose, I hereby authorize CW Group to obtain a copy of my Motor Vehicle Report from Harleysville Insurance Company. I understand that CW Group will obtain updated Motor Vehicle Reports on an annual basis or more frequently, if deemed necessary.

Stara McLeod — Employee name (please print)

10-17-17 — Date

Stara McLeod — Employee signature

**please complete and attach copy of driver's license.*

[redacted] — Operator's license number

[redacted] — Operator's Date of Birth

South Carolina — State issued if other than Connecticut

Teresa M. Ratliff — Manager's Signature

10-17-17 — Date

Fax to Burns, Brooks & McNeil: TSmall@burnsbrooksmcneil.com

Employee _____ WILL NOT be an Authorized driver for CW Resources Inc.

_____ Manager's Signature

_____ Date

Jun-13

9a

Employee/Staff
SM Initial JCM

CW RESOURCES, INC.

MOTOR VEHICLE RECORD POLICY

It is the policy and requirement of CW Resources, Inc. that motor vehicle records (MVR) of employees who operate company owned, leased or rented vehicles must meet the grading requirements stated below.

MVR's will be examined prior to the start of employment and at least annually thereafter. Any job offer that is made to an employee-candidate for a position with driving duties shall be contingent upon an MVR meeting the required standards. Continued employment in a position with driving duties also requires an MVR meeting the standards outlined below.

The standards for MVR's are as follows:

1. All operators must have a valid driver's license for at least three years.

2. No new driver will be hired with a "borderline" or "poor" (major violations) MVR. MVR's will be graded based on the table below, as minimum requirements.

3. Driving records must remain "acceptable" or "clear" as graded on the table below for continued employment in positions with driving duties. Major violations may result in immediate termination of employment.

Any exceptions to these guidelines must be referred to senior management for written approval. The auto insurance carrier will be consulted on any/all MVR's not meeting the minimum criteria.

Motor Vehicle Grading Criteria (last three years)

Number of Minor Violations	Number of at-fault accidents			
	0	1	2	3
0	Clear	Acceptable	Borderline	Poor
1	Acceptable	Acceptable	Borderline	Poor
2	Acceptable	Borderline	Poor	Poor
3	Borderline	Poor	Poor	Poor
4	Poor	Poor	Poor	Poor
Any major Violation	Poor	Poor	Poor	Poor

Minor Violation:
Any minor violation other than a major except:
*Motor vehicle equipment, load or size requirement
*Improper/failure to display license plates
*Failure to sign or display registration
*Failure to have driver's license in possession (if valid license exists)

Major Violations
*Driving under influence of alcohol/drugs
* Failure to stop/report an accident
* Reckless driving/speeding contest
* Driving while impaired
* Making a false accident report
* Homicide, manslaughter or assault arising out of the use of a vehicle
* Driving while license is suspended/revoked
* Careless driving
* Attempting to elude a police officer

DRIVER'S POLICY STATEMENT

All CW Resources, Inc. employees who operate agency owned, rented or leased vehicles are responsible for complying with any and all related policies and procedures. It is expected that employees will drive in a safe manner and keep within the confines of the law.

Failure to comply with state ordinances, regulations or law, or any CW Resources, Inc. policy or procedure may result in disciplinary action up to and including termination.

Examples of this are:
-Speeding
-Failure to wear a seat belt
-Smoking in company vehicle
-Misuse of vehicle
-Motor vehicle accident

Jun-13

9b

Employee/Staff

In the event that you are involved in a motor vehicle accident and it is determined that the accident was a result of a failure to comply with state ordinances, regulations or law, disciplinary action will result up to and including termination. JM Initial

Additionally the following is subject to immediate dismissal from employment:
-Any major motor vehicle violation -Improper use of company vehicle for personal business

As the driver of a CW Resources, Inc. owned, rented or leased vehicle for the purpose of conducting official and authorized business. I understand and agree to abide by the established policies and procedures. Furthermore, if at any time I do not understand a policy or procedure, I will ask my supervisor for clarification.

I understand and agree that:
1. I have received, read and understand CW Resources, Inc. "Motor Vehicle Record Policy" and "Driver's Policy Statement".
2. I have a valid Connecticut Driver's License.
3. I will not permit any unauthorized individual to drive a CW Resources, Inc. vehicle.
4. I will not permit any unauthorized passenger(s) in a CW Resources, Inc. vehicle.
5. I will use the seat belt at all times and will enforce that my passengers use their seatbelt. Any individual refusing to use a seat belt or who continuously removes their seat belt while underway, will be reported to my supervisor immediately.
6. I know and observe all applicable traffic laws, ordinances and regulations.
7. I am financially responsible for any and all fines issued which result from my improper driving of the vehicle.
8. I will not operate the vehicle under the influence of alcohol and/or drugs. In the event that I am taking prescribed medication or an over the counter medication as per intended use, I may drive provided they do not impair my driving ability or cause drowsiness.
9. I will not converse on the cell phone while driving. I will pull off the road into a safe area (parking lot, place of business, etc.) or call the person back when I am no longer in the vehicle (see separate policy regarding cell phone use).
10. When the vehicle is not in use and vacant of passengers, I will remove the keys, make sure the windows are closed and that the doors are locked.
11. I will not leave individuals unattended in a vehicle.
12. I will not smoke in the vehicle at any time nor will I allow passengers to smoke in vehicle.
13. Before leaving any area in which the vehicle was parked without my being present, I will conduct a walk around the vehicle and visually inspect the exterior for damages that were not previously observed. Any and all new marks, dents or damage will be reported to my supervisor or his/her designed immediately.
14. I will immediately report all accidents, property damage or violations to the appropriate authorities and alert my supervisor or his/her designee immediately. I will summon the police to the scene of all accidents regardless of who is at fault or regardless of how minor an accident may be.
15. I will not exceed the speed limit or drive the vehicle at speeds that are unsafe for the road conditions.
16. If I am to be transporting consumers, I have or will get within the next 45 days, a valid PSL (Public Service License). In the event that I am unable to obtain a PSL, I will submit the reasons in writing to my supervisor for further review and possible consideration for continued employment.
17. I understand that as an employee of CW Resources, Inc., I am subject to all of the agency policies and procedures, rules and regulations and that any infraction is grounds for disciplinary action, up to and including termination from employment.

Stara McLeod Printed Name of Employee/Driver	Stara McLeod Signature of Driver	10-17-17 Date
Lucrece M. Ratcliff Printed Name of Witness	Ratcliff Signature of Witness	10-18-17 Date

Jun-13

9c

PMA COMPANIES

WC INCIDENT REPORT

FACILITY: CW Resources #0296848 456/NC CLAIM # W002335075

EMPLOYEE'S NAME (FIRST, MI, LAST) Stara McLeod

HOME ADDRESS (STREET, CITY, STATE, ZIP) [redacted]

HOME PHONE [redacted] MARITAL STATUS (CIRCLE ONE) (M) S W D

DOB [redacted] SS# [redacted] MALE (FEMALE)

JOB TITLE Custodian DATE OF HIRE 11/6/2017 FT /PT/ OTHER

WORK SCHEDULE 6:30pm to 10:30pm REGULAR WORK HOURS Monday thru Friday

WAGE INFORMATION $ 9.34 /HR $ _____ /WK OR $ _____ /ANNUAL

SUPERVISOR'S NAME Lunesa Ratcliff WORK PHONE # 803-406-9044

DATE OF INCIDENT March 26, 2018 TIME OF INCIDENT 8:00 AM/(PM)

DATE EMPLOYER NOTIFIED April 2, 2018

DESCRIPTION OF INCIDENT:

Stara lifted the full mop bucket to the sink in order to empty it, and as she lowered it after emptying, she felt a "popping" and pain in her back

DESCRIPTION OF INJURY:

Back injury

IS INJURED WORKER LOSING TIME (YES) or NO IS INJURED WORKER ON MODIFIED DUTY: YES or (NO)

EQUIPMENT, MATERIAL, SUBSTANCE INVOLVED: Mop Bucket

PRIOR INJURY OR PRE-EXISTING CONDITION (S) (IF YES, DESCRIBE) _____

WITNESS (ES): Gequan Charles, Annie Crawford

REFERRED FOR TREATMENT (SPECIFY FACILITY) Toomey Health Center, Sumter, SC

EMPLOYEE DECLINES TREATMENT YES (NO) (IF YES EMPLOYEE'S SIGNATURE REQUIRED) _____

REPORT COMPLETED BY: (PRINT) Teresa Lewis (via Lunesa Ratcliff) DATE 4/19/2018

SIGNATURE: Teresa Lewis

CW Resources – Accident/Injury Investigation Report

Attached to the First Report of Injury. If completion of this form will delay the First report of injury – submit afterward.

The purpose of this investigation is to gather objective information and observations from the inured person and others to determine the cause of the accident/incident in order to minimize/prevent the accident/incident from occurring again. It is important to gather information which is objective in nature, however, opinions/subjective matters may still be of value and should be expanded upon when gathering details.

Incident Details:

Name of Injured Person:	Occupation:	Department:	Length of Employment:
Stara Mccleod	Custodial	Shaw AFB, SC	6 months
Date of Incident:	**Time of Incident:**	**AM or (PM)**	**Date Reported:**
26 Mar 2018	8:00 PM		2 Apr 2018

Date the First Report of Injury completed? 16 Apr 2018

INVESTIGATION

(The section to be completed by interviewing the injured employee and witnesses to the incident)

Employee's Supervisor:	Supervisor's Phone Number:
Lunesa M. Ratcliff	803-406-9044

Were Safety Codes/Rules Violated? yes If yes, explain Improper lifting of mop bucket,

Injury Type – Mark all that apply:

__Body Motion	__Extreme Hot/Cold Temperature	__Flame/Fire/Smoke	__Overexertion
__Slip/Trip/Fall elevation	__Slip/Trip/Fall same level	__Motor Vehicle Accident	__Caught In/Under
__Puncture	__Struck By	__Rubbed or Abraded	__Chemicals
__Electrical	__Furniture/Fixtures	__Machine/Tools	__Falling Objects
__Sharp Object	✓Client	__Other: Back Injured per Stara say	

Cause of Incident – Mark all that apply and explain, in detail under analysis:

__Failure to us proper PPE	__Improper use of Body	__Failure to Wear Proper Attire
__Equipment Failure	__Equipment Improper Use	__Improper Material Handling
__Excessive/Unsafe Speed	__Poor Housekeeping	__Horseplay
__Lack of Attention	__Wet/Slippery Surface	__Uneven Surface
__Fatigue	__Bypassing Safety Devices	__Failure to Secure/Warn
✓Lifting	__Client Behavior	__Other:

Rev. 2-16

Analysis: Be Specific – the information below should paint a picture of the incident and is reviewed by people who aren't familiar with the work location and the tasks performed:

How did injury occur happen? Per Stara McCleod say when she was lifting up and pour the dirty water from the mop bucket, that when she injured her back.

Where did it happen? Bldg # 2453 Annex Child Care Center

Did supervisor report to scene of accident? NO If yes, what was observed? _____

Who witnessed the injury? Gegnan Charles, Annie Crawford
Record the witness(es) accounts and use additional paper as needed _____

Steps Taken to Prevent Similar Occurrence – Please explain and give details
(The section to be completed by interviewing the injured employee and witnesses to the incident)

Stara McCleod needs to attend the Safety Training (Lifting)

Supervisor Signature Teresa M. Dathorff Date _____

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Individual Payroll History
MCLEOD, STARA
CW RESOURCES, INC.

Operator: KJM

06/15/2018 08:35

For the Period 11/11/2017 06/09/2018

Check# / Status	Date / Dept	Gross	Fed W/H	FICA	Reg Pay / Medicare	Other Pay / CT W/H	Reg hrs / --Other Deductions---	Overtime	Holiday	Sick	Leave	Rate / Net
dd561278	11/11/2017	152.56			0.00	0.00	13.00	0.00	3.33	0.00	0.00	0.00
P	456		0.00	9.46	2.21	0.00	69.72 NC1		-69.72 SB1	5.03 SC		135.86
dd563181	11/18/2017	173.78			0.00	0.00	18.60	0.00	0.00	0.00	0.00	0.00
P	456		0.00	10.77	2.52	0.00	79.41 NC1		-79.41 SB1	6.19 SC		154.30
dd564502	11/25/2017	111.26			0.00	0.00	8.40	0.00	3.51	0.00	0.00	0.00
P	456		0.00	6.90	1.61	0.00	50.85 NC1		-50.85 SB1	3.09 SC		99.66
dd566260	12/02/2017	201.50			0.00	0.00	21.57	0.00	0.00	0.00	0.00	0.00
P	456		0.00	12.49	2.92	0.00	92.09 NC1		-92.09 SB1	7.85 SC		178.24
dd567741	12/09/2017	177.40			0.00	0.00	18.99	0.00	0.00	0.00	0.00	0.00
P	456		0.00	11.00	2.57	0.00	81.07 NC1		-81.07 SB1	6.40 SC		157.43
dd569486	12/16/2017	185.24			0.00	0.00	19.83	0.00	0.00	0.00	0.00	0.00
P	456		0.00	11.48	2.69	0.00	84.67 NC1		-84.67 SB1	6.87 SC		164.20
dd571100	12/23/2017	158.44			0.00	0.00	16.96	0.00	0.00	0.00	0.00	0.00
P	456		0.00	9.82	2.30	0.00	72.41 NC1		-72.41 SB1	5.33 SC		140.99
dd572805	12/30/2017	95.02			0.00	0.00	5.31	0.00	3.86	0.00	0.00	0.00
P	456		0.00	5.89	1.38	0.00	43.42 NC1		-43.42 SB1	2.44 SC		85.31
dd574109	01/06/2018	87.72			0.00	0.00	5.55	0.00	3.84	0.00	0.00	0.00
P	456		0.00	5.44	1.27	0.00	40.09 NC1		-40.09 SB1	2.15 SC		78.86
dd576001	01/13/2018	255.57			0.00	0.00	27.36	0.00	0.00	0.00	0.00	0.00
P	456		0.00	15.85	3.71	0.00	116.82 NC1		-116.82 SB1	11.59 SC		224.42
dd577723	01/20/2018	200.75			0.00	0.00	17.69	0.00	3.80	0.00	0.00	0.00
P	456		0.00	12.45	2.91	0.00	91.75 NC1		-91.75 SB1	7.38 SC		178.01
dd579186	01/27/2018	175.35			0.00	0.00	18.77	0.00	0.00	0.00	0.00	0.00
P	456		0.00	10.87	2.54	0.00	80.14 NC1		-80.14 SB1	5.86 SC		156.08
dd580514	02/03/2018	190.29			0.00	0.00	20.37	0.00	0.00	0.00	0.00	0.00
P	456		0.00	11.80	2.76	0.00	86.96 NC1		-86.96 SB1	6.75 SC		168.98
dd582400	02/10/2018	213.36			0.00	0.00	22.84	0.00	0.00	0.00	0.00	0.00
P	456		0.00	13.23	3.09	0.00	97.52 NC1		-97.52 SB1	8.13 SC		188.91
dd584145	02/17/2018	111.82			0.00	0.00	11.97	0.00	0.00	0.00	0.00	0.00
P	456		0.00	6.93	1.62	0.00	51.10 NC1		-51.10 SB1	2.89 SC		100.38
dd585477	02/24/2018	190.95			0.00	0.00	16.19	0.00	4.25	0.00	0.00	0.00
P	456		0.00	11.84	2.77	0.00	87.27 NC1		-87.27 SB1	6.79 SC		169.55
dd587387	03/03/2018	209.43			0.00	0.00	22.42	0.00	0.00	0.00	0.00	0.00
P	456		0.00	12.98	3.04	0.00	95.72 NC1		-95.72 SB1	7.90 SC		185.51
dd588715	03/10/2018	148.26			0.00	0.00	15.87	0.00	0.00	0.00	0.00	0.00
P	456		0.00	9.19	2.15	0.00	67.76 NC1		-67.76 SB1	4.51 SC		132.41
dd590211	03/17/2018	173.94			0.00	0.00	18.62	0.00	0.00	0.00	0.00	0.00
P	456		0.00	10.78	2.52	0.00	79.50 NC1		-79.50 SB1	5.79 SC		154.86
dd591986	03/24/2018	189.64			0.00	0.00	20.30	0.00	0.00	0.00	0.00	0.00
P	456		0.00	11.76	2.75	0.00	86.66 NC1		-86.66 SB1	6.71 SC		168.42

Individual Payroll History
MCLEOD, STARA
CW RESOURCES, INC.

Operator: KJM

06/15/2018 08:35

For the Period 11/11/2017 06/09/2018

Check# / Status	Date / Dept	Gross	Fed W/H	Reg Pay / FICA	Other Pay / Medicare	Reg hrs / CT W/H	Overtime / --Other Deductions---------	Holiday	Sick	Leave	Rate / Net
dd593918	03/31/2018	165.82		0.00	0.00	17.75	0.00	0.00	0.00	0.00	0.00
P	456		0.00	10.28	2.40	0.00	75.77 NC1	-75.77 SB1	5.38 SC		147.76

**** TOTALS ****	Gross	Reg Pay	Other Pay	Reg hrs	Overtime	Holiday	Sick	Leave	Net
	3,568.10	0.00	0.00	359.36	0.00	22.59	0.00	0.00	3,170.13

Deduction Totals

FED	Federal Income tax	0.00
FIC	FICA tax	221.21
MED	Medicare tax	51.73
CT	State Income tax	0.00
NC1	Special Benefit-Non Cash	1,630.70
SB1	H&W Special Benefits-Non Cash	-1,630.70
SC	South Carolina	125.03

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Certificate of Counsel

The undersigned hereby certifies that the Record on Appeal contains all material proposed to be included by any of the parties and not any other material.

s/ Andrea C. Roche
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