

THE STATE OF SOUTH CAROLINA
In the Supreme Court

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APPEAL FROM GREENVILLE COUNTY
Court of Common Pleas

S.C. Supreme Court

G. Edward Welmaker, Circuit Court Judge

Opinion No. 5059 (S.C. Ct. App. filed December 5, 2012)

Kellie N. Burnette, ... Respondent,

v.

City of Greenville and Hewitt Coleman & Associates, ... Petitioners.

APPENDIX TO PETITION FOR WRIT OF CERTIORARI

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THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM SOUTH CAROLINA
GREENVILLE COUNTY COURT OF COMMON PLEAS

CASE TRACKING NO: 2011198006

KELLIE N. BURNETTE..... APPELLANT,

v.

CITY OF GREENVILLE.....RESPONDENTS.
AND HEWITT COLEMAN & ASSOCIATES

RECORD ON APPEAL

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INDEX

I. ORDERS

Single Commissioner's Decision and Order filed October 14, 2009.....	1
Single Commissioner's Order Denying Motion to Admit.....	15
Additional Evidence dated September 23, 2009	
Full Commission's Order Denying Motion to Admit.....	17
Additional Evidence Dated November 16, 2009	
Full Commission's Decision and Order filed April 1, 2010.....	18
Circuit Court Order filed July 7, 2011	27
Circuit Court Order filed July 29, 2011	29

II. PLEADINGS/WORKERS' COMPENSATION FORMS/MOTIONS

Claimant's Form 50 dated May 8, 2008	30
Respondents' Form 51 dated May 13, 2008	31
Claimant's Form 50 dated June 10, 2009	32
Respondents' Form 51 dated June 15, 2009	33
Claimant's Form 58 dated August 19, 2009	34
Respondents' Form 58 dated August 24, 2009	36
Claimant's Motion to Admit Additional Evidence dated September 17, 2009	37
Respondents' Return to Motion to Admit Additional Evidence.....	51
dated September 23, 2009	
Claimant's Motion to Admit Additional Evidence dated November 3, 2009	54
Respondents' Return to Motion to Admit Additional Evidence dated	63
November 5, 2009	

III. CIRCUIT COURT APPEAL DOCUMENTS

Claimant's Appeal to Circuit Court filed April 28, 2010	67
Letter to Honorable Edward Welmaker filed June 29, 2011 and documents outlining what Claimant sought in an order	69
Motion to Alter or Amend Judgment filed July 19, 2011	71

IV. TRANSCRIPT

Transcript of Hearing before Single Commissioner dated September 3, 2009	73

V. APAS/EXHIBITS

APA No. 1 (1-8).....	135
APA No. 2 (10-12, 18, 23-25)	143
APA No. 3 (28-33, 35-37, 41-45, 49, 57, 59, 61, 70, 72, 77, 79, 81, 83, ... 85, 87, 89, 92, 94, 96, 98, 101-102, 105, 107, 109, 111, 113, 116, 118, 120, 122-124, 126-127, 129-130, 132-140, 142-147)	150
APA No. 4 (pp. 148-155, 198).....	213
APA No. 5 (pp. 222-223).....	222
APA No. 6 (pp. 231-232, 237, 255-257)	224
APA No. 7 (pp. 265-266).....	230
APA No. 8 (pp. 267-287).....	232
APA No. 9 (pp. 288-290).....	253
APA No. 10 (pp. 291-295).....	256
APA No. 11 (pp. 296-307).....	261
APA No. 12 (pp. 308-318).....	273

APA No. 13 (pp. 319-321).....	284
APA No. 14 (pp. 322-329).....	287
APA No. 15 (pp. 330-342).....	295
Claimant's Exhibit 2	308
Claimant's Exhibit 3	318
Claimant's Exhibit 4	319
Claimant's Exhibit 5	322
Claimant's Exhibit 6	323
Claimant's Exhibit 7	324
Claimant's Exhibit 8	328

VI. CERTIFICATE OF COUNSEL

Executed Certificate of Counsel	329

DECISION AND ORDER
OF
THE SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO.: 0720591

Kellie Burnette, Employee,

Claimant,

v.

City of Greenville, Employer
and Self Insurer, and Hewitt,
Coleman & Associates, TPA,

Defendants.

Hearing:

Held in Greenville, South Carolina, on
September 3, 2009.

Appearances:

Claimant represented by Douglas A. Churdar of
Greenville, South Carolina.

Defendants represented by Horton, Drawdy,
Ward & Jenkins, P.A., by Michael A. Farry of
Greenville, South Carolina.

Purpose of Hearing:

To determine issues set forth in Forms 50 and 51.

Decision and Order:

By: Susan S. Barden, Commissioner

Filed:

October 14, 2009

STIPULATIONS

Counsel for the parties stipulated at the hearing to the following issues:

1. The purpose of this hearing is to determine issues as set forth in Forms 50 and 51, together with any other issues which may timely come before the Commission.
2. Notice of the hearing was timely and properly served upon all parties of interest.
3. Venue, set in Greenville County, is proper.
4. Claimant's average weekly wage is \$1,000.00, resulting in the maximum compensation rate of \$645.94.
5. Claimant seeks benefits under the South Carolina Workers' Compensation Act based upon an injury by accident occurring on June 16, 2007, while in the employ of the Defendant/Employer, and therefore the South Carolina Workers' Compensation Commission has jurisdiction of this case.

APA SUBMISSIONS

Under the Administrative Procedures Act, the following records were submitted into evidence.

APA #1	Center for Health and Occupational Services (Kevin Kopera, MD), 6/21/04 – 10/15/05	Pages 1-9
APA #2	Piedmont Physical Medicine (Robert G. Schwartz, MD), 6/21/05 – 8/23/05	Pages 10-27
APA #3	Carolina Center for Advanced Management of Pain (John Satterthwaite, MD), 8/28/07 – 8/17/09	Pages 28-147

APA #4	Carolina Center for Advanced Management of Pain (David Tollison, PhD), 8/28/07 – 6/22/09	Pages 148-221
APA #5	Orthopaedic Associates (David Mitchell, MD), 9/19/08 – 09/26/08	Pages 222-230
APA #6	Piedmont Neurosurgical (Michael Bucci, MD), 10/22/08 – 8/6/09	Pages 231-264
APA #7	Disability Recommendation to SC Retirement System (Michael J. Sheehan), 4/14/08	Pages 265-266
APA #8	Rehabilitation Associates (Benson Hecker, PhD), 8/14/09	Pages 267-287
APA #9	Dr. Michael N. Bucci, Piedmont Spine and Neurosurgical Group, P.A., 12/4/08 – 3/10/09	Pages 288-290
APA #10	Dr. John R. Satterthwaite, Carolinas Center for Advanced Management of Pain, 7/23/09	Pages 291-295
APA #11	Dr. Linda Giambalva, Holly Tree Family Practice, 1/21/97 – 3/31/09	Pages 296-307
APA #12	Dr. Alan G. Posta, Jr., Carolina Orthopaedic Center, 11/29/06 – 6/11/07	Pages 308-318
APA #13	Dr. David Mitchell, Orthopaedic Associates, 9/26/08	Pages 319-321
APA #14	Dr. Kevin Kopera, Center for Health and Occupational Services, 11/15/05 – 1/24/07	Pages 322-329
APA #15	Dr. Wes Merriwether, St. Francis WorkWell, 9/3/08 – 5/14/04	Pages 330-342

At the hearing, Claimant submitted Supplement to Exhibit 1 (specific to lumbar spine injury) consisting of a total of 3 pages, a copy of which was provided for the first time to counsel for Defendants.

STATEMENT OF THE CASE

Counsel for the Claimant, as the moving party, advised that Claimant was seeking compensation for permanent and total disability based upon greater than 50% disability to Claimant's back under §42-9-30(19) S.C. Code Ann. Claimant's counsel also advised that in the alternative Claimant was seeking compensation for permanent and total disability under §42-9-10 due to a combination of several injured body parts including Claimant's neck, upper back, low back, and psychological problems.

Claimant's counsel also advised that Claimant was seeking an Order that the award be made in a lump sum with Utica Mohawk allocation language.

Counsel for Defendants advised that Claimant had sustained an admitted injury to Claimant's neck and upper back, however, Defendants denied that Claimant's low back problems were casually related to the admitted accident of June 16, 2007. Defense counsel further advised that if Claimant's low back problems was casually related which Defendants expressly denied, then and in such event Claimant would not be at maximum medical improvement and any determination as to permanency would be premature.

Counsel for Defendants also pointed out that Claimant had undergone cervical surgery by Dr. Bucci and Dr. Bucci had opined that Claimant had a 10% impairment to her spine as of April 3, 2009 set forth at APA #6, p. 255. Counsel further stated that the 28% cervical spine rating by Dr. Bucci set forth at APA #5, p. 231 was a regional rating to Claimant's cervical spine. The regional cervical impairment rating converted to a whole person impairment rating of 10% as set forth in the Guides to the Evaluation of Permanent Impairment Fifth Edition as found in §15.13 at p. 427. A copy of §15.13 from the Guides to

the Evaluation of Permanent Impairment Fifth Edition was marked as Defendant's Exhibit

1.

EVIDENCE OF THE CASE

Kellie Burnette testified that she was 5'10" tall, weighed 236 pounds, and had gained weight in the last several years since her injury while working for the City of Greenville. She stated that she was right handed and had attended Greenville Tech taking criminal justice classes. She also testified that she attended the Criminal Justice Academy in Columbia and had worked as a police officer for the City of Greenville since 2001. She stated that she was injured August 23, 2003 in a car accident when a suspect's vehicle struck her vehicle. She stated she had injuries to her low back but did not have pain radiating into her legs. She also said that she did not have any anxiety or depression from the first injury and she returned to work full duty after the August 23, 2003 accident.

Kellie Burnette testified that her job as a police officer was a physical job where she had to run, bend, stoop and lift heavy weights. She also was required to wear a bullet proof vest and a duty belt.

Kellie Burnette testified that on June 16, 2007 she was injured while attempting to affect an arrest. She said she was trying to remove a suspect from a vehicle when the suspect pulled away while she was halfway in the vehicle. Kellie Burnette said that she had one knee on the seat and the other foot on the ground and she was thrown back from the car when the suspect tried to escape arrest. She felt pain in her neck and low back. She testified that she finished her shift that evening but was forced to medically retire from

the City of Greenville Police Department in March of 2008. She testified that she was never able to return to full duty and has not worked anywhere since she medically retired from the City of Greenville.

Kellie Burnette testified that she is still being treated by Dr. John Satterthwaite and Dr. David Tollison. She stated that she has pain throughout her entire back and neck including down through her low back and into her legs. She also stated that she has pain radiating into her arms.

Kellie Burnette testified that she now suffers from depression, as she is not able to work like she wanted to and not able to get out and do things that she used to. She said that she is unable to do outdoor things and be physically active like she was prior to her accident. She says she does not like to be around other people or crowds. She stated that she is able to stand comfortably for about 20 or 30 minutes, and able to sit comfortably for 20 to 30 minutes and then has to get up and move around. Kellie Burnette testified that she has trouble sleeping at night. She did say that she is able to mow her lawn but has to take a break. Kellie Burnette testified that her parents have a boat which she has used on two occasions.

Under cross-examination, Kellie Burnette admitted that the only surgery she had as a result of the June 16, 2007 accident was cervical disc surgery performed by Dr. Bucci on October 27, 2008. Kellie Burnette further admitted that she had been dismissed by Dr. Bucci on March 24, 2009.

Kellie Burnette testified on cross examination that Dr. John Satterthwaite continues to see her for pain management, consisting of mostly medication. Claimant was further

questioned by defense counsel about her parents' boat which she and her roommate had taken to the lake during 2009. Claimant admitted that she hooked the boat behind her pickup truck and drove to the lake in July of 2009. Kellie Burnette was questioned about a reference in a report of July 23, 2009 by Monica Speak (nurse of Dr. Satterthwaite) found at APA #10, p. 291 which states "... that the sun cover on her boat flew off and she and a friend had to pick it up and put it in the truck. Tuesday she started having increased lower back pain that radiates to her left and into her buttocks." Claimant denied that the boat cover incident which occurred the weekend prior to July 23, 2009 caused her back to hurt worse and to cause pain to radiate to her left and into her buttocks. After several attempts to explain what happened with the boat cover and boat and how it may or may not have affected her back as referenced in the July 23, 2009 report, Claimant finally testified that the report was incorrect.

Kellie Burnette further admitted that she had joined a gym over the last 2 months and had been about 10 times and would stay at the gym for about an hour and a half each time. She also admitted that she went out to eat an evening or two each week. She further admitted that she would drive herself to the doctor, go to the grocery store as needed, run errands, and would do some housework.

Kellie Burnette also admitted that she received a disability retirement check from the Police Officer Association in the amount of approximately \$1807.00 a month. Claimant testified that this check was for life as long as she stayed disabled and did not work.

After careful study and evaluation of all the medical evidence submitted, together with the testimony presented, including the observation of the physical facts of the injury,

and based upon the foregoing are the following:

FINDINGS OF FACT

1. The parties to this proceeding are subject to and bound by the terms and provisions of the South Carolina Workers' Compensation Act, with the City of Greenville as Employer and Self Insurer and Hewitt, Coleman & Associates, TPA.

2. On June 16, 2007, Kellie Burnette was employed by the City of Greenville at an average weekly wage of \$1,000.00, resulting in the maximum compensation rate of \$645.94.

3. Claimant injured her neck and upper back in an admitted accident on June 16, 2007, and also sustained admitted psychological overlay.

4. Claimant alleges that she also injured her low back (or aggravated a pre-existing condition), a claim I find is not supported by the greater weight of the evidence.

5. Claimant is 30 years of age (testimony of Claimant).

6. Claimant has 2 years plus one semester of college where she studied business and criminal justice. Claimant is conversant with various levels of the spine by name. I place great weight on Claimant's educational background in my decision/award in this case (testimony of Claimant).

7. Claimant's job history includes work as a police officer and work as a sales associate/photo lab technician at a camera store (testimony of Claimant).

8. Because of her admitted neck injury, Claimant underwent cervical fusion surgery. After the surgery, Claimant reported that her "upper extremity pain has resolved."

I give greater weight to this record than I give to the Claimant's hearing testimony, which was liberally laced with exaggeration. Another indicator that the surgery was a success is a different medical note pre-dating the date of the surgery, stating that Claimant "can't get out of bed." Post-surgery, Claimant is able (at a minimum) to drive a pickup with a boat attached, drive the boat as well, and work out at a gym – sometimes for 1 ½ hours at a time (testimony of Claimant; Claimant's APA #3, p. 77; Defendants' APA #9, p. 288).

9. Because of Claimant's favorable surgical outcome, Dr. Bucci (authorized surgeon) imposed a 50-lb. weight restriction. I give greater weight to this record than I give to later records or to Claimant's testimony regarding her alleged post-surgical condition (Defendants' APA #9, p. 288; testimony of Claimant).

10. Claimant reached maximum medical improvement on June 22, 2009 (Claimant's APA #3, p. 37).

11. The authorized treating physicians assigned whole person impairment ratings of 25% and 28% (Claimant's APA #3, pp. 37 and 43; Claimant's APA #6, p. 231).

12. Medical evidence notes that Claimant takes various medications "with good effect and no side effects." According to Claimant's own testimony, Claimant's medications do not keep her from driving (including driving her pickup truck with her parents' boat attached). I place great weight on the fact that Claimant's medications cause no side effects, and that she is capable of driving (e.g., Claimant's APA #3, pp. 45, 49, 57, 59, 61 and 70).

13. Medical records indicate that Claimant "remains active" within her limitations (Claimant's APA #3, p. 41).

14. Authorized treating physician, Dr. Satterthwaite, states that Claimant is capable of performing sedentary work, an opinion upon which I place great weight. However, Claimant told Dr. Satterthwaite that she is "not interested in a desk job" (Claimant's APA #3, pp. 35 and 129-130).

15. Authorized treating psychologist, Dr. Tollison, states that Claimant is "able to maintain competent employment with restrictions," an opinion upon which I place great weight (Claimant's APA #4, pp. 153-154).

16. Claimant's memory (both recent and remote) is noted throughout the medical records to be "normal" (e.g., Claimant's APA #3, pp. 54 and 58).

17. The only genuine discomfort I observed at the hearing was in the expression on Claimant's face during Defendants' counsel's cross examination of Claimant (a) on whether or not she hooks the boat up to her truck (finally at one point in her testimony, she says, "I did"), and how frequently she drives the boat/takes it out; and (b) about the boat cover incident, as documented in Defendants' APA #10, pp.s 291-292. As to the latter issue, Claimant's laborious but unconvincing "explanation" (as the transcript will reflect) is not at all believable.

18. Claimant's contention that she aggravated her pre-existing low back condition is not supported by the greater weight of the evidence: (a) on the date of the accident, Claimant had "chronic" low back pain from a previous accident for which she received a workers' compensation award of 17.5% in 2006; I find that the greater weight of the evidence (excluding Claimant's self-serving testimony) shows that condition was and is ongoing, but was not aggravated by the accident in issue; (b) Claimant's testimony that her

interp

pre-existing back condition did not affect her legs until after the accident in issue is refuted by the medical evidence (e.g., Claimant's APA #3, p. 41 – "has ongoing back and *left leg pain from her previous back injury*;" and p. 124 – "at that time [referring to a May 2004 MRI] noting RLE paresthesia"); and Claimant's APA #2, p. 17 – an EMG study from 2005 showing left L5 nerve root irritation; (c) as of July 1, 2009 (2 months prior to the date of the hearing before the undersigned), Claimant's back pain is noted to be fairly "well-controlled" with medications; (d) Claimant's lumbar MRI—undergone after the date of the accident in issue—shows only a "minimal" protrusion with no nerve root displacement or impingement, and comparatively, no greater pathology of any significance (if any) than the MRI of 2004; (e) in September 2008 (post-accident in issue), Claimant noted "minimal" leg pain," a record to which I give greater weight than I give to later records or Claimant's testimony at the hearing; (f) an early medical record (just a few months after the date of the accident in issue) from Dr. Satterthwaite states that Claimant "[h]ad an injury in June where she hurt her neck." This record goes on to say that Claimant has neck pain later in the day with working; there is no mention of back pain after working (e.g., Claimant's APA #1, pp. 2-5 and 10, as to Claimant's history of "chronic" low back pain; Claimant's APA #3, pp. 83 – "'minimal" leg pain, 132 – "had an injury where she hurt her neck," 134 – neck pain aggravated by accident in issue, with no mention of aggravation of back, and 146-147 (2008 MRI); Claimant's APA #6, p. 237 – prior workers' compensation award; Defendants' APA #11, p. 301, as to a history of "chronic" low back pain; Defendants' APA #14, pp. 322-328, as to a history of "chronic" low back pain; Defendants' APA #14, page 322-328, as to a history of "chronic" low back pain; Defendants' APA #15, pp. 330 and 332-333, as to the

findings from Claimant's 2004 MRI).

19. In any event, if Claimant aggravated her low back condition in the accident in issue, the aggravation was temporary, and her condition returned to baseline or is the result of an intervening accident; (a) in late 2008 – 1 year after the date of the accident in issue, Claimant's roommate told Dr. Mitchell that Claimant is "up at night and cannot sleep and walks around complaining of 'neck' [no mention of back] pain" (Claimant's APA #4, p. 222; Defendants' APA #13, pp. 319-320); (b) Claimant's condition was significantly worsened by the unrelated, intervening boat cover incident; I base this conclusion on the fact that a medical record of July 1, 2009, states that Claimant's gait and station are "normal," and her pain is noted to be a "6". After the boat cover incident (described on July 23, 2009, as occurring over the preceding weekend, Claimant's gait and station are documented as "antalgic" and her pain level is a "9" Claimant's APA #3, p. 41; Defendants' APA #10, pp. 291-292).

20. Claimant is entitled to receive medications specified by authorized treating physicians (or comparable medications) pursuant to the dictates of Dodge.

21. I strongly believe that Claimant has exaggerated her condition to various providers and to the undersigned in order to "maximize" her case/award.

22. As I believe and find there is work that Claimant is capable of obtaining and sustaining, I further find Claimant is not permanently and totally disabled. Claimant strikes the undersigned as someone who simply does not wish to work (medical evidence as a whole; testimony of Claimant, including but not limited to the issue of the amount of her monthly police disability income *vis a vis* her average weekly wage).

23. Claimant sustained 25% permanent partial disability to her spine (for cervical injury) pursuant to §42-9-30(19). I find that there is no disability or loss of use beyond the 25% impairment rating.

24. Pursuant to §42-3-180, Utica-Mohawk Mills v. Orr, 227 SC 226, 87 SE 2nd 587 (1955), and Sciarotta v. Bowen, 837 F2d 135 (3rd Civ. 1988), the future proceeds of \$48,445.50 shall be allocated as follows: \$29,609.54 shall be paid to Claimant in future disability benefits at the rate of \$10.74 per week, commencing on June 22, 2009 and continuing for a period of 2,756 weeks, representing the life expectancy of Claimant pursuant to §19-1-150; and \$18,835.96 shall be paid to Claimant's attorney as attorney fees (\$16,148.50) and costs (\$2,687.46) pursuant to a written agreement between Claimant and her attorney.

Subject
to the
approval
of a
Hon (61)
JJB

CONCLUSIONS OF LAW

Accordingly as provided in § 42-17-40 S. C. Code Ann., it is the determination of this Commissioner:

1. Under § 42-17-160, Claimant sustained an injury by accident to her neck and upper back resulting in admitted psychological overlay arising out of and in the course of her employment.
2. Under § 42-15-60, Claimant received proper medical care.
3. Under § 42-9-30(19), Claimant shall receive compensation for permanent partial disability of 25% to the spine.
4. Under §42-15-60 and pursuant to the dictates of Dodge v. Bruccoli, 514 S.E.

2nd 593 (S.C. App. 1999), Claimant is entitled to medical treatment and medications which in the opinion of the authorized treating physicians tends to lessen the Claimant's period of disability.

ORDER

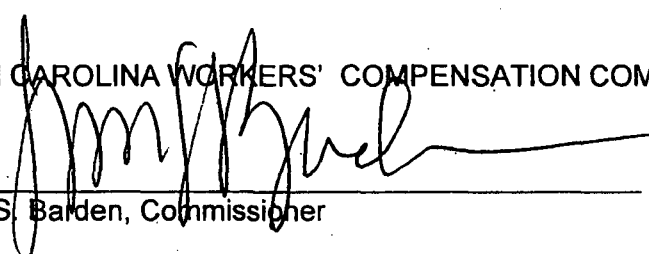
IT IS ORDERED that Claimant shall receive compensation benefits at the rate of \$645.94 from June 22, 2009 for 75 weeks based upon 25% permanent partial disability to the spine.

Defendants shall be responsible for medication and treatments specified by the authorized treating physicians so long as Claimant's future medical treatment and medication tends to lessen the Claimant's period of disability pursuant to Dodge v. Brucoli.

No hearing costs are assessed in this instance.

IT IS SO ORDERED.

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION



Susan S. Barden, Commissioner

Dated: 10/12/09

MF
De

CERTIFICATE OF SERVICE
This is to certify that the undersigned has this date served this order in the above entitled action upon all parties to this cause by depositing a copy hereof, postage paid, in the United States mail addressed to the attorney or attorneys for said parties.
This 14th day of October, 2009
By KRISTI Love
Administrative Assistant to the Commissioner

BEFORE THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

WCC FILE NO. 0720591

Kellie Burnette,)
)
 Claimant,)
 vs.)
)
 City of Greenville,)
)
 Employer,)
)
 City of Greenville,)
)
 Carrier,)
 Defendants)
)

A Motion regarding the following issue(s) has been received.

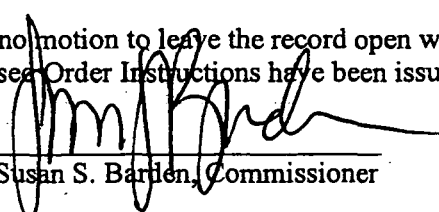
- ☐ Discovery or Subpoena
☐ Appointment of guardian Ad Litem
☐ Attorney's appearance before the Commission
☐ Withdrawal of Representation
☐ Attorney's Fee
☐ Claim Pending Commission Review
☐ Postpone
☐ Adjourned the Scheduled Hearing
☐ Self Insurance Privileges
☐ Penalties and Interest
☐ Third Party Practice
☒ Other: Motion to Admit Additional Evidence to Complete the Record.

The following disposition has been made: ☐ Granted ☒ Denied

- ☐ Set for Hearing
☐ Have Attorneys brief the Issue

Reason: The hearing was held, no motion to leave the record open was requested at the hearing, and Proposed Order Instructions have been issued.

Columbia, SC


Susan S. Barden, Commissioner

CERTIFICATE OF SERVICE

WCC FILE NO. 0720591

This is to certify that the undersigned has this date served this Order in the above-captioned action upon all parties to this cause depositing a copy hereof, first class postage paid, or if indicated below by certified mail, return receipt requested, in the United States mail addressed to the attorney or attorneys for said parties.

This 23rd day of September, 2009.

BY

KRISTI LOVE

Kristi Love, Assistant to Commissioner Barden

cc:

Douglas A. Churdar, Esquire
Douglas A. Churdar, P.C.
712 East Washington Street,
Greenville, SC 29601

Michael Farry, Esquire
Horton Law Firm
PO Box 10167
Greenville, SC 29603

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
JUDICIAL CONFERENCE DECISION AND ORDER

Kellie N. Burnette v City of Greenville
SCWCC: 0720591
Commissioner: Barden

This matter was heard before the South Carolina Workers' Compensation Full Commission in Judicial Conference. The Commissioners considered the matter and ordered the matter handled in the following manner:

IT IS, THEREFORE, ORDERED the pending motion be, and hereby is;

☐ Granted. ☒ Denied. ☐ Set for Hearing.

BEFORE THE;

☐ Hearing Comm. ☐ Jurisdictional Comm. ☐ Full Commission.

☐ Interlocutory. ☐ Dismissed.

IT IS, THEREFORE, ORDERED this matter be, and hereby is; remanded to take such action and enter an Order consistent with the Court's directive.

☐ Remand to Panel as indicated below.

☐ Barden	☐ Lyndon	☐ Williams
☐ Beck	☐ Roche	☐ Wilkerson
☐ Huffstetler		

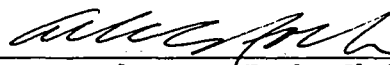
☐ Remand for Order consistent with the Order of the Court.

☐ Remand to the Hearing Commissioner.
☐ Remand to the Jurisdictional Commissioner.

☐ Other: _____

☐ Remand: ☐ Panel Oral Argument. ☐ En Banc Oral Argument.

AND IT IS SO ORDERED.


Andrea Pope Roche, Chair

Columbia, South Carolina

11/16 2009

CONCURRING:

Commissioner David Huffstetler
Commissioner Susan S. Barden
Commissioner G. Bryan Lyndon
Commissioner Derrick Williams
Commissioner Avery Wilkerson
Commissioner T. Scott Beck

NOT PARTICIPATING:

☒
☐
☐
☐
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☐

DISSENTING:

☐
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☐

CERTIFICATE OF SERVICE

THIS IS TO CERTIFY THE UNDERSIGNED HAS THIS DATE SERVED THIS ORDER IN THE ABOVE ENTITLED ACTION UPON ALL PARTIES BY DEPOSITING A COPY HEREOF, POSTAGE PAID, IN THE UNITED STATES MAIL

This 17 day of November, 2009.

By: Valerie D Deller
SCWCC Judicial Department

Douglas Churda
Michael A. Tarry

APPELLATE PANEL
DECISION AND ORDER
OF THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO.: 0720591

Kellie Burnett, Employee,

Claimant/Appellant,

v.

City of Greenville, Employer and Self-Insured,
and Hewitt, Coleman & Associates, Inc., TPA,

Defendants/Respondents.

Appellate Panel Review held in Columbia,
South Carolina, on February 24, 2010, per
notices timely and properly served on
all parties of interest.

Appellate Panel Decision and Order filed
4-1, 2010.

Appearances:

Claimant/Appellant represented by Douglas A. Churdar
of Greenville, South Carolina.

Defendants/Respondents represented by Horton, Drawdy,
Ward & Jenkins, P.A., by Michael A. Farry of Greenville,
South Carolina.

STATEMENT OF THE CASE

The parties were heard by Commissioner Susan S. Barden on September 3, 2009, in Greenville, South Carolina. On October 14, 2009, Commissioner Barden issued the following Order:

FINDINGS OF FACT

1. The parties to this proceeding are subject to and bound by the terms and provisions of the South Carolina Workers' Compensation Act, with the City of Greenville as Employer and Self Insurer and Hewitt, Coleman & Associates, TPA.
2. On June 16, 2007, Kellie Burnette was employed by the City of Greenville at an average weekly wage of \$1,000.00, resulting in the maximum compensation rate of \$645.94.
3. Claimant injured her neck and upper back in an admitted accident on June 16, 2007, and also sustained admitted psychological overlay.
4. Claimant alleges that she also injured her low back (or aggravated a pre-existing condition), a claim I find is not supported by the greater weight of the evidence.
5. Claimant is 30 years of age (testimony of Claimant).
6. Claimant has 2 years plus one semester of college where she studied business and criminal justice. Claimant is conversant with various levels of the spine by name. I place great weight on Claimant's educational background in my decision/award in this case (testimony of Claimant).
7. Claimant's job history includes work as a police officer and work as a sales associate/photo lab technician at a camera store (testimony of Claimant).
8. Because of her admitted neck injury, Claimant underwent cervical fusion surgery. After the surgery, Claimant reported that her "upper extremity pain has resolved." I give greater weight to this record than I give to the Claimant's hearing testimony, which was liberally laced with exaggeration. Another indicator that the surgery was a success is a different medical note pre-dating the date of the surgery, stating that Claimant "can't get out of bed."

Post-surgery, Claimant is able (at a minimum) to drive a pickup with a boat attached, drive the boat as well, and work out at a gym – sometimes for 1 ½ hours at a time (testimony of Claimant; Claimant's APA #3, p. 77; Defendants' APA #9, p. 288).

9. Because of Claimant's favorable surgical outcome, Dr. Bucci (authorized surgeon) imposed a 50-lb. weight restriction. I give greater weight to this record than I give to later records or to Claimant's testimony regarding her alleged post-surgical condition (Defendants' APA #9, p. 288; testimony of Claimant).

10. Claimant reached maximum medical improvement on June 22, 2009 (Claimant's APA #3, p. 37).

11. The authorized treating physicians assigned whole person impairment ratings of 25% and 28% (Claimant's APA #3, pp. 37 and 43; Claimant's APA #6, p. 231).

12. Medical evidence notes that Claimant takes various medications "with good effect and no side effects." According to Claimant's own testimony, Claimant's medications do not keep her from driving (including driving her pickup truck with her parents' boat attached). I place great weight on the fact that Claimant's medications cause no side effects, and that she is capable of driving (e.g., Claimant's APA #3, pp. 45, 49, 57, 59, 61 and 70).

13. Medical records indicate that Claimant "remains active" within her limitations (Claimant's APA #3, p. 41).

14. Authorized treating physician, Dr. Satterthwaite, states that Claimant is capable of performing sedentary work, an opinion upon which I place great weight. However, Claimant told Dr. Satterthwaite that she is "not interested in a desk job" (Claimant's APA #3, pp. 35 and 129-130).

15. Authorized treating psychologist, Dr. Tollison, states that Claimant is "able to maintain competent employment with restrictions," an opinion upon which I place great weight (Claimant's APA #4, pp. 153-154).

16. Claimant's memory (both recent and remote) is noted throughout the medical records to be "normal" (e.g., Claimant's APA #3, pp. 54 and 58).

17. The only genuine discomfort I observed at the hearing was in the expression on Claimant's face during Defendants' counsel's

cross examination of Claimant (a) on whether or not she hooks the boat up to her truck (finally at one point in her testimony, she says, "I did"), and how frequently she drives the boat/takes it out; and (b) about the boat cover incident, as documented in Defendants' APA #10, pp.s 291-292. As to the latter issue, Claimant's laborious but unconvincing "explanation" (as the transcript will reflect) is not at all believable.

18. Claimant's contention that she aggravated her pre-existing low back condition is not supported by the greater weight of the evidence: (a) on the date of the accident, Claimant had "chronic" low back pain from a previous accident for which she received a workers' compensation award of 17.5% in 2006; I find that the greater weight of the evidence (excluding Claimant's self-serving testimony) shows that condition was and is ongoing, but was not aggravated by the accident in issue; (b) Claimant's testimony that her pre-existing back condition did not affect her legs until after the accident in issue is refuted by the medical evidence (e.g., Claimant's APA #3, p. 41 – "has ongoing back and *left leg pain from her previous back injury.*" and p. 124 – "at that time [referring to a May 2004 MRI] noting RLE paresthesia"); and Claimant's APA #2, p. 17 – an EMG study from 2005 showing left L5 nerve root irritation; (c) as of July 1, 2009 (2 months prior to the date of the hearing before the undersigned), Claimant's back pain is noted to be fairly "well-controlled" with medications; (d) Claimant's lumbar MRI—undergone after the date of the accident in issue—shows only a "minimal" protrusion with no nerve root displacement or impingement; and comparatively, no greater pathology of any significance (if any) than the MRI of 2004; (e) in September 2008 (post-accident in issue), Claimant noted "minimal" leg pain," a record to which I give greater weight than I give to later records or Claimant's testimony at the hearing; (f) an early medical record (just a few months after the date of the accident in issue) from Dr. Satterthwaite states that Claimant "[h]ad an injury in June where she hurt her neck." This record goes on to say that Claimant has neck pain later in the day with working; there is no mention of back pain after working (e.g., Claimant's APA #1, pp. 2-5 and 10, as to Claimant's history of "chronic" low back pain; Claimant's APA #3, pp. 83 – "minimal" leg pain, 132 – "had an injury where she hurt her neck," 134 – neck pain aggravated by accident in issue, with no mention of aggravation of back, and 146-147 2008 MRI; Claimant's APA #6, p. 237 – prior workers' compensation award; Defendants' APA #11, p. 301, as to a history of "chronic" low back pain; Defendants' APA #14, pp. 322-328, as to a history of "chronic" low back pain; Defendants' APA #14, page 322-328, as to a history of

"chronic" low back pain; Defendants' APA #15, pp. 330 and 332-333, as to the findings from Claimant's 2004 MRI).

19. In any event, if Claimant aggravated her low back condition in the accident in issue, the aggravation was temporary, and her condition returned to baseline or is the result of an intervening accident; (a) in late 2008 – 1 year after the date of the accident in issue, Claimant's roommate told Dr. Mitchell that Claimant is "up at night and cannot sleep and walks around complaining of 'neck' [no mention of back] pain" (Claimant's APA #4, p. 222; Defendants' APA #13, pp. 319-320); (b) Claimant's condition was significantly worsened by the unrelated, intervening boat cover incident; I base this conclusion on the fact that a medical record of July 1, 2009, states that Claimant's gait and station are "normal," and her pain is noted to be a "6". After the boat cover incident (described on July 23, 2009, as occurring over the preceding weekend, Claimant's gait and station are documented as "antalgic" and her pain level is a "9" Claimant's APA #3, p. 41; Defendants' APA #10, pp. 291-292).

20. Claimant is entitled to receive medications specified by authorized treating physicians (or comparable medications) pursuant to the dictates of Dodge.

21. I strongly believe that Claimant has exaggerated her condition to various providers and to the undersigned in order to "maximize" her case/award.

22. As I believe and find there is work that Claimant is capable of obtaining and sustaining, I further find Claimant is not permanently and totally disabled. Claimant strikes the undersigned as someone who simply does not wish to work (medical evidence as a whole; testimony of Claimant, including but not limited to the issue of the amount of her monthly police disability income *vis a vis* her average weekly wage).

23. Claimant sustained 25% permanent partial disability to her spine (for cervical injury) pursuant to §42-9-30(19). I find that there is no disability or loss of use beyond the 25% impairment rating.

24. Pursuant to §42-3-180, Utica-Mohawk Mills v. Orr, 227 SC 226, 87 SE 2nd 587 (1955), and Sciarotta v. Bowen, 837 F2d 135 (3rd Civ. 1988), the future proceeds of \$48,445.50 shall be allocated as follows: \$29,609.54 shall be paid to Claimant in future disability benefits at the rate of \$10.74 per week, commencing on June 22, 2009 and continuing for a period of 2,756 weeks, representing the life expectancy of Claimant pursuant to §19-1-150; and \$18,835.96

shall be paid to Claimant's attorney as attorney fees (\$16,148.50) and costs (\$2,687.46) pursuant to a written agreement between Claimant and her attorney.

CONCLUSIONS OF LAW

Accordingly as provided in § 42-17-40 S. C. Code Ann., it is the determination of this Commissioner:

1. Under § 42-17-160, Claimant sustained an injury by accident to her neck and upper back resulting in admitted psychological overlay arising out of and in the course of her employment.
2. Under § 42-15-60, Claimant received proper medical care.
3. Under § 42-9-30(19), Claimant shall receive compensation for permanent partial disability of 25% to the spine.
4. Under §42-15-60 and pursuant to the dictates of Dodge v. Bruccoli, 514 S.E. 2nd 593 (S.C. App. 1999), Claimant is entitled to medical treatment and medications which in the opinion of the authorized treating physicians tends to lessen the Claimant's period of disability.

ORDER

IT IS ORDERED that Claimant shall receive compensation benefits at the rate of \$645.94 from June 22, 2009 for 75 weeks based upon 25% permanent partial disability to the spine.

Defendants shall be responsible for medication and treatments specified by the authorized treating physicians so long as Claimant's future medical treatment and medication tends to lessen the Claimant's period of disability pursuant to Dodge v. Bruccoli.

No hearing costs are assessed in this instance.

IT IS SO ORDERED.

Within the statutory period, counsel for Claimant/Appellant filed a Request for Commission review (Form 30) setting forth grounds for review, copies of which were furnished to all interested parties prior to oral argument scheduled before the Appellate

Panel of the Full Commission for February 24, 2010. Prior to oral argument, the Commission received Briefs from all parties. All proffered testimony has been taken. Such, together with all documented evidence, has been delivered to individual members of the Appellate Panel of the Full Commission and has since been under study and consideration.

By appeal, the Claimant/Appellant respectfully submits the following grounds for appeal:

1. Whether Claimant sustained injury to the low back?
2. Whether Claimant's physical limitations alone render her permanently and totally disabled?
3. Whether Claimant's mental/psychological limitations alone render her permanently and totally disabled?
4. Whether Claimant's pre-existing 17.5% disability to the back combined under Ellison with her new injury to the cervical spine – C5-6 fusion/25% and 28% whole person impairment per treating physicians – and new injury to the lumbar spine – injured disk at L5-S1/16% lumbar impairment per treating physicians results in 50% or more loss of use of the back under § 42-9-30? (This is a 6/16/07 injury.)
5. Whether Claimant's pre-existing 17.5% disability to the back and 10% impairment to the upper left extremity combined under Ellison with her new injury to the cervical spine – C5-6 fusion/25% and 28% whole person impairment per treating physicians – and new injury to lumbar spine – injured disk at L5-S1/16% lumbar impairment per treating physicians and new mental/psychological limitations cause her to be permanently and totally disabled under § 42-9-10?
6. Whether Claimant is entitled to referral to an orthopaedic or neurosurgeon for injured disk at L5-S1 as requested by her treating physician and lawyer?
7. Whether credibility findings relating to how Claimant aggravated her back several weeks before the hearing but after all

treating physicians had rated her for impairment revolve around an irrelevant and immaterial issue or are supported by the evidence?

8. Whether overall credibility findings are supported by the evidence?

Pursuant to § 42-17-50, S.C. Code Ann. (1985) we, the Appellate Panel, have reviewed the award, weighed the evidence as presented, and considered all issues raised on appeal. This Appellate Panel may make its own findings of fact and reach its own conclusions of law.

After careful review in the instant case, the Appellate Panel of the SC Workers' Compensation Commission has determined by a unanimous vote that all of the hearing commissioner's findings of fact and conclusions of law are correctly stated. The findings of fact and conclusions of law by the hearing commissioner as set forth hereinabove are adopted verbatim by the Appellate Panel, are incorporated herein by reference as if set forth fully herein. Therefore, the Order of the hearing commissioner is affirmed.

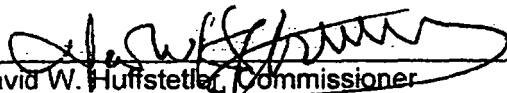
ORDER

IT IS THEREFORE ORDERED that the Order by the hearing commissioner filed October 14, 2009 is hereby unanimously affirmed by the Appellate Panel, and the same shall constitute the Decision and Order of the Appellate Panel as set forth hereinabove.

IT IS SO ORDERED.

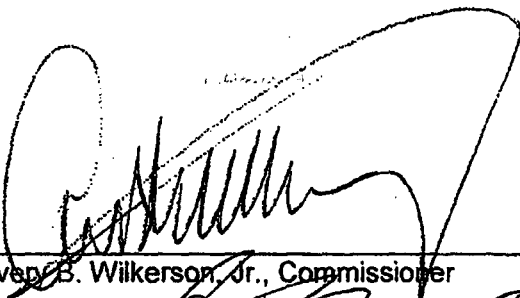
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

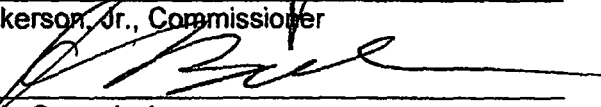
AFFIRMATION



David W. Huffstetler, Commissioner

CONCUR


Avern B. Wilkerson, Jr., Commissioner


T. Scott Beck, Commissioner

CERTIFICATE OF SERVICE

This is to certify that the undersigned has this date served this order in the above entitled action upon all parties to this cause by depositing a copy heretof, postage paid, in the United States mail addressed to the attorney or attorneys for said parties.

This 1st day of April, 2010
By Valerie D. Deller

Administrative Assistant to the Commissioner

Douglas A. Churda
Michael A. Farry

STATE OF SOUTH CAROLINA

COUNTY OF GREENVILLE

IN THE COURT OF COMMON PLEAS

JUDGMENT IN A CIVIL CASE

CASE NO: 2010CP2303442

2011 JUL -7 P 4: 15

Kellie N Burnette vs. Greenville City Of

FILED-CLERK OF COURT
GREENVILLE CO. S.C.
JUL 11 2011

CHECK ONE:

- ☐ **JURY VERDICT.** This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.
- ☐ **DECISION BY THE COURT.** This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.
- ☐ **ACTION DISMISSED (CHECK REASON):** ☐ Rule 12(b), SCRCP; ☐ Rule 41(a),
SCRCP (Vol. Nonsuit); ☐ Rule 43(k), SCRCP (Settled); ☐ Other: _____
- ☐ **ACTION STRICKEN (CHECK REASON):** ☐ Rule 40(j) SCRCP; ☐ Bankruptcy:
☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award;
☐ Other: _____
- ☐ **DISPOSITION OF APPEAL TO THE CIRCUIT COURT (CHECK APPLICABLE BOX):**
☐ Affirmed; ☐ Reversed; ☐ Remanded;
☐ Other: _____

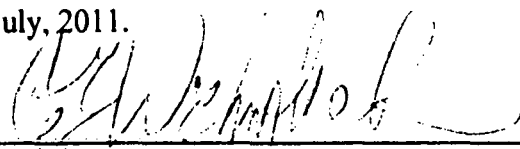
NOTE: ATTORNEYS ARE RESPONSIBLE FOR NOTIFYING LOWER COURT, TRIBUNAL, OR ADMINISTRATIVE AGENCY OF THE CIRCUIT COURT RULING IN THIS APPEAL.

IT IS ORDERED AND ADJUDGED: ☐ See attached order; ☐ Statement of Judgment by the Court:

This matter comes before me on appellant's appeal from the decision of the Workers' Compensation Full Commission. Appellant contends that the Commission's finding of twenty-five percent permanent partial disability is not supported by substantial evidence, and must therefore be set aside. This of course is an intensely factual based inquiry, necessitating the "clearly erroneous...in view of substantial evidence on the whole record" standard of review for such administrative agency decisions found in S.C. Code § 1-23-380 (2009). See also Transportation Ins. Co. and Flagstar Corp. v. South Carolina Second Injury Fund, 389 S.C. 422, 427, 699 S.E.2d 687, 689-90 (2010); Lark v. Bi-Lo, Inc., 276 S.C. 130, 276 S.E.2d 304 (1981). As the Court explained in Shealy v. Aiken County, "substantial evidence is not a mere scintilla of evidence nor evidence viewed from one side, but such evidence, when the whole record is considered, as would allow reasonable minds to reach the conclusion the Full Commission reached." Shealy v. Aiken Co., 341 S.C. 448, 454-55, 535 S.E.2d 438, 442 (2000). Appellant claims that the decision should be set aside in light of the South Carolina Retirement System's finding that the Appellant was entitled to disability. See Claimant Exhibit 6. However, based on a thorough review of the entirety of the record, and considering the insightful arguments by both counsel, this Court finds that the Commission had ample evidence upon which to base its decision. As such, this Court finds that the Commission's decision is supported by substantial evidence. Therefore, the Commission's decision is AFFIRMED.

Dated at Greenville, South Carolina, this the 9 day of July, 2011.

Court Reporter:


PRESIDING JUDGE - G. EDWARD WELMAKER

This judgment was entered on the 7/7/11 and a copy mailed first class this 7/7/11 to attorneys of record or to parties (when appearing pro se) as follows:

Douglas A. Churdar 712 E. Washington St. Greenville, SC
29601

ATTORNEY(S) FOR THE PLAINTIFF(S)

Michael Allen Farry Horton Drawdy Ward & Jenkins, PA
P.O. Box 10167 Greenville, SC 29603

ATTORNEY(S) FOR THE DEFENDANT(S)

Paul B. Wickensimer Greenville County Clerk Of Court
- Clerk of Court

STATE OF SOUTH CAROLINA
COUNTY OF GREENVILLE
IN THE COURT OF COMMON PLEAS

JUDGMENT IN A CIVIL CASE

CASE NO: 2010CP2503442

Kellie N Burnette vs. Greenville City Of

CHECK ONE:

- ☐ **JURY VERDICT.** This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.
- ☐ **DECISION BY THE COURT.** This action came to trial or hearing before the court. The issues have been tried or heard a decision rendered.
- ☐ **ACTION DISMISSED (CHECK REASON):** ☐ Rule 12(b), SCRPC; ☐ Rule 41(a), SCRPC (Vol. Nonsuit); ☐ Rule 43(k), SCRPC (Settled); ☐ Other: _____
- ☐ **ACTION STRICKEN (CHECK REASON):** ☐ Rule 40(j) SCRPC; ☐ Bankruptcy; ☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award; ☐ Other: _____
- ☐ **DISPOSITION OF APPEAL TO THE CIRCUIT COURT (CHECK APPLICABLE BOX):**
☐ Affirmed; ☐ Reversed; ☐ Remanded; ☐ Other: _____

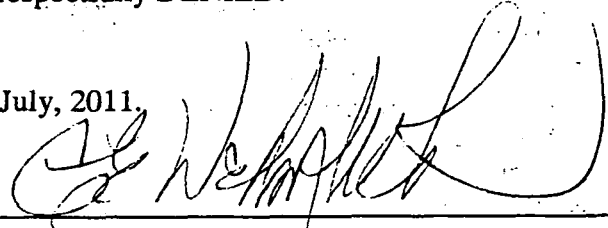
NOTE: ATTORNEYS ARE RESPONSIBLE FOR NOTIFYING LOWER COURT, TRIBUNAL, OR ADMINISTRATIVE AGENCY OF THE CIRCUIT COURT RULING IN THIS APPEAL.

IT IS ORDERED AND ADJUDGED: ☐ See attached order; ☐ Statement of Judgment by the Court:

This matter comes before the court on appellant's motion to amend this court's order of July 7, 2011. Appellant contends that the court did not address an alternate basis for reversing the decision of the Workers' Compensation Commission. After a thorough review of appellant's motion and supporting documentation, this court's previous order, and the notes from the hearing, appellant's motion is respectfully DENIED.

Dated at Greenville, South Carolina, this the 29th day of July, 2011.

Court Reporter:


PRESIDING JUDGE - G. EDWARD WELMAKER

This judgment was entered on the , and a copy mailed first class this , to attorneys of record or to parties (when appearing pro se) as follows:

Douglas A. Churdar 712 E. Washington St. Greenville, SC 29601

ATTORNEY(S) FOR THE PLAINTIFF(S)

Michael Allen Farry Horton Drawdy Ward & Jenkins, PA
P.O. Box 10167 Greenville, SC 29603

ATTORNEY(S) FOR THE DEFENDANT(S)

Paul B. Wickensimer Greenville County Clerk Of Court



Claimant's Name: Kellie Burnette SSN: [REDACTED] Employer's Name: City of Greenville
Address: [REDACTED] Address: P.O. Box 207
City: [REDACTED] State: SC City: Greenville State: SC Zip: 29602
Home Phone: [REDACTED] Work Phone: () - Insurance Carrier: Hewitt Coleman & Associate
Preparer's Name: Douglas A. Churdar Law Firm: Douglas A. Churdar, P.C. Preparer's Phone #: 864-233-0203

Complete each information blank. To request a hearing, check Box 13b, indicate the kinds of benefits claimed by checking the box(es) at Lines 6, 7, 8, and 9, and file this form in duplicate.

A claim for workers' compensation benefits is made based on the following grounds:

Date of Injury or Illness: 6/16/07

☒ Injury ☐ Illness ☐ Repetitive Trauma

1a. The claimant sustained an injury to neck/upper back/mid back/lower back & psyche (Part(s) of Body Injured) on 6/16/07 (Month/Day/Year) in Greenville county, state of South Carolina.

1b. Body part(s) affected are: neck/upper back & lower back

Briefly describe how the accident occurred. Claimant, a police officer, was trying to pull a suspect from a car & the suspect drove away while Claimant was partially in car.

2. Both the claimant and the employer were subject to the South Carolina Workers' Compensation Act at the time of injury.

3. The relationship of employer and employee existed at the time of injury.

4. At the time of the injury the claimant was performing services arising out of and in the course of employment.

5. Notice of the accidental injury was given to the Employer on 6/16/07 (Month/Day/Year) in the following manner:

Verbally and Incident Report

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

☒ (a) medical examination and treatment for: neck/upper back/mid back/lower back & psyche

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

☒ 7. Due to injury, the claimant requests temporary total disability benefits because of lost compensable time from work and wages for the period of: April 1, 2008 to present as well as sporadic days missed prior to April 1, 2008.

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

☒ (1) General Disability:

☒ Total

☐ (2) Specific Disability:

☐ Total

☐ (3) Wage Loss

☐ Partial

☐ Partial

☐ 9. 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 \$600.00 +/-, 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:
City of Greenville Police Department

11a. Further grounds or unusual aspects of claim:

Treating physician has opined that Claimant is need of treatment for cervical spine, thoracic spine, and depression. Employer/Carrier has denied treatment.

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

11c. To the best of your knowledge, did you have any prior permanent disability? yes
If yes, describe: 17.5% disability to back per Order dated 1/11/06

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: _____

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

Preparer's Signature

Title

Email

Date

Refer to R.67-204 through R.67-210 and R.67-601 through R.67-615. Questions about the use of this form may be directed to the Commission's Claims Department.

South Carolina Workers' Compensation Commission

1612 Marion Street • Post Office Box 1715

Columbia, South Carolina 29202-1715

(803) 737-5739

www.wcc.sc.gov

WCC File #: **0720591**

Carrier File #:

Carrier Code #:

Employer FEIN #:

Claimant's Name: Kellie BurnetteSSN: [REDACTED]Employer's Name: City of GreenvilleAddress: [REDACTED]Address: P.O. Box 2207City: [REDACTED] State: SC Zip: [REDACTED]City: Greenville State: SC Zip: 29602Home Phone: () - Work Phone: () -Date of Injury: 6/16/07Insurance Carrier: TPA - Hewitt, Coleman & Associates, Inc.Preparer's Name: Michael A. FarryLaw Firm: Horton Law FirmPreparer's Phone #: (864) 233-4351Date of Injury or Illness: 6/16/07**Complete each information blank. Specify clearly when contentions are admitted in part and denied in part. The employer/carrier in answer to the claim, respectfully shows:**

1. It is **admitted** the employee sustained an injury to her neck and upper back or about the date set forth in the Form 50. The reasons for denial are: **It is denied Claimant sustained any compensable injury to mid back/lower back and psyche.**
2. It is **admitted** both the employer and employee were subject to the Workers' Compensation Act at the time in question. The reasons for denial are: See paragraph 1.
3. It is **admitted** the relationship of employer and employee existed at the time in question. The reasons for denial are: See paragraph 1.
4. It is **admitted** at the time in question the employee was performing services arising out of and in the course of employment. The reasons for denial are: See paragraph 1.
5. It is **admitted** notice of injury was given the employer. The reasons for denial are: See paragraph 1.
6. It is **denied** the employee **Needs / Is Entitled to Additional** medical care as a result of injury or illness. The reasons for denial are: Claimant has refused to make herself available for medical evaluation and treatment, and therefore, pursuant to §42-15-60 of the Workers' Compensation Act, Defendants have suspended any further compensation benefits until such time as Claimant's refusal to present herself for treatment ceases. See letter of 3/17/08 to Claimant's attorney attached hereto.
7. It is **denied** the employee is entitled to temporary total disability for the period(s) of : See paragraphs 1 and 6.
8. It is **denied** the employee is permanently disabled. The reasons for denial are: Premature for determination. See paragraphs 1 and 6.
9. It is **denied** the employee has serious disfigurement.
10. It is contended that an average weekly wage of \$ Form 20 to be filed applies, according to attached Form 20 as provided by law.
11. Further contentions, grounds of defense, or unusual aspects are: See paragraph 6.
12. Estimated time needed for hearing: 30 minutes

I certify I have served this document pursuant to R.67-212 by delivering a copy to:

Name: Douglas A. ChurdarAddress: 712 East Washington Street, Greenville, SC 29601on the 12th day of May, 2008 by ☒ first class mail ☐ personal service ☐ certified mail.

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

Preparer's Signature [Signature]Attorney for Defendants
Titlemfarry@hortonlawfirm.net
Email5/13/08
Date

Refer to R.67-204 through R.67-210 and R.67-601 through R.67-615. Questions about the use of this form may be directed to the Commission's Judicial Department. Pursuant to R.67-606, a Form 20 must be filed with the Claims Department at least 30 days from the date of filing this form.



WCC File #: **0720591**
Carrier File #: **0010701415-001**
Carrier Code #: **0000852**
Employer FEIN #: **576000236**

Claimant's Name: Kellie Burnette SSN: [REDACTED] Employer's Name: City of Greenville
Address: [REDACTED] Address: P.O. Box 207
City: [REDACTED] State: SC City: Greenville State: SC Zip: 29602
Home Phone: [REDACTED] Work Phone: () Insurance Carrier: Hewitt Coleman & Associate
Preparer's Name: Douglas A. Churdar Law Firm: Douglas A. Churdar, P.C. Preparer's Phone #: 864-233-0203

Complete each information blank. To request a hearing, check Box 13b, indicate the kinds of benefits claimed by checking the box(es) at Lines 6, 7, 8, and 9, and file this form in duplicate.

A claim for workers' compensation benefits is made based on the following grounds:

Date of Injury or Illness: 6/16/07

☒ Injury ☐ Illness ☐ Repetitive Trauma

1a. The claimant sustained an injury to spine; psyche/depression (Part(s) of Body Injured) on 6/16/07 (Month/Day/Year) in Greenville county, state of South
1b. Carolina.

Body part(s) affected are: neck/upper back & lower back

Briefly describe how the accident occurred. Claimant, a police officer, was trying to pull a suspect from a car & the suspect drove away while Claimant was partially in car.

2. Both the claimant and the employer were subject to the South Carolina Workers' Compensation Act at the time of injury.
3. The relationship of employer and employee existed at the time of injury.
4. At the time of the injury the claimant was performing services arising out of and in the course of employment.
5. Notice of the accidental injury was given to the Employer on 6/16/07 (Month/Day/Year) in the following manner:

Verbally and Incident Report

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

☐ (a) medical examination and treatment for: spine injury; psyche/depression

☐ (b) additional medical examination and treatment for: spine injury; psyche/depression

☐ 7. Due to injury, the claimant requests temporary total disability benefits because of lost compensable time from work and wages for the period of:

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

☒ (1) General Disability:

☒ Total

☐ (2) Specific Disability:

☐ Total

☐ (3) Wage Loss

☐ Partial

☐ Partial

☐ 9. 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 \$600.00 +/-, 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:
City of Greenville Police Department

11a. Further grounds or unusual aspects of claim:

11b. List names and addresses of all physicians or other medical specialists who have seen or treated the Claimant as a result of the accident:
John Satterthwaite, MD/David Tollison PhD, 220 Roper Mtn. Ext.; David Mitchell, MD, 115 Deacon Tiller Court, Duncan, SC 29334; Michael Bucci, MD, 3 St. Frances Drive, Ste, 330;

11c. To the best of your knowledge, did you have any prior permanent disability? yes
If yes, describe: Impairment ratings of 5% and 13% to spine after MVA in 2003.

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

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

Preparer's Signature: Douglas A. Churdar Title: Attorney Email: dachurdar@aol.com Date: 6/10/09

Refer to R.67-204 through R.67-210 and R.67-601 through R.67-615. Questions about the use of this form may be directed to the Commission's Claims Department.

South Carolina Workers' Compensation Commission

1612 Marion Street • Post Office Box 1715

Columbia, South Carolina 29202-1715

(803) 737-5739

www.wcc.sc.gov

WCC File #: **0720591**

Carrier File #:

Carrier Code #:

Employer FEIN #:

Claimant's Name: Kellie BurnetteSSN: [REDACTED]Employer's Name: City of GreenvilleAddress: [REDACTED]Address: P.O. Box 2207City: [REDACTED] State: SC Zip: [REDACTED]City: Greenville State: SC Zip: 29602Home Phone: () - () Work Phone: () - ()Date of Injury: 6/16/07Insurance Carrier: TPA - Hewitt, Coleman & Associates, Inc.Preparer's Name: Michael A. FarryLaw Firm: Horton Law FirmPreparer's Phone #: (864) 233-4351**Date of Injury or Illness: 6/16/07****Complete each information blank. Specify clearly when contentions are admitted in part and denied in part. The employer/carrier in answer to the claim, respectfully shows:**

- It is **admitted** the employee sustained an injury to her neck and upper back or about the date set forth in the Form 50. The reasons for denial are **It is denied Claimant sustained any compensable injury to mid back/lower back and any compensable injury resulting in any disability to psyche.**
- It is **admitted** both the employer and employee were subject to the Workers' Compensation Act at the time in question. The reasons for denial are: See paragraph 1.
- It is **admitted** the relationship of employer and employee existed at the time in question. The reasons for denial are: See paragraph 1.
- It is **admitted** at the time in question the employee was performing services arising out of and in the course of employment. The reasons for denial are: See paragraph 1.
- It is **admitted** notice of injury was given the employer. The reasons for denial are: See paragraph 1.
- It is **denied** the employee **Needs / Is Entitled to Additional** medical care as a result of injury or illness. The reasons for denial are: Claimant has been provided causally related medical treatment and has reached MMI and been dismissed by the authorized treating physician. Any alleged need for further medical care is not casually related to nor the proximate result of admitted accident on 6/16/07.
- It is **denied** the employee is entitled to temporary total disability for the period(s) of : See paragraphs 1 and 6.
- It is **denied** the employee is permanently disabled. The reasons for denial are: See medical reports.
- It is **denied** the employee has serious disfigurement.
- It is contended that an average weekly wage of \$ **Form 20 to be filed** applies, according to attached Form 20 as provided by law.
- Further contentions, grounds of defense, or unusual aspects are: Defendants request a credit for all compensation payments made after Claimant reached MMI to be applied toward compensation due Claimant for permanent partial disability.
- Estimated time needed for hearing: 30 minutes

I certify I have served this document pursuant to R.67-212 by delivering a copy to:

Name: Douglas A. ChurdarAddress: 712 East Washington Street, Greenville, SC 29601on the 15th day of June, 2009 by ☒ first class mail ☐ personal service ☐ certified mail.

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

Michael A. Farry

Preparer's Signature

Attorney for Defendants
Titlemfarry@hortonlawfirm.net
Email6/15/09
Date

Refer to R.67-204 through R.67-210 and R.67-601 through R.67-615. Questions about the use of this form may be directed to the Commission's Judicial Department. Pursuant to R.67-606, a Form 20 must be filed with the Claims Department at least 30 days from the date of filing this form.



Claimant's Name: <u>Kellie Burnette</u>		Employer's Name: <u>City of Greenville</u>	
Address: <u>[REDACTED]</u>		Address: <u>P.O. Box 2207</u>	
City: <u>[REDACTED]</u>	State: <u>SC</u>	City: <u>Greenville</u>	State: <u>SC</u>
Zip: <u>[REDACTED]</u>		Zip: <u>29602</u>	
Home Phone: <u>(864) 444-9600</u>		Work Phone: <u>() -</u>	
Carrier: <u>Hewitt Coleman & Associates</u>			
Preparer's Name: <u>Douglas A. Churdar, P.C.</u>		Preparer's Phone #: <u>(864) 233-0203</u>	

A claim for workers' compensation benefits is made based on the following grounds:

☐ Injury ☐ Illness ☐ Repetitive Trauma

1. Compensation Rate: \$645.94 2. AWW: \$1000.00 +/- Date of Injury: 6/16/07
3. Type of injury and body part(s): Neck/upper back/mid back/lower back/buttocks & legs/ & psyche
4. Facts in controversy: Whether Claimant is permanently and totally disabled and entitled to disability benefits and lifetime medical

5. Legal issues involved: A. In this 6/16/07 claim, Claimant is P & T under either:

1. **§ 42-9-30** (8/23/03 Spine injury resulting in 17.5 % loss of use of the back per Decision and Order filed 1/11/06 in WCC File No. 0311607 and 6/16/07 spine injury resulting in C5-6 fusion – 25% and 28% whole person impairments by treating physicians – as well as exacerbation of/new injury to lumbar spine (injured disk at L5-S1) – 16% lumbar impairment by treating physician - combine for **50% or more loss of use of the back**

-OR-

2. **§ 42-9-10 (multiple physical injuries)** (see number 3 above).

Claimant entitled to continued medical under § 42-9-10, to include referral to an orthopaedic or neurosurgeon for injured disk at L5-S1

-AND-

B. lump sum; Utica Mohawk v. Mills language

6. Unusual aspects: None
7. Witnesses (designate if expert):* Claimant

8. Exhibits:
 - Exhibit 1 – Significant Excerpts from Records/Reports
 - Exhibit 2 – Decision & Order dated 1/11/06 in WCC File No. 0311607
 - Exhibit 3 – Photo of Police Car from 8/23/03 injury
 - Exhibit 4 – Greenville Police Dept. Incident Report by Claimant dated 6/16/07
 - Exhibit 5 – Greenville Police Dept. Incident Reports by fellow officers
 - Exhibit 6 – Disability recommendation to SCRS dated 4/14/08
 - Exhibit 7 – Three Letters requesting surgical evaluation of lumbar spine

9. Medical evidence (indicate report pursuant to R.67-612; deposition or appearance):
See Notice of Witnesses & APAs.

10. Name, address, and specialty, if any, of the treating physician: John R. Satterthwaite, MD (Pain Management); David Tollison, PhD (Psychology); David Mitchell, MD (Orthopaedics); Michael Bucci, MD (Neurosurgery)

11. Impairment rating(s); body part(s); physician and date of opinion: 25% whole person/72% cervical spine – John Satterthwaite, MD on 6/22/09
12% whole person/16% lumbar spine – John Satterthwaite, MD 7/1/09
10% - Michael Bucci, MD 4/3/09
28% whole person (cervical fusion) – Michael Bucci, MD 8/6/09
12. I am amending my Form 50/51 in the following manner: _____

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

Signature: Wong Churdar

Email: dachurdar@churdarlaw.com

Date of hearing: 9/3/09

Time needed for hearing: 1 hour

On behalf of ☒ Claimant ☐ Employer

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.

WCC Form # 58
Rev. 9/07

58

PRE-HEARING BRIEF



Claimant's Name: Kellie Burnette Employer's Name: City of Greenville
Address: [REDACTED] Address: P.O. Box 2207
City: [REDACTED] State: SC Zip: [REDACTED] City: Greenville State: SC Zip: 29602
Home Phone: () - Work Phone: () - Carrier: TPA - Hewitt, Coleman & Associates, Inc.
Preparer's Name: Michael A. Farry Preparer's Phone #: (864) 233-4351

A claim for workers' compensation benefits is made based on the following grounds:

☒ Injury ☐ Illness ☐ Repetitive Trauma

1. Compensation Rate: \$645.94 Max. 2. AWW: _____ Date of Injury: 6/16/07
3. Type of injury and body part(s): Claimant was struggling with a suspect to remove him from the car when suspect drove away dragging Claimant partially inside vehicle.
4. Facts in controversy: Whether Claimant's low back complaints and problems are causally related to the admitted accident. Whether Claimant has reached MMI, and if so, the amount of permanent partial disability Claimant sustained as a result of the admitted accident.
5. Legal issues involved: See paragraph 4.
6. Unusual aspects: None
7. Witnesses (designate if expert):* Gloria Moody and Claimant's supervisor, together with other representatives of Employer as needed.
8. Exhibits: See paragraph 9.
9. Medical evidence (indicate report pursuant to R.67-612; deposition or appearance):
Dr. Michael Bucci, Dr. John R. Satterthwaite, Dr. C. David Tollison, Dr. Linda Giambalvo, Dr. Alan G. Posta, Jr., Dr. David Mitchell, Dr. Kevin Kopera, and Dr. Wes Merriwether submitted pursuant to R.67-612.
10. Name, address, and specialty, if any, of the treating physician: Dr. Michael Bucci, Piedmont Neurosurgical Group; Dr. John R. Satterthwaite and Dr. C. David Tollison, Carolinas Center for Advanced Management of Pain
11. Impairment rating(s); body part(s); physician and date of opinion: 10% to cervical spine, Dr. Michael Bucci, 4/3/09; 25% to whole person corresponds to 72% to cervical spine; 12% to whole person corresponds to 16% to lumbar spine, Dr. John R. Satterthwaite, 7/1/09; 5% to spine, Dr. Kevin Kopera, 8/19/04
12. I am amending my Form 50/51 in the following manner: _____

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

Signature: Michael A. Farry

Email: mfarry@hortonlawfirm.net

Date of hearing: 9/3/09 at 11:00 a.m.

Time needed for hearing: 30 minutes

On behalf of ☐ Claimant ☒ Employer

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.

STATE OF SOUTH CAROLINA

COUNTY OF GREENVILLE

Kellie Burnette,

Claimant,

vs.

City of Greenville,

Employer/Defendant.

BEFORE THE SOUTH CAROLINA
WORKER'S COMPENSATION
COMMISSION

WCC File No. 0720591

**MOTION TO ADMIT ADDITIONAL
EVIDENCE TO COMPLETE
THE RECORD**

Claimant hereby moves to admit the following as additional evidence to complete the record in the above-referenced case: office note of John Satterthwaite, MD dated 8/24/09; and office notes of David Tollison, Ph.D. dated 8/4/09 and 8/18/09. This Motion is based upon the reasoning contained in the attached letter to the single Commissioner dated September 17, 2009.

Date: 9/17/09



Douglas A. Chundar
S.C. Bar No. 11971
712 East Washington Street
Greenville, SC 29601
Phone: (864) 233-0203
Fax: (864) 233-3020

DOUGLAS A. CHURDAR, P. C.

Attorney At Law

712 EAST WASHINGTON STREET
GREENVILLE, SOUTH CAROLINA 29601
TELEPHONE (864) 233-0203
FACSIMILE (864) 233-3020
E-MAIL: dachurdar@churdarlaw.com

September 17, 2009

Commissioner Susan Barden
SC Workers' Compensation Commission
P.O. Box 1715
Columbia, SC 29201-1715

Re: Kellie Burnette v. City of Greenville
WCC File No.: 0720591

Dear Commissioner Barden:

At the hearing in the above case, the majority of Mike Farry's cross-examination focused on a July 23, 2009 note from John Satterthwaite, MD. I did not have that note at the time I submitted APA's, as you can see that notes from Dr. Satterthwaite's practice were obtained via facsimile on July 13, 2009. When I received the Employer's APA's from Mr. Farry sometime after August 24, 2009, I noticed the July 23, 2009 note which mentioned the "sun cover" incident but did not believe it addressed anything that was material or relevant. Treating physicians had already provided opinions regarding the *cause* of Claimant's lumbar back injury and provided impairment ratings and filled out questionnaires regarding her limitations. The fact that she may or may not have exacerbated her back injury afterward would not change any of those opinions. Likewise, I didn't believe it bore on her credibility, as she never denied nor would she deny the ability to drive a boat under limited circumstances.

You will recall that Claimant testified Dr. Satterthwaite's nurse practitioner ("N.P.") had misunderstood her if the N.P. meant by her notation that the "sun cover" incident caused Claimant's increased lumbar pain; that she had not told the N.P. she hurt her back moving the sun cover; but that she had mentioned the sun cover incident within the context of explaining she wanted to go boating and had brought her parents' boat up to Greenville from Columbia. She testified further that the increase in lumbar pain was because she had turned awkwardly while watering flowers.

On September 8, 2009, I participated in a conference call with you and Mr. Farry, during which you asked about records for a visit with Dr. Satterthwaite in August 2009. I told you I did not have any such records. However, after the conference call, I obtained a note from an August

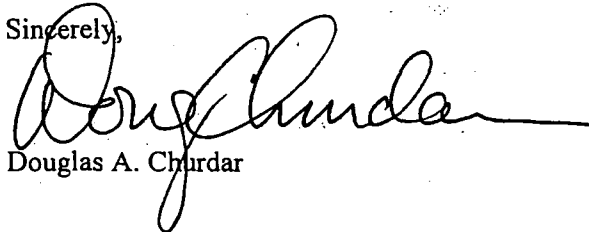
2009 visit with Dr. Satherthwaite and emailed it to you. (copy attached) No one indicated that the note was unwanted or would not be considered, and Mr. Farry did not object. The morning of September 9, 2009, before I received your Request for Proposed Order in the mail, I received two (2) notes for visits with Dr. Tollison in August 2009, including a note dated 8/04/09. In that note Dr. Tollison's assistant wrote: "Patient's mood is frustrated and down over her increased pain that she states occurred while she was watering some flowers and turned a certain way..." I immediately scanned and emailed those notes to you (copy attached) and further had a copy of the email and notes hand-delivered to you in Greenville, still not knowing that the "sun cover" issue was going to be significant. Mr. Farry sent an email objecting to submission of the notes. After I received the Request for Proposed Order, it was apparent that the "sun cover" incident and cross-examination addressing it played an important role in your assessment of Claimant's credibility. You stated that "Claimant's laborious but unconvincing explanation (as the transcript will reflect) is not at all believable." The "sun cover" incident also affected your opinion on causation with respect to Claimant's lumbar pain. You stated that the lumbar pain Claimant experiences now was "significantly worsened by the unrelated, intervening boat cover incident."

Accordingly, I have filed a *Motion to Admit Additional Evidence to Complete the Record* as to the August 2009 notes. It is important to acknowledge and to consider that Claimant's testimony at the hearing was completely consistent with her report to Dr. Tollison's assistant on August 4, 2009. I know the Claimant to be honest and reliable.

Again, I did not have these notes, as I don't typically feel compelled to go back continually for more records after MMI and impairment ratings and questionnaires are filled out. I did not believe this issue would be or should have been significant for the reasons state above. But in that it was, the record should be complete.

Thank you very much.

Sincerely,



Douglas A. Churdar

DAC:crt

Enclosure(s)

cc: Michael Farry, Esq.

Charlene Tewell

From: Charlene Tewell [charlene@churdarlaw.com]
Sent: Tuesday, September 08, 2009 11:03 AM
To: 'Love, Kristi'; 'dachurdar@churdarlaw.com'; 'Mike Farry'
Subject: RE: Burnette
Attachments: 2009_09_08_10_58_35.pdf

Kristi:

Please forward this to Commissioner Barden. She asked whether Kellie Burnette had an appointment in August, and Doug did not have a treatment note. Attached is a treatment note we obtained this morning for a visit on August 24, 2009. Also, Doug wanted to point out to Commissioner Barden that Dr. Satterthwaite's physician statement (the one with the confusing attachments) was dated August 17, 2009, approximately 3 ½ weeks after the July 23, 2009 treatment note. Hope this helps.

Charlene

From: Love, Kristi [mailto:klove@wcc.sc.gov]
Sent: Tuesday, September 08, 2009 8:45 AM
To: dachurdar@churdarlaw.com; Mike Farry
Cc: Charlene Tewell
Subject: RE: Burnette

9:15 IT IS.

Thank you!
Kristi

From: Doug Churdar [mailto:dachurdar@churdarlaw.com]
Sent: Tuesday, September 08, 2009 8:31 AM
To: Mike Farry; Doug Churdar
Cc: Love, Kristi; Charlene Tewell
Subject: Re: Burnette

Thanks, Mike. I didn't get the earlier email. I'm not in the office until 9:15. Will that work, Kristi?

Sent from my Verizon Wireless BlackBerry

From: "Mike Farry"
Date: Tue, 8 Sep 2009 08:25:13 -0400
To: <dachurdar@churdarlaw.com>
Subject: FW: Burnette
Doug, I noticed that Ms. Kristie Love is using a different email address for you.

Michael A. Farry
Horton, Drawdy, Ward & Jenkins, P.A.
P.O. Box 10167
Greenville, SC 29603
mfarry@hortonlawfirm.net
Phone: 864-233-4351

Fax: 864-233-7142

-----Original Message-----

From: Mike Farry

Sent: Tuesday, September 08, 2009 8:16 AM

To: 'Love, Kristi'; Douglas A Churdar, P.C.

Subject: RE: Burnette

Any time is fine with me.

Michael A. Farry

Horton, Drawdy, Ward & Jenkins, P.A.

P.O. Box 10167

Greenville, SC 29603

mfarry@hortonlawfirm.net

Phone: 864-233-4351

Fax: 864-233-7142

-----Original Message-----

From: Love, Kristi [mailto:klove@wcc.sc.gov]

Sent: Tuesday, September 08, 2009 8:06 AM

To: Mike Farry; Douglas A Churdar, P.C.

Subject: Burnette

Good morning.

If possible, Commissioner Barden would like to have a conference call with you this morning between 8:30 and 9:30. Please let me know when you're available.

Thanks,
Kristi

Kristi Love

Assistant to Commissioner Susan S. Barden

South Carolina Workers' Compensation Commission

PO Box 1715

Columbia, SC 29202

803/737-5660

Carolinas Center for Advanced Mgmt of Pain - Greenville Office
220 Roper Mountain Road Ext Greenville, SC 29615
8642956399 Fax: 8642952337

September 8, 2009
Page 1
Chart Document

MS KELLIE BURNETTE
Female DOB ~~REDACTED~~

18381

Home: ~~REDACTED~~
Ins: VOC REHAB

08/24/2009 - Office Visit: Follow-Up Pain
Provider: John Satterthwaite MD
Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

Follow-Up Visit

Chief Complaint: Back and neck pain
History of Present Illness: Ongoing neck and back pain.
Returns today with a multitude of questions.
Looking for other possible treatments or ideas.
Has questions written out on 3 pages of paper.

Location Of Pain: Neck and back
Description Of Pain: Numbness, Sharp, Aching, Burning
Pain Rating: 8
Activity: Stayed The Same
Did Medications Help? Yes
Is the patient taking any new medications? No
Does the patient have any new medical or surgical problems? No
Is the patient experiencing increased sadness, anxiety, or family problems? Yes
Comments: Ongoing anxiety, somatization

Past, Family, and Social History

Past History (Reviewed - No Changes Since Last Visit): Depression, ADHD, osteoarthritis, torn left medial meniscus
Surgery: SLAP procedure left shoulder, broken nose, ACDIF C5-C6 10/08

ALLERGIES: NKDA

Family History (Reviewed - No Changes Since Last Visit): Migraine headaches, back problem, depression

Social History (Reviewed - No Changes Since Last Visit): Single
High school graduate

Worked as a Greenville City Police officer, work-related injury 8/23/03, Attorney Doug Churdar STOPPED WORKING April, 2008, medical retirement from police department.
Denies tobacco
Occasional alcohol

Review of Systems

General: fatigue

Eyes: denies blurring, diplopia, irritation, discharge, vision loss, eye pain, photophobia

Ear/Nose/Throat: denies ear pain or discharge, tinnitus, decreased hearing, nasal obstruction or discharge, nosebleeds, sore throat, hoarseness, dysphagia

Cardiovascular: Denies chest pain, palpitations, syncope, dyspnea on exertion, orthopnea, PND, peripheral edema

Respiratory: Denies cough, dyspnea, excessive sputum, hemoptysis, wheezing

Gastrointestinal: constipation on and off taking stool softeners and laxatives and is under control

Genitourinary: denies vaginal discharge, incontinence, dysuria, hematuria, urinary frequency,

Carolinas Center for Advanced Mgmt of Pain - Greenville Office
220 Roper Mountain Road Ext Greenville, SC 29615
8642956399 Fax: 8642952337

September 8, 2009
Page 2
Chart Document

MS KELLIE BURNETTE

Female DOB: ~~01/01/1960~~

18381

Home: ~~(864) 295-6399~~

Ins: VOC REHAB

amenorrhea, menorrhagia, abnormal vaginal bleeding, pelvic pain
Musculoskeletal: back pain, neck pain, muscle cramps, left knee
Skin: denies rash, itching, dryness, suspicious lesions
Neurologic: weakness
Psychiatric: depression
Endocrine: cold intolerance
Hematologic/Lymphatic: denies abnormal bruising, bleeding, enlarged lymph nodes
Allergic/Immunologic: denies urticaria, hay fever, persistent infections, HIV exposure

Vital Signs

Ht: 70 in.

Plan

Questions answered. Discussed her options for management. She needs to accept that there is not much we can do for her, she is going to have to do most of the work and accept that it may not get much better with surgery, procedures, etc.

Wanting a referral to Dr Buccì for her low back disc problem. Will schedule that and she will live with his decision.

Spent about 45 minutes in direct face to face counselling and discussion.

Medications are refilled.

She will follow up with the NP.

Already rated.

New Prescriptions/Refills:

CELEBREX 200 MG CAPS (CELECOXIB) take one PO QD #30 x 0 : John Satterthwaite MD (08/24/2009)

AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) 1 qhs #30 x 0 : John Satterthwaite MD (08/24/2009)

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours. #90 x 0 : John Satterthwaite MD (08/24/2009)

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 2 po hs #60 x 0 : John Satterthwaite MD (08/24/2009)

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm #90 x 0 : John Satterthwaite MD (08/24/2009)

NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po tid for 7 days then qid #120 x 0 : John Satterthwaite MD (08/24/2009)

ROXICODONE 15 MG TABS (OXYCODONE HCL) 1po q4-6 h prn pain max 4 per day #120 x 0 : John Satterthwaite MD (08/24/2009)

Current Medication List:

ROXICODONE 15 MG TABS (OXYCODONE HCL) 1po q4-6 h prn pain max 4 per day

NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po tid for 7 days then qid

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 2 po hs

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours.

AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) 1 qhs

CELEBREX 200 MG CAPS (CELECOXIB) take one PO QD

CYMBALTA 30 MG CPEP (DULOXETINE HCL) one qd

Carolinas Center for Advanced Mgmt of Pain - Greenville Office
220 Roper Mountain Road Ext Greenville, SC 29615
8642956399 Fax: 8642952337

September 8, 2009
Page 3
Chart Document

MS KELLIE BURNETTE

Female DOB: ~~XXXXXXXXXX~~

18381

Home: ~~XXXXXXXXXX~~

Ins: VOC REHAB

PROZAC 20 MG CAPS (FLUOXETINE HCL) one bid
ZYRTEC 10 MG TABS (CETIRIZINE HCL) 1 po qhs other MD
ADDERALL 20 MG TABS (AMPHETAMINE-DEXTROAMPHETAMINE) bid - Dr Giambalvo

New Orders:

Referral to Spine Surgeon [XXXXX]

Expanded [99213]

Return for follow-up 1 month [xxxxx]

Prescriptions:

CELEBREX 200 MG CAPS (CELECOXIB) take one PO QD #30 x 0

Entered and Authorized by: John Satterthwaite MD

Signed by: John Satterthwaite MD on 08/24/2009

Method used: Print then Give to Patient

AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) 1 qhs #30 x 0

Entered and Authorized by: John Satterthwaite MD

Signed by: John Satterthwaite MD on 08/24/2009

Method used: Print then Give to Patient

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours. #90 x 0

Entered and Authorized by: John Satterthwaite MD

Signed by: John Satterthwaite MD on 08/24/2009

Method used: Print then Give to Patient

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 2 po hs #60 x 0

Entered and Authorized by: John Satterthwaite MD

Signed by: John Satterthwaite MD on 08/24/2009

Method used: Print then Give to Patient

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm #90 x 0

Entered and Authorized by: John Satterthwaite MD

Signed by: John Satterthwaite MD on 08/24/2009

Method used: Print then Give to Patient

NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po tid for 7 days then qid #120 x 0

Entered and Authorized by: John Satterthwaite MD

Signed by: John Satterthwaite MD on 08/24/2009

Method used: Print then Give to Patient

ROXICODONE 15 MG TABS (OXYCODONE HCL) 1po q4-6 h prn pain max 4 per day #120 x 0

Entered and Authorized by: John Satterthwaite MD

Signed by: John Satterthwaite MD on 08/24/2009

Method used: Print then Give to Patient

Signed by John Satterthwaite MD on 08/24/2009 at 4:34 PM

Charlene Tewell

From: Charlene Tewell [charlene@churdarlaw.com]
Sent: Wednesday, September 09, 2009 10:24 AM
To: 'Love, Kristi'
Cc: 'Mike Farry'; 'dachurdar@churdarlaw.com'
Subject: Kellie N. Burnette v. City of Greenville
Attachments: 2009_09_09_10_11_32.pdf

Kristi:

Please forward this to Commissioner Barden.

Commissioner Barden:

Dr. Tollison's office (associated with Dr. Satterthwaite) faxed these two (2) notes to my office yesterday. You will recall that Mike Farry cross-examined Kellie Burnette about a treatment note referencing a cushion flying off a boat in transport on a Saturday and an increase in pain the following Tuesday. I wasn't completely sure which point was important to him (that she has driven a boat or what was the cause of the pain the following Tuesday; of course all of this occurred after she had been rated by everyone). If the point was the cause of the pain the following Tuesday, you may recall Ms. Burnette said there was apparent confusion by Dr. Satterthwaite's nurse, because picking up the cushion did not cause the increase in pain. Ms. Burnette testified that she turned the wrong way while watering some flowers, and that was the cause of the increase in pain. Attached is a note from 8/04/09, which is the first time she saw Dr. Tollison or his staff after this incident. The note states "PT's mood is frustrated and down over her increased pain that she states occurred while she was watering some flowers and turned a certain way. She states the pain was so increased that she could not rest or do normal daily tasks." I am not sure of the relevance of all this, but if in your view this bears on credibility I want to make sure you have the full picture.

Thank you,

Douglas A. Churdar, P.C.
712 East Washington Street
Greenville, SC 29601
Phone (864) 233-0203
Fax (864) 233-3020

Carolinas Center for Advanced Management of Pain
1330 Boiling Springs Rd Suite 2700 Spartanburg, SC 29303
8645830053 Fax: 8645830390

September 8, 2009
Page 1
Chart Document

MS KELLIE BURNETTE

Female DOB ~~08/24/1979~~

18381

Home ~~903-754-0000~~

Ins: VOC REHAB

08/04/2009 - Office Visit: Psych F/U

Provider: Lisa Richardson LISW-CP

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

This document contains confidential information

Age: 29 Years Old

Gender: Female

Employment Status: Last worked 3-08, medically retired police officer City Greenville

Prior Mental Health: Diagnosed ADHD in 1999 while attending college. Initial evaluation by Dr. Tollison on 6-23-08.

Education Level: Graduated high school + few college courses

History of Present Illness: Referred Dr. Satterthwaite. August 2003 work-related MVA, full spine, facial trauma. In June 2007 reinjury. Depression secondary to pain and lifestyle change, feelings of loss, feelings of worthlessness, sadness/discouragement, irritability. Dx: Adj D/O Mixed, & 307.89. WC approved.

Psychological Testing P-3 8-27-07, Anxiety Aver, Dep top 27, Soma 34%. P-3 on 6-23-08 Dep top 12, Anxiety 22, and Soma 29th percentile. P-3 on 2-4-09, Dep 9th, Anxiety 18th, Soma 19th.

Progress Note

Clinical Status: Pt's mood is frustrated and down over her increased pain that she states occurred while she was watering some flowers and turned a certain way. She states the pain was so increased that she could not rest or do normal daily tasks. She has been doing stretches from her physical therapy ongoing and doing massages to get some relief. She is working on using distraction and pacing to cope with the pain, but she has experienced some difficulty with this recent flair-up. She worries that everything that can be looked at for the cause of her pain is done before she closes her case so that she can accept this is her pain level she has to cope with the rest of her life.

Treatment:

supportive therapy
insight and educational therapy

Assessment

Status of Existing Problems:

Assessed PAIN DISORDER (PSYCH/MEDICAL) as unchanged - Lisa Richardson LISW-CP

Plan

Pt to continue to use distraction and follow-up in one to two weeks for a session to discuss that I am leaving the practice and discuss the transfer of care to Dr. Tollison Ph.D

Current Medication List:

ROXICODONE 15 MG TABS (OXYCODONE HCL) 1 po q4-6 h prn pain max 4 per day

NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po tid for 7 days then qid

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 2 po hs

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours.

AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) 1 qhs

CELEBREX 200 MG CAPS (CELECOXIB) take one PO QD

SE1/08/2009/TUE 12:08 PM

FAX No.

P. 002/002

Carolinas Center for Advanced Management of Pain
1330 Boiling Springs Rd Suite 2700 Spartanburg, SC 29303
8645830053 Fax: 8645830390

September 8, 2009

Page 2

Chart Document

MS KELLIE BURNETTE

Female DOB: ~~01/01/1975~~

18381

Home: ~~(864) 583-1234~~

Ins: VOC REHAB

ZYRTEC 10 MG TABS (CETIRIZINE HCL) 1 po qhs other MD
CYMBALTA 30 MG CPEP (DULOXETINE HCL)
ADDERALL 20 MG TABS (AMPHETAMINE-DEXTROAMPHETAMINE) bid - Dr Giambalvo
PROZAC 20 MG CAPS (FLUOXETINE HCL) one bid

New Orders:

Return for follow-up 1 week [xxxxx]

OP Psychotherapy 45 - 50 min. [90806]

Signed by Lisa Richardson LISW-CP on 08/04/2009 at 5:38 PM

Carolinas Center for Advanced Management of Pain
1330 Boiling Springs Rd Suite 2700 Spartanburg, SC 29303
8645830053 Fax: 8645830390

September 8, 2009
Page 1
Chart Document

MS KELLIE BURNETTE

Female DOB: ~~08/20/1980~~

18381

Home: ~~(864) 583-0053~~

Ins: VOC REHAB

08/18/2009 - Office Visit: Psych F/U

Provider: Charles David Tollison PhD

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

This document contains confidential information

Age: 29 Years Old

Gender: Female

Employment Status: Last worked 3-08, medically retired police officer City Greenville

Prior Mental Health: Diagnosed ADHD in 1999 while attending college. Initial evaluation by Dr. Tollison on 6-23-08.

Education Level: Graduated high school + few college courses

History of Present Illness: Referred Dr. Satterthwaite. August 2003 work-related MVA, full spine, facial trauma. In June 2007 reinjury. Depression secondary to pain and lifestyle change, feelings of loss, feelings of worthlessness, sadness/discouragement, irritability. Dx: Adj D/O Mixed, & 307.89. WC approved.

Psychological Testing P-3 8-27-07, Anxiety Aver, Dep top 27, Soma 34%. P-3 on 6-23-08 Dep top 12, Anxiety 22, and Soma 29th percentile. P-3 on 2-4-09, Dep 9th, Anxiety 18th, Soma 19th.

Progress Note

Clinical Status: She feels a little better, less stressed and anxious, since adding Cymbalta and she wishes to continue...."I keep a lot of stress in my muscles and they seem more relaxed." Still not getting out of house as much as I wish, and we discuss again the benefit of distraction techniques. She reports being denies life insurance recently based on medical and she feels it due to her history of injury and residual pain. She plans to try another insurance company. Sleeping a little better of late. She is stable, mildly improved.

Treatment: Combination of education, support, and coping skills training with continuing clinical re-assessment

Assessment

Status of Existing Problems:

Assessed ADJUSTMENT DISORDER/MIXED as improved - Charles David Tollison PhD

Assessed PAIN DISORDER (PSYCH/MEDICAL) as improved - Charles David Tollison PhD

Plan

Continue current treatment plan and notify me of any significant change in condition. Get out more and use distraction techniques and keep mentally occupied to avoid excessive rumination. Develop an action plan. Focus on thoughts, feelings, and behavior. Stay on psychotropics and return in a month, sooner if need.

New Prescriptions/Refills:

CYMBALTA 30 MG CPEP (DULOXETINE HCL) one qd #30 x 0 : Charles David Tollison PhD
(08/18/2009)

PROZAC 20 MG CAPS (FLUOXETINE HCL) one bid #60 x 0 : Charles David Tollison PhD
(08/18/2009)

Current Medication List:

Carolinas Center for Advanced Management of Pain
1330 Boiling Springs Rd Suite 2700 Spartanburg, SC 29303
8645830053 Fax: 8645830390

September 8, 2009

Page 2

Chart Document

MS KELLIE BURNETTEFemale DOB: ~~01/01/1968~~

18381

Home: ~~864-583-1838~~

Ins: VOC REHAB

ROXICODONE 15 MG TABS (OXYCODONE HCL) 1po q4-6 h pm pain max 4 per day
NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po tid for 7 days then qid
BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm
FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 2 po hs
LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours.
AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) 1 qhs
CELEBREX 200 MG CAPS (CELECOXIB) take one PO QD
ZYRTEC 10 MG TABS (CETIRIZINE HCL) 1 po qhs other MD
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ADDERALL 20 MG TABS (AMPHETAMINE-DEXTROAMPHETAMINE) bid - Dr Giambalvo
PROZAC 20 MG CAPS (FLUOXETINE HCL) one bid

New Orders:

OP Psychotherapy 45 - 50 min. [90806]

Return for follow-up 1 month [xxxxx]

Signed by Charles David Tollison PhD on 08/18/2009 at 4:03 PM

COPY

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
P.O. Box 1715 - 1612 Marion Street
Columbia, South Carolina 29202-1715

WCC File # 0720591
Carrier File #
Carrier Code #
Employer FEIN

<u>Kellie Burnette</u> Claimant's Name	<u>[REDACTED]</u> SSN	<u>City of Greenville</u> Employer's Name
<u>[REDACTED]</u> Address	<u>[REDACTED] SC [REDACTED]</u> City State Zip	<u>P.O. Box 2207 Greenville SC 29602</u> Address City State Zip
<u>(864) 862-3234</u> Home Phone	<u>()</u> Work Phone	<u>Hewitt Coleman & Associates</u> Insurance Carrier
<u>Douglas A. Churdar</u> Preparer's Name		<u>(864) 233-0203</u> Phone #

The undersigned attorney for the Claimant certifies that on the 17 day of September, 2009, he served a copy of the **Motion to Admit Additional Evidence to Complete the Record** with attachments in the above-captioned action, on all counsel of record by depositing in the United States mail, with due and proper postage affixed thereto, copies of the same addressed to:

Michael A. Farry, Esq.
Horton Law Firm
PO Box 10167
Greenville, SC 29603

SCWCC
SEP 18 2009
JUDICIAL

Date:

9/17/09



Douglas A. Churdar
S.C. Bar # 11071
712 East Washington Street
Greenville, SC 29601
Phone: 864.233.0203

BEFORE THE SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

STATE OF SOUTH CAROLINA	)	
	)	W.C.C. FILE NO.: 0720591
COUNTY OF GREENVILLE	)	
Kellie Burnette, Employee,	)	
	)	
Claimant,	)	RETURN TO MOTION TO ADMIT
	)	ADDITIONAL EVIDENCE TO
v.	)	COMPLETE THE RECORD
	)	
City of Greenville, Employer and	)	
Self-Insured, Hewitt, Coleman &	)	
Associates, TPA,	)	
	)	
Defendants.	)	

Defendants, by their undersigned counsel, do hereby respond to Claimant's Motion to Admit Additional Evidence to Complete the Record as follows:

1. This claim was tried before Commissioner Susan S. Barden on September 3, 2009 and there was no request by Claimant to keep the record open for the submission of additional evidence, and moreover, no provision by Commissioner Barden to permit additional evidence to be submitted.

2. On September 8, 2009 at the request of Commissioner Susan S. Barden, a conference call was held with counsel for Claimant, counsel for Defendant, and Commissioner Barden participating. During this conference call, Commissioner Barden had several questions concerning the APA Submissions and further inquired of the attorneys of record if anyone had anything further that needed to be considered. Counsel for Claimant and Defendants each advised that they had nothing further to submit.

3. On September 8, 2009, Commissioner Barden issued a request for

proposed order, copies of which were sent to attorneys of record.

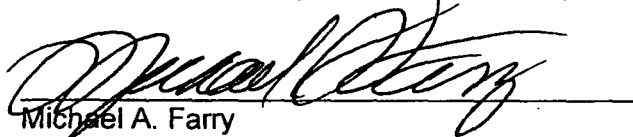
4. Commissioner Barden has now made a decision and requested counsel for Defendants to prepare a proposed order. To permit the submission of any additional evidence would be improper since the hearing was completed September 3, 2009, the record closed at that time, Commissioner Barden has made a decision issuing a request for proposed order, and further to admit such evidence would deny Defendants the opportunity to cross-examine Claimant with respect to the evidence which Claimant attempts to now introduce.

5. Claimant's Motion fails to comply with Regulation 67-215.

Therefore, based upon the foregoing, Defendants respectfully request that Claimant's Motion to Admit Additional Evidence to Complete the Record be denied.

Respectfully submitted,

HORTON, DRAWDY, WARD & JENKINS, P.A.



Michael A. Farry
P.O. Box 10167
Greenville, SC 29603
(864) 233-4351
Attorneys for Defendants

September 23, 2009

BEFORE THE SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

STATE OF SOUTH CAROLINA

COUNTY OF GREENVILLE

Kellie Burnette, Employee,

Claimant,

v.

**City of Greenville, Employer and
Self-Insured, Hewitt, Coleman &
Associates, Inc., TPA,**

Defendants.

WCC FILE NO.: 0720591

CERTIFICATE OF SERVICE

I, Lynn Chandler, an employee with the firm of Horton, Drawdy, Ward & Jenkins, P.A., do hereby certify that on September 23, 2009 I served Return to Motion to Admit Additional Evidence to Complete the Record on the following person(s) by causing same to be placed in the United States mail, postage prepaid, addressed as follows:

Douglas A. Churdar
Attorney at Law
712 East Washington Street
Greenville, SC 29601


Lynn Chandler

STATE OF SOUTH CAROLINA)

COUNTY OF GREENVILLE)

Kellie Burnette,)

Claimant,)

vs.)

City of Greenville,)

Employer/Defendant.)

BEFORE THE SOUTH CAROLINA
WORKER'S COMPENSATION
COMMISSION

WCC File No. 0720591

**MOTION TO ADMIT ADDITIONAL
EVIDENCE TO COMPLETE
THE RECORD**

Pursuant to R67-707, Claimant hereby moves the Full Commission to admit the following as additional evidence to complete the record in the above-referenced case: office note of David Tollison, Ph.D. dated 8/4/09. This Motion is based upon the reasoning contained in the attached affidavit.

Date: 11/3/09



Douglas A. Chudgar
S.C. Bar No. 11971
712 East Washington Street
Greenville, SC 29601
Phone: (864) 233-0203
Fax: (864) 233-3020

SCWCC
NOV 04 2009
JUDICIAL

STATE OF SOUTH CAROLINA	)	BEFORE THE SOUTH CAROLINA
	)	WORKER'S COMPENSATION
COUNTY OF GREENVILLE	)	COMMISSION
	)	
Kellie Burnette,	)	
	)	WCC File No. 0720591
Claimant,	)	
	)	
vs.	)	AFFIDAVIT OF DOUG CHURDAR
	)	
City of Greenville,	)	
	)	
<u>Employer/Defendant.</u>	)	

Personally appeared before me, Douglas A. Churdar, who first being duly sworn stated as follows upon personal knowledge or upon information and belief:

1. I represent Claimant in the above-referenced case.
2. On July 13, 2009, I obtained updated treatment notes from the Carolina Center for Advanced Management of Pain ("Carolina Center"), in anticipation of an upcoming hearing. The Carolina Center employs two of the Claimant's treating physicians, John Satterthwaite, MD ("Dr. Satterthwaite") and David Tollison, Ph.D. ("Dr. Tollison"). These notes included a note for Claimant's most recent visit with Dr. Satterthwaite on July 1, 2009.
3. On August 19, 2009, I served Claimant's Pre-Hearing Brief, Notice of Witnesses, APA's, and Exhibits.
4. On August 24, 2009, Employer's counsel served Employer's Pre-Hearing Brief, Notice of Witnesses, and APA's. Defendant's APA's included a note for Claimant's July 23, 2009 visit with Dr. Satterthwaite. That note referenced an incident in which the sun-cover flew off a boat being pulled by Claimant, and the sun-cover was picked up by Claimant (the "sun-cover" incident). This occurred on a Saturday. According to the note, the Claimant began experiencing increased lumbar back pain on Tuesday. (Causation was not stated, but it is a reasonable inference the reporter linked the two.)

5. Claimant had no reason to believe the "sun-cover" issue would be significant at all because it is immaterial and irrelevant. All treating physicians had already provided opinions regarding the cause of Claimant's lumbar back injury and had provided impairment ratings and filled out questionnaires regarding limitations (See APA 3, pp. 30-41; APA 4, pp. 149-154; APA 6, pp. 231-232). Indeed, almost one month after the "sun-cover" visit on July 23, 2009, Dr. Satterthwaite provided a physician's statement in which he stated that Claimant's "injury on June 16, 2007 exacerbated a prior lumbar spine injury or caused new injury." (See APA 3, p. 30). The issue of how Claimant aggravated her back several weeks before the hearing was not expected to play a role.

6. On September 3, 2009, this case was heard before Commissioner Susan Barden. The majority of Employer's cross-examination focused on the July 23, 2009 note. Claimant denied that the "sun-cover" incident was the cause of aggravation. Employer's counsel worked from the premise that Dr. Satterthwaite's nurse practitioner had linked the "sun-cover" incident to Claimant's increase in lumbar pain causally and asked whether the nurse practitioner had "gotten confused" and otherwise purported to impeach Claimant. Although the Commissioner allowed Employer's counsel to cross examine Claimant fully regarding this issue, Claimant's counsel did not and does not consider the "sun-cover" incident to be in any way material or relevant for the following reasons: a.) Claimant had already testified that she likes to go boating when possible and had gone boating two times during summer 2009, one time turning back after putting gas in the boat because the water was rough, and the other time enjoying an evening in the boat because the water was calm. In other words, the fact that she goes boating was not a matter for impeachment; and b.) If the cross examination was to address the cause of Claimant's increased lumbar pain on the Tuesday following the "sun-cover" incident, it addressed irrelevant matter in that treating physicians had already provided opinions regarding the cause of Claimant's lumbar back injury and

had provided impairment ratings and filled out questionnaires regarding limitations. The fact that Claimant may or may not have aggravated her back injury afterward would not change any of those opinions. Claimant testified that the nurse practitioner had misunderstood her, that Claimant had not told the nurse practitioner she hurt her back moving the sun-cover, but that she had mentioned the "sun-cover" incident within the context of explaining she wanted to go boating and had brought her parents' boat up to Greenville from Columbia. Claimant further testified that the increased lumbar pain was because she turned awkwardly while watering flowers.

7. On September 8, 2009, Commissioner Barden requested a conference call and therein inquired about records for a visit with Dr. Satterthwaite in August 2009. I told her I was not aware whether any other records existed at that time. However, after the conference call I obtained a note from an August 2009 visit with Dr. Satterthwaite and emailed it to the Commissioner. I was not told that the record was unwanted and would not be considered, and Employer's counsel did not object.

8. On September 9, 2009, I received two notes for visits with Dr. Tollison in August 2009, including a note dated 8/4/09. In that note, Dr. Tollison's assistant wrote: "Patient's mood is frustrated and down over her increased pain that she states occurred while she was watering some flowers and turned a certain way. She states the pain was so increased that she could not rest or do normal daily tasks..." I immediately scanned and emailed that note to the Commissioner, still not knowing or expecting that the "sun-cover" incident was going to be significant to her. (See attached Email dated 9/09/09 and Note dated 8/04/09). I simply wanted the Commissioner to see that Claimant's testimony at the hearing was completely consistent with her report to Dr. Tollison's assistant on August 4, 2009.

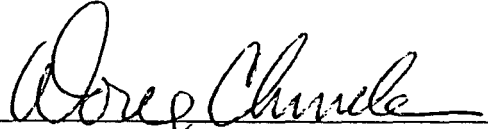
9. After scanning and emailing the 8/4/09 note from Dr. Tollison's office, I received an email from Employer's counsel in which he indicated his objection to the submission of any further

evidence. He indicated that he had received a Request for Proposed Order. Shortly after receiving the email, I received via regular mail a Request for Proposed Order.

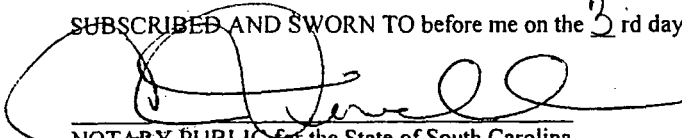
10. Based upon the Order, it is obvious that the "sun-cover" incident and cross-examination addressing it played a disproportionate and significant role in the Commissioner's assessment of Claimant's credibility. With regard to the "sun-cover" incident, the Commissioner specifically found "Claimant's laborious but unconvincing 'explanation' (as the transcript will reflect) is not at all believable." In addition to affecting her credibility, the "sun-cover" incident affected the Commissioner's opinion on causation. The Commissioner found that the low back pain Claimant experiences now was "significantly worsened by the unrelated, intervening boat cover incident."

11. Because the "sun cover" incident, which is completely immaterial and irrelevant, was unexpectedly used as a basis for determining that Claimant is not truthful and also that she aggravated her back in that incident rather than while watering some flowers, the following additional evidence should be admitted: note of David Tollison, Ph.D. dated 8/4/09.

Date: 11/3/09


Douglas A. Chardar
S.C. Bar No. 11971
712 East Washington Street
Greenville, SC 29601
Phone: (864) 233-0203
Fax: (864) 233-3020

SUBSCRIBED AND SWORN TO before me on the 3rd day of November, 2009.


NOTARY PUBLIC for the State of South Carolina

My Commission Expires: 9/25/12

Charlene Tewell

From: Charlene Tewell [charlene@churdarlaw.com]
Sent: Wednesday, September 09, 2009 10:24 AM
To: 'Love, Kristi'
Cc: 'Mike Farry'; 'dachurdar@churdarlaw.com'
Subject: Kellie N. Burnette v. City of Greenville
Attachments: 2009_09_09_10_11_32.pdf

Kristi:

Please forward this to Commissioner Barden.

Commissioner Barden:

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Thank you,

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712 East Washington Street
Greenville, SC 29601
Phone (864) 233-0203
Fax (864) 233-3020

Carolinas Center for Advanced Management of Pain

1330 Boiling Springs Rd Suite 2700 Spartanburg, SC 29303
8645830053 Fax: 8645830390

September 8, 2009

Page 1

Chart Document

MS KELLIE BURNETTE

Female DOB: ~~08/23/1980~~

18381

Home: ~~(803) 733-1000~~

Ins: VOC:REHAB

08/04/2009 - Office Visit: Psych F/U

Provider: Lisa Richardson LISW-CP

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

This document contains confidential information

Age: 29 Years Old

Gender: Female

Employment Status: Last worked 3-08, medically retired police officer City Greenville

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Education Level: Graduated high school + few college courses

History of Present Illness: Referred Dr. Satterthwaite. August 2003 work-related MVA, full spine, facial trauma. In June 2007 reinjury. Depression secondary to pain and lifestyle change, feelings of loss, feelings of worthlessness, sadness/discouragement, irritability. Dx: Adj D/O Mixed, & 307.89. WC approved.

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Treatment:

supportive therapy
insight and educational therapy

Assessment

Status of Existing Problems:

Assessed PAIN DISORDER (PSYCH/MEDICAL) as unchanged - Lisa Richardson LISW-CP

Plan

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FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 2 po hs

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours.

AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) 1 qhs

CELEBREX 200 MG CAPS (CELECOXIB) take one PO QD

Carolinas Center for Advanced Management of Pain
1330 Boiling Springs Rd Suite 2700 Spartanburg, SC 29303
8645830053 Fax: 8645830390

September 8, 2009
Page 2
Chart Document

MS KELLIE BURNETTE

Female DOB: ~~06/06/1976~~

18381

Home: ~~864-583-0053~~

Ins: VOC REHAB

ZYRTEC 10 MG TABS (CETIRIZINE HCL) 1 po qhs other MD
CYMBALTA 30 MG CPEP (DULOXETINE HCL)
ADDERALL 20 MG TABS (AMPHETAMINE-DEXTROAMPHETAMINE) bid - Dr Giambalvo
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New Orders:

Return for follow-up 1 week [xxxxx]
OP Psychotherapy 45 - 50 min. [90806]

Signed by Lisa Richardson LISW-CP on 08/04/2009 at 5:38 PM

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
P.O. Box 1715 - 1612 Marion Street
Columbia, South Carolina 29202-1715

WCC File # 0720591
Carrier File # 0010701415001
Carrier Code #0000852
Employer FEIN 576000236

<u>Kellie Burnette</u> Claimant's Name	<u>[REDACTED]</u> SSN	<u>City of Greenville</u> Employer's Name
<u>[REDACTED]</u> Address	<u>[REDACTED] SC [REDACTED]</u> City State Zip	<u>P.O. Box 2207</u> <u>Greenville</u> <u>SC</u> <u>29602</u> Address City State Zip
<u>(864) 862-3234</u> Home Phone	<u>()</u> Work Phone	<u>Hewitt Coleman & Associates</u> Insurance Carrier
	<u>Douglas A. Churdar</u> Preparer's Name	<u>(864) 233-0203</u> Phone #

The undersigned attorney for the Claimant certifies that on the 8th day of November, 2009, he served a copy of Claimant's *Motion to Admit Additional Evidence to Complete the Record* with attachments in the above-captioned action, on all counsel of record by depositing in the United States mail, with due and proper postage affixed thereto, copies of the same addressed to:

Michael A. Farry, Esq.
Horton Law Firm
PO Box 10167
Greenville, SC 29603

Date: 11/3/2009


Douglas A. Churdar
S.C. Bar # 11971
712 East Washington Street
Greenville, SC 29601
Phone: 864.233.0203

BEFORE THE SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

STATE OF SOUTH CAROLINA)

COUNTY OF GREENVILLE)

Kellie Burnette, Employee,)

Claimant,)

v.)

City of Greenville, Employer and
Self-Insured, Hewitt, Coleman &
Associates, TPA,)

Defendants.)

W.C.C. FILE NO.: 0720591

RETURN TO MOTION TO ADMIT
ADDITIONAL EVIDENCE TO
COMPLETE THE RECORD

SCWCC

NOV 10 2009

JUDICIAL

Defendants, by their undersigned counsel, do hereby respond to Claimant's Motion to Admit Additional Evidence to Complete the Record as follows:

1. This is basically the same Motion as was filed by Claimant November 3, 2009 which was denied by Commissioner Barden by Order filed and served September 23, 2009, copy of which is attached and marked Exhibit A.

2. This claim was tried before Commissioner Susan S. Barden on September 3, 2009 and there was no request by Claimant to keep the record open for the submission of additional evidence, and moreover, no provision by Commissioner Barden to permit additional evidence to be submitted.

3. On September 8, 2009 at the request of Commissioner Susan S. Barden, a conference call was held with counsel for Claimant, counsel for Defendant, and Commissioner Barden participating. During this conference call, Commissioner Barden had several questions concerning the APA Submissions and further inquired of the attorneys of record if anyone had anything further that needed to be considered.

Counsel for Claimant and Defendants each advised that they had nothing further to submit.

4. On September 8, 2009, Commissioner Barden issued a request for proposed order, copies of which were sent to attorneys of record.

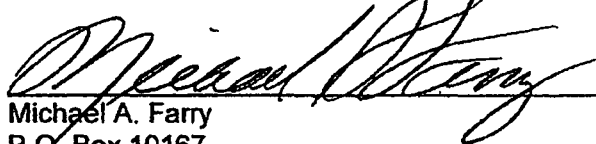
5. On October 14, 2009, an Order by Commissioner Barden was filed and served upon attorneys of record.

6. Claimant's Motion fails to comply with Regulation 67-707, in that the additional evidence is not of "the same nature and character required for granting a new trial"; "is evidence of a cumulative or impeaching character 'that would not have' likely produced a different result had the evidence been procurable at the first hearing"; and is not evidence which "by reasonable diligence could not have been secured" prior to the hearing.

Therefore, based upon the foregoing, Defendants respectfully request that Claimant's Motion to Admit Additional Evidence to Complete the Record be denied again.

Respectfully submitted,

HORTON, DRAWDY, WARD & JENKINS, P.A.



Michael A. Farry
P.O. Box 10167
Greenville, SC 29603
(864) 233-4351
Attorneys for Defendants

November 5, 2009

Exhibit A

BEFORE THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

WCC FILE NO. 0720591

Kellie Burnette,)
)
 Claimant,)
 vs.)
)
 City of Greenville,)
)
 Employer,)
)
 City of Greenville,)
)
 Carrier,)
 Defendants)

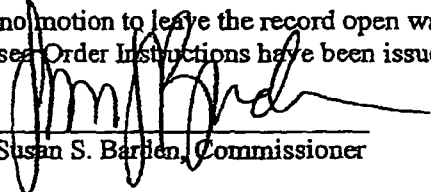
A Motion regarding the following issue(s) has been received.

- ☐ Discovery or Subpoena
- ☐ Appointment of guardian Ad Litem
- ☐ Attorney's appearance before the Commission
 - ☐ Withdrawal of Representation
 - ☐ Attorney's Fee
- ☐ Claim Pending Commission Review
 - ☐ Postpone
 - ☐ Adjourned the Scheduled Hearing
- ☐ Self Insurance Privileges
- ☐ Penalties and Interest
- ☐ Third Party Practice
- ☒ Other: Motion to Admit Additional Evidence to Complete the Record.

The following disposition has been made: ☐ Granted ☒ Denied
☐ Set for Hearing
☐ Have Attorneys brief the Issue

Reason: The hearing was held, no motion to leave the record open was requested at the hearing, and Proposed Order Instructions have been issued.

Columbia, SC


Susan S. Barlen, Commissioner

BEFORE THE SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

STATE OF SOUTH CAROLINA)

WCC FILE NO.: 0720591

COUNTY OF GREENVILLE)

Kellie Burnette, Employee,)

Claimant,)

v.)

CERTIFICATE OF SERVICE

City of Greenville, Employer and)
Self-Insured, Hewitt, Coleman &)
Associates, Inc., TPA,)

Defendants.)

I, Lynn Chandler, an employee with the firm of Horton, Drawdy, Ward & Jenkins, P.A., do hereby certify that on November 5, 2009 I served Return to Motion to Admit Additional Evidence to Complete the Record on the following person(s) by causing same to be placed in the United States mail, postage prepaid, addressed as follows:

Douglas A. Churdar
Attorney at Law
712 East Washington Street
Greenville, SC 29601



Lynn Chandler

STATE OF SOUTH CAROLINA

COUNTY OF GREENVILLE

Kellie N. Burnette, Employee,

Claimant,

vs.

City of Greenville, Employer, and Hewitt
Coleman & Associates, Carrier,

Defendants.

IN THE COURT OF COMMON PLEAS
THIRTEENTH JUDICIAL CIRCUIT

2010 APR 28 P 3: 25

C.A. No.: 2010-CP-23- 3442

FILED-CLERK OF COURT
GREENVILLE CO S.C.

**APPEAL FROM DECISION & ORDER
OF THE SOUTH CAROLINA WORKERS'
COMPENSATION COMMISSION**
(WCC File No. 0720591)

Pursuant to §42-17-60 SC Code Ann. (1976, as amended)¹, Claimant hereby appeals the Decision and Order of the South Carolina Workers' Compensation Commission (WCC File No. 0720591), which was filed April 1, 2010, on the following grounds:

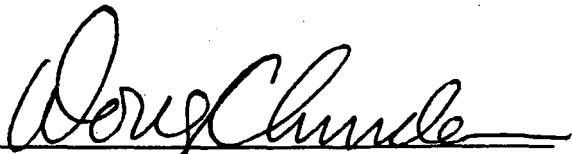
1. The Commission's finding that Claimant did not sustain an injury to the low back is not supported by substantial evidence.
2. The Commission's finding that Claimant is not permanently and totally disabled is not supported by substantial evidence.
3. The Commission's finding that Claimant is not credible relates to an irrelevant and immaterial issue and is not supported by substantial evidence.
4. To the extent not identified above, all grounds raised before the Full Commission are incorporated herein.

Claimant requests that the Decision and Order be reversed or modified or ordered modified by this Court to provide: that Claimant injured her low back at L5-S1; that Claimant is entitled to medical treatment for her low back, including authorization of a referral to an

¹ This claim arises from an injury on June 16, 2007, and thus appeal is made to the Court of Common Pleas of the county in which the accident happened.

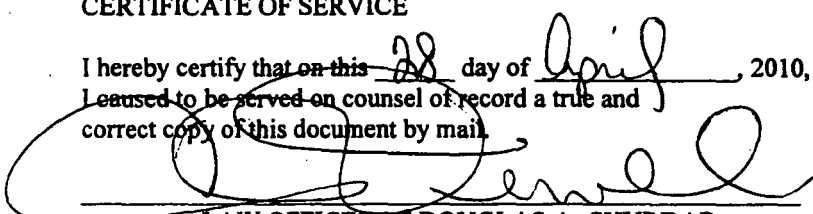
orthopaedic or neurosurgeon; that Claimant is permanently and totally disabled under §42-9-30(19) or under §42-9-10; and that the Commission's finding that Claimant is not credible is not supported by substantial evidence.

Date: 4/28/10


Douglas A. Churdar
S.C. Bar No. 41971
712 East Washington Street
Greenville, SC 29601
Phone: (864) 233-0203
Fax: (864) 233-3020

CERTIFICATE OF SERVICE

I hereby certify that on this 28 day of April, 2010,
~~I caused to be served on counsel of record a true and~~
correct copy of this document by mail.


LAW OFFICES OF DOUGLAS A. CHURDAR

DOUGLAS A. CHURDAR, P. C.

Attorney At Law

712 EAST WASHINGTON STREET
GREENVILLE, SOUTH CAROLINA 29601
TELEPHONE (864) 233-0203
FACSIMILE (864) 233-3020
E-MAIL: dachurdar@churdarlaw.com

June 29, 2011

FILED-CLERK OF COURT
GREENVILLE CO. S.C.
PAUL R. WICKERMAN

2011 JUN 29 PM 2:31

HAND-DELIVERED

Honorable Edward Welmaker

RE: Kellie Burnette, Employee v. City of Greenville, Employer, and Hewitt Coleman & Associates, Carrier
Case No.: 2010-CP-23-3442
WCC File No.: 0720591

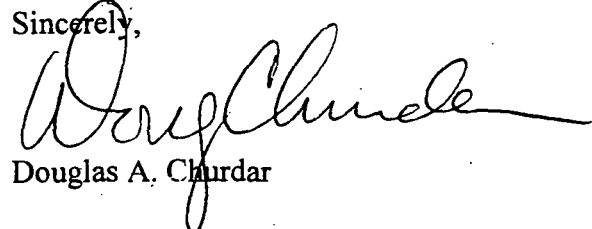
Dear Judge Welmaker:

You will hear a Workers' Compensation appeal tomorrow at 10:00 a.m. Attached you will find the Record on Appeal.

I am attaching for your review Appellant's Memorandum to the Full Commission and Appellant's Reply Brief to the Full Commission. These two (2) documents essentially summarize Claimant's position. Also attached is a document explaining what Claimant seeks in an order and an outline of excerpts from medical records relating to the significant issue of whether Claimant sustained a lumbar spine injury in this case.

Thank you very much.

Sincerely,



Douglas A. Churdar

Attachment(s)

cc: Michael A. Farry, Esq.

KELLIE BURNETTE V. CITY OF GREENVILLE

CASE NO. 2010-CP-23-3442

WCC FILE NO. 0720591

CLAIMANT SEEKS AN ORDER

1. That Claimant is permanently and totally disabled by her cervical spine injury and psychological injury without regard to the injury to the low back but that she sustained injury to the low back/disk injury at L5-S1 and that she is entitled to have treatment at L5-S1;

OR, ALTERNATIVELY,

That Claimant sustained an injury to the low back/disk injury at L5-S1 for which she has not received treatment and, thus, that she is not at MMI and is entitled to receive treatment for her L5-S1 disk injury in this case with the issue of disability to be resolved later;

2. That the Commissioner's finding that Claimant is not credible relates to an irrelevant and immaterial issue and is not supported by substantial evidence.

STATE OF SOUTH CAROLINA
COUNTY OF GREENVILLE

Kellie N. Burnette, Employee,

Claimant,

vs.

City of Greenville, Employer; and Hewitt
Coleman & Associates, Carrier,

Defendants.

IN THE COURT OF COMMON PLEAS
THIRTEENTH JUDICIAL CIRCUIT

C.A. No.: 2010-CP-23-03442

**MOTION TO ALTER OR
AMEND JUDGMENT**

FILED
CLERK OF COURT
JAN 19 PM 4:27

Pursuant to Rule 59 (a) or (e) SCRCP, Claimant/Appellant moves that the Court alter or amend its judgment (entered 7/7/11 and received by mail on 7/11/11) on the grounds that the Court failed to rule on or address her alternative basis for reversing the Workers' Compensation Commission, **namely that Appellant sustained injury to the low back/disc injury at L5-S1 for which she has not received treatment and, thus, that she is not at MMI and is entitled to receive treatment for her L5-S1 injury in this case, with the issue of disability to be resolved later.** (See Attachment 1) This argument is based upon the fact that Appellant's first accident on 8/23/03 resulted in a normal MRI and "just persistent, boring lumbar pain" or "myofascial pain." However, according to her only two treating physicians and a disability examiner for the South Carolina Retirement System, Appellant sustained injury at L5-S1 on 6/17/07 resulting in an abnormal MRI (an injured disc) and lumbar radiculopathy. The Commissioner cannot substitute her medical judgment for that of the authorized treating physicians and other medical experts by comparing the two MRIs herself and drawing her own conclusions. With regard to this narrow issue of injury at L5-S1, the Appellant requests that the Court review her request for an order seeking the alternative relief (Attachment 1) and its Memo

Regarding Whether Appellant Sustained Lumbar Spine Injury on 6/17/2007 (Attachment 2), both of which were provided to the Court.

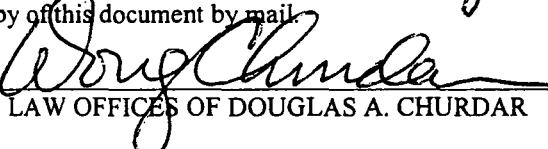
Based upon the above, Appellant seeks an Order finding that the Commission's finding that she did not sustain an injury to the low back/disc injury at L5-S1 is not supported by substantial evidence and remand this case to the Workers' Compensation Commission with such a finding and instructions that Appellant receive treatment for her L5-S1 injury, with the issue of disability to be resolved later.

Date: 7/19/11


Douglas A. Churdar
S.C. Bar No. 11971
712 East Washington Street
Greenville, SC 29601
Phone: (864) 233-0203
Fax: (864) 233-3020

CERTIFICATE OF SERVICE

I hereby certify that on this 19 day of July, 2010,
I caused to be served on counsel of record a true and
correct copy of this document by mail.


LAW OFFICES OF DOUGLAS A. CHURDAR

STATE OF SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION
CASE NUMBER - 0720591

KELLIE N. BURNETTE,	)	
	)	
CLAIMANT,	)	SINGLE COMMISSION HEARING
	)	
VS.	)	BEFORE
	)	
CITY OF GREENVILLE,	)	COMMISSIONER SUSAN S. BARDEN
	)	
EMPLOYER/	)	
CARRIER,	)	
	)	
DEFENDANTS.	)	
	)	

WORKERS' COMPENSATION COMMISSION HEARING TAKEN
BEFORE SARA L. QUATTLEBAUM, A NOTARY PUBLIC IN AND FOR
THE STATE OF SOUTH CAROLINA, COMMENCING AT THE HOUR OF
11:02 AM ON THURSDAY, SEPTEMBER 3, 2009, 301
UNIVERSITY-RIDGE, GREENVILLE, SOUTH CAROLINA.

COPY

SARA QUATTLEBAUM, Independent Court Reporter
148 LAKE HARBOR DRIVE
LEXINGTON, SC 29072
(803)447-0272

APPEARANCES**FOR THE CLAIMANT**

DOUGLAS A. CHURDAR, ESQUIRE
 712 E. WASHINGTON STREET
 GREENVILLE, SOUTH CAROLINA 29601
 (864) 233-0203

FOR THE DEFENDANT

MICHAEL A. FARRY, ESQUIRE
 HORTON LAW FIRM
 POST OFFICE BOX 10167
 GREENVILLE, SOUTH CAROLINA 29603
 (864) 233-4351

ALSO PRESENT

CLAUDIA MAJOR

SARA L. QUATTLEBAUM
 Independent Court Reporter
 148 LAKE HARBOR DRIVE
 LEXINGTON, SOUTH CAROLINA 29072
 (803) 808-0394

INDEX**WITNESS**

DIRECT EXAMINATION BY MR. CHURDAR.....	11
CROSS EXAMINATION BY MR. FARRY.....	41
REDIRECT EXAMINATION BY MR. CHURDAR.....	59
RE-CROSS EXAMINATION BY MR. FARRY.....	60
CERTIFICATE	63

SARA QUATTLEBAUM, Independent Court Reporter
 (803) 447-0272

1 THE COURT: Today's date is September 3, 2009.

2 This is South Carolina Workers' Compensation
3 Commission File No. 0720591.

4 This is the case of the Claimant, Ms. Kellie
5 Burnette, who is present today and represented by
6 Attorney Doug Churdar, versus the Employer, the City
7 of Greenville, which is self-insured and represented
8 by Attorney Mike Farry.

9 The purpose of today's hearing is to determine
10 issues raised in Forms 50 and 51.

11 Ms. Burnette's average weekly wage is \$1,000
12 yielding the maximum compensation rate for 2007 or
13 \$645.94.

14 The date of this admitted accident was June 16,
15 2007.

16 Are there any objections to APAs, jurisdiction,
17 venue or any other items?

18 MR. CHURDAR: None from the Claimant.

19 MR. FARRY: None from the Defendants.

20 THE COURT: Thank you both. Without objection
21 the Commission File becomes a part of the record with
22 the exception of self-serving declarations and
23 unstipulated medical reports.

24 Prior to going on the record we held a prehearing
25 conference. It is the position of the Claimant that

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(803)447-0272

1 she is permanently and totally disabled pursuant to
2 either statutory theory, whether that be 42-9-30, Item
3 19 in that she has sustained a 50 percent or greater
4 loss of use of her spine; alternatively 42-9-10 in
5 that the combination of her injured body parts and
6 conditions that she is entitled to - and other
7 factors, that she is entitled to a finding under that
8 theory, as well and of course under either theory
9 entitled to receive lifetime causally-related
10 medicals.

11 She seeks her award in a lump sum with the
12 provision of Utica Mohawk language in the order.

13 It's her position that - and the admitted body
14 parts and conditions in this case are the neck, the
15 upper back and psychological overlay. The low back is
16 specifically denied.

17 It is the Claimant's position that even if I do
18 not find that the low back condition is compensable
19 that she is entitled to the finding of permanent total
20 disability regardless, that her other injuries and her
21 psychological condition render her permanently and
22 totally disabled.

23 She would point to my attention as a starting
24 point in determining disability the rating of the
25 authorized treating physician, Dr. Bucci who assigned

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(803)447-0272

1 a 28 percent impairment rating to her spine..

2 It is the Defendants' position that while the
3 neck and the upper back are admitted body parts and
4 the Defendants also admit psychological overlay, it is
5 the Defendants' position that the low back is not
6 compensable and benefits for that should be denied,
7 and further if I find that the lower back is
8 compensable it would be the Defendants' position that
9 the Claimant has not reached maximum medical
10 improvement. They would like the opportunity to
11 direct treatment to see if a cure can be affected or
12 if Ms. Burnett's lower back condition can be, if not
13 alleviated, certainly improved before any
14 determination of permanency is made.

15 Therefore, it would be the Defendants' position
16 that the Claimant has reached maximum medical
17 improvement as to her neck and upper back and
18 psychological condition. But if I do find the low
19 back is compensable that she would not, in fact, be at
20 MMI.

21 If she is at MMI it would be the Defendants'
22 position that the Claimant is entitled to some
23 permanency with regard to her cervical spine but that
24 it would be something less than total disability. And
25 the Defendants would contend that the award would be

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1 appropriately made pursuant to 42-9-30, Item 19
2 analysis and not 42-9-10.

3 The Defendants disagree with - and of course I
4 have just been handed all the medical records and
5 haven't reviewed them, but certainly will do so at the
6 conclusion of the hearing. But it's the Defendants'
7 position that the rating of Dr. Bucci was changed from
8 10 percent to 28 percent in a several-month period
9 without seeing the Claimant. I'm not going to get
10 into a back-and-forth on that because I haven't read
11 the records, the questionnaire or reviewed the other
12 medical documents. But it would be the Claimant's
13 position, of course, that he, in fact, signed an
14 impairment rating which would be appropriate after a
15 fusion surgery.

16 The Defendants, of course, would contend
17 otherwise.

18 But in any event, it would be the Defendants'
19 position that the Claimant is not permanently and
20 totally disabled and while she is entitled to an award
21 it would be something less than total disability.

22 As far as lump sum is concerned, it would be the
23 Defendants' position that it is, of course, the
24 Claimant's burden of proof that she is entitled to
25 receive it. And the Defendants take no position as

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1 far as the allocation language of Utica Mohawk.

2 Is that a fair summary, gentlemen? Is there
3 anything that either of you would like to add, clarify
4 or correct at this juncture? I will entertain that
5 now. Mr. Churdar, you are the moving party. I will
6 start with you.

7 MR. CHURDAR: Thank you, Commissioner. I would
8 like to make sure we have an understanding of our
9 position on this issue. If the low back is determined
10 to be compensable it is -

11 THE COURT: It is his position that she is not at
12 MMI. Your position is you still want permanency
13 decided.

14 MR. CHURDAR: If she is not at MMI - there is a
15 case, I wish I had - I don't think she has to be at
16 MMI. I think that the body parts for which she is at
17 MMI could take her to permanent total and she still
18 would be entitled to treatment for the low back.

19 THE COURT: Okay.

20 MR. CHURDAR: I've got a case somewhere in this
21 file regarding that.

22 THE COURT: I think I did read into the record
23 that you believe she is permanently and totally
24 disabled regardless of the low back.

25 MR. CHURDAR: That is correct.

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(803)447-0272

1 THE COURT: But your position is that I can go
2 ahead and decide permanency based on the cervical
3 psychological conditions alone.

4 MR. CHURDAR: That is correct.

5 THE COURT: I want to hear from Mr. Farry on
6 that.

7 MR. FARRY: As to that issue I would contend that
8 if the low back is compensable necessitating further
9 medical treatment any determination as to permanency
10 would be premature and we should not have a bifurcated
11 award with respect to some body parts and others. And
12 particularly with the overlap psychological plays with
13 additional pain, stress, treatment, whatnot with the
14 low back that it would be premature to award
15 permanency.

16 THE COURT: And I believe the case you are
17 speaking of is the psychological issue, which was, I
18 think, perhaps denied. And I can't remember the name
19 of the case right now; it just escapes me, but that
20 the Commission can go ahead and decide permanency on
21 the physical injuries even though the psychological
22 aspect had not been yet treated. I don't recall the
23 name of the case.

24 MR. FARRY: In that case I believe it was the
25 case that had multiple body parts absent the

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(803)447-0272

1 psychological so they took it out of Singleton.

2 Therefore that's not what we have here.

3 THE COURT: I do think it's a little bit
4 different here. But that was - that's the way I
5 recall those facts.

6 MR. FARRY: One other point, which spoke to the
7 contentions as you read them into the record.
8 Dr. Bucci signed a 14(b) April 3, 2009.

9 THE COURT: Of course I don't know where that is.

10 MR. FARRY: It's APA No. 6 at Page 255.

11 THE COURT: Okay.

12 MR. FARRY: Ten percent impairment to the whole
13 body based upon the cervical spine as being the
14 affected body part. It is our contention that if you
15 looked at the AMA Guide fifth Edition Section 15.3 the
16 criteria for converting whole person impairment to
17 regional spine and divide by .35, that 10 percent,
18 that's how they arrived at the 28 percent that's
19 founded APA No. 5, Page 231. So it is our contention
20 that he hasn't really changed his impairment. He just
21 converted to a regional -

22 THE COURT: Okay.

23 MR. FARRY: - cervical spine impairment as
24 opposed to the entire spine.

25 THE COURT: Okay. So you believe the 28 percent

1 to be a regional?

2 MR. FARRY: Regional impairment.

3 THE COURT: Okay.

4 MR. FARRY: And the ten percent is to the spine
5 whole person which is what we based the back on.

6 THE COURT: Okay.

7 MR. CHURDAR: Our position would be that on the
8 14(b), he did not identify a body part. And then with
9 regard to the evaluation it was under the DRE method
10 of the AMA Guide Fifth Edition. He made it clear it
11 was 28 percent whole person.

12 THE COURT: Okay. I will review it all. I will
13 make a finding accordingly. All right. Anything else
14 before we hear from Ms. Burnette?

15 MR. FARRY: None from the Defendants.

16 THE COURT: All right. Your first and only
17 witness is Ms. Burnette; is that correct?

18 MR. CHURDAR: Yes.

19 KELLIE NICHOLE BURNETTE,

20 Having been first duly sworn, testified as follows:

21 THE COURT: Please state your full name for the
22 record.

23 THE WITNESS: Kellie Nicole Burnette.

24 THE COURT: Is that Nicole with a C or K? I
25 always ask.

SARA QUATTLEBAUM, Independent Court Reporter
(803)447-0272

1 THE WITNESS: N-I-C-H-O-L-E.

2 THE COURT: I had it wrong on both accounts.
3 Please answer any questions your lawyer has. I'm
4 going to ask you something, Ms. Burnette, that as best
5 you can if you will direct your responses to me.

6 THE WITNESS: Okay.

7 THE COURT: I know it's a little bit awkward, but
8 that's why I put him there and you there so that we
9 would both be facing you.

10 THE WITNESS: Sure.

11 THE COURT: Whenever you are ready, sir.

12 MR. CHURDAR: Thank you, Commissioner.

13 DIRECT EXAMINATION

14 BY MR. CHURDAR:

15 Q Kellie, would you please tell the Commissioner your
16 address?

17 A ~~3000 North Carolina Street~~ and that's ~~3000 North Carolina Street~~ South
18 Carolina, ~~NC~~.

19 Q And your date of birth, please?

20 A ~~11/11/71~~.

21 Q And your height?

22 A 5'10".

23 Q And your weight?

24 A It's 236.

25 Q And have you gained weight since - have you gained

1 weight in the last several years?

2 A Yes, I have.

3 Q Has it gone up and down?

4 A Yes.

5 Q Tell the Commissioner briefly how much your weight has
6 changed.

7 A After the first injury in 2003 I gained a lot of
8 weight. I went out for surgery in 2007 on my
9 shoulder. And I was placed on light duty for a period
10 of six months. During that six months I was able to
11 lose some weight. Also previously, sort of prior to
12 that as well, there was a period of time where I had
13 lost some weight. But I did gain it back. There
14 again, I went out for surgery during that six-month
15 period. I had lost, to me, a good bit of weight.
16 Then when I came back after this injury I had gained a
17 much greater amount of weight.

18 Right now I am trying to get it off in order to
19 help myself and try to lessen the pain that I do have.
20 So I am right now in the process of trying to lose
21 weight.

22 Q Have you gained weight as a result of this injury that
23 occurred on June 16, 2007?

24 A Yes. Also after having surgery and being sedentary
25 for so long I gained even more weight. I was not able

SARA QUATTLEBAUM, Independent Court Reporter
(803)447-0272

1 to be as active.

2 Q But you recently lost weight is what you are telling
3 us, the Commissioner?

4 A Yes.

5 Q Are you right handed or left handed?

6 A I'm right handed.

7 Q How far did you go in school, Kellie?

8 A I had some college.

9 Q Where did you go to college?

10 A Greenville Tech.

11 Q What did you study at college?

12 A When I started at Tech I took business courses. I
13 changed my major and went to criminal justice. I then
14 decided to apply with the police department and was
15 hired.

16 THE COURT: How much college did you have, a
17 semester of two semesters?

18 THE WITNESS: No. I had about two years and then
19 while working I tried -

20 THE COURT: Did you get an associates?

21 THE WITNESS: No, ma'am.

22 THE COURT: So you got two years of courses in
23 either business and/or criminal justice?

24 THE WITNESS: Maybe a little additional because I
25 tried to go back while I was working maybe a semester.

SARA QUATTLEBAUM, Independent Court Reporter
(803)447-0272

1 THE COURT: Two years with working a semester
2 roughly?

3 THE WITNESS: Yes, ma'am.

4 BY MR. CHURDAR:

5 Q Did you receive any special training after you left
6 Greenville Tech?

7 A Yes, I did. I went to the South Carolina Criminal
8 Justice Academy in Columbia. I've had training that
9 pertains to being a police officer, also.

10 Q Now I want to ask you about medications that you take,
11 and I'm going to ask you what you are taking, who is
12 prescribing it, why you are taking it and whether
13 you're on normal dosage or additional dosage today.

14 A Yes.

15 Q Okay. What, if you would, with regard to each
16 mediation tell us what medications you are taking?

17 A I'm taking Roxicodone.

18 Q Who prescribes it?

19 A Dr. Satterthwaite.

20 Q Why?

21 A Pain.

22 Q Are you on your normal dose or are you taking
23 additional -

24 A Today I'm taking additional. I'm taking the maximum
25 amount.

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- 1 Q What other medication?
- 2 A Baclofen.
- 3 Q Who prescribed it?
- 4 A Dr. Satterthwaite.
- 5 Q Why?
- 6 A It's for muscle spasms.
- 7 Q Are you on your normal dose or are you taking any
- 8 additional?
- 9 A I'm taking the max prescribed.
- 10 Q Do you not take the max prescribed every day?
- 11 A There might be one or two that I take that's
- 12 prescribed as needed. If I can go - if I can get by
- 13 without taking the maximum amount I try to do that. A
- 14 day like today where I know I'm going to be up I try
- 15 to take it on an hourly basis so I can try to manage
- 16 the pain the best possible way.
- 17 Q All right. You said Roxicodone and Baclofen; what
- 18 else are you taking?
- 19 A Flexeril.
- 20 Q Who prescribed it?
- 21 A Dr. Satterthwaite.
- 22 Q Why?
- 23 A That's for muscle spasms.
- 24 Q Are you taking a normal dose or additional today?
- 25 A I'm taking the maximum prescribed. I normally take

1 that one as prescribed every day.

2 Q What else do you take?

3 A Neurontin, that's for nerve pain and also prescribed
4 by Dr. Satterthwaite. I'm taking the regular dosage
5 as prescribed.

6 Q What else?

7 A Lidocaine patches, five percent, three, I'm taking all
8 of those.

9 THE COURT: Do you take those medications every
10 day?

11 THE WITNESS: The others, yes. The Lidocaine
12 patches, no.

13 BY MR. CHURDAR:

14 Q After the Lidocaine patches, what else?

15 A Celebrex. It's an anti-inflammatory that's prescribed
16 by Dr. Satterthwaite.

17 Q Why is that? That's an anti-inflammatory.

18 A Uh-huh.

19 Q Okay. Are you on your maximum dose today or -

20 A It's as prescribed. I take it as prescribed every
21 day. Prozac, you will be glad to know I'm taking that
22 one as prescribed. I'm taking that for depression and
23 anxiety.

24 Q Who is prescribing that?

25 A That one is prescribed by Dr. Tollison.

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1 Q All right.

2 A And I'm taking Cymbalta, as well, as prescribed.

3 Q Why is that?

4 A That's for depression and anxiety as well. That was
5 prescribed by Dr. Tollison.

6 Q Anything else?

7 A I'm taking Adderall.

8 Q Why is that?

9 A ADHD as prescribed by my family physician,
10 Dr. Giambalvo.

11 THE COURT: Were you taking that prior to this
12 accident?

13 THE WITNESS: Yes, ma'am.

14 THE COURT: Okay.

15 BY MR. CHURDAR:

16 Q All of these medications other than the Adderall, have
17 you started taking them since the accident of 2003 or
18 the accident that we are here about today?

19 A Yes.

20 Q Are there any other medications that you are taking
21 that you haven't mentioned?

22 A Did you write those down? I'm sorry. How many is
23 that?

24 Q No, I do not. Cymbalta, Prozac, Celebrex, Roxicodone,
25 Baclofen, Flexeril, Neurontin, Lidocaine patches and

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1 Adderall; anything else you can think of?

2 A Just over-the-counter Zyrtec for allergies.

3 Q And I will tell you this. I didn't say this in front
4 of you or her, but if this goes a long time and you
5 want to get up you can. You can do whatever you need
6 to do to be comfortable. Have you been primarily a
7 police officer as an adult?

8 A Yes.

9 Q Have you - before becoming a police officer and going
10 to the police academy did you do any other work?

11 A Yes.

12 Q What did you do?

13 A I worked at Ritz Camera and Wolf Camera.

14 THE COURT: What did you do there?

15 THE WITNESS: I was a sales associate and a photo
16 lab technician. Basically it's just a glorified
17 cashier.

18 THE COURT: Okay.

19 THE WITNESS: It sounds technical but it was -

20 THE COURT: Let me back you up. You were asked
21 whether you had done police officer work most of your
22 adult life. How many years have you been a police
23 officer?

24 THE WITNESS: It was just under seven.

25 THE COURT: And has all of that been with

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(803)447-0272

1 Greenville?

2 THE WITNESS: Yes, ma'am.

3 THE COURT: Okay.

4 BY MR. CHURDAR:

5 Q So when you worked for Ritz and Wolf in the camera
6 shops, did you spend a lot of time on your feet?

7 A Yes.

8 Q Did you do -

9 A The entire shift basically.

10 Q So eight hours pretty much on your feet?

11 A Yes.

12 Q All right. You became a police officer in what year?

13 A In 2001.

14 Q I believe you became a police officer for the City of
15 Greenville Police Department, correct?

16 A That's correct. It was in June 2001.

17 Q Now, as a police officer have you been injured a
18 number of times?

19 A Yes, many.

20 Q What are some of the ways you've been injured just
21 briefly?

22 A As far as the cause, the incident involved?

23 Q Sure.

24 A That would be a lot of times trying to affect an
25 arrest and having to fight a combative or resistant

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1 subject while just trying to gain control and place
2 him under arrest. Also just, you know, it may be like
3 during a pursuit chasing a suspect.

4 MR. FARRY: Commissioner, I don't know where the
5 relevancy is and I'm going to object to this line of
6 testimony. If we can deal with the injury that brings
7 us here today and coming forth, how we are doing now.

8 THE COURT: Streamline things a little bit.

9 MR. CHURDAR: We will streamline things. Let's
10 talk - I do believe as we go forward talking a little
11 bit about the injury in 2003 and comparing what she
12 had as a result of that versus what she has now, I
13 think it's significant.

14 THE COURT: Well, I'll let you go with that and
15 when he objects I'll - if he has one I'll listen to it
16 and we will take it from there.

17 BY MR. CHURDAR:

18 Q Have you essentially undergone two major injuries
19 while working for the police department?

20 A Yes, major.

21 Q Was one of those August 1, 2003 - August 2003. Excuse
22 me.

23 A It was August 23, 2003.

24 Q Very briefly tell the Commissioner how you were
25 injured August 23, 2003.

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1 MR. FARRY: Commissioner, again, that injury,
2 we've tried it. It's been awarded. We are here on a
3 new accident date. To the extent it's impacted her
4 preexisting problems, she can testify to that. But
5 this ankle bone, knee bone, leg bone, hip bone; the
6 first accident I think is a waste of time.

7 MR. CHURDAR: Commissioner, I really -

8 THE COURT: Well, I don't know enough about that
9 accident to know how it interplays with this one. So
10 I'm going to let him go. I don't want you to - we
11 don't need to belabor all of that. But I'm going to
12 let you go. Just so I have a history of what happened
13 before and if it impacts this or what. I don't know
14 enough about it to really make a ruling, Mr. Farry.

15 MR. FARRY: I understand.

16 THE COURT: I'm going to let him go a little bit.

17 BY MR. CHURDAR:

18 Q Did you injure your back in August 2003?

19 A Yes, I did.

20 THE COURT: Was that your low back, your upper
21 back; what was it?

22 THE WITNESS: It was a collision. And I actually
23 injured everything - about everything on the left
24 side.

25 THE COURT: Neck on down, you mean?

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(803)447-0272

1 THE WITNESS: Yes, ma'am.

2 THE COURT: I'm not trying to put words in your
3 mouth. You were indicating -

4 THE WITNESS: That's correct.

5 THE COURT: So your neck down to your low back?

6 THE WITNESS: Actually all the way down to my
7 ankle.

8 THE COURT: Okay.

9 THE WITNESS: I was t-boned in the driver's side.

10 THE COURT: So your whole left side is what you
11 are telling me? Is that what you said?

12 THE WITNESS: Yes, ma'am. I took the impact on
13 the left side and as a result there were a lot of
14 injuries on the left side of my body.

15 THE COURT: Okay.

16 BY MR. CHURDAR:

17 Q Exhibit 3, is this a photograph of the automobile that
18 you were in on August 23, 2003?

19 A Yes, sir.

20 Q These are photographs. Okay. Now, as far as your
21 back goes, was the injury, the permanent injury or the
22 ongoing injuries to your back mostly the cervical, the
23 thoracic or the lumbar portion of your back?

24 THE COURT: Make sure she understands what those
25 terms mean.

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1 MR. CHURDAR: She does.

2 THE WITNESS: I do.

3 THE COURT: Okay.

4 THE WITNESS: By now I do.

5 THE COURT: I just wanted to make sure so if I
6 found out later that she didn't know what you were
7 talking about. Let's make sure.

8 MR. CHURDAR: I know she does.

9 THE COURT: Cervical neck? Okay.

10 THE WITNESS: Yes, ma'am.

11 THE COURT: I know you are intelligent. I'm not
12 trying to denigrate or -

13 THE WITNESS: I don't know everything but those
14 three -

15 THE COURT: Some people don't have a clue as to
16 what those words mean. That can be important.

17 THE WITNESS: Thank you. I appreciate that.

18 THE COURT: Okay.

19 THE WITNESS: Yes, ma'am. As far as ongoing
20 injuries I had lumbar pain. low back pain.

21 THE COURT: Okay.

22 THE WITNESS: Thoracic, some thoracic pain.

23 THE COURT: Those were the residuals from that
24 accident in 2003?

25 THE WITNESS: Yes, ma'am.

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1 BY MR. CHURDAR:

2 Q Did you ever have pain in your buttocks and in your
3 legs as a result of the first accident?

4 A No. I had - the pain then was in the immediate area.
5 It didn't radiate like it does now.

6 Q Did you - did you make any claim for radiculopathy or
7 pain radiating down into your legs as a result of that
8 accident?

9 A No.

10 Q Did you make any claim for depression or anxiety as a
11 result of that accident?

12 A No.

13 Q All right. Before we talk about the second major
14 injury, I want to ask you briefly about your duties as
15 a police officer, what kind of - how physical it was.
16 What were your duties when you were working for the
17 police department?

18 A They would vary from day to day, hour to hour, but you
19 could have to - you might have to stand and direct
20 traffic an entire shift from - you might have to do
21 that one day or for a couple of hours. But then you
22 might have to pursue a suspect on foot. You might
23 have to sit in your car all day or you may be in and
24 out of the vehicle. You might have to work on uneven
25 terrain.

SARA QUATTLEBAUM, Independent Court Reporter
(803)447-0272

1 THE COURT: You are saying - I'm hearing you say
2 there was no standard day where you did the same thing
3 all the day?

4 THE WITNESS: No.

5 THE COURT: Go ahead.

6 BY MR. CHURDAR:

7 Q Generally speaking, how physical was the job? I mean,
8 did -

9 A It was very physical. You might have to fight a
10 combative subject just for your safety. You might
11 have to pursue somebody on foot through woods. You
12 might have to jump through a window. Or you might
13 have to sit for a long period of time. There could be
14 days when you have to do all of those.

15 Q Did you have to run?

16 A Yes.

17 Q Did you have to bend and stoop?

18 A Yes.

19 Q Did you have to get on your knees?

20 A Yes.

21 Q Did you have to lift heavy weights?

22 A At times, yes.

23 Q When I say heavy weights I mean - why don't you tell
24 the Commissioner what type of weight you would be
25 talking about when you say at times?

SARA QUATTLEBAUM, Independent Court Reporter
(803)447-0272

- 1 A You may have to lift a person, a body. There would.
2 be other things, but the most frequent or the heaviest
3 weight I think of a person, to give you an idea.
- 4 Q How about your uniform? Does your uniform weigh a lot
5 or lots of your uniform weigh a lot?
- 6 A Yes. I had a bullet proof vest, a duty belt with
7 weapons, boots.
- 8 Q How much did the bullet proof vest weigh, if you know?
- 9 A I would give a rough estimate five to seven pounds.
- 10 Q How about the duty belt?
- 11 A Again, a rough estimate may be 20, 25 pounds roughly.
- 12 Q All right.
- 13 A It would depend on what equipment you had.
- 14 Q Let's talk about the injury that is the subject of
15 this claim. Okay. That occurred on June 16, 2007,
16 correct?
- 17 A I'm sorry?
- 18 Q The injury that's the subject of this claim -
- 19 A Uh-huh.
- 20 Q - why we are here today, that occurred on June 16,
21 2007?
- 22 A That's correct.
- 23 Q At that time had you returned to full duty as a result
24 of your injuries on August 23, 2003?
- 25 A I did.

SARA QUATTLEBAUM, Independent Court Reporter
(803)447-0272

1 Q Had you been full duty for an extended period of time
2 or had there been any periods of light duty between
3 2003 and -

4 A There have been both. I was during that time full and
5 light duty.

6 Q You mentioned something about an injury to your left
7 shoulder. When did that occur?

8 A That occurred in, I believe it was the latter part of
9 2006. I also had there were two injuries to my
10 shoulder, one in the collision on August 23, 2003 but
11 also in 2006.

12 Q What happened in 2006?

13 A I was at my residence trying to hang some curtains. I
14 was thrown into the wall. I just put my hand out
15 against the wall and my arm dislocated. It came out
16 of the socket. As a result I had torn the labrum.

17 Q All right. That was before June 16, 2007?

18 A Yes, it was.

19 Q Were you treated for that?

20 A Yes, I was.

21 Q Was surgery performed on your left shoulder?

22 A Yes, it was.

23 Q Were you given any kind of restrictions or impairment
24 rating as a result of that?

25 A I was.

1 Q Who gave you those?

2 A Dr. Allen Posta.

3 Q And what was the impairment rating he gave you to the
4 left shoulder? Do you know?

5 A I don't recall.

6 Q Okay. Do you know if it was in the records? Do you
7 know if it was in the records?

8 A I believe he did put it in the records.

9 Q All right. Now, going to June 16, 2007 you were
10 injured trying to remove a suspect from a car; is that
11 correct?

12 A Yes, I was.

13 Q Very briefly tell the Commissioner how -

14 THE COURT: This is admitted, so you are not
15 going to a lot of detail with that. Just give me a
16 brief sketch.

17 THE WITNESS: I answered a call that I was given.
18 During an investigation of a call on my cell phone.

19 THE COURT: Just tell me how it happened, the
20 mechanics of it. You don't have to get into how it
21 leads up. You went to the car and all of that. Just
22 tell me how it happened.

23 THE WITNESS: There was another officer next to
24 me. The door was open. I was close to the door jam.
25 Officer Castenada was next to me. She refused to get

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(803)447-0272

1 out of the car. She was wanted. We had to get her
2 out of the car and affect an arrest. I saw her
3 reaching for the gear shift. She was - you could hear
4 the car revving up, so we knew she was trying to get
5 away. He pulled out his tazer to try to taze her
6 while I reached in. I put my knee on the corner of
7 the front seat, and I reached in front of her across
8 her trying to keep her from getting her hand on the
9 gear shift. While she was being combative he couldn't
10 get the tazer to be effective because she was moving.
11 We couldn't keep contact, at which time she was able
12 to get in and drive and pull away. I was halfway in
13 the car. When she pulled away I had one foot on the
14 ground. My knee was up on the seat. I was twisted.
15 And then I was knocked back. I knew I had to stay
16 clear of the tires, stay out from under them
17 basically. And I knew I had to keep my head from
18 hitting the ground. So -

19 THE COURT: So she drove off with you -

20 THE WITNESS: Yes. So I was dragged forward and
21 was finally was thrown back from the car. I was still
22 twisted. I hit the curb on my back and when I fell I
23 kept my head up. I forced it to stay up so it
24 wouldn't hit. At the time of impact I felt a shock go
25 up both sides of my neck all the way up to my head. I

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(803)447-0272

1 also felt a shock in my low back. I did compose
2 myself and we pursued her in the vehicle.

3 BY MR. CHURDAR:

4 Q Did you finish out your shift that night?

5 A I did.

6 Q Did you work the next day?

7 A No, I didn't.

8 Q When were you next scheduled to work?

9 A The next day I was - it was my day off. I was
10 scheduled to come in. This happened on Saturday. I
11 was scheduled off Sunday. I was scheduled to come in
12 on Monday. That would have been my normal day off.
13 However, they needed my help from what I was doing
14 while I was on off duty. So they offered me overtime
15 that Monday to come in to work. But I was unable to.
16 I had to call in and say I couldn't work.

17 Q Over the next several months did you begin missing
18 work?

19 A Yes, I did.

20 Q I submitted something to the Commissioner showing that
21 you were retired, medically retired in March of 2008.
22 Between the time you were injured and the time you
23 were medically retired, do you have any idea how many
24 days you missed?

25 A I believe it was -

1 Q I mean all together.

2 A I believe -

3 THE COURT: She was paid for these days was she
4 not? I don't think we need to -

5 MR. CHURDAR: All right. That's fine.

6 BY MR. CHURDAR:

7 Q Were you able to ever return to full duty?

8 A Yes. Well, no. I'm sorry. I stayed on full duty and
9 then I went to light duty and then I was totally out.
10 I did not return after that.

11 Q All right. Since you were medically retired have you
12 worked anywhere?

13 A No.

14 Q Your doctors at this time are Satterthwaite and
15 Tollison; is that correct?

16 A Yes.

17 Q Let me ask you a series of questions, if I could,
18 about your low back. Try to differentiate for the
19 Commissioner what's different about your back now than
20 it was after the August 23, '03 injury? You said
21 something about pain throughout the entire back. Is
22 that different from what it was as a result of the
23 August 23, 2003 injury?

24 A Yes, it is. I had low back pain and some in the
25 middle, the thoracic area. Now it's in my entire back

1 and neck. It starts from my neck and goes down to my
2 low back, the buttocks area. The pain also at times,
3 it does radiate down a nerve of my leg.

4 Q Before the injury - before the surgery that Dr. Bucci
5 did on you, did you have radiating pain into your arms
6 ever?

7 A Yes, I did.

8 Q Was that different from the August 23, '03 injury?

9 A Yes. I didn't have that pain down there, down my arms
10 from the 2003 incident.

11 Q Are there any other differences in your back other
12 than the radiating pain down into your legs and the
13 pain and the radiation out of your neck?

14 A Is there - I'm sorry.

15 Q Different from the way you were - the way your back
16 was before this June 16, 2007 injury?

17 A Yes, it's very different.

18 MR. FARRY: I object to the form of the question.
19 I am very confused. Are we talking about now or are
20 we talking about some time since '07? Or are we
21 talking about 6/03? I think we need to get a little
22 bit -

23 THE COURT: It's getting a little bit confusing.
24 I agree with that. Maybe you can rephrase.

25 MR. CHURDAR: Let me -

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(803)447-0272

1 THE COURT: I think she has testified as to the
2 differences post this accident, but just to make sure
3 the record is clean and clarified.

4 MR. CHURDAR: Let me move on. I will get into
5 that with some specific limitations.

6 THE COURT: Okay.

7 BY MR. CHURDAR:

8 Q You mentioned depression. How - and I'm talking about
9 at this point now, today. I'm going to talk about
10 your mental issues and then we will talk about your
11 physical issues. Tell us about your depression and
12 how that affects you.

13 A I'm very depressed. I said that before, but I'm very
14 depressed because basically I feel like I lost my
15 life. I'm sorry.

16 THE COURT: Take a minute if you need one. Tell
17 us when you are ready to proceed.

18 BY MR. CHURDAR:

19 Q If you know, what do you think caused the depression?

20 A Not being able to work like I wanted to.

21 Q How does that affect you now, Kellie? Are you able to
22 get out?

23 A No. Not like I'd like or be able to. Sorry, I
24 usually don't cry. I would rather be working. I
25 enjoyed my job. I miss it. And I hope - even the

1 hard days were better than this. I feel like I lost
2 my life. And like my interests and hobbies, I was
3 very physical and just liked outdoor things. All of
4 my interests seemed to be more physical, you know,
5 like lifting weights. I like going camping, fishing,
6 sports, things like that. I'd go out with friends or
7 I'd work on my house. I enjoyed that and my yard.

8 And now I'm basically trying to come up with
9 new interests, things that interest me, something
10 where I get some satisfaction or pleasure.

11 Q Let me ask you this. You have also been diagnosed
12 with anxiety. How has your anxiety affected you,
13 specifically how it might impact your ability to
14 work?

15 A I have some issues especially related to vehicles. I
16 want to be in control of a vehicle. I want to drive.
17 I'm nervous about other drivers around me now in cars.
18 But I have a lot of anxiety, like I said, especially
19 when dealing with cars. I don't really like to be
20 around a lot of people any more like I used to,
21 especially crowds. I don't want to be around a lot
22 of people because I don't want to tell them how I'm
23 doing.

24 Q All right. Let me ask you about the kind of things
25 that you are able to do now physically. Okay. How

- 1 long do you feel like you can stand comfortably now
2 at one time?
- 3 A Standing, it would be about 20, 30 minutes.
- 4 Q And if you had to keep standing how long could you gut
5 it out to stand?
- 6 A If I had to maybe an hour and a half, two hours at the
7 most.
- 8 Q When is the last time you think you stood an hour and
9 a half or more?
- 10 A I really can't - if at all possible I will sit down or
11 lay down.
- 12 Q How long do you think you can sit comfortably at one
13 time?
- 14 A Maybe about 20, 30 minutes, but then I would have to
15 move or adjust or something, try to stand up to make
16 myself - not that I would be comfortable but as
17 comfortable as I could in that situation.
- 18 Q How long could you stand up if you just had to - I
19 mean sit if you just had to gut it out?
- 20 A If I had to gut it out, again it would probably be
21 about an hour and a half, two hours.
- 22 Q How long can you alternatively sit and stand at this
23 time?
- 24 A Two to three hours.
- 25 Q Okay.

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(803)447-0272

1 A It would depend. I mean, if I'm already having a bad
2 day it would be even less.

3 Q How long can you - how far can you walk?

4 A Maybe about a block or two, somewhere around that.

5 Q What would stop you from continuing to walk beyond a
6 couple of blocks?

7 A The pain, I would need to at least sit down or
8 something, sit down or lay down.

9 Q Do you have problems kneeling?

10 A Yes, I do.

11 Q What problems do you have with kneeling? Can you do
12 it at all?

13 A Yes. If I just had to kneel down and maybe pick up
14 something, something along those lines I could do
15 that. But if I just had to kneel down and stay there
16 for a minute or two or definitely longer that's very
17 difficult, painful.

18 Q How about bending at your waist? Do you have problems
19 bending at your waist?

20 A Yes, I do.

21 Q Do you have problems squatting or stooping?

22 A Yes, I do.

23 THE WITNESS: Can I take a minute? I'm sorry.

24 THE COURT: Sure.

25 MR. CHURDAR: You could just -

SARA QUATTLEBAUM, Independent Court Reporter
(803)447-0272

1 THE WITNESS: I have to step out for just a
2 minute.

3 THE COURT: Yes. We will take a brief recess.

4 (OFF THE RECORD)

5 THE COURT: We are back on the record.

6 BY MR. CHURDAR:

7 Q I was asking you about bending and stooping. How many
8 pounds can you lift, Kellie?

9 A 15, 20, I just had to pick it up.

10 Q Do you have problems turning different parts of your
11 body? Your back, do you have problems turning or
12 twisting your back?

13 A Yes.

14 Q Do you have problems sleeping at night?

15 A Yes, very much so.

16 Q What do you think is the average amount of sleep you
17 get per night?

18 A That varies by night. I can get, you know, maybe six,
19 seven, eight hours. But some nights I could get two
20 or three and be lucky to get that.

21 Q What affects your sleep?

22 A Pain, anxiety.

23 Q Do you have hobbies that you engage in?

24 A Yes.

25 Q What are some of those hobbies that you engage in?

SARA QUATTLEBAUM, Independent Court Reporter
(803)447-0272

- 1 A I like working in my yard and around the house.
- 2 Q How do you -
- 3 A I like going - I like going camping and being
- 4 outdoors. I can't do that now. I like being on the
- 5 lake. I like sports, but I can't participate in them
- 6 now.
- 7 Q How do you do your gardening? How do you do your
- 8 gardening with your limitations?
- 9 A I can't do certain things for like any period of time,
- 10 especially repetitive motions.
- 11 Q But are you able to do it somewhat?
- 12 A Somewhat.
- 13 Q How do you - are you limited in the amount of time you
- 14 can do it or the types of things you can do? Just
- 15 please be specific.
- 16 A Yeah. Like I might be able to mow my lawn, but I have
- 17 to take a break. I can't do raking or sweeping but I
- 18 can use my pressure washer.
- 19 Q All right. How about other activities? You mentioned
- 20 being at the lake. Do you ever go boating?
- 21 A I like to, but I have not been able to do that much.
- 22 But I love to be on the lake.
- 23 Q Do you have a boat?
- 24 A My parents do, but I don't.
- 25 Q Have you used the boat in the past couple of years?

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1 A This season I've only been out twice. Last season I
2 wasn't out at all. The season before that I went out
3 several times.

4 Q Okay. How were you able to do boating with your
5 limitations?

6 A Well, I drive the boat and read the water. But also I
7 stay like where it's calmer. I only go out when it's
8 calm. I will stay like closer to coves or something.
9 When I've gone out this season, one time I went out
10 and it was too choppy. I just took the boat out and
11 filled it up with gas and it was too bad. I had to go
12 back in. That was all I could do. But the second
13 time I went out it was fine.

14 THE COURT: Go ahead.

15 BY MR. CHURDAR:

16 Q Are you able to do housework?

17 A It's very limited and it's varies from day to day,
18 hour to hour.

19 Q Are you asking for whatever award that the
20 Commissioner might make to be in a lump sum?

21 A Yes, I am.

22 Q Could you explain why you would need the award in a
23 lump sum and what you would do with it?

24 A Yes. Well, when I had to go out I had financial
25 problems because I wasn't able to work my side job and

1 so I got behind in payments. I had to max out my
2 credit cards. But I had a truck that I had leased and
3 I tried to turn it back in. They wouldn't let me. So
4 I had to buy it or another by the end of this year. I
5 did have a great credit score, but it took a hit
6 because I had to wait for - I had to - while I was out
7 I wasn't getting paid during that time. And then
8 after that I had to wait a month for the state
9 retirement check to come. Even then it was much less
10 than I was getting when I was working and also working
11 my part-time job, my side job as a police officer. So
12 I got very behind. And like I said my credit scores
13 were much lower.

14 Q Just tell the Commissioner what you would do with the
15 money if the award were made to you in lump sum.

16 A I would pay my credit cards up and buy a vehicle.
17 Like I said I need to at the end of this year, whether
18 it's that or another one, I would have to have
19 something. And I don't have any in reserve. I would
20 pay off my house so I don't have to worry about a
21 mortgage.

22 Q All right. Are you asking to be evaluated by any
23 other doctors for your lower back?

24 A Am I asking?

25 Q Yes.

1 A Yes, I am. I haven't had any - well the only
2 diagnostic tests I've had after the June incident was
3 an MRI and an x-ray. I have not had any other
4 diagnostic tests. I have just had the pain treatment
5 and physical therapy. I would just -
6 Dr. Satterthwaite said -

7 MR. FARRY: Object to what Dr. Satterthwaite
8 said as being hearsay.

9 THE COURT: Sustained.

10 THE WITNESS: I understand.

11 THE COURT: He asked for medication treatment
12 for the low back. I read it into the record.

13 THE WITNESS: But I want to be able to manage
14 the pain to the best of my ability and know all
15 options.

16 MR. CHURDAR: Thank you very much. I don't
17 have any further questions.

18 THE COURT: Thank you. Please answer any
19 questions Mr. Farry has. You can look his way.

20 CROSS EXAMINATION

21 BY MR. FARRY:

22 Q This accident that brings us here today for this claim
23 is June 16, 2007, correct?

24 A I'm sorry.

25 Q June 16, 2007 is the accident that brings us here

- 1 today?
- 2 A It is; yes, sir.
- 3 Q All right. Since that accident you had one surgery on
- 4 your neck as a result of that accident, correct?
- 5 A Yes, I did.
- 6 Q Now, you talked moments ago about the surgery on your
- 7 shoulder that Dr. Posta, I believe, did. It looks
- 8 like in January 2007, correct?
- 9 A Yes, it is.
- 10 Q And that shoulder surgery you paid for through your
- 11 private insurance, correct?
- 12 A I did.
- 13 Q And the surgery on your shoulder I believe you told me
- 14 was necessitated because you were working on putting
- 15 up some drapes, drilling in the wall and felt the
- 16 dislocation of your arm?
- 17 A That's correct.
- 18 Q Now, Dr. Bucci is the doctor that operated on your
- 19 neck that did the surgery, correct?
- 20 A Yes, sir.
- 21 Q You had your surgery in October of 2008 and he
- 22 dismissed you in March 2009 according to his records.
- 23 Does that sound right?
- 24 A Can you repeat that question?
- 25 Q Sure. October 2008 you had surgery by Dr. Bucci. He

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- 1 dismissed you March 24, 2009, correct?
- 2 A I believe that's correct. Yes.
- 3 Q You have not been back to see Dr. Bucci since?
- 4 A No, I have not.
- 5 Q You do not have any appointments scheduled to go back
6 to see Dr. Bucci?
- 7 A No, I have not.
- 8 Q As far as you know he's dismissed you?
- 9 A Yes.
- 10 Q Now, you have continued to see Dr. Satterthwaite for
11 pain management, correct?
- 12 A Yes.
- 13 Q You have got now a Nissan Titan pickup truck, correct?
- 14 A I do.
- 15 Q That's what you drive?
- 16 A Yes.
- 17 Q Now, I took your deposition and you told me you didn't
18 have a boat but you mentioned that your parents have a
19 boat?
- 20 A Yes.
- 21 Q You use that boat in the summertime?
- 22 A I've only used it twice.
- 23 Q At least twice in the summertime you hooked it up to
24 your truck, dragged it to the lake, backed it down and
25 put it in the water?

- 1 A No. I tried to tow it to my house. They live in
2 Greenville. I tried to tow it up to my house, but I
3 wasn't able to go out on it. I took it back down
4 there. But my dad's friend hooked it up for me. When
5 I took it back my dad owns it.
- 6 Q But you drive your truck with that boat dragging
7 behind it to the lake?
- 8 A I wasn't able to go to the lake.
- 9 Q Whenever you took the boat to the lake this year your
10 truck goes to the lake and the boat is following it,
11 hooked up to it.
- 12 A No, sir.
- 13 Q That doesn't happen?
- 14 A My parents live on the lake in Columbia.
- 15 Q So it's your testimony you are just going to hook up
16 the boat to your truck and go to the lake?
- 17 A I wasn't able to. I hooked the boat up and drove it
18 to my house. I wasn't able to go out. So I took the
19 boat back and both times I went out it was in
20 Columbia.
- 21 Q Okay. You had the boat out in July of 2009?
- 22 A I'm really not sure as to the date. I know I've had
23 it out twice.
- 24 Q When you go see Dr. -
- 25 A I believe it was July, yes.

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1 Q When you go see Dr. Satterthwaite and see Monica
2 Speak, his nurse practitioner on those days that you
3 don't see Dr. Satterthwaite, they ask you how you are
4 doing and you are honest with them; aren't you?

5 A Yes.

6 Q What you have been doing and how your back and pain is
7 at that time, correct?

8 A Correct.

9 Q And according to records that we have -

10 MR. FARRY: APA 10 Page 291, Commissioner.

11 BY MR. FARRY:

12 Q You saw Monica Speak on July 23 of this year; does
13 that sound right?

14 A I believe that is. I'm not sure of the exact date,
15 but that sounds like it would be right.

16 Q And on that date you were honest with them as to what
17 you had been doing, how you were feeling, right?

18 A Yes.

19 Q And on that date you returned with increased back
20 pain. Your lower back was hurting more; wasn't it?

21 A Yes.

22 Q And you told the doctor that, right?

23 A I did.

24 Q And you told the doctor that over the weekend the sun
25 cover on her boat flew off and she and a friend had to

- 1 pick it up and put it in the truck. Do you remember
2 when that happened?
- 3 A I do, but that's incorrect as it's on that paper.
- 4 Q Oh, it is.
- 5 A It is.
- 6 Q The doctor didn't get it down right?
- 7 A It's - can I explain?
- 8 Q I'm asking. Did the doctor get it down right?
- 9 A No.
- 10 Q What happened? What's wrong?
- 11 A They state there that it was my boat and it wasn't.
- 12 Q You told us it's your mother's boat or your daddy's
13 boat; your parents' boat.
- 14 A I have.
- 15 Q Anything else wrong with that?
- 16 A Say it again, please?
- 17 Q I'm reading. "She recites an incident on the weekend
18 in which the sun cover on her boat flew off and she
19 and a friend had to pick it up and put it in their
20 truck. Tuesday she started having increased lower
21 back pain that radiates into her left and into her
22 buttocks."
- 23 A What's written down there as it is is not totally
24 correct. The - I did tow the boat back like I said.
25 The - it was the cushion on the top that goes across

- 1 the back of the boat. It flew off on the highway.
2 It clipped the corner of the car behind me.
- 3 Q You had to go get it?
- 4 A I did. And I went back -
- 5 Q And threw it in the back of your truck.
- 6 A No. I pulled up the highway. I had to go back on the
7 highway, come back down. I pulled up beside it.
8 Jennifer, who was with me at the time -
- 9 Q What's Jennifer's last name?
- 10 A Jennifer Hall.
- 11 Q That's your partner that you live with now?
- 12 A That's correct. She picked it up, and we leaned it up
13 against the truck. She picked it up from the ground.
14 We leaned it up against the truck. Then as it was
15 leaned up against the truck she stood on one side and
16 I stood on the other and we just pushed it up in the
17 truck. But there was wind against the tailgate.
- 18 Q The report says, "The wind blew off the cover. You
19 and a friend had to pick it up and put it in the
20 truck." That's what happened.
- 21 A The report is wrong. Like I said, that incident
22 happened but it didn't happen as she noted it.
- 23 Q Somehow they got it wrong from what you told them at
24 the time it was typed; is that what your testimony is?
- 25 A Yes.

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(803)447-0272

1 Q Okay. Now, do they have it right that after that
2 happened you had increased back pain?

3 A She also -

4 Q Answer my question and then you may explain. My
5 question is after this incident and you went to the
6 doctor and they put in this report "Tuesday started
7 having increased low back pain"; is that accurate
8 following the incident?

9 A No. I had back pain on that Tuesday. The boat
10 incident happened on Saturday.

11 Q It says on Tuesday your back started hurting worse
12 because of having to do the boat thing.

13 A It wasn't because of that.

14 MR. CHURDAR: I will object to that.

15 THE WITNESS: And I told her that.

16 MR. CHURDAR: The document speaks for itself.

17 It doesn't say that.

18 THE WITNESS: I told her and this is actually -

19 THE COURT: You are saying that there is no
20 connection. You tell me.

21 MR. FARRY: That's what I'm trying to figure
22 out.

23 THE WITNESS: Yes, I would be more than happy
24 to tell you. What happened, she was asking me why I
25 told her that on -

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1 THE COURT: Just tell what it was.

2 THE WITNESS: Tuesday, Tuesday night I was out
3 watering the flowers. I turned and that's when the -
4 that's when I had the nerve pain. Every movement
5 after that I felt a nerve when I was getting hit.

6 BY MR. FARRY:

7 Q So did the boat incident have anything to do with
8 making your back hurt worse?

9 A No. And I told her that, that this happened on
10 Tuesday and that's when it happened and how it
11 happened. I said, as a matter of fact I was going to
12 take the boat out, but I couldn't take the boat out.
13 I said even worse than that the boat cover fell off.
14 I said we had to -

15 Q Why would you tell them about a boat incident on the
16 weekend if your back. -

17 A It was came up in conversation.

18 Q Let me finish my question.

19 MR. CHURDAR: I would object to the -

20 THE COURT: I'm going to - she needs to answer
21 his questions. She can explain it. I want her to
22 explain any answer. But she needs to be responsive.
23 He has the right to answer the question. You can
24 object to any question he asks, but he has the right
25 to ask about the medical record. It's relevant, and

1 I'm going to let him ask it.

2 MR. CHURDAR: I don't have any problems with
3 that. My objection is not about that. It's that he
4 seems, in my opinion, to be cutting her off when she
5 is trying to explain her answers.

6 THE COURT: She needs to answer the question
7 and then she can explain. If he cuts her off after
8 she is answering it then I am going to stop him.

9 MR. CHURDAR: All right.

10 THE COURT: Okay. Go ahead. Fair enough?

11 MR. FARRY: Yes, ma'am.

12 THE COURT: Okay.

13 BY MR. FARRY:

14 Q Why would you tell Monica Speak or Dr. Satterthwaite
15 about a boat incident on the weekend where the cover
16 flew off, you had to stop and pick it up and put it in
17 your truck when your back started hurting on Tuesday
18 worse if the boat incident didn't have anything to do
19 with making your back hurt?

20 A It was brought up in conversation. I was trying to
21 explain to her, and I'm not sure exactly how it came
22 up. I believe it was because I said I was going to
23 take the boat out. I was like - I said I couldn't
24 even do that. She said, Have you been on the boat? I
25 said no. I said, as a matter of fact, I said,

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1 Saturday when I tried to bring it to my house the
2 boat cover came off. She goes, Well, how much did
3 that weigh? And I didn't have a clue. Then she said
4 Well - I said - she said, Well, it had to be while
5 you were picking that up. I said, No. I said, That
6 happened on Saturday. I said, As a matter of fact, we
7 both were leaning up against the truck. And I
8 explained to her as I did you we got in the truck and
9 we just - we were using it as leverage on the tailgate
10 and put it in the back of the truck. And I said, That
11 happened on a Saturday. I said, The pain that I had
12 was on Tuesday. But I brought it up because I said,
13 As a matter of fact, I couldn't even take the boat
14 out. I said, I was supposed to go boating but I
15 couldn't even do that because of the pain.

16 Q But the pain got worse Tuesday when you were watering
17 the -

18 A I said, As a matter of fact - because she was asking
19 me - like I said, it all started because she had asked
20 me if I had been out on the boat instead of as a
21 matter of fact this happened. She goes, Well, then it
22 had to have been when you picked up that cushion. I
23 said, No, it wasn't.

24 Q I'm not asking what she said. You had increased back
25 pain on Tuesday?

1 A I did.

2 Q You told the doctor that?

3 MR. CHURDAR: Your Honor, I object.

4 THE WITNESS: I know exactly when it happened.

5 THE COURT: He hasn't gotten an answer to his
6 question. I'm going to let him get the answer and
7 then she can explain. He hasn't gotten an answer. At
8 least I haven't heard one.

9 MR. FARRY: I haven't, either. I'm trying to
10 narrow it down as sharply as I can. If you need to
11 explain -

12 THE COURT: Answer the question and don't go
13 somewhere else. Answer his question.

14 BY MR. FARRY:

15 Q You had increased back pain on Tuesday?

16 A Yes.

17 Q As you told Monica Speak?

18 A Correct.

19 Q You've testified that you were watering and you
20 twisted and you felt more pain in your back?

21 A I felt it shooting down a nerve. That was - yes.

22 Q You had the boat out the weekend before the Tuesday?

23 A I didn't. I was bringing it back.

24 Q The boat was hooked up to your car and you were
25 driving down the road the weekend before the Tuesday?

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- 1 A Yes.
- 2 Q The cover falls off or flies off. You have to stop
3 and deal with that the weekend before Tuesday?
- 4 A Yes.
- 5 Q You had to pick it up and put it back in your truck?
- 6 A Yes.
- 7 Q Is it your testimony under oath today that you never
8 put that boat in the water on that weekend?
- 9 A Yes.
- 10 Q But you have since this accident hooked that boat up
11 to your truck and backed it down to the lake and put
12 it in the water?
- 13 A I have - you said I have since?
- 14 Q This accident.
- 15 A Yes. When I took it back.
- 16 Q Now, you've joined a gym over the last couple of
17 months, correct?
- 18 A I did.
- 19 Q And you have been to that gym about ten times you told
20 me in your deposition over the last four or five
21 weeks?
- 22 A Yes. Approximately, I told you.
- 23 Q Right. And you go with your partner that you live
24 with and you all go together normally?
- 25 A Correct.

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- 1 Q And you go to this gym that you have been to roughly
2 ten times in the last four or five weeks and you -
3 A It's been more than that.
4 Q Pardon?
5 A It's been more than that.
6 Q It's been more than ten times?
7 A No. It's been more - I've only been that many times
8 in a longer period.
9 Q Two months?
10 A I think it might be longer, maybe three, two -
11 Q Two to three months.
12 A Yes, sir.
13 Q Fair enough?
14 A Yes.
15 Q When you go to the gym you stay there about an hour
16 and a half?
17 A If I can, yes.
18 Q You do exercises and do things that you are able to
19 do?
20 A That I am able to do. Yes.
21 Q You go out to eat an average of one or two times a
22 week and sometimes in the afternoon?
23 A Yes.
24 Q You do that with Jennifer Hall and I think Stella's is
25 a restaurant that you like to go to?

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- 1 A Correct.
- 2 Q You drive yourself to the doctor when you have to go
3 to the doctor?
- 4 A I do.
- 5 Q You take your Titan truck, pickup truck and go to the
6 doctor?
- 7 A Yes.
- 8 Q Do errands when you have to go to the doctor?
- 9 A If I have any. Yes.
- 10 Q Go to the grocery store when you need to?
- 11 A No.
- 12 Q You don't go to the grocery store?
- 13 A Yes, when I can.
- 14 Q Right. When you can and need to you go.
- 15 A No. If I need to it doesn't always mean I can. I may
16 need to but I may be in so much pain that I can't go.
- 17 Q Occasionally you go to the grocery store to get the
18 groceries you need?
- 19 A Occasionally I go to the grocery store. Yes.
- 20 Q Okay. You do some housework as you are able?
- 21 A Correct.
- 22 Q You mentioned this anxiety you have about being in
23 small cars.
- 24 A Yes.
- 25 Q That's why I think you drive the Titan pickup truck

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1 and your partner has a Volkswagen that you don't like
2 to ride in because it's small, correct?

3 A (Indicates yes)

4 Q You mentioned a disability check that you get from the
5 state or the police officer's association. You get
6 about \$1800 a month on that disability, correct?

7 MR. CHURDAR: I would object to that -

8 THE WITNESS: Yes.

9 MR. CHURDAR: - on the grounds of relevance.

10 THE COURT: I think that goes to lump sum.

11 MR. FARRY: Absolutely.

12 THE COURT: Go ahead.

13 THE WITNESS: That's a police officer's
14 retirement -

15 BY MR. FARRY:

16 Q Disability?

17 A Yes. it is through the state.

18 Q Right. And my understanding, based on what you told
19 me in your deposition, that as long as you stay
20 disabled that check will run for life?

21 A I believe it does.

22 Q And your understanding of that policy there's a review
23 period maybe in five or seven years as to how you are
24 doing?

25 A It's actually three.

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- 1 Q Three years?
- 2 A I've told you before because I didn't know, but I
- 3 looked at it since then and it was set at three years
- 4 from my case.
- 5 Q And you've applied for social security disability but
- 6 you've been turned down?
- 7 A Correct.
- 8 Q And that decision is on appeal?
- 9 A Yes.
- 10 Q You are continuing to see Dr. David Tollison
- 11 periodically, correct?
- 12 A Yes.
- 13 Q And his nurse practitioner, I believe, is leaving the
- 14 practice?
- 15 A Yes.
- 16 Q And he is going to see you regularly as opposed to the
- 17 nurse practitioner or a new one?
- 18 A Until a replacement is hired, yes.
- 19 Q Right. Now, your first accident that your attorney
- 20 asked you about, this August '03, we had a hearing.
- 21 There was an award in January and you received an
- 22 award of 17.5 percent to your back. Does that sound
- 23 right or do you remember the amount?
- 24 A I don't recall that.
- 25 MR. FARRY: It's already in evidence,

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1 Commissioner.

2 BY MR. FARRY:

3 Q But you didn't get any award for any disability to
4 your legs or any to your upper back or neck or arm or
5 any of the other things you say you got hurt in that
6 first one; did you? Or do you remember?

7 A I don't remember.

8 Q Fair enough. Now, Dr. Satterthwaite, when he saw you
9 on July 1, 2009 you were honest with him about what
10 kind of problems you were having then?

11 A Yes.

12 Q Have you seen his July 1, 2009 report?

13 A No. I don't believe I have.

14 MR. FARRY: APA Page 41, Commissioner, and it's
15 under APA No. 3.

16 BY MR. FARRY:

17 Q Are you aware that Dr. Satterthwaite states, and I
18 will quote: "She has ongoing back and left-leg pain
19 from her previous back injury. But again, this is
20 fairly well controlled with medications."

21 Have you seen this?

22 A It was - like I said, in the immediate area right here
23 and that was it.

24 Q Okay.

25 MR. FARRY: I don't have any further questions,

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1 Commissioner.

2 THE COURT: Anything on redirect?

3 MR. CHURDAR: Yes.

4 REDIRECT EXAMINATION

5 BY MR. CHURDAR:

6 Q Kellie, when you were asked about this record of you
7 bringing the boat up, just so the Commissioner
8 understands. Was your intent to bring the boat up and
9 use it -

10 MR. FARRY: Objection to this as leading.

11 THE COURT: Sustained.

12 BY MR. CHURDAR:

13 Q What was your intent when you were bringing the boat
14 up that Saturday?

15 A I did intend to go boating.

16 Q Did you intend to go boating that day?

17 A No.

18 Q Did you intend to go boating later?

19 A Yes.

20 Q Between the time that you intended to go boating and
21 going boating did you begin to have problems with your
22 back going down into your legs?

23 A Yes.

24 Q Is that the reason you didn't go boating?

25 A Yes.

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1 Q What happened after you had those problems that you
2 referred to with regard to - how did you do? Were you
3 able to carry on as usual or were you laid up?

4 A No. I was laid up. And that was the longest period I
5 had been laid up. Usually if I had nerve pain it
6 would only last maybe a day or two. But this actually
7 lasted for about two and a half weeks.

8 Q And during that time when you were laid up did you ask
9 me to write another letter to Mr. Farry about your
10 lower back?

11 A Yes, I did.

12 Q Do you know that I did that?

13 A Yes.

14 MR. CHURDAR: And that would be a part of
15 Exhibit, I think, 7.

16 THE WITNESS: I'm just going to stand up.

17 MR. CHURDAR: Go ahead.

18 BY MR. CHURDAR:

19 Q After this July note did you end up keeping the boat
20 up here or returning it to Columbia?

21 A No. I took it back to Columbia.

22 MR. CHURDAR: I don't have any further questions.

23 THE COURT: Mr. Farry?

24 /

25 /

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RE-CROSS EXAMINATION

2 BY MR. FARRY:

3 Q When did you take the boat back to Columbia? Your
4 parent's boat, when did you take it back to Columbia?
5 Now, this July 23 visit is with Dr. Satterthwaite's
6 office, July 23, '09. That's when you talk about the
7 Tuesday additional back pain. When did you take the
8 boat back to Columbia? A week, two, three after you
9 had it up here? How long?

10 A It wasn't three weeks. I'm trying to think if it was
11 like maybe a week.

12 Q A week or two after that weekend, fair enough?

13 A Maybe a week and a half later.

14 Q A week or two after the weekend that the cover falls
15 off and you have to drive around, stop, pick it up,
16 however you pick it up?

17 A Yes.

18 Q A week or two?

19 A Yes.

20 Q How did it get back to Columbia?

21 A I think it was maybe a week and a half.

22 Q So the boat was still hooked up to your truck for that
23 week and a half?

24 A No.

25 Q So you unhooked it and then at some point you hooked

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(803)447-0272

1 it back up to your truck and drive to Columbia?

2 A Yes.

3 Q With the boat?

4 A Yes.

5 Q And you drove it because it's your truck?

6 A Yes.

7 MR. FARRY: Thank you. I don't have any further
8 questions.

9 THE COURT: Anything else?

10 MR. CHURDAR: Nothing further.

11 THE COURT: All right. Any witnesses?

12 MR. FARRY: Defendants' case.

13 THE COURT: That concludes this proceeding.

14 (The hearing concluded at 11:26 AM)

Center for Health and Occupational Services

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OUTPATIENT VISIT

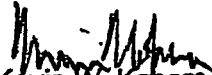
June 2007

Patient: Kellie Burnette
SSN: ~~XXXXXXXXXX~~
Date: 10/11/05

Pre

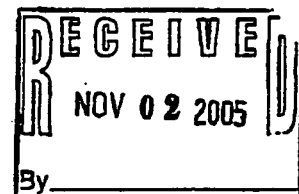
Ms. Burnette returns today for a follow up appointment and basically continues to have pain in her back area similar to prior visits. She reports that Darvocet is no longer providing the pain relief that it used to. She feels she is benefiting from Flexeril and Ambien and feels that she is benefiting from Cataflam. When I last saw Ms. Burnette on July 26th I did perform a local injection into the left upper lumbar musculature, but I am not certain that it provided any significant benefit. Since I last saw Ms. Burnette I did receive some medical records that she has been seen by Dr. Schwartz and has received treatment and I was unaware of this. It does appear that Ms. Burnette was evaluated by Dr. Schwartz on 6/21/05. He made a variety of diagnoses including a possible left L5 nerve root irritation as well as a C4-5 facet syndrome as well as myofascial pain in the thoracic region. EMG test was performed on 7/18/05 and the impression is left L5 nerve root irritation in light of a normal EMG. On 7/18/05 Ms. Burnette underwent a lumbar facet block. She would undergo a diagnostic ultrasound on 7/22/05 and would undergo a lumbar epidural steroid injection also on that day. On 8/2/05 Ms. Burnette underwent a cervical nerve block and also underwent a posterior shoulder capsule ligament injection. On 8/16/05 she underwent a second cervical nerve block and posterior shoulder ligament injection. Ms. Burnette informs me that she continues to see Dr. Schwartz. She will be seeing him in early November but is unsure of what the treatment plan is at this point. At this point I am hesitant to perform further injections on Ms. Burnette since she is receiving injections through Dr. Schwartz. I am not certain as to what my role is at this point, but I am afraid I am limited in what I can offer Ms. Burnette.

On exam she continues to have myofascial pain in the thoracic and primarily lumbar regions. I elected to continue her on Cataflam 50 mg three times daily and Ambien 10 mg at night and Flexeril 10 mg up to one per day as needed for muscle spasm. I gave her a limited supply of Tylenol with Codeine #3 to see if this more effective than Darvocet. Beyond this I am limited in what I can offer Ms. Burnette. I will see her in one month and perhaps she can update me on what Dr. Schwartz recommends in terms of further treatment. Ms. Burnette continues her regular job duties as a police officer.


Kevin W. Kopera, M.D., MPH

KWK/dn 10/18/05

C: Janie Russo, Hewitt Coleman, PO Box 5500, Greenville, SC 29606



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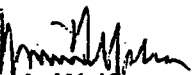
OUTPATIENT VISIT

Patient: Kelly Burnette
SSN: [REDACTED]
Date: 7/26/05

Ms. Burnette returns today for another routine appointment. She has chronic low back pain. I last saw Ms. Burnette about a month ago when she did receive a local trigger point injection and reports a very good response and pleased with how she has done. This was performed in the left lower lumbar region. She is also continuing to take Cataflam and Flexeril and occasionally takes Darvocet and feels that she is doing well on this regimen. Ms. Burnette requests another injection today. We did discuss caution in overdoing the injections but I felt that we could do another one today and then monitor her response. On exam Ms. Burnette continues to have a trigger point but this time it is in the left upper lumbar region. She otherwise appears to have functional range of motion in the spine and appears neurologically intact in the extremities with no deficits in strength or sensation.

IMPRESSION: Chronic low back pain.

PLAN: Ms. Burnette underwent another trigger point injection this time into the left upper lumbar paraspinal musculature. Sterile technique was used and Ms. Burnette tolerated the injection without difficulty. She was given new refills on Cataflam and Flexeril as well as a limited supply of Darvocet and I should also mention that she does take Ambien as well. She is given a two month supply and will be reassessed at that time.


Kevin W. Kopera, M.D., MPH

KWK/dc 7/29/05

C: Janie Russo, Hewitt Coleman, P.O. Box 5500, Greenville, SC 29606

AUG 02 2005

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OUTPATIENT VISIT

Patient: *Kellie* Kelly Burnette
SSN: ~~XXXXXXXXXX~~
Date: 6/28/05

Ms. Burnette returns today for a follow up appointment. She is being managed for chronic low back pain. Ms. Burnette presents today with continued myofascial pain in the lumbar area but even in the thoracic and cervical areas as well. She states that since she last saw me she has switched from Mobic to Cataflam with good results. She continues to take Darvocet on rare occasions. She takes Ambien frequently at night as well as Flexeril often at night as well to ensure a good sleep pattern. Ms. Burnette continues to work as a police officer and things seem to be going fairly well.

On exam today Ms. Burnette had a discrete trigger point in the left lumbar paraspinal region. She had some trigger points at other locations in the lumbar, thoracic and cervical regions but not to the same degree. Ms. Burnette is neurologically intact in the upper and lower extremities with no deficits in strength or sensation.

IMPRESSION: Chronic low back pain

PLAN: Ms. Burnette is continuing to experience chronic myofascial pain in the lumbar region. Today she inquired about anything more aggressive. I do not feel that physical therapy would result in long term relief as she has had this approach before. We discussed a local trigger point injection and elected to pursue this approach. Today an injection was performed under sterile technique using a Depo Medrol Sensocaine mixture. Ms. Burnette tolerated the injection well and her response will be reassessed in 1 month. She otherwise was continued on her medications including Cataflam and Flexeril with a limited supply of Darvocet.

Kevin W. Kopera
Kevin W. Kopera, M.D., MPH

KWK/dn 7/6/05

C: Janie Russo, Hewitt Coleman, PO Box 5500, Greenville, SC 29606

0003

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OUTPATIENT VISIT

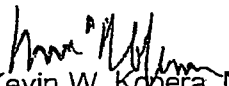
Patient: Kellie Burnette
SSN: [REDACTED]
Date: 3/28/05

Ms. Burnette returns once again for a follow up appointment. Ms. Burnette is continuing to have chief complaint of chronic low back pain. She has also had some pain in the thoracic area as well. Ms. Burnette otherwise is in good health. She continues to work her regular job duties as a police officer. She takes Ambien at nighttime and continues to require this medication. She takes Darvocet on occasion, but not regularly. We had placed her on Mobic but she has not found this to be as effective as Bextra and wishes to go back on the Bextra medication.

On physical examination today Ms. Burnette has a couple of trigger points in the upper trapezius muscles bilaterally as well as across the anterior chest bilaterally. She has her usual degree of tenderness in the lumbar area and has some discomfort with palpation over the right knee area. Palpation over other regions of the body was well tolerated. Sensation and strength are grossly intact. There is no swelling or edema evidence.

IMPRESSION: Chronic low back pain most consistent with myofascial pain

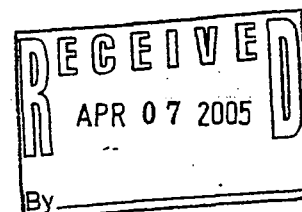
PLAN: Ms. Burdette raises the possibility that she may have fibromyalgia. She currently does not meet the definition of this diagnosis as her pain is not widespread enough but certainly she has myofascial pain and features of fibromyalgia and this was discussed with Ms. Burnette. She otherwise is stable on her medications. She still has a refill or two on Darvocet so did not require it today but required refills on Ambien and we placed her back on Bextra and discussed possible health risks of this medication. Ms. Burnette will be reassessed once again in 3 months and from my standpoint she remains medically stable.


Kevin W. Kopera, M.D., MPH

KWK/dn 3/30/05

C: Janie Russo, Hewitt Coleman, PO Box 5500, Greenville, SC 29606

0004



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OUTPATIENT VISIT

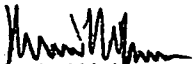
Patient: Kellie Burnette
SSN: [REDACTED]
Date: 12/28/04

Ms. Burnette returns today for routine follow up appointment. I have seen Ms. Burnette on a number of occasions for low back pain, which is chronic. Today Ms. Burnette reports and describes no new symptoms but simply continues to have low back pain. She finds the medications Bextra and Ambien to be helpful. She takes Darvocet only on rare occasions. On a positive note Ms. Burnette has been able to continue her regular job duties as a police officer and things are going fairly well in this regard. She is going to be transitioning from uniform patrol to community patrol and she feels this will help her.

On exam today Ms. Burnette has some discomfort with deep palpation in the lumbar region similar to prior visits. She demonstrates excellent ROM at the waist with no restriction. Her strength and sensation are grossly intact in the lower extremities with no obvious neurologic deficits. Gait pattern is normal. Ms. Burnette appears emotionally stable.

IMPRESSION: Chronic low back pain.

PLAN: Ms. Burnette will be continued on her medications with the exception that we did discuss the fact that Bextra has some recent health concerns as of late. I discussed this with Ms. Burnette and we elected to switch her to Mobic 15 mg daily. She otherwise continues Ambien 10 mg at nighttime and will attempt to rely less on this medication. She was given a limited supply of Darvocet to take only for when her pain is particularly severe and it would not be anticipated that she would require the medicine daily. Ms. Burnette remains at maximum medical improvement as previously stated and I will reassess her once again in 3 months for continued medication management.


Kevin W. Kopera, M.D., MPH

KWK/dn 1/6/05

C: Janie Russo, Hewitt Coleman, PO Box 5500, Greenville, SC 29606

0005

JAN 06 2005

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OUTPATIENT VISIT

NAME: Kellie Burnette
SSN: [REDACTED]
DATE: 8/19/04

Ms. Burnette returns today for a follow-up appointment. She has been seen in the past for low back pain. Ms. Burnette recently has failed to respond to the medication Vioxx. She has been taking Darvocet for pain management. Ms. Burnette continues to focus on low back pain and is not describing any radicular symptoms. On physical examination today Ms. Burnette actually tolerates palpation over the lumbar area well without any significant discomfort. She actually demonstrates excellent range of motion at the waist in all directions without any apparent discomfort but yet Ms. Burnette does rate her pain currently as 7 on a 0-10 but does appear comfortable. She does report a fairly high level of pain but does not demonstrate much pain behavior.

IMPRESSION: Chronic low back pain.

PLAN: Ms. Burnette and I reviewed her condition once again. We spent time reviewing her prior diagnostic studies and prior treatment. Today I elected to place Ms. Burnette on a final trial of anti-inflammatory medication specifically placing her on Bextra 20 mg daily. I did give her a refill on the medication Darvocet but indicated to her that I did not anticipate her continuing this on a long term basis. Ms. Burnette also emphasized difficulty sleeping and I gave her a limited supply of Ambien to try for this and hopefully this will help her re-establish her sleep pattern. Beyond this I am afraid I am limited in what I can offer Ms. Burnette and discussed this with her. Unfortunately there does appear to be some permanency to her condition. At this point I feel that Ms. Burnette has reached maximum medical improvement as it relates to the work injury specifically the motor vehicle accident occurring in August of last year. Ms. Burnette's condition falls into *Lumbar Category II as defined in the AMA Guides to the Evaluation of Permanent Impairment, 5th Edition*, and in Ms. Burnette's case this correlates to a 5% permanent impairment to the spine. I would not place her on any specific work restrictions at this time.


Kevin W. Koper, M.D., MPH

KWK/dc

C: Wes Meriweather, M.D., 131 Commonwealth Drive, Suite 200, Greenville, SC 29615
Janie Russo, Hewitt Coleman, P.O. Box 5500, Greenville, SC 29606

0006

Center for Health and Occupational Services

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OUTPATIENT EVALUATION

Patient: Kellie Burnette

SSN: [REDACTED]

Date: 6/21/04

Ms. Burnette is a 24 year old woman that presents today for evaluation and treatment of low back pain, which has become chronic. Ms. Burnette is status post a motor vehicle accident that occurred during her job duties as police officer. This occurred on 8/23/03. Ms. Burnette was at a stop and apparently a suspect was fleeing and broad-sided Ms. Burnette's vehicle at a high rate of speed. Ms. Burnette had a number of injuries including a fractured nose, which later required surgical intervention for which she has recovered fully. She also had injuries to her upper extremities and her knees but with time these would improve. Ms. Burnette's low back pain did persist. She recalls being treated at the Work Well Program and received about 2 months of physical therapy but her symptoms have unfortunately persisted. She did go a period of time without medical intervention but more recently has sought further treatment. MRI imaging was obtained of the lumbar spine on 5/11/04. The MRI scan is available for review today and upon my review I would consider it to be normal. Ms. Burnette also recalls being given medicines such as Ultram, Ultracet, and Lortab without much benefit. Currently, she is taking Darvocet in the evening with some benefit. Ms. Burnette has also taken Naprosyn and Ibuprofen with some results.

In terms of current symptoms, Ms. Burnette emphasizes having continuous low back pain. The pain increases towards the latter part of the day or her work shift. Also the pain is notable with prolonged standing or sitting. Ms. Burnette emphasizes having good mobility and strength. She continues to do exercises instructed to her through physical therapy. She denies symptoms in either lower extremity including denying any weakness or numbness. Ms. Burnette describes some tightness in the lumbar region and these are her main symptoms.

PAST MEDICAL HISTORY: Ms. Burnette is in good health. She reports having some seasonal allergies but denies any medication allergies. Ms. Burnette denies any other significant past medical history.

REVIEW OF SYSTEMS: Review of systems is negative. Ms. Burnette denies any fevers of unexplained weight loss. She is not describing any conditions of significance affecting the eyes, ears, nose, throat, heart, stomach, lungs, liver or kidneys.

SOCIAL HISTORY: Ms. Burnette has worked as a police officer for 3 years. She has been able to continue her regular work activities. Ms. Burnette is a non-smoker. She is single.

PHYSICAL EXAMINATION: Ms. Burnette is alert, friendly and cooperative during today's assessment. She displays a normal affect. Ms. Burnette is 5'10" in height and weighs 200 lbs. Ms. Burnette's blood pressure is 144/74 with a heart rate of 82. Ms. Burnette did not place a rating on her pain today. Ms. Burnette tolerates palpation over the lumbar region well without significant pain. This includes palpation over the lumbar area and sacrum and adjacent soft tissues. Ms. Burnette also demonstrates good flexibility at the waist with only some restriction in terms of lumbar extension. Ms. Burnette demonstrates good muscle strength in both lower extremities with no weakness identified. Sensation is intact throughout both lower extremities as well. Patella and ankle reflexes appear to be intact and symmetrical bilaterally. Straight leg raise testing is negative bilaterally. Faber testing is

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Kellie Burnette
6/21/04

Page 2

also negative bilaterally. Ms. Burnette is able to stand on one leg without difficulty and is able to perform a squat without difficulty as well.

IMPRESSION: Chronic low back pain most consistent with myofascial pain.

PLAN: Ms. Burnette and I reviewed her condition. She is neurologically intact and nerve tension signs are absent. Review of MRI imaging clearly reveals there is no evidence of a surgical lesion and this was all discussed with Ms. Burnette. As part of her job duties she does wear a significant amount of equipment on her uniform and the belt that she wears probably weighs approximately 25 lbs and this may be contributing some to Ms. Burnette's symptoms. I do not feel that she was appropriate for an injection today and she seems well versed in appropriate exercises. Today I elected to have another trial of anti-inflammatory medication for Ms. Burnette and I elected to give her the medication Vioxx, which she will take daily. If it is not affective she will contact the office. Ms. Burnette may continue her regular activities in the interim and I will reassess her in about 2 months and at that point she may be approaching maximum medical improvement as it relates to her work injury.


Kevin W. Kopera, M.D., MPH

KWK/dn 6/28/04

C: Wes Merriwether, M.D., 131 Commonwealth Drive, Ste 200, Greenville, SC 29615
Janie Russo, Hewitt Coleman, PO Box 5500, Greenville, SC 29606

0008

**QUESTIONNAIRE REGARDING
KELLIE N. BURNETTE**

TO: Robert G. Schwartz, M.D.
RE: Patient: Kellie N. Burnette
ID: ~~REDACTED~~
DOB: ~~REDACTED~~

Please answer the questions below to a reasonable degree of medical certainty.

PERMANENT IMPAIRMENT.

1. Has Kellie N. Burnette reached MMI with respect to injuries sustained in an automobile accident on August 23, 2003? ☒ Yes ☐ No
2. If so, has Ms. Burnette sustained permanent impairment as a result of the accident?
☒ Yes ☐ No
3. If so, what is the permanent impairment sustained by Ms. Burnette, e.g. what percentage to what body part? 15% SPINE (8% LUMBAR 5% CERVICAL)

FUTURE MEDICAL TREATMENT

1. Does Ms. Burnette need future medical treatment to maintain her current level of impairment and to lessen her period of disability? ☒ Yes ☐ No
2. If so, what treatment does Ms. Burnette need and at approximately what intervals?

Intermittent PO meds + injection
may be necessary

Date: 8/23/05Robert G. Schwartz, M.D.

0010

BURNETTE, KELLIE

#22896

DATE: 8/16/05

She is about 30 percent improved in her neck and shoulder. She is not yet able to isolate the rectus abdominis. I re-instructed in the same.

CERVICAL PARAVERTEBRAL NERVE BLOCK: The patient was notified of potential complications. Using a clean technique and a direct PA trajectory, the skin was pierced one fingerbreadth lateral to the midline with a 1½-inch needle. The needle was advanced down to the bone and repositioned laterally until symptoms in the region of the right C3/4 level were reproduced. One-half cc of 1% Xylocaine with 1 ggt of sodium morrhuate was injected. The patient was in the seated position and tolerated the procedure well.

POSTERIOR SHOULDER CAPSULE LIGAMENT INJECTION: The patient was notified of potential complications. Using a clean technique, 2 cc of 1% Xylocaine with 1 ggt of sodium morrhuate was injected into the right posterior shoulder capsule ligament via the posterior approach with the patient in the seated position. The patient tolerated the procedure well. Therapeutic modality application followed.

R2W.

RGS/lo/pms

0011

BURNETTE, KELLIE

#22896

DATE: 7/18/05

EMG result reviewed. The Biodex study has not yet been scheduled. Diagnostic ultrasound of the multifidus and related paraspinal soft tissues as well as right shoulder ordered.

LUMBAR FACET REGION (MEDIAL BRANCH/POST. RAMI BRANCH) BLOCK: The patient was notified of potential complications. Using a clean technique and a posteromedial trajectory, the skin was pierced three fingerbreadths lateral to the midline with a 3-inch needle. The needle was advanced down to the bone and walked superiorly until symptoms in the region of the left L5/S1 facet were reproduced. Two cc of 1% Xylocaine was injected. The patient was in the prone position and tolerated the procedure well.

RGS/lo *pm5*

BURNETTE, KELLIE

#22896

DATE: 8/2/05

She does not have that much additional gain in her back. Her Biodex study shows quite weak flexors. Muscle re-education with a myofascial release technique was performed, with emphasis on correcting the rectus abdominis.

CERVICAL PARAVERTEBRAL NERVE BLOCK: The patient was notified of potential complications. Using a clean technique and a direct PA trajectory, the skin was pierced one fingerbreadth lateral to the midline with a 1½-inch needle. The needle was advanced down to the bone and repositioned laterally until symptoms in the region of the right C3/4 level were reproduced. One-half cc of 1% Xylocaine with 1 ggt of sodium morrhuate was injected. The patient was in the seated position and tolerated the procedure well.

POSTERIOR SHOULDER CAPSULE LIGAMENT INJECTION: The patient was notified of potential complications. Using a clean technique, 2 cc of 1% Xylocaine with 1 ggt of sodium morrhuate was injected into the right posterior shoulder capsule ligament via the posterior approach with the patient in the seated position. The patient tolerated the procedure well. Therapeutic modality application followed.

R2W.

RGS/lo *pm5*

0012

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Robert G. Schwartz, M.D.

BURNETTE, KELLIE

#22896

DATE: 6/21/05

Ms. Burnette is a 25-year old female with a chief complaint of thoracolumbar pain, followed by low back pain and then neck pain, followed by interscapular pain. Symptoms began 8/23/03 after a broadside MVA that occurred while at work. She denies weakness, but says she gets numbness of her left hand. She complains of difficulty sleeping, but has been taking Ambien and is fatigued because of the same. She complains of increased frequency, though has no bowel and bladder incontinence. Symptoms do increase with Valsalva. Apparently, in 1997, she had difficulty with her right shoulder and was treated by Dr. Giambalvo with physical therapy. She has recently been told that she has carpal tunnel syndrome of her right wrist and was placed on Cataflam by Dr. Giambalvo. She questions whether or not she has fibromyalgia. She ranks her pain a 7/10. She has been seen by Dr. Kopera primarily. An MRI done earlier this year was apparently normal, with a possible bulge. She has had medications by mouth and physical therapy.

PMH: Positive for ADHD. She has had a remote left wrist fracture.

SH: She is single. She drinks occasionally, but does not smoke. She works for the City of Greenville as a police officer full-time.

PE: Heart rate and regularity, respiratory rate, and weight are recorded on the physical assessment sheet in the chart. General appearance is within acceptable norms for nutrition and grooming. Orientation to person, time, and place is intact. Overt signs of depression, anxiety, or agitation are not present during today's examination.

Musculoskeletal examination of the head, neck, spine, ribs, pelvis, and bilateral upper and lower extremities was performed. There are no abnormally palpable lymph nodes in the neck or groin. There are no rashes, ulcers, or abnormally palpable scars. There is no evidence of misalignment, asymmetry, crepitation, defects, tenderness, or effusions in the peripheral joints. Coordination for finger to nose, heel to shin, and rapid alternating movements is normal. Gait and station are normal. Peripheral pulses are intact. There is no evidence of ulceration or trophic change.

Reflexes are symmetric. Motor strength and tone are normal. Sensation is intact to pinprick. Phalen's is positive on right, with Tinel's negative. Spurling's reproduces pain ipsilaterally bilaterally. She has spasm at C4/5, in the scalene on right, and in the trapezius on left. There is a trigger point at T6/7 and T12 on right. There is no obvious change in lordosis or paraspinal spasm. She fatigues with toe walking on left. Straight leg raising, Bragard's, Fabere's and SI stretch tests are negative, with bowstring positive on left and reverse straight leg raising positive on right and crossed to left. She has palpable spasm at L5, left more predominant than right.

0018

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Robert G. Schwartz, M.D.

NAME: KELIE N BURNETT

AGE: 25

HISTORY OF PRESENT ILLNESS:

0023

1. WHERE DO YOU HURT? LOWER BACK, MIDDLE BACK, UPPER BACK (MUSCLES)

2. HOW WOULD YOU DESCRIBE THE PAIN (SHARP, SHOOTING, DULL, ACHY, CRAMPING, ETC.?)

LOWER BACK - CONSTANT PRESSURE, ACHY, SOMETIMES SHARP

MIDDLE BACK - CONSTANT PRESSURE, ACHY, MIDDLE & UPPER BACK MUSCLE - SHARP

3. WHAT DATE DID IT START? (COMPLETE EVEN IF PAIN IS NOT YOUR PRIMARY COMPLAINT) AFTER MVA 8-23-03

4. WHAT CAUSED IT TO START (CAR WRECK, WORK INJURY, SPORTS INJURY, DON'T KNOW, ETC.?)

MOTOR VEHICLE COLLISION

THROWN

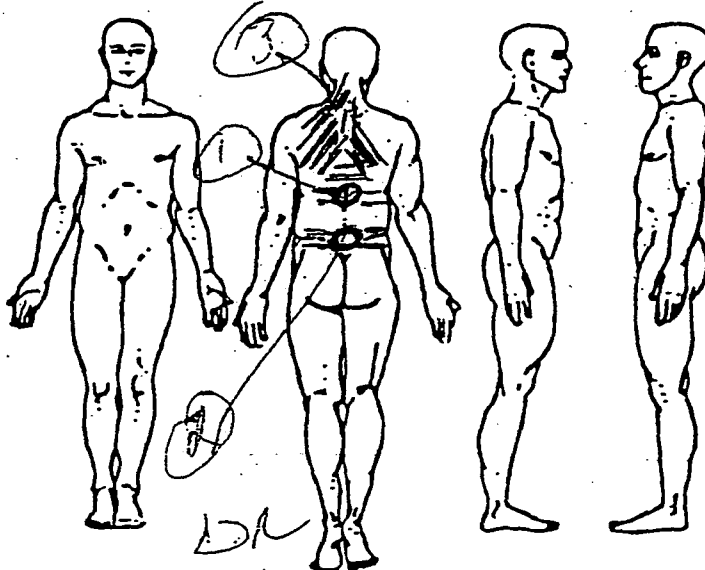
5. IF YOU WERE IN A CAR WRECK: (A) WERE YOU THE DRIVER OR PASSENGER? DRIVER

(B) DID YOU HAVE ON A SEATBELT? YES (C) HOW FAST WERE BOTH CARS TRAVELING? 67 MPH / BACK

(D) HOW MUCH VISIBLE DAMAGE WAS THERE TO YOUR CAR? EXTENSIVE - TOTALLED; EXTRACTED

(E) WHAT DID IT COST TO FIX THE CAR? N/A

6. PLEASE MARK ON THE DRAWINGS BELOW THE AREAS WHERE YOU FEEL PAIN.



As the car
crash
vertical

(NORTH)
EAST

DR
CC
CC
CC

B. 1. DO YOU HAVE ANY WEAKNESS IN PARTS OF YOUR BODY? NO WHERE? _____

2. DO YOU HAVE ANY NUMBNESS (pins & needles or cold feelings) IN PARTS OF YOUR BODY?
WHERE? NO Shoulder/Arm 6-10

3. PLEASE CHECK WHICH OF THESE SYMPTOMS, IF ANY, YOU HAVE NOTICED ASSOCIATED WITH YOUR PAIN:

____ EARS RINGING
____ BLURRED VISION
____ TROUBLE SWALLOWING
X CHRONIC FATIGUE

____ CONGESTION
____ TROUBLE SLEEPING
OTHER HEIGHTENED SENSITIVITY TO SMELL AS WELL AS SIGHT

4. DO YOU HAVE ANY PROBLEM WITH LOSS OF BOWEL OR BLADDER CONTROL? NO; URINATION MORE FREQUENTLY

5. HAVE YOU EVER HAD A PAIN IN THE PAST IN THE SAME PART OF YOUR BODY? SHOULDER (RIGHT)
CAUSED BY TENSE MUSCLE D.T. - of shoulder. '97

6. DOES YOUR PAIN INCREASE IF YOU COUGH OR SNEEZE? YES

7. DOES THE WEATHER OR TEMPERATURE AFFECT YOUR PAIN? YES No questions

8. DO YOU ALWAYS HAVE COLD HANDS OR FEET? NO AMS

C. 1. WHAT MAKES THE PAIN BETTER? NOTHING

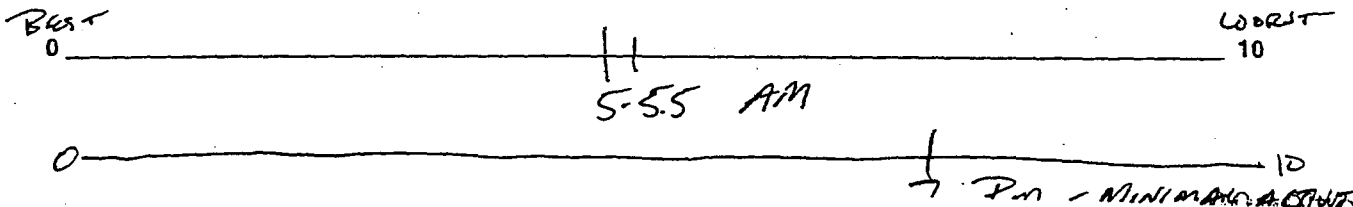
2. WHAT MAKES IT WORSE? PAINING, BENDING, WALKING/RUNNING FOR A PERIOD OF TIME, CARRYING A BACKPACK, SITTING FOR AN EXTENDED PERIOD OF TIME

3. HOW MANY MINUTES CAN YOU SIT UNTIL YOU MUST STAND? 30-45

4. HOW MANY MINUTES CAN YOU STAND UNTIL YOU MUST SIT? 30-45

D. MARK ON THE LINE BELOW YOUR ESTIMATE OF YOUR AVERAGE PAIN:

0024



E. 1. PLEASE NAME ANY DOCTORS YOU HAVE SEEN FOR YOUR PAIN SO FAR. DR. KEVIN KOPELA

2. WHAT TEST HAVE THEY DONE (BLOOD TEST, XRAYs, CT SCANS, BONESCAN, MYELOGRAM, EMG, MRI)?

MRI 11/07

3. WHERE WERE THESE TEST DONE? HEALTH SOUTH D. AGNOSTICS

4. WERE ANY OF THEM ABNORMAL? NO IN WHAT WAY? SLIGHT BULGING DISC - NOT ABNORMAL HOWEVER - W/IN LIMITS

5. HAVE YOU EVER HAD FREQUENT OR SEVERE INFECTIONS? NO

6. DO YOU HAVE A PERSONAL OR FAMILY HISTORY OF ANY BLEEDING, BRUSING OR CLOTTING DISORDERS?

NO

7. HAVE YOU HAD ANY UNUSUAL ENVIRONMENTAL EXPOSURES? YES METHAMPHETAMINE CAR

8. HAVE YOU EVER TAKEN AN MMPI?

F. 1. WHAT MEDICINE HAVE YOU TAKEN FOR THE PAIN IN THE PAST? REXTRA, VIXX, MOBIC,

DARVOCE, DEMEROL, AMBIEN, FLEXERIL

2. WHAT PAIN MEDICINES ARE YOU TAKING NOW?

NAME	DOSAGE	FREQUENCY	DATE STARTED
DARVOCE		1-2 TIMES DAY	8-28-03
MOBIC		1 DAY	3-05
AMBIEN	10mg	1 @ NIGHT	2004
EFFEXOR	75mg	1 DAY	2000
ZYRTEC	10mg	1 DAY	2000
RHINO COR		1 DAY	2000
FLEXERIL	10mg	1 DAY	2005
CATAFLAM	50mg	3 DAY	2005

3. HAVE YOU EVER HAD ANY SURGERY FOR YOUR PAIN? NO WHAT KIND? N/A

4. WHAT OTHER KIND OF TREATMENT (PHYSICAL THERAPY, CHIROPRACTIC, HYPNOSIS, INJECTIONS, ETC.) HAVE YOU TRIED FOR YOUR PAIN? PHYSICAL THERAPY

0025

PHYSICIAN'S STATEMENT

TO: John Satterthwaite, MD

RE: Kellie Burnette

DOB:

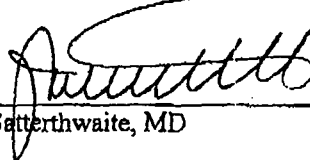
Chart No.: 18381

Our office began treating Kellie Burnette in August 2007 for persistent back and neck pain. We received an old MRI dated May 11, 2004 showing minimal disk bulge at L4-5 and L5-S1 without stenosis. Ms. Burnette had been in an accident on June 16, 2007 and complained of increased lower back pain and radiculopathy symptoms. Accordingly, our office ordered a new MRI on December 13, 2007, and the MRI was completed on January 7, 2008. The new MRI showed some central disk protrusion at L5-S1. On March 13, 2008, our office indicated a referral to Steadman Hawkins for evaluation. To my knowledge, that evaluation has never taken place.

I have diagnosed Ms. Burnette with L5-S1 disk protrusion with radiculopathy down into the upper buttocks and legs. I have treated her with a variety of medications and epidural steroid injections. I still believe she should be seen by an orthopaedic surgeon or neurosurgeon to determine whether she is a surgical candidate. It is my opinion to a reasonable degree of medical certainty that her injury on June 16, 2007 exacerbated a prior lumbar spine injury or caused new injury.

8/17/09

Date


John Satterthwaite, MD

*One month
after boat
lover*

AUG 17/2009/MON 08:45 AM
08/12/2009 15:52 8642333028

FAX No.
DOUGLAS A CHURDAR

P.003
PAGE 03/04

Carolinas Center for Advanced Management of Pain
1330 Boiling Springs Rd Suite 2700 Spartanburg, SC 29303
8645830053 Fax: 8645830390

June 12, 2009
Page 3
Chart Document

MS KELLIE BURNETTE

Female DOB: ~~XXXXXX~~

18381

Home: ~~XXXXXXXXXX~~

Ins: VOC REHAB

Assessed MYOFASCIAL PAIN SYNDROME as unchanged - Kimberly Parker FNPC - Signed
Assessed SPONDYLOSIS - LUMBOSACRAL as unchanged - Kimberly Parker FNPC - Signed
Assessed CERVICALGIA as unchanged - Kimberly Parker FNPC - Signed
Assessed Z-JOINT SYNDROME as unchanged - Kimberly Parker FNPC - Signed
Assessed LUMBAR RADICULOPATHY as unchanged - Kimberly Parker FNPC - Signed

Plan

noting spasms-will refer to physical therapy to help with this and also ROM/strengthening
ESI has worn off-did help with back and leg pain-will schedule for another one L5-S1
reviewed MRI-does have HNP L5-S1 would like to see surgeon-will refer to Steadman Hawkins for
evaluation

Still awaiting approval for treatment of neck-when approved will order the x-rays and determine further
treatment from that

unable to continue working in current capacity-must have sedenatary job with ability to get up and stretch
every hour with limited bending/pushing/pulling-see restriction sheet
Continue current pain management program. taking meds as prescribed and they are helpful-RF given
FU for ESI, call with problems

New Prescriptions/Refills:

LORTAB 10 10-500 MG TABS (HYDROCODONE-ACETAMINOPHEN) 1 po qid prn pain max of 4 per
day *** 30 DAY SUPPLY *** NO EARLY REFILLS #120 x 0, 03/13/2008, Kimberly Parker FNPC

Current Medication List:

LORTAB 10 10-500 MG TABS (HYDROCODONE-ACETAMINOPHEN) 1 po qid prn pain max of 4 per
day *** 30 DAY SUPPLY *** NO EARLY REFILLS
BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm
AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) 1 qhs prn sleep
CELEBREX 200 MG CAPS (CELECOXIB) take one PO BID
FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 HS
CYMBALTA 30 MG CPEP (DULOXETINE HCL) 4 po qhs
LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12
hours and remove for 12 hours.
ADDERALL 20 MG TABS (AMPHETAMINE-DEXTROAMPHETAMINE) bid - Dr Giambalvo
ZYRTEC 10 MG TABS (CETIRIZINE HCL) 1 po qhs other MD

New Orders:

Referral to Orthopaedist [XXXXX]
Return for Epidural Steroid Injection [XXXXX]
Physical Therapy Referral [XXXXX]

Prescriptions:

LORTAB 10 10-500 MG TABS (HYDROCODONE-ACETAMINOPHEN) 1 po qid prn pain max of 4 per
day *** 30 DAY SUPPLY *** NO EARLY REFILLS #120 x 0

Entered by: Kimberly Parker FNPC
Authorized by: John Satterthwaite MD
Signed by: Kimberly Parker FNPC on 03/13/2008
Method used: Print then Give to Patient
RxD: 1521039228401010

0029

AUG 17/2009/MON 08:46 AM
08/12/2009 15:52 8642333020

FAX No.
DOUGLAS A CHURDAR

P. 004
PAGE 84/84

Carolinas Center for Advanced Management of Pain
1330 Bolling Springs Rd Suite 2700 Spartanburg, SC 29303
8645830053 Fax: 8645630390

June 12, 2009
Page 3
Chart Document

MS KELLIE BURNETTE

Female DOB: ~~XXXXXX~~

18381

Home: ~~XXXXXXXXXX~~
Ins: VOC REHAB

Comments: RLE laterally above knee, medially below knee

Assessment

Status of Existing Problems:

Assessed CERVICAL SPONDYLOSIS as unchanged - Kimberly Parker FNPC - Signed
Assessed THORACIC SPONDYLOSIS as unchanged - Kimberly Parker FNPC - Signed
Assessed MYOFASCIAL PAIN SYNDROME as unchanged - Kimberly Parker FNPC - Signed
Assessed SPONDYLOSIS - LUMBOSACRAL as unchanged - Kimberly Parker FNPC - Signed
Assessed Z-JOINT SYNDROME as unchanged - Kimberly Parker FNPC - Signed

New Problems:

LOW BACK PAIN SYNDROME (ICD-724.2)

Plan

continue use of R/S medical as this is helpful

reviewed and discussed last lumbar MRI was 5/4 and had disc bulges L4-L5 and L5-S1 at that time
noting back pain with RLE paresthesia-needs new lumbar MRI-ordered

Continue current pain management program. taking meds as prescribed and they are helpful-RF given

consider lumbar ESI

noting some break thru pain every other day-has had ultram without problems

will give ultram 50mg 1 po qd prn break thru pain. Advised of type medication, how to take, and side effects. To call with any problems, concerns, or side effects.

Reminded to bring all unused medications into appointments

noting fatigue and weight gain-will see Giambalvo about this for labs-if labs are normal consider changing off cymbalta

FU 1 month

call with problems

New Prescriptions/Refills:

ULTRAM 50 MG TABS (TRAMADOL HCL) 1 po QD prn break thru pain #30 x 0 : Kimberly Parker FNPC
(12/13/2007)

Current Medication List:

ULTRAM 50 MG TABS (TRAMADOL HCL) 1 po QD prn break thru pain

ULTRAM ER 300 MG TB24 (TRAMADOL HCL) Take one in the morning with food PRN for pain.

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm

AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) 1 qhs prn sleep

CELEBREX 200 MG CAPS (CELECOXIB) take one PO BID

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 po tid pm muscle spasm

CYMBALTA 30 MG CPEP (DULOXETINE HCL) 4 po qhs

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours.

ADDERALL 20 MG TABS (AMPHETAMINE-DEXTROAMPHETAMINE) bid - Dr Giambalvo

ZYRTEC 10 MG TABS (CETIRIZINE HCL) 1 po qhs other MD

New Orders:

Expanded [99213]

Return for follow-up 1 month [xxxxx]

MRI, lumbar spine, w/o contrast [CPT-72148]

0030

MEDICAL OPINION RE: ABILITY TO DO WORK-RELATED ACTIVITIES
(PHYSICAL)NAME: **KELLIE BURNETTE** SSN: ~~62-24-2222~~

To determine your patient's ability to do *work-related activities on a day-to-day basis in a regular work setting*, please give us your opinion – based on your examination – of how your patient's physical capabilities are affected by the impairment(s).

1. Maximum ability to lift and carry on an *occasional* basis (no more than 1/3 of an 8-hour day).
☐ No limitation ☐ 100# ☐ 50# ☐ 20# ☒ 15 ☐ 10# ☐ less than 10#
2. Maximum ability to lift and carry on a *frequent* basis (1/3 to 2/3 of an 8-hour day).
☐ No limitation ☐ 50# ☐ 25# ☐ 10# ☒ less than 10#
3. Maximum ability to stand and walk (with normal breaks) during an 8-hour day.
☐ No limit ☐ about 6hrs ☐ about 4hrs ☐ about 3hrs ☐ about 2hrs ☒ less than 2hrs
4. Maximum ability to sit (with normal breaks) during an 8-hour day.
☐ No limit ☐ about 6hrs ☐ about 4hrs ☐ about 3hrs ☐ about 2hrs ☒ less than 2hrs
5. If your patient must periodically alternate sitting, standing or walking to relieve discomfort:

How long can your patient *sit* before changing position

0 5 10 15 20 30 45 60 90
Minutes

How long can your patient *stand* before changing position

0 5 10 15 20 30 45 60 90
Minutes

How *often* must your patient *walk around*!

0 5 10 15 20 30 45 60 90
Minutes

How *long* must your patient *walk each time*! Duration:

0 5 10 15 20 30 45 60 90
Minutes

Does your patient need to opportunity to shift *at will* from sitting or standing/walking?

☒ Yes ☐ No

0031

6. Will your patient sometimes need to lie down at unpredictable intervals during a work shift?

☒ Yes ☐ No

If yes, how often do you think this will happen? DAILY

7. What medical findings support the limitations described above?

See medical record

8. How often can your patient perform the following *postural activities*?

	*Frequently	**Occasionally	Never
Twist			☒
Stoop (bend)			☒
Crouch			☒
Climb stairs		☒	
Climb ladders			☒

*Frequently: from one-third to two-thirds of an eight hour day

**Occasionally: from very little up to one-third of an eight hour day

9. How much can be the patient:

	Seldom	Occasionally	Frequently	Constantly
Reach (including overhead)	☒			
Handle (gross manipulation)		☒		
Finger (fine manipulation)		☒		
Feel			☒	
Push/pull	☒			

- A. How are these physical functions affected? Increased pain and weakness

- B. What medical findings support this? See chart

10. State any other work-related activities which are affected by the impairment such as need for assistive device for ambulation need to elevate leg, limits on kneeling, crawling, balancing, seeing, hearing or speaking, or limitations related to a mental impairment. What medical findings support this?

No kneeling, crawling, balancing, unprotected heights

11. On the average, how often do you anticipate that your patient's impairments or treatment would cause your patient to be absent from work?
- ☐ Never ☐ About once a month ☒ About three times a month
☐ Less than once a month ☐ About twice a month ☐ More than three times a month
12. How significant is the pain in the treatment of this patient? (CIRCLE ONE LETTER)
- A) Pain is not present to any appreciable degree.
- B) Pain is present, but does not prevent this individual from functioning in everyday activities or work.
- ☒ C) Pain is present to such an extent as to be distracting to adequate performance of daily activities or work.
- D) Pain is profound and intractable; it virtually incapacitates this individual.
13. To what extent will such physical activity as walking, standing, bending, stooping, movement of extremities, etc. increase the degree of pain experienced by this patient? (CIRCLE ONE LETTER)
- A) No increase in the level of pain whatsoever.
- B) Some increase may occur but not to such an extent as to prevent adequate functioning in such tasks.
- ☒ C) Greatly increased pain is likely to occur, and to such a degree as to cause distraction from the task or even total abandonment of the task.
- D) Increase of pain to such a degree as to require increased medication for pain and substantial amounts of bed rest.

THE ABOVE OPTIONS ARE HELD WITH A REASONABLE DEGREE OF CERTAINTY BASED ON GENERALLY ACCEPTED STANDARDS IN MY PROFESSION.

Hammett

7/29/09

V In your best judgment, what are the long-term prospects of recovery for this patient in regard to level of pain? (Circle one letter)

- a) This individual should be free of pain within a matter of weeks or months.
- b) The frequency and degree of pain should diminish to an insignificant level in time, but may still be present to some extent.
- ☒ c) Although the level of pain may be less intense or less frequent in the future, it will still remain a significant element in this individual's life.
- d) Little improvement is likely in this case; in fact, the pain is likely to increase with time.

VI To what extent have treatments for pain (e.g. biofeedback, nerve stimulation, injections) served to lessen the degree of pain individuals with pain levels like those experienced by this patient? (Circle one letter)

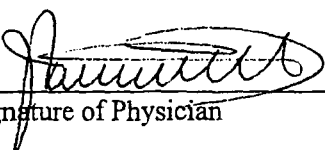
- a) Treatments of this type have not been prescribed for individuals with problems like those of this patient.
- b) Such treatments have been used successfully in cases like this one.
- ☒ c) Treatments of this kind have had no appreciable impact or have only briefly altered the level of pain that this patient experiences.

Comments:

To maintain current level of functioning,
ongoing medication management will be necessary.
Could do sedentary work.

6/22/09

Date


Signature of Physician

0035

**WORKERS COMPENSATION QUESTIONNAIRE REGARDING
KELLIE BURNETTE**

TO: John Satterthwaite, M.D.
FROM: Douglas A. Churdar (Attorney for Kellie Burnette)
RE: Kellie Burnette
SS #: [REDACTED]
DOB: [REDACTED]

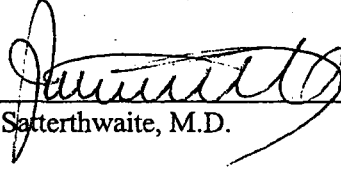
See the attached questionnaire dated 4/15/08. Since that questionnaire was completed, Kellie Burnette was diagnosed by David Mitchell, M.D. and Michael Bucci, M.D. with cervical stenosis and cord compression at C5-6, and Dr. Bucci performed a discectomy and fusion on 10/27/08.

Please answer the following questions to a reasonable degree of medical certainty.

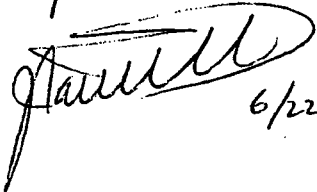
1. Did Ms. Burnette's accident on 6/16/07 increase her pain level?
☒ Yes ☐ No
2. Did Ms. Burnette's injury of 6/16/07 cause her anxiety and depression so that she needed/needs treatment/therapy?
☒ Yes ☐ No
3. As of today, has Ms. Burnette reached maximum medical improvement with regard to injuries sustained on 6/16/07 and for which you are treating her?
☒ Yes ☐ No
4. Otherwise, do you reaffirm your answers to the attached questionnaire?
☒ Yes ☐ No

If these are your opinions to a reasonable degree of medical certainty, please sign below.

Date: 6/22/09

By: 
John Satterthwaite, M.D.

Based on The AMA Guides - 5th Edition DRE IV
she has a 25% whole person impairment which translates
to a 72% impairment to the cervical spine.


6/22/09

Carolinas Center for Advanced Management of Pain
1330 Boiling Springs Rd Suite 2700 Spartanburg, SC 29303
8645830053 Fax: 8645830390

July 13, 2009
Page 1
Chart Document

MS KELLIE BURNETTE

Female DOB: [REDACTED]

18381

Home: [REDACTED]
Ins: VOC REHAB

07/01/2009 - Office Visit: MMI and Rating

Provider: John Satterthwaite MD

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

Follow-Up Visit

Chief Complaint: Neck and back pain

History of Present Illness: Ongoing neck and back pain

Doing well with medications.

Joined a health club and is exercising there and considering using the pool.

Getting massages.

She is continuing with neck pain and some right shoulder and upper arm pain, as well as occasional tingling in the right fingertips. She has recovered nicely from her cervical disc surgery. Her pain complaints continue, but are stable on medications. She also has ongoing back and left leg pain from her previous back injury, but again, this is fairly well-controlled with medications.

She remains active within her limitations. Activity related pain is the major problem. She has joined a health club and has begun to do some exercising and is also getting ready to do some exercising in the pool, which I have strongly encouraged.

Otherwise, she has no new complaints. She remains compliant with her medications.

Location Of Pain: Neck and left arm to the palm

Back and right leg

Description Of Pain: Numbness, Sharp, Aching, Burning, Electric/Shooting

Pain Rating: 6

Activity: Increased

Did Medications Help? Yes

Is the patient taking any new medications? No

Does the patient have any new medical or surgical problems? No

New Problems:

POSTLAMINECTOMY SYNDROME - CERVICAL (ICD-722.81)

Is the patient experiencing increased sadness, anxiety, or family problems? No

Past, Family, and Social History

Past History: Depression, ADHD, osteoarthritis, torn left medial meniscus

Surgery: SLAP procedure left shoulder, broken nose, ACDIF C5-C6 10/08

ALLERGIES: NKDA

Family History (Reviewed - No Changes Since Last Visit): Migraine headaches, back problem, depression

Social History: Single

High school graduate

Worked as a Greenville City Police officer, work-related injury 8/23/03, Attorney Doug Churdar

STOPPED WORKING April, 2008, medical retirement from police department.

Denies tobacco

Occasional alcohol

0041

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1330 Boiling Springs Rd Suite 2700 Spartanburg, SC 29303
8645830053 Fax: 8645830390

July 13, 2009
Page 2
Chart Document

MS KELLIE BURNETTE

Female DOB: [REDACTED]

18381

Home: [REDACTED]
Ins: VOC REHAB

Review of Systems

General: fatigue

Eyes: denies blurring, diplopia, irritation, discharge, vision loss, eye pain, photophobia

Ear/Nose/Throat: denies ear pain or discharge, tinnitus, decreased hearing, nasal obstruction or discharge, nosebleeds, sore throat, hoarseness, dysphagia

Cardiovascular: Denies chest pain, palpitations, syncope, dyspnea on exertion, orthopnea, PND, peripheral edema

Respiratory: Denies cough, dyspnea, excessive sputum, hemoptysis, wheezing

Gastrointestinal: Denies nausea, vomiting, diarrhea, constipation, change in bowel habits, abdominal pain, melena, hematochezia, jaundice

Genitourinary: denies vaginal discharge, incontinence, dysuria, hematuria, urinary frequency, amenorrhea, menorrhagia, abnormal vaginal bleeding, pelvic pain

Musculoskeletal: back pain, neck pain, muscle cramps, left knee

Skin: denies rash, itching, dryness, suspicious lesions

Neurologic: weakness

Psychiatric: depression

Endocrine: denies cold intolerance, heat intolerance, polydipsia, polyphagia, polyuria, weight change

Hematologic/Lymphatic: denies abnormal bruising, bleeding, enlarged lymph nodes

Allergic/Immunologic: denies urticaria, hay fever, persistent infections, HIV exposure

Vital Signs

Ht: 70 in. Wt: 237 lbs.

Physical Exam

General:

General appearance: well developed, well nourished, no acute distress

Communication ability: communicates by voice, normal quality

Gait and station: Normal

Psychiatric

Mental Status: AAO x3

Judgement/Insight: Intact

Mood/Affect: Appropriate

Recent/Remote Memory: Normal

Head and Face

Inspection: normocephalic, no scars, lesions, or masses

Facial strength: no weakness

Assessment

Status of Existing Problems:

Assessed POSTLAMINECTOMY SYNDROME - CERVICAL as unchanged - John Satterthwaite MD

Assessed LUMBAR RADICULOPATHY as unchanged - John Satterthwaite MD

Assessed CERVICAL RADICULOPATHY as unchanged - John Satterthwaite MD

Assessed MYOFASCIAL PAIN SYNDROME as unchanged - John Satterthwaite MD

Assessed CERVICALGIA as unchanged - John Satterthwaite MD

Assessed LOW BACK PAIN SYNDROME as unchanged - John Satterthwaite MD

New Problems:

Carolinas Center for Advanced Management of Pain
1330 Boiling Springs Rd Suite 2700 Spartanburg, SC 29303
8645830053 Fax: 8645830390

July 13, 2009
Page 3
Chart Document

MS KELLIE BURNETTE

Female DOB: [REDACTED]

18381

Home: [REDACTED]

Ins: VOC REHAB

POSTLAMINECTOMY SYNDROME - CERVICAL (ICD-722.81)

Plan

At this particular time, she remains stable on medications. I would now consider her at Maximum Medical Improvement from her work related injury on June 16, 2007. Based on the Cervical DRE IV, in the AMA Guides, Fifth Edition, she has a 25% impairment to the whole person, which corresponds to a 72% impairment of the cervical spine, which is permanent. In so far as the lumbar spine, based on the lumbar DRE II, she would have a 12% impairment to the whole person, which corresponds to a 16% impairment to the lumbar spine, which is permanent.

Insofar as restrictions, she should avoid bending, stooping, squatting, crawling, climbing ladders, unprotected heights, overhead work, repetitive use of the arms or legs, and prolonged work at a computer. Her lifting restrictions would include 15 pounds occasionally for lifting, carrying, pushing, and pulling. She should not be made to sit longer than 30 minutes or stand longer than 20 minutes without a break. Future care would include medications and possible cervical or lumbar epidural injections. Intermittent Physical Therapy might be necessary.

Psychological evaluation, rating, and recommendations for future care will be made by Dr. Tollison. Her medications are refilled. She will follow-up in one month.

New Prescriptions/Refills:

AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) 1 qhs #30 x 0 : John Satterthwaite MD (07/01/2009)
LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours. #90 x 0 : John Satterthwaite MD (07/01/2009)
FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 2 po hs #60 x 0 : John Satterthwaite MD (07/01/2009)
ROXICODONE 15 MG TABS (OXYCODONE HCL) 1po q4-6 h prn pain max 4 per day #120 x 0 : John Satterthwaite MD (07/01/2009)

Current Medication List:

ROXICODONE 15 MG TABS (OXYCODONE HCL) 1po q4-6 h prn pain max 4 per day
NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po bid
BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm
FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 2 po hs
LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours.
AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) 1 qhs
PROZAC 20 MG CAPS (FLUOXETINE HCL) one bid
ADDERALL 20 MG TABS (AMPHETAMINE-DEXTROAMPHETAMINE) bid - Dr Giambalvo
ZYRTEC 10 MG TABS (CETIRIZINE HCL) 1 po qhs other MD

New Orders:

Return for follow-up 1 month [xxxxx]
Expanded [99213]

Prescriptions:

AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) 1 qhs #30 x 0
Entered and Authorized by: John Satterthwaite MD
Signed by: John Satterthwaite MD on 07/01/2009
Method used: Print then Give to Patient

0043

Carolinas Center for Advanced Management of Pain

1330 Boiling Springs Rd Suite 2700 Spartanburg, SC 29303
8645830053 Fax: 8645830390

July 13, 2009

Page 4

Chart Document

MS KELLIE BURNETTE

Female DOB: ~~XXXXXXXXXX~~

18381

Home: ~~XXXXXXXXXX~~

Ins: VOC REHAB

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours. #90 x 0

Entered and Authorized by: John Satterthwaite MD

Signed by: John Satterthwaite MD on 07/01/2009

Method used: Print then Give to Patient

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 2 po hs #60 x 0

Entered and Authorized by: John Satterthwaite MD

Signed by: John Satterthwaite MD on 07/01/2009

Method used: Print then Give to Patient

ROXICODONE 15 MG TABS (OXYCODONE HCL) 1po q4-6 h prn pain max 4 per day #120 x 0

Entered and Authorized by: John Satterthwaite MD

Signed by: John Satterthwaite MD on 07/01/2009

Method used: Print then Give to Patient

Signed by John Satterthwaite MD on 07/01/2009 at 8:11 PM

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1330 Boiling Springs Rd Suite 2700- Spartanburg, SC 29303
8645830053 Fax: 8645830390

July 15, 2009
Page 1
Chart Document

MS KELLIE BURNETTEFemale DOB: ~~06-11-1968~~

18381

Home: ~~(864) 583-3333~~
Ins: VOC REHAB**05/27/2009 - Office Visit: Follow-Up Pain**

Provider: MONICA P SPEAK NP

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

Follow-Up Visit**Chief Complaint:** Chronic varying pain in back and neck.**History of Present Illness:** Patient returns today and states that pain is basically the same with no new paresthesia, no bowel or bladder problems. Taking medications with good effect and no side effects.

Needs refills.

Has been seen by Ortho and has left torn medial meniscus. She is going to PT and taking celebrex and may need surgery.

Medicine containers brought in, amts appropriate for date filled.

Returns MSIR 15 mgs x 7 to be destroyed.

She is satisfied with her pain management at present.

With the addition of Flexeril and Ambien at bedtime she is now sleeping and her pain level is reduced.

Location Of Pain: as above.**Description Of Pain:** Sharp, Aching, Burning, Electric/Shooting**Pain Rating:** 6**Activity:** Increased**Did Medications Help?** Yes**Is the patient taking any new medications?** No**Does the patient have any new medical or surgical problems?** No**Is the patient experiencing increased sadness, anxiety, or family problems?** No**Data Reviewed:** Old Charts**Past, Family, and Social History****Past History (Reviewed - No Changes Since Last Visit):** Depression, ADHD, osteoarthritis, Torn left medial meniscus.**Surgery:** SLAP procedure left shoulder, broken nose**ALLERGIES:** NKDA**Family History (Reviewed - No Changes Since Last Visit):** Migraine headaches, back problem, depression**Social History (Reviewed - No Changes Since Last Visit):** Single

High school graduate

Works full time, regular duty as a Greenville City Police officer, work-related injury 8/23/03, Attorney Doug

Churdar STOPPED WORKING April, 2008, medical retirement from police department.

Denies tobacco

Occasional alcohol

Review of Systems**General:** fatigue**Eyes:** denies blurring, diplopia, irritation, discharge, vision loss, eye pain, photophobia**Ear/Nose/Throat:** denies ear pain or discharge, tinnitus, decreased hearing, nasal obstruction or

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1330 Boiling Springs Rd Suite 2700 Spartanburg, SC 29303
8645830053 Fax: 8645830390

July 15, 2009
Page 1
Chart Document

MS KELLIE BURNETTE

Female DOB: ~~06/26/1973~~

18381

Home: ~~864-583-1234~~
Ins: VOC REHAB

04/29/2009 - Office Visit: Follow-Up Pain

Provider: MONICA P SPEAK NP

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

Follow-Up Visit

Chief Complaint: Chronic varying pain in back and neck.

History of Present Illness: Patient returns today and states that pain is basically the same with no new paresthesia, no bowel or bladder problems. Taking medications with good effect and no side effects. Needs refills.

Still having problems with sleep as the Remeron did not help. We will D/C this and restart the Ambien as well as have her take 2 Flexeril at hs.

Discussed sleep pattern and getting up at same time every day.

Location Of Pain: as above

Description Of Pain: Sharp, Aching, Burning, Electric/Shooting

Pain Rating: 7

Activity: Stayed The Same

Did Medications Help? Yes

Is the patient taking any new medications? No

New Meds:

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 2 po hs

AMBIEN 10-MG TABS (ZOLPIDEM TARTRATE) 1 qhs

Does the patient have any new medical or surgical problems? No

Is the patient experiencing increased sadness, anxiety, or family problems? No

Data Reviewed: Old Charts

Past, Family, and Social History

Past History (Reviewed - No Changes Since Last Visit): Depression, ADHD, osteoarthritis

Surgery: SLAP procedure left shoulder, broken nose

ALLERGIES: NKDA

Family History (Reviewed - No Changes Since Last Visit): Migraine headaches, back problem, depression

Social History (Reviewed - No Changes Since Last Visit): Single

High school graduate

Works full time, regular duty as a Greenville City Police officer, work-related injury 8/23/03, Attorney Doug

Churdar STOPPED WORKING April, 2008, medical retirement from police department.

Denies tobacco

Occasional alcohol

Review of Systems

General: fatigue

Eyes: denies blurring, diplopia, irritation, discharge, vision loss, eye pain, photophobia

Ear/Nose/Throat: denies ear pain or discharge, tinnitus, decreased hearing, nasal obstruction or discharge, nosebleeds, sore throat, hoarseness, dysphagia

0049

Carolinas Center for Advanced Management of Pain
1330 Bolling Springs Rd Suite 2700 Spartanburg, SC 29303
8645830053 Fax: 8645830390

July 15, 2009
Page 1
Chart Document

MS KELLIE BURNETTE

Female DOB: ~~01/01/1968~~

18381

Home: ~~(864) 447-3000~~
Ins: VOC REHAB

03/23/2009 - Office Visit: Follow-Up Pain

Provider: MONICA P SPEAK NP

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

Follow-Up Visit

Chief Complaint: Chronic varying pain in neck and back

History of Present Illness: Patient returns today and states that pain is basically the same with no new paresthesia, no bowel or bladder problems. Taking medications with good effect and no side effects. Needs refills. Having left knee pain which started again as a constant ache and stiffness rather than an occasional ache. Medicine containers brought in, ams appropriate for date filled. She is not sleeping well and she is taking Ambien. We will try Restoril 15 mgs approval for change per Dr. Satterthwaite.

Location Of Pain: as above

Description Of Pain: Sharp, Aching, Burning, Electric/Shooting

Pain Rating: 8

Activity: Increased

Did Medications Help? Yes

Is the patient taking any new medications? No

New Meds:

OPANA 10 MG TABS (OXYMORPHONE HCL) 1 po q4-6h pm pain max 4/day (30 DAY SUPPLY NO EARLY REFILLS.) *MAY FILL ON* 3/19/09
RESTORIL 15 MG CAPS (TEMAZEPAM) 1 po hs insomnia

Does the patient have any new medical or surgical problems? No

Is the patient experiencing increased sadness, anxiety, or family problems? No

Data Reviewed: Old Charts

Past, Family, and Social History

Past History (Reviewed - No Changes Since Last Visit): Depression, ADHD, osteoarthritis

Surgery: SLAP procedure left shoulder, broken nose

ALLERGIES: NKDA

Family History (Reviewed - No Changes Since Last Visit): Migraine headaches, back problem, depression

Social History (Reviewed - No Changes Since Last Visit): Single

High school graduate

Works full time, regular duty as a Greenville City Police officer, work-related injury 8/23/03, Attorney Doug

Churdar STOPPED WORKING April, 2008, medical retirement from police department.

Denies tobacco

Occasional alcohol

Review of Systems

General: fatigue

Eyes: denies blurring, diplopia, irritation, discharge, vision loss, eye pain, photophobia

0057

Carolinas Center for Advanced Management of Pain
1330 Boiling Springs Rd Suite 2700 Spartanburg, SC 29303
8645830053 Fax: 8645830390

July 15, 2009
Page 3
Chart Document

MS KELLIE BURNETTE

Female DOB: ~~06-23-1970~~

18381

Home: ~~(864) 277-0000~~

Ins: VOC REHAB

Assessed THORACIC SPONDYLOSIS as unchanged - MONICA P SPEAK NP
Assessed MYOFASCIAL PAIN SYNDROME as unchanged - MONICA P SPEAK NP
Assessed SPONDYLOSIS - LUMBOSACRAL as unchanged - MONICA P SPEAK NP
Assessed Z-JOINT SYNDROME as unchanged - MONICA P SPEAK NP
Assessed LOW BACK PAIN SYNDROME as unchanged - MONICA P SPEAK NP

Plan

Change Roxicodone to Opana 10 mgs 1 po q4-6h max 4/day

Change Ambien to Restoril 15 mgs 1 hs for insomnia

Follow up in 1 month

Patient doing well on present pain management program. We will continue with the same medications.

Patient is stable with medical management of chronic pain. Other treatments such as injections no longer help and is satisfied with the present treatment plan.

Patient may call and move appointment forward if he/she feels they need to be seen earlier.

Side effects of new meds and/or increase in present meds were explained to patient and patient

instructed to call if having any problems with the new medication

Returns Wellbutrin, and # 29 Ambien CR

New Prescriptions/Refills:

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours. #90 x 0 : MONICA P SPEAK NP (03/23/2009)

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 HS #30 x 0 : MONICA P SPEAK NP (03/23/2009)

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm #90 x 0 : MONICA P SPEAK NP (03/23/2009)

NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po bid #60 x 0 : MONICA P SPEAK NP (03/23/2009)

OPANA 10 MG TABS (OXYMORPHONE HCL) 1 po q4-6h prn pain max 4/day (30 DAY SUPPLY NO EARLY REFILLS.) *MAY FILL ON* 3/19/09 #120 x 0 : MONICA P SPEAK NP (03/23/2009)

RESTORIL 15 MG CAPS (TEMAZEPAM) 1 po hs insomnia #30 x 0 : MONICA P SPEAK NP (03/23/2009)

Current Medication List:

OPANA 10 MG TABS (OXYMORPHONE HCL) 1 po q4-6h prn pain max 4/day (30 DAY SUPPLY NO EARLY REFILLS.) *MAY FILL ON* 3/19/09

ROXICODONE 15 MG TABS (OXYCODONE HCL) 1 po q4-6 h prn pain max 4 per day

NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po bid

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 HS

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours.

EFFEXOR XR 150 MG CP24 (VENLAFAXINE HCL) 1 QD (3-10-09 titrate down & stop)

WELLBUTRIN XL 150 MG TB24 (BUPROPION HCL) 1 QD (3-10-09 titrate down 6 days and off)

ADDERALL 20 MG TABS (AMPHETAMINE-DEXTROAMPHETAMINE) bid - Dr Glambalvo

ZYRTEC 10 MG TABS (CETIRIZINE HCL) 1 po qhs other MD

RESTORIL 15 MG CAPS (TEMAZEPAM) 1 po hs insomnia

PROZAC 20 MG CAPS (FLUOXETINE HCL) one qd

New Orders:

Expanded [99213]

Return for follow-up 1 month [xxxxx]

0059

Carolinas Center for Advanced Management of Pain
1330 Boiling Springs Rd Suite 2700 Spartanburg, SC 29303
8645830053 Fax: 8645830390

July 15, 2009

Page 1

Chart Document

MS KELLIE BURNETTEFemale DOB: ~~XXXXXXXXXX~~

18381

Home: ~~XXXXXXXXXX~~

Ins: VOC REHAB

02/19/2009 - Office Visit: Medication Management Visit**Provider: MONICA P SPEAK NP****Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office****Medication Management Visit****Chief Complaint:** Chronic varying pain in back and neck.

KELLIE BURNETTE returns today requesting refill of medication. The patient is taking the prescribed medication appropriately with benefit. The patient denies any side effects from the medication. Therefore the chart was reviewed and the medication renewed. The patient will follow-up accordingly.

Prescriptions:**ROXICODONE 15 MG TABS (OXYCODONE HCL) 1 po q6h 2 week supply #60 x 0**

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Signed by: MONICA P SPEAK NP on 02/19/2009

Method used: Print then Give to Patient

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours. #90 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Signed by: MONICA P SPEAK NP on 02/19/2009

Method used: Print then Give to Patient

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 HS #30 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Signed by: MONICA P SPEAK NP on 02/19/2009

Method used: Print then Give to Patient

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm #90 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Signed by: MONICA P SPEAK NP on 02/19/2009

Method used: Print then Give to Patient

NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po bid #60 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Signed by: MONICA P SPEAK NP on 02/19/2009

Method used: Print then Give to Patient

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours. #90 x 5

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Signed by: MONICA P SPEAK NP on 02/19/2009

Method used: Print then Give to Patient

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 HS #30 x 5

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Signed by: MONICA P SPEAK NP on 02/19/2009

Method used: Print then Give to Patient

0061

MS. KENNETH BURNETT
Home: 864-583-0053 Fax: 864-583-0390
Date: 11/18/2008 Time: 1:13 PM

11/18/2008 - Office Visit: Follow-Up Pain

Provider: MONICA P SPEAK NP

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

Follow-Up Visit

Chief Complaint: cpn back and neck

History of Present Illness: Patient is S/P ACF by Dr. Bucci on 10/27/08 and she is doing better. States that her neck pain is improved with the surgery. otherwise Pt states that the pain has not changed in intensity or character since last visit. No new numbness, tingling, or weakness. No new bowel or bladder problems reported.

Patient states taking medication as directed. Also states medication helps with pain reduction. Patient states having no side effects from medications. Patient states needs refills on meds. Medicine containers brought in, amts appropriate for date filled.

Medications were last filled 10/30/08 **

States that she is getting benefit from the Neurontin.

Also is getting benefit from her sessions from Dr. Tollison. She will see him in December but does not have enough of her Effexor to last. We will give her 1 month refill on this.

Location Of Pain: asabove

Description Of Pain: Numbness, Sharp, Aching, Burning, Electric/Shooting

Activity: Decreased

Did Medications Help? Yes

Is the patient taking any new medications? No

New Meds:

CELEBREX 200 MG CAPS (CELECOXIB) take one PO BID hold due to ACF

Does the patient have any new medical or surgical problems? No

Is the patient experiencing increased sadness, anxiety, or family problems? No

Data Reviewed: Old Charts

Past, Family, and Social History

Past History (Reviewed - No Changes Since Last Visit): Depression, ADHD, osteoarthritis

Surgery: SLAP procedure left shoulder, broken nose

ALLERGIES: NKDA

Family History (Reviewed - No Changes Since Last Visit): Migraine headaches, back problem, depression

Social History (Reviewed - No Changes Since Last Visit): Single

High school graduate

Works full time, regular duty as a Greenville City Police officer, work-related injury 8/23/03, Attorney Doug Churdar STOPPED WORKING April, 2008, medical retirement from police department.

Denies tobacco

Occassional alcohol

Review of Systems

General: fatigue

0070

Carolinas Center for Advanced Management of Pain

1330 Boiling Springs Rd Suite 2700 Spartanburg, SC 29303
8645830053 Fax: 8645830390

June 12, 2009

Page 3

Chart Document

MS KELLIE BURNETT
Female DOB: 1/5/58
Inst: VCC REHAB

Sympathetic Function: Normal

Assessment

Status of Existing Problems:

Assessed DISPLACEMENT - LUMBAR DISC W/O MYELOPATHY as unchanged - MONICA P SPEAK NP

Assessed CERVICALGIA as unchanged - MONICA P SPEAK NP

Assessed CERVICAL RADICULOPATHY as unchanged - MONICA P SPEAK NP

Assessed CERVICAL SPONDYLOSIS as unchanged - MONICA P SPEAK NP

Assessed THORACIC SPONDYLOSIS as unchanged - MONICA P SPEAK NP

Assessed MYOFASCIAL PAIN SYNDROME as unchanged - MONICA P SPEAK NP

Assessed SPONDYLOSIS - LUMBOSACRAL as unchanged - MONICA P SPEAK NP

Assessed LOW BACK PAIN SYNDROME as unchanged - MONICA P SPEAK NP

Plan

Refill meds

continue present meds

Med pick up next month

Pt will call prior to appt if has any problems

Pain medications and treatment plan help improve the patient's quality of life.

New Prescriptions/Refills:

NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po bid #60 x 0 : MONICA P SPEAK NP (11/18/2008)

EFFEXOR XR 150 MG CP24 (VENLAFAXINE HCL) 1 po daily #30 x 0 : MONICA P SPEAK NP (11/18/2008)

ROXICODONE 15 MG TABS (OXYCODONE HCL) 1po q4-6 h prn pain max 4 per day #120 x 0 : MONICA P SPEAK NP (11/18/2008)

Current Medication List:

ROXICODONE 15 MG TABS (OXYCODONE HCL) 1po q4-6 h prn pain max 4 per day

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm

AMBIEN CR 12.5 MG TBCR (ZOLPIDEM TARTRATE) 1 po qhs

CELEBREX 200 MG CAPS (CELECOXIB) take one PO BID hold due to ACF

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 HS

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours.

EFFEXOR XR 150 MG CP24 (VENLAFAXINE HCL) 1 po daily

NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po bid

ADDERALL 20 MG TABS (AMPHETAMINE-DEXTROAMPHETAMINE) bid - Dr Giambalvo

ZYRTEC 10 MG TABS (CETIRIZINE HCL) 1 po qhs other MD

New Orders:

Focused [99212]

Return for Med Pickup [XXXXX]

Prescriptions:

NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po bid #60 x 0

Entered by: MONICA P SPEAK NP

0072

MS KELLIE BURNETT

Female

1968

INS VOIC REHAP

10/01/2008 - Office Visit: Follow-Up Pain

Provider: MONICA P SPEAK NP

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

Follow-Up Visit

Chief Complaint: Chronic varying pain in back and neck

MEDS: Lortab 10 mgs today,

History of Present Illness: Patient call last Saturday stating that her medication was not controlling her pain. She has been to see Dr. D Mitchell orthoped who told her she had some bulging discs in her neck and her pain medication was not controlling her pain now. She was instructed to take 1 extra Lortab per day and to call the office to move her appointment forward for reassessment. She is here today to be reassessed.

Patient has been taking the Lortab 5 times per day and states she can not function. She also states that she can't sleep either. Her friend says she can't get out of bed. She asks is there anything that can be done to get her out of this pain?

Discussed the situation with Dr. Satterthwaite he is in with Patient during visit.

Location Of Pain: as above

Description Of Pain: Numbness, Sharp, Aching, Burning, Electric/Shooting

Pain Rating: 9

Activity: Decreased

Did Medications Help? No

Is the patient taking any new medications? No

New Meds:

ROXICODONE 15 MG TABS (OXYCODONE HCL) 1po q4-6 h prn pain max 4 per day

EFFEXOR XR 150 MG CP24 (VENLAFAXINE HCL) 1 po daily

NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po bid

Does the patient have any new medical or surgical problems? No

Is the patient experiencing increased sadness, anxiety, or family problems? No

Data Reviewed: Old Charts

Past, Family, and Social History

Past History (Reviewed - No Changes Since Last Visit): Depression, ADHD, osteoarthritis

Surgery: SLAP procedure left shoulder, broken nose

ALLERGIES: NKDA

Family History (Reviewed - No Changes Since Last Visit): Migraine headaches, back problem, depression

Social History (Reviewed - No Changes Since Last Visit): Single

High school graduate

Works full time, regular duty as a Greenville City Police officer, work-related injury 8/23/03, Attorney Doug Churdar STOPPED WORKING April, 2008, medical retirement from police department.

Denies tobacco

Occasional alcohol

0077

MS KELLIE BURNETTE
Remains [redacted] 18881 [redacted] Ins. VIO REBAR

Assessment

Status of Existing Problems:

Assessed PAIN DISORDER (PSYCH/MEDICAL) as unchanged - MONICA P SPEAK NP
Assessed CERVICAL RADICULOPATHY as unchanged - MONICA P SPEAK NP
Assessed ADJUSTMENT DISORDER/MIXED as unchanged - MONICA P SPEAK NP
Assessed DISPLACEMENT - LUMBAR DISC W/O MYELOPATHY as unchanged - MONICA P SPEAK NP
Assessed CERVICAL SPONDYLOSIS as unchanged - MONICA P SPEAK NP
Assessed THORACIC SPONDYLOSIS as unchanged - MONICA P SPEAK NP
Assessed MYOFASCIAL PAIN SYNDROME as unchanged - MONICA P SPEAK NP
Assessed SPONDYLOSIS - LUMBOSACRAL as unchanged - MONICA P SPEAK NP
Assessed CERVICALGIA as unchanged - MONICA P SPEAK NP
Assessed Z-JOINT SYNDROME as unchanged - MONICA P SPEAK NP
Assessed LOW BACK PAIN SYNDROME as unchanged - MONICA P SPEAK NP
Assessed LUMBAR RADICULOPATHY as unchanged - MONICA P SPEAK NP
Assessed DEPRESSION as unchanged - MONICA P SPEAK NP

Plan

Dr. Satterthwaite in with Patient and he decided the following:

- 1) Changed Lortab to Roxicodone 15 mgs 1 po q4-6h pm pain max 4/day
- 2) Effexor changed to 150 mgs daily
- 3) start Neurontin 300 mgs BID
- 4) Try for CESI

follow up 1 month

Pt will call prior to appt if has any problems

Patient has a full bottle of Lortab and we will hold it for her to see if the Roxicodone will work for pain. It will be locked in Narcotic box, per Dr. Satterthwaite's instructions. Ms

New Prescriptions/Refills:

NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po bid #60 x 0 : MONICA P SPEAK NP (10/01/2008)
ROXICODONE 15 MG TABS (OXYCODONE HCL) 1po q4-6 h pm pain max 4 per day #120 x 0 :
MONICA P SPEAK NP (10/01/2008)
EFFEXOR XR 150 MG CP24 (VENLAFAXINE HCL) 1 po daily #30 x 0 : MONICA P SPEAK NP
(10/01/2008)

Current Medication List:

ROXICODONE 15 MG TABS (OXYCODONE HCL) 1po q4-6 h pm pain max 4 per day
BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm
AMBIEN CR 12.5 MG TBCR (ZOLPIDEM TARTRATE) 1 po qhs
CELEBREX 200 MG CAPS (CELECOXIB) take one PO BID
FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 HS
LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours.
EFFEXOR XR 150 MG CP24 (VENLAFAXINE HCL) 1 po daily
NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po bid
ADDERALL 20 MG TABS (AMPHETAMINE-DEXTROAMPHETAMINE) bid - Dr Giambalvo
ZYRTEC 10 MG TABS (CETIRIZINE HCL) 1 po qhs other MD

MS KELLIE BURNE III

Female DOB: 11/11/1967

11/11/1967

Home Health Care
First VOC REHAB

09/15/2008 - Office Procedure: Epidural Steroid Injection

Provider: John Satterthwaite MD

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

Epidural Steroid Injection

Indications:

Lumbar HNP

Continues to get benefit from ESI

Increasing back and leg pain

Repeat injection

Procedure:

After informed consent was obtained, the patient was placed in the prone position and the back was prepped with Betadine and draped in the usual sterile fashion. Fluoroscopy was used to localize the appropriate interspace. Local anesthesia was administered using a 27 gauge needle and 1% Lidocaine. Using a 18 gauge Touhy needle and loss of resistance technique, the epidural space was entered at the L5-S1 interspace. No blood or CSF was noted returning from the needle. Following negative aspiration, 40mg Triamcinolone in 3cc normal saline with 1cc of .25% Bupivacaine was injected into the space. The needle was removed and the puncture wound was dressed.

Observations

- The patient was monitored for an appropriate length of time after the procedure and then discharged home, in good condition, with a driver.

- The patient was instructed to refrain from driving for 12 hours and to contact the office immediately if any of the following were noted: new or different pain in the back, loss of bladder or bowel control, new pain, numbness or weakness of the legs, redness or drainage from the needle insertion site.

- No sedation was given.

- The patient tolerated the procedure well.

The following complications were noted:

None

Orders

c-arm [CPT-77003]

Single Lumbar / Caudal [62311]

Triamcinolone 10mg [J3301]

Return for follow-up 1 month [xxxxx]

Updated Medication List

LORTAB 10 10-500 MG TABS (HYDROCODONE-ACETAMINOPHEN) 1 po qid prn pain max of 4 per day *** 30 DAY SUPPLY *** NO EARLY REFILLS

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm

AMBIEN CR 12.5 MG TBCR (ZOLPIDEM TARTRATE) 1 po qhs

CELEBREX 200 MG CAPS (CELECOXIB) take one PO BID

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 HS

0081

MS KELLIE BURNETTE

Female

1988

Inst VOG 888888

09/04/2008 - Office Visit: Follow-Up Pain

Provider: John Satterthwaite MD

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

Follow-Up Visit

Chief Complaint: Neck and back pain

History of Present Illness: PT helped on a "limited" basis. Got about 30% relief from back pain. Did not address the neck.

LESI help for several weeks. Pain primarily in the back and hips. Minimal leg pain.

Medications are beneficial unless she is active such as housework or shopping.

Neck pain going to upper back, bilateral shoulders to upper arm. Constant. Increased by sitting, and anything which aggravates the back. Having headaches with it.

Had neck xrays in the last 2-3 weeks, at the request of Comp, at the Exigent Center but those are not available for me to look at, nor was I sent a report. Do not know what they show.

Approved to see Dr Tollison and will schedule an appointment today.

Location Of Pain: Neck, back and hips

Description Of Pain: Sharp, Aching, Burning

Pain Rating: 7

Activity: Stayed The Same

Did Medications Help? Yes

Did Injection Help? Yes

Percent: 60% for several weeks

Is the patient taking any new medications? No

Does the patient have any new medical or surgical problems? No

New Problems:

CERVICAL RADICULOPATHY (ICD-723.4)

DISPLACEMENT - LUMBAR DISC W/O MYELOPATHY (ICD-722.10)

Is the patient experiencing increased sadness, anxiety, or family problems? No

Past, Family, and Social History

Past History (Reviewed - No Changes Since Last Visit): Depression, ADHD, osteoarthritis

Surgery: SLAP procedure left shoulder, broken nose

ALLERGIES: NKDA

Family History (Reviewed - No Changes Since Last Visit): Migraine headaches, back problem, depression

Social History (Reviewed - No Changes Since Last Visit): Single

High school graduate

Works full time, regular duty as a Greenville City Police officer, work-related injury 8/23/03, Attorney Doug Churdar STOPPED WORKING April, 2008

Denies tobacco

Occasional alcohol

Review of Systems

0083

MISKELLIE BURNETTE [06] [3-8] [06] [3-8]

Patrick's Test: Negative
Straight Leg Raise: Negative
Palpation: Tender
Midline, Facets, Paravertebral
Comments: L5-S1

RUE: 5/5
RLE: 5/5
LUE: 5/5
LLE: 5/5

RUE: 2+
RLE: 2+
LUE: 2+
LLE: 2+

Right Brachioradialis: 1+
Right Achilles: 3+
Left Biceps: 0
Left Brachioradialis: 1+
Sensory Decreased sensation to light touch, Negative allodynia/hyperpathia
Comments: Right L5, S1
 Right hand
Neuro Clonus
Comments: 2 beat right foot
Sympathetic Function: Normal

Status of Existing Problems:
 Assessed CERVICALGIA as unchanged - John Satterthwaite MD - Signed
 Assessed LOW BACK PAIN SYNDROME as unchanged - John Satterthwaite MD - Signed
 Assessed MYOFASCIAL PAIN SYNDROME as improved - John Satterthwaite MD - Signed
 Assessed LUMBAR RADICULOPATHY as improved - John Satterthwaite MD - Signed
 Assessed DEPRESSION as unchanged - John Satterthwaite MD - Signed

New Problems:
 CERVICAL RADICULOPATHY (ICD-723.4)
 DISPLACEMENT - LUMBAR DISC W/O MYELOPATHY (ICD-722.10)

Need to look at cervical x-rays.
With absent left biceps reflex and sensory changes in the right hand, I think a cervical MRI may be indicated, with and without contrast.
Continue the same medications for now and encouraged to do home exercises and lose weight.
Will order MRI and see in 2-3 weeks with those and cervical x-rays.

174

MS KEULIE BURNETTE

HOME ACCT: 1111111111
INS: VOC REHAB

08/15/2008 - Office Visit: Follow-Up Pain

Provider: Kimberly Parker NP

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

Follow-Up Visit

Chief Complaint: Here for FU on chronic pain in back and neck

History of Present Illness: states taking meds as prescribed without side effects and they are helpful. states that has 2 more visits of physical therapy left-states that this helps some and going to finish out the therapy

No changes in overall pain and no new bowel or bladder changes.

brought in meds-taking appropriately

states has W/C hearing coming up

states that had x-rays of neck at Exogent and going to have cervical MRI

states saw Dr. Tollison and interested in seeing him again

Location Of Pain: back and neck

Description Of Pain: Sharp, Aching, Burning

Pain Rating: 7

Activity: Stayed The Same

Did Medications Help? Yes

Did Injection Help? Yes

Percent: 30% and last 4-5 weeks and then begin to wear off

Is the patient taking any new medications? No

Does the patient have any new medical or surgical problems? No

Is the patient experiencing increased sadness, anxiety, or family problems? No

Past, Family, and Social History

Past History (Reviewed - No Changes Since Last Visit): Depression, ADHD, osteoarthritis

Surgery: SLAP procedure left shoulder, broken nose

ALLERGIES: NKDA

Family History (Reviewed - No Changes Since Last Visit): Migraine headaches, back problem, depression

Social History (Reviewed - No Changes Since Last Visit): Single

High school graduate

Works full time, regular duty as a Greenville City Police officer, work-related injury 8/23/03, Attorney Doug Churdar STOPPED WORKING APRIL, 2008

Denies tobacco

Occasional alcohol

Review of Systems

General: fatigue

Eyes: denies blurring, diplopia, irritation, discharge, vision loss, eye pain, photophobia

Ear/Nose/Throat: denies ear pain or discharge, tinnitus, decreased hearing, nasal obstruction or discharge, nosebleeds, sore throat, hoarseness, dysphagia

0087

MISKELENE BURNETT

18584

185 / 000 REMAP

Assessed LUMBAR RADICULOPATHY as unchanged - Kimberly Parker NP - Signed
Assessed DEPRESSION as unchanged - Kimberly Parker NP - Signed

Plan

Continue current pain management program. taking meds as prescribed and they are helpful-RF given
will schedule for ESI L5-S1 1 month, as helps with pain
trying to walk some in the evenings-level ground-to help with reconditioning and weight loss
interested in FU with Dr. Tollison but awaiting hearing before can schedule this
taking celebrex bid-discussed risks/benefits of NSAIDS-patient states going to drop down and try taking
celebrex QD-if pain increases then going to increase back to bid
FU 1 month for ESI
call with problems

New Prescriptions/Refills:

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12
hours and remove for 12 hours. #90 x 3 : Kimberly Parker NP (08/15/2008)
CYMBALTA 30 MG CPEP (DULOXETINE HCL) 4 po qhs #120 x 3 : Kimberly Parker NP (08/15/2008)
FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 HS #30 x 3 : Kimberly Parker NP (08/15/2008)
CELEBREX 200 MG CAPS (CELECOXIB) take one PO BID #60 x 3 : Kimberly Parker NP (08/15/2008)
AMBIEN CR 12.5 MG TBCR (ZOLPIDEM TARTRATE) 1 po qhs #30 x 3 : Kimberly Parker NP
(08/15/2008)
BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm #90 x 3 : Kimberly Parker NP
(08/15/2008)
LORTAB 10 10-500 MG TABS (HYDROCODONE-ACETAMINOPHEN) 1 po qid prn pain max of 4 per
day *** 30 DAY SUPPLY *** NO EARLY REFILLS #120 x 1 : Kimberly Parker NP (08/15/2008)

Current Medication List:

LORTAB 10 10-500 MG TABS (HYDROCODONE-ACETAMINOPHEN) 1 po qid prn pain max of 4 per
day *** 30 DAY SUPPLY *** NO EARLY REFILLS
BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm
AMBIEN CR 12.5 MG TBCR (ZOLPIDEM TARTRATE) 1 po qhs
CELEBREX 200 MG CAPS (CELECOXIB) take one PO BID
FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 HS
CYMBALTA 30 MG CPEP (DULOXETINE HCL) 4 po qhs
LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12
hours and remove for 12 hours.
ADDERALL 20 MG TABS (AMPHETAMINE-DEXTROAMPHETAMINE) bid - Dr Giambalvo
ZYRTEC 10 MG TABS (CETIRIZINE HCL) 1 po qhs other MD

New Orders:

Expanded [99213]
Return for Epidural Steroid Injection [XXXXXX]

Prescriptions:

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12
hours and remove for 12 hours. #90 x 3

Entered by: Kimberly Parker NP
Authorized by: John C Haasis MD
Signed by: Kimberly Parker NP on 08/15/2008
Method used: Print then Give to Patient

0089

MS KENNETH BURNETTE

Remainder

18887

Home Health Care
In-Home Rehab

07/17/2008 - Office Procedure: Epidural Steroid Injection

Provider: John Satterthwaite MD

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

Epidural Steroid Injection

Indications:

L5-S1 disc protrusion with radiculopathy
Increasing back and leg pain
Returns for repeat ESI

Procedure:

After informed consent was obtained, the patient was placed in the prone position and the back was prepped with Betadine and draped in the usual sterile fashion. Fluoroscopy was used to localize the appropriate interspace. Local anesthesia was administered using a 27 gauge needle and 1% Lidocaine. Using a 18 gauge Touhy needle and loss of resistance technique, the epidural space was entered at the L5-S1 interspace. No blood or CSF was noted returning from the needle. Following negative aspiration, 40mg Triamcinolone in 3cc normal saline with 1cc of .25% Bupivacaine was injected into the space. The needle was removed and the puncture wound was dressed.

Observations

- The patient was monitored for an appropriate length of time after the procedure and then discharged home, in good condition, with a driver.
- The patient was instructed to refrain from driving for 12 hours and to contact the office immediately if any of the following were noted: new or different pain in the back, loss of bladder or bowel control, new pain, numbness or weakness of the legs, redness or drainage from the needle insertion site.
- No sedation was given.
- The patient tolerated the procedure well.

The following complications were noted:
None

Orders

c-arm [CPT-77003]
Single Lumbar / Caudal [62311]
Triamcinolone 10mg [J3301]
Return for follow-up 1 month [xxxxx]

Updated Medication List

LORTAB 10 10-500 MG TABS (HYDROCODONE-ACETAMINOPHEN) 1 po qid prn pain max of 4 per day *** 30 DAY SUPPLY *** NO EARLY REFILLS
BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm
AMBIEN CR 12.5 MG TBCR (ZOLPIDEM TARTRATE) 1 po qhs
CELEBREX 200 MG CAPS (CELECOXIB) take one PO BID
FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 HS
CYMBALTA 30 MG CPEP (DULOXETINE HCL) 4 po qhs

0092

MS KELLIE BURNETT
Female 15-1-1971 18361 Home Care 25-1-2009
HIS VOC REHAB

06/18/2008 - Office Visit: Follow-Up Pain
Provider: MONICA P SPEAK NP
Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

Follow-Up Visit

Chief Complaint: Chronic varying pain in back
History of Present Illness: Patient is S/P LESI with 50 % reduction in pain. The injection continues to work. She is able to continue her activities but her indurance is low.
Discussed how to build up her indurance with gradual exercise and water aerobics.
Patient states taking medication as directed. Also states medication helps with pain reduction.
Medicine containers brought in, amts appropriate for date filled.
Without the medication the patient states all activities would have to be curtailed. The medicine makes the pain bearable according to the patient.

Having some sleepiness with her medication

Location Of Pain: as above
Description Of Pain: Sharp, Aching, Dull
Pain Rating: 7
Activity: Decreased
Did Medications Help? Yes
Did Injection Help? Yes
Percent: 50
Is the patient taking any new medications? No
Does the patient have any new medical or surgical problems? No
Is the patient experiencing increased sadness, anxiety, or family problems? No
Data Reviewed: Old Charts

Past, Family, and Social History

Past History (Reviewed - No Changes Since Last Visit): Depression, ADHD, osteoarthritis
Surgery: SLAP procedure left shoulder, broken nose

ALLERGIES: NKDA

Family History (Reviewed - No Changes Since Last Visit): Migraine headaches, back problem, depression
Social History (Reviewed - No Changes Since Last Visit): Single
High school graduate
Works full time, regular duty as a Greenville City Police officer, work-related injury 8/23/03, Attorney Doug Churdar STOPPED WORKING ARIL, 2008
Denies tobacco
Occassional alcohol

Review of Systems

General: fatigue

0094

MS KELLIE BURNETTE

(888)

Int. VOC REHAB

Palpation: Tender
Trapezius/LS

Thoracolumbar

ROM: decreased flexion
Patrick's Test: Negative
Straight Leg Raise: Negative
Palpation: Tender
Midline, Facets
Comments: bilateral L4-5, s1

Muscle Stretch Reflex

Sensory Intact to light touch/pin prick, Negative allodynia/hyperpathia
Neuro No Atrophy or Clonus
Sympathetic Function: Normal

Assessment

Status of Existing Problems:

Assessed CERVICAL SPONDYLOSIS as unchanged - Monica Speak, FNP
Assessed THORACIC SPONDYLOSIS as unchanged - Monica Speak, FNP
Assessed MYOFASCIAL PAIN SYNDROME as unchanged - Monica Speak, FNP
Assessed SPONDYLOSIS - LUMBOSACRAL as unchanged - Monica Speak, FNP
Assessed CERVICALGIA as unchanged - Monica Speak, FNP
Assessed Z-JOINT SYNDROME as unchanged - Monica Speak, FNP
Assessed LOW BACK PAIN SYNDROME as unchanged - Monica Speak, FNP
Assessed LUMBAR RADICULOPATHY as unchanged - Monica Speak, FNP
Assessed DEPRESSION as unchanged - Monica Speak, FNP

Plan

Refill meds

Patient doing well on present pain management program. We will continue with the same medications.

Schedule repeat LESI L5-S1

follow up after injection as directed by MD

The combination of injections and medications allows the patient to lead a more active lifestyle with family and friends.

Restart PT for low back

New Prescriptions/Refills:

AMBIEN CR 12.5 MG TBCR (ZOLPIDEM TARTRATE) 1 po qhs #30 x 0, 06/18/2008, Monica Speak, FNP

LORTAB 10 10-500 MG TABS (HYDROCODONE-ACETAMINOPHEN) 1 po qid pm pain max of 4 per day *** 30 DAY SUPPLY *** NO EARLY REFILLS #120 x 1, 06/18/2008, Monica Speak, FNP

Current Medication List:

LORTAB 10 10-500 MG TABS (HYDROCODONE-ACETAMINOPHEN) 1 po qid pm pain max of 4 per day *** 30 DAY SUPPLY *** NO EARLY REFILLS

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm

0096

MSKELLIE BURNETT
1988

05/19/2008 - Office Procedure: Epidural Steroid Injection

Provider: John Satterthwaite MD

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

Epidural Steroid Injection

Indications:

L5-S1 disc protrusion with radiculopathy
Good benefit from previous ESI
Return of back and leg pain
Repeat ESI

Procedure:

After informed consent was obtained, the patient was placed in the prone position and the back was prepped with Betadine and draped in the usual sterile fashion. Fluoroscopy was used to localize the appropriate interspace. Local anesthesia was administered using a 27 gauge needle and 1% Lidocaine. Using a 18 gauge Touhy needle and loss of resistance technique, the epidural space was entered at the L5-S1 interspace. No blood or CSF was noted returning from the needle. Following negative aspiration, 40mg Triamcinolone in 3cc normal saline with 1cc of .25% Bupivacaine was injected into the space. The needle was removed and the puncture wound was dressed.

Observations

- The patient was monitored for an appropriate length of time after the procedure and then discharged home, in good condition, with a driver.
- The patient was instructed to refrain from driving for 12 hours and to contact the office immediately if any of the following were noted: new or different pain in the back, loss of bladder or bowel control, new pain, numbness or weakness of the legs, redness or drainage from the needle insertion site.
- No sedation was given.
- The patient tolerated the procedure well.

The following complications were noted:

None

Orders

c-arm [CPT-77003]
Single Lumbar / Caudal [62311]
Triamcinolone 10mg [J3301]
Return for follow-up 1 month [xxxxx]

Updated Medication List

LORTAB 10 10-500 MG TABS (HYDROCODONE-ACETAMINOPHEN) 1 po qid pm pain max of 4 per day *** 30 DAY SUPPLY *** NO EARLY REFILLS
BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm
AMBIEN CR 12.5 MG TBCR (ZOLPIDEM TARTRATE) 1 po qhs
CELEBREX 200 MG CAPS (CELECOXIB) take one PO BID
FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 HS

0098

MS KELLIE BURNETT

1858

NS VQC REHAB

04/10/2008 - Office Visit: Follow-Up Pain

Provider: Kimberly Parker NP

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

Follow-Up Visit

Chief Complaint: Here for FU on chronic pain in back and neck

History of Present Illness: states that going to physical therapy and this has helped with spasms and ROM (going to VBS)

doesn't feel like she can continue her job and states needs to remain out of work

ESI decreased pain about 20% and still feeling effects

states has problems falling asleep and staying asleep at times

denies any controlled medications from outside sources or use of illegal substances

No changes in overall pain and no new bowel or bladder changes.

brought in letter from attorney-requesting that this be filled out by Dr. Satt

Location Of Pain: back and neck

Description Of Pain: Sharp, Aching, Burning

Pain Rating: 6

Activity: Stayed The Same

Did Medications Help? Yes

Did Injection Help? Yes

Percent: 20%

Is the patient taking any new medications? No

New Meds:

AMBIEN CR 12.5 MG TBCR (ZOLPIDEM TARTRATE) 1 po qhs

Does the patient have any new medical or surgical problems? No

Is the patient experiencing increased sadness, anxiety, or family problems? No

Past, Family, and Social History

Past History (Reviewed - No Changes Since Last Visit): Depression, ADHD, osteoarthritis

Surgery: SLAP procedure left shoulder, broken nose

ALLERGIES: NKDA

Family History (Reviewed - No Changes Since Last Visit): Migraine headaches, back problem, depression

Social History (Reviewed - No Changes Since Last Visit): Single

High school graduate

Works full time, regular duty as a Greenville City Police officer, work-related injury 8/23/03, Attorney Doug

Churdar Denies tobacco

Occassional alcohol

Review of Systems

General: fatigue

Eyes: denies blurring, diplopia, irritation, discharge, vision loss, eye pain, photophobia

Ear/Nose/Throat: denies ear pain or discharge, tinnitus, decreased hearing; nasal obstruction or

0101

MS KELLIE BURNETTE

19381

1115 VOC REHAB

discharge, nosebleeds, sore throat, hoarseness, dysphagia

Cardiovascular: Denies chest pain, palpitations, syncope, dyspnea on exertion, orthopnea, PND, peripheral edema

Respiratory: Denies cough, dyspnea, excessive sputum, hemoptysis, wheezing

Gastrointestinal: Denies nausea, vomiting, diarrhea, constipation, change in bowel habits, abdominal pain, melena, hematochezia, jaundice

Genitourinary: denies vaginal discharge, incontinence, dysuria, hematuria, urinary frequency, amenorrhea, menorrhagia, abnormal vaginal bleeding, pelvic pain

Musculoskeletal: back pain, neck pain, muscle cramps

Skin: denies rash, itching, dryness, suspicious lesions

Neurologic: weakness

Psychiatric: depression

Endocrine: denies cold intolerance, heat intolerance, polydipsia, polyphagia, polyuria, weight change

Hematologic/Lymphatic: denies abnormal bruising, bleeding, enlarged lymph nodes

Allergic/Immunologic: denies urticaria, hay fever, persistent infections, HIV exposure

Vital Signs

Ht: 70 in.

Physical Exam

General

General appearance: obese

Communication ability: communicates by voice, normal quality

Gait and station: Normal

Psychiatric

Mental Status: AAO x3

Judgement/Insight: Intact

Mood/Affect: Appropriate

Recent/Remote Memory: Normal

Extremities

Pedal pulses: +

Thoracolumbar

Palpation: Tender

Midline, Paravertebral

Comments: lower lumbar

Muscle Stretch Reflex

Sensory: Decreased sensation to light touch

Comments: RLE laterally above and below knee, medially at ankle

Assessment

Status of Existing Problems:

Assessed CERVICAL SPONDYLOSIS as unchanged - Kimberly Parker FNPC - Signed

Assessed THORACIC SPONDYLOSIS as unchanged - Kimberly Parker FNPC - Signed

Assessed LUMBAR RADICULOPATHY as unchanged - Kimberly Parker FNPC - Signed

0102

MS KELLIE BURNETTE

Female DOB 01/01/1967

18337

Home Health Care
INS VOC REHAB

03/26/2008 - Office Procedure: Epidural Steroid Injection

Provider: John Satterthwaite MD

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

Epidural Steroid Injection

Indications:

L5-S1 disc protrusion with radiculopathy
Increasing pain in spite of medications
Previous ESI with benefit
Repeat injection

Procedure:

After informed consent was obtained, the patient was placed in the prone position and the back was prepped with Betadine and draped in the usual sterile fashion. Fluoroscopy was used to localize the appropriate interspace. Local anesthesia was administered using a 27 gauge needle and 1% Lidocaine. Using a 18 gauge Touhy needle and loss of resistance technique, the epidural space was entered at the L5-S1 interspace. No blood or CSF was noted returning from the needle. Following negative aspiration, 40mg Triamcinolone in 3cc normal saline with 1cc of .25% Bupivacaine was injected into the space. The needle was removed and the puncture wound was dressed.

Observations

- The patient was monitored for an appropriate length of time after the procedure and then discharged home, in good condition, with a driver.
- The patient was instructed to refrain from driving for 12 hours and to contact the office immediately if any of the following were noted: new or different pain in the back, loss of bladder or bowel control, new pain, numbness or weakness of the legs, redness or drainage from the needle insertion site.
- No sedation was given.
- The patient tolerated the procedure well.

The following complications were noted:
None

Orders

c-arm [CPT-77003]
Single Lumbar / Caudal [62311]
Triamcinolone 10mg [J3301]
Return for follow-up 2 weeks [xxxxx]

Updated Medication List

LORTAB 10 10-500 MG TABS (HYDROCODONE-ACETAMINOPHEN) 1 po qid pm pain max of 4 per day *** 30 DAY SUPPLY *** NO EARLY REFILLS
BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm
AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) 1 qhs pm sleep
CELEBREX 200 MG CAPS (CELECOXIB) take one PO BID
FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 HS

0105

MS KELLIE BURNETT
18881
JUN 12 2009

03/13/2008 - Office Visit: Follow-Up Pain

Provider: Kimberly Parker NP

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

Follow-Up Visit

Chief Complaint: Here for FU on chronic pain in back and neck

History of Present Illness: states taking meds as prescribed without side effects and they are helpful. still don't have approval to treat neck

patient states that was told today by the paralegal that she can't see anyone but Dr. Satt/no NP, per the insurance company-states insurance company was going to call and tell us that. advised that we don't have a message to that affect and if that's what insurance is demanding then they will need to refer her elsewhere.

patient has missed numerous days of work-states that returned to work after being off for a few days R/T pain and then was out on Friday and Sat nights secondary to pain.

loratab filled on 2/20/08

pain level noted with meds to be 5/10

Location Of Pain: back and neck

Description Of Pain: Sharp, Aching, Burning

Pain Rating: 5

Activity: Stayed The Same

Did Medications Help? Yes

Is the patient taking any new medications? No

Does the patient have any new medical or surgical problems? No

Is the patient experiencing increased sadness, anxiety, or family problems? No

Past, Family, and Social History

Past History (Reviewed - No Changes Since Last Visit): Depression, ADHD, osteoarthritis

Surgery: SLAP procedure left shoulder, broken nose

ALLERGIES: NKDA

Family History (Reviewed - No Changes Since Last Visit): Migraine headaches, back problem, depression

Social History (Reviewed - No Changes Since Last Visit): Single

High school graduate

Works full time, regular duty as a Greenville City Police officer, work-related injury 8/23/03, Attorney Doug

Churdar Denies tobacco

Occasional alcohol

Review of Systems

General: fatigue

Eyes: denies blurring, diplopia, irritation, discharge, vision loss, eye pain, photophobia

Ear/Nose/Throat: denies ear pain or discharge, tinnitus, decreased hearing, nasal obstruction or discharge, nosebleeds, sore throat, hoarseness, dysphagia

Cardiovascular: Denies chest pain, palpitations, syncope, dyspnea on exertion, orthopnea, PND, peripheral edema

0107

MS KIMBERLY BURNETTE
18881
Hawkins VOC RE-HAB

Assessed MYOFASCIAL PAIN SYNDROME as unchanged - Kimberly Parker FNPC - Signed
Assessed SPONDYLOSIS - LUMBOSACRAL as unchanged - Kimberly Parker FNPC - Signed
Assessed CERVICALGIA as unchanged - Kimberly Parker FNPC - Signed
Assessed Z-JOINT SYNDROME as unchanged - Kimberly Parker FNPC - Signed
Assessed LUMBAR RADICULOPATHY as unchanged - Kimberly Parker FNPC - Signed

Plan

noting spasms-will refer to physical therapy to help with this and also ROM/strengthening
ESI has worn off-did help with back and leg pain-will schedule for another one L5-S1
reviewed MRI-does have HNP L5-S1 would like to see surgeon-will refer to Steadman Hawkins for
evaluation
still awaiting approval for treatment of neck-when approved will order the x-rays and determine further
treatment from that
unable to continue working in current capacity-must have sedentary job with ability to get up and stretch
every hour with limited bending/pushing/pulling-see restriction sheet
Continue current pain management program. taking meds as prescribed and they are helpful-RF given
FU for ESI, call with problems

New Prescriptions/Refills:

LORTAB 10 10-500 MG TABS (HYDROCODONE-ACETAMINOPHEN) 1 po qid prn pain max of 4 per
day *** 30 DAY SUPPLY *** NO EARLY REFILLS #120 x 0, 03/13/2008, Kimberly Parker FNPC

Current Medication List:

LORTAB 10 10-500 MG TABS (HYDROCODONE-ACETAMINOPHEN) 1 po qid prn pain max of 4 per
day *** 30 DAY SUPPLY *** NO EARLY REFILLS
BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm
AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) 1 qhs prn sleep
CELEBREX 200 MG CAPS (CELECOXIB) take one PO BID
FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 HS
CYMBALTA 30 MG CPEP (DULOXETINE HCL) 4 po qhs
LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12
hours and remove for 12 hours.
ADDERALL 20 MG TABS (AMPHETAMINE-DEXTROAMPHETAMINE) bid - Dr Giambalvo
ZYRTEC 10 MG TABS (CETIRIZINE HCL) 1 po qhs other MD

New Orders:

Referral to Orthopaedist [XXXXX]
Return for Epidural Steroid Injection [XXXXX]
Physical Therapy Referral [XXXXX]

Prescriptions:

LORTAB 10 10-500 MG TABS (HYDROCODONE-ACETAMINOPHEN) 1 po qid prn pain max of 4 per
day *** 30 DAY SUPPLY *** NO EARLY REFILLS #120 x 0

Entered by: Kimberly Parker FNPC
Authorized by: John Satterthwaite MD
Signed by: Kimberly Parker FNPC on 03/13/2008
Method used: Print then Give to Patient
RxID: 1521039228401010

MS KELLIE BURNETTE

Female

18381

Howe...
JRS/VGC/REHAB

02/20/2008 - Office Visit: Follow-Up Pain

Provider: MONICA P SPEAK NP

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

Follow-Up Visit

Chief Complaint: Chronic pain in back and neck

History of Present Illness: Patient is S/P LSI with 20 % reduction in pain. Her neck also hurts. Her neck pain causes her to have headaches.

She has applied for medical retirement for the police department.

Patient states that she has rec'd approval for treatment on her neck.

I have explained to her that until we receive written approval we can not treat her neck through her workers comp. Pt acknowledges understanding of instructions.

Patient states taking meds as directed without side effects.

Patient states having no side effects from medications.

Patient states taking meds as directed without side effects.

Patient brought in Lortab bottle only fill 1/31 and has 7 pills left.

She states that she has had to take more than 1 per day.

She also states the Ultram ER and regular Ultram are not helping.

Discussed with Dr. Satterthwaite and we are to increase Lortab to QID prn and DC ultram.

Location Of Pain: back, neck

Description Of Pain: Sharp, Aching, Burning

Pain Rating: 8

Activity: Stayed The Same

Did Medications Help? Yes

Is the patient taking any new medications? No

New Meds:

LORTAB 10 10-500 MG TABS (HYDROCODONE-ACETAMINOPHEN) 1 po qid prn pain max of 4 per day *** 30 DAY SUPPLY *** NO EARLY REFILLS

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 HS

Does the patient have any new medical or surgical problems? No

Is the patient experiencing increased sadness, anxiety, or family problems? No

Data Reviewed: Old Charts

Past, Family, and Social History

Past History (Reviewed - No Changes Since Last Visit): Depression, ADHD, osteoarthritis

Surgery: SLAP procedure left shoulder, broken nose

ALLERGIES: NKDA

Family History (Reviewed - No Changes Since Last Visit): Migraine headaches, back problem, depression

Social History (Reviewed - No Changes Since Last Visit): Single

High school graduate

Works full time, regular duty as a Greenville City Police officer, work-related injury 8/23/03, Attorney Doug

Churdar Denies tobacco

Occasional alcohol

0111

MS KELLIE BURNETTE

Female DOB: 1/1/1961

18381

Ins VOC REHAB

Pedal pulses: pulses 2+, symmetric

Cervical

ROM FROM painfull

Palpation: Tender

Paracervical, Trapezius/LS, Midline

Comments: C3-7, T1

Thoracolumbar

ROM: decreased rotation/extension

Comments: painfull

Patrick's Test: Negative

Straight Leg Raise: Negative

Palpation: Tender

Midline, Facets, SI, Paravertebral, Gluts

Comments: L3-5

Muscle Stretch Reflex

Sensory Intact to light touch/pin prick, Negative allodynia/hyperpathia

Neuro No Atrophy or Clonus

Sympathetic Function: Normal

Assessment

Status of Existing Problems:

Assessed CERVICAL SPONDYLOSIS as unchanged - Monica Speak, FNP

Assessed THORACIC SPONDYLOSIS as unchanged - Monica Speak, FNP

Assessed MYOFASCIAL PAIN SYNDROME as unchanged - Monica Speak, FNP

Assessed SPONDYLOSIS - LUMBOSACRAL as unchanged - Monica Speak, FNP

Assessed CERVICALGIA as unchanged - Monica Speak, FNP

Assessed Z-JOINT SYNDROME as unchanged - Monica Speak, FNP

Assessed LOW BACK PAIN SYNDROME as unchanged - Monica Speak, FNP

Assessed LUMBAR RADICULOPATHY as unchanged - Monica Speak, FNP

Assessed DEPRESSION as unchanged - Monica Speak, FNP

Plan

Refill meds

Stop ultarm and ultram ER per Dr. Satt

Increase Lortab to 4 per day per Dr. Satt

Change Flexeril to hs only per Dr. Satt

follow up 1 month

Pt needs to bring in all pill containers

Pt needs to get us written approval to treat neck problems

Pt acknowledges understanding of instructions.

Side effects of new meds and/or increase in present meds were explained to patient and patient instructed to call if having any problems with the new medication

New Prescriptions/Refills:

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12

0113

MS KELLIE BURNEIDE

Female Date of Birth: 1/1/1981

18881

1155 VOUCHER

01/30/2008 - Office Procedure: Epidural Steroid Injection

Provider: John Satterthwaite MD

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

Epidural Steroid Injection

Indications:

L5-S1 disc protrusion with back and leg pain.

Increasing pain with activity, not always controlled with Ultram. Requesting something stronger for these episodes. Will increase Ultram to bid prn, add Lortab 10 qd prn severe pain, continue Ultram ER.

For ESI today

Procedure:

After informed consent was obtained, the patient was placed in the prone position and the back was prepped with Betadine and draped in the usual sterile fashion. Fluoroscopy was used to localize the appropriate interspace. Local anesthesia was administered using a 27 gauge needle and 1% Lidocaine. Using a 18 gauge Touhy needle and loss of resistance technique, the epidural space was entered at the L5-S1 interspace. No blood or CSF was noted returning from the needle. Following negative aspiration, 40mg Triamcinolone in 3cc normal saline with 1cc of .25% Bupivacaine was injected into the space. The needle was removed and the puncture wound was dressed.

Observations

- The patient was monitored for an appropriate length of time after the procedure and then discharged home, in good condition, with a driver.

- The patient was instructed to refrain from driving for 12 hours and to contact the office immediately if any of the following were noted: new or different pain in the back, loss of bladder or bowel control, new pain, numbness or weakness of the legs, redness or drainage from the needle insertion site.

- No sedation was given.

- The patient tolerated the procedure well.

The following complications were noted:

None

Orders

c-arm [CPT-77003]

Single Lumbar / Caudal [62311]

Triamcinolone 10mg [J3301]

Return for follow-up 1 month [xxxxx]

Updated Medication List

ULTRAM ER 300 MG TABS (TRAMADOL HCL) Take one in the morning with food PRN for pain.

LORTAB 10 10-500 MG TABS (HYDROCODONE-ACETAMINOPHEN) 1 qd prn severe pain

ULTRAM 50 MG TABS (TRAMADOL HCL) 1 po q 12 h prn break thru pain

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm

AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) 1 qhs prn sleep

CELEBREX 200 MG CAPS (CELECOXIB) take one PO BID

0116

MSKEULIE BURNETTE
Female DOB: 11/11/1961

MS VOC REHAB

01/10/2008: Office Visit: Follow-Up Pain

Provider: Kimberly Parker NP

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

Follow-Up Visit

Chief Complaint: Here for FU on chronic pain in back and neck.

History of Present Illness: states taking meds as prescribed without side effects and they are helpful- states doesn't feel impaired

brought in meds and taking appropriately

states that fell and has stitches in left arm and was given short round of lortab but is off of this now (ER gave her)

states decreased cymbalta to 3 and taking QHS

states that has bloodwork scheduled which will include thyroid panel.

states that her uniform weighs about 20-25 pounds and then her vest weighs 5-7 pounds

states wonders longterm if she will be able to continue doing what she is doing now

Location Of Pain: back and neck

Description Of Pain: Sharp, Aching, Burning

Pain Rating: 7

Activity: Stayed The Same

Did Medications Help? Yes

Is the patient taking any new medications? No

Does the patient have any new medical or surgical problems? Yes

New Problems:

LUMBAR RADICULOPATHY (ICD-724.4)

Is the patient experiencing increased sadness, anxiety, or family problems? No

Past, Family, and Social History

Past History (Reviewed - No Changes Since Last Visit): Depression, ADHD, osteoarthritis

Surgery: SLAP procedure left shoulder, broken nose

ALLERGIES: NKDA

Family History (Reviewed - No Changes Since Last Visit): Migraine headaches, back problem, depression

Social History (Reviewed - No Changes Since Last Visit): Single

High school graduate

Works full time, regular duty as a Greenville City Police officer, work-related injury 8/23/03, Attorney Doug

Churdar Denies tobacco

Occasional alcohol

Review of Systems

General: fatigue

Eyes: denies blurring, diplopia, irritation, discharge, vision loss, eye pain, photophobia

Ear/Nose/Throat: denies ear pain or discharge, tinnitus, decreased hearing, nasal obstruction or

MS KELLIE BURNETTE

Female 03-25-1955

(B381)

Home Health
MS VOC REHAB

Assessment

Status of Existing Problems:

Assessed MYOFASCIAL PAIN SYNDROME as unchanged - Kimberly Parker FNPC

Assessed CERVICALGIA as unchanged - Kimberly Parker FNPC

New Problems:

LUMBAR RADICULOPATHY (ICD-724.4)

Plan

reviewed lumbar MRI-facet hypertrophy, as well as HNP L5-S1-

discussed ESI L5-S1 will schedule for this

Continue current pain management program. taking meds as prescribed and they are helpful-RF given
FU for ESI, call with problems

New Prescriptions/Refills:

ULTRAM 50 MG TABS (TRAMADOL HCL) 1 po QD prn break thru pain #30 x 0 : Kimberly Parker FNPC
(01/10/2008)

Current Medication List:

ULTRAM 50 MG TABS (TRAMADOL HCL) 1 po QD prn break thru pain

ULTRAM ER 300 MG TB24 (TRAMADOL HCL) Take one in the morning with food PRN for pain.

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm

AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) 1 qhs prn sleep

CELEBREX 200 MG CAPS (CELECOXIB) take one PO BID

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 po tid prn muscle spasm

CYMBALTA 30 MG CPEP (DULOXETINE HCL) 4 po qhs

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12
hours and remove for 12 hours.

ADDERALL 20 MG TABS (AMPHETAMINE-DEXTROAMPHETAMINE) bid - Dr Giambalvo

ZYRTEC 10 MG TABS (CETIRIZINE HCL) 1 po qhs other MD

New Orders:

Expanded [99213]

Return for Epidural Steroid Injection [XXXXX]

Prescriptions:

ULTRAM 50 MG TABS (TRAMADOL HCL) 1 po QD prn break thru pain #30 x 0

Entered by: Kimberly Parker FNPC

Authorized by: John Satterthwaite MD

Signed by: Kimberly Parker FNPC on 01/10/2008

Method used: Print then Give to Patient

Signed by Kimberly Parker FNPC on 01/16/2008 at 9:14 AM

0120

MS KELLIE BURNETT

12/13/2007 - Office Visit: Follow-Up Pain

Provider: Kimberly Parker NP

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

Follow-Up Visit

Chief Complaint: Here for FU on chronic pain in back and neck

History of Present Illness: no radiation of pain into arms and neck
states that has gained weight about 20-25 pounds over the last few months
states not eating differently but is more sedentary
states taking meds as prescribed without side effects and they are helpful.
didn't bring in meds with her
No changes in overall pain and no new bowel or bladder changes.
working

Location Of Pain: back and neck

Description Of Pain: Sharp, Aching

Pain Rating: 7

Activity: Stayed The Same

Did Medications Help? Yes

Is the patient taking any new medications? Yes

New Meds:

ULTRAM 50 MG TABS (TRAMADOL HCL) 1 po QD pm break thru pain

ZYRTEC 10 MG TABS (CETIRIZINE HCL) 1 po qhs other MD

Does the patient have any new medical or surgical problems? No

New Problems:

LOW BACK PAIN SYNDROME (ICD-724.2)

Is the patient experiencing increased sadness, anxiety, or family problems? No

Past, Family, and Social History

Past History (Reviewed - No Changes Since Last Visit): Depression, ADHD, osteoarthritis

Surgery: SLAP procedure left shoulder, broken nose

ALLERGIES: NKDA

Family History (Reviewed - No Changes Since Last Visit): Migraine headaches, back problem, depression

Social History (Reviewed - No Changes Since Last Visit): Single

High school graduate

Works full time, regular duty as a Greenville City Police officer, work-related injury 8/23/03, Attorney Doug

Churdar Denies tobacco

Occasional alcohol

Review of Systems

General: fatigue

MS KELLIE BURNETTE

Female DOB

1988

Home (803) 585-1234

MS VOO RENAI

Eyes: denies blurring, diplopia, irritation, discharge, vision loss, eye pain, photophobia
Ear/Nose/Throat: denies ear pain or discharge, tinnitus, decreased hearing, nasal obstruction or discharge, nosebleeds, sore throat, hoarseness, dysphagia
Cardiovascular: Denies chest pain, palpitations, syncope, dyspnea on exertion, orthopnea, PND, peripheral edema
Respiratory: Denies cough, dyspnea, excessive sputum, hemoptysis, wheezing
Gastrointestinal: Denies nausea, vomiting, diarrhea, constipation, change in bowel habits, abdominal pain, melena, hematochezia, jaundice
Genitourinary: denies vaginal discharge, incontinence, dysuria, hematuria, urinary frequency, amenorrhea, menorrhagia, abnormal vaginal bleeding, pelvic pain
Musculoskeletal: back pain, neck pain, muscle cramps
Skin: denies rash, itching, dryness, suspicious lesions
Neurologic: weakness
Psychiatric: depression
Endocrine: denies cold intolerance, heat intolerance, polydipsia, polyphagia, polyuria, weight change
Hematologic/Lymphatic: denies abnormal bruising, bleeding, enlarged lymph nodes
Allergic/Immunologic: denies urticaria, hay fever, persistent infections, HIV exposure

Vital Signs

Ht: 70 in.

Physical Exam

General

General appearance: well developed, well nourished, no acute distress
Communication ability: communicates by voice, normal quality
Gait and station: Normal

Psychiatric

Mental Status: AAO x3
Judgement/Insight: Intact
Mood/Affect: Appropriate
Recent/Remote Memory: Normal

Extremities

Pedal pulses: +

Cervical

Palpation: Tender
Trapezius/LS
Comments: bilateral

Thoracolumbar

ROM: decreased flexion
Palpation: Tender
Midline, Paravertebral
Comments: lower lumbar-midline and muscles, thoracic muscles

Muscle Stretch Reflex

Sensory: Decreased sensation to light touch

0123

MS KELLIE BURNETT

(RAB)

ins. yoc. RELAS

Comments: RLE laterally above knee; medially below knee

Assessment

Status of Existing Problems:

Assessed CERVICAL SPONDYLOSIS as unchanged - Kimberly Parker FNPC - Signed
Assessed THORACIC SPONDYLOSIS as unchanged - Kimberly Parker FNPC - Signed
Assessed MYOFASCIAL PAIN SYNDROME as unchanged - Kimberly Parker FNPC - Signed
Assessed SPONDYLOSIS - LUMBOSACRAL as unchanged - Kimberly Parker FNPC - Signed
Assessed Z-JOINT SYNDROME as unchanged - Kimberly Parker FNPC - Signed

New Problems:

LOW BACK PAIN SYNDROME (ICD-724.2)

Plan

continue use of R/S medical as this is helpful
reviewed and discussed last lumbar MRI was 5/4 and had disc bulges L4-L5 and L5-S1 at that time
noting back pain with RLE paresthesia-needs new lumbar MRI-ordered
Continue current pain management program. taking meds as prescribed and they are helpful-RF given
consider lumbar ESI
noting some break thru pain every other day-has had ultram without problems
will give ultram 50mg 1 po qd pm break thru pain. Advised of type medication, how to take, and side effects. To call with any problems, concerns, or side effects.
Reminded to bring all unused medications into appointments
noting fatigue and weight gain-will see Gimbalvo about this for labs-if labs are normal consider changing off cymbalta
FU 1 month
call with problems

New Prescriptions/Refills:

ULTRAM 50 MG TABS (TRAMADOL HCL) 1 po QD pm break thru pain #30 x 0 : Kimberly Parker FNPC
(12/13/2007)

Current Medication List:

ULTRAM 50 MG TABS (TRAMADOL HCL) 1 po QD pm break thru pain
ULTRAM ER 300 MG TB24 (TRAMADOL HCL) Take one in the morning with food PRN for pain.
BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm
AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) 1 qhs pm sleep
CELEBREX 200 MG CAPS (CELECOXIB) take one PO BID
FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 po tid pm muscle spasm
CYMBALTA 30 MG CPEP (DULOXETINE HCL) 4 po qhs
LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours.
ADDERALL 20 MG TABS (AMPHETAMINE-DEXTROAMPHETAMINE) bid - Dr Giambalvo
ZYRTEC 10 MG TABS (CETIRIZINE HCL) 1 po qhs other MD

New Orders:

Expanded [99213]
Return for follow-up 1 month [xxxxx]
MRI, lumbar spine, w/o contrast [CPT-72148]

MS. KELLIE BURNETTE

Female 48 Yrs Old

18981

Home (404) 222-2222

Ins: VOC RHAB

11/15/2007 - Office Visit: Follow-Up Pain

Provider: John Satterthwaite MD

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

Follow-Up Visit

Chief Complaint: Neck and back pain

History of Present Illness: Did not get teaching job. Neck some better, but still has bad days. Back about the same. Medications not helping the neck pain when it is really bad. Weather change and activities are main factors.

Muscle stimulator helping.

Neck pain bilateral at C2-C4 facet areas with headaches and spasm. No arm pain. Probably facet. Probably should get cervical spine xrays to check the facets.

Location Of Pain: Back and neck

Description Of Pain: Sharp, Aching

Pain Rating: 7

Activity: Stayed The Same

Did Medications Help? Yes

Is the patient taking any new medications? No

Does the patient have any new medical or surgical problems? No

New Problems:

Z-JOINT SYNDROME (ICD-724.8)

Is the patient experiencing increased sadness, anxiety, or family problems? No

Vital Signs

Ht: 70 in.

Physical Exam

Cervical

ROM Full with facet pain on extension and rotation

Spurling's Test Negative

Palpation: Tender

Suboccipital, Paracervical

Comments: bil C2-C4 facet

Manual Muscle Testing

RUE: 5/5

RLE: 5/5

LUE: 5/5

LLE: 5/5

Muscle Stretch Reflex

RUE: 2+

RLE: 2+

0126

MS KELLIE BURNETTE

Sample Doc

(338)

INS. VOC. REHA

LUE: 2+

LLE: 2+

Sensory Intact to light touch/pin prick, Negative allodynia/hyperpathia

Neuro No Atrophy or Clonus

Sympathetic Function: Normal

Assessment

New Problems:

Z-JOINT SYNDROME (ICD-724.8)

Plan

Continue medications

C-spine films

Consider facet injections if pain continues to increase.

Additional Studies: C-Spine films

New Prescriptions/Refills:

ULTRAM ER 300 MG TB24 (TRAMADOL HCL) Take one in the morning with food PRN for pain. #30 x 2
: John Satterthwaite MD (11/15/2007)

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm #90 x 2 : John Satterthwaite MD
(11/15/2007)

AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) 1 qhs pm sleep #30 x 2 : John Satterthwaite MD
(11/15/2007)

CELEBREX 200 MG CAPS (CELECOXIB) take one PO BID #60 x 2 : John Satterthwaite MD
(11/15/2007)

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 po tid pm muscle spasm #90 x 2 : John
Satterthwaite MD (11/15/2007)

CYMBALTA 30 MG CPEP (DULOXETINE HCL) 4 po qhs #120 x 2 : John Satterthwaite MD (11/15/2007)

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12
hours and remove for 12 hours. #90 x 2 : John Satterthwaite MD (11/15/2007)

Current Medication List:

ULTRAM ER 300 MG TB24 (TRAMADOL HCL) Take one in the morning with food PRN for pain.

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm

AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) 1 qhs pm sleep

CELEBREX 200 MG CAPS (CELECOXIB) take one PO BID

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 po tid pm muscle spasm

CYMBALTA 30 MG CPEP (DULOXETINE HCL) 4 po qhs

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12
hours and remove for 12 hours.

ADDERALL 20 MG TABS (AMPHETAMINE-DEXTROAMPHETAMINE) bid - Dr Giambalvo

New Orders:

Expanded [99213]

Return for follow-up 1 month [xxxxx]

X-ray exam, cervical spine, 2-3 views [CPT-72040]

Prescriptions:

0127

MISKELLIE BURNETTE

Female

(B38)

Ins. Vol. REHAB

10/18/2007 - Office Visit: Follow-Up Pain

Provider: John Satterthwaite MD

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

Follow-Up Visit

Chief Complaint: Back and neck pain

History of Present Illness: The patient returns today with ongoing complaints of back and neck pain. She continues to work with some difficulty. She does well in the early part of the day, but after standing or walking for long periods, sitting for long periods, and getting in and out of the car, she has a significantly increase in neck and back pain. This is compounded by wearing her utility belt and vest. Aside from the stresses of these activities, the belt alters the posture for her lower back, increasing the stress. Her medications are helping. She has just gotten her RS Medical stimulator and has not tried it yet. On the days that she does not work, her pain level is much lower. It is much better controlled with medications.

When asked if she would like to try a sedentary job, she is not interested in a desk job but does state that she has applied for teaching position, which would not require her to wear the vest and belt and allow her to change positions frequently from standing to sitting.

Location Of Pain: Neck and back pain

Description Of Pain: Sharp, Aching

Pain Rating: 6

Activity: Stayed The Same

Did Medications Help? Yes

Is the patient taking any new medications? No

Does the patient have any new medical or surgical problems? No

Is the patient experiencing increased sadness, anxiety, or family problems? Yes

Comments: still somewhat depressed

Past, Family, and Social History

Past History (Reviewed - No Changes Since Last Visit): Depression, ADHD, osteoarthritis

Surgery: SLAP procedure left shoulder, broken nose

ALLERGIES: NKDA

Family History (Reviewed - No Changes Since Last Visit): Migraine headaches, back problem, depression

Social History (Reviewed - No Changes Since Last Visit): Single

High school graduate

Works full time, regular duty as a Greenville City Police officer, work-related injury 8/23/03, Attorney Doug

Churdar Denies tobacco

Occasional alcohol

Vital Signs

Ht: 70 in.

MS KELLIE BURNETTE

Female DOB

189811

Last V/OG REFILL

Plan

I would like for her to continue her medications that she is currently taking. I have been asked by her Worker's Compensation adjuster to define some work restrictions. She is currently working unrestricted. She does not want significant restrictions that would place her at a desk job or remove her from her job completely. She does feel that she would benefit from limitations to standing and sitting to one hour at a time without rest breaks. She was on her feet working last weekend for several hours, and that was quite uncomfortable to both her neck and back.

She has applied for teaching position, which sounds ideal for her. I would strongly recommend that she be seriously considered for that position as I think she is a dedicated officer and wishes to continue working in law enforcement. It would also be good to get her out of the patrol car so that she does not have to use it for long periods with poor back support and get in and out of the vehicle. The belt and vest are quite heavy and do alter her posture with sitting and standing, increasing problems with her spinal alignment and the potential for increasing her neck and back pain.

With this note I will forward these recommendations to the insurance adjuster.

I will see her back in one month.

I do note there is a notation in the chart that she is not to be seen by other physicians in this office. Although I will primarily be taking care of her, there are times when I am not in the office and the nurse practitioner will have to get prescriptions signed by the physician present on the premises and I would ask that these be honored.

New Prescriptions/Refills:

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm #90 x 0 : John Satterthwaite MD (10/18/2007)

AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) 1 qhs pm sleep #30 x 0 : John Satterthwaite MD (10/18/2007)

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 po tid pm muscle spasm #90 x 0 : John Satterthwaite MD (10/18/2007)

ULTRAM ER 300 MG TB24 (TRAMADOL HCL) Take one in the morning with food PRN for pain. #30 x 0 : John Satterthwaite MD (10/18/2007)

Current Medication List:

ULTRAM ER 300 MG TB24 (TRAMADOL HCL) Take one in the morning with food PRN for pain.

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm

AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) 1 qhs pm sleep

CELEBREX 200 MG CAPS (CELECOXIB) take one PO BID

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 po tid pm muscle spasm

CYMBALTA 30 MG CPEP (DULOXETINE HCL) 4 po qhs

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours.

ADDERALL 20 MG TABS (AMPHETAMINE-DEXTROAMPHETAMINE) bid - Dr Giambalvo

New Orders:

Expanded [99213]

Return for follow-up 1 month [xxxxx]

Prescriptions:

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm #90 x 0

Entered and Authorized by: John Satterthwaite MD

Signed by: John Satterthwaite MD on 10/18/2007

0130

MS KELLIE BURNETT

Female 55

1938

Ins VOC REHAB

09/24/2007 - Office Visit: Follow-Up Pain

Provider: John Satterthwaite MD

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

Follow-Up Visit

Chief Complaint: Neck and back pain

History of Present Illness: ESI, injections by Dr Schwartz in the past with some benefit. Using TENS with benefit. Current medications seem to be working better than previous medications from Dr. Kopera. Having neck pain later in the day with working. Had an injury in June where she hurt her neck. Having problems which sound facet / muscle related. May need to check cervical xrays if this persists.

Location Of Pain: Back and neck

Description Of Pain: Sharp, Aching

Pain Rating: 7

Activity: Stayed The Same

Did Medications Help? Yes

Is the patient taking any new medications? No

New Meds:

AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) 1 qhs prn sleep

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 po tid prn muscle spasm

ADDERALL 20 MG TABS (AMPHETAMINE-DEXTROAMPHETAMINE) bid - Dr Giambalvo

Does the patient have any new medical or surgical problems? No

New Problems:

SPONDYLOSIS - LUMBOSACRAL (ICD-721.3)

CERVICALGIA (ICD-723.1)

Is the patient experiencing increased sadness, anxiety, or family problems? No

Data Reviewed: Old Charts, Med Records

Past, Family, and Social History

Past History: Depression, ADHD, osteoarthritis

Surgery: SLAP procedure left shoulder, broken nose

ALLERGIES: NKDA

Family History: Migraine headaches, back problem, depression

Social History: Single

High school graduate

Works full time, regular duty as a Greenville City Police officer, work-related injury 8/23/03, Attorney Doug

Churdar Denies tobacco

Occassional alcohol

Review of Systems

General: fatigue

Eyes: denies blurring, diplopia, irritation, discharge, vision loss, eye pain, photophobia

Ear/Nose/Throat: denies ear pain or discharge, tinnitus, decreased hearing, nasal obstruction or

MS KELLIE BURNETTE

discharge, nosebleeds, sore throat, hoarseness, dysphagia

Cardiovascular: Denies chest pain, palpitations, syncope, dyspnea on exertion, orthopnea, PND, peripheral edema

Respiratory: Denies cough, dyspnea, excessive sputum, hemoptysis, wheezing

Gastrointestinal: Denies nausea, vomiting, diarrhea, constipation, change in bowel habits, abdominal pain, melena, hematochezia, jaundice

Genitourinary: denies vaginal discharge, incontinence, dysuria, hematuria, urinary frequency, amenorrhea, menorrhagia, abnormal vaginal bleeding, pelvic pain

Musculoskeletal: back pain, muscle cramps

Skin: denies rash, itching, dryness, suspicious lesions

Neurologic: weakness

Psychiatric: depression

Endocrine: denies cold intolerance, heat intolerance, polydipsia, polyphagia, polyuria, weight change

Hematologic/Lymphatic: denies abnormal bruising, bleeding, enlarged lymph nodes

Allergic/Immunologic: denies urticaria, hay fever, persistent infections, HIV exposure

Vital Signs

Ht: 70 in. Wt: 225 lbs.

Physical Exam

General

General appearance: well developed, well nourished, no acute distress

Communication ability: communicates by voice, normal quality

Gait and station: Normal

Psychiatric

Mental Status: AAO x3

Judgement/Insight: Intact

Mood/Affect: Appropriate

Recent/Remote Memory: Normal

Head and Face

Inspection: normocephalic, no scars, lesions, or masses

Facial strength: no weakness

Cervical

ROM decreased w/ lateral rotation

Spurling's Test: Negative

Palpation: Tender

Suboccipital, Paracervical, Trapezius/LS

Comments: C2-C5 facets

Trapezius spasm

Thoracolumbar

ROM: FROM

Patrick's Test: Negative

Straight Leg Raise: Negative

Palpation: Tender

Paravertebral

MSK/ELLIE BURNETTE

Female: 10/12/1968

13380

INS: VOC/REHAB

Manual Muscle Testing

RUE: 5/5

RLE: 5/5

LUE: 5/5

LLE: 5/5

Muscle Stretch Reflex

RUE: 2+

RLE: 2+

LUE: 2+

LLE: 2+

Sensory Decreased sensation to light touch, Negative allodynia/hyperpathia

Neuro No Atrophy or Clonus

Sympathetic Function: Normal

Tinnel's: Negative

Assessment

Status of Existing Problems:

Assessed CERVICALGIA as deteriorated - John Satterthwaite MD

Assessed MYOFASCIAL PAIN SYNDROME as deteriorated - John Satterthwaite MD

New Problems:

SPONDYLOSIS - LUMBOSACRAL (ICD-721.3)

CERVICALGIA (ICD-723.1)

Plan

Continue current medications

Await outcome of negotiations on current injury before further evaluation of the neck

She continues to work but pain still remains an issue

Has refills on most medications.

Current increased neck pain seems to have been aggravated by an injury in June when she was jerked by a car trying to leave the scene.

Will see back in a month and try to sort this out.

New Prescriptions/Refills:

AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) 1 qhs pm sleep #30 x 0 : John Satterthwaite MD
(09/24/2007)

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm #90 x 0 : John Satterthwaite MD
(09/24/2007)

Current Medication List:

ULTRAM ER 300 MG TB24 (TRAMADOL HCL) Take one in the morning with food PRN for pain.

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm

AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) 1 qhs pm sleep

CELEBREX 200 MG CAPS (CELECOXIB) take one PO BID

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 po tid pm muscle spasm

CYMBALTA 30 MG CPEP (DULOXETINE HCL) 4 po qhs

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12

Carolinas Center for Advanced Management of Pain
1330 Boiling Springs Rd Suite 2700 Spartanburg, SC 29303
8645830053 Fax: 8645830390

June 12, 2009
Page 4
Chart Document

MS KELLIE BURNETT
Female (B38) Home Ins VCC REHAB

hours and remove for 12 hours.

* RS MEDICAL MUSCLE STIMULATION VEST for thoracic myofascial pain.

ADDERALL 20 MG TABS (AMPHETAMINE-DEXTROAMPHETAMINE) bid - Dr Giambalvo

New Orders:

Expanded [99213]

Return for follow-up 1 month [xxxxx]

Prescriptions:

AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) 1 qhs prn sleep #30 x 0

Entered and Authorized by: John Satterthwaite MD

Signed by: John Satterthwaite MD on 09/24/2007

Method used: Print then Give to Patient

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm #90 x 0

Entered and Authorized by: John Satterthwaite MD

Signed by: John Satterthwaite MD on 09/24/2007

Method used: Print then Give to Patient

Signed by John Satterthwaite MD on 09/24/2007 at 4:42 PM

0135

MS KELLIE BURNETTE

BSB

Home Care

Ins MOOREHEAD

09/11/2007 - Office Visit: Follow-Up Pain

Provider: Justin Kelby Hutcheson MD

Location of Care: Carolinas Center for Advanced Management of Pain

Follow-Up Visit

Chief Complaint: neck and lbp pain

History of Present Illness: 28 yo police officer s/p MVC with chronic neck and lbp that seems like chronic ligamentous strain, myofascial pain, possibly some underlying arthritis.

T-spine MRI results: Normal T-spine MRI. No DDD, facet arthropathy.

Noted 60 mg cymbalta less effective for depression.

Pain Rating: 9

Activity: Stayed The Same

Did Medications Help? Yes

Is the patient taking any new medications? No

New Meds:

CYMBALTA 30 MG CPEP (DULOXETINE HCL) 4 po qhs

* RS MEDICAL MUSCLE STIMULATION VEST for thoracic myofascial pain

Does the patient have any new medical or surgical problems? No

Is the patient experiencing increased sadness, anxiety, or family problems? No

Data Reviewed: MRI

Past, Family, and Social History

Past History (Reviewed - No Changes Since Last Visit): pmh: depression, ADHD, OA
all: NKDA

med: darvocet, flexeril 10 bid ambien 10 qhs, celebrex, lexapro, adderall

ps/hx: shoulder sx, broken nose

Family History (Reviewed - No Changes Since Last Visit): migraine, back problem, depression

Social History (Reviewed - No Changes Since Last Visit): single, high school grad, FT police officer, work-related injury, attorney D. Churdar, no tob, positive etoh, no ivdu

Review of Systems

General: fatigue

Eyes: denies blurring, diplopia, irritation, discharge, vision loss, eye pain, photophobia

Ear/Nose/Throat: denies ear pain or discharge, tinnitus, decreased hearing, nasal obstruction or discharge, nosebleeds, sore throat, hoarseness, dysphagia

Cardiovascular: Denies chest pain, palpitations, syncope, dyspnea on exertion, orthopnea, PND, peripheral edema

Respiratory: Denies cough, dyspnea, excessive sputum, hemoptysis, wheezing

Gastrointestinal: Denies nausea, vomiting, diarrhea, constipation, change in bowel habits, abdominal pain, melena, hematochezia, jaundice

Genitourinary: denies vaginal discharge, incontinence, dysuria, hematuria, urinary frequency, amenorrhea, menorrhagia, abnormal vaginal bleeding, pelvic pain

Musculoskeletal: back pain, muscle cramps

Skin: denies rash, itching, dryness, suspicious lesions

Neurologic: weakness

0136

MS KELLIE BURNETT

Psychiatric: depression

Endocrine: denies cold intolerance, heat intolerance, polydipsia, polyphagia, polyuria, weight change

Hematologic/Lymphatic: denies abnormal bruising, bleeding, enlarged lymph nodes

Allergic/Immunologic: denies urticaria, hay fever, persistent infections, HIV exposure

Vital Signs

Ht 70 in.

Physical Exam

General

General appearance: well developed, well nourished, no acute distress

Communication ability: communicates by voice, normal quality

Gait and station: Normal

Psychiatric

Mental Status: AAO x3

Judgement/Insight: Intact

Mood/Affect: Appropriate

Head and Face

Inspection: normocephalic, no scars, lesions, or masses

Facial strength: no weakness

Ears, Nose and Throat

External ear: normal, no lesions or deformities

External nose: normal, no lesions or deformities

Lips/teeth/gums: normal dentition

Oropharynx: tongue normal, posterior pharynx without erythema or exudate

Neck

Neck: supple, no masses, trachea midline

Eyes

Inspection of conjunctivae & lids: Normal

Pupils and Irises: grossly intact by confrontation

Pupils: equal, round, reactive to light and accommodation

EOM: extraocular movements intact, normal gaze alignment

Cranial Nerves

5th (Trigeminal): normal corneal reflex

7th (Facial): no weakness

8th (Auditory): grossly intact

9th (Glossophar): grossly intact

11th (Spinal access): grossly intact

12th (Hypoglossal): tongue midline on protrusion no fasciculations

Cervical

ROM decreased w/ lateral rotation

Spurling's Test Negative

MS KELLIE BURNETT

Female DOB: 09/05/1979

1838

Home: (864) 444-9600

IS YOUR REHAB

Palpation: Tender
Suboccipital, Paracervical
Comments: bilateral C2-4

Muscle Stretch Reflex

Sensory Intact to light touch/pin prick, Negative allodynia/hyperpathia
Neuro No Atrophy or Clonus
Sympathetic Function: Normal

Assessment

Comments: Notes mild benefit from increased doses of muscle relaxants. Will continue flexeril and baclofen. Warned about doing baclofen without weaning. Also notes more facet loading pain in the cervical C2-4 region bilaterally.

Plan

Increase dose of cymbalta to 120/d, continue muscle relaxants,
add RS medical muscle stimulator for intractable myofascial pain.
T-spine MRI normal.
Plan left C2-4 Medial branch injections.

New Prescriptions/Refills:

RS MEDICAL MUSCLE STIMULATION VEST for thoracic myofascial pain #1 x 0 : Justin Kelby Hutcheson, MD (09/11/2007)
CYMBALTA 30 MG CPEP (DULOXETINE HCL) 4 po qhs #120 x 1 : Justin Kelby Hutcheson, MD (09/11/2007)

Current Medication List:

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm
AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) 1 qhs
CELEBREX 200 MG CAPS (CELECOXIB) take one PO BID
FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 po tid muscle spasm
CYMBALTA 30 MG CPEP (DULOXETINE HCL) 4 po qhs
LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours.
ULTRAM ER 300 MG TB24 (TRAMADOL HCL) Take one in the morning with food PRN for pain.
* RS MEDICAL MUSCLE STIMULATION VEST for thoracic myofascial pain

New Orders:

Return for Medial Branch Nerve Block [XXXXX]
Focused [99212]

Prescriptions:

RS MEDICAL MUSCLE STIMULATION VEST for thoracic myofascial pain #1 x 0
Entered and Authorized by: Justin Kelby Hutcheson, MD
Signed by: Justin Kelby Hutcheson, MD on 09/11/2007
Method used: Print then Give to Patient
CYMBALTA 30 MG CPEP (DULOXETINE HCL) 4 po qhs #120 x 1
Entered and Authorized by: Justin Kelby Hutcheson, MD
Signed by: Justin Kelby Hutcheson, MD on 09/11/2007

Carolinas Center for Advanced Management of Pain
1330 Boiling Springs Rd Suite 2700 Spartanburg, SC 29303
8645830053 Fax: 8645830390

June 12, 2009
Page 4
Chart Document

MS KELLIE BURNETTE

Female DOB: 01/15/1968

DOB: 01/15/1968

Home: 864-583-0053

MS VOLXREHAB

Method used: Print then Give to Patient

Signed by Justin Kelby Hutcheson, MD on 09/11/2007 at 2:32 PM

0139

MSIKELIE BURNETTE

Female DOB

(8881)

Home Address: 1330 Boiling Springs Rd Suite 2700 Spartanburg, SC 29303
HSA: VOID REF: 1330

08/28/2007 - Office Visit: Initial Office Visit

Provider: Justin Kelby Hutcheson MD

Location of Care: Carolinas Center for Advanced Management of Pain

New Patient Visit

Chief Complaint: back and neck pain

27 yo police officer workers comp pt with persistent back and neck pain that Dr. Kopera was treating for Myofascial pain with darvocet, flexeril pt, tens. She states pain started after being T-boned in mvc at work. Pain is mainly in muscles of thoracic spine.

Diagnostically MRI L-spine minimal disc bulge L4/5 L5/S1 without stenosis

Therapeutically: She has received benefit from Pt, TENS, ambien, flexeril, and celebrex. She has failed darvocet, lunesta, skelaxin, cataflam. Trigger points were mildly helpful. She had 2 es's but not certain what level with no relief.

Referring MD: KEVIN W KOPERA, MD

Age: 27 Year Old

Sex: Female

Race: Undetermined

History of Present Illness

Location of Pain: neck and bilateral paraspinals thoracic, upper lumbar

Description of Pain: Sharp, Dull/Aching, Pressure, Electrical/Shooting, Cramping

Is The Pain Always The Same: No

Duration of Pain: Constant

Aggravating Factors: Sitting, Standing

Comments: wearing duty belt

Alleviating Factors: Lying Down

Additional History

Previous Treatments: Nerve Blocks/Injections, Epidural Steroids, Chiropractor, Narcotic Pain Medication, Physical Therapy, TENS

Previous Diagnostic Studies: MRI

Data Reviewed: Old Charts, MRI

Past Treatment

Has patient been treated in another pain management center? Yes

Where: dr. kopera

Has patient ever had previous psychiatric or psychological treatment? No

Has patient ever required treatment for substance abuse or alcohol abuse? No

Sleep Disturbances

Does the patient ever have difficulty falling asleep? Yes

Does the patient have difficulty maintaining sleep? Yes

Is the patient ever awakened by pain? Yes

Does the patient have difficulty staying awake during the day? Yes

Past, Family, and Social History

0140

Carolinas Center for Advanced Management of Pain

1330 Boiling Springs Rd Suite 2700 Spartanburg, SC 29303
8645830053 Fax: 8645830390

June 12, 2009

Page 3

Chart Document

MS KELLIE BURNETT

Female DOB: 01/01/1981

18981

Home: 864-583-1111

18981

Ears, Nose and Throat

External ear: normal, no lesions or deformities

External nose: normal, no lesions or deformities

Lips/teeth/gums: normal dentition

Oropharynx: tongue normal, posterior pharynx without erythema or exudate

Neck

Neck: supple, no masses, trachea midline

Eyes

Inspection of conjunctivae & lids: Normal

Pupils and Irises: grossly intact by confrontation

Pupils: equal, round, reactive to light and accommodation

EOM: extraocular movements intact, normal gaze alignment

Cranial Nerves

5th (Trigeminal): normal corneal reflex

7th (Facial): no weakness

8th (Auditory): grossly intact

9th (Glossophar): grossly intact

11th (Spinal access): grossly intact

12th (Hypoglossal): tongue midline on protrusion no fasciculations

Cervical

ROM FROM

Spurling's Test Negative

Palpation: Tender

Paracervical, Trapezius/LS

Comments: left facets c4-6, bilat traps

Thoracolumbar

ROM: FROM

Patrick's Test: Negative

Straight Leg Raise: Negative

Palpation: Tender

Facets

Comments: bilat L4-S1

Manual Muscle Testing

RUE: 5/5

RLE: 5/5

LUE: 5/5

LLE: 5/5

Muscle Stretch Reflex

RLE: 1+

LLE: 1+

Sensory Intact to light touch/pin prick, Negative allodynia/hyperpathia

Neuro No Atrophy or Clonus

0142

MS KELLIE BURNETT

Female, DOB

1988

Home - Ins - VCC - RELEAS

Sympathetic Function: Normal

Knees

Comments: FROM, no crepitus

Shoulders

Comments: FROM, no pain with active or passive ROM, rotator cuff muscles intact

Other Exam

Comments: hips FROM, no pain with int/ext rotation
ankles FROM

Assessment

New Problems:

CERVICAL SPONDYLOSIS (ICD-721.0)
THORACIC SPONDYLOSIS (ICD-721.2)
MYOFASCIAL PAIN SYNDROME (ICD-729.1)
DEPRESSION (ICD-311)

Comments: 27 yo female with persistent myofascial pain and minimal spondylosis that has not responded to adequate therapy. Will pursue additional workup including mri T-spine to r/o significant, possibly overlooked pathology and adjust medications to treat MPS.

Plan

thoracic MRI

RTC 1 month

Stop lexapro, add cymbalta titrate to 60 mg/d for depression and pain

Increase flexeril to 10 TID, add baclofen titrates to 10 tid,

Continue celebrex and ambien for now. Add ultram ER and lidoderm for pain

At next visit consider upper-torso TENS Unit from RSI, psych eval for depression.

New Prescriptions/Refills:

AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) 1 qhs #30 x 0 : Justin Kelby Hutcheson, MD
(08/28/2007)

ULTRAM ER 300 MG TB24 (TRAMADOL HCL) Take one in the morning with food PRN for pain. #30 x 1
: Justin Kelby Hutcheson, MD (08/28/2007)

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12
hours and remove for 12 hours. #90 x 2 : Justin Kelby Hutcheson, MD (08/28/2007)

CYMBALTA 30 MG CPEP (DULOXETINE HCL) 1 po qd x7 days then 2 po qd #60 x 0 : Justin Kelby
Hutcheson, MD (08/28/2007)

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 po tid muscle spasm #90 x 0 : Justin Kelby
Hutcheson, MD (08/28/2007)

CELEBREX 200 MG CAPS (CELECOXIB) take one PO BID #60 x 2 : Justin Kelby Hutcheson, MD
(08/28/2007)

AMBIEN 5 MG TABS (ZOLPIDEM TARTRATE) 1 qhs #30 x 0 : Justin Kelby Hutcheson, MD (08/28/2007)

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm #90 x 0 : Justin Kelby Hutcheson, MD
(08/28/2007)

0143

MS KELLIE BURNETT

Female 1/1/1968

18884

MS KELLIE BURNETT
Sins: V010 REHAB

Current Medication List:

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm
AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) 1 qhs
CELEBREX 200 MG CAPS (CELECOXIB) take one PO BID
FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 po tid muscle spasm
CYMBALTA 30 MG CPEP (DULOXETINE HCL) 1 po qd x7 days then 2 po qd
LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours.
ULTRAM ER 300 MG TB24 (TRAMADOL HCL) Take one in the morning with food PRN for pain.

New Orders:

NP - Comprehensive [99204]
MRI, thoracic spine, w/o contrast [CPT-72146]
Return for follow-up 1 month [xxxxx]
P3 [96103]

Prescriptions:

AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) 1 qhs #30 x 0

Entered and Authorized by: Justin Kelby Hutcheson, MD

Signed by: Justin Kelby Hutcheson, MD on 08/28/2007

Method used: Print then Give to Patient

ULTRAM ER 300 MG TB24 (TRAMADOL HCL) Take one in the morning with food PRN for pain. #30 x 1

Entered and Authorized by: Justin Kelby Hutcheson, MD

Signed by: Justin Kelby Hutcheson, MD on 08/28/2007

Method used: Print then Give to Patient

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours. #90 x 2

Entered and Authorized by: Justin Kelby Hutcheson, MD

Signed by: Justin Kelby Hutcheson, MD on 08/28/2007

Method used: Print then Give to Patient

CYMBALTA 30 MG CPEP (DULOXETINE HCL) 1 po qd x7 days then 2 po qd #60 x 0

Entered and Authorized by: Justin Kelby Hutcheson, MD

Signed by: Justin Kelby Hutcheson, MD on 08/28/2007

Method used: Print then Give to Patient

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 po tid muscle spasm #90 x 0

Entered and Authorized by: Justin Kelby Hutcheson, MD

Signed by: Justin Kelby Hutcheson, MD on 08/28/2007

Method used: Print then Give to Patient

CELEBREX 200 MG CAPS (CELECOXIB) take one PO BID #60 x 2

Entered and Authorized by: Justin Kelby Hutcheson, MD

Signed by: Justin Kelby Hutcheson, MD on 08/28/2007

Method used: Print then Give to Patient

AMBIEN 5 MG TABS (ZOLPIDEM TARTRATE) 1 qhs #30 x 0

Entered and Authorized by: Justin Kelby Hutcheson, MD

Signed by: Justin Kelby Hutcheson, MD on 08/28/2007

Method used: Print then Give to Patient

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm #90 x 0

Entered and Authorized by: Justin Kelby Hutcheson, MD

Signed by: Justin Kelby Hutcheson, MD on 08/28/2007

Method used: Print then Give to Patient

Carolinas Center for Advanced Management of Pain
1330 Boiling Springs Rd Suite 2700 Spartanburg, SC 29303
8645830053 Fax: 8645830390

June 12, 2009
Page 6
Chart Document

MSIKELLE BURNETTE
Female 17/2/1988 158cm 55kg
JIS VOOREHIS

Signed by Justin Kelby Hutcheson, MD on 08/28/2007 at 3:19 PM

0145



GREENVILLE (060053)
1 Cannon Drive
Greenville, SC 29605
(864) 242-4011
(864) 233-2677

Final Report

Patient Name: BURNETTE, KELLIE
DOB: ~~08/12/1978~~ Sex: F
Accession: 2543545
Visit Number: 890097
Exam: (53) MRILSPWO - LUMBAR SPINE WO CONTRAST MRI

MRN: 2074961

Completed: 01/07/2008 9:24 AM EST

Requesting Provider: SATTERTHWAITE MD, JOHN R
220 ROPER MOUNTAIN EXT
GREENVILLE, SC 29615

Phone: (864) 295-6399

Fax: (864) 295-2337

MRI LUMBAR SPINE**HISTORY:** Lower back pain.**TECHNICAL:** Sagittal T2, STIR, T1, and axial T1 and T2-weighted images of the lumbar spine were obtained. Comparison is made to the prior examination of 5-11-2004.**FINDINGS:** Images obtained demonstrate conus to have a normal appearance and end at L1. Signal intensity within the bone marrow along with vertebral body height and alignment appear unremarkable.

At L5-S1, mild facet hypertrophy and ligamentum flavum hypertrophy are identified. Very small minimal central disc protrusion is identified on sagittal image #6, axial image #19. I see no significant narrowing of the spinal canal or nerve root impingement.

At L4-5, mild facet hypertrophy is present. I see no focal disc protrusion or spinal canal stenosis.

At L3-4, I see no focal disc protrusion. The discs at L2-3 and L1-2 appear within normal limits.

CONCLUSION: MINIMAL CENTRAL DISC PROTRUSION AT L5-S1 WITHOUT SPINAL CANAL STENOSIS OR NERVE ROOT DISPLACEMENT OR IMPINGEMENT.

End of diagnostic report for accession:2543545

Interpreting Provider: MAMRICK MD, RICHARD RADIOLOGIST
Transcribed By: LW 01/07/2008 3:01 PM EST
Signed By: MAMRICK MD, RICHARD 01/07/2008 3:38 PM EST

0146

AUG. 2. 2007 11:58AM Hewitt, Coleman & Associates

NO. 8302 P. 11713

HEALTHSOUTH
Diagnostic Center of Greenville1 Cannon Drive
Greenville SC 29605

Account #: 109850

Name: BURNETTE, KELLIE NICHOLE

Home Phone: (252) 333-1111

SSN: [REDACTED]

Date of Birth: [REDACTED] Sex: F

Ref: 02187 WEST MERRYWEATHER MD

Date of Procedure: 5/11/04

R64242-4011

MRI LUMBAR SPINE**HISTORY:** Lower back pain.**TECHNIQUE:** T1- and T2-weighted sagittal and axial images of the lumbar spine were obtained.**FINDINGS:** Vertebral height and signal intensity within the bone marrow appears normal. The conus medullaris has a normal appearance and ends at the level of the superior endplate of L1. There is minimal diffuse disc bulging at L5-S1 and L4-5 without evidence of focal disc herniation or nerve root impingement. The disc spaces at L3-4, L2-3, and L1-2 appear within normal limits.**IMPRESSION:** MINIMAL DIFFUSE DISC BULGING AT L5-S1 AND L4-5 WITHOUT EVIDENCE OF A FOCAL DISC PROTRUSION, SPINAL CANAL STENOSIS, OR NERVE ROOT IMPINGEMENT.

Richard A. Mamrigo, MD

Thank you for referring this patient to HealthSouth Diagnostic Center.

dd: 05/12/2004

dt: 05/12/2004

RECEIVED
MAY 11 2004

0147

MEDICAL CERTIFICATE

RE: Kellie Burnette

SS #: ~~6-3-2007~~

DOB: ~~6-3-79~~

DOA: 6/16/07

It is my opinion within a reasonable degree of psychological certainty that the following statements are most probably true.

Do Kellie Burnette's psychological problems result from injuries she sustained on or about June 16, 2007?

☒ Yes ☐ No ☐ Unknown

Comments:

Date: 6-22-09

By: C. David Tollison, Ph.D.
Charles David Tollison, Ph.D.

0148

MEDICAL CERTIFICATE

RE: Kellie Burnette

SS #: [REDACTED]

DOB: [REDACTED]

DOA: 6/16/07

It is my opinion within a reasonable degree of psychological certainty that the following statements are most probably true.

Has Kellie Burnette reached maximum medical improvement for injuries to her psyche (depression and anxiety) sustained on or about June 16, 2007 after her accident at work?

☒ Yes ☐ No ☐ Unknown

Comments:

Date: 6-22-09

By: C. D. Tollison, Ph.D.
Charles David Tollison, Ph.D.

0149

MEDICAL CERTIFICATE

RE: Kellie Burnette

SS #: ~~REDACTED~~

DOB: ~~REDACTED~~

DOA: 6/16/07

It is my opinion within a reasonable degree of psychological certainty that the following statements are most probably true.

Will Kellie Burnette be able to deal with the public?

☒ Yes ☐ No ☐ Unknown

Comments:

For brief periods of time and in situations that are not highly stressful.

Date: 6-22-09

By: C. David Tollison
Charles David Tollison, Ph.D.

0150

MEDICAL CERTIFICATE

RE: Kellie Burnette
SS #: [REDACTED]
DOB: [REDACTED]
DOA: 6/16/07

It is my opinion within a reasonable degree of psychological certainty that the following statements are most probably true.

How will Kellie Burnette's psychological problems affect her concentration, persistence and pace through an eight (8) hour workday?

Comments:

Some limitation in ability to maintain concentration over long periods of time. She would require periodic breaks.

Date: 6-22-09

By: C. David Tollison
Charles David Tollison, Ph.D.

0151

MEDICAL CERTIFICATE

RE: Kellie Burnette
SS #: ~~XXXXXXXXXX~~
DOB: ~~XXXXXX~~
DOA: 6/16/07

It is my opinion within a reasonable degree of psychological certainty that the following statements are most probably true.

What further treatment will Ms. Burnette need to lessen her disability or maintain her level of functioning?

Comments:

*She will require periodic psychological treatment, probably
4 visits annually, and will need to remain on psychotropic
medication*

Date: 6-22-09

By: C. David Tollison
Charles David Tollison, Ph.D.

0152

MEDICAL CERTIFICATE

RE: Kellie Burnette

SS #: ~~██████████~~

DOB: ~~██████~~

DOA: 6/16/07

It is my opinion within a reasonable degree of psychological certainty that the following statements are most probably true.

Will Kellie Burnette be able to maintain competent employment?

☒ Yes ☐ No ☐ Unknown
with restrictions

Comments:

Psychologically, unable to function as law enforcement officer. She probably function in a relatively stress-free position without significant demands. She would require breaks and rest periods.

Date: 6-22-09

By: C. David Tollison, Ph.D.
Charles David Tollison, Ph.D.

0153

DOUGLAS A. CHURDAR, P. C.

Attorney At Law

712 EAST WASHINGTON STREET
GREENVILLE, SOUTH CAROLINA 29601
TELEPHONE (864) 233-0203
FACSIMILE (864) 233-3020
E-MAIL: dachurdar@churdarlaw.com

July 1, 2009

C. David Tollison, Ph D.
Carolinas Center for Advanced Management of Pain
220 Roper Mountain Road Extension
Greenville, SC 29615

RE: Kellie Burnette

Dear Dr. Tollison:

Attached you will find a questionnaire which you completed on June 22, 2008. In response to various questions, you indicated that Ms. Burnette could deal with the public "[f]or brief periods of time", that her psychological problems would affect her "ability to maintain concentration over long periods of time. She would require periodic breaks", and that to maintain employment "[s]he would require breaks and rest periods".

In light of these responses, please answer the following question to a reasonable degree of psychological certainty:

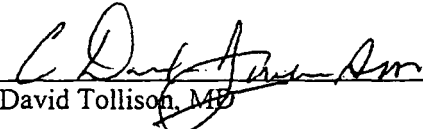
1. Will Ms. Burnette need breaks on an unscheduled or "as needed" basis to maintain competent employment?

☒ Yes ☐ No

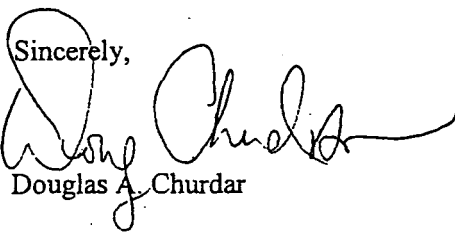
If this is your opinion to a reasonable degree of psychological certainty, please sign below and return to me.

Date: 7-22-09

Thank you.


David Tollison, MD

Sincerely,


Douglas A. Churdar

0154

Carolinas Center for Advanced Management of Pain
1330 Boiling Springs Rd Suite 2700 Spartanburg, SC 29303
8645830053 Fax: 8645830390

July 15, 2009
Page 1
Chart Document

MS KELLIE BURNETTE

Female DOB: ~~XXXXXX~~

18381

Home: ~~XXXXXXXXXX~~
Ins: VOC REHAB

06/18/2009 - Office Visit: Psych F/U

Provider: Charles David Tollison PhD

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

This document contains confidential information

Age: 29 Years Old

Gender: Female

Employment Status: Last worked 3-08, medically retired police officer City Greenville

Prior Mental Health: Diagnosed ADHD in 1999 while attending college. Initial evaluation by Dr. Tollison on 6-23-08.

Education Level: Graduated high school + few college courses

History of Present Illness: Referred Dr. Satterthwaite. August 2003 work-related MVA, full spine, facial trauma. In June 2007 reinjury. Depression secondary to pain and lifestyle change, feelings of loss, feelings of worthlessness, sadness/discouragement, irritability. Dx: Adj D/O Mixed, & 307.89. WC approved.

Psychological Testing P-3 8-27-07, Anxiety Aver, Dep top 27, Soma 34%. P-3 on 6-23-08 Dep top 12, Anxiety 22, and Soma 29th percentile. P-3 on 2-4-09, Dep 9th, Anxiety 18th, Soma 19th.

Progress Note

Clinical Status: I have received and reviewed a letter from Jamey Feuerherd of Hewitt Coleman who includes a copy of the recent rating by Dr. Buccì of 10 percent and ability to return to work without restrictions. This is obviously a physical impairment and I will share with Dr. Satterthwaite the case he has not seen it.

She is complaining of combination of pain and associated psychological symptoms. We discuss Dr. Buccì's rating and she reports, "He doesn't know the whole story, I've been medically retired from my job, I don't know how I'm going to physically be able to do anything productive." Her impairments are primarily physical and her psychological symptoms are secondary.

"I've been doing okay.....everything we've tried I think the Prozac is the best, but I still don't have any happiness.....seems like nothing excites me or interests me anymore, I don't even want to go anywhere, I can make myself but it takes an effort."

Treatment: Combination of education, support, and coping skills training with continuing clinical re-assessment

Assessment

Status of Existing Problems:

Assessed ADJUSTMENT DISORDER/MIXED as unchanged - Charles David Tollison PhD

Assessed PAIN DISORDER (PSYCH/MEDICAL) as unchanged - Charles David Tollison PhD

Plan

Continue current treatment plan and notify me of any significant change in condition. Decrease psychological symptom severity through rehearsal of cognitive-behavioral techniques and distraction. Return appointment with Ms. Richardson and return to me in a month.

New Prescriptions/Refills:

PROZAC 20 MG CAPS (FLUOXETINE HCL) one bid #60 x 0 : Charles David Tollison PhD (06/18/2009)

Current Medication List:

0155

MS KELLIE BURNETTE	Home Phone: 313-361-1111
Female DOB: 2/15/1971	MS VOOREN

06/23/2008 - Office Visit: Pysch Initial Consult

Provider: Charles David Tollison PhD

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

This document contains confidential information

Psychological Evaluation

Medical History

Patient is referred by Dr. Satterthwaite for psychological evaluation and treatment of depression and associated symptoms secondary to a work injury when she was T-boned in a MVA and sustained injury to full spine with facial trauma and this occurred on or about August 2003. Then, on June 16, 2007 she was helping to remove a suspect from a car when the suspect drove off while she was partially in the car and she experienced exacerbation of pain. She has received physical therapy, TENS, and injections with marginal benefit. Pain intensity increased with exertion and physical activity. Otherwise, she reports herself as healthy.

Treating Physicians: John R. Satterthwaite, MD

Alcohol: minimal, infrequent

Illegal Substances Denies

Tobacco: Denies

Psychological Assessment

Patients describes symptoms of depression secondary to pain intensity, duration, and lifestyle alteration. She denies psychological symptoms of significance prior to work injury and pain onset. She is struggling in attempts to make the multiple adjustments necessitated by pain and lifestyle change and admits, "I'm not dealing with all this very well." She talks of feelings of loss related to previous lifestyle. She enjoyed being a law enforcement officer and took satisfaction in her career. She is now mourning this loss, with reduced feelings of self-esteem and self-worth. She is frustrated over duration of pain and suffering, and discouraged over failure of treatment to date to eliminate pain and return her to work and productivity. Medical records are reviewed from Dr. Satterthwaite, Dr. Schwartz, Dr. Kopera. Dr. Satterthwaite opines that her depression is related to pain. She complains of irritability and being short with people due to pain and frustration.

She was diagnosed with ADHD in about 1999 while going to college. She describes her ADHD as "an occasional annoyance" that has never limited her functioning in any manner.

Pain Patient Profile (P-3) psychological testing administered by Dr. Satterthwaite on 8-28-07 is valid with test results confirming an intensity of Anxiety in the Average Range, Depression in top 27th percentile, and Somatization in top 34th percentile, with all scores compared to a national sample of patients in pain.

P-3 testing is re-administered and is valid. Test results confirm an intensity of Depression in top 12th percentile, Anxiety in top 22nd percentile, and Somatization in top 29th percentile. Compared to August 2007 testing, some deterioration in psychological functioning.

Prior mental health treatment: No

Sleep: Trouble achieving and maintaining restful sleep due to difficulty finding comfortable position

Crying: "Definitely increased" and she reports that she was never one to cry before "all this" and she now becomes "down and discouraged"

Appetite/Weight: Increase of about 30 lbs in past two years and she attributes to physical inactivity.

Orthopaedic Associates PA
115 Deacon Tiller Court Duncan, SC 29334
864-582-6396 Fax 864-595-4080

September 30, 2008

Page 1

Chart Document

Kellie Michelle Burnette

09/26/2008 - Office Visit Follow up: MRI espine
Provider: David Mitchell MD
Location of Care: Orthopaedic Associates PA

History of Present Illness

Family Physician: Dr. Giambolvo

History From: Patient

Problem #1

Type: back and neck pain

DOI: 06/2007

Kellie Burnette is a 29 year old former police officer at City of Greenville. She was seen and evaluated 09/19/08 and some of her medical records were reviewed as well as some today. The patient has been treated by Dr. Satterthwaite for her lower back pain. She has an injured disk at L5-S1 and some myofascial pain. She also has some attention deficit disorder symptoms. Her friend in the room with her says that she is up at night and cannot sleep and walks around complaining of neck pain. These symptoms are a little bit more severe than she had told me before.

Past Medical History

Patient indicates history of Mental disorder and Other medical problem.

MEDICATIONS

EFFEXOR XR 75 MG CP24 (VENLAFAXINE HCL) take one q day
LORTAB 10 10-500 MG TABS (HYDROCODONE-ACETAMINOPHEN) take one QID
AMBIEN CR 12.5 MG TBCR (ZOLPIDEM TARTRATE) take one q day
BACLOFEN 10 MG TABS (BACLOFEN) take one TID
FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) Take one q day
CELEBREX 200 MG CAPS (CELECOXIB) take one BID
ADDERALL 20 MG TABS (AMPHETAMINE-DEXTROAMPHETAMINE) take one BID
ZYRTEC ALLERGY 10 MG TABS (CETIRIZINE HCL) take one q day

ALLERGIES

No known allergies

Revised - 09/30/2008

Past Surgical History

Surgical history includes Arthroscopic Shoulder Surgery(left), Low Back Disc Surgery and Other Surgery.

Social History

Patient is single, Non-smoker, and lives with spouse/partner. Has no children. Drinks alcohol 1-3 times per

0222

Orthopaedic Associates PA
115 Deacon Tiller Court Duncan, SC 29334
864-582-6396 Fax: 864-595-4080

September 30, 2008
Page 2
Chart Document

PHYSICAL EXAMINATION

week. Does not exercise. Education completed: High School.

Family History

Patient denies any pertinent family medical history.

Review of Systems

General: Complains of weight gain, fatigue.

Eyes: Denies blurring, vision loss.

Ears/Nose/Throat: Denies difficulty breathing, deafness, hoarseness, hearing aid, dentures.

Cardiovascular: Denies swelling in hands or feet, palpitations, chest pain.

Respiratory: Denies wheezing, coughing, shortness of breath.

Gastrointestinal: Complains of constipation.

Genitourinary: Denies urinary frequency, incontinence, painful urination.

Musculoskeletal: Complains of muscle weakness, back pain, joint pain, joint swelling, stiffness.

Skin: Denies rashes, lumps, lesions, itching, sores.

Neurologic: Complains of numbness/tingling in arms/legs.

Psychiatric: Complains of difficulty sleeping, anxiety, depression.

Endocrine: Complains of heat or cold intolerance, excessive thirst.

Heme/Lymphatic: Complains of chills, sweats.

Allergic/Immunologic: Denies latex allergy, hives, hay fever.

VITAL SIGNS

Ht: 70 in. Wt: 245 lbs.

GENERAL EXAM

Appearance: Healthy

Mental Status: Alert & Oriented x 3, No Acute Distress

Hand Dominance: Right

Gait: Normal

PHYSICAL EXAMINATION

The patient continues to complain of cervical neck pain. She does not really complain of any numbness in her upper extremities and her grip strength is good but she has positive Spurling's exam.

MRI

We have reviewed the MRI that shows C5-6 has a right parasagittal disk protrusion and osteophyte narrowing of the spinal canal. This seems to be flattened to the ventral surface of the spinal cord to the right of midline.

PLAN

It is my opinion that the patient should continue with her treatment for her lower back pain and myofascial pain and cervical neck pain. It would also be my opinion that she be seen by a neurosurgeon in Greenville, Dr. Steve Gardner, for evaluation of her disk protrusion at C5-6 which may be the source of a lot of her neck discomfort.

**QUESTIONNAIRE REGARDING
KELLIE N. BURNETTE**

TO: Michael Bucci, M.D.
RE: Patient: Kellie N. Burnette
DOB:

You have treated Kellie N. Burnette, a former police officer, for a work-related injury to her cervical spine, which occurred on 6/16/07. The injury occurred after Ms. Burnette was dragged and twisted while trying to remove a suspect from a car. In October 2008, you performed a fusion at C5-6. Please answer the questions below to a reasonable degree of medical certainty.

PERMANENT IMPAIRMENT

1. Has Kellie Burnette reached MMI with respect to her cervical spine injury of 06/16/07?
☒ Yes ☐ No
2. Has Kellie sustained permanent impairment to her cervical spine as a result of the accident?
☒ Yes ☐ No
3. Using the AMA Guides, 5th ed., what is Kellie Burnette's DRE category?
IV
4. Using the AMA Guides, 5th ed., what is the permanent impairment sustained by Kellie Burnette to the whole person as a result of her cervical spine injury of 06/16/07?
28%

0231

RETURN TO WORK

5. When you previously filled out a Physician's Statement on April 3, 2009:

a.) Were you aware that Kellie Burnette had already been medically retired from her work as a police officer for the City of Greenville? (See Attachment A)

____ Yes ☒ No

b.) Were you aware of injury to her lumbar spine resulting from an automobile accident in 2003? (See Attachment B)

____ Yes ☒ No

c.) Were you aware that she was seen (before you treated her) and continues to be seen by John Satterthwaite, MD for pain management and David Tollison, Ph.D. for depression/anxiety?

____ Yes ☒ No

d.) Were you aware that, in addition to nerve blocks and epidural steroid injections, she takes the following prescription meds: roxicodone, neurontin, baclofen, flexeril, lidoderm patch, ambient, adderall, zyrtec, celebrex, and prozac?

____ Yes ☒ No

e.) Were you aware of limitations on her resulting from a prior back injury, pain and depression/anxiety? (See attachment C)

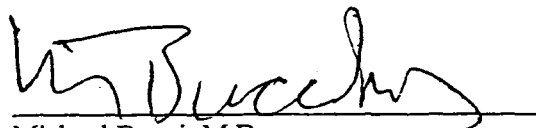
____ Yes ☒ No

6. At this time, do you believe Kellie Burnette is able to return to work as a police officer without restrictions?

____ Yes ☒ No

Date:

8/6/09


Michael Bucci, M.D.

treatment in the form of pain medications and injections to maintain her current level of impairment and to lessen her period of disability.

FINDINGS OF FACT

Based on all of the evidence presented, the undersigned Commissioner hereby makes the following findings of fact:

1. Claimant sustained an admitted and compensable injury to her back on August 23, 2003.

2. As a result of the injury to Claimant's back, Claimant has back pain on a daily basis in both the upper and lower portions. As a result, she must take pain medication. Even with her pain medication, she cannot perform the duties of her position as well as she could before the accident.

3. Claimant reached MMI with regard to her back injury on August 19, 2004. Claimant sustained a 17.5% loss of use of the back as a result of her back injury.

4. Claimant is entitled to future medical treatment under § 42-15-60, as interpreted by the South Carolina Court of Appeals in *Dodge v. Brucoli, Clark, Layman, Inc.*, 334 SC 574 (Ct. App. 1999), for her back, including but not limited to pain management as prescribed by Dr. Kevin Kopera, which would tend to lessen the Claimant's period of disability in order to maintain her current level of functioning.

5. Claimant sustained a compensable injury to her left lower extremity (left ankle, left knee, and left hip) on August 23, 2003; however, she has no permanent disability resulting from the injury to her left lower extremity.

South Carolina Workers' Compensation Commission
1612 Marion Street • Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737-5723
www.wcc.sc.gov



Physician's Statement

Claimant's Name: Kellie BurnetteEmployer's Name: City of GreenvillePhysician's Name: Dr. Michael BucciInsurance Carrier: Self-Insured Administered by: Hewitt ColemanPractice/Clinic: Piedmont Spine and Neurosurgical GroupSCWCC File No: 0720591Preparer's Name: Jamey FeuerherdPhone: (864) 240-5837

The undersigned physician has been authorized by the Employer/Carrier to treat this Claimant for his or her injury by accident pursuant to §§42-15-60, 42-1-172 or 42-11-10.

Date of Injury or Illness: 6/16/2007Date of first office visit: 2008 Date of last visit: 3/24/09Diagnosis or nature of injury or illness: 2008Body part(s) injured: C-5 spine Body part(s) affected: _____

Date of Maximum Medical Improvement: _____

Based on the AMA Guidelines, the claimant has sustained a 10 % medical impairment to injured body part(s) and a _____ % medical impairment to _____ other affected body part(s).

☒ The claimant is able to return to work without restriction.

☐ The claimant is able to return to work with the following restrictions:

☐ The claimant is unable to return to work at his or her current employment.

As of the date I last saw this patient, it is my professional medical opinion the claimant:

☒ will not need future medical care related to his or her work related injury or illness based on a reasonable degree of medical certainty (more likely than not).

☐ will need future medical care and treatment related to his or her work related injury or illness based on a reasonable degree of medical certainty (more likely than not) and that medical care and treatment including medication is as follows:

[Signature]
Treating Physician

4/3/09
Date

0255

Piedmont Spine and Neurosurgical Group, P.A.

3 St. Francis Dr. Suite 330
Greenville, SC 29601
Phone: (864) 220-4263
Fax: (864) 220-5836

HISTORY AND PHYSICAL REPORT

Kellie Burnette

ID: 46220

DOB: [REDACTED] (29 years)

Date of Encounter: 03/24/2009 10:46 AM

History of Present Illness

Patient's words: Overall the patient is doing well with return of normal strength in the upper extremities. Flexion and extension cervical spine x-rays show a stable fusion at C5-6.
The patient is a 29 year old female

History

There is no documented history at this time.

Physical Exam

The physical exam findings are as follows:

Neurologic

Motor:

Tone: - Normal.

Strength: 5/5 normal muscle strength - All Muscles.

Reflexes (Dermatomes): 2/2 Normal - All.

Plantar Reflexes (L4-S2) - Bilateral - Flexion. **Coordination** - Normal. **Gait** - Normal.

Assessments

- **CERVICAL MYELOPATHY (721.1)**
- **SPINAL STENOSIS IN CERVICAL REGION (723.0)**
- **CERVICAL HNP (722.0)**
- **REVIEW OF FILMS (V72.5)**

FOLLOW UP AS NEEDED

Michael N. Bucci

Michael N Bucci MD

0256

Kellie Burnette

ID: 46220

DOB: 09/05/1979 (29 years)

Wednesday, April 1, 2009

Page 1 / 1

ST FRANCIS DOWNTOWN
One St. Francis Drive
Greenville, S.C. 29601
864-255-1000

OPERATIVE REPORT

NAME: Burnette, Kellie N	SEX: F	MR: ~~XXXXXXXXXX~~
LOC: 07 07061	AGE: 29	ACCT: 4995621
DOB: ~~XXXXXXXXXX~~	DSCH:	PT: I
ADMIT: 10/27/2008		MSV: MED

PREOPERATIVE DIAGNOSIS: Cervical stenosis with cord compression C5-6.

POSTOPERATIVE DIAGNOSIS: Cervical stenosis with cord compression C5-6.

OPERATIONS AND PROCEDURES:

1. Anterior cervical spine total discectomy with decompression of spinal cord and nerve root C5-6.
2. Anterior cervical spine interbody fusion with structured allograft C5-6.
3. Anterior cervical spine instrumentation with Atlantis Plating System C5-6.

SURGEON: Dr. Bucci

ANESTHESIA: General endotracheal.

ESTIMATED BLOOD LOSS: Minimal.

PREPARATION: Betadine.

COMPLICATIONS: None.

HISTORY OF PRESENT ILLNESS: This is a 29-year-old police officer status post a work related accident with persistent neck and upper extremity pain and numbness. MRI scanning confirmed a large disk herniation at C5-6 with spinal cord compression and she was admitted for surgery as conservative measures had failed.

OPERATIVE NOTE: The patient was brought to the operating room and she was carefully placed under general endotracheal anesthesia without complications. She was placed supine with a roll under the shoulder blades and the head gently extended on a Richard's pillow. The right side of the neck was carefully prepped with Betadine in the usual sterile fashion. A linear incision was drawn out at the level of the cricothyroid cartilage on the right. This was then infiltrated with 1% Xylocaine with epinephrine and incised with a 15 blade sharply through the skin, subcutaneous tissues, and platysma.

OPERATIVE REPORT - ST. FRANCIS - DOWNTOWN
Page 1 of 3 Physician copy for (Michael N Bucci, MD)

0257

DISABILITY RECOMMENDATION TO SCRS

SHE209
H15447

Claim Level IN	Claim Type SCRS	Filing Date 02/15/08	SSN ~~541-123-4567~~
		S/A Receipt Date 03/11/08	Date of Birth ~~03/11/08~~
Address of Originating Office S C RETIREMENT SYSTEM P O BOX 11960 CAPITOL STATION COLUMBIA SC 29211			Name and Address of Claimant KELLIE NICHOLE BURNETTE ~~1000 BURNETTE ST COLUMBIA SC 29204~~
Claimant Disabled			
A. ALLOWED		B. Onset	
		Disability Began 03/13/08	Disability Ceased
		C. Diary	
		Type MRN	Mo/Yr 03/11 04/11
Claimant Not Disabled			
A.	Primary Diagnosis	Code 01	Body Sys 7240
	Disorders of Back (Discogenic and Degenerative)	Secondary Diagnosis	Code 12
		Affective/Mood Disorders	Body Sys 2960
B. Disability Ceased	Basis Code BC	Reason MED/VOC PREVENTS JOB DUTIES	
VR Action	A. Screen In	B. Screen Out	X C. Prev. Ref.

Remarks

Michael Sheehan

Michael J. Sheehan, Disability Examiner

Date: 04/14/08

SCRS Action

Date: 4/17/08



Disability Approved
as Recommended



Disability Disapproved
as Recommended



Other Action

SCR99 (7/05)

RECEIVED
APR 17 2008
CUSTOMER CLAIMS

0265

**DISABILITY RATIONALE
SOUTH CAROLINA RETIREMENT SYSTEM**

NAME: KELLIE N BURNETTE

SSN: ~~000000000~~

CLAIM TYPE: SCRS

MEDICAL SOURCES

ST FRANCIS WOMENS HOSPITAL,
DR JOHN SATTERTHWAITE MD, 03/24/08
DR JOHN SATTERTHWAITE MD,
DR ROBERT G SCHWARTZ MD, 04/10/08
DR KEVIN W KOPERA MD, 03/21/08

RATIONALE

This 28 year old Police Corporal alleges disability since 8/23/03 due to back and neck pain, arthritis, myofascial pain, nerve damage, leg pain, and depression. The medical evidence indicates that she has a history of motor vehicle incident injuries in 8/03 and 6/07, however she has continued to work and perform her regular duties. On exam 8/28/07, an MRI of the lumbar spine showed minimal disc bulges at 2 levels. An MRI of the thoracic spine 9/07 was within normal limits. She currently experience problems with back, neck, and leg pain, and she has been treated with nerve blocks and epidural steroid injection therapy. A new MRI of the lumbar spine ordered 12/07 shows a disc herniation at L5-S1. On exam 3/13/08, she was scheduled for further ESI therapy, and referred to an orthopedist. Her back condition will limit her to lifting and/or carrying 50 pounds occasionally and 25 pounds frequently, with occasional bending. Her past job required lifting and/or carrying 50 pounds or more, and frequent bending. Her limitations preclude returning to this job, and disability is recommended as of 3/13/08. Due to the possibility of medical improvement, a medical review is recommended in 3 years.

DDS Examiner

April 14, 2008

Michael Sheehan

Claim No: H15447
RSRAT (3/07)

RECEIVED
APR 17 2008
CUSTOMER CLAIMS

0266

REHABILITATION ASSOCIATES

Benson Hecker, Ph.D.

August 14, 2009

506 Pettigru St.
Greenville, SC 29601
(864) 242-1142

Douglas A. Churdar
Attorney at Law
712 East Washington Street
Greenville, South Carolina 29601

RE: Kellie N. Burnette

Dear Mr. Churdar:

This report is in reference to the above captioned matter and the formulation of a vocational opinion.

I Referral Question

Kellie Burnette was referred by her attorney for evaluation of her vocational/training potential. This evaluation was performed by Dr. Benson Hecker in Greenville, South Carolina on Tuesday 11, 2009.

II Medical History

The following medical records were reviewed:

-) **South Carolina Worker's Compensation Commission, Decision/Order, 1/11/06**
-) **GHS, Emergency Department, 8/23/03 History of work related MVA.**
-) **Bon Secours St. Francis Health System—Work Well, 8/26/03 - 5/14/04**

8/26/03 Treatment for MVA injuries. Examination performed and x-rays taken.
Assessment

- 1 – Left face, shoulder, elbow, wrist and knee contusions.
- 2 – Left AC sprain
- 3 – Left ankle sprain
- 4 – Nasal fracture

Plan: I will switch her pain medicine to Darvocet N-100 as the hydrocodone containing compounds have not helped. She will take this up to one every four hours as needed for pain, #30 given. Also, she was given a low dose of ibuprofen as she will stop that and begin ibuprofen 800 mg three times a day with food. At

0267

Burnette

this point, I do not feel that she is fit to return to work, especially with the nature of her job and the fact that she will be on narcotic pain medication. I have recommended no return to duty until she sees me back in one week or sooner if more symptoms develop or she recovers more quickly and would like to discuss potential restrictions and return to duty.

9/3/03 Recheck of multiple injuries after a MVA. Basically overall, she is doing much better. Still has a lot of pain in her low back as well as in that left knee and left trapezius. No real new complaints. There is some questionable instability in the knee. She denies any constipation with the pain medicines or other abdominal complaints. Examination performed.

Assessment: 1) Left shoulder contusion; 2) Trapezius muscle strain; 3) Left MCL sprain; and 4) lumbar strain.

Plan: ibuprofen 600 mg, Flexeril 10; Darvocet-N 100 which has been working well with her pain without side effects. She will use this at bedtime or for severe pain during the day. Restrictions at this time are no prolonged sitting or standing, alternate as needed and sedentary work only. Please note that she may require lying down for back pain relief for 10 minutes every hour. See in one week

9/10/03 Here for recheck of shoulder, back and knee, improved but still with discomfort. Back is really most uncomfortable. She describes pain basically in area of the trapezius, worse with repetitive use of the left upper extremity. No pain deep within the shoulder. Pain is well relieved with Darvocet. Low back pain is across the low back. No significant exacerbating factors save for prolonged sitting. No radicular complaints. Knee is still uncomfortable. She says it feels like it is deep within the knee with some swelling. Also over the medial knee. The brace does help somewhat; it will be a little more comfortable with walking but still without mechanical symptoms. Examination performed.

Assessment: 1) Left shoulder girdle strain; 2) Deltoid/acromion contusion left shoulder; 3) lumbar strain; and 4) MCL strain with meniscal derangement.

Plan: Physical therapy to address the trapezius strain and lumbar strain at this point. MRI is recommended for evaluation of the internal structures of the left knee, particularly evaluating the medial meniscus and MCL. I have also refilled her Darvocet today to be used just at night and to begin to wean off this. I also gave her a prescription for ibuprofen 600 mg 4 times a day, which she will continue for the next two weeks as she is tolerating this well. The plan will be to see her back after the MRI. Until then, she will remain in the brace with her current work duties save for taking it off and lying down for discomfort for her back and adding in to limit repetitive use of the left arm to no more than 10 times per hour.

10/22/03 Recheck of MVA. Doing great. Does have occasional back soreness with sitting for prolonged periods of time. Her knee is doing well. She has been running straight ahead without significant discomfort. Still pain with twisting type activity as expected. Again, overall much improved. The shoulder seems to nag her more than anything. It is into the trap, in the area of the medial scapula.

Burnette

Worse with activity and PT seemed to be helping this significantly. Still has persistent discomfort in the left shoulder. Examination performed.

Assessment: Trap strain, shoulder girdle strain, deltoid contusion knee and back. Resolving appropriately.

Return her to full duty at this point. I think she would be fine to do that. She understands she may have some soreness particularly after sitting in the vehicle for a while with the vest on but I have encouraged activity as tolerated. For her shoulder I think we ought to give her a couple more weeks of PT. This seemed to be helping this resolve and these can be persistent particularly after the traumatic injury that she had. So I would like to pursue two more weeks of PT, particularly for range of motion, strengthening and modalities as indicated. No medications at this time. See prn.

5/5/04 Has not been seen since November of last year. Was involved in a MVA, just had persistent back pain. The last time I saw her, she was having just a little bit of back pain, but it seemed to be resolving with physical therapy. She has continued the physical therapy type exercises on her own but is having persistent, increasing back pain in the same area as previous through the central lumbar spine. She had a week or so off work, and it did not seem to improve any with rest. It does seem to be worse at the end of the day. She does not notice any radicular pain or mechanical symptoms, just persistent, boring lumbar pain. Performs regular duties but just with discomfort. No LOBBC, no recent injury or other back injury in her previous history. Examination performed.

Assessment: Persistent lumbar back pain s/p MVA.

Plan: At this point, we need to rule out any underlying pathology congenital or otherwise. The recommendation is for an MRI. Pending the results, I have basically reached the extent of my ability to treat and recommend a referral to either an orthopedic specialist or a physiatrist, likely the latter, considering her history unless this is based on MRI surgical problem. We are going to switch her anti-inflammatories to Anaprox DS with foot to see if she can get better relief with this. She will continue exercising and icing as tolerated. Plan is for a F/U after MRI.

5/14/04 Recheck of back and basically MRI review. The MRI looks pretty good with minimal disk bulging at L5-S1 and L4-5, but no evidence of focal disk protrusion, spinal canal stenosis, or nerve root impingement by the radiologist read. Symptom wise she is still having soreness throughout and it feels like it may be increasing actually with tightness and discomfort across the low back. She is tolerating the Naproxen, but it is not giving adequate relief of discomfort at this time.

Assessment: Lumbar strain—chronic

Plan: Naproxen prn. We are going to add in Ultram to be taken first at bedtime and then if she tolerates this she may take it up to 3 times a day. We will plan for referral to physiatry, probably Dr. Kopera to review the case and then to manage her at his expertise. I will follow at a distance and she may f/u with me prn.

Burnette

) **Piedmont Physical Medicine & Rehabilitation, Dr. Schwartz,
6/21/05 – 8/23/05**

6/21/05 Seen with chief complaint of thoracolumbar pain followed by low back pain and then neck pain, followed by interscapular pain. History of MVA, injuries and treatment. She denies weakness, but says she gets numbness of her left hand. She c/o difficulty sleeping, but has been taking Ambien and is fatigued because of the same. She c/o increased frequency, though has no bowel and bladder incontinence. Previous medical history described. She described her pain a 7/10. She has been seen by Dr. Kopera primarily. An MRI done earlier this year was apparently normal, with a possible bulge. She has had medications by mouth and physical therapy. Examination performed.

Impression: Possible left L5 nerve root irritation and the presence of C4-5 facet syndrome, with T6-7 and %12 MFS. Possible right carpal tunnel syndrome.

Plan: Obtain prior x-rays and records. EMG scheduled. LS Biodex study in PT ordered.

7/18/05 Diagnostic Ultrasound. Lumbar Facet Regional (medial Branch/Post Rami Branch) Block.

8/2/05 Cervical paravertebral nerve block. Posterior shoulder capsule ligament injections

8/16/05 Cervical paravertebral nerve block. Posterior shoulder capsule ligament injection.

8/23/05 Questionnaire

1 – Has Kellie N. Burnette reached MMI with respect to injuries sustained in an automobile accident on 8/23/03?—yes

2 – If so, has Ms. Burnette sustained permanent impairment as a result of the accident?—yes

3 – If so, what is the permanent impairment sustained by Ms. Burnette, e.g. what percentage to what body part?

13% spine (8% lumbar, 5% cervical)

Does Ms. Burnette need future medical treatment to maintain her current level of impairment to lessen her period of disability?—yes

If so, what treatment does Ms. Burnette need and at approximately what intervals?
Intermittent PO meds and injection may be necessary

) **Dr. Kopera, Center for Health & Occupational Services, 6/21/04 – 10/11/05**

6/21/04 This is a 24 year old woman who presents today for evaluation and treatment of low back pain which has become chronic. She is s/p MVA that occurred during her job duties as police officer on 8/23/03. History of accident,

Burnette

injuries and treatment. Currently she is taking Darvocet in the evening with some benefit. Ms. Burnette has also taken Naprosyn and ibuprofen with some results. In terms of current symptoms, Ms. Burnette emphasizes having continuous low back pain. The pain increases towards the latter part of the day or her work shift. Also the pain is notable with prolonged standing or sitting. Ms. Burnette emphasizes having good mobility and strength. She continues to do exercises instructed to her through physical therapy. She denies symptoms in either lower extremity including denying any weakness or numbness. Ms. Burnette describes some tightness in the lumbar region and these are her main symptoms.

Examination performed.

Impression: Chronic low back pain most consistent with myofascial pain.

Plan: She is neurologically intact and nerve tension signs are absent. Review of MRI imaging clearly reveals there is no evidence of a surgical lesion and this was all discussed with Ms. Burnette. As part of her job duties she does wear a significant amount of equipment of her uniform and the belt that she wears probably weighs approximately 25 pounds and this may be contributing some to Ms. Burnette's symptoms. I do not feel that she was appropriate for an injection today and she seems well versed in appropriate exercises. Today I elected to have another trial of anti-inflammatory medication for Ms. Burnette and I elected to give her the medication Vioxx, which she will take daily. If it is not affective she will contact the office. Ms. Burnette may continue her regular activities in the interim and I will reassess her in about 2 months and at that point she may be approaching MMI as it relates to her work injury

8/19/04 She has been seen in the past for low back pain. Ms. Burnette recently has failed to respond to the medication Vioxx. She has been taking Darvocet for pain management. She continues to focus on low back pain and is not describing any radicular symptoms. Examination performed. She does rate her pain currently as 7/10 but does appear to be comfortable. She does report a fairly high level of pain but does not demonstrate much pain behavior.

Impression:

Plan: Today I elected to place her on a final trial of anti-inflammatory medication specifically placing her on Bextra. I did give her a refill of Darvocet but indicated that I did not anticipate her continuing this on a long term basis. She also emphasized difficulty sleeping and I gave her a limited supply of Ambien to try for this and hopefully this will help her re-establish her sleep pattern. Beyond this I am afraid I am limited in what I can offer Ms. Burnette and discussed this with her. Unfortunately there does appear to be some permanency to her condition. At this point I feel she has reached MMI as it relates to the work injury specifically the MVA occurring in August of last year. Ms. Burnette's condition falls into Lumbar Category II as defined in the AMA Guides to the Evaluation of Permanent Impairment, 5th Edition, and in Ms. Burnette's case this correlates to a 5% permanent impairment to the spine. I would not place her on any specific work restrictions at this time

Burnette

12/28/04 Seen in routing f/u. I have seen Ms. Burnette on a number of occasions for low back pain, which is chronic. Today she reports and describes no new symptoms but simply continues to have low back pain. She finds the medications Bextra and Ambien to be helpful. She takes Darvocet only on rare occasions. On a positive note Ms. Burnette has been able to continue her regular job duties as a police officer and things are going fairly well in this regard. She is going to be transitioning from uniform patrol to community patrol and she feels this will help her. Examination performed.

Impression: Chronic low back pain.

Plan: Ms. Burnette will be continued on her medications with the exception that we did discuss the fact that Bextra has some recent health concerns as of late. I discussed this with Ms. Burnette and we elected to switch her to Mobic. She otherwise continues Ambien 10 mg at nighttime and will attempt to rely less on this medication. She was given a limited supply of Darvocet to take only for when her pain is particularly severe and it would not be anticipated that she would require the medicine daily. Mr. Burnette remains at MMI as previously stated and I will reassess her once again in 3 months for continued medication management.

3/28/05 F/U and is continuing to have chief c/o chronic low back pain. She has also had some pain in the thoracic area as well. She continues to work her regular job duties as a police officer. She takes Ambien at nighttime and continues to require this medication. She takes Darvocet on occasion but not regularly. We had placed on Mobic but she has not found this to be as effective as Bextra and wishes to go back on the Bextra medication. Examination performed.

Impression: Chronic low back pain most consistent with myofascial pain.

Plan: Ms. Burnette raises the possibility that she may have fibromyalgia. She currently does not meet the definition of this diagnosis as her pain is not widespread enough but certainly she has myofascial pain and features of fibromyalgia and this was discussed. She still has a refill or two on Darvocet so did not require it today but required refills on Ambien and we placed her back on Bextra and discussed possible health risks of this medication. She will be reassessed once again in 3 months and from my standpoint she remains medically stable.

6/28/05 She is being managed for chronic low back pain. She presents today with continued myofascial pain in the lumbar area but even in the thoracic and cervical areas as well. She states that since she last saw me she has switched from Mobic to Cataflam with good results. She continues to take Darvocet on rare occasions. She takes Ambien frequently at night as well as Flexeril often at night as well to ensure a good sleep pattern. She continues to work as a police officer and things seem to be going fairly well. Examination performed.

Impression: Chronic low back pain

Plan: She is continuing to experience chronic myofascial pain in the lumbar region. Today she inquired about anything more aggressive. I do not feel that physical therapy would result in long term relief as she has had this approach before. We discussed a local trigger point injection and elected to pursue this

Burnette

approach. Today she was injected. She otherwise was continued on her medications including Cataflam and Flexeril with a limited supply of Darvocet.

7/26/05 She has chronic low back pain. I last saw her about a month ago when she did receive a local trigger point injection and reports a very good response and pleased with how she has done. She also is continuing to take Cataflam and Flexeril and occasionally takes Darvocet and feels that she is doing well on this regimen. She requests another injection today and we did discuss caution in overdoing the injections but I felt that we could do another one today and then monitor her response. Examination performed.

Impression: Chronic low back pain.

Plan: She underwent another trigger point injection this time into the left upper lumbar paraspinal musculature. She was given new refills on Cataflam and Flexeril as well as a limited supply of Darvocet and I should also mention that she does take Ambien as well.

10/11/05 Returns today for a f/u appointment and basically continues to have pain in her low back area similar to prior visits. She reports that Darvocet is no longer providing the pain relief that is used to. She feels she is benefiting from Flexeril and Ambien and feels that she is benefiting from Cataflam. When I last saw Mr. Burnette on July 26th I did perform a local injection into the left upper lumbar musculature, but I am not certain that it provided any significant. Since I last saw Ms. Burnette I did receive some medical records that she has been seen by Dr. Schwartz and has received treatment and I was unaware of this. It does appear that Ms. Burnette was evaluated by Dr. Schwartz on 6/21/05. He made a variety of diagnoses including a possible left L5 nerve root irritation as well as a C4-5 facet syndrome as well myofascial pain in the thoracic region. EMG test was performed on 7/18/05 Ms. Burnette underwent a lumbar facet block. She would undergo a diagnostic ultrasound on 7/22/05 and would undergo a lumbar epidural steroid injection also on that day. On 8/2/05 Ms. Burnette underwent a cervical nerve block and also underwent a posterior shoulder capsule ligament injection. On 8/26/05 she underwent a second cervical nerve block and posterior shoulder ligament injection. Ms. Burnette informs me that she continues to see Dr. Schwartz. She will be seeing him in early November but is unsure of what the treatment plan is at this point. At this point I am hesitant to perform further injections on Ms. Burnette since she is receiving injections through Dr. Schwartz. I am not certain as to what my role is at this point, but I am afraid I am limited in what I can offer Ms. Burnette. Examination performed.

I elected to continue her on Cataflam and Ambien and Flexeril. I gave her a limited supply of Tylenol with Codeine #3 to see if this is more effective than Darvocet. Beyond this I am limited in what I can offer Ms. Burnette. I will see her in one month and perhaps she can update me on what Dr. Schwartz recommends in terms of further treatment. She continues her regular job duties as a police officer.

Burnette

-) **Disability recommendations, 4/14/08** Disability approved as recommended. This 28 year old Police Corporal alleges disability since 8/23/03 due to back and neck pain, arthritis, myofascial pain, nerve damage, leg pain and depression. The medical evidence indicates that she has a history of motor vehicle incident injuries in 8/03 and 6/07,, however, she has continued to work and perform her regular duties. On exam 8/28/07, an MRI of the lumbar spine showed minimal disc bulges at 2 levels. An MRI of the thoracic spine 9/07 was within normal limits. She currently experiences problems with back, neck and leg pain, and she has been treated with nerve blocks and ESI therapy. A new MRI of the lumbar spine ordered 12/07 shows a disc herniation at L5-S1. On exam 3/13/08, she was scheduled for further ESI therapy, and referred to an orthopedist. Her back condition will limit her to lifting and/or carrying 50 pounds occasionally and 25 pounds frequently, with occasional bending. Her past job required lifting and/or carrying 50 pounds or more, and frequent bending. Her limitations preclude returning to this job, and disability is recommended as of 3/13/08. Due to the possibility of medical improvement, a medical review is recommended in 3 years.

) **Orthopaedic Associates, 9/19/08 - 9/26/08**

9/19/08 She presents today with medical records. She has been injured in two on the job accidents as a Greenville Police Officer. She was injured in August 2003 and June 2007. Her last injury was a T-bone accident. Medications reviewed. She has received epidural steroids from Dr. Satterthwaite. She has had 3-4 rounds of physical therapy which is appropriate. She reports now that she has been medically retired from her job which she really enjoyed. She also reports that she has had left shoulder surgery for torn labrum.

Medications: Effexor, Lortab, Ambien, Baclofen, Flexeril, Celebrex, Adderall, Zyrtec.

Examination performed.

Assessment: Neck pain, Pain in thoracic spine, Back pain, lumbar

Plan: Given that she has not responded to conservative therapy and has continued pain and problems related to headaches and fatigue of her neck we are going to obtain an MRI of her neck to make sure there is no pathologic entity of her neck.

9/26/08 Kellie Burnette is a 29 year old former police officer at City of Greenville. She was seen and evaluated 9/19/08 and some of her medical records were reviewed as well as some today. The patient has been treated by Dr. Satterthwaite for her lower back pain. She has an injured disk at L5-S1 and some myofascial pain. She also has some attention deficit disorder symptoms. Her friend in the room with her says that she is up at night and cannot sleep and walks around complaining of neck pain. These symptoms are a little bit more severe than she had told me before.

Medications: Effexor, Lortab, Ambien, Baclofen, Flexeril, Celebrex, Adderall, Zyrtec allergy.

Examination performed and MRI reviewed.

Burnette

Plan: It is my opinion that the patient should continue with her treatment for her lower back pain and myofascial pain and cervical neck pain. It would also be my opinion that she should be seen by a neurosurgeon in Greenville, Dr. Gardner for evaluation of her disk protrusion at C5-6 which may be the source of a lot of her neck discomfort.

) **Piedmont Spine & Neurosurgical Group, 10/22/08 - 3/24/09**

10/22/08 Patient reports constant intense pain in the neck with tingling and numbness in the arm to the hand which includes the thumb. The patient was a police officer and was trying to arrest a suspect who tried to take off in a car which made her twist and fall backwards. This happened on 6/2007. Being upright aggravates the pain especially riding in a car. The patient is a 29 year old female.

Medications: Neurontin, Baclofen, Effexor, Cyclobenzaprine, Oxycodone, Celebrex, Ambien

10/23/08 Patient reports constant intense pain in the neck with tingling and numbness in the arm to the hand which includes the thumb. The patient was a police officer and was trying to arrest a suspect who tried to take off in a car which made her twist and fall backwards. This happened on 6/07. Being upright aggravates the pain especially riding in a car. MRI scanning of the cervical spine shows a huge area of disk herniation with cord compression at C5-6. The patient is a 29 year old female.

Examination performed.

Assessments: Cervical HNP, Cervical myelopathy, spinal stenosis in cervical region.

Assessment/Plan note: Anterior cervical discectomy and fusion C5-6 with allograft and plating.

10/27/08 Surgery

- 1 - Anterior cervical spin total discectomy with decompression of spinal cord and nerve root C5-6
- 2 - Anterior cervical spine interbody fusion with structured allograft C5-6
- 3 - Anterior cervical spine instrumentation with Alantis Plating System C5-6

3/24/09 Overall the patient is doing well with return of normal strength in the upper extremities. Flexion and extension cervical spine x-rays show a stable fusion. Examination performed.

Assessments: Cervical myelopathy, spinal stenosis in cervical region, cervical HNP

F/U as needed

Physicians Statement:

First seen -2008

Last visit—3/29/09

The patient is able to return to work without restrictions

Burnette

Will not need future medical care related to his/her work related injury or illness based on a reasonable degree of medical certainty.(more likely than not)

-) **Carolinas Center for Advanced Management of Pain, 2/4/09 – 6/18/09,
Dr. C.D. Tollison, Ph.D**

Assessments:

Adjustment disorder/mixed

Pain disorder (psych/medical)

Treatment: Individualized psychotherapy, Psychotropic medication, objective evaluation.

-) **Carolinas Center for Advanced Management of Pain, 8/28/07 – 7/1/09**

8/28/07 – 12/13/07 Treatment for back, neck pain.

Assessments:

Cervical spondylosis

Thoracic spondylosis

Myofascial pain syndrome

Depression

Cervicalgia

Spondylosis

Spondylosis-Lumbosacral

Z-joint syndrome

Low back pain syndrome

Treatments: Examinations, evaluations, Ambien, Ultram, Lidoderm patch, Cymbalta, Flexeril, Celebrex, Baclofen

1/10/08 – 12/23/08 Treatment for chronic neck/back pain.

Assessments:

Myofascial pain syndrome

Cervicalgia

Lumbar radiculopathy

Cervical spondylosis

Thoracic spondylosis

Spondylosis-lumbosacral

Z-joint syndrome

Low back pain syndrome

Depression

Adjustment Disorder

Treatments: Examinations, Ultram, Baclofen, Celebrex, Flexeril, Cymbalta, Lidoderm Patch, Adderall, Zyrtec, injections, Lortab, Cymbalta, Roxicodone, Neurontin.

1/19/09 – 7/1/09 Treatment for chronic neck/back pain

Assessments:

Displacement-lumbar disc w/o myelopathy

Burnette

Cervical radiculopathy
Thoracic spondylosis
Myofascial pain syndrome
Spondylosis – lumbosacral
Z-Joint syndrome
Low back pain syndrome
Adjustment disorder/mixed
Depression
Pain disorder (psych/medical)

Treatments: Wellbutrin, Effexor, Lidoderm patch, Flexeril, Ambien, Baclofen, Neurontin, Roxicodone, Opana (pain), Restoril, Adderall, Zyrtec, Prozac, Morphine sulfate, Remeron, Celebrex.

) **Dr. Satterthwaite, 6/22/09 Questions:**

- 1 – Did Ms. Burnette's accident on 6/16/07 increase her pain level?—yes
 - 2 – Did Ms. Burnette's injury of 6/16/07 cause her anxiety and depression so that she needed/needs treatment/therapy?—yes.
 - 3 – As of today, has Ms. Burnette reached MMI with regard to injuries sustained on 6/16/07 and for which you are treating her?—yes
 - 4 – Otherwise, do you reaffirm your answers to the attached questionnaire?—yes
- Based on the AMA Guides—5th Edition, DRE IV she has a 25% whole person impairment which translates to a 72% impairment to the cervical spine

Attached Questionnaire:

- 1 – Did Ms. Burnette more likely than not sustain injury to her neck/cervical spine in the accident on 6/16/07?—yes

- 2 – Does Ms. Burnette need treatment of her neck/cervical spine?—yes

Thoracic Spine:

- 1 – Did Ms. Burnette more likely than not sustain injury to her thoracic spine in the accident on 6/16/07?—yes. Associated with neck.

- 2 – Does Ms. Burnette need treatment of her thoracic spine?—yes. Associated with neck.

Depression:

- 1 – Was Ms. Burnette's depression more likely than not caused or worsened by her chronic pain in the lumbar spine or neck/cervical spine or thoracic spine or all three?—yes

- 2 – Does Ms. Burnette need treatment for her depression?—yes

Missed Work:

- 1 – Ms. Burnette has sporadically missed work because of pain since 6/16/07. She used all of her personal leave time. After being assigned light duty work, she has still missed several days of work because of pain. Did the accident on June 16/07 cause or contribute to these missed days of work?—yes

- 2 – Will Ms. Burnette's level of pain affect her ability to consistently work, even if assigned to light duty work?—yes

- 3 – Will Ms. Burnette's level of pain prevent her from performing the duties of a police officer?—yes

Burnette

6/22/09 Clinical Assessment of Pain

1 – How significant is pain in the treatment of this patient?

Pain is present to such an extent as to be distracting to adequate performance of activities or work.

2 – To what extent will such physical activity as walking, standing, bending, stooping, moving of extremities etc. increase the degree of pain experienced by this patient?

Greatly increased pain is likely to occur, and to such a degree as to cause distraction from the task or even total abandonment of the task.

3 – To what extent can the medication (s) prescribed (or typically prescribed in cases like this one) be expected to affect the patient in this case?

Some side effects can be expected, but will only mildly troublesome.

4 – In your best judgment, to what extent will the pain and/or prescribed medication affect this patient's ability to perform his/her previous work activities?

Pain and/or drug side effects can be expected to be severe and to limit effectiveness due to distraction, inattentiveness, drowsiness, etc

5 – In your best judgment, what are the long-term prospects of recovery for this patient in regard to level of pain?

Although the level of pain may be less intense or less frequent in the future, it will still remain a significant element in this individual's life.

6 – To what extent have treatments for pain (e.g. biofeedback, nerve stimulation, injections) served to lessen the degree of pain individuals with pain levels like those experienced by this patient?

Treatments of this kind have had no appreciable impact or have only briefly altered the level of pain that this patient experiences.

To maintain current level of functioning ongoing medication management will be necessary. Could do sedentary work.

Medical Opinion RE: ability to do work-related activities—physical

1 – maximum ability to lift/carry on an occasional basis (no more than 1/3 of an 8-hour day)—15 pounds

2 – Maximum ability to lift and carry on a frequent basis (1/3 to 2/3 of an 8-hour day). Less than 10#

3 – Maximum ability to stand and walk (with normal breaks) during an 8-hour day. Less than 2 hours

4 – Maximum ability to sit (with normal breaks) during an 8-hour day.

Burnette

Less than 2 hours

5 - If your patient must periodically alternate sitting, standing or walking to relieve discomfort.

1 - How long can your patient sit before changing positions --- 30 minutes

2 - How long can your patient stand before changing positions---20 minutes

3 - How often must your patient walk around---30 minutes

4 - How long must your patient walk each time---10 minutes

5 - Does your patient need to have opportunity to shift at will from sitting/standing/walking---yes

6 - Will your patient sometimes need to lie down at unpredictable intervals during a work shift---yes

If yes, how often---daily

7 - What medical findings support the limitations described above

See medical record.

8 - How often can your patient perform the following postural activities.

Twist/Stoop (bend)/crouch/climb ladders-----never

Climb stairs---occasionally

9 - How much can be the patient:

Reach/push/pull---seldom

Handle (gross/fine manipulation)---occasionally

Feel---frequently

How are these physical functions affected? Increased pain and weakness.

What medical findings support this?---see chart

10 - State any other work-related activities which are affected by the impairment such as need for assistive device for ambulation need to elevate leg, limits on kneeling, crawling, balancing, seeing, hearing or speaking, or limitations related to a mental impairment. What medical findings support this? No kneeling, crawling, balancing, unprotected heights.

11 - On the average, how often do you anticipate that your patient's impairments or treatment would cause your patient to be absent from work?---about three (3) times a month

12 - How significant is the pain in the treatment of this patient? Pain is present to such an extent as to be distracting to adequate performance of daily activities or work

13 - To what extent will such physical activity as walking, standing, bending, stooping, movement of extremities, etc. increase the degree of pain experienced by this patient.

Burnette

Greatly increased pain is likely to occur, and to such a degree as to cause distraction from the task or even total abandonment of the task.

) **Dr. Tollison, Ph.D., 6/22/09 Questions**

Do Kellie Burnette's psychological problems result from injuries she sustained on or about 6/16/07?—yes

Has Kellie Burnette reached MMI for injuries to her psyche (depression and anxiety) sustained on or about 6/16/07 after her accident at work?—yes

Will Kellie Burnette be able to deal with the public?—yes
For brief periods of time and in situations that are not highly stressful.

How will Kellie Burnette's psychological problems affect her concentration, persistence and pace through an eight (8) hour workday?
Some limitation in ability to maintain concentration over long periods of time.
She would require periodic breaks.

What further treatment will Ms. Burnette need to lessen her disability or maintain her level of functioning?

She will require periodic psychological treatment, probably 4 visits annually, and will need to remain on psychotropic medication.

Will Kellie Burnette be able to maintain competent employment?—yes
Psychologically, unable to function as a law enforcement officer. She probably function in a relatively stress free position without significant demands. She would require breaks and rest periods.

Will Ms. Burnette need breaks on an unscheduled or "as needed" basis to maintain competent employment?—yes

) **Dr. Bucci, 8/6/09 Questions:**

1 – Has Kellie Burnette reached MMI with respect to her cervical spine injury of 6/16/07?—yes

2 – Has Kellie sustained permanent impairment to her cervical spine as a result of the accident?—yes

3 – Using the AMA Guides, 5th ed., what is Kellie Burnette's DRE category?—IV

4 – Using the AMA Guides, 5th ed., what is the permanent impairment sustained by Kellie Burnette to the whole person as a result of her cervical spine injury of 6/16/07?—28%

5 – When you previously filled out a Physician's Statement on 4/3/09

Burnette

a) Were you aware that Kellie Burnette had already been medically retired from her work as a police officer for the City of Greenville)?--no

b) Were you aware of injury to her lumbar spine resulting from her automobile accident in 2003?--no

c) Were you aware that she was seen (before you treated her) and continues to be seen by John Satterthwaite, MD for pain management and David Tollison, PH.D. for depression/anxiety?--no

d) Were you aware that, in addition to nerve blocks and epidural steroid injections, she takes the following prescription meds: Roxicodone, Neurontin, Baclofen, Flexeril, Lidoderm patch, Ambien, Adderall, Zyrtec, Celebrex and Prozac?--no

e) Were you aware of limitations on her resulting from a prior back injury, pain and depression/anxiety?--no

6 - At this time, do you believe Kellie Burnette is able to return to work as a police officer without restrictions?--no

III Education

Ms. Burnett completed her high school education in 1998. No other education is noted in the file with all skills for vocational purposes coming as a result of on-the-job training.

IV Work History

) City of Greenville Police Department, 6/2001 - 4/2008, \$15.75 per hour.

Additional compensation:

"Comp time" and time and one-half for overtime work

11 holidays

12 days paid vacation

Duties are as follows: Patrol Officer; Light duty after 6/16/07 injuries

) Wolf's Cameras, sales, 2-3 years

) Ritz Camera, 1-2 years

Burnette

) Wal Mart, Foto Lab, 1 year

Without considering any physical and/or emotional impairments, but only taking into account Ms. Burnette's age, education, vocational background and transferable skills, it is my opinion that Ms. Burnette would have been classified as a "good" employment prospect.

V Interview

Ms. Burnette arrived on time for her appointment. Her attire was appropriate, she was oriented to time, date and place, and her speech was clear, coherent and relevant.

Ms. Burnette presented a brief history of her accident, injuries and treatment along with the following:

Head – Senses were noted to be intact. A full range of motion was demonstrated, however, neck motion. Headaches were described as occurring approximately ten times per week with a duration of one hour each occasion. Prescribed medication and over-the-counter medications are use to help with headache symptoms.

Shoulders – Ms. Burnette stated that she has had left shoulder surgery and still experiences pain and arthritis in that shoulder. She described pain at 3-4/10 levels (mild/moderate) with limited activities. However, when exposed to cold weather conditions, if exposed to any stress, if lifting/carrying/pushing/pulling, pain will increase to 6-7 (moderate to moderately-severe). To help with her pain Ms. Burnette is required to stop activities, change positions and take medication. No problems noted on the right side.

Hands/arms – No problems noted

Chest/Stomach – No problems noted.

Burnette

Back – Ms. Burnette stated that her back pain is present “24/7” Using a pain scale ranging from one (none/mild) to ten (severe), Ms. Burnette stated that her pain, with limited activity, is 5-6 (moderate). When performing the following functions/activities, her pain increases to 8-9/10 levels (moderately-severe to severe). To help with her pain Ms. Burnette is required to stop activities, change positions, recline, take medications, use heat/ice/HEP’s/massage). Ms. Burnette also stated that she gets severe muscle spasms.

Hips – Ms. Burnette stated that she experiences bilateral hip pain, greater on the left.

Legs – Ms. Burnette stated that she has bilateral numbness, tingling and pain, greater on the left.

Sitting – Is able to sit comfortably for approximately 20-30 minutes.

Standing – Is able to stand comfortable for approximately 15 minutes.

Walking – Is able to walk comfortably for approximately 10 minutes.

Lifting/carrying – Is able to lift and/or carry a gallon of milk, light grocery items and approximately 15-20 pounds, but not repetitively.

Stooping/squatting/turning/twisting/forward bending, climbing – Is unable to perform these functions repetitively because in increasing pain.

Sleep – Ms. Burnette stated that she experiences insomnia and is taking medication to help with her sleep problems.

Nerves – Ms. Burnette stated that she experiences increased anxiety, depression and irritability. She also expressed concerns regarding her finances, health issues, activities of daily living, work, future, career and life situations.

Burnette

Physicians – Dr. Tollison, Ph.D, Lisa Richardson, Dr. Satterthwaite, Dr. Giamolvo
(PCP)

Medications: Baclofen, Flexeril, Celebrex, Neurontin, Ambien, Prozac, Cymbalta,
Lidoderm Patch, Adderol.

Work – When asked if she could perform some “lighter” work on a regular basis, Ms.

Burnette stated that she would be unable to do so because of the following:

She is unable to sit/stand/walk for prolonged periods of time.

She experiences reduced mentation because of her medications.

She is unable to effectively deal with any stress

She experiences too much pain

She is unable to use her upper extremities repetitively.

She experiences 3-4 “good” days and 3-4 “bad” days weekly and that even
on her “good” days she is unable to perform activities eight hours per day.

VI Vocational Opinion

Kellie N. Burnette is a twenty-nine year old female (D.O.B. 9/5/79) who was
injured while working. Medical records and interview material provide information with
regard to her accident, injuries, treatment, limitations and continuing pain.

South Carolina Worker’s Compensation Commission, Decision/Order, 1/11/06

GHS, Emergency Department, 8/23/03

Bon Secours St. Francis Health System—Work Well, 8/26/03 – 5/14/04

Piedmont Physical Medicine & Rehabilitation, Dr. Schwartz, 6/21/05 – 8/23/05

Dr. Kopera, Center for Health & Occupational Services, 6/21/04 – 10/11/05

Disability Recommendations, 4/14/08

Burnette

Orthopaedic Associates, 9/19/08 – 9/26/08

Piedmont Spine & Neurosurgical Group, 10/22/08 – 3/24/09

Carolinas Center for Advanced Management of Pain, 2/4/09 – 6/18/09;

Dr. C. D. Tollison, Ph.D.

Carolinas Center for Advanced Management of Pain, 8/28/07 – 7/1/09

Dr. Satterthwaite, 6/22/09

Dr. Tollison, Ph.D., 6/22/09

Dr. Bucci, 8/6/09

a) Based on Ms. Burnette's age education, vocational background and transferable skills, her impairments (physical/psychological), limitations and the effects of her chronic pain, it is my opinion that Ms. Burnette is unable to perform any substantial gainful work activity existing in significant numbers in open competition with others. Basis for this opinion is as follows:

Ms. Burnette sustained injuries as a result of work related accidents. Treatment has involved a variety of modalities including evaluations, surgery, pain medications, muscle relaxers, injections, anti-inflammatories, physical therapy, HEP's braces, pain patches, blocks, sleep medications, neuropathic pain medication and other conservative measures—all with no significant improvement in her functioning capacities or significant reduction of her chronic moderate to severe pain.

Functionally, Ms. Burnette is limited in her capacities for sitting, standing, walking, lifting, carrying, stooping, squatting, turning, twisting, forward bending and climbing. Review of limitations by her treating physician also note limitations in her capacities for stand/walking for less than two hours in an eight hour day as well as

Burnette

limitations in sitting to less than two hours per day. Additional limitations placed on Ms. Burnette were requirements of frequent change of positions, lying down at unpredictable levels and occasional reaching and/or fine/gross manipulation.

Despite the above identified treatments Ms. Burnette still experiences moderate to severe pain requiring that she stop activities, change positions take medications, recline, exercise and receive massages. It has also been opined that Ms. Burnette experiences pain to such an extent as to be distracting to adequate performance of activities of daily living and/or work and moving extremities, walking, standing, bending, or stooping would cause greatly increased pain which would cause distraction from a task or even total abandonment of a task. Further, it was opined by her treating pain physician that pain and/or medication can be expected to be severe and to limit effectiveness due to distraction, inattentiveness, or drowsiness.

Concurrently, and as a result of her work related injuries, Ms. Burnette is carrying diagnoses of: 1) An adjustment disorder/mixed; and 2) A pain disorder (psych/medical). Treatment has been noted in the medical records and has taken the forms of individualized psychotherapy and psychotropic medications. Specific limitations were noted with regard to her ability to effectively deal with stress, deal with the public, concentration, persistence and pace.

Vocationally translated, any work at varying skill and/or physical demand levels would require certain "basic" work related behaviors to be performed regularly e.g.:

Ability to maintain attendance/work station on a regular and continuing basis.

Ability to effectively get along with significant others;

Burnette

Ability to meet production quotas

Ability to effectively deal with "normal" work stresses while meeting quotas.

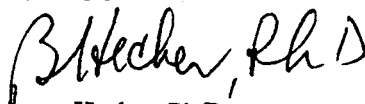
Ability to sustain concentration, persistence and pace in order to meet standards

Ability to use upper and/or lower extremities rapidly, repetitively and continuously.

Given Ms. Burnette's impairments, limitations, continuing moderate to severe pain and the effects on work behaviors as outlined in the medical records, it is my opinion that ms. Burnette is unable to sustain and work activity on a regular and continuing basis. As a result, it is my opinion that Ms. Burnette is unable to perform any substantial gainful work activity which exists in significant numbers in open competition with others.

Thank you for allowing me to work with this file.

Very truly yours,


Benson Hecker, Ph.D

Diplomate: American Board of Vocational Experts (ABVE)

Certified Life Care Planner (CLCP)

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HISTORY AND PHYSICAL REPORT

Kellie Burnette

ID: 46220

DOB: [REDACTED] (29 years)

Date of Encounter: 12/04/2008 02:22 PM

History of Present Illness

Patient's words: The patient is doing well postoperatively. The upper extremity pain has resolved.
The patient is a 29 year old female

History

There is no documented history at this time.

Physical Exam

The physical exam findings are as follows:

Neurologic

Motor:

Tone: - Normal.

Strength: 5/5 normal muscle strength - All Muscles.

Reflexes (Dermatomes): 2/2 Normal - All.

Plantar Reflexes (L4-S2) - Bilateral - Flexion. Coordination - Normal. Gait - Normal.

Assessments

- **SPINAL STENOSIS IN CERVICAL REGION (723.0)**
- **CERVICAL MYELOPATHY (721.1)**
- **CERVICAL HNP (722.0)**

Flex/Ext Cervical Spine (72052) (1 Units)

X-RAY EXAM OF NECK SPINE 2-3 VIEWS (72040) (1 Units)

FOLLOW UP IN 2 MONTHS

Neck exercises

Assessment/Plan Note: AP and lateral x-rays of the cervical spine will be taken today. Flexion and extension cervical spine x-rays will be taken in 8 weeks. She may liberalize her activities as tolerated. 50 pound weight limit restriction at this time.

Michael N. Bucci

Michael N Bucci MD

Kellie Burnette

ID: 46220

DOB: 09/05/1979 (29 years)

Thursday, June 4, 2009

Page 1 / 2

BON SECOURS ST. FRANCIS - DOWNTOWN**DIAGNOSTIC RADIOLOGY**

ONE ST FRANCIS DRIVE, GREENVILLE, SC 29601 (864) 255-1044

NAME: BURNETTE, KELLIE**ADMISSION NO:** 004995621**SEX:** F **AGE:** 29Y**DATE OF BIRTH:** ~~03/11/1979~~**LOCATION/NS:** -**DATE OF EXAM:** Dec 4 2008 3:05PM**MR#:** ~~000000000~~ **PATIENT CLASS:** O**ACC. #:** 7199674 **DISCH. DATE:** Oct 28, 2008**ORD. PHYSICIAN:** MICHAEL BUCCI**ORD. PHYSICIAN #** 756904*****Final Report*******ICD Codes / Adm. Diagnosis:** /**Examination:** SPINE CERV AP LAT - 2102040 - Dec 4 2008 3:06PM**CERVICAL SPINE SERIES 12/4/08****Reason:****REPORT:**

AP and lateral views of the cervical spine reveal findings of a prior interbody fusion at the C5-6 level. Metallic plate and screws are in place across this disc level. The cervical spine remains in normal alignment.

IMPRESSION:**FINDINGS OF INTERBODY FUSION AT THE C5-6 LEVEL.**

End of Report

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Interpreting/Reading Doctor: MARK D. MONSON (792266)**Transcribed by / Date:** DMV on 12/04/2008**Approved Electronically by / Date:** MARK D. MONSON (792266) 12/05/2008**Distribution:****Attending Doctor:** MICHAEL BUCCI**Alternate Doctor:** MICHAEL BUCCI

BON SECOURS ST. FRANCIS - DOWNTOWN**DIAGNOSTIC RADIOLOGY**

ONE ST FRANCIS DRIVE, GREENVILLE, SC 29601 (864) 255-1044

NAME: BURNETTE, KELLIE**ADMISSION NO:** 005017154**SEX:** F **AGE:** 29Y**DATE OF BIRTH:** ~~03/10/2009~~**LOCATION/NS:** XR-**DATE OF EXAM:** Mar 10 2009 3:09PM**MR#:** ~~000000000~~ **PATIENT CLASS:** O**ACC. #:** 7465125 **DISCH. DATE:****ORD. PHYSICIAN:** MICHAEL BUCCI**ORD. PHYSICIAN #** 756904*****Final Report*******ICD Codes / Adm. Diagnosis:** /**Examination:** CERVICAL SPINE FLEX EXT ONLY - 2102055 - Mar 10 2009 3:09PM**CERVICAL SPINE, 03/10/09:****Reason:** Neck pain.**REPORT:** Flexion and extension views of the cervical spine were obtained and compared to 12/04/08.

There are postoperative changes at C5-6. There is an anterior fixation plate. Alignment remains good. There is no subluxation. The spine appears stable with flexion and extension.

IMPRESSION: STABLE POSTOP CHANGES AT C5-6.
End of Report**STATEMENT OF CONFIDENTIALITY NOTICE:**

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Interpreting/Reading Doctor: JAMES B. HASWELL (792263)**Transcribed by / Date:** CP on 03/10/2009**Approved Electronically by / Date:** JAMES B. HASWELL (792263) 03/10/2009**Distribution:****Attending Doctor:** MICHAEL BUCCI**Alternate Doctor:**

*Radiate
Diff*

Carolinas Center for Advanced Mgmt of Pain - Spartanburg Office
1330 Bolling Springs Road Suite 2700 Spartanburg, SC 29303
8645830053 Fax: 8645830390

July 30, 2009
Page 1
Chart Document

MS KELLIE BURNETTE
Female DOB: ~~08-11-1963~~

18381

Home: ~~864-583-0053~~
Ins: VOC REHAB

07/23/2009 - Office Visit: Follow-Up Pain
Provider: MONICA P SPEAK NP
Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

Follow-Up Visit

Chief Complaint: Chronic varying pain in back and neck

History of Present Illness: Patient returns today with complaint increased lower back pain mainly on the left.

She recites an incident on the weekend in which the sun cover on her boat flew off and she and a friend had to pick it up and put in their truck.

Tuesday she start having increased lower back pain that radiates to her left and into her buttocks.

She also relates an increase in myofascial pain in her arms, back, chest, and legs with light touch. She describes the pain as being in a vise grip.

She is wondering if this could be the development of Fibromyalgia.

I have explained to her that a Rheumatologist would need to assess this for her.

She rates her pain as 9/10 VAS and does not feel that her medication is working to reduce her pain level.

Basically she is describing a neuropathic pain and she is only taking 600 mgs of Neurontin daily.

We will increase her Neurontin to 300 mgs tid for 1 week then she will go to 1 qid. She is not having any SE from this so we need to increase and see how she does.

Location Of Pain: as above

Description Of Pain: Numbness, Sharp, Aching, Burning, Electric/Shooting

Pain Rating: 9

Activity: Decreased

Did Medications Help? Yes

Is the patient taking any new medications? No

New Meds:

NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po tid for 7 days then qid

CELEBREX 200 MG CAPS (CELECOXIB) take one PO QD

Does the patient have any new medical or surgical problems? No

Is the patient experiencing increased sadness, anxiety, or family problems? No

Comments: seeing Dr. Tollison

Data Reviewed: Old Charts

Past, Family, and Social History

Past History (Reviewed - No Changes Since Last Visit): Depression, ADHD, osteoarthritis, torn left medial meniscus

Surgery: SLAP procedure left shoulder, broken nose, ACDIF C5-C6 10/08

ALLERGIES: NKDA

Family History (Reviewed - No Changes Since Last Visit): Migraine headaches, back problem, depression

Social History (Reviewed - No Changes Since Last Visit): Single

High school graduate

Worked as a Greenville City Police officer, work-related injury 8/23/03, Attorney Doug Churda

STOPPED WORKING April, 2008, medical retirement from police department.

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MS KELLIE BURNETTE

Female DOB: [REDACTED]

18381

Home: [REDACTED]

Ins: VOC REHAB

Denies tobacco
Occasional alcohol

Review of Systems

General: fatigue

Eyes: denies blurring, diplopia, irritation, discharge, vision loss, eye pain, photophobia

Ear/Nose/Throat: denies ear pain or discharge, tinnitus, decreased hearing, nasal obstruction or discharge, nosebleeds, sore throat, hoarseness, dysphagia

Cardiovascular: Denies chest pain, palpitations, syncope, dyspnea on exertion, orthopnea, PND, peripheral edema

Respiratory: Denies cough, dyspnea, excessive sputum, hemoptysis, wheezing

Gastrointestinal: constipation on and off taking stool softeners and laxatives and is under control

Genitourinary: denies vaginal discharge, incontinence, dysuria, hematuria, urinary frequency, amenorrhea, menorrhagia, abnormal vaginal bleeding, pelvic pain

Musculoskeletal: back pain, neck pain, muscle cramps, left knee

Skin: denies rash, itching, dryness, suspicious lesions

Neurologic: weakness

Psychiatric: depression

Endocrine: cold intolerance

Hematologic/Lymphatic: denies abnormal bruising, bleeding, enlarged lymph nodes

Allergic/Immunologic: denies urticaria, hay fever, persistent infections, HIV exposure

Vital Signs

Ht 70 in. Wt 234 lbs.

Physical Exam

General

General appearance: obese

Communication ability: communicates by voice, normal quality

Gait and station: antalgic

Comment: left leg

Psychiatric

Mental Status: AAO x3

Judgement/Insight: Intact

Mood/Affect: Appropriate

Recent/Remote Memory: Normal

Neck

Neck: supple, no masses, trachea midline

Extremities

Periph. circulation: no cyanosis, clubbing, edema, or varicosities

Thoracolumbar

ROM: Decreased in all directions

Palpation: Tender

Midline, Facets, SI

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July 30, 2009
Page 3
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MS KELLIE BURNETTE

Female DOB: ~~03/25/1973~~

18381

Home: ~~(864) 233-1234~~

Ins: VOC REHAB

Comments: left

Muscle Stretch Reflex

Sensory Negative allodynia/hyperpathia

Neuro No Atrophy or Clonus

Sympathetic Function: Normal

Assessment

Status of Existing Problems:

Assessed POSTLAMINECTOMY SYNDROME - CERVICAL as unchanged - MONICA P SPEAK NP

Assessed LUMBAR RADICULOPATHY as unchanged - MONICA P SPEAK NP

Assessed DISPLACEMENT - LUMBAR DISC W/O MYELOPATHY as unchanged - MONICA P SPEAK NP

Assessed MYOFASCIAL PAIN SYNDROME as unchanged - MONICA P SPEAK NP

Assessed CERVICALGIA as unchanged - MONICA P SPEAK NP

Assessed CERVICAL RADICULOPATHY as unchanged - MONICA P SPEAK NP

Assessed CERVICAL SPONDYLOSIS as unchanged - MONICA P SPEAK NP

Plan

Refill meds

Increase Neurontin to tid for 7 days and then increase to qid.

Restart Celebrex 200 mgs 1 daily

Follow up in 1 month

Pt will call prior to appt if has any problems

Patient may call and move appointment forward if he/she feels there is a need to be seen earlier.

Treatment plan helps to decrease patient's level of pain and has improved quality of life allowing for enjoyed activities with family.

I have told her that if she believes she has Fibromyalgia she will need to be assessed by a Rheumatologist. I have also told her that her PCP can give her a referral for this. She asks if this is related to her W/C injury and I told her that we are not able at this time to relate a possible diagnosis of Fibromyalgia to her W/C injury.

New Prescriptions/Refills:

AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) 1 qhs #30 x 0 : MONICA P SPEAK NP (07/23/2009)

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours. #90 x 0 : MONICA P SPEAK NP (07/23/2009)

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 2 po hs #60 x 0 : MONICA P SPEAK NP (07/23/2009)

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm #90 x 0 : MONICA P SPEAK NP (07/23/2009)

ROXICODONE 15 MG TABS (OXYCODONE HCL) 1po q4-6 h prn pain max 4 per day #120 x 0 : MONICA P SPEAK NP (07/23/2009)

CELEBREX 200 MG CAPS (CELECOXIB) take one PO QD #30 x 0 : MONICA P SPEAK NP (07/23/2009)

NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po tid for 7 days then qid #120 x 0 : MONICA P SPEAK NP (07/23/2009)

Current Medication List:

ROXICODONE 15 MG TABS (OXYCODONE HCL) 1po q4-6 h prn pain max 4 per day

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July 30, 2009
Page 4
Chart Document

MS KELLIE BURNETTE

Female DOB: ~~2/2/68~~

18381

Home:
Ins: VOC REHAB

NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po tid for 7 days then qid
BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm
FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 2 po hs
LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours.
AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) 1 qhs
CELEBREX 200 MG CAPS (CELECOXIB) take one PO QD
ZYRTEC 10 MG TABS (CETIRIZINE HCL) 1 po qhs other MD
CYMBALTA 30 MG CPEP (DULOXETINE HCL)
ADDERALL 20 MG TABS (AMPHETAMINE-DEXTROAMPHETAMINE) bid - Dr Giambalvo
PROZAC 20 MG CAPS (FLUOXETINE HCL) one bid

New Orders:

Expanded [99213]

Return for follow-up 1 month [xxxxx]

Prescriptions:

AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) 1 qhs #30 x 0

Entered by: MONICA P SPEAK NP
Authorized by: John Satterthwaite MD
Signed by: MONICA P SPEAK NP on 07/23/2009
Method used: Print then Give to Patient

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours. #90 x 0

Entered by: MONICA P SPEAK NP
Authorized by: John Satterthwaite MD
Signed by: MONICA P SPEAK NP on 07/23/2009
Method used: Print then Give to Patient

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Signed by: MONICA P SPEAK NP on 07/23/2009
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Entered by: MONICA P SPEAK NP
Authorized by: John Satterthwaite MD
Signed by: MONICA P SPEAK NP on 07/23/2009
Method used: Print then Give to Patient

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Entered by: MONICA P SPEAK NP
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Signed by: MONICA P SPEAK NP on 07/23/2009
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Authorized by: John Satterthwaite MD
Signed by: MONICA P SPEAK NP on 07/23/2009
Method used: Print then Give to Patient

NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po tid for 7 days then qid #120 x 0

Entered by: MONICA P SPEAK NP
Authorized by: John Satterthwaite MD

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July 30, 2009
Page 5
Chart Document

MS KELLIE BURNETTE

Female DOB: ~~XXXXXXXXXX~~

18381

Home: ~~XXXXXXXXXX~~

Ins: VOC REHAB

Signed by: MONICA P SPEAK NP on 07/23/2009
Method used: Print then Give to Patient

Signed by MONICA P SPEAK NP on 07/23/2009 at 12:12 PM

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CLAIMS DEPT

PROGRESS NOTES

Name: Kellie Burnette

DATE

Burnette, Kellie

1-21-97

- S: 17 YO who twisted her left ankle while skiing yesterday. No real swelling. Some pain with walking.
- O: Mild tenderness in the area of the anterior _____ fibular _____ in the left ankle. No anterior or posterior drawer. No swelling or subjective numbness. Good peripheral pulses. No boney tenderness.
- A/P: 1. Left Ankle Sprain. 1) She was placed in an air cast. Will keep elevated. 2) Take Advil. 3) Begin ROM exercises. Will return if symptoms do not improve for x-ray. LLG/lse

Burnette, Kellie

2-7-97

- S: 17 YO with several day history of sinus pressure, yellow nasal drainage, slight cough, no fever.
- O: Moderate maxillary sinus tenderness. TMs clear. Op red. No exudate. Neck without adenopathy. Lungs clear.
- A/P: 1. Sinusitis. 1) Claritin D. 2) Amoxicillin 500 mg. tid x 10 days. Call for failure to improve. LLG/lse

Burnette, ~~Carey~~ Kellie

8-17-98 (MON)

- S: 17-YOWF who lost her voice with laryngitis and mild sore throat and congestion.
- O: She is AF. TM's and OP mildly congested. Neck supple. Lungs clear. Harsh raspy voice.
- A/P: Laryngitis. Treat with Zpak and fluids and Tylenol. LAB/td

Burnette, Kellie

9-29-99 (Wed)

- S: 20 YO with pain in left shoulder area for about a year, but worse recently. She does play a lot of sports. Carries fairly heavy backpack at school, but has had no definite injury. Pain is over the area of left trapezius muscle. No pain shooting down her arms.
- O: Normal muscle strength and DTRs in her arms. There is tenderness over left trapezius muscle with mild muscle spasm. No cervical tenderness. Full range of motion of her neck. No tenderness over shoulder.
- A/P: 1. Left trapezius strain. Will place on Relafen 750 mg 2 po q d x 10 days. Neck stretching exercises. If no improvement at that time, will send to physical therapy. Linda L. Giambalvo, M.D./lwp

Burnette, Kellie

12-22-99 (Wed)

- S: 20 YO with persistent pain just medial to right scapula for a little over a year. Relafen did not help. She has now had several month history also of pain over inferior lateral right patella. Hurts particularly going up and down stairs or after she has been sitting for a while. At times some mild swelling. No locking or giving way. She has also developed a sore throat, thick, yellow nasal drainage, some sinus pressure. No fever.
- O: Mild tenderness and muscle spasm just along the medial border of right scapula. Heart RRR without murmur. Lungs clear. OP erythematous. Neck with mild anterior cervical lymphadenopathy. Mild maxillary sinus tenderness. TMs clear. She is mildly tender over lateral inferior patella. Full range of motion of knee. No anterior or posterior drawer. No effusion.
- A/P: 1. Knee pain, probable chondromalacia. Will try Cataflam 200 mg q d. Samples are given. Knee exercises. If no improvement within 7 to 10 days, will check x-ray and possibly send to PT.
2. Upper back pain, muscular in nature. Cataflam as above. Call if symptoms do not improve.
3. Pharyngitis/early sinusitis. Amoxicillin 875 mg bid x 10 days. Sudafed as needed. Call for failure to improve. Linda L. Giambalvo, M.D./lwp

PROGRESS NOTES

Name: Kellie Burnette

DATE	
12/18/99	Pt. sched. @ PT @ VBS 967-3082 re shoulder pain on 1-3-00 @ 0915. Pt. aware per LG — BS.
12/31/99	3-pack TAD # 1 @ NR Wal-mart 234-6971 for improvement per LG — BS —

Burnette, Kellie

03-07-00 (TUES)

S: 20-YOWF with lump in the genital area, no fever or chills. Not sexually active and has not had a pap smear before.

O: AF. BP 112/54. Vaginal area shows normal external female. Has 1 small 1/2cm lymph node in the lower groin that is lateral to the right majora labia. No labial infection. Some mild folliculitis.

A/P: Lymphadenopathy. Treat with Duricef 500 bid x 10 days. Will follow. Larry A. Berglund, M.D. /ld

Burnette, Kellie

4-18-00 (Tue)

S: 20 YO with painful menstrual periods for some time, a lot worse recently. She had to miss school 2 days last week. Periods are slightly irregular, but usually occur every 28 to 40 days. Flow is not particularly heavy. Menarche was at age 13 or 14. She did have some nausea and headache with her period last week. She has never been sexually active. No pelvic pain any other times of her cycle. No abnormal vaginal discharge. She also states she is having trouble with attention span at school. She has noticed this at least since junior high school. Unable to concentrate well when reading, easily distractible. Fidgety and restless at times. She is concerned about the possibility of ADD. Denies symptoms of depression.

O: Heart RRR without murmur. Lungs clear. Abdomen soft, non-tender. External genitalia is normal. Cervix without lesions. Pap is obtained. Uterus normal size, no adnexal masses or tenderness

A/P: 1. Dysmenorrhea. Will try Vioxx 50 mg on the first day of her period and then 25 mg q d. Thereafter, if this does not help, will consider birth control pills. She will call after her next period and let us know.
2. Possible ADD. Will try Effexor 37.5 mg XR q d x 1 week, then 75 XR 1 q d. Recheck in 3 weeks.
Linda L. Giambalvo, M.D. /lwp

4-21-00	Pt requesting to start BCP for menstrual periods instead of Vioxx Triphasil 28 TAD # 1 pack @ 28 Publix 987-7086 per LG/BS

Burnette, Kellie

5-9-00 (Tue)

S: 20 YO for recheck of Effexor. She was placed on this for symptoms of ADD. She has a lot of trouble concentrating on reading and school work, fidgetiness, restlessness in class. She was placed on Effexor at last visit. She may have had a little bit of improvement in concentration. Mood is doing better. She is sleeping a little bit better at night.

O: Alert, somewhat restless in the exam room. Heart RRR without murmur. Lungs clear. Neck without adenopathy.

A/P: 1. Probable ADD. Continue Effexor. She is still having some trouble concentrating, but mood has improved. Will recheck again in 2 weeks prior to school restarting in the fall. If no better at that time, may consider trial of Ritalin. Linda L. Giambalvo, M.D. /lwp

PROGRESS NOTES

Name: Kellie Burnette

Burnette, Kellie

5-24-00 (Wed)

- S: 20 YO with left shoulder pain over scapula for several months. She started playing softball again recently and pain has worsened. She is up at night with discomfort. Celebrex did not help in the past. At times pain seems to shoot a little bit into her left arm. There was no distinct injury.
- O: Mild pain with abduction of left shoulder and with internal rotation. There is full ROM of shoulder. No pain over deltoid or anterior shoulder. There is tenderness diffusely in muscles overlying the scapula. Heart RRR without murmur. Lungs clear. X-ray of left shoulder is unremarkable.
- A/P: 1. Left shoulder scapula pain, possible bursitis. Will send for physical therapy. Will try Relafen 750 mg 2 po q d. She will call us for insurance authorization once she schedules appt. time with physical therapy.
- Linda L. Giambalvo, M.D./lwp

6-1-00	appt. Dr. S. Geary, 271-6060, eval @ shoulder pn, Mon 6-12-00, 3 ³⁰ , per Dr. L. Giambalvo
6-2-00	pt notified office that her dizziness has resolved much
6-2-00	Vertigo returned Antivert 25mg, 9 ⁰⁰ pm #10-NRE Public
	9847086 ————— nrc/jtt

Burnette, Kellie

6-19-00 (Mon)

- S: 20-year-old patient comes in secondary to headaches and dizziness off and on over the last week or so. Patient reports that she feels dizzy. It is not anything that has progressively worsened. Feels like a funny feeling in her head with dizziness off and on lasting for several hours at a time. If she goes to sleep it gets better. Strobing lights tend to make it worse. Denies any nausea, fever, chills or other symptoms. The only thing new that she can discern is that she has started birth control Triphasil and she is on Effexor. Other than this, there are no new changes. She does wear glasses. She had a recent eye exam a few months ago and reports that she was dilated and had her pressures checked. This was normal.
- O: VSS. Supine blood pressure was 120/64 with a pulse of 60. Standing blood pressure is 122/72 with a pulse of 60. Afebrile. HEENT exam reveals TM's are slightly injected on the left. On the right there is some air fluid levels. Oral pharynx is slightly erythematous. Nasal passages are clear. Oral cavity and pharynx clear. Neck is supple. Chest is clear in the anterior and posterior fields. Cardiac exam reveals RRR. Abdominal exam benign. Neurological exam nonfocal.

LABORATORY: Fasting blood sugar is 91. Hemoglobin 12.5.

- A/P: 1. Disequilibrium and labyrinthitis secondary to serous otitis. We will give Antivert to see if there is interval improvement. If no improvement with Antivert, would consider discontinuing birth control to make sure that this is not a cause of relationship. If any symptoms progressively worsen, she is to call us emergently. Mark T. White, M.D./ccp

6-24-00	pt can't dizziness for all & Dr. L. tomorrow result

Burnette, Kellie

6-27-00 (Tue)

- S: 20 YO with continued dizziness now for close to a month. No pressure in her ears. No allergy symptoms. No vision changes. No numbness, weakness, or trouble with coordination. Dizziness occurs when she moves her head certain ways. Antivert did not help.
- O: TMs clear. No maxillary sinus tenderness. PERL. Extraocular movements normal. Normal facial sensation and movement. Neck without adenopathy. Lungs clear. Normal finger to nose and heel to shin testing. Normal DTRs in upper and lower extremities.
- A/P: 1. Intermittent vertigo. Will try Zyrtec 10 mg qid If no improvement within the next several days, will call and let us know. Linda L. Giambalvo, M.D./lwp

PROGRESS NOTES

Name: Kellie Burnette

DATE

Burnette, Kellie

8-1-00 (Tue)

- S: 20 YO who is very active in sports with a week or two history of right sided knee pain. She has a history of knee pain last year, although this seems to be in a little bit different location. Pain is mostly over right lateral knee. No swelling, locking, or giving way. Aleve helps a little bit, but not completely. There was no definite injury.
- O: There is mild tenderness over right lateral collateral ligament. No tenderness elsewhere. No effusion. No anterior or posterior drawer. No laxity to varus or valgus pressure.
- A/P: 1. Knee pain, probable ligament strain. Will try Celebrex 200 mg q d. Samples for 12 day supply are given. Will also begin physical therapy. If no improvement over the next several weeks, will send to orthopedist. Linda L. Giambalvo, M.D./lwp

Burnette, Kellie

12-17-01 (Mon)

- S: 22 YO with sinus congestion, cough, laryngitis, x 24 hours.
- O: VSS. Afebrile. HEENT: oropharynx erythematous. Neck supple. Chest clear. CV normal.
- A/P: 1. Pharyngitis, viral versus bacterial. Watchful waiting. If symptoms worsen, will consider antibiotic therapy but for now supportive management. Mark T. White, MD/vz

Burnette, Kellie

3-19-02 (Tue)

- S: 22 YO with clear nasal drainage, sneezing, runny nose, postnasal drainage for the past several weeks. History of prior allergy symptoms in the spring as well. No yellow drainage or sinus pressure.
- O: Clear nasal congestion. TMs clear. OP slightly red. Neck without adenopathy. Lungs clear.
- A/P: 1. Allergic rhinitis. Rhinocort AQ 1 squirt in each nostril q d. Zyrtec 1 q d #30 with 3 refills. Call for failure to improve. Linda L. Giambalvo, M.D./lwp

Burnette, Kellie

3-11-03 (Tue)

- S: 23 YO with pain in right trapezius muscle area since last Thursday. She is a police officer and had been on the firing range a couple of days earlier and also had gotten a new puppy which may have strained her shoulder.
- O: Tenderness over trapezius muscle area on the right. Full ROM of neck and shoulder. Normal DTRs in upper extremities.
- A/P: Trapezius muscle strain. Bextra 10 mg bid as needed. Samples are given. Call if symptoms are not improved over the next couple of days. Linda L. Giambalvo, M.D./lwp

Burnette, Kellie

3-4-04 (Thur)

- S: Here today with pain in the right knee for 3 days. She said it hurts with walking to the lateral knee area. It is point specific. She had a previous injury about 9 months ago during a scuffle. She is a police officer and was wrestling with a man and she fell and landed on her knee. X-ray at that time was within normal limits.
- O: WF NAD. There is no obvious swelling or deformity to her right knee. There is point specific tenderness to the right lateral patella. Again, no effusion or swelling. No joint instability.
- A: 1. Right knee pain.
- P: Will treat with Cataflam 50 mg 1 t.i.d prn #30. If pain continues, will need further evaluation with x-ray or possible MRI. I did refill her Zyrtec 10 mg 1 q d #90 with 3 refills and Rhinocort-AQ 3 month supply 2 sprays in each nostril q d. Also, Effexor 75 mg XR 1 tab daily #90 with 1 refill. Should follow up if symptoms worsen or do not improve. Kristi R. Williams, FNP/Mark T. White, MD/lwp

PROGRESS NOTES

Name: Kellie Burnette

Burnette, Kellie

6-29-04 (Tue)

- S: 24 YO for Pap and pelvic. She is having no problems with her periods. Triphasil is doing well. Dysmenorrhea is well controlled. She is still being treated by physiatrist for back pain following MVA at work in August. She is currently taking Darvocet 2 q hs, Vioxx, in addition to the Zyrtec, Rhinocort, and Triphasil. She takes Effexor 75 XR for ADD and is doing well on this. No chest pain or shortness of breath. No GI or urinary tract symptoms. She has had surgery for broken nose following the accident last year. Family history of grandmother with breast cancer. Grandmother with lung cancer. Grandparents with hypertension and coronary artery disease. She drinks alcohol occasionally. Does not smoke. She exercises at the gym regularly. NKDA.
- O: Weight 212. Height 5' 10". BP 128/74. Heart RRR without murmur, rub, or gallop. Lungs clear. Neck without adenopathy, thyromegaly, JVD, or bruit. Abdomen soft, non-tender, normal bowel sounds. No hepatosplenomegaly or masses. Breasts without masses, asymmetry, or discharge. External genitalia is normal. Cervix without lesions. Pap is obtained. Uterus normal size, no adnexal masses or tenderness.
- A/P: 1. Pap and pelvic. Exam is normal. Continue Triphasil. Continue monthly self-breast exam.
2. Back pain. Continue follow-up with physiatrist.
3. Allergies. Continue Zyrtec and Rhinocort.
4. ADD, doing well on Effexor 75 XR 1 q d.
5. She had recent blood work through work. She will get us a copy of this.
- Linda L. Giambalvo, M.D./lwp

7-27-04	Triphasil BC pills - T po qd - disp. T pak RFX-10 to CVS —	
	244-1851 per LH —	DB
8-4-04	Pt fitted c air cast to (L) ankle per LH. Pt scheduled	
	appt c D.A. for 8-6-04 —	DB

Burnette, Kellie

8-10-04 (Tue)

- S: 24 YO who sprained her ankle earlier this week. She was seen at Doctors Care, had a negative x-ray, and placed in an air splint. Is feeling much better. Still a little bit of swelling and some pain over lateral malleolus.
- O: There is mild tenderness and swelling over left lateral malleolus. Good ROM. No bruising. Good peripheral pulses.
- A/P: 1. Ankle sprain, improved. Will place back on full duty on Friday. Continue desk work until then. Begin ROM exercises. She is still also having a lot of trouble with back pain related to MVA about a year ago at work. Will try Daypro 2 po q d #60 with 3 refills. Flexeril 10 mg q hs prn #20 with 1 refill. Call for failure to improve. Linda L. Giambalvo, M.D./lwp

2-18-05	Effexor XR 75mg T po qd # 30 z 3 RFX + CVS —	
	244-1851 per LH —	DB

PROGRESS NOTES

Name: Kellie Burnette

Burnette, Kellie

6-3-05 (Fri)

- S: Here today with right hand pain x 3 to 4 days. She denies any injury. She lifts weights, but has not lifted in a week. She is on Darvocet, Mobic, and Ambien for chronic back pain which she says she tries to only take 1 or 2 Darvocet a week and the Ambien and Mobic more to help her rest. She is being evaluated for possible fibromyalgia as well. Her right hand pain is mostly in the superior aspect of her wrist extending over the bend of the wrist and into her right lower forearm. Hurts worse when grabbing something such as a water bottle and lifting it up, that seems to worsen the pain. Some of the pain extends into her forefingers and thumbs. Does not awaken with numbness or tingling.
- O: WF NAD. Right hand is without obvious deformity or swelling. She has full ROM. Again, the pain is located more with the movements of grabbing something and lifting it.
- A: 1. Right hand pain.
- P: Will discontinue Mobic for now and try Cataflam 50 mg 1 t.i.d for the next several days. If symptoms are not improving, may consider trying a cock-up wrist splint as well. If no improvement, x-ray or to orthopedics for further evaluation. Kristi R. Williams, FNP/Larry A. Bergliad, MD/lwp

Burnette, Kellie

6-10-05 (Fri)

- S: Here today with sore throat that began 2 days ago. She denies any fever.
- O: WF NAD. TMs clear. OP slightly red, no exudate. No adenopathy. S-1, S-2 without murmur. Chest clear. RST is negative.
- A: 1. Pharyngitis. Rapid strep is negative. Throat culture pending.
- P: Z-PAK as directed only if needed before the culture is back. Kristi R. Williams, FNP/Mark T. White, MD/lwp

9/16/05 Effexor 75 XR i qd # 30 E 3RF CVS 244-1851 per Dr G ——— AH

Burnette, Kellie

9-30-05 (Fri)

- S: 26 YO for physical exam. She has a history of chronic pain following MVA as a police officer a couple of years ago. She is now seeing Dr. Schwartz and having some injections in her neck. Current meds are Effexor 75 XR, Darvocet prn, usually about 1 per day, Cataflam 1 t.i.d, Zyrtec 10 mg q d, Ambien 10 mg q hs, Flexeril 10 mg q hs, Flexeril 10 mg q hs. She is no longer on Triphasil. Periods are doing well without any problems. No chest pain, shortness of breath, or edema. ADD symptoms, which had been doing well on Effexor, are becoming more prominent, especially as she is taking more classes in school at Greenville Tech in addition to working. She has occasional constipation and takes Metamucil for this. Family history of grandmother with breast cancer. Grandmother with lung cancer. Grandparents with hypertension and heart disease. She does not smoke. She exercises regularly. Drinks alcohol occasionally.
- O: BP 128/80. Weight 234. TMs clear. OP normal. Neck without adenopathy, thyromegaly, JVD, or bruit. Heart RRR without murmur, rub, or gallop. Lungs clear. Breasts without masses, asymmetry, or discharge. Abdomen soft, non-tender, normal bowel sounds. No hepatosplenomegaly or masses. External genitalia is normal. Cervix without lesions. She is just finishing her period. Pap is obtained. Uterus normal size, no adnexal masses or tenderness.
- A/P: 1. Chronic pain. Continue follow-up with Dr. Schwartz.
2. ADD symptoms, worsening recently. Will increase Effexor to 150 XR. Call in 2 to 3 weeks if not improved.
3. Await results of Pap. Continue monthly self-breast exam.
4. Allergies. Have refilled her Zyrtec 10 mg q d. Linda L. Giambalvo, M.D./lwp

PROGRESS NOTES

Name: Kellie Burnette

DATE

Burnette, Kellie

1-4-06 (Wed)

S: 26 YO with sore throat x 1 week, congestion, slight fever. No sinus pressure.

O: OP is very erythematous. Neck with shoddy lymphadenopathy. No maxillary sinus tenderness. TMs clear. Lungs clear.

A/P: 1. Pharyngitis. Amoxicillin 875 mg b.i.d x 10 days.

2. Effexor does not seem to be doing well for ADD. She is having continued symptoms of inattention, procrastination, decreased focus. Will try stopping the Effexor and begin Adderall 10 mg b.i.d. Recheck in 1 week. Linda L. Giambalvo, M.D./lwp

Burnette, Kellie

2-15-06 (Wed)

S: 26 YO for recheck of ADD. She is improved on the Adderall, although she is not sure if dosage is quite enough. No jitteriness or other side effects. Focus has improved.

O: BP 118/76. Heart RRR without murmur. Lungs clear. Affect is bright.

A/P: 1. ADD, doing better on Adderall, but still some breakthrough symptoms. Will increase to 20 mg b.i.d and let us know how she is doing when she picks up her next prescription in a month. Linda L. Giambalvo, M.D./lwp

3-22-06 Adderall 20mg T po bid #60 O RF written per LG — DB
4-28-06 written Rx - Adderall 20mg T po b.i.d. - 70 RFS per LG. 2) Effexor 150mg XR -
- 200P #30 - 6 RFS per LG. Ready for plu — PG
6-2-06 written Rx - Adderall 20mg bid #60 - 70 RFS per LG. Ready for plu. PG
7-26-06 written Rx - Adderall 20mg bid #60 - 70 RFS per LG. Ready for plu. PG
10-25-06 Adderall 20mg T po bid #60 O RF written per LG — DB

Burnette, Kellie

11-10-06 (Fri)

S: 27 YO with 6 month history of left shoulder pain initially when she was doing some drilling and fell into a wall. She felt as if shoulder popped out of place and has been sore ever since gradually worsening over the past couple of months.

O: There is tenderness over deltoid and pain with rotation of left shoulder. No swelling. Full ROM.

A/P: 1. Progressive shoulder pain over the past 6 months, possible rotator cuff injury. Continue anti-inflammatories. Will send to orthopedist for further evaluation. Linda L. Giambalvo, M.D./lwp

11-14-06 Appt sched for pt w/ Dr. Posta 234-9900 on 11-29-06
10:00. Pt notified

Burnette, Kellie

11-20-06 (Mon)

S: Here today with sore throat, congestion, ear pain, all for 3 days. Has had fever with it.

O: WF NAD. TMs clear. OP is injected. Postnasal drip also noted that is yellow in color. Shoddy lymph nodes to anterior cervical chain. Chest clear.

A: 1. Pharyngitis/sinusitis.

P: Z-Pak as directed. Increase fluids. Follow up. Kristi R. Williams, FNP/Larry A. Berglund, MD/lwp

PROGRESS NOTES

Name: Kellie Burnette

DATE	3-13-07	Adderall 20mg i po bid # 60 Ø RF written per XH — DB
5-25-07	Written Rx - Adderall 20mg bid # 60 - Ø RFs - ready for ph; 2) called in -	
	Amibien 10mg i po QHS for insomnia # 30 - Ø RFs - CVS - 244-1851 per LG. — PG	
6-28-07	Amibien 10mg i po QHS for insomnia # 30 Ø RFs; 2) Flexeril 10mg i po QHS	
	per muscle spasms # 30 - 2 RF > 175 ...	

Burnette, Kellie

7-12-07 (Thur)

S: 27 YO with history of depression. She has been on Effexor for 7 years, but has had worsening symptoms of depression over the past 6 weeks, irritability, edginess, mood has been down, decreased motivation.

O: BP 122/78. Heart RRR without murmur. Lungs clear. Lower extremities without edema. Affect is bright today.

A/P: 1. Depression, irritability. Will taper off of the Effexor and begin Lexapro 10 mg q d. Recheck in 4 weeks. Linda L. Giambalvo, M.D./wp

10-26-07	Written Rx - Adderall 20mg bid # 60 - Ø RFs. Left note 2 Rx - starting if pt. is still on Lexapro - needs OV per LG — PG
12-11-07	Z-pak - TAD - disp # 1 Ø RF to CVS 244-1851 per XH — DB
2-19-08	Adderall 20mg i po bid # 60 Ø RF # written per XH — DB
7-25-08	Adderall 20mg i po bid # 60 - Ø RFs - written per LG (PG)

PROGRESS NOTES

Name: Kellie Burnette

DATE

Burnette, Kellie

12-16-08 (Tue)

- S: 29 YO female here for complete physical and Pap smear.
 PMH: ADD. Chronic low back pain. L5 disk bulge. Depression/PTSD and allergic rhinitis.
 PSH: Arthroscopy of the left shoulder with a labral repair in 2007. C5-C6 discectomy with spinal fusion done by Dr. Bucci in Oct. 2008.
 FH: See medical records.
 SH: She is on medical retirement from Greenville Police Department. She occasionally drinks alcohol. Does not smoke.
 GYN: Does not have any children. LMP 2 weeks ago.
 MEDS: See medical record.
 ALLERGIES: NKDA.
- O: Weight 257. BP 124/100. Other vitals stable. Well appearing. HEENT TMs, nares, OP clear. Sclerae clear. Funduscopic exam normal. Thyroid normal. No adenopathy. Cardiovascular RRR. Clear to auscultation bilaterally. No wheezing, rhonchi, or rale. Normal S-1, S-2 heart sounds. No murmurs, gallops, or rubs. Abdomen soft, flat, non-tender, positive bowel sounds. No rebound, guarding, or rigidity. Back non-tender. ROM limited. No CVA tenderness. Negative straight leg raise. GU external genitalia is normal. Speculum exam shows that the cervical os is closed. No discharge. Pap smear samples are taken. Bimanual exam is without masses or tenderness. Extremities no clubbing, cyanosis, or edema. Distal pulses are 2+. Neuro is non-focal. Psych somewhat flat affect. Mood is congruent. Labs: UA normal except for 3+ protein and trace ketones. Will follow up with a culture and a first morning urine. BUN and creatinine are pending.
- A/P: 1. High BP reading today. Ask patient to monitor at home. Would like to recheck this in 1 month in the office.
 2. Chronic low back pain. Continue to be followed by Carolina Center for Advanced Pain Management. Continue current meds.
 3. Depression/PTSD. Stable on the Effexor and the Wellbutrin. Patient is also currently in counseling and should continue with that.
 4. General health maintenance up to date at this point. TSH, CBC, CMP, lipid panel and UA are all pending. Patient will be called with results. Jill Aboulian, P.A./Mark T. White, MD/twp

10/18/08	Spoke to pt re lab results instructed ^{family} on diet and exercise
	to repeat labs in 1 mo — JH/CP
12/18/08	Labs/X-rays Ordered: LFT, TSH in 1 mo — JH/CP

Burnette, Kellie

1-23-09 (Fri)

- S: 29 YO for recheck of BP that was elevated at last visit. She has had ongoing back pain following injury in accident at work several years ago. She has had to go on medical disability for this and still has significant pain throughout the day. She has seen Dr. Satterthwaite. She was started on Wellbutrin recently and the dosage was just increased. This has helped a little bit. With her decreased activity she has had some significant weight gain over the past several years which has gotten her down as well. No chest pain, SOB or edema. Recent TSH was mildly elevated at 5.
- O: BP 114/80. Heart RRR without murmur. Lungs clear. Lower extremities without edema. Good peripheral pulses.
- A/P: 1. Elevated BP, improved today.
 2. Elevated TSH, fatigue, chronic pain from injury. Continue follow-up with Dr. Satterthwaite. Recheck thyroid function test. She also requests a CA-125 due to family history of cancer and had a mildly elevated LFT at last visit. Will recheck this today. Linda L. Giambalvo, M.D./twp

Name: Kellie Burnett

Burnette, Kellie

3-31-09 (Tue)

S: 29 YO with ongoing orthopedic issues related to previous MVA. She hurt her knee in accident in 2003, but had not had any ongoing pain. Over the past 3 weeks, however, she has had pain in the left knee, particularly along lateral knee. No swelling. Feels as if it is going to give out at times. No catching or locking.

O: There is tenderness over left lateral collateral ligament. No anterior or posterior drawer. Good ROM. Good peripheral pulses. No effusion.

A/P: 1. Knee pain. Celebrex 200 mg q d. If not improving over the next couple of weeks will send back to orthopedist. Linda L. Giambalvo, M.D./lwp *LLG*

[illegible]

Holly Tree Family Practice

Name Kellie Burnette

DOB [REDACTED]

Allergies NKDA

Date	Age	Wt	BP	Tm	C/O	Hx/Px	Dx	Tx/Ref.
1/2/97	17	182 ⁴		AF	(D) ankle - sking accident		1 2 3	1 Aircast 2 3
2/1/97	17	187 ⁴		AF	sinus inf. yesterday 983 drainage, coughing little		1 2 3	1 Clonidine 2 Amox 3
8-17-98		193		AF	lost voice, sinus drainage - since last wk.		1 2 3	1 2 3
9-29-99	20	198			pain in shoulders L > R posterior (D) neck		1 2 3	1 2 3
12-22-99	20			98'	shoulder pain, (R) knee; ST up & down steps		1 2 3	1 Amoxil 2 3 Swelling, occ. Celebrex
3/7/00	20	196	112/ 74		lump genital area sore		1 2 3	1 2 3
4-18-00	20			AF	painful periods, nausea HA's headache LMP 4-13-00		1-2 d, a little 2 sexually active 3 left school	1 Vioxx 2 3
5-9-00	20				no effort mood better		1 2 3	1 2 3
5-24-00	20	182	110/ 78	1	(D) shoulder pn. worse & (L) arm x months Celebrex		1 2 3	1 Relafen 2 3 help
6/19/00	20	129 144.60		98.6	HA's dizzy, off on x 1 wk FBS 94		1 2 3	1 ra Phas 2 3
6-27-00	20			98.7	dizzy, ear pressure x 1 mo. vision		1 2 3	1 Allergy 2 3
7-18-00					FAILED TO KEEP APPOINTMENT FOR: DISPOSITION: richer		1 2 3	1 2 3
8-1-00	20				lost mag. to Rochester (R) knee pain; & injury lateral		1 2 3	1 assureding 2 289 living way/100 3 above - little help
12/7/01	22			98.0	sinus drainage & congestion ST, laryngitis x 24		1 2 3	1 2 3
3/9-02	22			98.9	runny nose, sneezing, clear D/C		1 2 3	1 2 3
3/11-03	23				pain (R) shoulder & neck & down back		1 2 3	1 Thera. 2 3
1/1/04					(D) injury		1 2 3	1 2 3
KW 3-4-04	24	112/ 76		AF	Pain (R) knee x 3 days; menstrual issues 1 mos. ago		1 2 3	1 2 3

HOLLY TREE FAMILY PRACTICE, P.A.

Name Kellie Burnette

DOB [REDACTED]

Allergies NKDA

Date	Age	Wt	BP	Tm	C/O	Hx/Px	Dx	Tx/Ref.
LG 6-29-04	24	212 5'10"	128/ 74	AF	Pap-		1 2 3	1 Triphasil-28 2 3
8-4-04					pt cancelled		1 2 3	1 2 3
8-6-04					pt cancelled / resch		1 2 3	1 2 3
8-10-04	24	214			Follow-up @ ankle sprain		1 2 3	1 Back Pain 1 Day Pro 2 2 Phosasil 3
6/3/05	25	224 5'10"	128/ 74		R hand pain x 3-4 d. injury in Dorsal. M. An. (back pain)		1 2 3	1 R wrist 1 R 2 par 2 & to C-1. 3
6-10-05	25			98°	Some V. H. H. C.		1 2 3	1 2 3
9-30-05	26	234 120/80	120/ 80		CPX LMP 9-27-05	Constip Dr. Schwartz	1 2 3	1 1 Effexor 150 2 3
LG 1-4-06	26	228		99°	S.T. x 7 wk.	St. Fever	1 2 3	1 Amoxi/875mg 2 3
2-15-06	26		118/ 76		Shift congest.		1 2 3	1 2 3
X 7-25-06					ED TO KEEP APPOINTMENT FOR: DISPOSITION: OV		1 2 3	1 2 3
X 11-10-06	27	210 5'10"	116/ 76		Shoulder (2t) Gmo fell against wall MVA 2003		1 2 3	1 1 Xanax 2 2 Effexor 3 2 2 Phosasil
KG 11-20-06	27	210		99°	S.T. congestion, ✓ ears x 3 days		1 2 3	1 2 3
KG 9-12-07	27		122/ 78	AF	Intubability - depressed - x 6 wks.		1 2 3	1 1 Shoulder 1000 Xanax 2 2 2 Phosasil 3 3
JA 2-16-08	29	257 L.C.	124/ 100	AF	RF additall, Rhinocent Pap smear - LMP 12-1-08		1 2 3	1 2 3
1-19-09					pt rescheduled		1 2 3	1 2 3
LG 1-23-09	29	258 104/78	124/ 80		rev BP: lab work 3) Discon w/ r. fibrocytes	Dr. Saitler	1 2 3	1 2 3
LG 3-31-09	29	250 124/ 80			R knee x 3 wks = In injury swelling - unstable		1 2 3	1 1 Celebrex 2 2 Anusol HC 3
5/26/09 Cm					FAILED TO KEEP APPOINTMENT FOR: DISPOSITION: OV		1 2 3	1 2 3



CAROLINA ORTHOPAEDIC CENTER

11/29/06

BURNETT, Kelly

WHAT: Left shoulder injury
HOW: A fall
WHEN: 4-5 months ago

REFERRING PHYSICIAN: Dr. Linda Giambalvo

HISTORY: Ms. Burnett is a 27 year old right hand dominant female, seen at the request of Dr. Linda Giambalvo for problems related to the left shoulder. She has a history of a work-related injury secondary to an MVA dated 2003, and she is followed by Dr. Kevin Kopera and has been on Flexeril, Celebrex, Darvocet for that. She has had some achiness in her back but denies any previous shoulder problems. Denies any history of subluxation or dislocation. Denies any other significant medical problems. Patient denies any history of any RA, inflammatory arthropathy, gout or pseudogout. Patient was hanging some curtains 4-5 months ago when she fell with her arm in front of her, injuring the left shoulder. She felt a pop in her back. Since that time she has had persistent pain. Denies any right-sided problems. Denies any numbness or tingling. Patient is here today for exam. Health history is reviewed and dated 11/29/06. Please see the chart.

EXAM: She is roughly 5'10" and 210. She ambulates without difficulty. Patient has a slightly restricted range of cervical spine motion without radicular findings. The right shoulder has 0 to 180 degrees of active and passive forward elevation. Internal rotation is to T6. External rotation is to 70 degrees at the side. AC joint and SC joint is non-tender. Greater tuberosity is non-tender. Patient has negative biceps, negative lift-off, negative drop sign, negative O'Brian's sign. No posterior glenohumeral joint line tenderness. Rotator cuff strength is 5/5 with a negative external rotation stress test. There is no evident anterior or posterior apprehension with a negative sulcus sign. In the supine 90 degree abducted position she has 90 degrees of external rotation, 90 degrees of internal rotation. She has no anterior translation. She has a negative relocation test. No posterior translation. She is neurovascularly intact. Patient's left has 0 to 180 degrees of active forward elevation, 0 to 180 degrees of passive forward elevation with pain in the overhead position. Internal rotation is to T6. External rotation is to 70 degrees at the side. AC joint is markedly point tender, SC joint is non-tender. The greater tuberosity is mildly tender. Patient has a mildly positive bicepital stress test, negative Popeye sign, negative lift-off, negative drop sign, equivocal O'Brian's sign. No posterior glenohumeral joint line tenderness. Rotator cuff strength is 5/5 with some minimal discomfort. There is no anterior apprehension, with a negative sulcus sign. There is no posterior apprehension, although she does have some tenderness to posterior stress testing. I cannot elicit any instability. There is tenderness there. In the supine 90 degree abducted position she has 90 degrees of external rotation, 90 degrees of internal rotation with pain to internal rotation. The left shoulder is stable to ligamentous exam with no anterior translation, negative relocation test, and no posterior instability. Neurovascularly, patient is intact.

RADIOGRAPHS: Of the left shoulder are reviewed, including AP, AP in the scapular outlet, thrower's and axillary views, which demonstrate a Type I acromion with sclerosis of her distal clavicle without significant degenerative changes.

IMPRESSION

1. Left shoulder sprain
2. Rule out internal derangement left shoulder. Specifically rule out AC joint injury, posterior SLAP tear vs instability vs occult abnormality
3. Chronic back pain
4. Overweight



CAROLINA ORTHOPAEDIC CENTER

Page Two
11/29/06

BURNETT, Kelly
~~XXXXXXXXXX~~

PLAN: I am concerned about Kelly's left shoulder pain. I would like to obtain MRI of the left shoulder to assess the integrity of her rotator cuff, biceps tendon, labrum and intraarticular structures. I will reassess her progress back following the MRI.

Alan G. Posta, Jr., M.D./mak

Cc Linda Giambalvo, M.D.
(plus letter)

11/29/06

RADIOGRAPHS: Of the left shoulder are reviewed, including AP, AP in the scapular outlet, thrower's and axillary views, which demonstrate a Type I acromion with sclerosis of her distal clavicle without significant degenerative changes.

Alan G. Posta, Jr., M.D./mak



CAROLINA ORTHOPAEDIC CENTER

12/05/06

BURNETTE, Kellie N
~~XXXXXXXXXX~~

Ms. Burnette returns today for follow-up exam and review of her MRI. She notes the left shoulder is really giving her a lot of trouble. No new health issues. Her health history is reviewed and dated 12/5/06, please see the chart.

EXAM: She is an awake, alert, pleasant female, ambulating without difficulty. Her left shoulder has 0 to 180 degrees of active and passive forward elevation with overhead pain. Internal rotation is to T6. External rotation is to 70 degrees at the side. Her AC joint is point tender, greater tuberosity is mildly tender. SC joint is non-tender. She has a mildly positive bicepital stress test with a negative Popeye sign, negative lift-off, negative drop sign, positive O'Brian's sign. No posterior joint line tenderness. Rotator cuff strength is 5/5 with some mild pain. The left shoulder is stable to ligamentous exam. She is neurovascularly intact.

MRI of the left shoulder was reviewed, which demonstrates a Type I acromion with degenerative changes seen in her AC joint, with increased signal seen in the T2 weighted images. Rotator cuff appears intact. She has what appears to be a SLAP tear posteriorly. Biceps tendon appears intact.

IMPRESSION:

1. SLAP tear, left shoulder
2. AC joint arthritis, left shoulder
3. Rule out tear of the long head of the biceps tendon, left shoulder
4. Chronic low back pain
5. Overweight

PLAN: I had a discussion with Kellie regarding her condition. At this point I do believe she has exhausted non-operative modalities. I believe she would be a candidate for an arthroscopy of the left shoulder, ADCR. At the time of surgery I would address any rotator cuff, biceps tendon, labral or intraarticular pathology. This would be performed utilizing general anesthesia with an interscalene block on an outpatient basis. If there is biceps pathology, my preference would be to perform a biceps tenodesis to preserve length and strength. I would either do this arthroscopically vs a mini open approach. I discussed risks and benefits of the procedure with her and expected outcomes. I provided her with an ultra sling and we will schedule this at her convenience.

Alan G. Posta, Jr., M.D./mak

Cc Linda Giambalvo, M.D.



CENTER FOR
SPECIAL SURGERY

SURGICAL PROCEDURE NOTE

PATIENT: Kellie Burnette

DATE: 01/12/07

ACCOUNT: 8132

SS #:

PRE-OPERATIVE DIAGNOSIS:

1. SLAP tear, left shoulder
2. AC joint arthritis, left shoulder

POST-OPERATIVE DIAGNOSIS: Same

PROCEDURE: Arthroscopy of the left shoulder, arthroscopic SLAP repair, arthroscopic distal clavicle resection

OPERATIVE SURGEON: Alan G. Posta, Jr., M.D.

PATHOLOGY:

1. Type I acromion
2. AC joint arthritis
3. Type II SLAP tear

CPT CODES: 29804; 29807

ICD-9 CODES: 840.7; 715.11

HARDWARE UTILIZED: Three 3.0 Arthrex anchors

INDICATIONS: Patient is a 27 year old female, who fell, injuring the left shoulder. Pre-operative physical exam, radiographs and MRI demonstrate a Type I acromion with degenerative changes in her AC joint and a SLAP tear. Patient is electively admitted for operative reconstruction.

PROCEDURE: Following identification of the patient, patient was then taken to the operative suite. Following induction of general anesthesia, an interscalene block for post-op pain control, and 1 gm of I.V. Ancef, the patient was then positioned on the operating room table in the supine fashion. Left shoulder was then examined under anesthesia and noted to be stable through a full ROM. At this point the patient was carefully positioned in the lateral decubitus position, right side down. Axillary roll was placed. Bean bag was inflated and care was taken to pad the dependent lower and upper extremities. Left arm was then placed in the Dyonics traction device and 15 pounds of traction. The left shoulder was prepped and draped in a sterile fashion. Subacromial space was then injected with 10 cc of 1% xylocaine with epinephrine. Scope was introduced in the shoulder. Diagnostic arthroscopy was then commenced. Articular surfaces of the humeral head and glenoid were visualized and noted to be intact. Anterior, posterior, superior and inferior labrum were visualized and there was noted to be a Type II SLAP tear with an unstable bicepital anchor. Biceps itself was intact. Rotator cuff was visualized in its entirety on the undersurface and was intact. At this point the scope was flip-flopped from posterior to anterior portal. Posterior cuff was intact. Again, the Type II SLAP tear was confirmed. At this point the scope was placed back into the posterior portal and a clear cannula was placed anteriorly. The transrotator cuff portal was established. At this point, three 3.0 Arthrex anchors were placed at the 11, 12:30 and 1:30 position in the left shoulder. These were then passed with suture passers and secured. This yielded excellent labral repair which reapproximated the labrum back up on the glenoid rim. At this point the scope was introduced into the subacromial space. Hypertrophic, hemorrhagic bursal tissue was then resected. The bursal side of the cuff was noted to be intact. CA ligament was intact. At this point using an Oratek wand and acromionizing burr, an arthroscopic distal clavicle resection was then performed. The



CENTER FOR
SPECIAL SURGERY

Page Two

PATIENT: Kellie Burnette

DATE: 01/12/07

ACCOUNT: 8132

SS #: ~~312~~

distal 10 mm of distal clavicle were resected. Care was taken to preserve the posterior superior capsule. At this point, with the procedure complete, arthroscopic equipment was removed from the shoulder. The portals were approximated using 2-0 Nylon horizontal mattress sutures. A sterile dressing was applied. The Cryocuff and swathe was applied, and the patient was transferred to the RR in stable condition.

Alan G. Posta, Jr., M.D./mak

D&T: 01/12/07

CC: Chart



CAROLINA ORTHOPAEDIC CENTER

MICHAEL J. O'BOYLE, M.D.
Acute Trauma & Post Traumatic Reconstruction
Foot & Ankle Surgery

THOMAS B. PACE, M.D.
Arthritic Hip & Knee Surgery

ALAN G. POSTA, JR., M.D.
Sports Medicine & Shoulder, Elbow & Knee
Reconstructive Surgery

H. STANLEY REID, M.D.
Spine Surgery

01/25/07

BURNETTE, Kellie
~~XXXXXXXXXX~~

Kellie returns today, 2 weeks status post arthroscopy of the left shoulder, arthroscopic ASR, ADCR. She returns noting that she is doing very well.

EXAM: All portals are healed, sutures are removed. Passive forward elevation is 0 to 120. External rotation is to 45 ° at the side. She is neurovascularly intact.

IMPRESSION: Stable, status post arthroscopy of the left shoulder, ASR, ADCR

PLAN: I refilled her Oxycodone. She will continue in therapy as per our SLAP protocol. I will allow her to return to work on Monday, 2/5, to right arm use only. These restrictions will stand for 1 month. I will reassess her progress back in 1 month.

Alan G. Posta, Jr., M.D./mak

Cc Linda Giambalvo, M.D.
1338 Highway 14
Simpsonville SC 29681



CAROLINA ORTHOPAEDIC CENTER

02/21/07

BURNETTE, Kellie
BURNETTE, Kellie

Kellie returns today, 6 weeks status post arthroscopy of the left shoulder, ASR, ADCR. She returns noting that overall she is doing well. She has difficulty sleeping at night and some pain.

EXAM: Active forward elevation, left shoulder, is 0 to 120. Passively goes to 0 to 170. External rotation is to 45 ° at the side. She is neurovascularly intact.

IMPRESSION: Stable, status post arthroscopy of the left shoulder, ASR, ADCR

PLAN: I refilled her Oxycodone. We will advance her now in therapy to working on full motion and full strength. I will allow her to return to work. Her work restrictions will include no overhead use of the left arm and no repetitive use of the left arm, and no lifting > 30 pounds. These restrictions will stand for 1 month. I will reassess her progress back in 1 month.

Alan G. Posta, Jr., M.D./mak

Cc Linda Giambalvo, M.D.



CAROLINA ORTHOPAEDIC CENTER

04/02/07

BURNETTE, Kellie

Kellie returns today, 2 ½ months status post arthroscopy of the left shoulder, ASR, ADCR. She returns noting that her motion is doing well. She is a little bit weak.

EXAM: Active and passive forward elevation of the left shoulder is 0 to 180. Internal rotation is to T6. External rotation is to 60 degrees at the side. She has a negative O'Brian's sign today. She is somewhat weak and is neurovascularly intact.

IMPRESSION: Stable, status post arthroscopy of the left shoulder, ASR, ADCR.

PLAN: Kellie will be advanced to the full motion and strengthening phase of our shoulder rehab protocol. I will continue her on her current work restrictions, which include no overhead use of the left arm and no repetitive use of the left arm, and no lifting > 30 pounds. She will continue in therapy. I will reassess her progress back in 1 month, at which time I anticipate a rating and release.

Alan G. Posta, Jr., M.D./mak



CAROLINA ORTHOPAEDIC CENTER

05/07/07

BURNETTE, Kellie

~~BAILEY~~

BURNETTE
Ms. ~~Bailey~~ returns today for follow-up exam, noting that she is doing much better. She still has some weakness in the left shoulder. No new health issues. Her health history is reviewed and dated 5/7/07. Please see the chart.

EXAM: Her active and passive forward elevation of the left shoulder is 0 to 180. Internal rotation is to T6. External rotation is to 60° at the side. She still has some weakness and a little bit of pain. She is neurovascularly intact.

IMPRESSION: Stable, status post arthroscopy of the left shoulder, ASR, ADCR

PLAN: Kellie is a police officer and does need to be able to defend herself. She still has some weakness. I believe that an additional 6 weeks of aggressive therapy will improve her left shoulder. At this point she will continue rehabbing the left shoulder. I will continue her on her current work restrictions, which include no overhead use of the left arm, no repetitive use of the left arm, no lifting > 30 pounds. I will reassess her progress back in 6 weeks, at which time I anticipate return to full duties.

Alan G. Posta, Jr., M.D./mak



CAROLINA ORTHOPAEDIC CENTER

06/11/07

BURNETTE, Kellie

~~XXXXXXXXXX~~

Ms. Burnette returns today, 5 months status post arthroscopy of the left shoulder, ASR, ADCR. She returns noting that she is doing great. No new health issues. Her health history is reviewed and dated 6/11/07. Please see the chart.

EXAM: She is ambulating without difficulty. Active and passive forward elevation of the left shoulder is 0 to 180. Internal rotation is to T6. External rotation is to 60 degrees at the side. In the 90 degree abducted position she has 90 degrees of external and internal rotation. There is no pain or instability. She is neurovascularly intact.

IMPRESSION: Stable, status post arthroscopy of the left shoulder, ASR, ADCR

PLAN: Kellie has had an excellent result. At this point she has reached maximum medical improvement. Please see associated disability rating. I will allow her to return to work without restriction. She was instructed to contact our office if she has any further problems, otherwise. I will reassess her progress back on a prn basis.

Alan G. Posta, Jr., M.D./mak



CAROLINA ORTHOPAEDIC CENTER

06/11/07

BURNETTE, Kellie

DISABILITY RATING

Ms. Burnette has reached maximum medical improvement. Her permanent partial impairment of the left upper extremity related to her left shoulder is a 10% permanent partial impairment. This corresponds to a 6% whole body impairment. She is now cleared to return to work without restriction.

Please feel free to contact my office if you have any further questions.

Alan G. Posta, Jr., M.D./mak

Orthopaedic Associates PA
115 Deacon Tiller Court Duncan, SC 29334
864-682-6396 Fax: 864-595-4080

October 6, 2008
Page 1
Chart Document

Kellie Michelle Burnette

09/26/2008 - Office Visit: Follow up: MRI cspine
Provider: David Mitchell MD
Location of Care: Orthopaedic Associates PA

History of Present Illness
Family Physician: Dr. Giambolvo

History From: Patient

Problem #1
Type: back and neck pain
DOI: 06/2007

Kellie Burnette is a 29 year old former police officer at City of Greenville. She was seen and evaluated 09/19/08 and some of her medical records were reviewed as well as some today. The patient has been treated by Dr. Satterthwaite for her lower back pain. She has an injured disk at L5-S1 and some myofascial pain. She also has some attention deficit disorder symptoms. Her friend in the room with her says that she is up at night and cannot sleep and walks around complaining of neck pain. These symptoms are a little bit more severe than she had told me before.

Past Medical History

Patient indicates history of Mental disorder and Other medical problem.

MEDICATIONS

EFFEXOR XR 75 MG CP24 (VENLAFAXINE HCL) take one q day
LORTAB 10 10-500 MG TABS (HYDROCODONE-ACETAMINOPHEN) take one QID
AMBIEN CR 12.5 MG TBCR (ZOLPIDEM TARTRATE) take one q day
BACLOFEN 10 MG TABS (BACLOFEN) take one TID
FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) Take one q day
CELEBREX 200 MG CAPS (CELECOXIB) take one BID
ADDERALL 20 MG TABS (AMPHETAMINE-DEXTROAMPHETAMINE) take one BID
ZYRTEC ALLERGY 10 MG TABS (CETIRIZINE HCL) take one q day

ALLERGIES

No known allergies

Revised - 09/30/2008

Past Surgical History

Surgical history includes Arthroscopic Shoulder Surgery(left), Low Back Disc Surgery and Other Surgery.

Social History

Orthopaedic Associates PA
115 Deacon Tiller Court Duncan, SC 29334
864-582-6396 Fax 864-595-4080

October 6, 2008
Page 2
Chart Document

Kelli Michelle Burnette

Patient is single, Non-smoker, and lives with spouse/partner. Has no children. Drinks alcohol 1-3 times per week. Does not exercise. Education completed: High School.

Family History

Patient denies any pertinent family medical history.

Review of Systems

General: Complains of weight gain, fatigue.

Eyes: Denies blurring, vision loss.

Ears/Nose/Throat: Denies difficulty breathing, deafness, hoarseness, hearing aid, dentures.

Cardiovascular: Denies swelling in hands or feet, palpitations, chest pain.

Respiratory: Denies wheezing, coughing, shortness of breath.

Gastrointestinal: Complains of constipation.

Genitourinary: Denies urinary frequency, incontinence, painful urination.

Musculoskeletal: Complains of muscle weakness, back pain, joint pain, joint swelling, stiffness.

Skin: Denies rashes, lumps, lesions, itching, sores.

Neurologic: Complains of numbness/tingling in arms/legs.

Psychiatric: Complains of difficulty sleeping, anxiety, depression.

Endocrine: Complains of heat or cold intolerance, excessive thirst.

Heme/Lymphatic: Complains of chills, sweats.

Allergic/Immunologic: Denies latex allergy, hives, hay fever.

VITAL SIGNS

Ht: 70 in. Wt: 245 lbs.

GENERAL EXAM

Appearance: Healthy

Mental Status: Alert & Oriented x 3, No Acute Distress

Hand Dominance: Right

Gait: Normal

PHYSICAL EXAMINATION

The patient continues to complain of cervical neck pain. She does not really complain of any numbness in her upper extremities and her grip strength is good but she has positive Spurling's exam.

MRI

We have reviewed the MRI that shows C5-6 has a right parasagittal disk protrusion and osteophyte narrowing of the spinal canal. This seems to be flattened to the ventral surface of the spinal cord to the right of midline.

PLAN

It is my opinion that the patient should continue with her treatment for her lower back pain and myofascial pain and cervical neck pain. It would also be my opinion that she be seen by a neurosurgeon in Greenville,

Orthopaedic Associates PA
115 Deacon Tiller Court Duncan, SC 29334
864-582-6396 Fax 864-595-4080

October 6, 2008
Page 3
Chart Document

Kellie Nichole Barnette
Female, DOB: 01/01/1978, SSN: 123-45-6789, MRN: 123456789, Room: 1234, Bed: 5678

Dr. Steve Gardner, for evaluation of her disk protrusion at C5-6 which may be the source of a lot of her neck discomfort.

Dictated by Dr. Mitchell

New Orders:
Est. Level 3 [99213]

Signed by Casey L. Blackwell on 09/30/2008 at 2:43 PM

Center for Health and Occupational Services

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OUTPATIENT VISIT

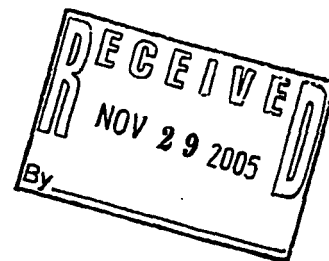
Patient: Kellie Burnette
SSN: ~~XXXXXXXXXX~~
Date: 11/15/05

Ms. Burnette is seen today for a follow up appointment and continues to have chronic low back pain. She has no change in her symptoms. Since I last saw her she underwent a series of sympathetic blocks performed by Dr. Schwartz and reports some improvement. She will be following up with Dr. Schwartz later on this month. Otherwise she is medically stable with no new symptoms. Today's visit was spent primarily in discussion with Ms. Burnette once again reviewing her condition during today's 15-minute office visit. She is relying on Cataflam 50 mg three times daily and Flexeril averaging 1 per day and Ambien 10 mg at nighttime. She had taken Tylenol with Codeine without benefit and we will place her back on Darvocet N 100 limiting her to one tablet per day as needed for pain. From my standpoint, Ms. Burnette is stable. I gave her a 2-month supply of her medications and will reassess her at that time. She continues to do her full job duties as a police officer.


Kevin W. Kopera, M.D., MPH

KWK/dn 11/22/05

C: Janie Russo, Hewitt Coleman, PO Box 5500, Greenville, SC 29606



Center for Health and Occupational Services

A service of GREENVILLE HEALTH CORPORATION

OUTPATIENT VISIT

Patient: Kellie Burnette
SSN: ~~XXXXXXXXXX~~
Date: 1/12/06

Ms. Burnette returns today for a follow up appointment for low back pain which is chronic. She informs me since her last visit she went for a Workers' Compensation hearing and indicates that she has been provided continued medical benefits. She continues to complain of pain in the lower thoracic spine and lumbar spine. She denies any symptoms in either upper or lower extremities. She is not describing numbness or weakness. She continues to take a medication regimen including Cataflam as well as Flexeril as needed. She takes Ambien at night and Darvocet as needed using the medication sparingly.

On exam Ms. Burnette has pain with deep palpation over the lower thoracic spine and lumbar spine. This is the most prominent finding on exam. She shows excellent flexibility at the spine with no restrictions. Her reflexes are intact in her legs as is sensation and strength. There is no swelling or edema in the legs and gait pattern is normal and functional.

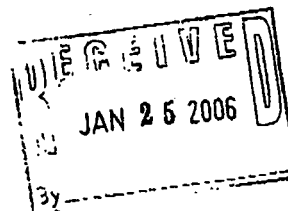
IMPRESSION: Chronic low back pain

PLAN: Ms. Burnette continues to have chronic low back pain most consistent with myofascial pain or mechanical back pain. She is medically stable at this time and she is doing as well as can be expected. Today her medications were simply renewed without change and I will reassess her in 3 months. She will continue with medication management.


Kevin W. Kopera, M.D., MPH

KWK/dn 1/18/06

C: Janie Russo, Hewitt Coleman, PO Box 5500, Greenville, SC 29606



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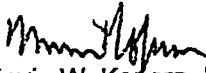
OUTPATIENT VISIT

Patient: Kellie Burnette
SSN: ~~XXXXXXXXXX~~
Date: 4/4/06

Ms. Burnette returns today for reassessment of chronic low back pain and is not doing as well. She has had more muscular pain as of late in the thoracic and lumbar region. She is no longer finding Cataflam to be helpful. These issues were all discussed and on examination there continues to be pain over the lumbar area and also throughout the entire thoracic area with palpation and the pain response is greater than typical. Mobility at the waist and spine today is somewhat limited by close to functional limits. Strength and sensation are intact in the upper and lower limbs. Gait pattern is functional.

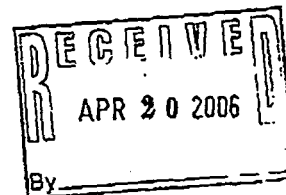
IMPRESSION: Exacerbation of chronic low back pain.

PLAN: Ms. Burdette is inquiring about a course of physical therapy and this seemed a reasonable approach. We will attempt to get approval for this and in the interim Ms. Burdette was changed from Cataflam to Celebrex 200 mg twice daily and otherwise continues on Ambien 10 mg at nighttime and Flexeril 10 mg averaging one per day with Darvocet N 100 averaging one of these tablets per day. Ms. Burnette will be reassessed in one month.


Kevin W. Kopera, M.D., MPH

KWK/dn 4/10/06

C: Janie Russo, Hewitt Coleman, PO Box 5500, Greenville, SC 29606



Center for Health and Occupational Services

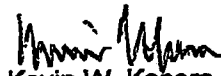
A service of GREENVILLE HEALTH CORPORATION

OUTPATIENT VISIT

Name: Kellie Burnette
SSN: ~~XXXXXXXXXX~~
Date: 05/02/06

Ms. Burnette is seen today for a followup appointment to reassess her low back pain which is chronic. Today she is in good spirits. She has begun physical therapy and has completed three of twelve approved visits and is showing improvement. Also she is doing better on Celebrex and this is helping her. She denies any new complaints. She still has pain but it is less intense and she is more comfortable. She has continued her job duties without significant difficulty. Her exam today is changed from 4/4/06 with the exception that she is overall more comfortable.

IMPRESSION: Chronic low back pain. Ms. Burnette will complete physical therapy as ordered and I will reassess her in one month. If she is stable at that time then the frequency of her office visits will be decreased. She is continued on Celebrex 200mg twice daily, Ambien 10mg in the evening, and Flexeril 1 per day for muscle spasm and Darvocet N-100 one tablet per day as needed for pain.


Kevin W. Kopera, M.D.

KWK/dc 05/10/06

c: Janie Russo, Hewitt Coleman, PO Box 5500, Greenville, SC 29606

MAY 22 2006

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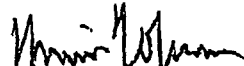
OUTPATIENT VISIT

Name: Kellie Burnette
SSN: [REDACTED]
DOB: [REDACTED]
Date: 05/31/06

Ms. Burnette is seen today for a followup appointment and she has chronic thoracic and lumbar pain most consistent with myofascial pain. She is close to completing a course of physical therapy with a final session scheduled for later on this week and she is doing quite well. The treating physical therapist is recommending use of a TENS unit as this has provided pain relief for Ms. Burnette. She continues to take Celebrex and Ambien. She is not taking Darvocet to the same degree and does not require a refill today for this. She has been taking Flexeril but today inquires about trying a different muscle relaxer and this was discussed. Today on exam a trigger point is identified in the upper thoracic region but otherwise palpation is well tolerated over the thoracic and lumbar areas. Ms. Burnette shows good flexibility at the waist. She is neurologically intact in the upper and lower extremities and there is no swelling or edema evident.

IMPRESSION: Myofascial pain in thoracic and lumbar regions.

PLAN: Ms. Burnette requested a trigger point injection today and I felt this was reasonable as a definite trigger point was identified in the upper thoracic region. Under sterile technique a Depo Medrol Sensorcaine injection was performed and well tolerated. Ms. Burnette will complete physical therapy as ordered and will receive a TENS unit. I will review the final physical therapy note and determine whether or not additional physical therapy will be needed. Ms. Burnette was given new refills today on Celebrex and Ambien and Flexeril was discontinued and replaced with the medication Skelaxin. Ms. Burnette may continue her regular activities without restriction.


Kevin W. Kopera, M.D.

KWK/dc 06/02/06

c: Janie Russo, Hewitt Coleman, PO Box 5500, Greenville, SC 29606

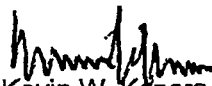
JUN 13 2006

OUTPATIENT VISIT

Name: Kellie Burnette
SSN: [REDACTED]
DOB: [REDACTED]
Date: 06/29/06

Ms. Burnette returns once again for continued management of chronic pain. Pain is most consistent with myofascial pain and today once again it is most prominent in the thoracic and lumbar regions. She feels she has declined since she has discontinued physical therapy but also feels that the TENS unit she has been using is benefitting her. She also indicates that Ambien is no longer as effective. She falls asleep well but does not maintain sleep and this was discussed. She continues on Celebrex and also has been taking Skelaxin. Today Ms. Burnette is focused on additional treatment and is inquiring about nerve blocks. She has had these procedures done before by Dr. Schwartz. Review of her case indicates that her prior MRI scan of the lumbar spine was essentially normal so I am not certain whether or not these injections will provide significant benefit. Her exam continues to reveal myofascial pain primarily in the lumbar region on today's assessment with no obvious deficits in strength or sensation. Affect is appropriate and Ms. Burnette is alert and oriented. She continues to work full time as a police officer.

IMPRESSION: Ms. Burnette continues to have myofascial pain. She is focused on the need for additional therapy which I will address with the carrier. She is inquiring about a nerve block and I am not certain this procedure will provide a long lasting benefit. She is also inquiring about additional physical therapy. She continues to use a TENS unit. I renewed her prescription today for Celebrex and Skelaxin and changed her Ambien to Ambien CR 12.5mg and offered her words of encouragement and will reassess her in one month. Of note is that she underwent a trigger point injection at her last visit in late May in the upper thoracic region and she had good pain relief from the trigger point injection.


Kevin W. Kopera, M.D.

KWK/dc 07/06/06

c: Janie Russo, Hewitt Coleman, PO Box 5500, Greenville, SC 29606

CENTER FOR HEALTH AND OCCUPATIONAL SERVICES

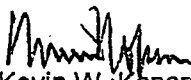
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430

OUTPATIENT VISIT

Patient: Kellie Burnette
ID#: ~~REDACTED~~
Date: 9/29/06

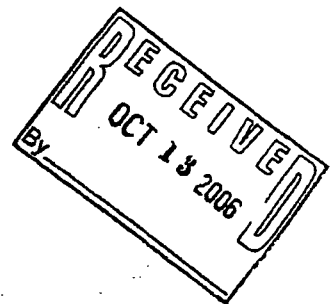
Ms. Burnette is seen today for reassessment. She has chronic myofascial pain most predominantly in the thoracic region. Her pain has been increasing as of late and she is quite concerned about it. She is not describing any new symptoms just the pain is of greater intensity. She is not sleeping as well on the Ambien and this was discussed. The Skelaxin is also not effective in controlling her muscle spasms. Today was spent reviewing Ms. Burnette's medical condition in depth and going over options. Ultimately, I elected to discontinue Ambien and placed her on Lunesta 3 mgs at bedtime. The Skelaxin will be discontinued and Flexeril will be restarted at 10 mgs up to two per day as needed for muscle spasm. Ms. Burnette continues to take Darvocet averaging one per day and Celebrex 200 mgs twice daily. Hopefully, the changes in the medication regimen will have a positive effect. Ms. Burnette's response will be assessed in one month. If her symptoms decline further, another course of physical therapy may need to be considered. Today's 15 minute office visit was spent with greater than 50% of the time in discussion with Ms. Burnette,


Kevin W. Kopera, M.D., MPH

KWK/md 10/06/06

C: Janie Russo, Hewitt Coleman, PO Box 5500, Greenville, SC 29606

1-0302234-001



CENTER FOR HEALTH AND OCCUPATIONAL SERVICES

OUTPATIENT VISIT

Name: Kellie Burnette
SSN: [REDACTED]
DOB: [REDACTED]
Date: 01/24/07

Ms. Burnette is seen today for routine follow-up appointment. She is followed for chronic myofascial pain in the thoracic region. As to the thoracic condition, she is stable, but she has had a new problem arise since I last saw her. She describes dislocating her left shoulder after a fairly trivial event and then would have MRI imaging done. Apparently, this revealed a SLAP lesion and Ms. Burnette would come under the care of the Dr. Posta. She would undergo surgical intervention on the left shoulder earlier this month and currently has the left arm in a sling. She did have repair of the SLAP lesion and I believe she also underwent excision of the distal clavicle. Ms. Burnette is on Oxycontin for post-surgical pain and this is not taking Darvocet. She has been taking Lunesta 3 mg in the evening and today requests to go back on Ambien CR which she had taken previously with better results. She is also taking Flexeril 10 mg twice daily with benefit in terms of controlling muscle spasms and also takes Celebrex 200 mg twice daily.

On exam, I did not aggressively do any range of motion of the left shoulder. Ms. Burnette shows good grip strength in the left hand. There is no swelling or edema in the distal left upper extremity. Sensation is intact in the left hand as well. Circulation is intact in the left arm with good capillary refill in the hand.

IMPRESSION:

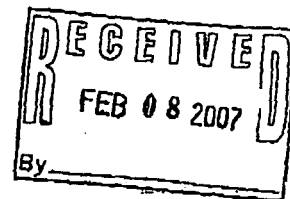
1. Chronic myofascial pain, thoracic region.
2. Status post left shoulder surgery for SLAP lesion.

PLAN: Ms. Burnette is stable from my standpoint and is simply continued on Celebrex, Ambien CR with the Lunesta being discontinued, and Flexeril. Darvocet was not prescribed as Ms. Burnette is taking Oxycontin through Dr. Posta's office. Ms. Burnette was given a three month supply of her medications and will be reassessed at that time.


Kevin W. Kopera, M.D.

KWK/gsl 01/25/07

CC: Janie Russo, Hewitt Caldman, PO Box 5500, Greenville, SC 29606



JAN 26 2007

May 19, 2004 2:46PM

No. 3062 P. 2/2

**Bon Secours St. Francis Health System
WorkWell****Office Notes**

PATIENT: BURNETTE, Kellie
DATE: 05/14/04
CHART #: 2458634
COMPANY: City of Greenville

SUBJECTIVE:

Ms. Burnette is here for re-check of her back and basically for an MRI review. The MRI looks pretty good with minimal disk bulging at L5-S1 and L4-5, but no evidence of focal disk protrusion, spinal canal stenosis, or nerve root impingement by the radiologists read. I have not reviewed the actual films today as they are not available for review. Symptom wise she is still having soreness throughout and it feels like it may be increasing actually with tightness and discomfort across the low back. Please see previous notes for details of her extensive history. She is tolerating the Naproxen, but it is not giving adequate relief of discomfort at this time.

ASSESSMENT:

Lumbar strain, chronic.

PLAN:

Naproxen pm. We are going to add in Ultram to be taken first at bedtime and then if she tolerates this she may take it up to three times a day. We will plan for referral to physiatry, probably Dr. Kopera to review the case and then to manage her at his expertise. I will follow at a distance and she may follow-up with me prn.


Wes Merrwether, MD
WM/pdm/mta

MAY.14.2004

9:11AM

ST FRANCIS WORKWELL

NO. 013

P.3


**BON SECOURS
ST. FRANCIS HEALTH SYSTEM**

WorkWell™ Occupational Health Center
St. Francis Women's & Family Hospital
131 Commonwealth Drive - Suite 200
Greenville, SC 29615
Phone: (864) 675-4600 Fax: (864) 675-4604

Today's Date: 5.14.04
Arrival Time: 935
Time In: 9:40A
Time Out: 1015
☐ Initial ☒ Re-check

051404

YELLIE BURNETTE
CITY OF GREENVILLE 467-4534
CLAUDIA MAJOR 467-8737
PACIYVA 8786703
EXCERDS ON 8/14

Post-Accident UDS? (Check Company List) ☐ Yes ☐ No Date of Injury: 5/14/04 Time of Injury: 9:35
Allergies: NADA
Current Job: Police Officer Home Phone: 864-675-4604

Treatment Authorized by: on file Title: Police Officer Date: 5/14/04

I hereby authorize the release of all medical information pertaining to this work related injury/illness to my employer, insurance company and referral physicians. Records from any medical provider involved in or relative to the diagnosis or treatment of this injury may be released to WorkWell™ Occupational Health Clinic. In addition, authorization is hereby given to this treating facility to perform any and all tests or procedures relative to my injury/illness or physical examination as deemed necessary by the attending physician and/or employer. Should this visit be found unrelated to my work and not part of a worker's compensation claim, I will not hold WorkWell™ Occupational Health Clinic or St. Francis Health System liable for the release of these records. If this injury is determined to not be work-related, I understand that I will be responsible for my bill.

Employee's Signature: on file Date: 5/14/04

Vital Signs: BP: 122/70 P: 68 T: 98.6
Chief Complaint: (where, what, when, how) lower back pain

Treatment: EXAM

Diagnosis: LUMBAR STRAIN

Medication Given: ULTRAM

Prescription? ☒ Yes ☐ No

X-Rays: ☐ Yes ☒ No Interpretation: None

Disposition: 1. Work Related 2. Non-Work Related 3. Undecided

1. May return to work/physical activity without restrictions Date: 5/14/04 MMI: 5/14/04

3. May return to work/physical activity with the following restrictions: Date: 5/14/04

☐ No prolonged sitting/standing Amount of Time: 1 hour

☐ No strenuous climbing, pulling or pushing Weight limit: 10 lbs

☐ Lifting limited to 10 lbs with 10 lbs (L) arm 10 lbs (R) arm ☐ no lifting

☐ No/limited lifting at waist level - Specify weight if limited: 10 lbs

☐ No/limited repetitive use of: 10 lbs (L) hand/arm/leg 10 lbs (R) hand/arm/leg - Specify # repetitions/Time: 10 reps/1 min

☐ Sedentary work only (0 - 10 lbs.)

☐ No significant physical activity without use of splint, crutches, brace, etc. 10 lbs

☐ No walking on rough terrain

☐ No/limited repetitive stooping, bending, squatting or twisting - Specify frequency per hour: 10 reps/1 min

☐ No/limited overhead lifting - Specify weight if limited: 10 lbs

☐ No exposure to heights above 10 ft

☐ Environmental restrictions ☐ Yes ☒ No

Exposure requires limitation to 10 lbs heat 10 lbs cold 10 lbs dust 10 lbs chemicals 10 lbs vibrations

If yes, please explain: 10 lbs

☐ Keep dressing clean & dry

☐ Other: 10 lbs

4. Employee is unable to work until recheck date - 10 days week

5. Is employee restricted by medication and/or treatment that might affect his/her ability to drive? ☐ Yes ☒ No ability to operate machinery? ☐ Yes ☒ No

6. Estimated date of maximal medical improvement (MMI): 5/14/04

Scheduled appointments:

✓ Follow-up appointment at WorkWell™ Occupational Health Center Date: 5/14/04 Time: 10:00

✓ To Specialist: 10:00 Date: 5/14/04 Time: 10:00

✓ To Physical Therapy: 10:00 Location: 10:00 Date: 5/14/04 Time: 10:00

✓ Other: 10:00 Date: 5/14/04 Time: 10:00

✓ Test/Procedures ordered: 10:00 Date: 5/14/04 Time: 10:00 Facility: 10:00

Name of Physician/Provider: 10:00 Physician/Provider Signature: 10:00

Instructions given by: 10:00 I understand the instructions given to me: 10:00

Company called by: 10:00 Time: 10:00 Company Rep Name/Title: 10:00

WASTE: WW
SPHS-565 WORKWELL OHS INJURY ASSESSMENT

Revised 10/14/00
PINK EMPLOYEE

GOLDENROD: MEDICAL RECORDS
C:\Injury Assessment Form with Blue Plate

Copy: CBO

HEALTHSOUTH
Diagnostic Center of Greenville1 Cannon Drive
Greenville, SC 29605

Account #: 109850

Name: BURNETTE, KELLIE NICHOLE

Home Phone: (864) 242-4011

SSN: [REDACTED]

Date of Birth: [REDACTED] Sex: F

Ref: 02187 WEST MERRYWEATHER MD

Date of Procedure: 5/11/04

864/242-4011

MRI LUMBAR SPINE**HISTORY:** Lower back pain.**TECHNIQUE:** T1- and T2-weighted sagittal and axial images of the lumbar spine were obtained.**FINDINGS:** Vertebral height and signal intensity within the bone marrow appears normal. The conus medullaris has a normal appearance and ends at the level of the superior endplate of L1. There is minimal diffuse disc bulging at L5-S1 and L4-5 without evidence of focal disc herniation or nerve root impingement. The disc spaces at L3-4, L2-3, and L1-2 appear within normal limits.**IMPRESSION:** MINIMAL DIFFUSE DISC BULGING AT L5-S1 AND L4-5 WITHOUT EVIDENCE OF A FOCAL DISC PROTRUSION, SPINAL CANAL STENOSIS, OR NERVE ROOT IMPINGEMENT.

Richard A. Mamrick, M.D./Jtd

Thank you for referring this patient to HealthSouth Diagnostic Center.

dd: 05/12/2004

dt: 05/12/2004

RECEIVED

MAY 17 2004

HC 5-14-04

**Bon Secours St. Francis Health System
WorkWell****Office Notes**

DATE: 05/05/04
PATIENT: BURNETTE, Kellie
CHART #: 2418746
COMPANY: City of Greenville

SUBJECTIVE:

Ms. Burnette has not been seen since November of last year. Was involved in a motor vehicle accident, has just had persistent back pain. The last time I saw her, she was having just a little bit of back pain, but it seemed to be resolving with physical therapy. She has continued the physical therapy type exercises on her own but is having persistent, increasing back pain in the same area as previous through the central lumbar spine. She had a week or so off work, and it did not seem to improve any with rest. It does seem to be worse at the end of the day. She does not notice any radicular pain or mechanical symptoms, just persistent, boring lumbar pain. Performs regular duties but just with discomfort. No LOBCC, no recent injury or other back injury in her previous history. No significant family or childhood history of musculoskeletal disease or injuries. Please see previous notes for details of her extensive history.

OBJECTIVE:

White female seated in no acute distress. Rises from a seated position without significant difficulty. No real palpable tenderness at bony or soft tissue landmarks about the back. She has normal range of motion with flexion and extension, side bending, and rotation. End range extension elicits some discomfort across the low back in about the area of L3-4, as does forward flexion and rising from a forward flexed position. Straight leg raise is negative bilaterally both lying and seated. Strength is excellent in the lower extremities. Reflexes are normal.

ASSESSMENT:

Persistent lumbar back pain status post motor vehicle accident.

PLAN:

At this point, we need to rule out any underlying pathology congenital or otherwise. The recommendation is for an MRI. Pending the MRI results, I have basically reached the extent of my ability to treat and recommend a referral to either an orthopedic specialist or a physiatrist, likely the latter considering her history unless this is based on MRI surgical problem. We are going to switch her anti-inflammatories to Anaprox DS 1 po bid with food to see if she can get better relief with this. She will continue exercising and icing as tolerated. The plan is for a follow-up after the MRI.

Wcs Merriwether, M.D.
WM/amg/mta

RECEIVED
MAY 17 2004

MAY. 5. 2004

5:29PM

ST FRANCIS WORKWELL

NO. 741 P. 2/2



BON SECOURS
ST. FRANCIS HEALTH SYSTEM

WorkWell™ Occupational Health Center
St. Francis Women's & Family Hospital
131 Commonwealth Drive - Suite 200
Greenville, SC 29615
Phone: (864) 675-4800 Fax: (864) 675-4804

Today's Date: 5.5.04Arrival Time: 12:25

Time In: _____

Time Out: 6:10☐ Initial☒ Re-check

KEILIE BURNETTE

CITY

CLAUDE MAJOR

F

HARRIS

467-4534

467-8757

09/16/2003

2414746

CLERK ON REIN

Post-Accident UDS? (Check Company List) ☐ Yes ☐ No	Date of Injury: <u>5/5/04</u>	Time of Injury: _____
Allergies: _____		
Current Job: _____	Home Phone: <u>864-453-4534</u>	

Treatment Authorized by: _____ Title: _____ Date: _____

I hereby authorize the release of all medical information pertaining to this work related injury/illness to my employer, insurance company and referral physicians. Records from any medical provider involved in or relative to the diagnosis or treatment of this injury may be released to WorkWell™ Occupational Health Clinic. In addition, authorization is hereby given to this testing facility to perform any and all tests or procedures relative to my injury/illness or physical examination as deemed necessary by the attending physician and/or employer. Should this visit be found unrelated to my work and not part of a worker's compensation claim, I will not hold WorkWell™ Occupational Health Clinic or St. Francis Health System liable for the release of these records. If this injury is determined to not be work-related, I understand that I will be responsible for my bill.

Employee's Signature: on fileDate: 5/5/04

Vital Signs: _____

BP: 110/75P: 84T: 98.6

Chief Complaint: (where, what, when, how) _____

Treatment: _____

Diagnosis: _____

Medication Given: _____

Prescription? ☐ Yes ☐ No

X-Rays _____

Yes ☐ No ☐

Interpretation: _____

Disposition: _____

1. ☒ Work Related ☐ Non-Work Related ☐ Undecided Date: 5/5/04 MMI _____
2. May return to work/physical activity without restrictions
3. May return to work/physical activity with the following restrictions:
 - ☐ No prolonged sitting/standing Amount of Time: _____
 - ☐ No strenuous climbing, pulling or pushing Weight limit: _____
 - ☐ Lifting limited to _____ lbs with _____ (L) arm _____ (R) arm ☐ no lifting
 - ☐ No/limited lifting at waist level - Specify weight if limited: _____
 - ☐ No/limited repetitive use of: _____ (L) hand/arm/leg _____ (R) hand/arm/leg - Specify # repetitions/Time: _____
 - ☐ Sedentary work only (0 - 10 lbs.)
 - ☐ No significant physical activity without use of splint, crutches, brace, etc. _____
 - ☐ No walking on rough terrain
 - ☐ No/limited repetitive stooping, bending, squatting or twisting - Specify frequency per hour: _____
 - ☐ No/limited overhead lifting - Specify weight if limited: _____
 - ☐ No exposure to heights above _____ ft.
 - ☐ Environmental restrictions ☐ Yes ☐ No
 - Exposure requires limitation to _____ heat _____ cold _____ dust _____ chemicals _____ vibrations
 - If yes, please explain: _____
 - ☐ Keep dressing clean & dry
 - ☐ Other: _____
4. Employee is unable to work until recheck date - _____ days _____ week
5. Is employee restricted by medication and/or treatment that might affect his/her ability to drive? ☐ Yes ☐ No ability to operate machinery? ☐ Yes ☐ No
6. Estimated date of maximal medical improvement (MMI): _____

Scheduled appointments:

☒ Follow-up appointment at WorkWell™ Occupational Health Center	Date: _____	Time: _____
☒ To Specialist: _____	Date: _____	Time: <u>RECEIVED</u>
☒ To Physical Therapy: _____	Location: _____	Date: _____
☒ Other: _____	Date: _____	Time: _____
☒ Test/Procedures ordered: _____	Date: _____	Time: _____
		Facility: <u>MAY 17 2004</u>

Name of Physician/Provider: AKRISTIAN Physician/Provider Signature: _____Instructions given by: AKRISTIAN I understand the instructions given to me: _____

Company called by: _____ Time: _____ Company Rep Name/Title: _____

WHITE: WW
864-666 WORKWELL OHS INJURY ASSESSMENT

YELLOW: EMPLOYER

GREEN: EMPLOYEE
Revised 10/14/99GOLDENROD: MEDICAL RECORDS
C-Injury Assessment Form with Blue Plate

Copy: CBO

HC 10-29-03

Bon Secours St. Francis Health System
WorkWell

Office Notes

274

DATE: 10/22/03
PATIENT: BURNETTE, Kellie
CHART#: 2415346
EMPLOYER: City of Greenville

SUBJECTIVE: Herc for recheck of MVA. Doing great. Does have some occasional back soreness with sitting for prolonged periods of time. Her kncc is doing well. Shc has been running straight ahead without significant discomfort. Still some pain with twisting type activity as expected. Again, overall much improved. The shoulder seems to nag her more than anything. It is into the trap, in the area of the medial scapula. Worse with activity and PT seemed to be helping this significantly. Still has persistent discomfort in the left shoulder.

OBJECTIVE: A white female in no acute distress. Knee and back are not examined today as these are improving and almost resolved. The shoulder has normal range of motion. There is some mild scapular asymmetry noted on movement. Some palpable tenderness still at the tip of the acromion in the deltoid fibers there. Also some within the trapezius. Rotator cuff strength is 5/5. She has mild discomfort superficially on the Jakob test and on the O'Brien test of the lateral shoulder.

ASSESSMENT: Trap strain, shoulder girdle strain, deltoid contusion knee and back. Resolving appropriately.

PLAN: Return her to full duty at this point. I think she would be fine to do that. She understands she may have some soreness particularly after sitting in the vehicle for a while with the vest on but I have encouraged activity as tolerated. For her shoulder I think we ought to give her a couple more weeks of PT. This seemed to be helping this resolve and those can be persistent particularly after the traumatic injury that she had. So I would like to pursue two more weeks of PT, particularly for range of motion, strengthening and modalities as indicated. No medications at this time. I will see her back pm.


Wcs Merriwether, MD
WM/njw/mta

RECEIVED
OCT 30 2003 335

Account #: 109850 M

Name: BURNETTE, KELLIE NICHOLE

Home Phone: ~~XXXXXXXXXX~~

SSN: ~~XXXXXXXXXX~~

Date of Birth: ~~XXXXXX~~ Sex: F

Ref: 02187 WEST MERRYWEATHER MD

Date of Procedure: 9/12/03

MRI LEFT KNEE

INDICATION: MCL pain, pain medially, pain on the inside of knee.

TECHNICAL: Coronal and sagittal multiecho T2-W images, axial FSE proton density fat-suppressed images were obtained.

FINDINGS: I am not given any specific history of trauma.

Quadriceps and patellar tendons are intact. ACL and PCL are intact. MCL and FCL are intact. Lateral meniscus demonstrates no tear. Medial meniscus demonstrates no tear. There may be some Grade I chondromalacia, possibly Grade II chondromalacia of the medial facet of the patella.

There is an area of bone marrow edema seen along the anterior aspect of the medial femoral condyle. Findings are non specific but are most commonly associated with bone contusion. Bone infarct could be another consideration. Infection and neoplasm typically do not have this appearance.

IMPRESSION: AREA OF INCREASED T2 SIGNAL SEEN ALONG THE ANTERIOR ASPECT OF THE MEDIAL FEMORAL CONDYLE MOST COMPATIBLE WITH A SMALL AREA OF BONE CONTUSION THOUGH, AGAIN, THIS IS NON SPECIFIC AS DISCUSSED ABOVE. NO EVIDENCE FOR MENISCAL TEAR OR MCL INJURY.

FRANK R. HAYDEN, JR., M.D./law

Thank you for referring this patient to HealthSouth Diagnostic Center.

ld: 9-12-2003

lt: 9-16-2003

RECEIVED
SEP 22 2003

HC 9-16-03

**Bon Secours St. Francis Health System
WorkWell**

274

Office Notes

PATIENT: BURNETTE, Kelly
DATE: 09/10/03
CHART #: 2415346
EMPLOYER: City of Greenville

SUBJECTIVE: Kelly is here for a recheck of her shoulder, back and knee, improved but still with discomfort. Back is really most uncomfortable. She describes pain basically in the area of the trapezius, worse with repetitive use of the left upper extremity. No mechanical symptoms. No pain deep within the shoulder. Pain is well relieved with Darvocet. Low back pain is across the low back. No significant exacerbating factors save for prolonged sitting. No radicular complaints. Knee is still uncomfortable. She says it feels like it is deep within the knee with some swelling. Also over the medial knee. The brace does help somewhat; it will be a little more comfortable with walking but still without mechanical symptoms. Please see previous notes for other details.

OBJECTIVE: White female in no acute distress. Palpable tenderness in the right trapezius and shoulder girdle musculature. Mild palpable tenderness at the tip of the acromion. Negative rotator cuff strength testing. Negative Jobst's and O'Brien's tests. Negative apprehension relocation test. Weakly positive impingement testing inferiorly. There is mild scapular thoracic dysfunction noted on the left. No significant palpable tenderness at the low back, just tightness across the low back. She has excellent range of motion, all with discomfort at end range, again across the low back. No tenderness to palpation at the SI joints or other bony landmarks. The knee: Ligamentous testing today still reveals a soft end point on MCL testing with some moderate discomfort and point tenderness over the anterior medial meniscus.

ASSESSMENT:

1. Left shoulder girdle strain.
2. Deltoid/acromion contusion left shoulder.
3. Lumbar strain.
4. MCL strain with meniscal derangement.

PLAN: Physical therapy to address the trapezius strain and lumbar strain at this point. MRI is recommended for evaluation of the internal structures of the left knee, particularly evaluating the medial meniscus and MCL. I have also refilled her Darvocet today to be

RECEIVED
SEP 17 2003

4

HC 9-16-03

**Bon Secours St. Francis Health System
WorkWell**

Office Notes

PATIENT: BURNETTE, Kelly
DATE: 09/10/03
PAGE TWO

used just at night and to begin to wean off this. I also gave her a prescription for ibuprofen 600 mg 4 times a day, which she will continue for the next two weeks as she is tolerating this well. The plan will be to see her back after the MRI. Until then, she will remain in the brace with her current work duties save for taking it off and lying down for discomfort for her back and adding in to limit repetitive use of the left arm to no more than 10 times per hour.


Wes McRiwerther, M.D.
WM/amg/mta

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SEP 17 2003

338

303



**BON SECOURS
ST. FRANCIS HEALTH SYSTEM**

WorkWell™ Occupational Health Center
St. Francis Women's & Family Hospital
131 Commonwealth Drive - Suite 200
Greenville, SC 29615
Phone: (864) 675-4600 Fax: (864) 675-4604

Today's Date: 9, 10, 03

Arrival Time: 10:35

Time In: 10:50

Time Out: 1155A

☐ Initial

☒ Re-check

KELLIE BURNETTE

CITY

467-4534

CLAUDIA

467-5737

CAR ACCIDENT

08/26/2003

ECKERDS ON MAIN

2415346

Post-Accident UDS? (Check Company List) ☐ Yes ☐ No	Date of Injury: <u>9/10/03</u>	Time of Injury: <u>10:35</u>
Allergies:		
Current Job:		Home Phone:

Treatment Authorized by: _____ Title: _____ Date: _____

I hereby authorize the release of all medical information pertaining to this work related injury/illness to my employer, insurance company and referral physicians. Records from any medical provider involved in or relative to the diagnosis or treatment of this injury may be released to WorkWell™ Occupational Health Clinic. In addition, authorization is hereby given to this treating facility to perform any and all tests or procedures relative to my injury/illness or physical examination as deemed necessary by the attending physician and/or employer. Should this visit be found unrelated to my work and not part of a worker's compensation claim, I will not hold WorkWell™ Occupational Health Clinic or St. Francis Health System liable for the release of these records. If this injury is determined to not be work-related, I understand that I will be responsible for my bill.

Employee's Signature: on file

Date: _____

Vital Signs:

BP: _____

P: _____

T: _____

Chief Complaint: (where, what, when, how)

Treatment:

Diagnosis:

Medication Given:

Prescription? ☐ Yes ☐ No

X-Rays

Yes ☐ No ☐

Interpretation:

Disposition:

1. ☒ Work Related ☐ Non-Work Related ☐ Undecided
2. May return to work/physical activity without restrictions Date: _____ MMI: _____
3. May return to work/physical activity with the following restrictions: Date: 9/11/03
 - ☐ No prolonged sitting/standing Amount of Time: ACT AS APP
 - ☐ No strenuous climbing, pulling or pushing Weight limit: _____
 - ☐ Lifting limited to _____ lbs with _____ (L) arm _____ (R) arm ☐ no lifting
 - ☐ No/limited lifting at waist level - Specify weight if limited: _____
 - ☐ No/limited repetitive use of: (L) hand/arm/leg (R) hand/arm/leg - Specify # repetitions/Time: 5/10x/1hr
 - ☐ Sedentary work only (0 - 10 lbs.)
 - ☐ No significant physical activity without use of splint, crutches, brace, etc.
 - ☐ No walking on rough terrain
 - ☐ No/limited repetitive stooping, bending, squatting or twisting - Specify frequency per hour: _____
 - ☐ No/limited overhead lifting - Specify weight if limited: _____
 - ☐ No exposure to heights above _____ ft.
 - ☐ Environmental restrictions ☐ Yes ☐ No
 - Exposure requires limitation to _____ heat _____ cold _____ dust _____ chemicals _____ vibrations
 - If yes, please explain: _____
 - ☐ Keep dressing clean & dry
 - ☐ Other _____
4. Employee is unable to work until recheck date - _____ days _____ week
5. Is employee restricted by medication and/or treatment that might affect his/her ability to drive? ☐ Yes ☐ No ability to operate machinery? ☐ Yes ☐ No
6. Estimated date of maximal medical improvement (MMI): _____

Scheduled appointments:

☒ Follow-up appointment at WorkWell™ Occupational Health Center

☒ To Specialist

☒ To Physical Therapy

☐ Other

☒ Test/Procedures ordered: MEI @ KATE

Date: 10/1/03

Date: _____

Date: _____

Date: 9/12/03

Time: 930

Time: _____

Time: _____

Time: 230pm

Facility: Houlihan

Name of Physician/Provider: HC M

Physician/Provider Signature: [Signature]

Instructions given by: [Signature] I understand the instructions given to me: [Signature]

Company called by: _____

Time: _____

339 Company Rep Name/Title: _____

WHITE: WW
SFHS-585 WORKWELL OHS INJURY ASSESSMENT

PINK: EMPLOYEE
Revised 10/1/00

GOLDENROD: MEDICAL RECORDS
C: Injury Assessment Form with Blue Data

Copy: CBO

RECEIVED

SEP 12 2003

116
274

HC 922.03

**Bon Secours St. Francis Health System
WorkWell**

Office Notes

DATE: 09/03/03
PATIENT: BURNETTE, Kelly
CHART #: 2415346
EMPLOYER: City of Greenville

SUBJECTIVE: Ms. Burnette is here for a recheck of multiple injuries after a motor vehicle accident. Basically overall, she is doing much better. Still has a lot of pain in her low back as well as in that left knee and left trapezius. No real new complaints. No mechanical symptoms. There is some questionable instability in the knee. She denies any constipation with the pain medicines or other abdominal complaints. Denies dysuria or any systemic complaints related as possible cause of back pain. Please see previous notes for other details. She is tolerating medicines well.

OBJECTIVE: White female in no acute distress. There is some tenderness to palpation in the left trapezius musculature up into the left lateral paraspinal musculature. Neck range of motion is normal. Tenderness to palpation at the tip of the acromion. No other tenderness to palpation at bony or soft tissue landmarks. Range of motion is normal but with discomfort on abduction at the subacromial space. Negative Jobst's and O'Brien's test. Negative rotator cuff testing. Low back: There is tenderness to palpation along the low back. No point tenderness, just generally in the musculature. She has completely normal range of motion but with discomfort at end range across the low back. No point bony tenderness, no radicular pain on exam today. Good strength in the lower extremities. Reflexes are normal. Left knee: Tenderness on valgus stress and tenderness to palpation at the medial joint line. Otherwise, ligamentous testing is normal, and there is no other tenderness to palpation. Circumduction testing is uncomfortable at the medial knee.

ASSESSMENT:

1. Left shoulder contusion.
2. Trapezius muscle strain.
3. Left MCL sprain.
4. Lumbar strain.

m

RECEIVED

340

305

**Bon Secours St. Francis Health System
WorkWell**

Office Notes

DATE: 09/03/03
PATIENT: BURNETTE, Kelly
PAGE TWO

PLAN: Ibuprofen 600 mg 4 times a day. Flecseril 10 mg, # 20, ½-1 at bedtime. Darvocet-N 100 which has been working well with her pain without side effects. She will use this at bedtime or for severe pain during the day. Restrictions at this time are no prolonged sitting or standing, alternate as needed, and sedentary work only. Please note that she may require lying down for back pain relief for 10 minutes every hour. I will see her back in one week.

Wes Merriwether, M.D.
WM/amg/mta



RECEIVED
SEP 24 2003

341


**BON SECOURS
ST. FRANCIS HEALTH SYSTEM**

WorkWell™ Occupational Health Center
St. Francis Women's & Family Hospital
131 Commonwealth Drive - Suite 200
Greenville, SC 29615
Phone: (864) 675-4600 Fax: (864) 675-4604

Today's Date: 9/3/03Arrival Time: 9:41Time In: 10:05Time Out: 10:59☐ Initial☒ Re-check

0303

Kellie Burnette

KELLIE BURNETTE

CITY

467-4534

CLAUDIA

467-5737

F 08/26/2003

CAR ACCIDENT

2415346

ECKERDS ON MAIN

Post-Accident UDS? (Check Company List) ☐ Yes ☐ NoDate of Injury: 9/3/03Time of Injury: 10:05

Allergies:

Current Job:

Home Phone:

Treatment Authorized by:

Title:

Date:

I hereby authorize the release of all medical information pertaining to this work related injury/illness to my employer, insurance company and referral physicians. Records from any medical provider involved in or relative to the diagnosis or treatment of this injury may be released to WorkWell™ Occupational Health Clinic. In addition, authorization is hereby given to this treating facility to perform any and all tests or procedures relative to my injury/illness or physical examination as deemed necessary by the attending physician and/or employer. Should this visit be found unrelated to my work and not part of a worker's compensation claim, I will not hold WorkWell™ Occupational Health Clinic or St. Francis Health System liable for the release of these records. If this injury is determined to not be work-related, I understand that I will be responsible for my bill.

Employee's Signature: On fileDate: 9-3-03

Vital Signs:

BP: 110/70P: 68T: 98.6Chief Complaint: (where, what, when, how) Lower back painTreatment: Physical therapyDiagnosis: (L) Spinal contusion/strain (L) ACL strain (L) L5/S1 discMedication Given: INDOCIN 600 / FLEXERIL 150 / PCN 1200Prescription? ☒ Yes ☐ No

X-Rays

Yes ☐ No ☐

Interpretation:

Disposition:

- ☒ Work Related ☐ Non-Work Related ☐ Undecided
- May return to work/physical activity without restrictions Date: 7/8/03 MMI: 7/8/03
- May return to work/physical activity with the following restrictions:
 - ☒ No prolonged sitting/standing Amount of Time: 15 min
 - ☐ No strenuous climbing, pulling or pushing Weight limit: 10 lbs
 - ☐ Lifting limited to 10 lbs with (L) arm (R) arm ☐ no lifting
 - ☐ No/limited lifting at waist level - Specify weight if limited: 10 lbs
 - ☐ No/limited repetitive use of (L) hand/arm/leg (R) hand/arm/leg - Specify # repetitions/Time: 10 min
 - ☒ Sedentary work only (0 - 10 lbs.)
 - ☐ No significant physical activity without use of splint, crutches, brace, etc.
 - ☐ No walking on rough terrain
 - ☐ No/limited repetitive stooping, bending, squatting or twisting - Specify frequency per hour: 10 min
 - ☐ No/limited overhead lifting - Specify weight if limited: 10 lbs
 - ☐ No exposure to heights above 10 ft.
 - ☐ Environmental restrictions ☐ Yes ☐ No
 - Exposure requires limitation to heat cold dust chemicals vibrations
 - If yes, please explain: MMT require lying down for face pain 7-10 min / HR
 - ☐ Keep dressing clean & dry
 - ☒ Other: MMT require lying down for face pain 7-10 min / HR
- Employee is unable to work until recheck date - 7 days 1 week
- Is employee restricted by medication and/or treatment that might affect his/her ability to drive? ☐ Yes ☐ No ability to operate machinery? ☐ Yes ☐ No
- Estimated date of maximal medical improvement (MMI): 7/8/03

Scheduled appointments:

☒ Follow-up appointment at WorkWell™ Occupational Health CenterDate: 9-10-03Time: 10:30 AM☐ To Specialist:

Date:

Time:

☐ To Physical Therapy:

Location:

Date:

Time:

☐ Other:☐ Test/Procedures ordered:

Date:

Time:

Facility:

Name of Physician/Provider: MERIN THORPhysician/Provider Signature: [Signature]Instructions given by: ASLHI understand the instructions given to me: [Signature]Company called by: WHITE, WWTime: 3:42Company Rep Name/Title: GOLDENROD, MEDICAL RECORDSWHITE, WW
SPHS-585 WORKWELL OHS INJURY ASSESSMENT

YELLOW: EMPLOYER

PINK: EMPLOYEE
Revised 10/14/99GOLDENROD, MEDICAL RECORDS
City Injury Assessment Form with Blue Plate

Copy: CBD

DECISION AND ORDER
OF THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
WCC FILE NO. 0311607

Kellie N. Burnette, Employee,

Claimant,

vs.

City of Greenville, Employer,

Defendant.

Hearing: Held on December 9, 2005 in Greenville, South Carolina

Appearance: Claimant represented by Douglas A. Churdar of Greenville, South Carolina
Defendant represented by Michael A. Farry of Greenville, South Carolina

Purpose of Hearing: To determine the issues set forth on Forms 50 & 51

Decision and Order: By George N. Funderburk, Commissioner

Filed: *January 11, 2006*

STIPULATIONS

Counsel for the parties stipulated at the hearing to the following:

1. The purpose of the hearing was to determine the issues set forth on WCC Forms 50 and 51 and any other issues which may timely have come before the Commissioner.
2. The South Carolina Workers' Compensation Commission timely and properly served notice of the hearing upon all parties of interest, and the parties and/or their representatives appeared and submitted evidence on the claim.
3. The file of the South Carolina Workers' Compensation Commission was made part of the record, with the exception of any self-serving declarations or unstipulated medical reports.
4. Venue was properly set in Greenville, South Carolina.
5. Claimant seeks benefits under the South Carolina Workers' Compensation Act based upon accidental injury occurring while in the employ of Defendant/Employer and, therefore, the South Carolina Workers' Compensation Commission has jurisdiction of the case.
6. Claimant suffered a work-related injury to her back on August 23, 2003.
7. Claimant had an average weekly wage of \$626.47, thereby giving Claimant a comp rate of \$417.65.
8. Claimant reached MMI on August 19, 2004.
9. Claimant has been treated by Robert G. Schwartz, M.D., who has not been authorized by Employer, and Employer has not paid for Dr. Schwartz's treatment.
10. The APA and medical notes/records were timely presented and without objection were made part of the record.

APA SUBMISSIONS

Under the Administrative Procedures Act, the following records were submitted into evidence:

- APA #1** Treatment notes/records from Greenville Memorial Hospital dated 08/23/03 (pp. 1-11);
- APA #2** Treatment notes/records from Arlington Avenue ENT dated 08/25/03 through 10/01/03 (pp. 12-15);
- APA #3** Treatment notes/records from St. Francis Hospital Workwell Occupational Health dated 08/26/03 through 05/14/04 (pp. 16-48);
- APA #4** Treatment notes/records from HealthSouth Diagnostic dated 09/12/03 through 05/11/04 (pp. 49-50);
- APA #5** Treatment notes/records from Center for Health and Occupational Services (Kevin Kopera, M.D.) dated 06/21/04 through 07/26/05 (pp. 51-58);
- APA #6** Treatment notes/records from Piedmont Physical Medicine (Robert G. Schwartz, M.D.) dated 06/21/05 through 08/23/05 (pp. 59-79);
- APA #7** Questionnaire filled out by Robert Mahon, M.D. of Arlington Avenue ENT dated 01/07/05 (p. 80);
- APA #8** Treatment notes/records from Bon Secours St. Francis Health System Outpatient Physical Therapy dated 09/11/03 through 10/07/03 (pp. 81-95);
- APA #9** Treatment notes/records from Center for Health and Occupational Services (Kevin Kopera, M.D.) dated 10/11/05 (pp. 96).

EXHIBITS

Plaintiff submitted the following exhibits into evidence:

- Exhibit #1** Photographs of Kellie N. Burnette's police vehicle
- Exhibit #2** Significant excerpts from medical records/reports
- Exhibit #3** Kellie N. Burnette's W2s or 1099s for tax year 2003

CLAIMANT BIOGRAPHICAL

AGE 26

GENDER Female

WEIGHT 230 POUNDS

MARITAL STATUS Single

EDUCATION: Claimant completed high school.

STATEMENT OF CASE

Claimant filed a Form 50 on May 30, 2005, and Defendant filed a Form 51 on June 9, 2005. Claimant withdrew her Form 50. Claimant filed an amended Form 50 on September 13, 2005, and Defendant filed a second Form 51 on September 19, 2005. A hearing was set for December 9, 2005.

Claimant contends that she sustained compensable injuries to her left lower extremity, left upper extremity, neck and back, and to her nose and face. Claimant further contends that she has permanent partial disability to her back, permanent partial disability to her left lower extremity, and visible scarring on her face. Claimant further contends that Employer should be required to pay for treatment by Robert G. Schwartz, M.D., past and future.

Defendants admitted that Claimant sustained a compensable accident on August 23, 2002 resulting in permanent partial disability to the back. Defendants deny that Claimant sustained

any permanent injury resulting in any permanent partial disability to her left lower extremity, left upper extremity, neck, nose and face. Defendants acknowledge that to the extent Claimant has any physical scarring to the face, she would be entitled to appropriate compensation for same.

EVIDENCE OF THE CASE

Claimant testified on her own behalf. Claimant testified that she has worked for Defendant as a police officer for several years. On August 23, 2003, Claimant was seated in her police vehicle and was struck by an automobile in the driver's door. The automobile was traveling at a high rate of speed. Claimant testified that she sustained injury to her left lower extremity (left ankle, left knee, and left hip), left upper extremity (left elbow, left wrist, and left shoulder), and to her neck and back. Claimant also sustained a broken nose and lacerations to her face.

Claimant testified that after all of the treatment she has undergone, she still has problems with her left lower extremity, primarily with her left ankle and knee. She has pain in these areas on a daily basis. She no longer has problems with her left upper extremity, including her left elbow or left wrist or left shoulder.

Claimant's primary problem is with her back. Claimant testified that she has chronic back pain on a daily basis in the upper and lower part of her back. As a result of this chronic pain, Claimant takes Darvocet often, Ambien every day, Cataflam three times per day, and Flexeril every night. These medications are prescribed by her treating physician, Kevin Kopera, M.D.

Claimant testified that she has permanent scarring to her left temple, on the left side of the bridge of her nose, and beside her left nostril. The Commissioner was able to observe Claimant's facial scarring.

Claimant testified that her left ankle and knee injury and her back injury affect her ability to perform her duties as a police officer. Her duties require her to sit for extended periods of time, which she cannot do without significant pain; stoop and bend regularly, which she cannot do without significant pain; lift, which she cannot do to the extent she could before the accident or without significant pain; stand and walk, which she cannot do for extended periods of time or without significant pain; run, which she cannot do as well as she could before the accident or without significant pain. As a matter of fact, Claimant testified that her running scores in police department physicals have progressively worsened since her injury as a result of problems with her left ankle and knee and an increase of almost 30 pounds, which she attributes to her injury and resulting lessened activity.

Claimant's treating physician is Kevin Kopera, M.D. Dr. Kopera opines that Claimant has chronic low back pain. According to Dr. Kopera, Claimant reached MMI on August 19, 2004 and has sustained a 5% permanent impairment to the back. Since that time, Dr. Kopera has seen Claimant every several months and has prescribed pain medication for her. When Dr. Kopera saw Claimant in October 2005, he prescribed Cataflam 50mg three times daily and Ambien mg at night and Flexeril 10mg up to one per day as need for muscle spasm. He also prescribed Claimant Tylenol with Codeine #3 to see if it would be more effective for pain relief than Darvocet. He indicated he would see her in November 2005. Claimant testified that she did, in fact, see Dr. Kopera in November 2005 and that he again prescribed Cataflam, Ambien, Flexeril, and Darvocet.

Claimant has also been seen by Robert G. Schwartz, M.D., who has given Claimant trigger point injections and other injections. According to Dr. Schwartz, Claimant has sustained a 13% impairment to the back. Dr. Schwartz opines that Claimant will need future medical

treatment in the form of pain medications and injections to maintain her current level of impairment and to lessen her period of disability.

FINDINGS OF FACT

Based on all of the evidence presented, the undersigned Commissioner hereby makes the following findings of fact:

1. Claimant sustained an admitted and compensable injury to her back on August 23, 2003.
2. As a result of the injury to Claimant's back, Claimant has back pain on a daily basis in both the upper and lower portions. As a result, she must take pain medication. Even with her pain medication, she cannot perform the duties of her position as well as she could before the accident.
3. Claimant reached MMI with regard to her back injury on August 19, 2004. Claimant sustained a 17.5% loss of use of the back as a result of her back injury.
4. Claimant is entitled to future medical treatment under § 42-15-60, as interpreted by the South Carolina Court of Appeals in *Dodge v. Bruccoli, Clark, Layman, Inc.*, 334 SC 574 (Ct. App. 1999), for her back, including but not limited to pain management as prescribed by Dr. Kevin Kopera, which would tend to lessen the Claimant's period of disability in order to maintain her current level of functioning.
5. Claimant sustained a compensable injury to her left lower extremity (left ankle, left knee, and left hip) on August 23, 2003; however, she has no permanent disability resulting from the injury to her left lower extremity.

6. Claimant sustained a compensable injury to her left upper extremity (left wrist, left elbow, and left shoulder) on August 23, 2003; however, she has no permanent disability resulting from the injury to her left upper extremity.

7. Claimant sustained visible scarring to her face on the left side of her temple and on the left side of the bridge of her nose.

CONCLUSIONS OF LAW

It is the conclusion of the undersigned Commissioner that the following sections of South Carolina Code Annotated (Law. Co-op. 1976) apply in this case.

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

2. Under Section 42-1-130, the Claimant was a covered employee.

3. Under Section 42-1-140, the Employer was a covered employer.

4. Under Section 42-3-150, there was an employer/employee relationship between the parties.

5. Under Section 42-17-20, venue in Greenville County, South Carolina, was proper and stipulated to by the parties.

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

7. Under Section 42-1-160, the Claimant sustained a compensable injury by accident arising out of and in the course of his employment on August 23, 2003.

8. Under Section 42-1-40, the Claimant's compensation rate is \$417.65.

9. Under Section 42-15-60, the Defendants are to pay for all causally related past medical expenses allowed under the Act.

10. Under § 42-15-30(19) Claimant has sustained a 17.5% loss of use to the back as the result of her back injury.

11. Claimant has sustained permanent scarring to her face, for which she is entitled to 2 weeks of compensation.

12. Claimant is entitled to future medical treatment under § 42-15-60, as interpreted by the South Carolina Court of Appeals in *Dodge v. Bruccoli, Clark, Layman, Inc.*, 334 SC 574 (Ct. App. 1999), for her back, including but not limited to pain management as prescribed by Dr. Kevin Kopera, which would tend to lessen the Claimant's period of disability in order to maintain her current level of functioning.

13. Claimant is not entitled to monetary benefits for her compensable injuries to her left lower extremity (left ankle, left knee, and left hip) or to her left upper extremity (left wrist, left elbow, and left shoulder).

ORDER

It is therefore ordered, that Defendant shall pay Claimant fifty-four and one-half (54.5) weeks (52.5 weeks for disability to her back and 2 weeks for permanent scarring to her face) of monetary benefits at a weekly compensation rate of \$417.65 in a lump sum upon request of Claimant. It is further ordered that Defendant is to pay for all causally related past medical expenses allowed under the Act. It is further ordered that Defendant shall pay for all future medical treatment under § 42-15-60, as interpreted by the South Carolina court of Appeals in *Dodge v. Bruccoli, Clark, Layman, Inc.*, 334 SC 574 (Ct. App. 1999), to Claimant's back, including but not limited to pain management as prescribed by Dr. Kevin Kopera, which would tend to lessen the Claimant's period of disability in order to maintain her current level of

functioning. Employer is not required to pay for treatment by Robert G. Schwartz, M.D., past and future.

AND IT IS SO ORDERED.

Date:

11/6/06


George N. Funderburk, Commissioner

CERTIFICATE OF SERVICE

This is to certify that the undersigned has this date served this order in the above entitled action upon all parties to this cause by depositing a copy hereof, postage paid, in the United States mail addressed to the attorney or attorneys for said parties.

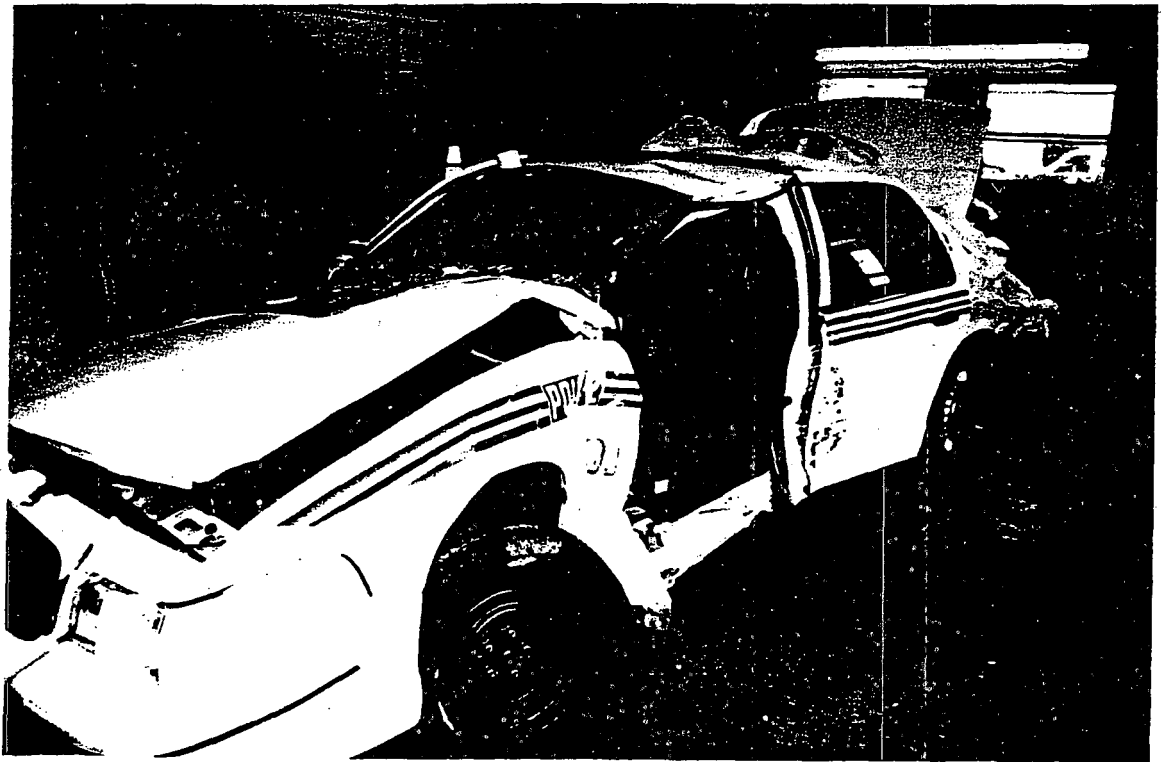
DAC
MAF

This 11 day of Jan, 2006

By



Administrative Assistant to the Commissioner



8/23/03 MVA

37

0,7, 0 00, 0,4, 7,4, 8,3

WOLFF

US 1ST, FAILURE TO STOP FOR POLICE VEHICLE, ASSAULT ON POLICE TIMES 2

17 JUN '07 8:13

ROLL CALL

320

NDI

SUPPLEMENTAL REPORT

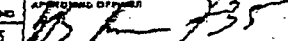
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INC. ENT

ENT

[illegible]

while observing officers Burnett and Casteneda conducting a interview with the susp above observed the susp resisting officers
nt: to place her under arrest. Officer Casteneda was engaged with his taser drive stunning her while she was in the drivers seat and
managed to start the vehicle and pressing the accelerator. when R/O got to the vehicle the susp engaged the vehicle in drive and
rved to the left knocking officer Burnett to the ground. R/O notified HQ that officers were in pursuit of the susp on Pendleton St
ands town. Officer Casteneda was the first unit and followed the susp into Peis's on Pendleton St. bail out of her vehicle and ran
ind the business. R/O responded to the rear around on Perry Av. and observed Officer Casteneda attempt to arrest the susp who still
uld not comply and was engaged with officer Casteneda. R/O responded back around due to the area being fenced in where the susp
handcuffed. Sgt. Browning notified/ Sgt. Hawkins responded to the scene. R/O escorted officer Casteneda to GCDC, where susp
photographed by Sgt. Browning left side above hip. See original reports for further.

TYPE									TOTAL VALUE
STOLEN									
DAMAGED									
MURDER									
RECOVERED									
FINED									
SUBJECT IDENTIFIED		SUBJECT LOCATED		☐ ACTIVE ☐ ADMM. CLOSED ☐ YES ☐ NO ☐ UNFOUNDED		☐ ARRESTED UNDER 18 ☐ YES ☐ NO ☐ BAND OVER		☐ EX-CLEAR UNDER 18 ☐ YES ☐ NO ☐ TELL-CLEAR 18 AND OVER	
SEARCH FOR ADDITIONAL CLEARANCE: ☐ DIVISION SLATL ☐ NO PROSECUTION ☐ VICTIM/RELATIVE COOPERATION ☐ EXTRADITION DENIED ☐ AVOIDS AND ARREST									
REPORTED BY OFFICER/STAFF #	DATE	LASTED	APPROVING OFFICER				DATE	EXT. NO.	
C.A. Rimer	6/7/07	205					6/7/07	205	
			☐ YES ☐ NO		(OFFICER)				

CRIME ANALYSIS

SLED

RECORDS

DETECTIVES

ROLL CALL

W/Z/L/O7 AD

17 JAN 27 1965



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SINCE 1923

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August 2, 2007

RE: Patient: Kellie Burnette
SSN: ~~XXXXXXXXXX~~
Date of Injury: 8/23/03
Claim Number: 001-0302234-001

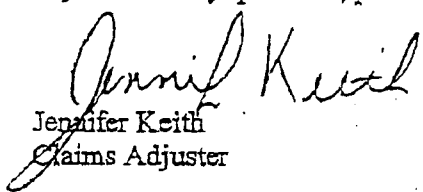
My name is Jennifer Keith with Hewitt, Coleman and Associates and we are the Third Party Administrator's for the City of Greenville's workers compensation program. I am the adjuster handling the work comp claim for the above and mentioned patient.

Kellie Burnette is authorized to see Dr. John Satterthwaite for evaluation and treatment of her lower back for pain management.

Please send medical notes and bills to the following address:

Hewitt, Coleman
PO Box 6528
Greenville, SC 29606

If you have any questions, please do not hesitate to call me at 864-240-5836. Thank you.


Jennifer Keith
Claims Adjuster

Property and Casualty-Claim Division
850 South Pleasantburg Drive, Suite 205 • P.O. Box 6528, Greenville, SC 29606-6528
Phone: (864) 240.5800 • (800) 421.9139 • Fax: (864) 233.2486
www.hewittcoleman.com



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October 12, 2007

Dr. John Satterthwaite
Carolinas Center for Advanced Management of Pain
220 Roper Mountain Ext.
Greenville, SC 29615

RE: Kellie Burnette vs. City of Greenville
DOI: 8/23/03

Dear Dr. Satterthwaite:

We recently received your September 24, 2007 office note in which Ms. Burnette is complaining of neck pain, which was the result of a June injury when Ms. Burnette was jerked by a car trying to leave the scene. You diagnosed the patient with Lumbosacral Spondylosis and Cervicalgia as well as some depression symptoms.

As you know, Ms. Burnette is a police officer for the City of Greenville. Her job is physically and mentally demanding. I have attached a copy of the job requirements for a police officer for your review.

Given the demands of Ms. Burnette's job and her current diagnosis, do feel that Ms. Burnette is able to perform her job with no restrictions or limitations?

Your attention to this matter is appreciated.

Sincerely,

Jennifer Keith
Claims Adjuster
864-240-5836

323



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December 7, 2007

Dr. John Satterthwaite
Carolinas Center for Advanced Management of Pain
220 Roper Mountain Ext.
Greenville, SC 29615

RE: Kellie Burnette vs. City of Greenville
DOI: 8/23/03

Dear Dr. Satterthwaite:

Ms. Burnette was referred to your office for continued treatment of chronic pain for her lower back only. Please see attached authorization letter dated August 2, 2007.

It appears that Ms. Burnette is currently getting treatment neck problems. We have not authorized any treatment for her neck and we will not be covering treatment for her neck. This will have to be filed under her personal insurance. We will only cover treatment for the lower back.

Your attention to this matter is appreciated.

Sincerely,


Jennifer Herkert
Claims Adjuster
864-240-5836

cc: Douglas Churdar, Esquire
Mike Farry, Esquire

Property and Casualty Claim Division
850 South Pleasantburg Drive, Suite 205 • P.O. Box 6528, Greenville, SC 29606-6528
Phone: (864) 240.5800 • (800) 421.9139 • Fax: (864) 233.2486
www.hewittcoleman.com

DOUGLAS A. CHURDAR, P. C.

Attorney At Law

712 EAST WASHINGTON STREET
GREENVILLE, SOUTH CAROLINA 29601
TELEPHONE (864) 233-0203
FACSIMILE (864) 233-3020
E-MAIL: dachurdar@churdarlaw.com

July 27, 2009

VIA FACSIMILE ONLY

Michael A. Farry, Esq.
Horton Law Firm
PO Box 10167
Greenville, SC 29603

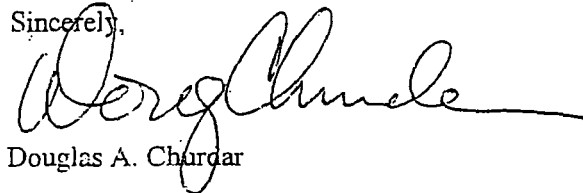
RE: Kellie Burnette v. City of Greenville
WCC File No.: 0311607

Dear Michael:

Please note that this letter relates to Kellie Burnette's *first* workers' compensation claim, which resulted in injury to her back, including her low back. Kellie has literally been in bed for several days because of problems with her low back. Of course, she has been treated by Dr. Satterthwaite for pain, and she recently moved an appointment up to get the pain addressed. However, she is having some problems in her legs now, and she would like to have her lower back examined and, if necessary, treated. You may recall that in correspondence dated January 20, 2009, I mentioned that Kellie is concerned about her low back and wants to have it evaluated. She wants to see David Mitchell, MD, at Orthopaedic Associates, whom the City of Greenville previously sent her to see. Please let me know that can be arranged easily and without dispute as soon as possible.

Thank you very much.

Sincerely,



Douglas A. Churdar

cc: Kellie Burnette

DOUGLAS A. CHURDAR, P. C.

Attorney At Law

712 EAST WASHINGTON STREET
GREENVILLE, SOUTH CAROLINA 29601
TELEPHONE (864) 233-0203
FACSIMILE (864) 233-3020
E-MAIL: dachurdar@churdarlaw.com

May 29, 2009

Michael A. Farry, Esq.
Horton Law Firm
PO Box 10167
Greenville, SC 29603

RE: Kellie Burnette v. City of Greenville
WCC File No.: 0720591

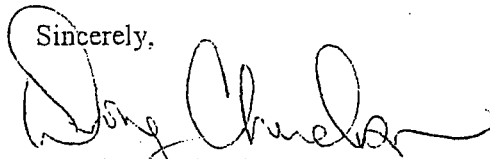
Dear Michael:

Two things. First, to reiterate my letter from January 20, 2009 and Charlene's fax of May 8, 2009, Kellie is concerned about her lower back and wants to have it evaluated. She wants a solution short of lifelong pain management. She previously saw David Mitchell, M.D. at Orthopedic Associates wants to see him again to specifically address what if anything can be done for her lower back short of lifelong pain management. Please let me know something regarding this.

Secondly, I am enclosing travel expenses for Kellie. According to my figures, she is to be reimbursed a total of \$1,223.99 for mileage to/from the attached doctor visits. Please make the check payable to Kellie N. Burnette and return to our office.

Thank you.

Sincerely,


Douglas A. Churdar

Enclosure(s)
cc: Kellie Burnette

6/3/09
Spoke to Lynn /
She said they received
letter & mileage & forwarded it
to adjuster. (chp)

DOUGLAS A. CHURDAR, P. C.

Attorney At Law

712 EAST WASHINGTON STREET
GREENVILLE, SOUTH CAROLINA 29601
TELEPHONE (864) 233-0203
FACSIMILE (864) 233-3020
E-MAIL: dachurdar@churdarlaw.com

January 20, 2009

VIA FACSIMILE ONLY 233-7142

Michael A. Farry, Esq.
Horton Law Firm
PO Box 10167
Greenville, SC 29603

RE: *Kellie Burnette v. City of Greenville*
WCC File No.: 0720591

Dear Michael:

Three things.

First, by way of follow-up to my letter dated January 8, 2009 regarding Kellie Burnette's medication, I am enclosing a treatment note dated January 19, 2009. As you can see, Dr. Satterthwaite's nurse practitioner has made it clear that Kellie is *not* taking her medication inappropriately. Neither Kellie nor I understand the mix-up, because that is clearly what the prior note said. However, that is clearly untrue.

Second, Kellie is concerned about her lower back and wants to have it evaluated. She wants a solution short of lifelong pain management. She previously saw David Mitchell, M.D. at Orthopedic Associates and would be glad to see him again to specifically address what if anything can be done for her lower back short of lifelong pain management.

Third, Kellie has recently had problems getting her medications filled. My paralegal, Charlene, spoke to Glennis about the matter. The problem is that Kellie was not getting her *increased* dosage of Wellbutrin, but apparently she has also not been approved to receive Effexor on the grounds that the prescription was written by a doctor other than Dr. Satterthwaite. Apparently, this doctor is Eugene Mironer, M.D., who is with Dr. Satterthwaite's practice. This really should not be a problem, and I hope this clarification helps. Please notify the employer so

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March 13, 2008

Dr. John Satterthwaite
Carolinas Center for Advanced Management of Pain
220 Roper Mountain Ext.
Greenville, SC 29615

RE: Kellie Burnette vs. City of Greenville
DOI: August 23, 2003 and June 16, 2007
DOB: ~~REDACTED~~

Dr. Satterthwaite:

This letter authorizes you to treat Ms. Burnette for her work related neck injury sustained on June 16, 2007.

We ask that you personally see Ms. Burnette, as this is a very complicated case involving multiple injuries and varied complaints. Ms. Burnette's medical ailments include some personal issues as well. Recent medical reports received show that she is being seen by a nurse practitioner instead of by the doctor. It is in Ms. Burnette's best interest to be seen by you, due to the complexities of her case.

Ms. Burnette has varied complaints of back and neck pain and takes an extensive variety of medications. Some complaints and medications are due to personal illness and some are due to her work related injuries.

Ms. Burnette advised the City Nurse that she sustained a personal fall on January 1, 2008. Is it possible for you to determine if the January 2008 fall exacerbated her complaints of back, neck and other pain in any way?

Please address when you expect Ms. Burnette to reach MMI.

We appreciate your seeing Ms. Burnette and request your attention to these matters.

Sincerely,

Jennifer Herkert
Claims Adjuster
864-240-5836

328

cc: Doug Churdar, Esquire Property and Casualty Claim Division
850 South Pleasantburg Drive, Suite 205 • P.O. Box 6528, Greenville, SC 29606-6528
Mike Farry, Esquire
Phone: (864) 240.5800 • (800) 421.9139 • Fax: (864) 233.2486
www.hewittcoleman.com

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM SOUTH CAROLINA
GREENVILLE COUNTY COURT OF COMMON PLEAS

CASE TRACKING NO: 2011198006

KELLIE N. BURNETTE..... APPELLANT,

v.

CITY OF GREENVILLE.....RESPONDENTS.
AND HEWITT COLEMAN & ASSOCIATES

CERTIFICATE OF COUNSEL

The undersigned hereby certifies that this Record on Appeal contains all material proposed to be included by any of the parties and not any other material.

January 26, 2012



Douglas A. Churdar, Esq.
Douglas A. Churdar, P.C.
712 East Washington Street
Greenville, SC 29601
(864) 233-0203

Attorney for Appellant

THE STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

APPEAL FROM GREENVILLE COUNTY
COURT OF COMMON PLEAS
G. EDWARD WELMAKER, CIRCUIT COURT JUDGE

2010-CP-23-3442
CASE TRACKING NO. 2011198006

KELLIE N. BURNETTE,.....Appellant,

v.

CITY OF GREENVILLE,.....Respondents.
AND HEWITT COLEMAN & ASSOCIATES

**APPENDIX
TO
RECORD ON APPEAL**

David A. Wilson
Michael A. Farry
HORTON, DRAWDY, WARD, MULLINAX
& FARRY, P.A.
307 Pettigru Street
Greenville, South Carolina 29601

ATTORNEYS FOR RESPONDENTS

Douglas A. Churdar, Esquire
Douglas A. Churdar, P.C.
712 East Washington Street
Greenville, SC 29601

ATTORNEYS FOR APPELLANT

INDEX

PAGE

APA SUBMISSIONS

APA (pages 15-17).....	1
APA (pages 46-58).....	4
APA (page 60).....	17
APA (pages 66-69).....	18
APA (page 71).....	22
APA (page 73).....	23
APA (page 141).....	24
APA (pages 156-197).....	25
APA (pages 199-221).....	67
APA (page 263).....	90

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Robert G. Schwartz, M.D.

BURNETTE, KELLIE

#22896

DATE: 7/22/05

Diagnostic Musculoskeletal Ultrasonography

Musculoskeletal ultrasonography is a diagnostic procedure that utilizes reflections of sound waves (echoes) to generate an image of the area studied. B-mode imaging generates a tomographic image in two dimension form from a single scanning plane. M-mode imaging generates an image which displays variation of echo depth over time while the transducer probe is in a fixed position.

Diagnostic musculoskeletal ultrasonography was performed over the cervical/thoracic multifidus and related paraspinal soft tissues as well as right shoulder.

A 7.5 MgHz wand was used.

Diagnostic Ultrasound Impression: There is a hypoechoic signal at C3/4 and the right posterior shoulder capsule. The rest of the area studied showed a normal echogenic pattern.

Clinical Impression: Results reviewed. Options discussed. OA mobilization and scapulothoracic exercises reviewed. She reports 50 percent improvement from the lumbar facet region block.

Epidural Steroid Injection

History: The history and physical exam are reflected within the office notes.

Procedure: The patient was notified of potential complications. With an aseptic technique and the patient in the left lateral decubitus position, the L5/S1 interspace was identified. Using a paramedian, PA approach and a 3-inch needle, the skin was pierced and the needle advanced down to the bone. The needle was then walked superiorly until the upper edge of the posterior ramus was identified. The needle was then advanced and, with loss of resistance technique, the epidural space was identified. 4 mg of Dexamethasone in 3 cc of normal saline was injected. The patient was observed in the left lateral decubitus position for 20 minutes after the injection. No complications were noted.

Impression: Immediate additional benefit obtained.

R10D.

Robert G. Schwartz, MD/lo /Pms

0015

Piedmont Physical Medicine & Rehabilitation, PA Robert G. Schwartz, M.D

317 St. Francis Drive # 350 Greenville SC 29601 Ph 864.235.1834 Fax 864.235.2486 piedmontpmr.com

Test Date: 7/18/2005

Patient: kellie burnette
ID#: 22896

DOB: ~~REDACTED~~

Physician: Robert Schwartz, MD
Ref Phys: Linda Giambalvo, MD

Nerve Conduction Studies Anti Sensory Summary Table

Site	Stimulus	Peak Latency (ms)	Normal Peak Latency (ms)	Amplitude (mV)	Normal Amplitude (mV)	Site	Stimulus	Peak Latency (ms)	Normal Peak Latency (ms)
Right Median Anti Sensory (3rd Digit)						Wrist	3rd Digit	2.8	14.0
Left Sural Anti Sensory (Lat Mall)						Calf	Lat Mall	3.2	14.0
Right Ulnar Anti Sensory (5th Digit)						Wrist	5th Digit	2.7	14.0

Motor Summary Table

Site	Stimulus	Onset Latency (ms)	Normal Onset Latency (ms)	Amplitude (mV)	Normal Amplitude (mV)	Site	Stimulus	Onset Latency (ms)	Normal Onset Latency (ms)	Amplitude (mV)	Normal Amplitude (mV)
Right Median Motor (Abd Poll Brev)						Elbow	Wrist	3.6	21.0	58.3	>50
Left Peroneal Motor (Ext Dig Brev)						B Fib	Ankle	9.2	38.0	41.3	>40
Right Peroneal Motor (Ext Dig Brev)						B Fib	Ankle	7.2	32.0	44.4	>40
Right Ulnar Motor (Abd Dig Minimi)						B Elbow	Wrist	3.0	22.0	73.3	>50

F Wave Studies

Right Median (Mrkrs) (Abd Poll Brev)	25.78	<33
Left Peroneal (Mrkrs) (EDB)	NR	<50
Right Peroneal (Mrkrs) (EDB)	47.11	<50
Right Ulnar (Mrkrs) (Abd Dig Min)	26.67	<33

H Reflex Studies

Left Tibial (Gastroc)	32.00	
Right Tibial (Gastroc)	32.00	0.00

0016

Patient: burnette, kellie

Test Date: 7/18/2005

Page 2

EMG

Side	Muscle	Nerve	Root	Ins	Abn	Per	Lat	RIP	Wmp	Lat	Ref	En	Comment
Right	Abd Poll Brev	Median	C8-T1	Nml	Nml	Nml	Absent	Absent	Nml	0	Nml	Nml	
Right	ABD Dig Min	Ulnar	C8-T1	Nml	Nml	Nml	Absent	Absent	Nml	0	Nml	Nml	
Right	1stDorInt	Ulnar	C8-T1	Nml	Nml	Nml	Absent	Absent	Nml	0	Nml	Nml	
Right	FlexPollLong	Median (Ant Int)	C7-8	Nml	Nml	Nml	Absent	Absent	Nml	0	Nml	Nml	
Right	ExtIndicis	Radial (Post Int)	C7-8	Nml	Nml	Nml	Absent	Absent	Nml	0	Nml	Nml	
Right	ExtCarRad	Radial	C6-7	Nml	Nml	Nml	Absent	Absent	Nml	0	Nml	Nml	
Right	PronatorTeres	Median	C6-7	Nml	Nml	Nml	Absent	Absent	Nml	0	Nml	Nml	
Right	Biceps	Musculocut	C5-6	Nml	Nml	Nml	Absent	Absent	Nml	0	Nml	Nml	
Right	Triceps	Radial	C6-7-8	Nml	Nml	Nml	Absent	Absent	Nml	0	Nml	Nml	
Right	Deltoid	Axillary	C5-6	Nml	Nml	Nml	Absent	Absent	Nml	0	Nml	Nml	
Bilateral	C Paraspinals	PostRami	C1-C7	Nml	Nml	Nml	Absent	Absent	Nml	0	Nml	Nml	
Left	AbdHallucis	MedPlantar	S1-2	Nml	Nml	Nml	Absent	Absent	Nml	0	Nml	Nml	
Left	AbdDigQuinti	LatPlantar	S1-2	Nml	Nml	Nml	Absent	Absent	Nml	0	Nml	Nml	
Left	Ext Dig Brev	Dp Br Peron	L5, S1	Nml	Nml	Nml	Absent	Absent	Nml	0	Nml	Nml	
Left	AntTibialis	Dp Br Peron	L4-5	Nml	Nml	Nml	Absent	Absent	Nml	0	Nml	Nml	
Left	Peroneus Long	Sup Br Peron	L5-S1	Nml	Nml	Nml	Absent	Absent	Nml	0	Nml	Nml	
Left	VastusMed	Femoral	L2-4	Nml	Nml	Nml	Absent	Absent	Nml	0	Nml	Nml	
Left	MedGastroc	Tibial	S1-2	Nml	Nml	Nml	Absent	Absent	Nml	0	Nml	Nml	
Left	LatGastroc	Tibial	S1-2	Nml	Nml	Nml	Absent	Absent	Nml	0	Nml	Nml	
Bilateral	LS Paraspinals	PostRami	L1-S2	Nml	Nml	Nml	Absent	Absent	Nml	0	Nml	Nml	

Impression: There is evidence of a left L5 nerve root irritation.

Robert Schwartz, MD

0017

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July 15, 2009

Page 2

Chart Document

MS KELLIE BURNETTEFemale DOB: ~~XXXXXX~~

18381

Home: ~~XXXXXXXXXX~~

Ins: VOC REHAB

discharge, nosebleeds, sore throat, hoarseness, dysphagia

Cardiovascular: Denies chest pain, palpitations, syncope, dyspnea on exertion, orthopnea, PND, peripheral edema**Respiratory:** Denies cough, dyspnea, excessive sputum, hemoptysis, wheezing**Gastrointestinal:** Denies nausea, vomiting, diarrhea, constipation, change in bowel habits, abdominal pain, melena, hematochezia, jaundice**Genitourinary:** denies vaginal discharge, incontinence, dysuria, hematuria, urinary frequency, amenorrhea, menorrhagia, abnormal vaginal bleeding, pelvic pain**Musculoskeletal:** back pain, neck pain, muscle cramps, left knee**Skin:** denies rash, itching, dryness, suspicious lesions**Neurologic:** weakness**Psychiatric:** depression**Endocrine:** denies cold intolerance, heat intolerance, polydipsia, polyphagia, polyuria, weight change**Hematologic/Lymphatic:** denies abnormal bruising, bleeding, enlarged lymph nodes**Allergic/Immunologic:** denies urticaria, hay fever, persistent infections, HIV exposure**Vital Signs**

Ht: 70 in. Wt: 248 lbs.

Physical Exam**General****General appearance:** well developed, well nourished, no acute distress**Communication ability:** communicates by voice, normal quality**Gait and station:** Normal**Psychiatric****Mental Status:** AAO x3**Judgement/Insight:** Intact**Mood/Affect:** Appropriate**Recent/Remote Memory:** Normal**Neck****Neck:** supple, no masses, trachea midline**Extremities****Periph. circulation:** no cyanosis, clubbing, edema, or varicosities**Cervical****ROM:** decreased w/ lateral rotation**Thoracolumbar****ROM:** Decreased in all directions**Palpation:** Tender**Midline****Muscle Stretch Reflex****Sensory:** Negative allodynia/hyperpathia**Neuro:** No Atrophy or Clonus**Sympathetic Function:** Normal

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July 15, 2009

Page 3

Chart Document

MS KELLIE BURNETTE

Female DOB [REDACTED]

18381

Home: [REDACTED]

Ins: VOC REHAB

Assessment**Status of Existing Problems:**

Assessed LUMBAR RADICULOPATHY as unchanged - MONICA P SPEAK NP

Assessed DISPLACEMENT - LUMBAR DISC W/O MYELOPATHY as unchanged - MONICA P SPEAK NP

Assessed CERVICALGIA as unchanged - MONICA P SPEAK NP

Assessed CERVICAL RADICULOPATHY as unchanged - MONICA P SPEAK NP

Assessed CERVICAL SPONDYLOSIS as unchanged - MONICA P SPEAK NP

Assessed THORACIC SPONDYLOSIS as unchanged - MONICA P SPEAK NP

Assessed MYOFASCIAL PAIN SYNDROME as unchanged - MONICA P SPEAK NP

Assessed SPONDYLOSIS - LUMBOSACRAL as unchanged - MONICA P SPEAK NP

Assessed Z-JOINT SYNDROME as unchanged - MONICA P SPEAK NP

Assessed LOW BACK PAIN SYNDROME as unchanged - MONICA P SPEAK NP

Plan

Refill meds

continue present meds

Med pick-up next month

Patient is stable with medical management of chronic pain. Other treatments such as injections no longer help and is satisfied with the present treatment plan.

Treatment plan helps to decrease patient's level of pain and has improved quality of life allowing for enjoyed activities with family.

New Prescriptions/Refills:

AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) 1 qhs #30 x 0 : MONICA P SPEAK NP (05/27/2009)

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours. #90 x 0 : MONICA P SPEAK NP (05/27/2009)

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 2 po hs #60 x 0 : MONICA P SPEAK NP (05/27/2009)

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm #90 x 0 : MONICA P SPEAK NP (05/27/2009)

NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po bid #60 x 0 : MONICA P SPEAK NP (05/27/2009)

ROXICODONE 15 MG TABS (OXYCODONE HCL) 1po q4-6 h prn pain max 4 per day #120 x 0 : MONICA P SPEAK NP (05/27/2009)

Current Medication List:

ROXICODONE 15 MG TABS (OXYCODONE HCL) 1po q4-6 h prn pain max 4 per day

NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po bid

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 2 po hs

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours.

AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) 1 qhs

ADDERALL 20 MG TABS (AMPHETAMINE-DEXTROAMPHETAMINE) bid - Dr Giambalvo

ZYRTEC 10 MG TABS (CETIRIZINE HCL) 1 po qhs other MD

CELEBREX 200 MG CAPS (CELECOXIB) po

PROZAC 20 MG CAPS (FLUOXETINE HCL) one bid

New Orders:

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July 15, 2009

Page 4

Chart Document

MS KELLIE BURNETTEFemale DOB: ~~XXXXXXXXXX~~

18381

Home: ~~XXXXXXXXXX~~

Ins: VOC REHAB

Focused [99212]

Return for Med Pickup [XXXXXX]

Prescriptions:**AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) 1 qhs #30 x 0**

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Signed by: MONICA P SPEAK NP on 05/27/2009

Method used: Print then Give to Patient

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours. #80 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Signed by: MONICA P SPEAK NP on 05/27/2009

Method used: Print then Give to Patient

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 2 po hs #60 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Signed by: MONICA P SPEAK NP on 05/27/2009

Method used: Print then Give to Patient

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm #90 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Signed by: MONICA P SPEAK NP on 05/27/2009

Method used: Print then Give to Patient

NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po bid #60 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Signed by: MONICA P SPEAK NP on 05/27/2009

Method used: Print then Give to Patient

ROXICODONE 15 MG TABS (OXYCODONE HCL) 1po q4-6 h prn pain max 4 per day #120 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Signed by: MONICA P SPEAK NP on 05/27/2009

Method used: Print then Give to Patient

Signed by MONICA P SPEAK NP on 05/27/2009 at 3:09 PM

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July 15, 2009

Page 1
Chart Document**MS KELLIE BURNETTE**

Female DOB: [REDACTED]

18381

Home: [REDACTED]
Ins: VOC REHAB

04/29/2009 - Office Visit: Follow-Up Pain

Provider: MONICA P SPEAK NP

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

Follow-Up Visit**Chief Complaint:** Chronic varying pain in back and neck.**History of Present Illness:** Patient returns today and states that pain is basically the same with no new paresthesia, no bowel or bladder problems. Taking medications with good effect and no side effects. Needs refills.

Still having problems with sleep as the Remeron did not help. We will D/C this and restart the Ambien as well as have her take 2 Flexeril at hs.

Discussed sleep pattern and getting up at same time every day.

Location Of Pain: as above**Description Of Pain:** Sharp, Aching, Burning, Electric/Shooting**Pain Rating:** 7**Activity:** Stayed The Same**Did Medications Help?** Yes**Is the patient taking any new medications?** No**New Meds:**

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 2 po hs

AMBIEN 10-MG TABS (ZOLPIDEM TARTRATE) 1 qhs

Does the patient have any new medical or surgical problems? No**Is the patient experiencing increased sadness, anxiety, or family problems?** No**Data Reviewed:** Old Charts**Past, Family, and Social History****Past History (Reviewed - No Changes Since Last Visit):** Depression, ADHD, osteoarthritis**Surgery:** SLAP procedure left shoulder, broken nose**ALLERGIES:** NKDA**Family History (Reviewed - No Changes Since Last Visit):** Migraine headaches, back problem, depression**Social History (Reviewed - No Changes Since Last Visit):** Single

High school graduate

Works full time, regular duty as a Greenville City Police officer, work-related injury 8/23/03, Attorney Doug

Churdar STOPPED WORKING April, 2008, medical retirement from police department.

Denies tobacco

Occasional alcohol

Review of Systems**General:** fatigue**Eyes:** denies blurring, diplopia, irritation, discharge, vision loss, eye pain, photophobia**Ear/Nose/Throat:** denies ear pain or discharge, tinnitus, decreased hearing, nasal obstruction or discharge, nosebleeds, sore throat, hoarseness, dysphagia

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July 15, 2009

Page 2
Chart Document**MS KELLIE BURNETTE**

Female DOB: [REDACTED]

18381

Home: [REDACTED]

Ins: VOC REHAB

Cardiovascular: Denies chest pain, palpitations, syncope, dyspnea on exertion, orthopnea, PND, peripheral edema
Respiratory: Denies cough, dyspnea, excessive sputum, hemoptysis, wheezing
Gastrointestinal: Denies nausea, vomiting, diarrhea, constipation, change in bowel habits, abdominal pain, melena, hematochezia, jaundice
Genitourinary: denies vaginal discharge, incontinence, dysuria, hematuria, urinary frequency, amenorrhea, menorrhagia, abnormal vaginal bleeding, pelvic pain
Musculoskeletal: back pain, neck pain, muscle cramps, left knee
Skin: denies rash, itching, dryness, suspicious lesions
Neurologic: weakness
Psychiatric: depression
Endocrine: denies cold intolerance, heat intolerance, polydipsia, polyphagia, polyuria, weight change
Hematologic/Lymphatic: denies abnormal bruising, bleeding, enlarged lymph nodes
Allergic/Immunologic: denies urticaria, hay fever, persistent infections, HIV exposure

Vital Signs

Ht: 70 in. Wt: 250 lbs.

Physical Exam**General****General appearance:** well developed, well nourished, no acute distress**Communication ability:** communicates by voice, normal quality**Gait and station:** Normal**Psychiatric****Mental Status:** AAO x3**Judgement/Insight:** Intact**Mood/Affect:** Appropriate**Recent/Remote Memory:** Normal**Neck****Neck:** supple, no masses, trachea midline**Extremities****Periph. circulation:** no cyanosis, clubbing, edema, or varicosities**Thoracolumbar****ROM:** decreased flexion**Muscle Stretch Reflex****Sensory Negative allodynia/hyperpathia****Neuro No Atrophy or Clonus****Sympathetic Function:** Normal**Assessment****Status of Existing Problems:**

Assessed DISPLACEMENT - LUMBAR DISC W/O MYELOPATHY as unchanged - MONICA P SPEAK NP.

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July 15, 2009

Page 3
Chart Document**MS KELLIE BURNETTE**Female DOB: ~~XXXXXX~~

18381

Home: ~~XXXXXX~~

Ins: VOC-REHAB

Assessed CERVICALGIA as unchanged - MONICA P SPEAK NP
Assessed CERVICAL RADICULOPATHY as unchanged - MONICA P SPEAK NP
Assessed CERVICAL SPONDYLOSIS as unchanged - MONICA P SPEAK NP
Assessed THORACIC SPONDYLOSIS as unchanged - MONICA P SPEAK NP
Assessed MYOFASCIAL PAIN SYNDROME as unchanged - MONICA P SPEAK NP
Assessed SPONDYLOSIS - LUMBOSACRAL as unchanged - MONICA P SPEAK NP
Assessed Z-JOINT SYNDROME as unchanged - MONICA P SPEAK NP
Assessed LOW BACK PAIN SYNDROME as unchanged - MONICA P SPEAK NP
Assessed LUMBAR RADICULOPATHY as unchanged - MONICA P SPEAK NP

Plan

Refill meds
Stop Remeron
Restart Ambien
Increase Flexeril to 2 hs.
Follow up in 1 month

New Prescriptions/Refills:

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours. #90 x 0 : MONICA P SPEAK NP (04/29/2009)
BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm #90 x 0 : MONICA P SPEAK NP (04/29/2009)
NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po bid #60 x 0 : MONICA P SPEAK NP (04/29/2009)
ROXICODONE 15 MG TABS (OXYCODONE HCL) 1po q4-6 h prn pain max 4 per day #120 x 0 : MONICA P SPEAK NP (04/29/2009)
AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) 1 qhs #30 x 0 : MONICA P SPEAK NP (04/29/2009)
FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 2 po hs #60 x 0 : MONICA P SPEAK NP (04/29/2009)

Current Medication List:

MORPHINE SULFATE 15 MG TABS (MORPHINE SULFATE) 1 po qid prn pain 2 week supply
ROXICODONE 15 MG TABS (OXYCODONE HCL) 1po q4-6 h prn pain max 4 per day
NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po bid
BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm
FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 2 po hs
LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours.
AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) 1 qhs
ADDERALL 20 MG TABS (AMPHETAMINE-DEXTROAMPHETAMINE) bid - Dr Giambalvo
ZYRTEC 10 MG TABS (CETIRIZINE HCL) 1 po qhs other MD
CELEBREX 200 MG CAPS (CELECOXIB) po
PROZAC 20 MG CAPS (FLUOXETINE HCL) one bid

New Orders:

Expanded [99213]
Return for follow-up 1 month [xxxxx]

Prescriptions:

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July 15, 2009
Page 4
Chart Document

MS KELLIE BURNETTE

Female DOB: ~~XXXXXXXXXX~~

18381

Home: ~~XXXXXXXXXX~~

Ins: VOC REHAB

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours. #90 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Signed by: MONICA P SPEAK NP on 04/29/2009

Method used: Print then Give to Patient

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm #90 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Signed by: MONICA P SPEAK NP on 04/29/2009

Method used: Print then Give to Patient

NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po bid #60 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Signed by: MONICA P SPEAK NP on 04/29/2009

Method used: Print then Give to Patient

ROXICODONE 15 MG TABS (OXYCODONE HCL) 1po q4-6 h prn pain max 4 per day #120 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Signed by: MONICA P SPEAK NP on 04/29/2009

Method used: Print then Give to Patient

AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) 1 qhs #30 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Signed by: MONICA P SPEAK NP on 04/29/2009

Method used: Print then Give to Patient

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 2 po hs #60 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Signed by: MONICA P SPEAK NP on 04/29/2009

Method used: Print then Give to Patient

Signed by MONICA P SPEAK NP on 04/29/2009 at 3:03 PM

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July 15, 2009

Page 1
Chart Document**MS KELLIE BURNETTE**Female DOB: ~~01/01/1968~~

18381

Home: ~~864-583-1234~~

Ins: VOC-REHAB

04/15/2009 - Office Visit: Follow-Up Pain**Provider: MONICA P SPEAK NP****Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office****Follow-Up Visit****Chief Complaint:** Chronic varying pain in back, and leg.**History of Present Illness:** Patient returns today stating that the Opana is good for her pain but having to take it on an empty stomach is difficult. Also she is having constipation with the Opana. She does not feel "medicated with the Opana. Roxicodone is still not available to her. I have explained to her that our only other choice is Morphine and she does not like that idea.

She is also having trouble sleeping. She is taking amitriptyline 1-2 hs and still not sleeping.

However her pain level is now 7/10 this month from 8/10 last month.

She is on Celebrex from her pcp for her knee and she believes this is also helping her back.

We will try 2 weeks of MSIR and see how she does with it.

Suggested stool softeners 2 qam and pm with the MSIR.

Temazepam 15 mgs x 15 turned in and destroyed.

Location Of Pain: as above**Description Of Pain:** Sharp, Aching, Burning, Electric/Shooting**Pain Rating:** 7**Activity:** Stayed The Same**Did Medications Help?** Yes**Is the patient taking any new medications?** No**New Meds:**

MORPHINE SULFATE 15 MG TABS (MORPHINE SULFATE) 1 po qid prn pain 2 week supply

CELEBREX 200 MG CAPS (CELECOXIB) pcp

REMERON 15 MG TABS (MIRTAZAPINE) 1/2 tab hs

Does the patient have any new medical or surgical problems? No**Is the patient experiencing increased sadness, anxiety, or family problems?** No**Data Reviewed:** Old Charts**Past, Family, and Social History****Past History (Reviewed - No Changes Since Last Visit):** Depression, ADHD, osteoarthritis**Surgery:** SLAP procedure left shoulder, broken nose**ALLERGIES:** NKDA**Family History (Reviewed - No Changes Since Last Visit):** Migraine headaches, back problem, depression**Social History (Reviewed - No Changes Since Last Visit):** Single

High school graduate

Works full time, regular duty as a Greenville City Police officer, work-related injury 8/23/03, Attorney Doug Churdar STOPPED WORKING April, 2008, medical retirement from police department.

Denies tobacco

Occasional alcohol

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July 15, 2009

Page 2
Chart Document**MS KELLIE BURNETTE**Female DOB: ~~01/01/1968~~

18381

Home: ~~864-583-0053~~

Ins: VOC REHAB

Review of Systems**General:** fatigue**Eyes:** denies blurring, diplopia, irritation, discharge, vision loss, eye pain, photophobia**Ear/Nose/Throat:** denies ear pain or discharge, tinnitus, decreased hearing, nasal obstruction or discharge, nosebleeds, sore throat, hoarseness, dysphagia**Cardiovascular:** Denies chest pain, palpitations, syncope, dyspnea on exertion, orthopnea, PND, peripheral edema**Respiratory:** Denies cough, dyspnea, excessive sputum, hemoptysis, wheezing**Gastrointestinal:** Denies nausea, vomiting, diarrhea, constipation, change in bowel habits, abdominal pain, melena, hematochezia, jaundice**Genitourinary:** denies vaginal discharge, incontinence, dysuria, hematuria, urinary frequency, amenorrhea, menorrhagia, abnormal vaginal bleeding, pelvic pain**Musculoskeletal:** back pain, neck pain, muscle cramps, left knee**Skin:** denies rash, itching, dryness, suspicious lesions**Neurologic:** weakness**Psychiatric:** depression**Endocrine:** denies cold intolerance, heat intolerance, polydipsia, polyphagia, polyuria, weight change**Hematologic/Lymphatic:** denies abnormal bruising, bleeding, enlarged lymph nodes**Allergic/Immunologic:** denies urticaria, hay fever, persistent infections, HIV exposure**Vital Signs**

Ht: 70 in. Wt: 252 lbs.

Physical Exam**General****General appearance:** well developed, well nourished, no acute distress**Communication ability:** communicates by voice, normal quality**Gait and station:** Normal**Psychiatric****Mental Status:** AAO x3**Judgement/Insight:** Intact**Mood/Affect:** Appropriate**Recent/Remote Memory:** Normal**Neck****Neck:** supple, no masses, trachea midline**Cervical****ROM:** decreased w/ lateral rotation**Thoracolumbar****ROM:** decreased flexion**Muscle Stretch Reflex****Sensory:** Negative allodynia/hyperpathia**Neuro:** No Atrophy or Clonus**Sympathetic Function:** Normal

Carolinas Center for Advanced Management of Pain
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July 15, 2009
Page 3
Chart Document

MS KELLIE BURNETTE

Female DOB: [REDACTED]

18381

Home: [REDACTED]
Ins: VOC REHAB

Assessment

Status of Existing Problems:

Assessed DISPLACEMENT - LUMBAR DISC W/O MYELOPATHY as unchanged - MONICA P SPEAK NP

Assessed CERVICALGIA as unchanged - MONICA P SPEAK NP

Assessed CERVICAL RADICULOPATHY as unchanged - MONICA P SPEAK NP

Assessed CERVICAL SPONDYLOSIS as unchanged - MONICA P SPEAK NP

Assessed THORACIC SPONDYLOSIS as unchanged - MONICA P SPEAK NP

Assessed MYOFASCIAL PAIN SYNDROME as unchanged - MONICA P SPEAK NP

Plan

Change Opana 10 gs to MSIR 15 mgs 1 qid prn pain 2 week supply
continue other meds

Destroy Temazepam x 15 caps

Opana 10 mgs x 44 pills destroyed

Change Opana 10 mgs to MSIR 15 mgs 1 qid prn pain for 2 weeks

Discussed her sleeping problem with Dr Satterthwaite and Dr. Tollison and we will D/C amitriptyline and change to remeron 15 mgs 1/2 tab hs

Destroy sleeping meds.

New Prescriptions/Refills:

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours. #90 x 0 : MONICA P SPEAK NP (04/15/2009)

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 HS. #30 x 0 : MONICA P SPEAK NP (04/15/2009)

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm #90 x 0 : MONICA P SPEAK NP (04/15/2009)

NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po bid #60 x 0 : MONICA P SPEAK NP (04/15/2009)

REMERON 15 MG TABS (MIRTAZAPINE) 1/2 tab hs #15 x 0 : MONICA P SPEAK NP (04/15/2009)

MORPHINE SULFATE 15 MG TABS (MORPHINE SULFATE) 1 po qid prn pain 2 week supply #60 x 0 : MONICA P SPEAK NP (04/15/2009)

Current Medication List:

MORPHINE SULFATE 15 MG TABS (MORPHINE SULFATE) 1 po qid prn pain 2 week supply

ROXICODONE 15 MG TABS (OXYCODONE HCL) 1po q4-6 h prn pain max 4 per day

NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po bid

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 HS

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours.

ADDERALL 20 MG TABS (AMPHETAMINE-DEXTROAMPHETAMINE) bid - Dr Giambalvo

ZYRTEC 10 MG TABS (CETIRIZINE HCL) 1 po qhs other MD

RESTORIL 15 MG CAPS (TEMAZEPAM) 1 po hs insomnia (discontinued 4-9-09)

CELEBREX 200 MG CAPS (CELECOXIB) pcp

PROZAC 20 MG CAPS (FLUOXETINE HCL) one bid

REMERON 15 MG TABS (MIRTAZAPINE) 1/2 tab hs

New Orders:

Expanded [99213]

Return for follow-up 2 weeks [xxxxx]

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July 15, 2009

Page 4

Chart Document

MS KELLIE BURNETTEFemale DOB: ~~XXXXXXXXXX~~

18381

Home: ~~(803) XXX-XXXX~~

Ins: VOC REHAB

~~XXXXXXXXXX~~**Prescriptions:****LIDODERM 5 % PTCH (LIDOCAINE)** may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours. #90 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Signed by: MONICA P SPEAK NP on 04/15/2009

Method used: Print then Give to Patient

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 HS #30 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Signed by: MONICA P SPEAK NP on 04/15/2009

Method used: Print then Give to Patient

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm #90 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Signed by: MONICA P SPEAK NP on 04/15/2009

Method used: Print then Give to Patient

NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po bld #60 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Signed by: MONICA P SPEAK NP on 04/15/2009

Method used: Print then Give to Patient

REMERON 15 MG TABS (MIRTAZAPINE) 1/2 tab hs #15 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Signed by: MONICA P SPEAK NP on 04/15/2009

Method used: Print then Give to Patient

MORPHINE SULFATE 15 MG TABS (MORPHINE SULFATE) 1 po qld prn pain 2 week supply #60 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Signed by: MONICA P SPEAK NP on 04/15/2009

Method used: Print then Give to Patient

Signed by MONICA P SPEAK NP on 04/15/2009 at 5:31 PM

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July 15, 2009
Page 1
Chart Document

MS KELLIE BURNETTE

Female DOB [REDACTED]

18381

Home: [REDACTED]
Ins: VOC-REHAB

03/23/2009 - Office Visit: Follow-Up Pain

Provider: MONICA P SPEAK NP

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

Follow-Up Visit

Chief Complaint: Chronic varying pain in neck and back

History of Present Illness: Patient returns today and states that pain is basically the same with no new paresthesia, no bowel or bladder problems. Taking medications with good effect and no side effects. Needs refills. Having left knee pain which started again as a constant ache and stiffness rather than an occasional ache. Medicine containers brought in, amts appropriate for date filled. She is not sleeping well and she is taking Ambien. We will try Restoril 15 mgs approval for change per Dr. Satterthwaite.

Location Of Pain: as above

Description Of Pain: Sharp, Aching, Burning, Electric/Shooting

Pain Rating: 8

Activity: Increased

Did Medications Help? Yes

Is the patient taking any new medications? No

New Meds:

OPANA 10 MG TABS (OXYMORPHONE HCL) 1 po q4-6h prn pain max 4/day (30 DAY SUPPLY NO EARLY REFILLS.) *MAY FILL ON* 3/19/09

RESTORIL 15 MG CAPS (TEMAZEPAM) 1 po hs insomnia

Does the patient have any new medical or surgical problems? No

Is the patient experiencing increased sadness, anxiety, or family problems? No

Data Reviewed: Old Charts

Past, Family, and Social History

Past History (Reviewed - No Changes Since Last Visit): Depression, ADHD, osteoarthritis

Surgery: SLAP procedure left shoulder, broken nose

ALLERGIES: NKDA

Family History (Reviewed - No Changes Since Last Visit): Migraine headaches, back problem, depression

Social History (Reviewed - No Changes Since Last Visit): Single

High school graduate

Works full time, regular duty as a Greenville City Police officer, work-related injury 8/23/03, Attorney Doug Churdar STOPPED WORKING April, 2008, medical retirement from police department.

Denies tobacco

Occasional alcohol

Review of Systems

General: fatigue

Eyes: denies blurring, diplopia, irritation, discharge, vision loss, eye pain, photophobia

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July 15, 2009

Page 2

Chart Document

MS KELLIE BURNETTEFemale DOB:

18381

Home:

Ins: VOC REHAB

Ear/Nose/Throat: denies ear pain or discharge, tinnitus, decreased hearing, nasal obstruction or discharge, nosebleeds, sore throat, hoarseness, dysphagia**Cardiovascular:** Denies chest pain, palpitations, syncope, dyspnea on exertion, orthopnea, PND, peripheral edema**Respiratory:** Denies cough, dyspnea, excessive sputum, hemoptysis, wheezing**Gastrointestinal:** Denies nausea, vomiting, diarrhea, constipation, change in bowel habits, abdominal pain, melena, hematochezia, jaundice**Genitourinary:** denies vaginal discharge, incontinence, dysuria, hematuria, urinary frequency, amenorrhea, menorrhagia, abnormal vaginal bleeding, pelvic pain**Musculoskeletal:** back pain, neck pain, muscle cramps, left knee**Skin:** denies rash, itching, dryness, suspicious lesions**Neurologic:** weakness**Psychiatric:** depression**Endocrine:** denies cold intolerance, heat intolerance, polydipsia, polyphagia, polyuria, weight change**Hematologic/Lymphatic:** denies abnormal bruising, bleeding, enlarged lymph nodes**Allergic/Immunologic:** denies urticaria, hay fever, persistent infections, HIV exposure**Vital Signs**

Ht: 70 in. Wt: 249 lbs.

Physical Exam**General****General appearance:** obese**Communication ability:** communicates by voice, normal quality**Gait and station:** Normal**Psychiatric****Mental Status:** AAO x3**Judgement/Insight:** Intact**Mood/Affect:** Appropriate**Recent/Remote Memory:** Normal**Neck****Neck:** supple, no masses, trachea midline**Cervical****ROM:** decreased w/ lateral rotation**Thoracolumbar****ROM:** decreased flexion**Assessment****Status of Existing Problems:**

Assessed DISPLACEMENT - LUMBAR DISC W/O MYELOPATHY as unchanged - MONICA P SPEAK NP

Assessed CERVICALGIA as unchanged - MONICA P SPEAK NP

Assessed CERVICAL RADICULOPATHY as unchanged - MONICA P SPEAK NP

Assessed CERVICAL SPONDYLOSIS as unchanged - MONICA P SPEAK NP

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July 15, 2009

Page 4

Chart Document

MS KELLIE BURNETTEFemale DOB: ~~XXXXXXXXXX~~

18381

Home: ~~XXXXXXXXXX~~

Ins: VOC REHAB

Prescriptions:

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours. #90 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Signed by: MONICA P SPEAK NP on 03/23/2009

Method used: Print then Give to Patient

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 HS #30 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Signed by: MONICA P SPEAK NP on 03/23/2009

Method used: Print then Give to Patient

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm #90 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Signed by: MONICA P SPEAK NP on 03/23/2009

Method used: Print then Give to Patient

NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po bid #60 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Signed by: MONICA P SPEAK NP on 03/23/2009

Method used: Print then Give to Patient

OPANA 10 MG TABS (OXYMORPHONE HCL) 1 po q4-6h prn pain max 4/day (30 DAY SUPPLY NO
EARLY REFILLS.) *MAY FILL ON* 3/19/09 #120 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Signed by: MONICA P SPEAK NP on 03/23/2009

Method used: Print then Give to Patient

RESTORIL 15 MG CAPS (TEMAZEPAM) 1 po hs insomnia #30 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Signed by: MONICA P SPEAK NP on 03/23/2009

Method used: Print then Give to Patient

Signed by MONICA P SPEAK NP on 03/23/2009 at 11:56 AM

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July 15, 2009

Page 4

Chart Document

MS KELLIE BURNETTE

Female DOB [REDACTED]

18381

Home: [REDACTED]

Ins: VOC REHAB

(01/19/2009)

NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po bid #60 x 0 : MONICA P SPEAK NP (01/19/2009)

ROXICODONE 15 MG TABS (OXYCODONE HCL) 1po q4-6 h prn pain max 4 per day #120 x 0 :

MONICA P SPEAK NP (01/19/2009)

Current Medication List:

ROXICODONE 15 MG TABS (OXYCODONE HCL) 1po q4-6 h prn pain max 4 per day

NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po bid

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm

AMBIEN CR 12.5 MG TBCR (ZOLPIDEM TARTRATE) 1 po qhs

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 HS

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours.

EFFEXOR XR 150 MG CP24 (VENLAFAXINE HCL) 1 QD

WELLBUTRIN XL 150 MG TB24 (BUPROPION HCL) 1 QD

ADDERALL 20 MG TABS (AMPHETAMINE-DEXTROAMPHETAMINE) bid - Dr Giambalvo

ZYRTEC 10 MG TABS (CETIRIZINE HCL) 1 po qhs other MD

New Orders:

Focused [99212]

Return for Med Pickup [XXXXX]

Prescriptions:

WELLBUTRIN XL 150 MG TB24 (BUPROPION HCL) 1 QD #30 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Signed by: MONICA P SPEAK NP on 01/19/2009

Method used: Print then Give to Patient

EFFEXOR XR 150 MG CP24 (VENLAFAXINE HCL) 1 QD #30 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Signed by: MONICA P SPEAK NP on 01/19/2009

Method used: Print then Give to Patient

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours. #90 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Signed by: MONICA P SPEAK NP on 01/19/2009

Method used: Print then Give to Patient

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 HS #30 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Signed by: MONICA P SPEAK NP on 01/19/2009

Method used: Print then Give to Patient

AMBIEN CR 12.5 MG TBCR (ZOLPIDEM TARTRATE) 1 po qhs #30 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Signed by: MONICA P SPEAK NP on 01/19/2009

Method used: Print then Give to Patient

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm #90 x 0

Entered by: MONICA P SPEAK NP

Carolinas Center for Advanced Management of Pain
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July 15, 2009
Page 5
Chart Document

MS KELLIE BURNETTE

Female DOB: [REDACTED]

18381

Home: [REDACTED]
Ins: VOC REHAB

Authorized by: John Satterthwaite MD
Signed by: MONICA P SPEAK NP on 01/19/2009
Method used: Print then Give to Patient
NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po bid #60 x 0
Entered by: MONICA P SPEAK NP
Authorized by: John Satterthwaite MD
Signed by: MONICA P SPEAK NP on 01/19/2009
Method used: Print then Give to Patient
ROXICODONE 15 MG TABS (OXYCODONE HCL) 1po q4-6 h prn pain max 4 per day #120 x 0
Entered by: MONICA P SPEAK NP
Authorized by: John Satterthwaite MD
Signed by: MONICA P SPEAK NP on 01/19/2009
Method used: Print then Give to Patient

Signed by MONICA P SPEAK NP on 01/19/2009 at 3:05 PM

Carolinas Center for Advanced Management of Pain

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June 12, 2009

Page 1
Chart Document

MS KELLIE BURNETTE

Female DOB: 02/28/1958

18381

Home: 864-583-1234

Ins: VOC REHAB

12/23/2008 - Office Visit: Medication Management Visit

Provider: John Satterthwaite MD

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

Medication Management Visit

Chief Complaint: Patient called at 4pm today stating that her pain meds were refilled at her last visit (pickup), but not her other medicines. She will be out before Monday. One month refills were authorized to CVS 862-4414 for the meds below.

KELLIE BURNETTE returns today requesting refill of medication. The patient is taking the prescribed medication appropriately with benefit. The patient denies any side effects from the medication. Therefore the chart was reviewed and the medication renewed. The patient will follow-up accordingly.

Prescriptions:

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours. #90 x 0

Entered and Authorized by: John Satterthwaite MD

Signed by: John Satterthwaite MD on 12/23/2008

Method used: Telephoned to ...

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 HS #30 x 0

Entered and Authorized by: John Satterthwaite MD

Signed by: John Satterthwaite MD on 12/23/2008

Method used: Telephoned to ...

AMBIEN CR 12.5 MG TBCR (ZOLPIDEM TARTRATE) 1 po qhs #30 x 0

Entered and Authorized by: John Satterthwaite MD

Signed by: John Satterthwaite MD on 12/23/2008

Method used: Telephoned to ...

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm #90 x 0

Entered and Authorized by: John Satterthwaite MD

Signed by: John Satterthwaite MD on 12/23/2008

Method used: Telephoned to ...

Signed by John Satterthwaite MD on 12/23/2008 at 8:02 PM

MS KELLIE BURNETTE

Female DOB

18381

Home

Ins VOC REHAB

12/17/2008 - Office Visit: Medication Managemet Visit

Provider: MONICA P SPEAK NP

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

Medication Management Visit

Chief Complaint: Chronic varying pain in back and neck.

Discussed patient missing her appointment with Dr. Satterthwaite and per his direction I explained to the patient that this was an exception that we were able to slip her into our already over booked schedule. If she can not keep her scheduled appointments we will not be able to rprescribe her medications.

KELLIE BURNETTE returns today requesting refill of medication. The patient is taking the prescribed medication inappropriately with The patient denies any side effects from the medication. Therefore the chart was reviewed and the medication denied. The patient will follow-up accordingly.

Prescriptions:

NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po bid #60 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Signed by: MONICA P SPEAK NP on 12/17/2008

Method used: Print then Give to Patient

ROXICODONE 15 MG TABS (OXYCODONE HCL) 1po q4-6 h prn pain max 4 per day #120 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John Satterthwaite MD

Signed by: MONICA P SPEAK NP on 12/17/2008

Method used: Print then Give to Patient

Signed by MONICA P SPEAK NP on 12/17/2008 at 11:53 AM

Carolinas Center for Advanced Management of Pain

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8645830053 Fax: 8645830390

June 12, 2009

Page 2

Chart Document

MS KELLIE BURNETTE

Female DOB: 01/01/1962

18381

Home: 803/777-1111

Ins: VOC REHAB

Eyes: denies blurring, diplopia, irritation, discharge, vision loss, eye pain, photophobia

Ear/Nose/Throat: denies ear pain or discharge, tinnitus, decreased hearing, nasal obstruction or discharge, nosebleeds, sore throat, hoarseness, dysphagia

Cardiovascular: Denies chest pain, palpitations, syncope, dyspnea on exertion, orthopnea, PND, peripheral edema

Respiratory: Denies cough, dyspnea, excessive sputum, hemoptysis, wheezing

Gastrointestinal: Denies nausea, vomiting, diarrhea, constipation, change in bowel habits, abdominal pain, melena, hematochezia, jaundice

Genitourinary: denies vaginal discharge, incontinence, dysuria, hematuria, urinary frequency, amenorrhea, menorrhagia, abnormal vaginal bleeding, pelvic pain

Musculoskeletal: back pain, neck pain, muscle cramps

Skin: denies rash, itching, dryness, suspicious lesions

Neurologic: weakness

Psychiatric: depression

Endocrine: denies cold intolerance, heat intolerance, polydipsia, polyphagia, polyuria, weight change

Hematologic/Lymphatic: denies abnormal bruising, bleeding, enlarged lymph nodes

Allergic/Immunologic: denies urticaria, hay fever, persistent infections, HIV exposure

Vital Signs

Ht: 70 in.

Physical Exam

General

General appearance: obese

Communication ability: communicates by voice, normal quality

Gait and station: Normal

Psychiatric

Mental Status: AAO x3

Judgement/Insight: Intact

Mood/Affect: Appropriate

Recent/Remote Memory: Normal

Neck

Neck: supple, no masses, trachea midline

Cervical

ROM: decreased w/ lateral rotation

Palpation: Tender

Comments: no change

Thoracolumbar

ROM: Decreased in all directions

Palpation: Tender

Comments: no change

Muscle Stretch Reflex

Sensory: Negative allodynia/hyperpathia

Neuro: No Atrophy or Clonus

Carolinas Center for Advanced Management of Pain

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June 12, 2009

Page 4

Chart Document

MS KELLIE BURNETTE

Female DOB

1888

Home

Ins: VOC REHAB

Authorized by: John C Haasis MD

Signed by: MONICA P SPEAK NP on 11/18/2008

Method used: Print then Give to Patient

EFFEXOR XR 150 MG CP24 (VENLAFAXINE HCL) 1 po daily #30 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John C Haasis MD

Signed by: MONICA P SPEAK NP on 11/18/2008

Method used: Print then Give to Patient

ROXICODONE 15 MG TABS (OXYCODONE HCL) 1po q4-6 h prn pain max 4 per day #120 x 0

Entered by: MONICA P SPEAK NP

Authorized by: John C Haasis MD

Signed by: MONICA P SPEAK NP on 11/18/2008

Method used: Print then Give to Patient

Signed by MONICA P SPEAK NP on 11/18/2008 at 4:19 PM

0073

Carolinas Center for Advanced Management of Pain

1330 Boiling Springs Rd Suite 2700 Spartanburg, SC 29303

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June 12, 2009

Page 2

Chart Document

MS KELLIE BURNETTE

Female DOB: 04/14/1979

18381

Home: 864-583-1111

Ins: VOC REHAB

Past History: pmh: depression, adhd, oa

all: nkda

med: darvocet, flexeril 10 bid ambien 10 qhs, celebrex, lexapro, adderall

psxhx: shoulder sx, broken nose

Family History: migraine, back problem, depression

Social History: single, high school grad, FT police officer, work-related injury, attorney D. Churdar, no tob, positive etoh, no ivdu

Allergies:

Review of Systems

General: fatigue

Eyes: denies blurring, diplopia, irritation, discharge, vision loss, eye pain, photophobia

Ear/Nose/Throat: denies ear pain or discharge, tinnitus, decreased hearing, nasal obstruction or discharge, nosebleeds, sore throat, hoarseness, dysphagia

Cardiovascular: Denies chest pain, palpitations, syncope, dyspnea on exertion, orthopnea, PND, peripheral edema

Respiratory: Denies cough, dyspnea, excessive sputum, hemoptysis, wheezing

Gastrointestinal: Denies nausea, vomiting, diarrhea, constipation, change in bowel habits, abdominal pain, melena, hematochezia, jaundice

Genitourinary: denies vaginal discharge, incontinence, dysuria, hematuria, urinary frequency, amenorrhea, menorrhagia, abnormal vaginal bleeding, pelvic pain

Musculoskeletal: back pain, muscle cramps

Skin: denies rash, itching, dryness, suspicious lesions

Neurologic: weakness

Psychiatric: depression

Endocrine: denies cold intolerance, heat intolerance, polydipsia, polyphagia, polyuria, weight change

Hematologic/Lymphatic: denies abnormal bruising, bleeding, enlarged lymph nodes

Allergic/Immunologic: denies urticaria, hay fever, persistent infections, HIV exposure

Vital Signs

Ht: 70 in.

Physical Exam

General

General appearance: well developed, well nourished, no acute distress

Communication ability: communicates by voice, normal quality

Gait and station: Normal

Psychiatric

Mental Status: AAO x3

Judgement/Insight: Intact

Mood/Affect: Appropriate

Head and Face

Inspection: normocephalic, no scars, lesions, or masses

Facial strength: no weakness

Carolinas Center for Advanced Management of Pain

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8645830053 Fax: 8645830390

July 15, 2009

Page 2
Chart Document

MS KELLIE BURNETTE

Female DOB: ~~03/12/1979~~

18381

Home: ~~864/583-1234~~

Ins: VOC REHAB

ROXICODONE 15 MG TABS (OXYCODONE HCL) 1po q4-6 h prn pain max 4 per day
NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po bid
BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm
FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 2 po hs
LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours.
AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) 1 qhs
ADDERALL 20 MG TABS (AMPHETAMINE-DEXTROAMPHETAMINE) bid - Dr Giambalvo
ZYRTEC 10 MG TABS (CETIRIZINE HCL) 1 po qhs other MD
CELEBREX 200 MG CAPS (CELECOXIB) pcp
PROZAC 20 MG CAPS (FLUOXETINE HCL) one bid

New Orders:

OP Psychotherapy 45 - 50 min. [90806]

Return for follow-up 1 month [xxxxx]

Signed by Charles David Tollison PhD on 06/18/2009 at 4:37 PM

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July 15, 2009

Page 1

Chart Document

MS KELLIE BURNETTEFemale DOB: ~~XXXXXX~~

18381

Home: ~~XXXXXXXXXX~~

Ins: VOC REHAB

06/04/2009 - Office Visit: Psych F/U

Provider: Lisa Richardson LISW-CP

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

This document contains confidential information

Age: 29 Years Old

Gender: Female

Employment Status: Last worked 3-08, medically retired police officer City Greenville

Prior Mental Health: Diagnosed ADHD in 1999 while attending college. Initial evaluation by Dr. Tollison on 6-23-08.

Education Level: Graduated high school + few college courses

History of Present Illness: Referred Dr. Satterthwaite. August 2003 work-related MVA, full spine, facial trauma. In June 2007 reinjury. Depression secondary to pain and lifestyle change, feelings of loss, feelings of worthlessness, sadness/discouragement, irritability. Dx: Adj D/O Mixed, & 307.89. WC approved.

Psychological Testing P-3 8-27-07, Anxiety Aver, Dep top 27, Soma 34%. P-3 on 6-23-08 Dep top 12, Anxiety 22, and Soma 29th percentile. P-3 on 2-4-09, Dep 9th, Anxiety 18th, Soma 19th.

Progress Note**Clinical Status:**

Pt's mood is fairly stable on her medications. It is influenced by her pain intensity and limitations. She has been attempting to work in the yard some since she enjoyed it before, but she cannot do what she did before. She then has to lay down afterwards because pain is high. She has gotten some massages at physical therapy office which helped. She is going to physical therapy about her knee, and she may have to have surgery. She is coping better, but she really struggles with the loss of her job because she enjoyed the adrenaline rush of her job and being in the middle of stressful situations. She also was a physical person and pushed herself to handle pain. It frustrates her that she cannot push through some of her upper body pain. Focus on alternate ways to use self talk and work on challenging her negative self talk.

Treatment:

supportive therapy

insight and educational therapy

cognitive-behavioral therapy

Assessment**Status of Existing Problems:**

Assessed ADJUSTMENT DISORDER/MIXED as unchanged - Lisa Richardson LISW-CP

Plan

Pt to challenge her negative self talk about her limitations with more realistic coping statements daily to reduce stress. Continue scheduling pleasant activities to help distract from pain and engage in exercise to reduce stress.

Current Medication List:

ROXICODONE 15 MG TABS (OXYCODONE HCL) 1po q4-6 h prn pain max 4 per day

NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po bid

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 2 po hs

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12

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July 15, 2009

Page 2

Chart Document

MS KELLIE BURNETTE

Female DOB: ~~06/11/1988~~

18381

Home: ~~864-777-1111~~

Ins: VOC REHAB

hours and remove for 12 hours.

AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) 1 qhs

ADDERALL 20 MG TABS (AMPHETAMINE-DEXTROAMPHETAMINE) bid - Dr Giambalvo

ZYRTEC 10 MG TABS (CETIRIZINE HCL) 1 po qhs other MD

CELEBREX 200 MG CAPS (CELECOXIB) pcp

PROZAC 20 MG CAPS (FLUOXETINE HCL) one bid

New Orders:

OP Psychotherapy 45 - 50 min. [90806]

Return for follow-up 1 month [xxxxx]

Signed by Lisa Richardson LISW-CP on 06/04/2009 at 4:45 PM

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July 15, 2009
Page 1
Chart Document

MS KELLIE BURNETTE

Female DOB: [REDACTED]

18381

Home: [REDACTED]
Ins: VOC REHAB

05/21/2009 - Office Visit: Psych F/U

Provider: Charles David Tollison PhD

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

This document contains confidential information

Age: 29 Years Old

Gender: Female

Employment Status: Last worked 3-08, medically retired police officer City Greenville

Prior Mental Health: Diagnosed ADHD in 1999 while attending college. Initial evaluation by Dr. Tollison on 6-23-08.

Education Level: Graduated high school + few college courses

History of Present Illness: Referred Dr. Satterthwaite. August 2003 work-related MVA, full spine, facial trauma. In June 2007 reinjury. Depression secondary to pain and lifestyle change, feelings of loss, feelings of worthlessness, sadness/discouragement, irritability. Dx: Adj D/O Mixed, & 307.89. WC approved.

Psychological Testing P-3 8-27-07, Anxiety Aver, Dep top 27, Soma 34%. P-3 on 6-23-08 Dep top 12, Anxiety 22, and Soma 29th percentile. P-3 on 2-4-09, Dep 9th, Anxiety 18th, Soma 19th.

Progress Note

Clinical Status: She is feeling a little better, "I'm sleeping now" and she is back taking Ambien and Flexaril that is helping sleep. Little change in pain, but sleeping is allowing her to cope with pain a little better. Her work with Ms. Richardson is helping her and she wishes to continue. Cognitively intact and compliant with treatment. Denies suicidal and homicidal ideation. She looks a little better and she is stable.

Treatment: Combination of education, support, and coping skills training with continuing clinical re-assessment

Assessment

Status of Existing Problems:

Assessed ADJUSTMENT DISORDER/MIXED as unchanged - Charles David Tollison PhD

Assessed PAIN DISORDER (PSYCH/MEDICAL) as unchanged - Charles David Tollison PhD

Plan

Continue current treatment plan and notify me of any significant change in condition. Get out more and use distraction techniques and keep mentally occupied to avoid excessive rumination. Develop an action plan. Focus on thoughts, feelings, and behavior. Follow up with Ms. Richardson and return to

New Prescriptions/Refills:

PROZAC 20 MG CAPS (FLUOXETINE HCL) one bid #60 x 0 : Charles David Tollison PhD (05/21/2009)

Current Medication List:

MORPHINE SULFATE 16 MG TABS (MORPHINE SULFATE) 1 po qid prn pain 2 week supply

ROXICODONE 15 MG TABS (OXYCODONE HCL) 1po q4-6 h prn pain max 4 per day

NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po bid

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 2 po hs

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours.

AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) 1 qhs

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July 15, 2009

Page 2

Chart Document

MS KELLIE BURNETTE

Female DOB: [REDACTED]

18381

Home: [REDACTED]

Ins: VOC-REHAB

ADDERALL 20 MG TABS (AMPHETAMINE-DEXTROAMPHETAMINE) bid - Dr Giambalvo
ZYRTEC 10 MG TABS (CETIRIZINE HCL) 1 po qhs other MD
CELEBREX 200 MG CAPS (CELECOXIB) pop
PROZAC 20 MG CAPS (FLUOXETINE HCL) one bid

New Orders:

OP Psychotherapy 45 - 50 min. [90806]

Return for follow-up 1 month [xxxxx]

Signed by Charles David Tollison PhD on 05/21/2009 at 4:10 PM

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July 15, 2009

Page 1

Chart Document

MS KELLIE BURNETTEFemale DOB: ~~XXXXXXXXXX~~

18381

Home: ~~XXXXXXXXXX~~

Ins: VOC REHAB

04/30/2009 - Office Visit: Psych F/U**Provider: Lisa Richardson LISW-CP****Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office****This document contains confidential information****ctAge:** 29 Years Old**Gender:** Female**Employment Status:** Last worked 3-08, medically retired police officer City Greenville**Prior Mental Health:** Diagnosed ADHD in 1999 while attending college. Initial evaluation by Dr. Tollison on 6-23-08.**Education Level:** Graduated high school + few college courses**History of Present Illness:** Referred Dr. Satterthwaite. August 2003 work-related MVA, full spine, facial trauma. In June 2007 reinjury. Depression secondary to pain and lifestyle change, feelings of loss, feelings of worthlessness, sadness/discouragement, irritability. Dx: Adj D/O Mixed, & 307.89. WC approved.**Psychological Testing** P-3 8-27-07, Anxiety Aver, Dep top 27, Soma 34%. P-3 on 6-23-08 Dep top 12, Anxiety 22, and Soma 29th percentile. P-3 on 2-4-09, Dep 9th, Anxiety 18th, Soma 19th.**Progress Note**

Clinical Status: Pt's mood has been irritable. She was having trouble sleeping, and she started ambien last night which helped her sleep. She is also back on the pain medication that helped her better than what they had to put her own when the pharmacy was out. Her partner was having more stress at work, and she thinks her irritable attitude toward her was related to the stress rather than her pain. They are communicating which helps reduce stress. She is struggling with pacing her activities, and she has found herself buying things impulsively. She states she attempted to clue some items on paper for her significant other's school project, and her pain level of unbearable due to burning in a few short minutes when she raises her arms up to most tasks. She states I have been an athletic person and competitive all my life. I have tolerated pain, but this pain is different. She states "this is what gets in the way of doing a job that I really want to do."

Treatment:

supportive therapy

Assessment**Status of Existing Problems:**

Assessed ADJUSTMENT DISORDER/MIXED as unchanged - Lisa Richardson LISW-CP

Plan

Pt to continue to pace, use calming self statements, and schedule distraction activities daily.

Current Medication List:

MORPHINE SULFATE 15 MG TABS (MORPHINE SULFATE) 1 po qid prn pain 2 week supply

ROXICODONE 15 MG TABS (OXYCODONE HCL) 1po q4-6 h prn pain max 4 per day

NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po bid

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 2 po hs

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours.

AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) 1 qhs

ADDERALL 20 MG TABS (AMPHETAMINE-DEXTROAMPHETAMINE) bid - Dr Giambalvo

ZYRTEC 10 MG TABS (CETIRIZINE HCL) 1 po qhs other MD

JUL '15/2009/WED 03:08 PM

FAX No.

P. 012/047

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July 15, 2009
Page 2
Chart Document

MS KELLIE BURNETTE

Female DOB: ~~XXXXXXXXXX~~

18381

Home: ~~XXXXXXXXXX~~
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CELEBREX 200 MG CAPS (CELECOXIB) pcp
PROZAC 20 MG CAPS (FLUOXETINE HCL) one bid

New Orders:

OP Psychotherapy 45 - 50 min. [90806]
Return for Follow-Up [XXXXXX]

Signed by Lisa Richardson LISW-CP on 04/30/2009 at 4:55 PM

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July 15, 2009

Page 1

Chart Document

MS KELLIE BURNETTE

Female DOB: [REDACTED]

18381

Home: [REDACTED]

Ins: VOC REHAB

04/09/2009 - Office Visit: Psych F/U

Provider: Charles David Tollison PhD

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

This document contains confidential information

Age: 29 Years Old

Gender: Female

Employment Status: Last worked 3-08, medically retired police officer City Greenville

Prior Mental Health: Diagnosed ADHD in 1999 while attending college. Initial evaluation by Dr. Tollison on 6-23-08.

Education Level: Graduated high school + few college courses

History of Present Illness: Referred Dr. Satterthwaite. August 2003 work-related MVA, full spine, facial trauma. In June 2007 reinjury. Depression secondary to pain and lifestyle change, feelings of loss, feelings of worthlessness/sadness/discouragement, irritability. Dx: Adj D/O Mixed, & 307.89. WC approved.

Psychological Testing P-3 8-27-07, Anxiety Aver, Dep top 27, Soma 34%, P-3 on 6-23-08 Dep top 12, Anxiety 22, and Soma 29th percentile. P-3 on 2-4-09, Dep 9th, Anxiety 18th, Soma 19th.

Progress Note

Clinical Status: Last visit she changed over to Prozac "and thus far I feel a little better, still a little irritable but still I like how I'm feeling so far, just think maybe I need a little stronger dose." Cognitively intact and compliant with treatment. Denies suicidal and homicidal ideation. She still not getting to sleep at night, but once asleep she is usually okay. Getting out of house a little more and interacting more on Prozac.

Treatment: Combination of education, support, and coping skills training with continuing clinical re-assessment

Assessment**Status of Existing Problems:**

Assessed ADJUSTMENT DISORDER/MIXED as improved - Charles David Tollison PhD

Assessed PAIN DISORDER (PSYCH/MEDICAL) as unchanged - Charles David Tollison PhD

Plan

Trial of trazodone for sleep, per Dr. Mironer, and she will return to see Ms. Richardson. Continue current treatment plan and notify me of any significant change in condition. Urged to rehearse daily cognitive coping skills with restructuring of perceptions in combination with behavioral redirection and distraction techniques for therapeutic benefit. Telephone with need. Prozac increased to bid (total 40 mg).

New Prescriptions/Refills:

AMITRIPTYLINE HCL 25 MG TABS (AMITRIPTYLINE HCL) 1 or 2 tabs qhs #60 x 0 : Charles David Tollison PhD (04/09/2009)

PROZAC 20 MG CAPS (FLUOXETINE HCL) one bid #60 x 0 : Charles David Tollison PhD (04/09/2009)

Current Medication List:

OPANA 10 MG TABS (OXYMORPHONE HCL) 1 po q4-6h prn pain max 4/day (30 DAY SUPPLY NO EARLY REFILLS.) *MAY FILL ON* 3/19/09

ROXICODONE 15 MG TABS (OXYCODONE HCL) 1po q4-6 h prn pain max 4 per day

NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po bid

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July 15, 2009

Page 2

Chart Document

MS KELLIE BURNETTE

Female DOB: [REDACTED]

18381

Home: [REDACTED]

Ins: VOC REHAB

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 HS

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours.

ADDERALL 20 MG TABS (AMPHETAMINE-DEXTROAMPHETAMINE) bid - Dr Giambalvo

ZYRTEC 10 MG TABS (CETIRIZINE HCL) 1 po qhs other MD

RESTORIL 15 MG CAPS (TEMAZEPAM) 1 po hs insomnia (discontinued 4-9-09)

PROZAC 20 MG CAPS (FLUOXETINE HCL) one bid

AMITRIPTYLINE HCL 25 MG TABS (AMITRIPTYLINE HCL) 1 or 2 tabs qhs

New Orders:

OP Psychotherapy 45 - 50 min. [90806]

Signed by Charles David Tollison PhD on 04/09/2009 at 4:03 PM

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July 15, 2009

Page 1

Chart Document

MS KELLIE BURNETTE

Female DOB [REDACTED]

18381

Home: [REDACTED]

Ins: VOC REHAB

03/25/2009 - Office Visit: Psych F/U**Provider: Lisa Richardson LISW-CP****Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office****This document contains confidential information****Age:** 29 Years Old**Gender:** Female**Employment Status:** Last worked 3-08, medically retired police officer City Greenville**Prior Mental Health:** Diagnosed ADHD in 1999 while attending college. Initial evaluation by Dr. Tollison on 6-23-08.**Education Level:** Graduated high school + few college courses**History of Present Illness:** Referred Dr. Satterthwaite. August 2003 work-related MVA, full spine, facial trauma. In June 2007 reinjury. Depression secondary to pain and lifestyle change, feelings of loss, feelings of worthlessness, sadness/discouragement, irritability. Dx: Adj D/O Mixed, & 307.89. WC approved.**Psychological Testing** P-3 8-27-07, Anxiety Aver, Dep top 27, Soma 34%. P-3 on 6-23-08 Dep top 12, Anxiety 22, and Soma 29th percentile. P-3 on 2-4-09, Dep 9th, Anxiety 18th, Soma 19th.**Progress Note**

Clinical Status: Pt's mood is down today. She is having more problems with her knee. She is not sleeping as well, and she starts a new medication soon. She is still dreaming about her job and she verbalizes some feelings related to loss of her job today in the session. She has been irritable with her pain in her back. She finds pacing difficult to do because if she does any activity where she has to raise her arms up to wash dishes or sweep the pain shoots to a 10. She states then the pain stays at that level until she sleeps all night. She can keep her pain at a 5 if she takes her medication and sits or lays down. She is pushing herself to do some activities. She is arguing more with her partner over not doing the dishes and helping more. Her partner will say "you are home all day and don't have to work." Discuss communicating about her pain restrictions, needs, and concerns about stress and tension with her partner.

Treatment:

supportive therapy

insight and educational therapy

Plan

Pt to practice pacing and communicating her needs and concerns related to pain limitations to her partner to reduce stress and tension. Follow-up with Dr. Tollison Ph.D next session as scheduled and schedule with me at that session (consider bring partner to session).

Current Medication List:

OPANA 10 MG TABS (OXYMORPHONE HCL) 1 po q4-6h prn pain max 4/day (30 DAY SUPPLY NO EARLY REFILLS.) *MAY FILL ON* 3/19/09

ROXICODONE 15 MG TABS (OXYCODONE HCL) 1po q4-6 h prn pain max 4 per day

NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po bid

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 HS

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours.

EFFEXOR XR 150 MG CP24 (VENLAFAXINE HCL) 1 QD (3-10-09 titrate down & stop)

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July 15, 2009

Page 2

Chart Document

MS KELLIE BURNETTE

Female DOB: ~~██████████~~

18381

Home: ~~██████████~~

Ins: VOC REHAB

WELLBUTRIN XL 150 MG TB24 (BUPROPION HCL) 1 QD (3-10-09 titrate down 6 days and off)
ADDERALL 20 MG TABS (AMPHETAMINE-DEXTROAMPHETAMINE) bid - Dr Giambalvo
ZYRTEC 10 MG TABS (CETIRIZINE HCL) 1 po qhs other MD
RESTORIL 15 MG CAPS (TEMASEPAM) 1 po hs insomnia
PROZAC 20 MG CAPS (FLUOXETINE HCL) one qd

New Orders:

OP Psychotherapy 45 - 50 min. [90806]

Signed by Lisa Richardson LISW-CP on 03/25/2009 at 4:29 PM

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1330 Boiling Springs Rd Suite 2700 Spartanburg, SC 29303
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July 15, 2009

Page 1

Chart Document

MS KELLIE BURNETTE

Female DOB: [REDACTED]

18381

Home: [REDACTED]

Ins: VOC REHAB

03/10/2009 - Office Visit: Psych F/U**Provider: Charles David Tollison PhD****Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office****This document contains confidential information****Age:** 29 Years Old**Gender:** Female**Employment Status:** Last worked 3-08, medically retired police officer City Greenville**Prior Mental Health:** Diagnosed ADHD in 1999 while attending college. Initial evaluation by Dr. Tollison on 6-23-08.**Education Level:** Graduated high school + few college courses**History of Present Illness:** Referred Dr. Satterthwaite. August 2003 work-related MVA, full spine, facial trauma. In June 2007 reinjury. Depression secondary to pain and lifestyle change, feelings of loss, feelings of worthlessness, sadness/discouragement, irritability. Dx: Adj D/O Mixed, & 307.89. WC approved.**Psychological Testing** P-3 8-27-07, Anxiety Aver, Dep top 27, Soma 34%. P-3 on 6-23-08 Dep top 12, Anxiety 22, and Soma 29th percentile. P-3 on 2-4-09, Dep 9th, Anxiety 18th, Soma 19th.**Progress Note**

Clinical Status: Last visit the Ambien CR was changed to Ambien and Wellbutrin XL was increased to 300 mg and she has not noted any benefit. She also is reporting increased irritability and this could be medication related. She having some very mild friction in relationship because of irritability and "being grumpy." Cognitively intact and compliant with treatment. Denies suicidal and homicidal ideation.

Treatment: Combination of education, support, and coping skills training with continuing clinical re-assessment

Assessment**Status of Existing Problems:**

Assessed ADJUSTMENT DISORDER/MIXED as unchanged - Charles David Tollison PhD

Assessed PAIN DISORDER (PSYCH/MEDICAL) as unchanged - Charles David Tollison PhD

Plan

Titrate down and off Effexor XR and Wellbutrin XL for next 7-10 days and trial of Prozac and if not effective then consideration given to trial of Zoloft.

Continue current treatment plan and notify me of any significant change in condition. Get out more and use distraction techniques and keep mentally occupied to avoid excessive rumination. Develop an action plan. Focus on thoughts, feelings, and behavior. Return appointment in a month.

New Prescriptions/Refills:

AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) 1 tab qhs prn #30 x 0 : Charles David Tollison PhD (03/10/2009)

PROZAC 20 MG CAPS (FLUOXETINE HCL) one qd #30 x 0 : Charles David Tollison PhD (03/10/2009)

Current Medication List:

ROXICODONE 15 MG TABS (OXYCODONE HCL) 1po q4-6 h prn pain max 4 per day

NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po bid

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 HS

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July 15, 2009
Page 2
Chart Document

MS KELLIE BURNETTE

Female DOB: ~~XXXXXXXXXX~~

18381

Home: ~~(XXXXXXXXXX)~~
Ins: VOC REHAB

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours.

EFFEXOR XR 150 MG CP24 (VENLAFAXINE HCL) 1 QD (3-10-09 titrate down & stop)

WELLBUTRIN XL 150 MG TB24 (BUPROPION HCL) 1 QD (3-10-09 titrate down 6 days and off)

ADDERALL 20 MG TABS (AMPHETAMINE-DEXTROAMPHETAMINE) bid - Dr Giambalvo

ZYRTEC 10 MG TABS (CETIRIZINE HCL) 1 po qhs other MD

AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) 1 tab qhs pm

ROXICODONE 15 MG TABS (OXYCODONE HCL) 1 po q6h 2 week supply

PROZAC 20 MG CAPS (FLUOXETINE HCL) one qd

New Orders:

OP Psychotherapy 45 - 50 min. [90806]

Return for follow-up 1 month [xxxxx]

Signed by Charles David Tollison PhD on 03/10/2009 at 11:31 AM

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July 15, 2009

Page 1

Chart Document

MS KELLIE BURNETTEFemale DOB: ~~XXXXXXXXXX~~

18381

Home: ~~XXXXXXXXXX~~

Ins: VOC REHAB

02/04/2009 - Office Visit: Psych F/U**Provider: Charles David Tollison PhD****Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office****This document contains confidential information****Age: 29 Years Old****Gender: Female****Employment Status:** Last worked 3-08, medically retired police officer City Greenville**Prior Mental Health:** Diagnosed ADHD in 1999 while attending college. Initial evaluation by Dr. Tollison on 6-23-08.**Education Level:** Graduated high school + few college courses**History of Present Illness:** Referred Dr. Satterthwaite. August 2003 work-related MVA, full spine, facial trauma. In June 2007 reinjury. Depression secondary to pain and lifestyle change, feelings of loss, feelings of worthlessness, sadness/discouragement, irritability. Dx: Adj D/O Mixed, & 307.89. WC approved.**Psychological Testing** P-3 8-27-07, Anxiety Aver, Dep top 27, Soma 34%. P-3 on 6-23-08 Dep top 12, Anxiety 22, and Soma 29th percentile. P-3 on 2-4-09, Dep 9th, Anxiety 18th, Soma 19th.**Progress Note****Clinical Status:** "My pain works on me everyday.....everyday.....and I wish I could just have one day of not hurting!" Episodes of agitation and frustration related to pain "and I guess I just get too worked up." Discouraged over duration of pain, lack of significant response to date, and worries about future. Cognitively intact and compliant with treatment. Denies suicidal and homicidal ideation.

Last objective assessment of psychological functioning was back in June 2008 so today we administer the Pain Patient Profile (P-3) and testing is valid with no magnification of symptoms. Test results confirm an intensity of Depression in the top 9th percentile, Anxiety in top 18th, and Somatization in top 19th percentile, with all scores compared to a national sample of patients threatened for chronic pain.

Treatment: Combination of education, support, and coping skills training with continuing clinical re-assessment**Assessment****Status of Existing Problems:**

Assessed ADJUSTMENT DISORDER/MIXED as unchanged - Charles David Tollison PhD

Assessed PAIN DISORDER (PSYCH/MEDICAL) as unchanged - Charles David Tollison PhD

Plan

Ambien CR changed to Ambien and Wellbutrin XL bid 150 mg changed to 300 mg qd. Continue current treatment plan and notify me of any significant change in condition. Get out more and use distraction techniques and keep mentally occupied to avoid excessive rumination. Develop an action plan. Focus on thoughts, feelings, and behavior. Return appointment with Ms. Richardson and return to me in a month.

New Prescriptions/Refills:EFFEXOR XR 150 MG CP24 (VENLAFAXINE HCL) 1 QD #30 x 1 : Charles David Tollison PhD
(02/04/2009)AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) 1 tab qhs prn #30 x 0 : Charles David Tollison PhD
(02/04/2009)**Current Medication List:**

Carolinas Center for Advanced Management of Pain
1330 Bolling Springs Rd Suite 2700 Spartanburg, SC 29303
8645830053 Fax: 8645830390

July 15, 2009
Page 2
Chart Document

MS KELLIE BURNETTE

Female DOB: ~~XXXXXXXXXX~~

18381

Home: ~~XXXXXXXXXX~~

Ins: VOC REHAB

ROXICODONE 15 MG TABS (OXYCODONE HCL) 1po q4-6 h prn pain max 4 per day
NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po bid
BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm
FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 HS
LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours.
EFFEXOR XR 150 MG CP24 (VENLAFAXINE HCL) 1 QD
WELLBUTRIN XL 150 MG TB24 (BUPROPION HCL) 1 QD
ADDERALL 20 MG TABS (AMPHETAMINE-DEXTROAMPHETAMINE) bid - Dr Gjambalvo
ZYRTEC 10 MG TABS (CETIRIZINE HCL) 1 po qhs other MD
AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) 1 tab qhs prn

New Orders:

OP Psychotherapy 45 - 50 min. [90806]

P3 [96103]

Signed by Charles David Tollison PhD on 02/04/2009 at 3:44 PM

P-3 ®

Pain Patient Profile

Interpretive Report

by

C. David Tollison

and

Jerry C. Langley

ID Number 18381

Female

Age 29

2/4/2009 1:30:19 PM

Kellie Burnette

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[1.0 / 5.07 / 1.0]

INTRODUCTION

Pain resulting from physical injury, illness, or disease is a multidimensional phenomenon composed of physiologic, psychological, and other influencing variables. Factors such as depression, anxiety, and excessive somatic thought are specifically identified in the medical literature as actively contributing to the etiology, maintenance, and intensity of pain. When these factors are appropriately identified and clinically addressed, treatment outcomes resulting from nonsurgical, surgical, and rehabilitative interventions are significantly improved.

The P-3 is designed to identify pain patients who are experiencing emotional distress that may be affecting their symptoms and their response to treatment. The P-3 report also offers recommendations regarding the need for mental health treatment based on the patient's item responses. Clinicians should monitor changes in pain and psychological symptoms and reassess as clinically appropriate. The P-3 may be readministered periodically to measure treatment progress.

The profile, interpretations, and recommendations in this report are all based on pain patients as the primary reference group. However, when reviewing an individual's results, it is important to keep in mind that the average pain patient is significantly more depressed, anxious, and preoccupied with somatic thoughts than the average community subject.

The information in the P-3 report must be used in conjunction with professional judgment, taking into account the total context of the instrument's administration and any other pertinent information concerning the individual. The main body of the report should be considered a professional-to-professional consultation and should be used solely by the clinician. These results should be considered confidential. The Patient Summary can be shared with the patient if the clinician decides it is appropriate.

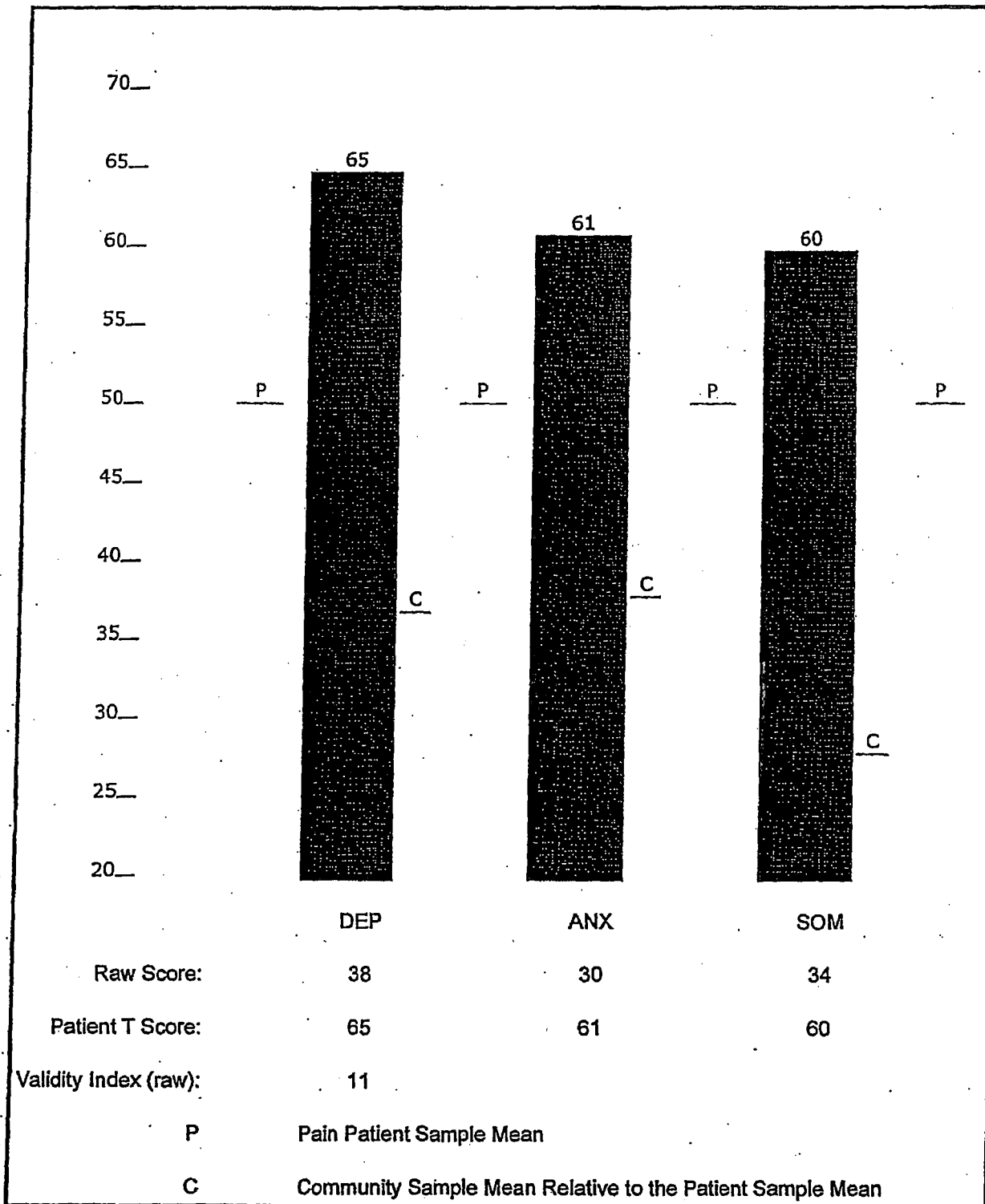
VALIDITY

The patient's score on the Validity Index suggests that she was able to read the items and appropriately attended to item content. It appears that she approached the test in an open and honest manner. Her score suggests that her test results can be interpreted with confidence.

RESULTS SUMMARY

The patient's item responses suggest higher-than-average levels of depression, anxiety, and somatization. Her above-average scores reflect symptoms that are likely to interfere with her physical treatment program.

Pain Patient Profile
The Individual Compared to the Patient Sample



Progress Report

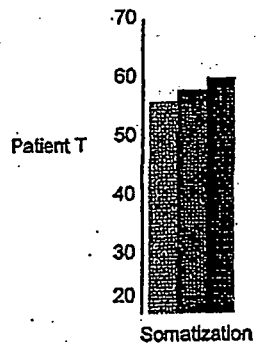
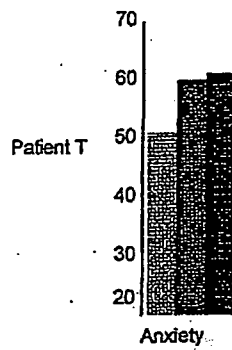
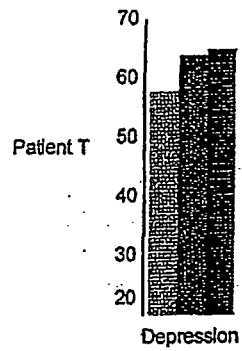
ID: 18381

Name: _____

Test Administrations

■ 8/28/2007 11:17:20 AM

■ 6/23/2008 1:10:39 PM



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[1.4 / 5.04 / 1.0]

CLINICAL INTERPRETATION

Depression

The patient's Depression score (65) is significantly above average for pain patients. Her item responses suggest serious depression. Only 9% of pain patients in the sample scored at this level or higher. The patient's depression is reflected in her endorsement of the most severe responses for the following test items. Although these responses may help the clinician understand the patient's emotional state, caution should be used when interpreting an individual item response because the client may have inadvertently marked the wrong response.

1. I have a lot of trouble with sleep.
6. I wake with pain and feeling tired most mornings.
8. Much of the time I feel useless to myself and others.
11. I am not happy.
12. I seem to have trouble completing tasks because I keep getting sidetracked.
22. I now have more trouble making decisions than I used to.
25. Most of the time I feel hopeless that my condition will improve.
40. I am almost always sad.
42. My life is in a rut.
43. I am not satisfied with my life at present.

The patient may be feeling worthless, helpless, and hopeless. She may be pessimistic about the future, and she may believe that her condition is permanent. She may be described by others as withdrawn, dependent, listless, and unresponsive. She is probably experiencing sleep and appetite disturbances, chronic lethargy, and fatigue. She may appear to be going through the motions without energy, optimism, motivation, or enthusiasm. Consequently, efforts to involve her in an active and participatory treatment plan for pain management may be unsuccessful. She may be so depressed that she has lost the will or expectation to improve. This can become a self-fulfilling prophecy. Often, patients with this level of affective distress are unable to see any way out of their situation and feel powerless to change their lives for the better. The patient should be thoroughly evaluated for suicidal thoughts and preoccupation with death. Referral to a mental health professional is strongly advised. It is very likely that depression is involved in her overall symptomatology.

Anxiety

The patient's Anxiety T score (61) suggests that she is more anxious than the average pain patient. Of the pain patients sampled, only 18% had an Anxiety T score of 61 or higher. The patient's anxiety is reflected in her endorsement of the most severe responses for the following test items. Although these responses may help the clinician understand the patient's emotional state, caution should be used when interpreting an individual item response because the client may have inadvertently marked the wrong response.

- 2. I often feel so nervous and on edge that I am miserable.
- 9. I have serious trouble remembering things.
- 16. I feel angry with somebody or something much of the time.
- 23. It is sometimes impossible to get my mind to relax.
- 26. I frequently say things in anger that I later wish I hadn't.
- 33. I feel nervous most of the time.

The patient's responses suggest that her anxiety symptoms include feelings of agitation, nervousness, generalized fear, and inner turmoil. She may also be feeling significant levels of anger, and she may find it difficult to control her temper. Autonomic activity may be heightened and may contribute to pain intensity. She may report feeling tense and unable to relax. She probably avoids crowds, social contact, and stressful or demanding situations. She may be described by others as agitated, tense, stressed, impatient, and distracted. Her concentration and attention are probably affected, and she may act impulsively without sufficient thought and deliberation. Efforts to involve her in long-term rehabilitation may be hampered by her emotional symptoms, which occupy much of her attention. The clinician should explore the possibility that sustained muscular contraction or other active autonomic response may be causing or prolonging her pain. The potential exists for her anxiety symptoms to interfere with physical treatment designed to reduce pain.

Somatization

The patient's Somatization T score (60) suggests that she has more physical problems, pain, and health-related concerns than the average pain patient. Of the pain patients sampled, only 19% had a T score of 60 or higher on the Somatization scale. The patient's somatization is reflected in her endorsement of the most severe responses for the following test items. Although these responses may help the clinician understand the patient's emotional state, caution should be used when interpreting an individual item response because the client may have inadvertently marked the wrong response.

- 4. I can no longer do my work and chores around the house.
- 5. My life is spent in pain.
- 13. I feel weak and tired much of the time.
- 21. I stay tired most of the time.
- 24. My neck and shoulders hurt.
- 29. The muscles in my body feel painfully tight.
- 30. My neck or back seems to hurt most of the time.
- 34. I believe that once you have a bad back you will probably always have trouble with it.
- 41. Sometimes my entire arm or leg feels numb.

These somatic issues trouble her and are adversely affecting her life. She may exhibit excessive concern about bodily functions, and her physical symptoms may be multiple and magnified. Pain migration may be exhibited, with pain complaints shifting from one anatomic part to another. Symptom substitution may also be demonstrated, whereby successful treatment of one problem is followed by development of new complaints.

This patient's Somatization score suggests that pain and health-related concerns occupy a disproportionate amount of her attention. Her somatic symptoms are upsetting, frustrating, distracting, unwanted, and poorly tolerated. She may be described by others as over-reactive, self-centered, demanding, pessimistic, complaining, whining, and bitter. She may challenge health professionals with demands for pain relief, yet she may exhibit a defeatist and noncompliant attitude toward appropriate treatment plans.

TREATMENT RECOMMENDATION

Because of the magnitude of the patient's depression and associated emotional distress, mental health consultation/treatment is strongly recommended before or as an adjunct to physical treatment for pain reduction.

ITEM RESPONSES

1: 3	2: 3	3: 1	4: 3	5: 3	6: 3	7: 3	8: 3	9: 3	10: 2
11: 3	12: 3	13: 3	14: 2	15: 2	16: 3	17: 2	18: 3	19: 2	20: 2
21: 3	22: 3	23: 3	24: 3	25: 3	26: 3	27: 2	28: 2	29: 3	30: 3
31: 2	32: 2	33: 3	34: 3	35: 2	36: 2	37: 2	38: 2	39: 1	40: 3
41: 3	42: 3	43: 3	44: 2						

End of Clinical Report

PATIENT SUMMARY

The P-3 was developed to assist health care professionals who work with patients who are experiencing pain and physical problems. Information from the P-3 can help you and your health care provider determine if emotional factors are influencing your symptoms or your treatment progress.

The P-3 provides information about three factors that are important to your health: depression, anxiety, and somatization. These terms are defined below.

Depression: feeling down, having low energy, and feeling tired, blue, and discouraged

Anxiety: feeling nervous, on edge, and irritable

Somatization: being overly concerned with and thinking too much about physical problems

Patients who are in pain usually experience more emotional distress than people who are not in pain. Depression, anxiety, and somatization are as much a part of pain as the physical aspects, and these feelings can make coping with pain more difficult.

The following interpretation is based on your responses to the P-3 items. You are encouraged to discuss your P-3 results with your health care provider.

Your Depression score indicates that you may be struggling with feelings of despair and that you may feel overwhelmed by your pain and physical problems. Your responses suggest that you may be feeling chronically tired and are struggling against the urge to give up hope of getting better. You should discuss these feelings with your health care provider so he or she can help you find ways to cope with them.

Your Anxiety score suggests that you may be somewhat anxious. You may feel tense and unable to relax. You may also feel that your mind is racing all the time. You may feel stressed and unable to think and concentrate as well as you would like. Your muscles may be tense, and this may be contributing to your pain. Pain can result in a variety of symptoms and feelings that are uncomfortable and unwanted. Discussing your feelings with your health care provider can be helpful. He or she can help you find ways to relax and cope with the stress caused by your symptoms.

Your Somatization score suggests that pain and health problems are having a negative effect on your life. You probably have multiple pain- and health-related problems that occupy a good deal of your attention and concentration. Your responses also indicate that you may have trouble completing tasks because you are distracted by your pain. You should discuss your concerns with your health care provider. He or she may be able to help you find ways to cope with the intensity of your symptoms and physical problems.

The treatment of pain sometimes requires a team effort from health care specialists. It is in your best interest to explore a combination of physical and psychological treatment options under the guidance and direction of your health care professional.

End of Patient Summary

End of Report

ION SECOURS ST. FRANCIS - DOWNTOWN

AGNOSTIC RADIOLOGY

ST FRANCIS DRIVE, GREENVILLE, SC 29601 (864) 255-1044

NAME: BURNETTE, KELLIE

ADMISSION NO: 005017154

SEX: F AGE: 29Y

DATE OF BIRTH: ~~XXXXXXXXXX~~

EXAMINATION/NS: XR-

DATE OF EXAM: Mar 10 2009 3:09PM

#: 523633972 PATIENT CLASS: O

ACC. #: 7465125 DISCH. DATE:

D. PHYSICIAN: MICHAEL BUCCI

ORD. PHYSICIAN # 756904

Final Report

Codes / Adm. Diagnosis: /

Examination: CERVICAL SPINE FLEX EXT ONLY - 2102055 - Mar 10 2009 3:09PM

CERVICAL SPINE, 03/10/09:

Reason: Neck pain.

REPORT: Flexion and extension views of the cervical spine were obtained and compared to 12/04/08.

There are postoperative changes at C5-6. There is an anterior fixation plate. Alignment remains good. There is no subluxation. The spine appears stable with flexion and extension.

IMPRESSION: STABLE POSTOP CHANGES AT C5-6.
of Report

STATEMENT OF CONFIDENTIALITY NOTICE:

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Interpreting/Reading Doctor: JAMES B. HASWELL (792263)

Described by / Date: CP on 03/10/2009

Received Electronically by / Date: JAMES B. HASWELL (792263) 03/10/2009

Signature:

Reading Doctor: MICHAEL BUCCI

Attending Doctor:

0181

Carolinas Center for Advanced Management of Pain1330 Boiling Springs Rd Suite 2700 Spartanburg, SC 29303
8645830053 Fax: 8645830390

July 15, 2009

Page 1
Chart Document**MS KELLIE BURNETTE**Female DOB: ~~01/22/1980~~

18381

Home: ~~(864) 583-0053~~

Ins: VOC REHAB

01/22/2009 - Office Visit: Psych F/U

Provider: Lisa Richardson LISW-CP

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

This document contains confidential information

Age: 29 Years Old

Gender: Female

Employment Status: Last worked 3-08, medically retired police officer City Greenville

Prior Mental Health: Diagnosed ADHD in 1999 while attending college. Initial evaluation by Dr. Tollison on 6-23-08.

Education Level: Graduated high school + few college courses

History of Present Illness: Referred Dr. Satterthwaite. August 2003 work-related MVA, full spine, facial trauma. In June 2007 reinjury. Depression secondary to pain and lifestyle change, feelings of loss, feelings of worthlessness, sadness/discouragement, irritability. Dx: Adj D/O Mixed, & 307.89. WC approved.

Psychological Testing P-3 8-27-07, Anxiety Aver, Dep top 27, Soma 34%. P-3 on 6-23-08 Dep top 12, Anxiety 22, and Soma 29th percentile.

Progress Note

Clinical Status: Pt saw Dr. Tollison Ph.D last two sessions. She does think her medications are helping her mood. She is still having a difficult time with the fact she cannot work in her field. She is having dreams where she is being ambushed or her gun malfunctions. She spent all of her time at work and doing part-time jobs. She spent her spare time doing yard work or catching up. She cannot do what she enjoys. She is having less pain in her neck, but her back still bothering. She is attempting to face and express the feelings of loss related to her inability to work. She is encouraged to share her feelings of recent stressors through active listening, positive regard, and questioning.

Treatment:supportive therapy
cognitive-behavioral therapy
insight and educational therapy**Assessment****Status of Existing Problems:**

Assessed ADJUSTMENT DISORDER/MIXED as unchanged - Lisa Richardson LISW-CP - Signed

Plan

PT to use distraction activities, relaxation techniques, and pacing to manage pain and regulate mood.

Current Medication List:

ROXICODONE 15 MG TABS (OXYCODONE HCL) 1po q4-6 h prn pain max 4 per day

NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po bid

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm

AMBIEN CR 12.5 MG TBCR (ZOLPIDEM TARTRATE) 1 po qhs

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 HS

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours.

EFFEXOR XR 150 MG CP24 (VENLAFAXINE HCL) 1 QD

WELLBUTRIN XL 150 MG TB24 (BUPROPION HCL) 1 QD

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July 15, 2009

Page 2

Chart Document

MS KELLIE BURNETTE

Female DOB: ~~REDACTED~~

18381

Home: ~~REDACTED~~

Ins: VOC REHAB

ADDERALL 20 MG TABS (AMPHETAMINE-DEXTROAMPHETAMINE) bid - Dr Giambalvo
ZYRTEC 10 MG TABS (CETIRIZINE HCL) 1 po qhs other MD

New Orders:

OP Psychotherapy 45 - 50 min. [90806]

Signed by Lisa Richardson LISW-CP on 01/22/2009 at 4:43 PM

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July 15, 2009
Page 1
Chart Document

MS KELLIE BURNETTE

Female DOB: ~~REDACTED~~

18381

Home: ~~REDACTED~~
Ins: VOC REHAB

01/06/2009 - Office Visit: Psych F/U

Provider: Charles David Tollison PhD

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

This document contains confidential information

Age: 29 Years Old

Gender: Female

Employment Status: Last worked 3-08, medically retired police officer City Greenville

Prior Mental Health: Diagnosed ADHD in 1999 while attending college. Initial evaluation by Dr. Tollison on 6-23-08.

Education Level: Graduated high school + few college courses

History of Present Illness: Referred Dr. Satterthwaite. August 2003 work-related MVA, full spine, facial trauma. In June 2007 reinjury. Depression secondary to pain and lifestyle change, feelings of loss, feelings of worthlessness, sadness/discouragement, irritability. Dx: Adj D/O Mixed, & 307.89. WC approved.

Psychological Testing P-3 8-27-07, Anxiety Aver, Dep top 27, Soma 34%. P-3 on 6-23-08 Dep top 12, Anxiety 22, and Soma 29th percentile.

Progress Note

Clinical Status: Last visit her Effexor XR was reduced to 75 mg qd and Wellbutrin XL was added and she reports "being a little better" and talks of some improvement in lethargy, interest, motivation, etc. "but it's still not where I wish it was." She still struggling, with desire to isolate herself. Cognitively intact and compliant with treatment. Denies suicidal and homicidal ideation.

Treatment: Combination of education, support, and coping skills training with continuing clinical re-assessment

Plan

Follow up with Ms. Richardson in about 2-3 weeks and return to me in a month. Continue current treatment plan and notify me of any significant change in condition. Get out more and use distraction techniques and keep mentally occupied to avoid excessive rumination. Develop an action plan. Focus on thoughts, feelings, and behavior. Wellbutrin XL is increased to bid and Effexor XR stays same. Telephone with need.

New Prescriptions/Refills:

EFFEXOR XR 75 MG CP24 (VENLAFAXINE HCL) 1 QD #30 x 0 : Charles David Tollison PhD
(01/06/2009)

WELLBUTRIN XL 150 MG TB24 (BUPROPION HCL) 1 QD #60 x 0 : Charles David Tollison PhD
(01/06/2009)

Current Medication List:

ROXICODONE 15 MG TABS (OXYCODONE HCL) 1po q4-6 h prn pain max 4 per day

NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po bid

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm

AMBIEN CR 12.5 MG TBCR (ZOLPIDEM TARTRATE) 1 po qhs

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 HS

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours.

EFFEXOR XR 75 MG CP24 (VENLAFAXINE HCL) 1 QD

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July 15, 2009

Page 2

Chart Document

MS KELLIE BURNETTE

Female DOB: ~~XXXXXX~~

18381

Home: ~~XXXXXXXXXX~~

Ins: VOC REHAB

WELLBUTRIN XL 150 MG TB24 (BUPROPION HCL) 1 QD
ADDERALL 20 MG TABS (AMPHETAMINE-DEXTROAMPHETAMINE) bid - Dr Giambalvo
ZYRTEC 10 MG TABS (CETIRIZINE HCL) 1 po qhs other MD

New Orders:

OP Psychotherapy 45 - 50 min. [90806]

Return for follow-up 1 month [xxxxx]

Signed by Charles David Tollison PhD on 01/06/2009 at 3:48 PM

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1330 Boiling Springs Rd Suite 2700 Spartanburg, SC 29303
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June 12, 2009

Page 1

Chart Document

MS KELLIE BURNETTE

Female DOB

18381

Home

Ins VOC REHAB

12/08/2008 - Office Visit: Psych F/U

Provider: Charles David Tollison PhD

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

This document contains confidential information

Age: 29 Years Old

Gender: Female

Employment Status: Last worked 3-08, medically retired police officer City Greenville

Prior Mental Health: Diagnosed ADHD in 1999 while attending college. Initial evaluation by Dr. Tollison on 6-23-08.

Education Level: Graduated high school + few college courses

History of Present Illness: Referred Dr. Satterthwaite. August 2003 work-related MVA, full spine, facial trauma. In June 2007 reinjury. Depression secondary to pain and lifestyle change, feelings of loss, feelings of worthlessness, sadness/discouragement, irritability. Dx: Adj D/O Mixed, & 307.89. WC approved.

Psychological Testing P-3 8-27-07, Anxiety Aver, Dep top 27, Soma 34%. P-3 on 6-23-08 Dep top 12, Anxiety 22, and Soma 29th percentile.

Progress Note

Clinical Status: Cervical spine surgery end of October, feels she is recovering and feels benefit from surgery. Mood "hasn't be very good, hard to get out of bed, can't get motivated, I just thought I would be better by now and time is passing and I keep hurting." She continues finding it difficult to open and express true feelings, and I think she does better with Ms Richardson than with me. "I hate myself for getting so fat, I disgust myself and I have absolutely no sex drive" and she describes nonorgasmia. Cognitively intact and compliant with treatment. Denies suicidal and homicidal ideation.

Treatment: Combination of education, support, and coping skills training with continuing clinical re-assessment

Assessment

Status of Existing Problems:

Assessed ADJUSTMENT DISORDER/MIXED as unchanged - Charles David Tollison PhD

Assessed PAIN DISORDER (PSYCH/MEDICAL) as unchanged - Charles David Tollison PhD

Plan

Continue current treatment plan and notify me of any significant change in condition. Urged to rehearse daily cognitive coping skills with restructuring of perceptions in combination with behavioral redirection and distraction techniques for therapeutic benefit. Effexor XR reduced to 75 mg one qd and addition of Wellbutin XL 150 qd. Telephone iwht need and return to me in one month.

New Prescriptions/Refills:

WELLBUTRIN XL 150 MG TB24 (BUPROPION HCL) 1 QD #30 x 0 : Charles David Tollison PhD (12/08/2008)

EFFEXOR XR 75 MG CP24 (VENLAFAXINE HCL) 1 QD #30 x 0 : Charles David Tollison PhD (12/08/2008)

Current Medication List:

ROXICODONE 15 MG TABS (OXYCODONE HCL) 1po q4-6 h prn pain max 4 per day

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm

AMBIEN CR 12.5 MG TBCR (ZOLPIDEM TARTRATE) 1 po qhs

0186

Carolinas Center for Advanced Management of Pain

1330 Boiling Springs Rd Suite 2700 Spartanburg, SC 29303
8645830053 Fax: 8645830390

June 12, 2009
Page 2
Chart Document

MS KELLIE BURNETTE

Female DOB ~~01/01/1981~~ 18381

Home ~~01/01/1981~~

Ins VOC REHAB

CELEBREX 200 MG CAPS (CELECOXIB) take one PO BID hold due to ACF
FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 HS
LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours.
EFFEXOR XR 150 MG CP24 (VENLAFAXINE HCL) 1 po daily (stopped 12//8/08)
NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po bid
ADDERALL 20 MG TABS (AMPHETAMINE-DEXTROAMPHETAMINE) bid - Dr Giambalvo
ZYRTEC 10 MG TABS (CETIRIZINE HCL) 1 po qhs other MD
EFFEXOR XR 75 MG CP24 (VENLAFAXINE HCL) 1 QD
WELLBUTRIN XL 150 MG TB24 (BUPROPION HCL) 1 QD

New Orders:

OP Psychotherapy 45 - 50 min. [90806]
Return for follow-up 1 month [xxxxx]

Signed by Charles David Tollison PhD on 12/08/2008 at 1:54 PM

MS KELLIE BURNETTE Home
Female DOB 1888 Ins VOC REHAB

11/12/2008 - Office Visit: Psych F/U
Provider: Lisa Richardson LISW-CP
Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office
This document contains confidential information

Age: 29 Years Old
Gender: Female
Employment Status: Last worked 3-08, medically retired police officer City Greenville
Prior Mental Health: Diagnosed ADHD in 1999 while attending college. Initial evaluation by Dr. Tollison on 6-23-08.
Education Level: Graduated high school + few college courses
History of Present Illness: Referred Dr. Satterthwaite. August 2003 work-related MVA, full spine, facial trauma. In June 2007 reinjury. Depression secondary to pain and lifestyle change, feelings of loss, feelings of worthlessness, sadness/discouragement, irritability. Dx: Adj D/O Mixed, & 307.89. WC approved.
Psychological Testing P-3 8-27-07, Anxiety Aver, Dep top 27, Soma 34%. P-3 on 6-23-08 Dep top 12, Anxiety 22, and Soma 29th percentile.

Progress Note

Clinical Status: Pt's mood is down. She is feeling frustrated due to increase limitations due to having cervical surgery a few weeks ago. She is having more pain and unable to lift more than five pounds or move her head up and down. She has been use to a fast pace job as a person in law enforcement and finds her limitations extremely frustrating. She is using deep breathing and watching tv and reading right now. She is attempting to keep in touch with her friends in law enforcement help boost her mood. She is encouraged to share her feelings of recent stressors through active listening, positive regard, and questioning. Discuss the importance of finding some meaning in life through volunteer or some activity later on that help her restlessness.

Treatment: combination of:
supportive therapy
cognitive-behavioral therapy

Assessment

Status of Existing Problems:

Assessed ADJUSTMENT DISORDER/MIXED as unchanged - Lisa Richardson LISW-CP

Plan

Pt to use relaxation techniques, distraction, and increased social contact to boost mood. Follow-up with Dr. Tollison Ph.D in a couple of weeks.

Current Medication List:

ROXICODONE 15 MG TABS (OXYCODONE HCL) 1po q4-6 h prn pain max 4 per day
BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm
AMBIEN CR 12.5 MG TBCR (ZOLPIDEM TARTRATE) 1 po qhs
CELEBREX 200 MG CAPS (CELECOXIB) take one PO BID
FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 HS
LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours.
EFFEXOR XR 150 MG CP24 (VENLAFAXINE HCL) 1 po daily
NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po bid

Carolinas Center for Advanced Management of Pain

1330 Boiling Springs Rd Suite 2700 Spartanburg, SC 29303

8645830053 Fax: 8645830390

June 12, 2009

Page 2

Chart Document

MS KELLIE BURNETTE

Female ~~DOB: 01/01/1968~~

18381

Home ~~467-7455~~

Ins VOGREHAB

ADDERALL 20 MG TABS (AMPHETAMINE-DEXTROAMPHETAMINE) bid - Dr Giambalvo
Zyrtec 10 MG TABS (CETIRIZINE HCL) 1 po qhs other MD

New Orders:

OP Psychotherapy 20 - 30 min. [90804]

Signed by Lisa Richardson LISW-CP on 11/12/2008 at 2:55 PM

Carolinas Center for Advanced Management of Pain

1330 Boiling Springs Rd Suite 2700 Spartanburg, SC 29303

8645830053 Fax: 8645830390

June 12, 2009

Page 1

Chart Document

MS KELLIE BURNETTE

Female DOB

1838

Home

Ins: VOC REHAB

10/09/2008 - Office Visit: Psych F/U

Provider: Charles David Tollison PhD

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

This document contains confidential information

Age: 29 Years Old

Gender: Female

Employment Status: Last worked 3-08, medically retired police officer City Greenville

Prior Mental Health: Diagnosed ADHD in 1999 while attending college. Initial evaluation by Dr. Tollison on 6-23-08.

Education Level: Graduated high school + few college courses

History of Present Illness: Referred Dr. Satterthwaite. August 2003 work-related MVA, full spine, facial trauma. In June 2007 reinjury. Depression secondary to pain and lifestyle change, feelings of loss, feelings of worthlessness, sadness/discouragement, irritability. Dx: Adj D/O Mixed, & 307.89. WC approved.

Psychological Testing P-3 8-27-07, Anxiety Aver, Dep top 27, Soma 34%. P-3 on 6-23-08 Dep top 12, Anxiety 22, and Soma 29th percentile.

Progress Note

Clinical Status: Pristiq and Lexapro both poorly tolerated and now taking Effexor XR and tolerating without any problems. Her basic personality is reserved and she has trouble opening up and talking about thoughts and feelings but she feels she is connecting and feeling comfortable and she is opening up more and more. Still not getting out of house as much as I wish, more than she was but still not enough, and she encouraged to use distraction techniques therapeutically. Some reduction in pain with recent medication change and, of course, her pain intensity drives her reactive psychological symptoms.

Treatment: Combination of education, support, and coping skills training with continuing clinical re-assessment

Assessment

Status of Existing Problems:

Assessed ADJUSTMENT DISORDER/MIXED as unchanged - Charles David Tollison PhD

Assessed PAIN DISORDER (PSYCH/MEDICAL) as unchanged - Charles David Tollison PhD

Plan

Follow up regularly with Ms. Richardson and return to me in two months, sooner if need. Stay on Effexor XR. Continue instruction in cognitive behavioral restructuring techniques with PRM. Telephone with need.

Current Medication List:

ROXICODONE 15 MG TABS (OXYCODONE HCL) 1po q4-6 h prn pain max 4 per day

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm

AMBIEN CR 12.5 MG TBCR (ZOLPIDEM TARTRATE) 1 po qhs

CELEBREX 200 MG CAPS (CELECOXIB) take one PO BID

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 HS

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours.

EFFEXOR XR 150 MG CP24 (VENLAFAXINE HCL) 1 po daily

NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po bid

ADDERALL 20 MG TABS (AMPHETAMINE-DEXTROAMPHETAMINE) bid - Dr Giambalvo

ZYRTEC 10 MG TABS (CETIRIZINE HCL) 1 po qhs other MD

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1330 Boiling Springs Rd Suite 2700 Spartanburg, SC 29303

8645830053 Fax: 8645830390

June 12, 2009

Page 1

Chart Document

MS KELLIE BURNETTE

Female DOB: 03-07-1979

18381

Home: 864-222-1333

Ins: VOC REHAB

10/02/2008 - Office Visit: Psych F/U

Provider: Lisa Richardson LISW-CP

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

This document contains confidential information

Age: 29 Years Old

Gender: Female

Employment Status: Last worked 3-08, medically retired police officer City Greenville

Prior Mental Health: Diagnosed ADHD in 1999 while attending college. Initial evaluation by Dr. Tollison on 6-23-08.

Education Level: Graduated high school + few college courses

History of Present Illness: Referred Dr. Satterthwaite. August 2003 work-related MVA, full spine, facial trauma. In June 2007 reinjury. Depression secondary to pain and lifestyle change, feelings of loss, feelings of worthlessness, sadness/discouragement, irritability. Dx: Adj D/O Mixed, & 307.89. WC approved.

Psychological Testing P-3 8-27-07, Anxiety Aver, Dep top 27, Soma 34%. P-3 on 6-23-08 Dep top 12, Anxiety 22, and Soma 29th percentile.

Progress Note

Clinical Status: Pt's mood is still down some, but she is getting benefit from effexor. She reports having increased pain last week, and her pain medication was not working. She states Dr. Satterthwaite changed it. She did read over the written material given to her at last session, and she used the deep breathing technique. She found it helped some, and she is working on pacing herself, and identifying some distraction activities she can do. She verbalizes some sadness over her losses since having the accident at work. She is not able to work at a job she loved and she also worked a second job to be able to have more income that she cannot do as well now. She misses her friends and social contact she had at work as well as her ability to do simple chores at her home. Encouraged sharing of feelings through active listening, positive regard, and questioning.

Treatment:

supportive therapy

insight and educational therapy

Assessment

Status of Existing Problems:

Assessed PAIN DISORDER (PSYCH/MEDICAL) as unchanged - Lisa Richardson LISW-CP

Assessed ADJUSTMENT DISORDER/MIXED as unchanged - Lisa Richardson LISW-CP

Plan

Pt to use relaxation techniques and distraction to help boost mood and manage pain. Follow-up with Dr. Tollison Ph.D for further treatment recommendations.

Current Medication List:

ROXICODONE 15 MG TABS (OXYCODONE HCL) 1po q4-6 h prn pain max 4 per day

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm

AMBIEN CR 12.5 MG TBCR (ZOLPIDEM TARTRATE) 1 po qhs

CELEBREX 200 MG CAPS (CELECOXIB) take one PO BID

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 HS

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours.

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June 12, 2009

Page 1

Chart Document

MS KELLIE BURNETTE

Female DOB: [REDACTED]

18381

Home: [REDACTED]
Ins: VOC REHAB

09/18/2008 - Office Visit: Psych F/U

Provider: Lisa Richardson LISW-CP

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

This document contains confidential information

Age: 29 Years Old

Gender: Female

Employment Status: Last worked 3-08, medically retired police officer City Greenville

Prior Mental Health: Diagnosed ADHD in 1999 while attending college. Initial evaluation by Dr. Tollison on 6-23-08.

Education Level: Graduated high school + few college courses

History of Present Illness: Referred Dr. Satterthwaite. August 2003 work-related MVA, full spine, facial trauma. In June 2007 reinjury. Depression secondary to pain and lifestyle change, feelings of loss, feelings of worthlessness, sadness/discouragement, irritability. Dx: Adj D/O Mixed, & 307.89. WC approved.

Psychological Testing P-3 8-27-07, Anxiety Aver, Dep top 27, Soma 34%. P-3 on 6-23-08 Dep top 12, Anxiety 22, and Soma 29th percentile.

Progress Note

Clinical Status: Pt is referred by Dr Tollison Ph.D for treatment to address depression secondary to pain and lifestyle changes. She was started on Pristiq, and it is keeping her awake at night. She is feeling frustrated and down over her inability to work at a job she loved with the police department. She was use to an active job and busy lifestyle. She would work in yard all day or on house projects. She states folding clothes will now increase her pain into the next day. She is struggling with how to accept this and deal with it. She has a difficult time talking about her feelings, and she is use to brushing them aside so counseling is something new to her. Teach patient the benefits of the relaxation response in reducing stress and instruct her in a deep breathing techniques.

Treatment: combination of:

supportive therapy

insight and educational therapy

Assessment

Status of Existing Problems:

Assessed ADJUSTMENT DISORDER/MIXED as unchanged - Lisa Richardson LISW-CP

Assessed PAIN DISORDER (PSYCH/MEDICAL) as unchanged - Lisa Richardson LISW-CP

Plan

Pt to practice deep breathing daily, and read over written material on coping with pain. Return for follow-up appointments already scheduled by Dr. Tollison Ph.D.

Current Medication List:

LORTAB 10 10-500 MG TABS (HYDROCODONE-ACETAMINOPHEN) 1 po qid prn pain max of 4 per day *** 30 DAY SUPPLY *** NO EARLY REFILLS

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm

AMBIEN CR 12.5 MG TBCR (ZOLPIDEM TARTRATE) 1 po qhs

CELEBREX 200 MG CAPS (CELECOXIB) take one PO BID

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 HS

CYMBALTA 30 MG CPEP (DULOXETINE HCL) 4 po qhs

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June 12, 2009

Page 2

Chart Document

MS KELLIE BURNETTE

Female DOB ~~03-07-1988~~

18381

Home ~~1000000000~~

Ins VOC REHAB

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours.

ADDERALL 20 MG TABS (AMPHETAMINE-DEXTROAMPHETAMINE) bid - Dr Giambalvo

ZYRTEC 10 MG TABS (CETIRIZINE HCL) 1 po qhs other MD

New Orders:

OP Psychotherapy 45 - 50 min. [90806]

Signed by Lisa Richardson LISW-CP on 09/18/2008 at 4:59 PM

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1330 Boiling Springs Rd Suite 2700 Spartanburg, SC 29303
8645830053 Fax: 8645830390

June 12, 2009

Page 1

Chart Document

MS KELLIE BURNETTE

Female DOB

18381

Home

Ins: VOC REHAB

09/12/2008 - Office Visit: Psych F/U

Provider: Charles David Tollison PhD

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

This document contains confidential information

Age: 29 Years Old

Gender: Female

Employment Status: Last worked 3-08, medically retired police officer City Greenville

Prior Mental Health: Diagnosed ADHD in 1999 while attending college. Initial evaluation by Dr. Tollison on 6-23-08.

Education Level: Graduated high school + few college courses

History of Present Illness: Referred Dr. Satterthwaite. August 2003 work-related MVA, full spine, facial trauma. In June 2007 reinjury. Depression secondary to pain and lifestyle change, feelings of loss, feelings of worthlessness, sadness/discouragement, irritability. Dx: Adj D/O Mixed, & 307.89. WC approved.

Psychological Testing P-3 8-27-07, Anxiety Aver, Dep top 27, Soma 34%. P-3 on 6-23-08 Dep top 12, Anxiety 22, and Soma 29th percentile.

Progress Note

Clinical Status: Initially evaluation 6-23-08 and she returns today to begin treatment that is authorized by workers' comp. We discuss and compare P-3 test results that confirm deterioration in psychological functioning from August 2007 compared to June 2008 "and that's how it feels, like I'm getting worse." Some nightmares, and she attributes part of this to 7 years of being a cop and partly due to pain and lifestyle change, and she wonders if she has some PTSD symptoms. She feels the Cymbalta "makes me tired, drains my motivation." Denies suicidal ideation.

Treatment: cognitive behavioral restructuring with both supportive and directive psychotherapy

Assessment

New Problems:

PAIN DISORDER (PSYCH/MEDICAL) (ICD-307.89)

ADJUSTMENT DISORDER/MIXED (ICD-309.28)

Plan

She wants to stop the Cymbalta and try something new.....took Effexor XR in past with some benefit, so will try Pristiq. Will schedule with Lisa Richardson, LISW-CP our counselor here for 2-3 visits, then return to me in one month for follow up assessment. She will telephone with need. Treatment goals include reducing intensity and scope of psychological symptoms associated with chronic pain.

Current Medication List:

LORTAB 10 10-500 MG TABS (HYDROCODONE-ACETAMINOPHEN) 1 po qid prn pain max of 4 per day *** 30 DAY SUPPLY *** NO EARLY REFILLS

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm

AMBIEN CR 12.5 MG TBCR (ZOLPIDEM TARTRATE) 1 po qhs

CELEBREX 200 MG CAPS (CELECOXIB) take one PO BID

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 HS

CYMBALTA 30 MG CPEP (DULOXETINE HCL) 4 po qhs

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours.

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8645830053 Fax: 8645830390

June 12, 2009

Page 2

Chart Document

MS KELLIE BURNETTE

Female DOB

18381

Home ~~Room~~

Ins VOC REHAB

ADDERALL 20 MG TABS (AMPHETAMINE-DEXTROAMPHETAMINE) bid - Dr Giambalvo
ZYRTEC 10 MG TABS (CETIRIZINE HCL) 1 po qhs other MD

New Orders:

OP Psychotherapy 45 - 50 min. [90806]

Return for follow-up 1 month [xxxxx]

Signed by Charles David Tollison PhD on 09/12/2008 at 12:45 PM

Carolinas Center for Advanced Management of Pain1330 Bolling Springs Rd Suite 2700 Spartanburg, SC 29303
8645830053 Fax: 8645830390

July 15, 2009

Page 1

Chart Document

MS KELLIE BURNETTEFemale DOB: ~~03-14-1979~~

18381

Home: ~~803-244-3000~~

Ins: VOC REHAB

07/02/2009 - Office Visit: Psych F/U

Provider: Lisa Richardson LISW-CP

Location of Care: Carolinas Center for Advanced Mgmt of Pain - Greenville Office

This document contains confidential information

Age: 29 Years Old

Gender: Female

Employment Status: Last worked 3-08, medically retired police officer City Greenville

Prior Mental Health: Diagnosed ADHD in 1999 while attending college. Initial evaluation by Dr. Tollison on 6-23-08.

Education Level: Graduated high school + few college courses

History of Present Illness: Referred Dr. Satterthwaite, August 2003 work-related MVA, full spine, facial trauma. In June 2007 reinjury. Depression secondary to pain and lifestyle change, feelings of loss, feelings of worthlessness, sadness/discouragement, irritability. Dx: Adj D/O Mixed, & 307.89. WC approved.

Psychological Testing P-3 8-27-07, Anxiety Aver, Dep top 27, Soma 34%. P-3 on 6-23-08 Dep top 12, Anxiety 22, and Soma 29th percentile. P-3 on 2-4-09, Dep 9th, Anxiety 18th, Soma 19th.

Progress Note

Clinical Status: Pt's mood is still up and down. She continues to struggle with the pain daily, and her limitations. She has trouble with concentration and trouble sleeping. She shares it is difficult to be around others and her partner does not always understand. She brings her into session to discuss pain in general and some ways to help her cope as well as do and don'ts to help the patient.

Treatment:supportive therapy
insight and educational therapy**Assessment****Status of Existing Problems:**

Assessed ADJUSTMENT DISORDER/MIXED as unchanged - Lisa Richardson LISW-CP

Assessed PAIN DISORDER (PSYCH/MEDICAL) as unchanged - Lisa Richardson LISW-CP

Plan

Pt to focus on use improved sleep schedule and distraction activities daily to reduce anxiety and boost mood.

Current Medication List:

ROXICODONE 15 MG TABS (OXYCODONE HCL) 1po q4-6 h prn pain max 4 per day

NEURONTIN 300 MG CAPS (GABAPENTIN) 1 po bid

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 2 po hs

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours.

AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) 1 qhs

PROZAC 20 MG CAPS (FLUOXETINE HCL) one bid

ADDERALL 20 MG TABS (AMPHETAMINE-DEXTROAMPHETAMINE) bld - Dr Giambalvo

ZYRTEC 10 MG TABS (CETIRIZINE HCL) 1 po qhs other MD

Carolinas Center for Advanced Management of Pain

1330 Boiling Springs Rd Suite 2700 Spartanburg, SC 29303
8645830053 Fax: 8645830390

July 15, 2009

Page 2

Chart Document

MS KELLIE BURNETTE

Female DOB: ~~01/15/1978~~

18381

Home: ~~864-583-0053~~

Ins: VOC REHAB

New Orders:

OP Psychotherapy 45 - 50 min. [90806]

Signed by Lisa Richardson LISW-CP on 07/02/2009 at 4:47 PM

Carolinas Center for Advanced Management of Pain

1330 Boiling Springs Rd Suite 2700 Spartanburg, SC 29303
8645830053 Fax: 8645830390

June 12, 2009

Page 2

Chart Document

MS KELLIE BURNETTE

Female DOB: ~~18381~~

18381

Home: ~~864-583-0053~~

Ins: VOC REHAB

Concentration/Memory: Cognitively intact and clear but she offers that she has a history of ADHD and this can sometimes be problematic and she takes Adderall "only as needed."

Suicidal Ideation/Intent Denies

Patient describes symptoms of: Sadness, Dysphoria, Anhedonia, Reduced pleasure in living, Guilt, Reduced/Lack of optimism, Discouragement, Reduced feelings of self esteem and self worth, Reduced feelings of self confidence, Irritability/Frustration, Helplessness, Feeling overwhelmed

Able to provide basic information on self? Yes

Oriented to time, person, place, and situation? Yes

Alert and responsive to inquiry? Yes

Associations in fact? Yes

Fluid verbalizations? Yes

Recite days of week in reverse order? Yes

Recite months of year in reverse order? Yes

Mentally calculate equation 100-7? Yes

Hallucinations/delusions/psychotic symptoms? No

Estimated Intelligence: average

Vocational History: Was employed as Police Officer for City of Greenville (<7 years) and is medically retired since April 2008 and last worked March 2007 on light duty.

Social History:

Age: 28 Years Old

DOB: ~~18381~~

Marital Status: Single

Children: no

Education: graduated high school and few colleges courses

Living Arrangement: roommate

Behavioral Observations

Height: 70

Weight: 235 lbs

Grooming/Hygiene: Appropriate

Eye Contact: Appropriate

Sit/Rise: Independent

Ambulation: Independent

Unusual Mannerisms: None Observed

Psychomotor Agitation/Retardation Within Normal Limits

Affect: Blunted

Mood: Anxious

Facial Expression: Within Normal Limits

Cooperative: Yes

Activities of Daily Living

License/Drive: Yes

Cook: Limited

Clean: Limited

Laundry: Limited

Shop/Errands: Limited

Personal Hygiene: Appropriate

Increased pain with physical activity so she paces herself and takes rest periods. She did not have a roommate prior to her injury but was forced to take this action due to finances once she no longer able to

MS KELLIE BURNETTE

Female DOB

18381

Home

(ins. VOC REHAB)

work. Roommate having to shoulder a heavier load than usual.

Social Functioning

Friends: reviewed - no changes required

Reduced interest in people and activities but she does have a significant other and she occasionally will go to a movie or restaurant. She does not attend events and functions as before "because I hurt all the time" and she spends much of her time lying down or resting.

Assessment

Two work injuries in August 2003 when she T-boned by driver going over 60 mph, and a June 2007 exacerbation of pain secondary to being partially in a car when suspect pulled away. Psychological symptoms secondary to pain intensity, duration, and lifestyle change. Struggling in attempts to accept her functional limitations and to adjust to the reality of pain and impairment.

It is my opinion that Ms. Burnette's work injury of June 2007 triggered the onset of adjustment challenge and development of psychological symptoms of anxiety and depression. The patient denies psychological symptoms prior to June 2007. Consequently, it is my opinion that her current psychological symptoms are causally-related to her work injury of June 2007. It is further my opinion that this patient is in need of psychological treatment targeting a reduction of symptoms secondary to pain and lifestyle change. Finally, it is my opinion that her diagnosed Adjustment Disorder with Depressive and Anxiety Features impairs her productively function, particularly her ability to maintain concentration, persistence, and pace. This impairment is obviously compounded by pain levels referenced by Dr. Satterthwaite.

Axis I - Adjustment Disorder with Mixed Depressive and Anxiety Features

Axis I - Somatoform Pain Disorder (307.89)

Axis II - deferred

Axis III - chronic spinal pain, secondary to trauma

Axis IV - occupational, economic, legal, social, health

Axis V - GAF 60

Plan

It is recommended that Ms. Burnette be involved in psychological treatment for symptoms associated with chronic pain. It is recommended that she continue psychotropic medications for her symptoms.

Updated Med List:

LORTAB 10 10-500 MG TABS (HYDROCODONE-ACETAMINOPHEN) 1 po qid prn pain max of 4 per day *** 30 DAY SUPPLY *** NO EARLY REFILLS

BACLOFEN 10 MG TABS (BACLOFEN) 1 po tid muscle spasm

AMBIEN CR 12.5 MG TBCR (ZOLPIDEM TARTRATE) 1 po qhs

CELEBREX 200 MG CAPS (CELECOXIB) take one PO BID

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) 1 HS

CYMBALTA 30 MG CPEP (DULOXETINE HCL) 4 po qhs

LIDODERM 5 % PTCH (LIDOCAINE) may place up to three patches over the painful area. leave on for 12 hours and remove for 12 hours.

ADDERALL 20 MG TABS (AMPHETAMINE-DEXTROAMPHETAMINE) bid - Dr Giambalvo

ZYRTEC 10 MG TABS (CETIRIZINE HCL) 1 po qhs other MD

Carolinas Center for Advanced Management of Pain

1330 Boiling Springs Rd Suite 2700 Spartanburg, SC 29303
8645830053 Fax: 8645830390

June 12, 2009
Page 4
Chart Document

MS KELLIE BURNETTE

Female DOB: 06/06/1978

18381

Home: 864-583-0053

Ins: VOC REHAB

Signed by Charles David Tollison PhD on 06/23/2008 at 4:27 PM

Kellie Burnette

P-3 ®

Pain Patient Profile

Interpretive Report

by

C. David Tollison

and

Jerry C. Langley

ID Number 18381

Female

Age 28

6/23/2008 1:10:39 PM

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[1.0 / 5.07 / 1.0]

INTRODUCTION

Pain resulting from physical injury, illness, or disease is a multidimensional phenomenon composed of physiologic, psychological, and other influencing variables. Factors such as depression, anxiety, and excessive somatic thought are specifically identified in the medical literature as actively contributing to the etiology, maintenance, and intensity of pain. When these factors are appropriately identified and clinically addressed, treatment outcomes resulting from nonsurgical, surgical, and rehabilitative interventions are significantly improved.

The P-3 is designed to identify pain patients who are experiencing emotional distress that may be affecting their symptoms and their response to treatment. The P-3 report also offers recommendations regarding the need for mental health treatment based on the patient's item responses. Clinicians should monitor changes in pain and psychological symptoms and reassess as clinically appropriate. The P-3 may be readministered periodically to measure treatment progress.

The profile, interpretations, and recommendations in this report are all based on pain patients as the primary reference group. However, when reviewing an individual's results, it is important to keep in mind that the average pain patient is significantly more depressed, anxious, and preoccupied with somatic thoughts than the average community subject.

The information in the P-3 report must be used in conjunction with professional judgment, taking into account the total context of the instrument's administration and any other pertinent information concerning the individual. The main body of the report should be considered a professional-to-professional consultation and should be used solely by the clinician. These results should be considered confidential. The Patient Summary can be shared with the patient if the clinician decides it is appropriate.

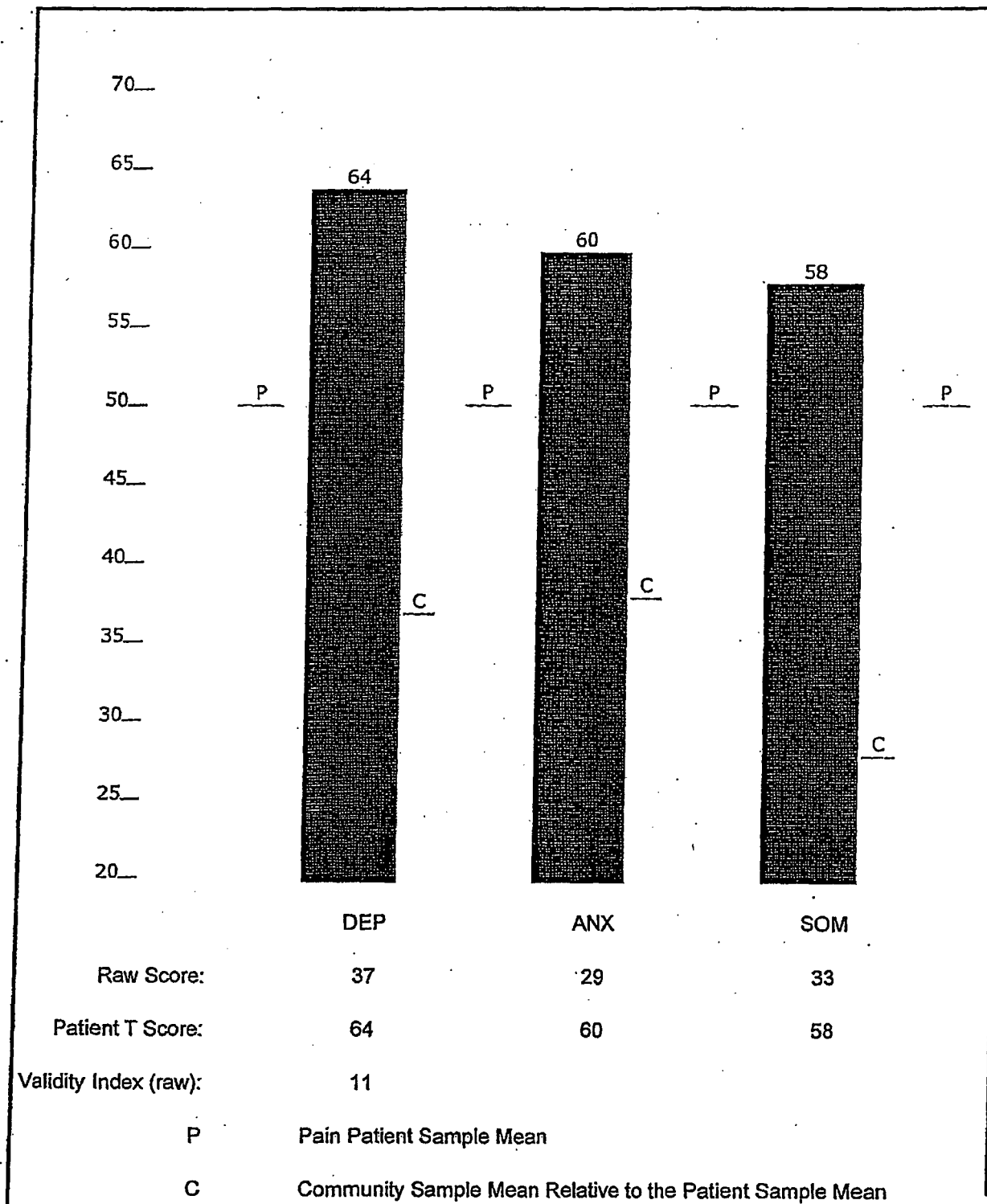
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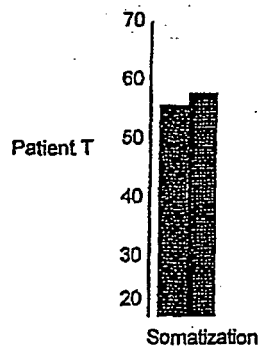
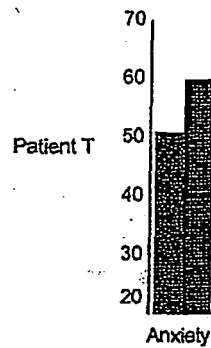
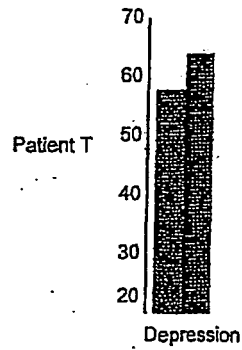
The patient's score on the Validity Index suggests that she was able to read the items and appropriately attended to item content. It appears that she approached the test in an open and honest manner. Her score suggests that her test results can be interpreted with confidence.

RESULTS SUMMARY

The patient's item responses suggest higher-than-average levels of depression, anxiety, and somatization. Her above-average scores reflect symptoms that are likely to interfere with her physical treatment program.

Pain Patient Profile
The Individual Compared to the Patient Sample





CLINICAL INTERPRETATION

Depression

The patient's Depression score (64) is significantly above average for pain patients. Her item responses suggest serious depression. Only 12% of pain patients in the sample scored at this level or higher. The patient's depression is reflected in her endorsement of the most severe responses for the following test items. Although these responses may help the clinician understand the patient's emotional state, caution should be used when interpreting an individual item response because the client may have inadvertently marked the wrong response.

1. I have a lot of trouble with sleep.
6. I wake with pain and feeling tired most mornings.
8. Much of the time I feel useless to myself and others.
11. I am not happy.
22. I now have more trouble making decisions than I used to.
25. Most of the time I feel hopeless that my condition will improve.
38. Recently, it seems like my life is filled with problems.
40. I am almost always sad.
42. My life is in a rut.
43. I am not satisfied with my life at present.

The patient may be feeling worthless, helpless, and hopeless. She may be pessimistic about the future, and she may believe that her condition is permanent. She may be described by others as withdrawn, dependent, listless, and unresponsive. She is probably experiencing sleep and appetite disturbances, chronic lethargy, and fatigue. She may appear to be going through the motions without energy, optimism, motivation, or enthusiasm. Consequently, efforts to involve her in an active and participatory treatment plan for pain management may be unsuccessful. She may be so depressed that she has lost the will or expectation to improve. This can become a self-fulfilling prophecy. Often, patients with this level of affective distress are unable to see any way out of their situation and feel powerless to change their lives for the better. The patient should be thoroughly evaluated for suicidal thoughts and preoccupation with death. Referral to a mental health professional is strongly advised. It is very likely that depression is involved in her overall symptomatology.

Anxiety

The patient's Anxiety T score (60) suggests that she is more anxious than the average pain patient. Of the pain patients sampled, only 22% had an Anxiety T score of 60 or higher. The patient's anxiety is reflected in her endorsement of the most severe responses for the following test items. Although these responses may help the clinician understand the patient's emotional state, caution should be used when interpreting an individual item response because the client may have inadvertently marked the wrong response.

- 2. I often feel so nervous and on edge that I am miserable.
- 16. I feel angry with somebody or something much of the time.
- 20. It seems like I stay upset much of the time.
- 23. It is sometimes impossible to get my mind to relax.
- 26. I frequently say things in anger that I later wish I hadn't.
- 35. I worry over almost everything.
- 36. Sometimes I feel like I am about to lose my mind.

The patient's responses suggest that her anxiety symptoms include feelings of agitation, nervousness, generalized fear, and inner turmoil. She may also be feeling significant levels of anger, and she may find it difficult to control her temper. Autonomic activity may be heightened and may contribute to pain intensity. She may report feeling tense and unable to relax. She probably avoids crowds, social contact, and stressful or demanding situations. She may be described by others as agitated, tense, stressed, impatient, and distracted. Her concentration and attention are probably affected, and she may act impulsively without sufficient thought and deliberation. Efforts to involve her in long-term rehabilitation may be hampered by her emotional symptoms, which occupy much of her attention. The clinician should explore the possibility that sustained muscular contraction or other active autonomic response may be causing or prolonging her pain. The potential exists for her anxiety symptoms to interfere with physical treatment designed to reduce pain.

Somatization

The patient's Somatization T score (58) suggests that she has more physical problems, pain, and health-related concerns than the average pain patient. Of the pain patients sampled, only 29% had a T score of 58 or higher on the Somatization scale. The patient's somatization is reflected in her endorsement of the most severe responses for the following test items. Although these responses may help the clinician understand the patient's emotional state, caution should be used when interpreting an individual item response because the client may have inadvertently marked the wrong response.

- 4. I can no longer do my work and chores around the house.
- 5. My life is spent in pain.
- 10. I have some serious health problems.
- 13. I feel weak and tired much of the time.
- 21. I stay tired most of the time.
- 24. My neck and shoulders hurt.
- 29. The muscles in my body feel painfully tight.
- 30. My neck or back seems to hurt most of the time.
- 34. I believe that once you have a bad back you will probably always have trouble with it.

These somatic issues trouble her and are adversely affecting her life. She may exhibit excessive concern about bodily functions, and her physical symptoms may be multiple and magnified. Pain migration may be exhibited, with pain complaints shifting from one anatomic part to another. Symptom substitution may also be demonstrated, whereby successful treatment of one problem is followed by development of new complaints.

This patient's Somatization score suggests that pain and health-related concerns occupy a disproportionate amount of her attention. Her somatic symptoms are upsetting, frustrating, distracting, unwanted, and poorly tolerated. She may be described by others as over-reactive, self-centered, demanding, pessimistic, complaining, whining, and bitter. She may challenge health professionals with demands for pain relief, yet she may exhibit a defeatist and noncompliant attitude toward appropriate treatment plans.

TREATMENT RECOMMENDATION

Because of the magnitude of the patient's depression and associated emotional distress, mental health consultation/treatment is strongly recommended before or as an adjunct to physical treatment for pain reduction.

ITEM RESPONSES

1: 3	2: 3	3: 1	4: 3	5: 3	6: 3	7: 3	8: 3	9: 2	10: 3
11: 3	12: 2	13: 3	14: 2	15: 1	16: 3	17: 2	18: 3	19: 1	20: 3
21: 3	22: 3	23: 3	24: 3	25: 3	26: 3	27: 2	28: 2	29: 3	30: 3
31: 2	32: 2	33: 2	34: 3	35: 3	36: 3	37: 1	38: 3	39: 1	40: 3
41: 1	42: 3	43: 3	44: 2						

End of Clinical Report

PATIENT SUMMARY

The P-3 was developed to assist health care professionals who work with patients who are experiencing pain and physical problems. Information from the P-3 can help you and your health care provider determine if emotional factors are influencing your symptoms or your treatment progress.

The P-3 provides information about three factors that are important to your health: depression, anxiety, and somatization. These terms are defined below.

Depression: feeling down, having low energy, and feeling tired, blue, and discouraged

Anxiety: feeling nervous, on edge, and irritable

Somatization: being overly concerned with and thinking too much about physical problems

Patients who are in pain usually experience more emotional distress than people who are not in pain. Depression, anxiety, and somatization are as much a part of pain as the physical aspects, and these feelings can make coping with pain more difficult.

The following interpretation is based on your responses to the P-3 items. You are encouraged to discuss your P-3 results with your health care provider.

Your Depression score indicates that you may be struggling with feelings of despair and that you may feel overwhelmed by your pain and physical problems. Your responses suggest that you may be feeling chronically tired and are struggling against the urge to give up hope of getting better. You should discuss these feelings with your health care provider so he or she can help you find ways to cope with them.

Your Anxiety score suggests that you may be somewhat anxious. You may feel tense and unable to relax. You may also feel that your mind is racing all the time. You may feel stressed and unable to think and concentrate as well as you would like. Your muscles may be tense, and this may be contributing to your pain. Pain can result in a variety of symptoms and feelings that are uncomfortable and unwanted. Discussing your feelings with your health care provider can be helpful. He or she can help you find ways to relax and cope with the stress caused by your symptoms.

Your Somatization score suggests that pain and health problems are having a negative effect on your life. You probably have multiple pain- and health-related problems that occupy a good deal of your attention and concentration. Your responses also indicate that you may have trouble completing tasks because you are distracted by your pain. You should discuss your concerns with your health care provider. He or she may be able to help you find ways to cope with the intensity of your symptoms and physical problems.

The treatment of pain sometimes requires a team effort from health care specialists. It is in your best interest to explore a combination of physical and psychological treatment options under the guidance and direction of your health care professional.

End of Patient Summary

End of Report

Kellie Burnette

P-3 ®

Pain Patient Profile

Interpretive Report

by

C. David Tollison

and

Jerry C. Langley

ID Number 18381

Female

Age 27

8/28/2007 11:17:20 AM

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INTRODUCTION

Pain resulting from physical injury, illness, or disease is a multidimensional phenomenon composed of physiologic, psychological, and other influencing variables. Factors such as depression, anxiety, and excessive somatic thought are specifically identified in the medical literature as actively contributing to the etiology, maintenance, and intensity of pain. When these factors are appropriately identified and clinically addressed, treatment outcomes resulting from nonsurgical, surgical, and rehabilitative interventions are significantly improved.

The P-3 is designed to identify pain patients who are experiencing emotional distress that may be affecting their symptoms and their response to treatment. The P-3 report also offers recommendations regarding the need for mental health treatment based on the patient's item responses. Clinicians should monitor changes in pain and psychological symptoms and reassess as clinically appropriate. The P-3 may be readministered periodically to measure treatment progress.

The profile, interpretations, and recommendations in this report are all based on pain patients as the primary reference group. However, when reviewing an individual's results, it is important to keep in mind that the average pain patient is significantly more depressed, anxious, and preoccupied with somatic thoughts than the average community subject.

The information in the P-3 report must be used in conjunction with professional judgment, taking into account the total context of the instrument's administration and any other pertinent information concerning the individual. The main body of the report should be considered a professional-to-professional consultation and should be used solely by the clinician. These results should be considered confidential. The Patient Summary can be shared with the patient if the clinician decides it is appropriate.

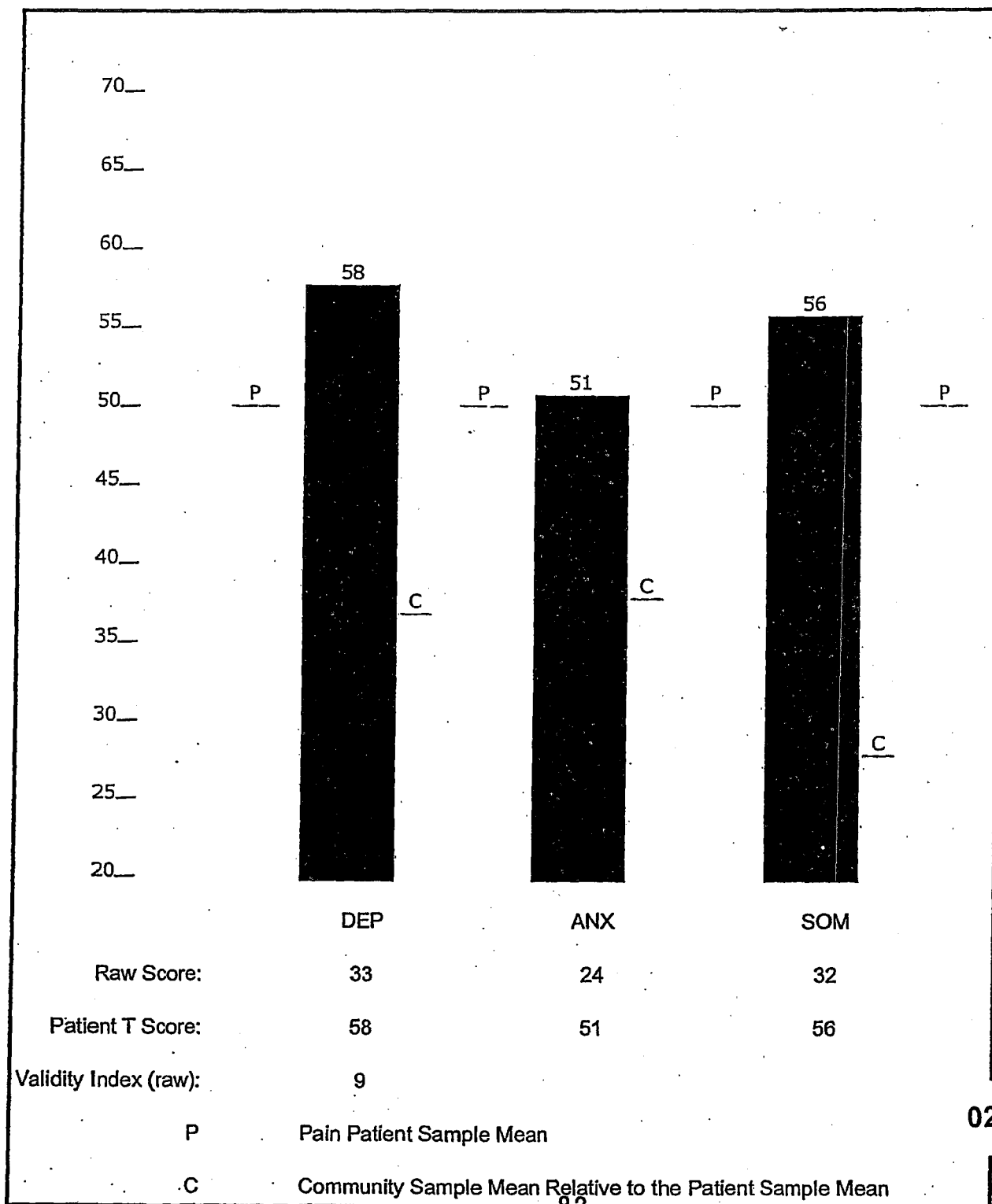
VALIDITY

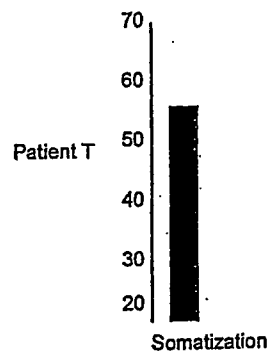
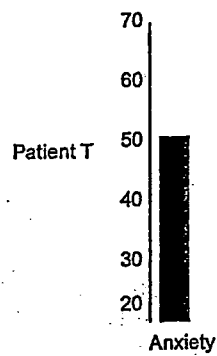
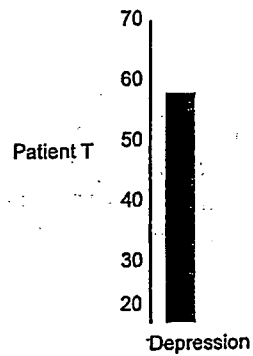
The patient's score on the Validity Index suggests that she was able to read the items and appropriately attended to item content. It appears that she approached the test in an open and honest manner. Her score suggests that her test results can be interpreted with confidence.

RESULTS SUMMARY

The patient's anxiety level is similar to that of the average pain patient. However, her levels of depression and somatic concentration are higher than average and may influence her pain perception and response to treatment.

Pain Patient Profile
The Individual Compared to the Patient Sample





CLINICAL INTERPRETATION

Depression

The patient's T score on the Depression scale (58) suggests that she is more depressed than the average pain patient. Of the pain patients sampled, only 27% had a Depression T score of 58 or higher. The patient's depression is reflected in her endorsement of the most severe responses for the following items. Although these responses may help the clinician understand the patient's emotional state, caution should be used when interpreting an individual item response because the client may have inadvertently marked the wrong response.

1. I have a lot of trouble with sleep.
6. I wake with pain and feeling tired most mornings.
11. I am not happy.
12. I seem to have trouble completing tasks because I keep getting sidetracked.
15. I have no interest in outside activities and other people.
40. I am almost always sad.
42. My life is in a rut.
43. I am not satisfied with my life at present.

Sleep and appetite disturbances may be noted as part of the patient's depression symptoms. She may be described by others as sad, lethargic, apathetic, listless, and aloof. Efforts to involve her in a participatory physical rehabilitation program may be hampered by her emotional state. It is likely that she suffered highly significant symptoms and problems with depression prior to pain onset or that she is currently feeling particularly distressed, drained, and emotionally burdened by the duration of her discomfort and the impact of her problems on her ability to function. The clinician should investigate whether a history of depression preceded pain onset or whether depression symptoms are reactive to pain. If depression is acute, the patient should be carefully and regularly monitored to guard against further emotional deterioration. It is very likely that the patient's psychological symptoms will interfere with physical pain treatment.

Somatization

The patient's Somatization T score (56) suggests that she has more physical problems, pain, and health-related concerns than the average pain patient. Of the pain patients sampled, only 34% had a T score of 56 or higher on the Somatization scale. The patient's somatization is reflected in her endorsement of the most severe responses for the following test items. Although these responses may help the clinician understand the patient's emotional state, caution should be used when interpreting an individual item response because the client may have inadvertently marked the wrong response.

- 4. I can no longer do my work and chores around the house.
- 5. My life is spent in pain.
- 10. I have some serious health problems.
- 13. I feel weak and tired much of the time.
- 21. I stay tired most of the time.
- 24. My neck and shoulders hurt.
- 29. The muscles in my body feel painfully tight.
- 30. My neck or back seems to hurt most of the time.
- 34. I believe that once you have a bad back you will probably always have trouble with it.

These somatic issues trouble her and are adversely affecting her life. She may exhibit excessive concern about bodily functions, and her physical symptoms may be multiple and magnified. Pain migration may be exhibited, with pain complaints shifting from one anatomic part to another. Symptom substitution may also be demonstrated, whereby successful treatment of one problem is followed by development of new complaints.

This patient's Somatization score suggests that pain and health-related concerns occupy a disproportionate amount of her attention. Her somatic symptoms are upsetting, frustrating, distracting, unwanted, and poorly tolerated. She may be described by others as over-reactive, self-centered, demanding, pessimistic, complaining, whining, and bitter. She may challenge health professionals with demands for pain relief, yet she may exhibit a defeatist and noncompliant attitude toward appropriate treatment plans.

Anxiety

Although the patient's Anxiety score is in the average range compared to other pain patients, she reports a number of symptoms of anxiety, agitation, and cognitive distress. She may have trouble controlling her anger. She may report being irritated by situations and events that formerly went relatively unnoticed. She is probably not comfortable in social situations and would prefer to avoid them. She reports feeling irritable, tense, worried, impatient, and upset, and she may find it difficult to relax and make decisions. Others may describe her as on edge, somewhat agitated, and distracted. These symptoms of anxiety may be beginning to strain her coping skills. Although her score on the Anxiety scale is not unusual for a pain patient, her anxiety symptoms may complicate her symptom perception and response to treatment.

TREATMENT RECOMMENDATION

Because of the above average intensity of the patient's depression, somatization symptoms, the clinician should consider the value of psychological treatment, perhaps as an adjunct to physical treatment. Consideration should be given to incorporating techniques to reduce distress, such as relaxation training, counseling, psychotropic medications, and exercise. In considering the value of psychotropic drugs, the clinician should take into account whether or not the individual has a propensity for substance abuse and impulsive behavior. Progression of the patient's depression, anxiety, and somatic concentration should be monitored over time, particularly if response to physical treatment is delayed.

ITEM RESPONSES

1: 3	2: 3	3: 1	4: 3	5: 3	6: 3	7: 3	8: 2	9: 2	10: 3
11: 3	12: 3	13: 3	14: 2	15: 3	16: 3	17: 2	18: 2	19: 1	20: 3
21: 3	22: 1	23: 3	24: 3	25: 2	26: 1	27: 1	28: 2	29: 3	30: 3
31: 1	32: 1	33: 1	34: 3	35: 1	36: 3	37: 1	38: 1	39: 1	40: 3
41: 1	42: 3	43: 3	44: 2						

End of Clinical Report

PATIENT SUMMARY

The P-3 was developed to assist health care professionals who work with patients who are experiencing pain and physical problems. Information from the P-3 can help you and your health care provider determine if emotional factors are influencing your symptoms or your treatment progress.

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Anxiety: feeling nervous, on edge, and irritable

Somatization: being overly concerned with and thinking too much about physical problems

Patients who are in pain usually experience more emotional distress than people who are not in pain. Depression, anxiety, and somatization are as much a part of pain as the physical aspects, and these feelings can make coping with pain more difficult.

The following interpretation is based on your responses to the P-3 items. You are encouraged to discuss your P-3 results with your health care provider.

Although depression is common in patients who are experiencing pain, your Depression score indicates that you may be especially troubled by these feelings. You may have less energy and feel less optimistic than you would like. You may be having sleep and appetite problems. Your responses also indicate that you may feel sad and that you may not enjoy being around others. You may be feeling discouraged, and you may not be enjoying life at present. You should discuss these feelings with your health care provider so he or she can help you find ways to cope with them.

Your Anxiety score is very similar to the average pain patient's score. Like other patients in your situation, you may be edgy, impatient, irritable, and easily frustrated. Your responses also suggest that you may have trouble relaxing and keeping your mind on tasks, which is normal for someone with painful physical problems. Your responses suggest that you are keeping your feelings of anxiety under control. Your health care provider can suggest some techniques for helping you to relax and reduce the stress caused by your symptoms.

Your Somatization score suggests that pain and health problems are having a negative effect on your life. You probably have multiple pain- and health-related problems that occupy a good deal of your attention and concentration. Your responses also indicate that you may have trouble completing tasks because you are distracted by your pain. You should discuss your concerns with your health care provider. He or she may be able to help you find ways to cope with the intensity of your symptoms and physical problems.

The treatment of pain sometimes requires a team effort from health care specialists. It is in your best interest to explore a combination of physical and psychological treatment options under the guidance and direction of your health care professional.

End of Patient Summary

End of Report

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3 St. Francis Dr. Suite 330
Greenville, SC 29601
Phone: (864) 220-4263
Fax: (864) 220-5836

HISTORY AND PHYSICAL REPORT

Kellie Burnette

ID: 46220

DOB: [REDACTED] (29 years)

Date of Encounter: 10/22/2008 04:32 PM

History of Present Illness

Patient's words: Patient reports constant intense pain in the neck with tingling and numbness in the arm to the hand which includes the thumb. The patient was a police officer and was trying to arrest a suspect who tried to take off in a car which made her twist and fall backwards. This incident happened on June 2007. Being upright aggravates the pain, especially riding in a car.
The patient is a 29 year old female

History

Allergy

No Known Allergies

Past Medical

Conservative Treatment - Prescription Medications, Physical Therapy, Injections
Arthritis
Depression
Surgery on nose
Scope of left shoulder

Social

RIGHT HANDED
Non smoker / no tobacco use
Alcohol use - Occasional alcohol use
Current Work/Study Status - Retired

Medications

Neurontin (Oral) Specific dose unknown - Active - Hx Entry.
Baclofen (Intrathecal) Specific dose unknown - Active - Hx Entry.
Effexor XR (Oral) Specific dose unknown - Active - Hx Entry.
Cyclobenzaprine HCl (Oral) Specific dose unknown - Active - Hx Entry.
Oxycodone HCl (Oral) Specific dose unknown - Active - Hx Entry.
Celebrex (Oral) Specific dose unknown - Active - Hx Entry.
Ambien CR (Oral) Specific dose unknown - Active - Hx Entry.

Family

High Blood Pressure
Heart Disease
Stroke
Cancer
Arthritis

Review of Systems

General: *Present:* Weight Gain.

Neurological: *Present:* Headaches.

Psychiatric: *Present:* Insomnia (*Sleep difficulty*).

Vitals

0263

Kellie Burnette

ID: 46220

DOB: 09/05/1979 (29 years)

Wednesday, April 1, 2009

Page 1 / 2

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM SOUTH CAROLINA
GREENVILLE COUNTY COURT OF COMMON PLEAS

CASE TRACKING NO: 2011198006

KELLIE N. BURNETTE..... APPELLANT,

v.

CITY OF GREENVILLE.....RESPONDENTS.
AND HEWITT COLEMAN & ASSOCIATES

FINAL BRIEF OF APPELLANT

Douglas A. Churdar, Esq.
Douglas A. Churdar, P.C.
712 East Washington Street
Greenville, SC 29601
Phone (864) 233-0203

Attorney for Appellant

TABLE OF CONTENTS

Table of Authorities	iii
Statement of Issues on Appeal	iv
Statement of the Case.....	1
Factual Background.....	2
Argument	
I. Standard of Review.....	11
II. The Single Commissioner's finding that Claimant did not injure her low back in this accident is not supported by substantial evidence.....	12
III. Considering the combined effects of Claimant's pre-existing impairments with the injuries sustained in this accident, the Single Commissioner's finding that Claimant is not permanently and totally disabled is not supported by substantial evidence.....	21
IV. The Single Commissioner's finding on credibility is immaterial and not supported by substantial evidence.....	26
Conclusion	28

TABLE OF AUTHORITIES

CASES

Aakjer v. Spagne

291 SC 165, 352 S.E. 2nd 503 (Ct. App. 1987)..... 27

Bass v. Kenco Group

366 SC 450, 622 SE 2d 577 (Ct. App 2005).....1, 24, 25

Ellison v. Frigidaire

371 SC 159, 638 SE 2d 664 (2006) 1, 21

Fishburne v. ATI Systems Intern.

384 S.C. 76, 84, 681 S.E. 2d 595, 599-600 (S.C. App. 2009) 11

Hoxit v. Michelin Tire Corp.

304 SC 461, 405 S.E. 2d 407 (1991) 11

Jones v. Georgia-Pacific Corp.

355 S.C. 413, 417, 586 S.E. 2d 111 (S.C. 2003) 11

Koon v. Spartan Mills

286 SC 190, 192 N. 1, 332 S.E. 2d 544, 545 N. 1 (Ct. App 1985).....22

Mullinax v. Winn-Dixie Stores, Inc.

318 S.C. 431, 435, 437, 443, 458 S.E. 2d 76, 79, 80, 83 (S.C. App. 1995).....11, 20

Thompson ex rel. Harvey v. Cisson Constr. Co.

377 S.C. 137, 151, 659 S.E. 2d 171, 178 (S.C. App. 2008).....11

STATEMENT OF ISSUES ON APPEAL

- I. Whether the Single Commissioner's finding that Claimant did not injure her low back in this accident is supported by substantial evidence.
- II. Whether considering the combined effects of Claimant's pre-existing impairments with the injuries sustained in this accident, the Single Commissioner's finding that Claimant is not permanently and totally disabled is supported by substantial evidence.
- III. Whether the Single Commissioner's finding on credibility is material and supported by substantial evidence.

STATEMENT OF CASE

Claimant is a police officer who has been medically retired. This injury occurred on June 16, 2007, when she was attempting to arrest a bad guy. She sustained injury to her neck (C5-6), low back (L5-S1) and depression and anxiety. Defendant admitted injury to the neck and the depression and anxiety. Defendant denied injury to the low back but contended that Claimant is not at MMI if the low back was injured. Based upon the combined effects of Claimant's neck (C5-6 fusion) and depression and anxiety and pre-existing physical impairments from two other injuries (See *Ellison vs. Frigidaire*, 371 SC 159, 638 SE 2d 664 (2006)), Claimant contended she is permanently and totally disabled under either § 42-9-30 (19)¹ or § 42-9-10 without regard to a final impairment rating to the low back. (See *Bass vs. Kenco Group* 366 SC 450, 622 SE 2d 577 (Ct. App 2005)). Moreover, Claimant contended that even if her low back was not at MMI, it could be presumed that an injured L5-S1 disc would result in permanent impairment. The case was heard by Commissioner Susan S. Barden pursuant to Claimant's Form 50 (R. p. 32) and Defendant's Form 51 (R. p. 33). The Single Commissioner ruled that Claimant did not sustain injury to the low back and that she is not permanently and totally disabled. (R. pp. 1-14) The Single Commissioner's findings were adopted by the Commission on April 1, 2010. (R. pp. 18-26) The Commission's decision was affirmed by the Circuit Court on July 7, 2011 (R. pp. 27-28) and July 29, 2011 (R. p. 29). Claimant filed her Notice of Appeal on August 24, 2011.

¹ This is a pre July 1, 2007 case, so permanent and total disability is presumed if Claimant has sustained a 50% or more loss of use to the back.

FACTUAL BACKGROUND

A. Pre-existing Physical Impairments from Two Other Injuries.

1. Work Accident August 23, 2003

As noted above, Claimant is a police officer who has been medically retired. She had two (2) significant injuries while in the line of duty. On August 23, 2003, she was attempting to arrest a different bad guy, who was driving a stolen car. The bad guy t-boned Claimant's squad car at a very high rate of speed, causing serious injury. (R. p. 318 – Photo of Squad Car from 8/23/03 injury.) Claimant filed a workers' compensation claim, and it was determined that she had sustained injury to the entire left side of her body, but significantly that she had sustained *17.5% disability to her back*. (R. pp. 314 and 316 – Decision and Order dated 1/11/06 in WCC File No. 0311607). It was further determined that she “has back pain on a daily basis in both the upper and lower portions..., “she must take pain medication...”, and “she cannot perform the duties of her position as well as she could before the accident.”...(R. p. 314) As will be discussed later, she was treated for pain management until the time of this injury by Kevin Kopera, MD. As will also be discussed later, it is significant that Claimant's low back pain was reported by her treating physicians as “just persistent, boring lumbar pain” and/or “chronic myofascial pain” that did not involve any radiculopathy.

2. Injury in 2006 (non work-related)

In approximately May 2006, Claimant dislocated her shoulder and sustained a torn labrum when she fell while hanging some curtains. (R. p. 99, lines 6-22; R. p. 267; R. pp. 273-283). She underwent surgery. Upon reaching maximum medical improvement, she was assigned a *10% permanent partial impairment to her left shoulder* by her treating orthopaedic, Alan G. Posta, Jr., MD. (R. p. 283).

B. Circumstances of this Accident.

On June 16, 2007, Claimant was again attempting to arrest a bad guy. She was partially inside the bad guy's vehicle while trying to wrestle her out. The bad guy drove off. Claimant was dragged forward while in a twisted or torqued position, thrown from the bad guy's vehicle, and fell against a curb (R. p. 100, line 19 – p. 102, line 2). She felt "a shock go up both sides of [her] neck all the way up to [her] head." (R. p. 101, lines 24-25). She "also felt a shock in [her] low back." (R. p. 102, line 1). Claimant had the next day off but was unable to come into work the day after that.

C. Significant Delays/Refusals to Authorize Treatment

At the time of this injury, Kevin Kopera, MD had been providing Claimant with pain management for her low back resulting from the first injury, but he was closing his practice. On August 2, 2007, Employer/Carrier authorized Claimant to see John Satterthwaite, MD only "for evaluation and treatment of her lower back for pain management." (R. p. 322) Claimant was unable to get an appointment with Dr. Satterthwaite's practice until August 28, 2007 (R. p. 206). For the first time, she described her pain as "electrical/shooting". Even after referring Claimant to Dr. Satterthwaite, Employer/Carrier refused for many months to authorize any treatment for Claimant's neck and refused and still refuses to this day to authorize a referral to an orthopaedic or neurosurgeon for a surgical evaluation of her low back.

As for the neck, in September 2007 Dr. Satterthwaite was still waiting on the "outcome of negotiations...before further evaluation of the neck" (R. p. 200). In a letter to Dr. Satterthwaite dated October 12, 2007, Employer/Carrier acknowledged Claimant's neck pain and her contention that it was a result of this injury (R. p. 323). However, Employer/Carrier still refused to authorize any treatment for Claimant's neck. Employer/Carrier explicitly instructed

Dr. Satterthwaite in a letter dated December 7, 2007: "We have not authorized any treatment for her neck, and we will not be covering treatment for her neck." (R. p. 324). In February 2008, Dr. Satterthwaite reported: "[U]ntil we receive written approval we cannot treat her neck..." (R. p. 186). This position continued until March 13, 2008 (R. p. 328). Thereafter, however, Employer/Carrier would only authorize pain management. Claimant sought a referral to a reputable orthopaedic or neurosurgeon for a surgical evaluation, eventually having to file a Form 40 – the equivalent of a motion to compel – and obtaining an Order requiring the referral. On September 19, 2008 she was finally seen by David Mitchell, MD, an orthopaedic who ordered an MRI of the cervical spine that revealed C5-6 disc protrusion (R. p. 223). She was then referred to Michael Bucci, MD, a neurosurgeon who performed a C5-6 fusion in October 2008 – 1 year and 4 months after this injury.

As for the low back, Claimant began for the first time to experience radiculopathy and was specifically diagnosed with lumbar radiculopathy. On December 13, 2007, Dr. Satterthwaite reported Claimant was "noting back pain with RLE paresthesia" and believed she needed a new MRI, which he ordered. (R. p. 193). The MRI showed "L5-S1 disc protrusion", and based on "L5-S1 disc protrusion with back and leg pain", Dr. Satterthwaite began administering epidural steroid injections to Claimant's lumbar spine area. (R. p. 188). Dr. Satterthwaite also attempted to refer Claimant to Steadman Hawkins – an orthopaedic practice. (R. p. 185) Employer/Carrier would not authorize the referral. Claimant's counsel wrote Employer/Carrier's counsel three times requesting a referral (R. pp. 325-327). Claimant still has not received a referral for an orthopaedic or neurosurgeon to look at her low back, despite another request by Dr. Satterthwaite in his Physician's Statement as late as July 2009 (R. p. 150) and a request by Claimant in her Form 50 (R. p. 32).

D. Attempts to Work

Upon returning to work,² Claimant had difficulty performing her duties, which required her to wear approximately thirty (30) pounds of equipment (R. p. 98, lines 4-13) and run, jump, bend, stoop, get on the knees, lift adult humans and get in and out of a squad car (R. p. 97, line 9 – p. 98, line 3). In the months following this injury, she began missing work. (R. p. 102, lines 6-19) From June 2007 to April 2008, she went from full duty to light duty to being unable to work at all (R. p. 103, lines 7-10). Afterall, she was working with two injured and untreated discs (C5-6 and L5-S1).

Claimant loved being a police officer. Despite her untreated injured discs, she and Dr. Satterthwaite attempted to keep her working as a police officer. These efforts were addressed in treatment notes. Dr. Satterthwaite noted on October 18, 2007 that “she is a dedicated officer and wishes to continue working in law enforcement” and that “she doesn’t want significant restrictions that would place her at a desk job or remove her from her job completely.” (R. p. 197) However, because of the difficulty Claimant was having on the street, she “applied for a teaching position, which would not require her to wear the vest and belt and allow her to change positions frequently from standing to sitting.” (R. p. 196) Only within this context did Dr. Satterthwaite note that Claimant “is not interested in a desk job...”³ (R. p. 196) Now that Claimant is medically retired, she “would rather be working. I enjoyed my job. I miss it...even the hard days were better than this.” (R. p. 105, line 24 – p. 106, line 1)

² The fact that Claimant struggled to work as a street cop for ten (10) months with two (2) untreated disc injuries, in addition to working for several years after her first injury while requiring ongoing pain management, argues against the finding that she is “someone who simply does not wish to work...” (R. p.12, paragraph 22).

³ The Single Commissioner found these words – “not interested in a desk job”- are evidence that Claimant does not want to work. In full and proper context, these words simply reveal Claimant’s desire to remain a street cop. (R. p. 10, paragraph 14)

E. Claimant's Account of Her Limitations

At the hearing, Claimant testified she can stand or sit comfortably for twenty (20) to thirty (30) minutes. (R. p. 107, lines 12-17) She can alternatively sit and stand two (2) to three (3) hours. (R. p. 107, lines 1-11) If she's "already having a bad day, it would be even less." (R. p. 108, lines 1-2) She can walk a block or two without sitting down and resting. (R. p. 108, lines 3-8) She has problems kneeling, bending at the waist, squatting, or stooping (R. p. 108, lines 9-22). She has problems twisting and turning her back. (R. p. 109, lines 10-13) She can lift fifteen (15) to twenty (20) pounds if she "just had to pick it up." (R. p. 109, lines 7-9) She has problems sleeping some nights, when she "could get two or three [hours] and be lucky to get that." (R. p. 109, lines 14-20)

Claimant also suffers from depression and anxiety. She began seeing David Tollison, PhD., on a regular basis. She is regularly prescribed psychotropic drugs. Claimant is very depressed. (R. p. 105, line 13) She feels like she lost her life. (R. p. 105, lines 14-15) She experiences a lot of anxiety, especially when driving. She's nervous about other drivers. (R. p. 106, lines 12-19) And she doesn't like to be around people, especially crowds (R. p. 106, lines 19-21).

F. Claimant's Medical Retirement

As noted previously, Claimant was eventually unable to work as a police officer. In March 2008, she applied for medical retirement. The SC Retirement System approved her application, and Claimant became medically retired on April 17, 2008 (R. pp. 230-231).

G. Impairments, Physical Restrictions, and Mental /Psychological Restrictions

Claimant's *authorized treating physicians* assigned her the following impairments, physical restrictions, and mental/psychological restrictions.

1. Impairment Ratings

a. Neck

- 28% whole person based on cervical fusion C5-6 per Michael Bucci, MD., neurosurgeon (R. p. 224)
- "25% impairment to the whole person, which corresponds to 72% impairment of the cervical spine" per John Satterthwaite, MD (R. p. 161)

b. Low Back

- "12% impairment to the whole person, which corresponds to a 16% impairment to the lumbar spine..." per John Satterthwaite, MD (R. p. 161)

2. Physical Restrictions (R. pp. 153-156)

- Lift 15 pounds on occasional basis
- Less than 10 pounds on a frequent basis
- Stand/walk less than two (2) hours per day
- Sit less than two (2) hours per day
- Sit/stand option
- Sit thirty (30) minutes before changing position
- Stand twenty (20) minutes before changing position
- Walk around every thirty (30) minutes for ten (10) minutes each time
- Needs to lie down at unpredictable intervals
- Twist – never
- Stoop – never
- Crouch – never

- Climb stairs – occasionally
- Climb ladders – never
- Reach – never
- Handle – occasionally
- Finger – occasionally
- Feel – frequently
- Push/pull – seldom
- No kneeling, crawling, balancing, unprotected heights
- Miss work about three (3) times per month
- Pain distracts from adequate performance of daily activities/work
- Pain causes abandonment of tasks
- Should avoid prolonged work at a computer (R. p. 161)

3. Mental/Psychological Restrictions

- Able to deal with the public “for brief periods of time and in situations that are not highly stressful.” (R. p. 215)
- Psychological problems cause “some limitations to maintain concentration over long periods of time. She would require breaks.” (R. p. 216)
- “She...would need to remain on psychotropic medication.” (R. p. 217)
- “Psychologically, unable to function as law enforcement officer. She probably function in a relatively stress-free position without significant demands. She would require breaks and rest periods.” (R. p. 218)
- The “periodic breaks” and “breaks and rest periods” referenced above must be “on an unscheduled or ‘as needed’ basis...” (R. p. 219)

H. Claimant's Hobbies/Activities

Despite her impairments and restrictions, Claimant has attempted to remain active within her limitations. She enjoys gardening and yard work, though she has to take breaks. She "can't do certain things for...any period of time, especially repetitive motions." (R. p. 110, lines 9-10) She might be able to mow her lawn if she takes breaks, but she cannot rake or sweep. (R. p. 110, lines 16-17) She does "very limited" housework. To "remain active within her limitations", Dr. Satterthwaite "strongly encouraged" Claimant "to join a health club" and "do some exercising". (R. p. 159) Claimant followed Dr. Satterthwaite's recommendation, and as of her hearing had gone to the health club about ten (10) times over a two or three month period. (R. p. 126, lines 1-11) She exercises within her limitations. (R. p. 126, lines 18-20) (Q: "You do exercises and do things that you are able to do?" A: "That I am able to do. Yes.")

Claimant's parents have a boat, and she loved to be on the lake. (R. p. 110, lines 21-24) Though she didn't go out on the boat summer 2008, she went out twice during summer 2009. (R. p. 111, lines 1-3; p. 115, lines 21-22) Her parents live on the lake in Columbia and keep the boat there, and both times she went out on the lake, she was at her parents' house in Columbia (R. p. 116, lines 9-20). Accordingly, those two times neither she nor anyone else had to hook the boat up and tow it. (R. p. 116, lines 9-20) She can only go out when the water is calm, and she tries to stay close to coves. (R. p. 111, lines 6-8) One of the times she went out summer 2009, she "had to go back in" because "it was too choppy." (R. p. 111, lines 9-12)

I. The “Boat Cover Incident”

After reaching MMI per Dr. Bucci and receiving an impairment rating from him on the neck (R. p. 224) and after reaching MMI per Dr. Satterthwaite and receiving impairment ratings from him on the neck and lumbar spine (R. pp. 158, 161) and after reaching MMI per Dr. Tollison and receiving restrictions from him (R. pp. 213-219), the “boat cover incident” occurred. On Saturday, July 18, 2009, Claimant towed her parents’ boat from Columbia to Greenville (R. p. 116, lines 1-8, 21). Her “dad’s friend hooked it up for [her].” (R. p. 116, line 4). While the boat was being towed, the boat cover blew off. Claimant’s friend lifted the boat cover and leaned it against the truck, and together they put it back on the boat. (R. p. 119, lines 1-17). Claimant never put the boat in the water. (R. p. 125, lines 7-9). On Tuesday, July 21, 2009, Claimant twisted her back while watering flowers. (R. p. 121, lines 2-5; p. 124, lines 19-21). On Thursday, July 23, 2009, Claimant was in severe pain and reported the pain to Dr. Satterthwaite’s nurse practitioner. The “boat cover incident” came up in conversation, because Claimant was talking about her desire to go boating and lamented the fact that her pain would prevent her from using the boat after she’d towed it from Columbia (R. p. 121, line 7 – p. 125, line 9) While not specifically stating Claimant’s pain was aggravated by the boat cover incident, the incident is addressed in the note. Claimant testified that, while it is true she aggravated her back pain, it was not the result of the “boat cover incident”, which she did not deny, but rather the “flower watering incident.” (R. p. 121, line 2 – p. 125, line 9) After the hearing, it became apparent the boat cover incident played a significant role in the Single Commissioner’s decision that Claimant is not credible and that the incident was an intervening cause of Claimant’s increased low back pain.

J. Vocational Evaluation

Claimant was evaluated by Benson Hecker, PhD. in August 2009. He concluded that she is not employable – “unable to perform any substantial gainful work activity existing in significant numbers in open competition with others.” (R. pp. 250-252)

ARGUMENT

I. STANDARD OF REVIEW

An appellate court should reverse or modify the Commission’s decision if it is affected by an error of law or is clearly erroneous in view of the reliable, probative, and substantial evidence in the whole record. *Fishburne v. ATI Systems Intern.*, 384 S.C. 76, 84, 681 S.E. 2d 595, 599-600 (S.C. App. 2009) (citing S. C. Code Ann. §1-23-380). “Substantial evidence is not a mere scintilla of evidence, nor the evidence viewed blindly from one side of the case, but is evidence which, considering the record as a whole, would allow reasonable minds to reach the conclusion that the administrative agency reached to justify its action.” *Thompson ex. rel. Harvey v. Cisson Const. Co.*, 377 S.C. 137, 151, 659 S.E. 2d 171, 178 (S.C. App. 2008); and *Jones v. Georgia-Pacific Corp.*, 355 S.C. 413, 417, 586 S.E. 2d 111, 113 (S.C. 2003). “When the evidence is susceptible of but one reasonable inference, the question becomes a matter of law.” *Mullinax v. Winn-Dixie Stores, Inc.*, 318 S.C. 431, 437, 458 S.E. 2d 76, 80 (S.C. App. 1995). Applying these principles to this case and particularly to the first argument, where there is a conflict in medical evidence, the findings of fact of the Commission are conclusive. *Id.* at 435, 79, citing *Hoxit v. Michelin Tire Corp.*, 304 SC 461, 405 S.E. 2d 407 (1991). However, when the only medical evidence before the Commission demonstrates that an injury occurred as a result of an accident, the existence of the injury and causation become matters of law. *Mullinax*, 318 S.C. at 443, 458 S.E. 2d at 83.

II. THE SINGLE COMMISSIONER'S FINDING THAT CLAIMANT DID NOT INJURE HER LOW BACK IN THIS ACCIDENT IS NOT SUPPORTED BY SUBSTANTIAL EVIDENCE.

The Single Commissioner, whose findings were adopted by the Commission, failed to compare Claimant's symptoms after her August 23, 2003 work injury with the injury in issue; undertook her own comparison of Claimant's May 11, 2004 MRI with her January 7, 2007 MRI that she is not qualified to undertake and that is inconsistent with the opinions of all treating physicians and the disability examiner for the SC Retirement System; and appears to have ignored the explicit opinion of Claimant's treating physician, Dr. Satterthwaite, on the issue of injury to Claimant's low back, arriving at her interpretation of his treatment notes that is inconsistent with his own interpretation.

A. Comparison of Claimant's Symptoms

1. After August 23, 2003 Injury – "Just persistent boring lumbar pain" and "normal" MRI.

After Claimant's August 23, 2003 work injury, she was treated by Wes Merriwether, MD. With regard to her condition, he reported the following:

- "Low back pain...No radicular complaints." (R. p. 302, 9/10/03 note).
- "...has just had persistent back pain...She does not notice any radicular pain...**just persistent boring lumbar pain.**" (R. p. 298, 5/05/04 note)

After treating Claimant for many months, Dr. Merriwether referred Claimant to Kevin Kopera, MD for pain management. With regard to her symptoms, Dr. Kopera reported the following:

- "She denies symptoms in either lower extremity, including denying any weakness or numbness...MRI imaging was obtained of the lumbar spine on 5/11/2004...I would consider it normal." (R. p. 141, 6/21/04 note)

Dr. Kopera continued to treat Claimant over the next two years before closing his practice, and his reports reflect that Claimant's symptoms were essentially unchanged. Dr. Kopera continued to report Claimant's condition as "chronic low back pain" and "myofascial pain."

- 6/21/2004

"...continuous low back pain...She denies symptoms in either lower extremity, including denying any weakness or numbness." (R. p. 141, 6/21/2004 note by Kevin Kopera, MD)

- 8/19/2004

"Ms. Burnette continues to focus on low back pain and is not describing any radicular symptoms." (R. p. 140, 8/19/2004 note by Kevin Kopera, MD)

- 12/28/2004

"Her strength and sensation are grossly intact in the lower extremities with no obvious neurological deficits." (R. p. 139, 12/28/2004 note by Kevin Kopera, MD)

- 3/28/2005

"...chronic low back pain most consistent with myofascial pain." (R. p. 138, 3/28/2005 note by Kevin Kopera, MD)

- 6/28/2005

"...continued myofascial pain in the lumbar area..." (R. p. 137, 6/28/2005 note by Kevin Kopera, MD)

- 10/11/2005

"...myofascial pain...primarily lumbar region." (R. p. 135, 10/11/2005 note by Kevin Kopera, MD)

- 1/12/2006

"She denies any symptoms in either upper or lower extremities." (R. p. 288, 1/12/2006 note by Kevin Kopera, MD)

- 5/31/2006

“Chronic thoracic and lumbar pain most consistent with myofascial pain.” (R. p. 291, 5/31/2006 note by Kevin Kopera, MD)

- 6/29/2006

“Myofascial pain...most prominent in the thoracic and lumbar region.” (R. p. 292, 6/29/2006 note by Kevin Kopera, MD)

“...her prior (5/11/2004) **MRI** of the lumbar spine was **essentially normal**...” (R. p. 292, 6/29/2006 note by Kevin Kopera, MD)

Claimant’s testimony at the hearing was consistent with the symptoms she reported to Drs. Merriwether and Kopera after her first injury but before this injury.

Q. Did you ever have pain in your buttocks and in your legs as a result of the first accident?

A. No. I had – the pain then was in the immediate area. It didn’t radiate like it does now.

Q. Did you make any claim for radiculopathy or pain radiating down into your legs as a result of that (8/23/03) accident?

A. No.

(R. p. 96, lines 1-9). ...

Q. Try to differentiate for the Commissioner what’s different about your back now than it was after the August 23, 2003 injury?

A. ...I had low back pain and some in the middle, the thoracic area. Now it’s in my entire back and neck. It starts from the neck and goes down to my low back, the buttocks area. The pain also at times, it does radiate down a nerve of my leg.

(R. p. 103, line 18 – p. 104, line 3).

2. After This Injury - Radiculopathy.

After this injury and as noted above, Claimant began having radicular pain into the buttocks and legs. (R. p. 96, lines 2-5; p. 103, line 17- p. 104, line 17). Because Dr. Kopera had closed his practice, Employer/Carrier eventually authorized her to be treated by Dr. Satterthwaite. Dr. Satterthwaite has stated: “Ms. Burnette had been in an accident on June 16, 2007 and complained of increased lower back pain and radiculopathy symptoms.” (R. p. 150)

From the point he began seeing her, Dr. Satterthwaite reported Claimant's condition to include radiculopathy – pain in the buttocks and legs.

- 8/28/2007

“Description of Pain:...Electrical/Shooting...” (R. p. 206, 8/28/07 note by Justin Hutcheson, MD)

- 12/13/2007

“RLE (right lower extremity) laterally above knee, medially below knee...” (R. p. 193, 12/13/2007 note by John Satterthwaite, MD)

“Noting back pain with RLE (right lower extremity) parasthesis – needs new lumbar MRI – ordered.” (R. p. 193, 12/13/2007 note by John Satterthwaite, MD)

- 1/07/2008 MRI

- 1/10/2008

“LUMBAR RADICULOPATHY... reviewed lumbar MRI – HNP (herniated nucleus pulposis) L5-S1 discussed ESI (epidural steroid injection) L5-S1...” (R. p. 190, 1/10/2008 note by John Satterthwaite, MD)

- 1/30/2008

“L5-S1 disc protrusion with back and leg pain.” (R. p. 188, 1/30/2008 note by John Satterthwaite, MD)

- 2/20/2008

“LUMBAR RADICULOPATHY.” (R. p. 187, 2/20/2008 note by John Satterthwaite, MD)

- 3/13/2008

“LUMBAR RADICULOPATHY as unchanged...ESI (epidural steroid injection) has worn off – did help with back and leg pain – will schedule for another one L5-S1. Reviewed MRI – does have HNP (herniated nucleus pulposis) L5-S1. Would like to see surgeon. Will refer to Steadman Hawkins for evaluation.” (R. p. 185, 3/13/2008 note by John Satterthwaite, MD)

- 3/26/2008

“L5-S1 disc protrusion with radiculopathy.” (R. p. 183, 3/26/08 note by John Satterthwaite, MD)

- 4/10/2008

“LUMBAR RADICULOPATHY” (R. p. 182, 4/10/2008 note by John Satterthwaite, MD)

- 4/14/2008

“A new MRI of the lumbar spine ordered 12/2007 shows a disk herniation at L5-S1...Her limitations preclude her returning to this job and disability is recommended as of 3/13/2008.” (R. p. 231, 4/14/2008 note by Michael Sheehan, disability examiner with SC Retirement Center)

- 5/19/2008

“L5-S1 disc protrusion with radiculopathy...return of back pain...repeat ESI (epidural steroid injection)” (R. p. 180, 5/19/08 note by John Satterthwaite, MD)

- 6/16/2008

“LUMBAR RADICULOPATHY.” (R. p. 179, 6/16/2008 note by John Satterthwaite, MD)

- 7/17/2008

“L5-S1 disc protrusion with radiculopathy...increasing back and leg pain...returns for repeat ESI (epidural steroid injection)” (R. p. 177, 7/17/2008 note by John Satterthwaite, MD)

- 8/15/2008

“LUMBAR RADICULOPATHY as unchanged” (R. p. 176, 8/15/2008 note by John Satterthwaite, MD)

- 9/04/2008

“Pain primarily in the back and hips. Minimal leg pain...DISPLACEMENT – LUMBAR DISC W/O MYELOPATHY” (R. p. 173, 9/04/2008 note by John Satterthwaite, MD)

“LUMBAR RADICULOPATHY” (R. p. 174, 9/04/2008 note by John Satterthwaite, MD)

- 9/15/2008

“Lumbar HNP (herniated nucleus pulposus)...Increasing back and leg pain.” (R. p. 172, 9/15/2008 note by John Satterthwaite, MD)

- 9/26/2008

“She has an injured disk at L5-S1...” (R. p. 222, 9/26/2008 note by David Mitchell, MD)

- Etcetera with no treatment of L5-S1

- “...Our office ordered a new MRI on 12/13/2007, and the MRI was completed on 1/07/2008. The new MRI showed some central disk protrusion at L5-S1. On 3/13/2008, our office was indicated a referral to Steadman Hawkins for evaluation. To my knowledge, that evaluation has never taken place.”

“I have diagnosed Ms. Burnette with L5-S1 disk protrusion with radiculopathy down into the upper buttocks and legs. I have treated her with a variety of medications and epidural steroid injections. I still believe she should be seen by an orthopaedic surgeon or neurosurgeon to determine whether she is a surgical candidate. It is my opinion to a reasonable degree of medical certainty that her injury on 6/16/2007 exacerbated a prior lumbar spine injury or caused new injury.” (R. pp. 150-152, 8/17/2009 note by John Satterthwaite, MD)

Claimant has never received a referral to an orthopaedic or a neurosurgeon as referenced in Dr. Satterthwaite’s note of March 13, 2008 (R. p. 185) or his Physician’s Statement of August 17, 2009 (R. p. 150). She continues to this day to have radicular pain in the buttocks and legs.

B. Claimant’s May 11, 2004 MRI Compared to January 7, 2008 MRI

The Single Commissioner actually undertook her own comparison of Claimant’s May 11, 2004 MRI with her January 7, 2008 MRI and relied upon her opinion regarding the results. She found that the January 7, 2008 MRI “shows...no greater pathology of any significance (if any) than the MRI of 2004.” (R. 21, paragraph 18d). Aside from the obvious problem with her qualifications to make and rely upon such a comparison, her opinion is inconsistent with that of the authorized treating physicians and a disability examiner for the SC Retirement System.

1. May 11, 2004 MRI – “Normal”

After Claimant's August 23, 2003 work injury, she underwent an MRI on May 11, 2004 because of continued low back pain. On May 14, 2004, Dr. Merriwether indicated "The MRI looks pretty good..." (R. p. 295). When Dr. Kopera first saw the MRI on June 21, 2004, he reported: "MRI imaging was obtained of the lumbar spine on 5/11/04...I would consider it to be normal." (R. p. 141). By June 29, 2006, he declined to offer Claimant injections because she had no disc injury. He stated "...her prior MRI (5/11/04) of the lumbar spine was essentially normal..." (R. p. 292).

2. January 7, 2008 MRI – “L5-S1 Disc Protrusion”, “An Injured Disc at L5-S1” and “Disc Herniation at L5-S1”

After this injury, Dr. Satterthwaite ordered an MRI that occurred on January 7, 2008. He and another treating physician and the disability examiner have opined that the second MRI shows a disc herniation at L5-S1. After the MRI, Dr Satterthwaite reported the results: "L5-S1 disc protrusion" (R. p. 188). In a Physician's Statement, he stated:

"We received an old MRI dated May 11, 2004 showing minimal disc bulge at L4-5 and L5-S1 without stenosis. Ms. Burnette had been in an accident on June 16, 2007 and complained of increased lower back pain and radiculopathy symptoms. Accordingly, our office ordered a new MRI on December 13, 2007 and the MRI was completed on January 7, 2008. The new MRI showed some central disc protrusion at L5-S1." (R. p. 150)

When Claimant was forced to file a Form 40 to obtain an Order requiring referral to an orthopaedic for her neck, she saw Dr. Mitchell. In addition to ordering and reviewing an MRI for Claimant's neck, he reviewed the January 7, 2008 MRI. He reported that Claimant "has an injured disc at L5-S1". (R. p. 222).

When Claimant applied for medical retirement, her records were reviewed by a disability examiner. In determining that she should be medically retired, the disability examiner reviewed

the January 7, 2008 MRI. He reported: "A new MRI of the lumbar spine ordered 12/7 shows a disc herniation at L5-S1 " (R. pp. 230-231).

3. Explicit Opinion of Treating Physician

The Single Commissioner also appears to have ignored the explicit opinion of Claimant's treating physician, Dr. Satterthwaite, on the issue of injury to Claimant's low back. He states:

"I have diagnosed Ms. Burnette with L5-S1 disc protrusion with radiculopathy down into the upper buttocks and legs...It is my opinion to a reasonable degree of medical certainty that her injury of June 16, 2007 exacerbated a prior lumbar spine injury or caused new injury." (R. p. 150)

In finding to the contrary, the Single Commissioner misinterpreted two of Dr. Satterthwaite's treatment notes in a manner inconsistent with his own explicit opinion.⁴ To support the conclusion that Claimant had radiculopathy before this accident, the Single Commissioner misinterpreted language in a July 1, 2009 note that says Claimant "has ongoing back and left leg pain from her previous injury..." (R. p. 159). Of course, as of July 2009, both back injuries were "previous." But after comparing Claimant's medical records following the August 23, 2003 injury with those following this injury, Claimant's testimony, and Dr. Satterthwaite's explicit opinion, the only reasonable interpretation of the above is that Dr. Satterthwaite was referring to radiculopathy following this injury. The Single Commissioner also misinterpreted language in a December 13, 2007 note by running the end of one line (which significantly does not extend to the right hand margin) into the beginning of the line below it to conclude that at the time of the May 2004 MRI Claimant was having right lower extremity paresthesia. The note, appearing exactly as below, states:

"reviewed and discussed last lumbar MRI was 5/2004 and had disc bulges at L4-L5 and L5-S1 at that time noting back pain with RLE paresthesia – needs new lumbar MRI – ordered." (R. p. 152 and 195)

⁴ These treatment notes suffer from a lack of punctuation and capitalization, but they are more reliably interpreted by their author than by the Commission.

In the Order, the Single Commissioner wrote “at that time [referring to a May 2004 MRI] noting RLE parasthesia.” (R. p. 21, paragraph 18b) The words in brackets are the Single Commissioner’s. The interpretation that the “RLE parasthesia” was noted at the time of the May 11, 2004 MRI is not Dr. Satterthwaite’s interpretation – it is the Single Commissioner’s misinterpretation. It is significant that Dr. Satterthwaite attached this *same* note to his Physician’s Statement as support for his opinion that Claimant injured L5-S1 in this accident and that the radiculopathy resulted from this accident (R. pp. 150-152). The first paragraph of his Physician’s Statement puts this entirely in context. Combined with Dr. Satterthwaite’s explicit opinion, the only reasonable interpretation of the note above (and clearly Dr. Satterthwaite’s interpretation, the lack of punctuation and capitalization notwithstanding) is that Claimant had disc bulges “at that time”, i.e. the May 11, 2004 MRI, but that she was currently, i.e. as of December 13, 2007, “noting back pain with RLE paresthesia.” That is why Dr. Satterthwaite believed she “needs new lumbar MRI”, and that is why he proceeded to order one after this injury.

Here, as in *Mullinax*, the only medical evidence before the Single Commissioner demonstrated that an injury occurred as a result of this accident, namely injury at L5-S1. Accordingly, this Court should determine as a matter of law that Claimant sustained injury to her low back and is entitled to treatment. See *Mullinax v. Winn-Dixie Stores, Inc.*, 318 S.C. 431, 458 S.E. 2d at 83.

III. CONSIDERING THE COMBINED EFFECTS OF CLAIMANT'S PRE-EXISTING IMPAIRMENTS WITH THE INJURIES SUSTAINED IN THIS ACCIDENT, CLAIMANT IS PERMANENTLY AND TOTALLY DISABLED BECAUSE SHE HAS SUSTAINED A 50% OR MORE LOSS OF USE OF THE BACK UNDER § 42-9-30 (19)⁵ OR UNDER § 42-9-10.

Under § 42-9-400 (a) as interpreted in *Ellison vs. Frigidaire*, 371 SC 159, 638 SE 2d 664 (2006),

“a Claimant may recover for greater disability than that incurred from a single injury to a particular body part if the combination with any pre-existing condition hinders reemployment. There is no requirement that the pre-existing condition aggravated the injury or that the injury aggravated the pre-existing condition, so long as there is a greater disability simply from ‘the combined effects’ of the injury in the pre-existing condition.” Id at 666.

At the time of injury in this case, Claimant had pre-existing 17.5% disability to the back and 10% impairment to the left shoulder. These serve to increase her disability from the injuries in this case to the point of permanent and total disability under § 42-9-30 (19) or § 42-9-10.

Under § 42-9-30 (19), simply adding Claimant's pre-existing 17.5% disability to the back to her impairment rating of 25% to the spine/whole person per Dr. Satterthwaite *or* 28% to the cervical spine/whole person per Dr. Bucci to 16% to the lumbar spine assigned in this case by Dr. Satterthwaite easily justifies the conclusion that Claimant has sustained a 50% or more loss of use to the back. But impairment and disability are not synonymous. The 10% impairment to Claimant's shoulder and the restrictions described by Plaintiff and placed upon her by Drs. Satterthwaite and Tollison, which will be discussed more fully below, greatly magnify these impairment ratings to a much more significant level of disability.

⁵ Again, this is a pre July 1, 2007 case.

Under § 42-9-10, Claimant is totally disabled because her incapacity for work resulting from this accident is total. Claimant need not prove that she suffers from "complete physical helplessness." *Koon vs. Spartan Mills*, 286 SC 190, 192 N. 1, 332 SE 2d 544, 545 N. 1 (Ct App 1985). And to her credit she does not claim that she is in a state of complete physical helplessness, as evidenced by her attempts to find some joy in life with yard work, exercise, and even boating twice on calm water over a two year period, all of which are within her limitations.

It is undisputed that Claimant cannot work as a police officer. The question, then, is what kind of work, if any, she can perform. In determining that Claimant is not permanently and totally disabled, the Single Commissioner emphasized the opinions of two treating physicians but ignored significant qualifications those same physicians placed on their opinions. The Single Commissioner found that Dr. Satterthwaite stated Claimant is "capable of performing sedentary work" and indicated further that his was "an opinion upon which I place great weight." (R. p. 20, paragraph 14) But to be comprehensive and valid, "great weight" must also be placed upon the numerous restrictions that Dr. Satterthwaite, a medical doctor rather than a vocational expert, placed upon Claimant that make it impossible to maintain even sedentary employment. Dr. Satterthwaite opines that she could stand less than two (2) hours per day and sit less than two (2) hours per day and that she could only sit thirty (30) minutes before changing position, stand twenty (20) minutes before changing position, walk around every thirty (30) minutes, sit/stand/walk *at will*, lie down at unpredictable intervals during a work shift, miss at least three (3) days of work per month, and be distracted from or abandon tasks because of pain. (R. pp. 153-155) She cannot work at a computer for a prolonged period. (R. p. 161) Claimant submits that no employer would hire a person to perform even sedentary work who can't stay seated and needs to lie down occasionally and would miss at least three (3) days of work per month, etc.,

and it is doubtful that anyone reading this brief would hire a person with those restrictions to perform even sedentary work.

The Single Commissioner also found that Dr. Tollison stated Claimant is “able to maintain competent employment with restrictions”, and again indicated that his was “an opinion upon which I place great weight.” (R. p. 20, paragraph 15) Here again to be comprehensive and valid, “great weight” must also be placed upon the numerous restrictions that Dr. Tollison, a psychologist rather than a vocational expert, places upon Claimant that make it impossible to maintain even sedentary employment. Dr. Tollison opines that she is depressed and anxious; she can only deal with the public “for brief periods of time and in situations that are not highly stressful;” she is limited in her “ability to maintain concentration over long periods of time,” and “she would require periodic breaks”; and that she could “probably function in a relatively stress-free position without significant demands” so long as she had “breaks and rest periods”, with these breaks and rest periods needing to be “unscheduled” or “as needed” to maintain that competent employment. (R. pp. 216-219) Here again, Claimant submits that no employer would hire an employee to perform even sedentary work who can’t deal with the public and needs to walk away anytime work gets stressful. Would anyone reading this brief hire a person with those restrictions to perform even sedentary work?

From an evidentiary standpoint, the following is more important. None of Claimant’s treating physicians are vocational experts, and they are not qualified to determine specifically whether the restrictions they place upon her will allow her to be employed at any particular exertional level. That is the work of a vocational expert. So it is highly significant that Claimant was evaluated by a qualified vocational expert, Benson Hecker, PhD. Dr. Hecker took all of Claimant’s medical records and physical restrictions into account, including her chronic pain, as

well as her education, vocational background, and transferrable skills, and he concluded that she is not employable. He went into significant detail in explaining the basis for his opinion. (R. pp. 232-252). Knowing full well that Claimant was claiming permanent and total disability, Employer/Carrier did not rebut Dr. Hecker's opinions with any vocational opinion. Employer/Carrier could easily have required Claimant to undergo a vocational evaluation but did not do so.

Finally, Claimant's desire to work is evidenced by her testimony. And if that testimony is questioned, it is also supported by Dr. Satterthwaite's medical records. In particular, a review of Dr. Satterthwaite's October 18, 2007 note shows the effort and interest of both Claimant and her treating physician in maintaining her work. (R. pp. 196-197) To underscore the nobleness of her efforts, bear in mind that she was attempting to work with two injured and untreated discs (C5-6 and L5-S1). While it is true that she was "not interested in a desk job" as opposed to working on the street as a police officer, she would love to work. She has expressed her desire to work. She is simply unable to do so.

In the event this Court concludes that Claimant did injure her low back and, because she has been denied treatment is not at MMI, it can still determine that she is permanently and totally disabled. In *Bass v. Kenco Group*, 366 SC 450, 622 SE 2d 577 (2005), a single commissioner had found that a claimant had reached MMI with respect to physical injuries but not with respect to psychological complications. The commissioner awarded permanent partial disability for the physical injuries, even though the claimant had not reached MMI with respect to his psychiatric or psychological injuries. The employer contended that, absent MMI with respect to *all injuries*, a claimant cannot receive an award of permanent benefits. On appeal, the court found that the claimant was not, in fact, precluded from an award of permanent benefits and that an award of

permanent partial disability was proper even though the claimant had “reached maximum medical improvement with respect to his shoulder but not his mental injuries.” *Id* at 467. The reasoning applied in *Bass* is even more compelling in this case, when claimant has injuries that should render her permanently and totally disabled. Here, the injuries for which Claimant is undisputedly at MMI combined to cause permanent and total disability under either § 42-9-30(19) or under § 42-9-10. That is the case without regard to whatever permanent impairment might be assigned to Claimant after treatment and/or surgery at L5-S1, although *some* permanent impairment to the lumbar spine can be presumed with a torn disc at L5-S1, regardless of whether surgery is performed.

IV. THE SINGLE COMMISSIONER'S FINDINGS ON CREDIBILITY, ESPECIALLY WITH REGARD TO THE "BOAT COVER INCIDENT", ARE IMMATERIAL AND NOT SUPPORTED BY SUBSTANTIAL EVIDENCE.

Claimant is a police officer who has been seriously injured in two work related accidents. The evidence is overwhelming that she suffered a disc injury at C5-6 and L5-S1, and it is undisputed that she suffers from depression and anxiety. Claimant worked for several years while in pain management following her August 23, 2003 injury, and she attempted to work for ten (10) months while being denied treatment for two injured discs (C5-6 and L5-S1). Claimant testified consistent with her injuries, impairment ratings, and restrictions, as well as the opinions of her treating physicians with respect to her injuries, impairments, and restrictions. **Not one treating physician has so much as hinted that Claimant is malingering or that her complaints are inconsistent with her injuries.** She has not attempted to portray herself as suffering from "complete physical helplessness." She volunteered information about her activities on direct examination. She didn't try to hide them.

Accordingly, her credibility should not be questioned, particularly when the centerpiece of the credibility issue is an irrelevant and immaterial incident, i.e. the "boat cover incident". This Court can review the hearing transcript R. pp. 115-125 – ten (10) pages dedicated to the "boat cover incident"- and recognize that there was confusion on the part of Employer/Carrier's counsel as to the details of the incident he was questioning Claimant about. That and the nature of cross examination is what accounts for the extended and confusing exchange. The facts regarding the "boat cover incident" are outlined on page 10 of this brief. If this panel reads that section first, they will completely understand why it took ten pages of transcript to attempt to unwind this issue.

When Claimant attempted to submit additional records (Motions to Admit - R. pp. 37-50; pp. 54-61) that completely support her claim that the "flower watering incident" caused aggravation to her back in July 2009, namely Dr. Tollison's note dated August 4, 2009, Employer/Carrier's counsel opposed consideration of those records. (Return to Motions to Admit - R. pp. 51-53; pp. 63-65) (Orders Denying - R. pp. 15-17) But even without those records, it is a stretch to conclude that Dr. Satterthwaite's record does any more than imply the "boat cover incident" caused aggravation to Claimant's back rather than the "flower watering incident." Further, it is a stretch to conclude Claimant is not credible because of the confusion. She openly stated three (3) different times that she went out on her parents' boat twice in the summer of 2009. She had nothing to hide.

To the extent that the "boat cover incident" constituted impeachment, it should not have, because it involved collateral matter. The general rule is that it is improper to allow impeachment on collateral matter. *Aakjer v. Spagne*, 291 SC 165, 352 SE 2nd 503 (Ct. App. 1987). The "boat cover incident" was collateral and thus irrelevant for the following reasons. No treating physician took it into account in rendering opinions on impairment or restrictions. Whatever the cause of the aggravation, the point is that it occurred after Claimant's injury and after all treating physicians had rendered their opinions on impairment. There is no evidence that Claimant or the treating physicians relied upon that incident to contend she is impaired and restricted and unable to work. For the same reasons, the low back aggravation incident, regardless of the cause, cannot be an "unrelated, intervening" incident that caused Claimant's condition. (The Single Commissioner found that "if Claimant aggravated her low back condition in the accident in issue, the aggravation was temporary, and her condition returned to baseline or is the result of ... the unrelated, intervening boat cover incident." (R. p. 22, paragraph 19) Here

again, Claimant and Dr. Satterthwaite based Claimant's impairments and restrictions on radiculopathy, which prompted an MRI showing an injured disc at L5-S1, all of which preceded the "boat cover incident." (R. pp. 150-152) It is clear that the injury to Claimant's low back was not a "temporary" aggravation. The only temporary aggravation occurred in July 2009. Regardless of the cause, by definition the temporary aggravation that occurred in July of 2009 cannot have been "intervening".

CONCLUSION

Based on the foregoing, Claimant asks that the Court of Appeals reverse the Circuit Court and find as a matter of law:

1. That Claimant injured her low back at L5-S1;
2. That Claimant is entitled to medical treatment for her low back, including a referral to an orthopaedic or neurosurgeon;
3. That Claimant is permanently and totally disabled under § 42-9-30 (19) (or) under § 42-9-10; and
4. That Claimant was a dedicated police officer who did not exaggerate her restrictions or limitations and has a good work ethic.

Date: 2/14/2012


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THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM SOUTH CAROLINA
GREENVILLE COUNTY COURT OF COMMON PLEAS

CASE TRACKING NO: 2011198006

KELLIE N. BURNETTE..... APPELLANT,

v.

CITY OF GREENVILLE.....RESPONDENTS.
AND HEWITT COLEMAN & ASSOCIATES

CERTIFICATE OF COUNSEL

The undersigned hereby certifies that this FINAL BRIEF OF APPELLANT complies with Rule
211(b), SCACR.

February 14, 2012



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THE STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

APPEAL FROM GREENVILLE COUNTY
COURT OF COMMON PLEAS
G. EDWARD WELMAKER, CIRCUIT COURT JUDGE

2010-CP-23-3442
CASE TRACKING NO. 2011198006

KELLIE N. BURNETTE,.....Appellant,

v.

CITY OF GREENVILLE,.....Respondents.
AND HEWITT COLEMAN & ASSOCIATES

FINAL BRIEF OF RESPONDENTS

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TABLE OF CONTENTS

Table of Authorities.....	ii
Argument.....	9
I. IS AN AWARD OF 25% DISABILITY TO THE SPINE SUPPORTED BY THE SUBSTANTIAL EVIDENCE IN THE RECORD WHICH INCLUDES RATINGS FROM THE TREATING PHYSICIANS OF 10% AND 25% TO THE WHOLE PERSON RELATED TO THE CERVICAL SPINE INJURY?.....	9
II. WHEN A CLAIM IS BASED, IN PART, UPON THE CLAIMANT'S HISTORY OF EVENTS AND HER SUBJECTIVE COMPLAINTS OF PAIN, IS THE CLAIMANT'S CREDIBILITY IMPORTANT?..	16
Conclusion.....	21

TABLE OF AUTHORITIES

Cases

<u>Aakjer v. Spagnoli</u> , 291 S.C. 165, 352 S.E.2d. 503 (Ct. App. 1987)	19
<u>Ellison v. Frigidaire Home Products</u> , 371 S.C. 159, 638 S.E. 2d. 654 (2007)	13,14
<u>Etheridge v. Monsanto Co.</u> , 349 S.C. 451,454, 562 S.E.2d. 679, 681 (Ct. App. 2002)	8
<u>Fields v. Owens Corning Fiberglass</u> , 301 S.C. 444, 393 S.E.2d. 172 (1990).....	7
<u>Lark v. Bi-Lo, Inc.</u> , 276 S.C. 130, 135, 276 S.E.2d. 304,306 (1981)	8
<u>Lee v. Harborside Café</u> , 350 S.C. 74, 564 S.E.2d. 354 (Ct. App. 2002)	7
<u>Parr v. Gaines</u> , 309 S.C. 477, 424 S.E.2d. 515 (Ct. App. 1992).....	19
<u>Potter v. Spartanburg School District 7</u> , Op. No. 4890 (S.C. Ct. App. Filed September 14, 2011).....	15
<u>Shealy v. Aiken County</u> , 341 S.C. 448, 455, 535 S.E.2d. 438, 442 (2000).....	15
<u>State v. Mizell</u> , 332 S.C. 273, 504 S.E.2d. 338 (Ct. App. 1998)	19
<u>State v. Williams</u> , 263 S.C. 290, 210 S.E.2d. 298 (1974)	19
<u>Taylor v. S.C. Dep't of Motor Vehicles</u> , 368 S.C. 33, 36, 627 S.E.2d. 751, 752 (Ct. App. 2006).....	9
<u>Tiller v. National Health Care Center</u> , 334 S.C. 333, 340, 513 S.E.2d. 843, 846 (1999).....	15

Statute

S. C. Code Ann. §42-9-30	7

STATEMENT OF THE CASE

This is a workers' compensation case. The Appellant Kellie Burnette (hereinafter "Claimant") filed her initial Form 50 on May 8, 2008 alleging an injury by accident on June 6, 2007. (ROA p. 30). The Claimant alleged injuries to her "neck/upper back/mid back/lower back and psyche." The Respondents City of Greenville, as employer, and Hewitt Coleman & Associates, as third-party administrators, (hereinafter collectively "Employer") filed a Form 51 admitting an injury by accident to the neck and upper back but denying the other injuries. (ROA p. 31).

The Claimant filed another Form 50 on June 10, 2009 alleging injuries to her "spine; psyche/depression." (ROA p. 32). The Employer filed a Form 51 once again admitting injury to the neck and upper back. (ROA p. 33). The Employer also alleged that the Claimant had reached maximum medical improvement ("MMI") and requested a credit for any compensation paid to Claimant after MMI. (ROA p. 23).

The evidentiary hearing was held September 3, 2006 before Commissioner Susan S. Barden. By Decision and Order filed October 14, 2009, the hearing commissioner found that the Claimant's injured her "neck and upper back in an admitted accident on June 16, 2007, and also sustained admitted psychological overlay." (ROA p. 8). The hearing commissioner denied the Claimants claim for injury to her low back. (ROA p. 8). The hearing commissioner found that the Claimant reached MMI on June 23, 2009 with a "25% permanent partial disability to her spine (for cervical injury)." (ROA p. 13). The hearing commissioner specifically found:

I strongly believe the Claimant has exaggerated her condition to various providers and to the undersigned in order to maximize her case/award. (ROA p. 12, para. 21).

On appeal, the Appellate Panel of the South Carolina Workers' Compensation Commission ("Full Commission") adopted verbatim the findings of fact and conclusions of law made by the hearing commissioner. (ROA p. 25).

The Claimant appealed to the circuit court. After oral arguments, the circuit court held that the substantial evidence in the record supported the findings of fact and conclusions of law as set forth by the hearing commissioner and the Full Commission. (ROA p. 27).

The Claimant filed a Motion to Alter or Amend Judgment on July 19, 2011. (ROA p. 71). The circuit court denied this motion by Form 4 Order filed July 29, 2011.

The Claimant now appeals to the Court of Appeals.

FACTS

The Claimant was a police officer for the City of Greenville. She has a long history of many injuries and infirmities. The specific traumatic injuries of which the City of Greenville is aware include a worker's compensation accident on August 23, 2003 and a shoulder injury in 2006.

As a result of the workers' compensation automobile accident on August 23, 2003, the Claimant received an award of 17.5% permanent partial disability to her back by Decision and Order filed January 11, 2006. (ROA p. 308). Long before January of 2006, the Claimant's low back pain had been diagnosed as "chronic." (ROA p. 287, 295-306). As early as September 3, 2003, the Claimant was already complaining of "a lot of pain in her low back". (ROA p.305). Despite also receiving injuries to her shoulder and knee in the August 23, 2003 automobile accident, the Claimant's "back is really most uncomfortable." (ROA p.302). She continued to have "persistent lumbar back pain status post motor vehicle accident" for many months. (ROA

p.298). She ultimately underwent an MRI on May 11, 2004 which revealed disc bulge at L5-S1 and L4-5. ("2004 MRI"). (ROA p.297). The 2004 MRI did not, however, reveal evidence of nerve root impingement or spinal canal stenosis. (ROA p.212).

The Claimant was ultimately referred to Dr. Kevin Kopera beginning June 21, 2004. The Claimant presented to Dr. Kopera on that date for "evaluation and treatment of low back pain, which has become chronic." (ROA p.141). The Claimant was complaining of "continuous low back pain" that is "notable with prolonged standing or sitting." (ROA p. 141). The Claimant's pain continued to escalate to the point where she requested "more aggressive treatment" and specifically inquired of Dr. Kopera if she might have fibromyalgia. (ROA p. 137-138). The Claimant underwent several local trigger point injections in the left lower lumbar region of her back. She also continued to take numerous medications for her back pain. (ROA p. 135-137).

While being treated by Dr. Kopera, the Claimant was also being treated by Dr. Robert Schwartz but the Claimant failed to inform Dr. Kopera of this additional treatment. (ROA p. 135). The Claimant was receiving injections from Dr. Schwartz as well as from Dr. Kopera.

When first evaluated by Dr. Schwartz on June 21, 2005, the Claimant was already taking the following medications: Darvocet, Mobic, Ambien, Effexor, Flexeril and Cataflam. The Claimant was complaining of "constant pressure" and "ache" in the lower back which was made worse by walking or sitting for extended periods of time. (ROA p. 147-149).

Dr. Schwartz ordered a nerve conduction study which was performed on July 18, 2005 revealing "left L5 nerve root irritation." (ROA Appendix p. 2-3). Based upon this testing, Dr. Schwartz performed an epidural steroid injection on July 22, 2005 and a lumbar facet region block on July 18, 2005. (ROA App. p. 1). Dr. Schwartz released the Claimant on August 23,

2005 with a 13% impairment rating to the spine. (ROA p. 143). Interestingly, the Claimant also asked Dr. Schwartz for a diagnosis of fibromyalgia. (ROA p. 146).

Dr. Alan Posta treated the Claimant for injuries related to the second known traumatic injury sustained by the Claimant. In May of 2006, the Claimant dislocated her shoulder and sustained a torn labrum while doing some housework. The Claimant told Dr. Posta that when she injured her shoulder, she also “felt a pop in her back and, since that time she has had persistent pain.” (ROA p. 273). Dr. Posta noted that the Claimant continued to suffer from “chronic back pain.” (ROA p.273). Dr. Kopera also noted that the Claimant’s back pain increased subsequent to the shoulder injury in 2006. (ROA p.293).

Dr. Posta released the Claimant for treatment related to the shoulder on June 11, 2007. The Claimant was cleared to return to work without restriction at this time. (ROA p. 283).

Just five days later, on June 16, 2007, the Claimant sustained the new injury-by-accident which is the subject of this claim.

The first doctor the Claimant saw after the June 16, 2007 accident was Dr. Justin Hutcheson at Carolinas Center for Advanced Management of Pain. This “initial office visit” was on August 28, 2007- almost two months after the accident. (ROA p.206). Dr. Hutcheson indicated that the Claimant was previously being treated by Dr. Kopera for “persistent back and neck pain” “after being T-boned in MVC at work.” (ROA p.206). The Claimant’s complaints of pain were in the “neck and bilateral paraspinals thoracic, upper lumbar”. (ROA p. 206). As of the time of her first appointment with Dr. Hutcheson, the Claimant was still taking the following medications for her low back pain: Baclofen, Ambien, Celebrex, Flexeril, Cymbalta, Lidocaine patch and Ultram. (ROA p.209).

After this evaluation, Dr. Hutcheson noted the Claimant's "new problems" to be "cervical spondylosis, thoracic spondylosis, myofascial pain syndrome and depression." (ROA p.208). Dr. Hutcheson did not find that the Claimant's back pain was a "new problem."

The Claimant's primary doctor at Carolina Center for Advanced Management of Pain because Dr. John Satterthwaite beginning September 24, 2007. (ROA p.198). Dr. Satterthwaite confirmed that the Claimant was seeing him because she "had an injury in June where she *hurt her neck*." (ROA p.198; APA p. 132)(emphasis added).

In an effort to clarify the source of the Claimant's subjective complaints of pain, Dr. Satterthwaite ordered an MRI of the Claimant's low back. ("2008 MRI"). The 2008 MRI confirmed no spinal canal stenosis or nerve root displacement or impingement. (ROA p.211).

When the Claimant continued to complain of back and neck pain, Dr. Satterthwaite asked the Claimant if "she would like to try a sedentary job" and the Claimant said that she would not. (ROA p.196).

After months of conservative treatment, it became apparent that the Claimant's primary problems were related to bulging discs in her neck. The Claimant was referred to Dr. David Mitchell at Orthopaedic Associates on September 19, 2008. Dr. Mitchell ordered an MRI of the Claimant's neck which was performed on September 22, 2008. This MRI revealed that "C5-6 has a right parasagittal disc protrusion and osteophyte narrowing of the spinal canal." (ROA p. 223). Dr. Mitchell referred the Claimant to a neurosurgeon.

The Claimant was first examined by Dr. Michael Bucci at Piedmont Spine and Neurosurgical Group on October 22, 2008. (ROA App. p. 90). Dr. Bucci performed an anterior cervical spine discectomy and interbody fusion on December 27, 2008. (ROA p.229; APA p.

257). He released the Claimant on April 3, 2009 to return to work without restriction with a 10% impairment to the spine. (ROA p. 227).

Subsequent to the neck surgery, the Claimant's condition improved. She began "taking medication with good effect and no side effects." (ROA p.163, 165). She was "doing well on present pain management program." She was "stable with medical management of chronic pain." (ROA App. p.5). The Claimant joined a health club sometime prior to July 1, 2009. (ROA p. 159). Her "pain rating" dropped from 9 as of October 1, 2008 down to 6 as of July 1, 2009. (ROA p. 159, 170).

As of July 1, 2009, the Claimant's condition was "fairly well controlled with medications" and the Claimant remained active within her limitations. (ROA p. 159). On this date, Dr. Satterthwaite opined that the Claimant had reached maximum medical improvement with a 25% impairment to the whole person related to the cervical spine and 12% impairment to the whole person related to the lumbar spine.¹ (ROA p. 161). Dr. Satterthwaite continued the Claimant on medication such as Baclofen, Flexeril, Lidocaine Patches and Ambien. (ROA p. 161).

The Claimant submitted all of the medical records of Dr. Satterthwaite as part of her APA Submissions except for the one dated July 23, 2009. The Claimant did not submit the July 23, 2009 record because it revealed a new injury. (ROA p. 256-260).

On July 23, 2009, just three weeks after a "pain rating" of 6 and a finding of MMI by Dr. Satterthwaite, the Claimant returned with a "pain rating" of 9 complaining of "increased lower back pain." The Claimant told the nurse practitioner that there was "an incident on the weekend in which the sun cover on her boat flew off and she and a friend had to pick it up and put it in

¹ Compare to 13% impairment rating to spine on August 23, 2005. (ROA p. 145; ROA App. p. 1).

their truck.” (“Boat Cover Incident”). (ROA p. 256). A few days later, she started “having increased lower back pain that radiates to her left and into her buttocks.” (ROA p. 256). Once again, the Claimant sought a diagnosis of fibromyalgia.

The Claimant was instructed to increase some of her medication for one week and follow-up in one month if necessary. (ROA p. 256, 258). The Claimant never returned to Dr. Satterthwaite before the hearing held on September 3, 2009. Instead, she directed her energy toward getting a vocational opinion from Benson Hecker on August 11, 2009. (ROA p. 232). Benson Hecker’s records also fail to reference the July 23, 2009 note of Dr. Satterthwaite or the Boat Cover Incident. (ROA p. 241-242).

During the same time period that the Claimant was being treated by Drs. Satterthwaite, Mitchell and Bucci for her physical problems, the Claimant was also being treated by Dr. David Tollison, Phd. David Tollison followed the Claimant from June 23, 2008 through June 18, 2009. (ROA p. 220, 221). He opined that the Claimant reached maximum medical improvement related to her psyche by June 22, 2009. (ROA p. 214). Tollison’s treatment for the Claimant involved various medications which the Claimant took “with good effect and no side effects”. (ROA p. 163-168).²

When testifying regarding the June 16, 2007 fall, the Claimant testified “at the time of impact I felt a shock go up both sides of my neck all the way up to my head. I also felt a shock in my low back.” (ROA p. 101-102). She also testified that her pain is now in her “entire back and neck. It starts from my neck and goes down to my low back, the buttocks area. The pain also at times it does radiate down a nerve of my leg.” (ROA p. 103-104). She further testified

² Psychological impairment is not compensable under S. C. Code Ann. §42-9-30. Fields v. Owens Corning Fiberglass, 301 S.C. 444, 393 S.E.2d. 172 (1990); Lee v. Harborside Café, 350 S.C. 74, 564 S.E.2d. 354 (Ct. App. 2002).

that she can only stand or sit comfortably for 20 to 30 minutes at a time and can also only walk a block or two. (ROA p. 107-108).

The Claimant confirmed during the September 30, 2009 hearing that she had not returned to Dr. Bucci since being released by him on March 24, 2009. (ROA p. 115). She also confirmed that she has no follow-up appointments with him. (ROA p. 115).

When asked about the July 2009 Boat Cover Incident, the Claimant tried to deny that that incident in any way exacerbated her lumbar back pain. (ROA p.115-122). In so denying, the Claimant tried to pin the exacerbation of her low back pain to watering flowers. (ROA p. 121). Her attempts to downplay the significance of this new injury by accident were convoluted and incredulous.

The Claimant also admitted at trial that she had recently joined a gym, attends regularly and works out for approximately an hour and a half each time she goes to the gym. (ROA p. 125-126). She also confirmed that she goes out regularly and can drive her truck without any problems. (ROA p. 126-127).

STANDARD OF REVIEW

The Administrative Procedures Act establishes the standard of review for decisions by the South Carolina Workers' Compensation Commission. Lark v. Bi-Lo, Inc., 276 S.C. 130, 135, 276 S.E.2d. 304,306 (1981). The Commission is the ultimate fact finder in workers' compensation cases. Etheridge v. Monsanto Co., 349 S.C. 451,454, 562 S.E.2d. 679, 681 (Ct. App. 2002). The findings of the Commission are presumed correct and will be set aside only if unsupported by substantial evidence. Lark, 276 S.C. at 135, 276 S.E.2d. at 306. Substantial evidence is not a mere scintilla of evidence, nor the evidence viewed blindly from one side of the case, but is evidence that, considering the record as a whole, would allow reasonable minds to

reach the conclusion the administrative agency reached in order to justify its action. Taylor v. S.C. Dep't of Motor Vehicles, 368 S.C. 33, 36, 627 S.E.2d. 751, 752 (Ct. App. 2006).

ARGUMENT

I. IS AN AWARD OF 25% DISABILITY TO THE SPINE SUPPORTED BY THE SUBSTANTIAL EVIDENCE IN THE RECORD WHICH INCLUDES RATINGS FROM THE TREATING PHYSICIANS OF 10% AND 25% TO THE WHOLE PERSON RELATED TO THE CERVICAL SPINE INJURY?

The hearing commissioner found that the Claimant sustained a 25% permanent partial disability³ to her spine related to the injury to her cervical spine. This award is supported by the reliable, probative and substantial evidence in the record and must be affirmed.

As a result of her fall on June 16, 2007, the Claimant injured her neck. The City of Greenville does not contest this fact. The record amply supports the finding that the only *permanent* injury was to the neck.

The first doctors the Claimant saw after the June 16, 2007 accident were Drs. Hutcheson and Satterthwaite at Carolinas Center for Advanced Management of Pain. In no uncertain terms, Dr. Satterthwaite noted in his records that Claimant "had an injury in June where she hurt her

³ The hearing commissioner found that "the authorized treating physicians assigned whole person ratings of 25% and 28%." This is not technically correct. It is not disputed that Dr. Satterthwaite assigned a 25% whole person rating based upon the impairment to the cervical spine. When the record is viewed in its entirety, however, it is apparent that Dr. Bucci only assigned a 10% impairment to the whole person.

When Dr. Bucci released the Claimant on April 3, 2009, he completed WCC Form 14B by noting that the Claimant sustained a 10% medical impairment. For body part injured, he noted "C-spine". (ROA p. 227). If he had truly meant that Claimant sustained a 10% impairment to the cervical spine, that would equate to only 3.5% to the whole person.

When Dr. Bucci completed a medical questionnaire on August 6, 2009, he assigned a 28% impairment rating purportedly "to the whole person as a result of the cervical spine injury." (ROA p. 224). It is apparent that Dr. Bucci was actually rating the cervical spine at 28% impairment. A 28% impairment rating to the cervical spine converts to a 10% whole person rating under §15.13 of the AMA Guides to the Evaluation of Permanent Impairment (5th ed.).

Dr. Bucci did not examine the Claimant between April 3, 2009 and August 6, 2009. He would have no basis to increase the rating from 10% to 28% to the whole person- much less 3.5% to 28%. The only logical explanation for the two ratings is that the 10% rating was to the whole person and the 28% was to the cervical spine. Those ratings are synonymous.

neck". (ROA p. 198). The Claimant's "current increased neck pain seems to have been aggravated by an injury in June when she was jerked by a car trying to leave the scene." (ROA p. 200).

Dr. Satterthwaite treated the Claimant conservatively for months- primarily through continuation and the occasional tweaking, of medications that the Claimant had already been taking prior to the June 16, 2007 accident. (ROA p. 197). He also gave the Claimant some epidural steroid injections. (ROA p. 172, 177, 180, 183, 188).

The Claimant was ultimately referred to Dr. Mitchell for evaluation because the Claimant "continues to complain of cervical neck pain." (ROA p. 223). Dr. Mitchell ordered an MRI which revealed "C5-6 has a right parasagittal disc protrusion." (ROA p. 223). Dr. Mitchell referred the Claimant to a neurosurgeon for surgical intervention regarding the neck.

Dr. Bucci operated on the Claimant's neck on October 27, 2008. (ROA p. 229). The Claimant tolerated the procedure well and recovered nicely. (ROA p. 228). Dr. Bucci released the Claimant to return to work without restrictions on April 3, 2009 with a 10% impairment rating. (ROA p. 227). (See footnote 3).

Dr. Satterthwaite continued to follow the Claimant for pain management after Dr. Bucci's release and her condition continued to improve gradually. Dr. Satterthwaite repeatedly noted that Claimant was "stable with medical management of chronic pain." (ROA p. 166; ROA App. p.5). The Claimant was also experiencing "no side effects from medication." (ROA p. 163, 164, 165, 167). The Claimant did not complain of any pain radiating down her legs subsequent to the

surgery on her neck. (ROA 163-169; ROA App. p. 4-23). In fact, even prior to the neck surgery, the Claimant had “minimal leg pain” and her lumbar radiculopathy had “improved.”⁴

Dr. Satterthwaite found that the Claimant reached MMI on July 1, 2009 with a 25% impairment to the whole person related to injury to the cervical spine. (ROA p. 161). Dr. Satterthwaite also assigned a 12% impairment rating to the whole person related to the lumbar spine but acknowledged that this was “ongoing back and left leg pain from her previous back injury.” (ROA p. 159, 161).

Dr. Satterthwaite’s opinion that the Claimant’s impairment to the lumbar spine was related to the prior injury is consistent with the prior award of the Commission of 17.5% disability to the spine. (See ROA p. 226). Dr. Satterthwaite’s impairment rating of 12% to the spine (related to the lumbar spine) is also consistent with the 13% impairment rating provided by Dr. Schwartz in 2005. (ROA p. 143).

The fact that the Claimant may have experienced some changes in her back pain between June 16, 2007 and the evidentiary hearing on September 3, 2009 does not equate to a new permanent injury or a compensable aggravation of the prior injury. The reason the Claimant received an award of 17.5% disability to the back by Order dated January 2006 was because she had permanent injury to her back and would suffer from continuing back pain in the future. Otherwise, she would not have received any permanency award related to the 2003 claim. When the record is viewed in its entirety, the Claimant’s back is essentially the same as it was prior to this accident on June 6, 2007.

⁴ Despite no reference to radicular pain for these months, the Claimant testified at trial that the pain “does radiate down a nerve” of her leg. (ROA p. 103-104). The medical records simply do not corroborate the Claimant’s testimony.

An EMG study of the Claimant's back from 2005 revealed a left L5 nerve root irritation. (ROA App. p. 3). The 2004 MRI of the Claimant's low back indicated minimal diffuse disc bulging at L5-S1 and L4-5 without evidence of focal disc protrusion, stenosis or nerve root impingement. (ROA p. 212). The May 2004 MRI revealed paresthesia in the leg. (ROA p. 193). Prior to the June 16, 2007 accident, the Claimant was taking a laundry list of medications for the lower back pain. She complained that she could only sit or stand for 30 minutes at a time without experiencing pain. (ROA p. 148).

Similarly, after the June 16, 2007 injury, and to this day, the Claimant still complains that she can only sit or stand 20 to 30 minutes at a time without experiencing pain. (ROA p. 107). She is still taking a laundry list of similar medications. (ROA 213-221; ROA App. p.25-89). The 2008 MRI also revealed no spinal canal stenosis or nerve root displacement or impingement. (ROA p. 211). The hearing commissioner's Finding of Fact No. 18 (which was adopted by the Full Commission) sets forth with clarity the similarities between the Claimant's back condition prior to and after the June 16, 2007 accident:

Claimant's contention that she aggravated her pre-existing low back condition is not supported by the greater weight of the evidence: (a) on the date of the accident, Claimant had "chronic" low back pain from a previous accident for which she received a workers' compensation award of 17.5% in 2006; I find that the greater weight of the evidence (excluding Claimant's self-serving testimony) shows that condition was and is ongoing, but was not aggravated by the accident in issue; (b) Claimant's testimony that her pre-existing back condition did not affect her legs until after the accident in issue is refuted by the medical evidence (e.g., Claimant's APA #3, p.41- "*has ongoing back and left leg pain from her previous back injury*:" and p. 124- "*at that time [referring to a May 2004 MRI] noting RLE paresthesia*"); and Claimant's APA #2, p. 17- an EMG study from 2005 showing left L5 nerve root irritation; (c) as of July 1, 2009 (2 months prior to the date of the hearing before the undersigned), Claimant's back pain is noted to be fairly "well-controlled" with medications; (d) Claimant's

lumbar MRI- undergone after the date of the accident in issue- shows only a "minimal" protrusion with no nerve root displacement or impingement, and comparatively, no greater pathology of any significance (if any) than the MRI of 2004; (e) in September 2008 (post-accident in issue), Claimant noted "minimal" leg pain," a record to which I give greater weight than I give to later records or Claimant's testimony at the hearing; (f) an early medical record (just a few months after the date of the accident in issue) from Dr. Satterthwaite states that Claimant "[h]ad an injury in June where she hurt her neck." This record goes on to say that Claimant has neck pain later in the day with working; there is no mention of back pain after working (e.g., Claimant's APA #1, pp. 2-5 and 10, as to Claimant's history of "chronic" low back pain; Claimant's APA #3, pp. 83-""minimal" leg pain, 132- "had an injury where she hurt her neck," 134- neck pain aggravated by accident in issue, with no mention of aggravation of back, and 146-147 (2008 MRI); Claimant's APA #6, p. 237- prior workers' compensation award; Defendants' APA #11, p. 301, as to a history of "chronic" low back pain; Defendants' APA #14, pp. 322-328, as to a history of "chronic" low back pain; Defendants' APA #14, page 322-328, as to a history of "chronic" low back pain; Defendants' APA #15, pp. 330 and 332-333, as to the findings from Claimant's 2004 MRI). (ROA p.10-11).

The only permanent disability the Claimant sustained as a result of the June 16, 2007 accident was to the neck. Her chronic low back pain as it currently exists is the same as it has been for years. Although she may have experienced intermittent flare-ups with her low back pain, which is to be expected with a 17.5% existing disability, she did not sustain any new *permanent* disability.

The Claimant argues that the holding in Ellison v. Frigidaire Home Products, 371 S.C. 159, 638 S.E. 2d. 654 (2007) requires a finding of permanent and total disability. The Claimant's reading of Ellison is too expansive.

Ellison stands for the proposition that an employee may recover greater disability than that which he or she incurred from a single injury to a particular body part if it combines with

preexisting condition(s) to hinder reemployment. Id. at 164, 638 S.E.2d. 666. Ellison does not stand for the proposition that the fact finder must enhance the award of disability or that such greater disability must result in a finding of permanent and total disability.

The present case, the hearing commissioner and the Full Commission expressly considered that Claimant's preexisting conditions. The hearing commissioner and the Full Commission discussed at length the evidence from all the health care providers. The hearing commissioner and the Full Commission made specific findings as to the credibility of the Claimant. In light of everything, the hearing commissioner and the Full Commission found that the Claimant sustained 25% permanent partial disability. But for the preexisting conditions, the hearing commissioner and the Full Commission may have awarded the Claimant less disability than 25%. The hearing commissioner and the Full Commission found as a matter of fact that the Claimant is not permanently and totally disabled. (ROA p.12). This finding is supported by the reliable probative and substantial evidence in the record and is not controlled by an error of law.

Dr. Satterthwaite opined that the Claimant is capable of working. (ROA p. 156, 196-197). Dr. Tollison opined the Claimant is capable of maintaining "competent employment." (ROA p. 218). The hearing commission and the Full Commission found as a matter of fact;

Claimant strikes the undersigned as someone who simply does not wish to work (medical evidence as a whole; testimony of Claimant, including but not limited to the issue of the amount of her monthly police disability income *vis a vis* her average weekly wage). (ROA p.12).

It is understandable that the Claimant does not like these opinions and may argue that there are confliction opinions. This court may not even agree with the Full Commission's findings of fact. The standard of review, however, is whether the substantial evidence in the

record supports the Full Commission's findings of fact. As correctly found by the circuit court, the substantial evidence does support these findings.

The Claimant also implies that the hearing commissioner and Full Commission are required to accept the opinions of her vocational expert as well as the opinion of the disability examiner for the South Carolina Retirement System.⁵ Such is simply not the law of this state.

The Full Commission is the ultimate finder of fact. The Full Commission has discretion to weigh and consider all the evidence, both lay and expert. Tiller v. National Health Care Center, 334 S.C. 333, 340, 513 S.E.2d. 843, 846 (1999). The Commission may disregard medical testimony if other competent evidence is presented. Id. The final determination of witness credibility and the weight to be accorded evidence is reserved to the Full Commission. Shealy v. Aiken County, 341 S.C. 448, 455, 535 S.E.2d. 438, 442 (2000); Potter v. Spartanburg School District 7, Op. No. 4890 (S.C. Ct. App. Filed September 14, 2011).

Accordingly, this case involves a specific loss to a scheduled member. The Claimant is only entitled to a disability award for the specific loss to the scheduled member. The Full Commission's finding that the Claimant sustained a 25% permanent and partial disability to the spine related to the neck injury is supported by the reliable, probative and substantial evidence in the record as found by the circuit court. The orders of the hearing commissioner, Full Commission and circuit court must all be affirmed.

⁵ Nevertheless, the State Retirement Disability examination was on April 4, 2008. (ROA p. 231). It was based upon incomplete records and it expressly states: "Due to the possibility of medical improvement, a medical review is recommended in three years." (ROA p. 231).

II. WHEN A CLAIM IS BASED, IN PART, UPON THE CLAIMANT'S HISTORY OF EVENTS AND HER SUBJECTIVE COMPLAINTS OF PAIN, IS THE CLAIMANT'S CREDIBILITY IMPORTANT?

The hearing commissioner and Full Commission found the Claimant not to be credible. Based upon the totality of the record, the hearing commissioner and Full Commission formed a strong belief that the Claimant "has exaggerated her condition to various providers and to the undersigned in order to "maximize" her case/award." (ROA p. 12 para. 21; 18-26). The hearing commissioner and the Full Commission also found that the Claimant's explanation of the Boat Cover Incident to be "laborious", "unconvincing" and "not at all believable." (ROA p. 10 para 17; 18-26). In light of these findings, the Claimant now takes the position that her credibility is irrelevant. This position is as disingenuous as the Claimant's testimony that the Boat Cover Incident did not exacerbate her low back pain.

From the date the Claimant underwent neck surgery on October 27, 2008 until July 1, 2009, the Claimant's back condition gradually and steadily improved. The Claimant's "pain rating" had dropped from a 9 to 6. She no longer had new complaints of pain. She no longer even complained of any radiculopathy in any of her extremities. Her gait was "normal." (ROA p. 160). Her pain was being managed by medications. She had joined the gym and started working out regularly. Her symptoms were not keeping the Claimant from living a relatively normal day-to-day existence. Based upon the plateau in her condition, the Claimant's treating physicians determined she had reached MMI. She received impairment ratings of 10% and 25% to the whole person.

Within days after the determination was made that she had reached MMI, the Claimant returned to Dr. Satterthwaite's office on July 23, 2009 complaining of "increased lower back pain mainly on the left." (ROA p. 256). The Claimant recited "an incident on the weekend in

which the sun cover on her boat flew off and she and her friend had to pick it up and put it in her truck." On Tuesday, she started "having increased lower back pain that radiates to her left and into her buttocks." (ROA p. 256). She also related "an increase in myofascial pain in her arms, back, chest and legs with light touch." She once again asked for a determination that she was developing fibromyalgia. (ROA p. 256). The Claimant rated her "pain as 9/10." Her gait was suddenly "antalgic." (ROA p. 257).

Given the fact that the Claimant's condition had been progressively and steadily improving over the prior six months, it was entirely relevant for the City of Greenville to inquire into this new incident that occurred prior to July 23, 2009 which resulted in the sudden deterioration of the Claimant's condition.

When asked on cross-examination whether the Claimant "told the doctor that over the weekend the suncover on her boat flew off and she and her friend had to pick it up and put it in the truck," the Claimant testified that that statement in the medical record was incorrect. (ROA p. 118). When asked how it was incorrect, the Claimant indicated first that "they state there that it was my boat and it wasn't." (Id.). It was apparent that the Claimant was caught off guard by this question and she knew she needed to somehow distance herself from it. All she could come up with initially was the fact that the medical chart was incorrect because it indicated that the boat was hers when it was really her parents- a fact that is truly irrelevant in the analysis.

The Claimant was then questioned whether there was anything else incorrect with the medical chart and she asked for the record to be re-read. After it was recited to her, the Claimant this time indicated that it was not a boat cover-it was simply a cushion that goes across the back of the boat. (ROA p. 118-119).

As to the statement in the medical record that "she and her friend had to pick it up and put it in their truck," the Claimant testified that also was incorrect. (ROA p. 119). She indicated that her partner Jennifer Hall is the one who picked up the cushion and the two of them leaned it against the truck. Then, the two of them pushed the cushion up into the truck. It is unclear exactly how the Claimant contends that the written report was contrary to her testimony of the event but, nevertheless, she maintained that the written report was wrong in that regard.

Finally, when asked about the reference in the medical record that the Claimant had increased low back pain beginning on Tuesday following the Boat Cover Incident, the Claimant tried to testify that the Boat Cover Incident had nothing to do with her increased pain. Instead, she claimed that it was due to "watering the flowers." (ROA p. 120-121). If the Claimant injured herself "watering the flowers," it does not help her claim anymore than if she injured her back with the Boat Cover Incident. Either way, the temporary exacerbation of her back pain was caused by something non-work related.

Nevertheless, the Claimant's testimony that she told Dr. Satterthwaite's office about the Boat Cover Incident but that it had nothing to do with her increased pain a few days later does not make sense. It is obvious that the Claimant told Dr. Satterthwaite's office about the Boat Cover Incident. Otherwise, Dr. Satterthwaite's office would have no reason to include that in the medical record. It is also obvious that the gist of the Boat Cover Incident contained in the medical record is correct although some of the finer details (who owned the boat, whether it was a boat cover or a boat cushion, whether they picked the cushion up and put it in the boat or just pushed it in the truck) may have been omitted.

The Claimant essentially argues that the fact finder should ignore the fact she is not credible. Her contention is that testimony regarding causation of her symptoms is a collateral

matter and “it is improper to allow impeachment on collateral matter.” (Brief of Appellant p. 21)(citing Aakjer v. Spagnoli, 291 S.C. 165, 352 S.E.2d. 503 (Ct. App. 1987)). While it is true, generally speaking, that a witness may be impeached only as to matters relevant to the case, the Claimant did not contemporaneously object to the cross-examination regarding the boat cover incident on the grounds of improper impeachment. (ROA p. 117-125). The failure to object to evidence at the time it is offered at trial constitutes a waiver of the right to have the issue heard on appeal. Parr v. Gaines, 309 S.C. 477, 424 S.E.2d. 515 (Ct. App. 1992). Nevertheless, the issue of causation of an injury or symptoms in a worker’s compensation case is not a collateral matter. It is one of the most relevant issues the fact finder must determine. In the end, however, it defies credulity that this whole Boat Cover Incident was relayed to the doctor’s office but had nothing to do with the Claimant’s increased symptoms.

Furthermore, considerable latitude and discretion is allowed the tribunal concerning the admissibility of testimony impeaching the witness. State v. Williams, 263 S.C. 290, 210 S.E.2d. 298 (1974); State v. Mizell, 332 S.C. 273, 504 S.E.2d. 338 (Ct. App. 1998).

In her Brief of Appellant, Claimant goes to great lengths to highlight her radicular pain in effort to undermine the findings of fact that she did not aggravate her preexisting back condition. Because radiculopathy is subjective, the credibility of the Claimant is critical in analyzing this issue. The Claimant’s objective clinical records do not reveal any aggravation of a back injury.

The Claimant underwent an MRI of her lumbar spine on May 11, 2004. (ROA p. 212). This MRI revealed “disc bulging” at L5-S1 and L4-5 without evidence of focal disc protrusion or nerve root impingement. (ROA p. 212).

The Claimant’s injury by accident to her neck was June 16, 2007. At trial, the Claimant testified that she immediately “felt a shock in my low back.” (ROA p. 101-102). This testimony

is not credible. Her initial examination at Carolina Center for Advance Management of Pain was on August 28, 2007, two and a half months after the accident. On this date, the Claimant did not complain of radicular pain in her legs. (ROA p. 206-210; ROA App. p. 24). She had full range of motion and straight leg tests were negative. (ROA p. 207).

On her follow up appointment on September 11, 2007, she also did not complain of radicular pain her legs. (ROA p. 202-205).

On September 24, 2007, the Claimant still had no radicular pain in her legs. (ROA p. 198-201). She still had full range of motion in her "Thoracolumbar" and negative straight leg raised test. (ROA p. 199).

On October 18, 2007 and November 15, 2007, the Claimant was still not complaining of radicular pain in her legs. (ROA p. 194, 196).

The first time after the June 16, 2007 accident that there was even a mention of any symptoms in the Claimant's legs was on December 13, 2007-six months after the neck injury. (ROA p. 191-193). This was also the first reference to any decreased range of motion in the lumbar spine. (ROA P. 192).⁶

The first reference to "lumbar radiculopathy" was on January 10, 2008 after the Claimant sustained yet another non work related fall. (ROA p. 189). The January 18, 2000 MRI still revealed no nerve root impingement at L5-S1. (ROA p. 211). Interestingly, the Claimant had "no focal disc protrusion or spinal canal stenosis" at L4-5. (ROA p. 211). The Claimant's objective findings actually improved since the 2004 MRI.

⁶ Even if the Claimant is correct in her assertion that the Full Commission misinterpreted this medical record, the results are the same. The June 16, 2007 accident did not injure the Claimant's low back.

From this point forward, the note "lumbar radiculopathy" began appearing in medical records despite the lack of subjective complaints for radiculopathy. (ROA p. 159,160, 168, 169, 170, 171,172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 184, 185, 186, 187).

It was not until after the boat cover incident in July of 2009 that there is any real reference to pain radiating from the lumbar spine. (ROA p. 256). This was *after* Dr. Satterthwaite had already found that the Claimant had reached MMI. (ROA p. 159).

The Claimant's subjective complaints of radicular pain do not correspond with the objective findings. The substantial evidence in the record supports the hearing commissioner's findings as adopted by the Full Commission that the Claimant did not suffer any aggravation of her preexisting lumbar injury or sustain a new lumbar injury.

The hearing commissioner and Full Commission were entirely appropriate in questioning the Claimant's credibility based upon her "laborious" and "unconvincing" effort to downplay the Boat Cover Incident. The fact finder was entirely appropriate in finding that "Claimant has exaggerated her condition to various providers and the undersigned to "maximize" her case/award." (ROA p. 12, para. 21).

CONCLUSION

The Claimant injured her neck on June 16, 2007. As of June 16, 2007, the Claimant had already been suffering from lower back pain for many years. From June 16, 2007 until the neck surgery in October of 2008, the Claimant complained of symptoms related to the neck as well as continued symptoms related to her pre-existing chronic lower back pain for which she had already received a 17.5% disability award from this Commission. After the neck surgery in October of 2008, the Claimant's back (cervical, thoracic and lumbar) gradually and progressively improved. The Claimant's primary treating physician found that she had reached MMI by July 1,

2009 and assigned an impairment rating of 25% to the whole person related to the impairment to the cervical spine. The Claimant's lumbar spine was essentially the same as it was before this admitted injury to the neck.

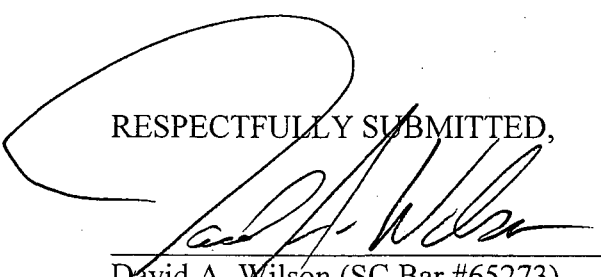
After this finding of MMI, the Claimant aggravated her lumbar back in either the Boat Cover Incident or the flower watering incident.

The Claimant's psychological issues are well-managed by medications and do not interfere with her normal daily activities.

Based upon this factual background, the hearing commissioner and the Full Commission found that the Claimant sustained a 25% disability to the spine as a result of the neck injury. The hearing commissioner and the Full Commission did not award any additional permanency related to the lumbar spine. These findings are supported by the reliable, probative and substantial evidence in the record. Accordingly, the circuit court properly applied its limited standard of review and affirmed the prior orders.

Based upon the foregoing, the Respondents City of Greenville and Hewitt Coleman & Associates respectfully request that the orders of the circuit court filed July 7, 2011 and July 29, 2011 be affirmed.

RESPECTFULLY SUBMITTED,



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Greenville, South Carolina
February 14, 2012

THE STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

APPEAL FROM GREENVILLE COUNTY
COURT OF COMMON PLEAS
G. EDWARD WELMAKER, CIRCUIT COURT JUDGE

2010-CP-23-3442
CASE TRACKING NO. 2011198006

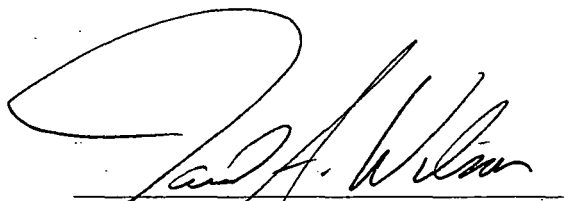
KELLIE N. BURNETTE,.....Appellant,

v.

CITY OF GREENVILLE,.....Respondents.
AND HEWITT COLEMAN & ASSOCIATES

CERTIFICATE OF COUNSEL

The undersigned certifies that this Final Brief complies with Rule 211(b),
SCACR.



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February 14, 2012

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

Kellie N. Burnette, Appellant,

v.

City of Greenville and Hewitt Coleman & Associates,
Respondents.

Appellate Case No. 2011-198006

Appeal From Greenville County
G. Edward Welmaker, Circuit Court Judge

Opinion No. 5059
Heard October 29, 2012 – Filed December 5, 2012

REVERSED AND REMANDED

Douglas A. Churdar, of Greenville, for Appellant.

Michael Allen Farry and David Alan Wilson, both of
Horton Drawdy Ward Mullinax & Farry, PA, of
Greenville, for Respondents.

CURETON, A.J.: Kellie N. Burnette appeals the circuit court's order affirming the decision of the Workers' Compensation Commission (Commission). Burnette argues the circuit court erred in affirming because the evidence in the record does not support the Commission's findings that (1) Burnette did not injure her lower back in her June 2007 incident, (2) Burnette is not permanently and totally disabled, and (3) Burnette's testimony was not credible. We reverse as to the June 2007 injury to Burnette's lower back, remand to the Commission for the entry of

findings of fact concerning the lumbar injury and Burnette's disability rating, and decline to address the issue of credibility.

FACTS

I. First Injury and 2004 MRI

After becoming a police officer for the City of Greenville (City¹) in 2001, Burnette suffered two work-related injuries. On August 23, 2003, she was driving a patrol car when a fleeing suspect in a stolen car collided with the driver's side in a "t-bone" accident. Burnette suffered a broken nose and injuries down her left side to her ankle, including her neck and lower back. In addition to surgery to repair her nose, Burnette received two months of physical therapy but continued experiencing chronic lower back pain. After the incident, she experienced continuing pain localized to her mid- and lower back. Although she was rated as having a 17.5% disability to her back, Burnette returned to work to full duty.

On June 21, 2004, Burnette began seeing Dr. Kopera for pain management. Dr. Kopera reviewed an MRI taken May 11, 2004, which he deemed normal. On August 19, 2004, Dr. Kopera determined Burnette had reached maximum medical improvement (MMI) but had a 5% permanent impairment to her lumbar spine. He noted Burnette presented with lower back pain but "no radicular symptoms," rated her pain at a 7 out of 10, and displayed excellent range of motion at the waist. During the course of treating Burnette, Dr. Kopera found chronic pain or tenderness in the lumbar region that by 2006 had moved to the thoracic region. He believed the pain was largely myofascial in nature. In April 2006, Dr. Kopera prescribed physical therapy for Burnette, which helped. She continued seeing Dr. Kopera until 2007, when he closed his practice and referred her to Dr. Satterthwaite.

During the summer of 2005, Burnette also saw Dr. Schwartz for pain management. Dr. Schwartz noted she presented with pain in her lower back, neck, interscapular area, and thoracolumbar region. He supplemented Burnette's oral pain medications with injections. On August 23, 2005, Dr. Schwartz opined Burnette had reached MMI from her 2003 injuries but had a permanent spinal impairment of 13%, which consisted of an 8% lumbar impairment and a 5% cervical impairment.

¹ This term also collectively references the City of Greenville and its insurance administrator, Hewitt Coleman & Associates.

II. Second Injury and Medical Retirement

On June 16, 2007, Burnette attempted to wrestle a suspect out of a car while her partner unsuccessfully tried to tase the suspect. With Burnette partially inside the vehicle, the suspect drove forward. First dragged by the car and then thrown from it, Burnette landed against a curb and felt a shock in her neck, head, and lower back. Burnette began missing work and was placed on light duty. Ten months later, on April 17, 2008, the South Carolina Retirement System placed Burnette on disability retirement from the police force with a recommendation that she be examined again in three years.

On August 28, 2007, Burnette began seeing Dr. Satterthwaite and his staff. She reported pain in the thoracic and lumbar regions that started after the 2003 car wreck. The treatment notes from Burnette's first visit indicate Dr. Hutcheson of that office reviewed her 2004 MRI and recorded seeing minimal disk bulges without stenosis at L4-5 and L5-S1. In early September 2007, Burnette reported neck and lower back pain she rated at 9 out of 10. Two weeks later, she rated the pain at 8. Dr. Satterthwaite noted Burnette had suffered "an injury in June where she hurt her neck" and that the "[c]urrent increased neck pain seem[ed] to have been [aggravated] by an injury in June when she was jerked by a car trying to leave the scene."

In October 2007, Dr. Satterthwaite examined Burnette with an eye toward making recommendations to the City's workers' compensation insurance administrator. At that time, Burnette rated her pain at 6 out of 10 but noted the pain increased when she sat or stood for long periods or entered or exited a car. In response to his question whether she might apply for a secretarial job, Burnette told Dr. Satterthwaite she was "not interested in a desk job but [did] state that she ha[d] applied for [a] teaching position, which would not require her to wear the vest and belt and [would] allow her to change positions frequently from standing to sitting." Noting the workers' compensation adjuster had asked him to define work restrictions for Burnette, Dr. Satterthwaite stated:

She is currently working unrestricted. She does not want significant restrictions that would place her at a desk job or remove her from her job completely. She does feel that she would benefit from limitations to standing and sitting to one hour at a time without rest breaks. She was

on her feet working last weekend for several hours, and that was quite uncomfortable to both her neck and back.

She has applied for [a] teaching position, which sounds ideal for her. I would strongly recommend that she be seriously considered for that position as I think she is a dedicated officer and wishes to continue working in law enforcement. It would also be good to get her out of the patrol car so that she does not have to use it for long periods with poor back support and get in and out of the vehicle. The belt and vest are quite heavy and do alter her posture with sitting and standing, increasing problems with her spinal alignment and the potential for increasing her neck and back pain.

III. 2008 MRI and Neck Surgery

Burnette did not get the teaching job, but her pain rating remained relatively stable at 7 out of 10 until February 2008, when it reached 8. In January 2008, Burnette underwent an MRI of her lumbar spine, which showed a minimal central disk protrusion without stenosis or impingement at L5-S1. A few days later, Dr. Satterthwaite's nurse practitioner noted Burnette had a herniated disk at L5-S1 and lumbar radiculopathy. In March 2008, rating her pain with medication at 5 out of 10, Burnette was experiencing spasms in her back. Dr. Satterthwaite's nurse practitioner referred her to physical therapy, noted they were "still awaiting approval for treatment of [the] neck," and indicated Burnette needed a sedentary job because she was unable to continue in her present position. A series of epidural steroid injections followed from March through September 2008. On September 15, 2008, Dr. Satterthwaite noted Burnette was suffering from increased back and leg pain. Despite receiving a pain injection two weeks earlier, on October 1, 2008, Burnette rated her pain at 9.

On October 27, 2008, Dr. Bucci performed a cervical laminectomy on Burnette, fusing together her C4 and C5 vertebrae. Following surgery, her neck pain improved, but her back pain did not. From March to May 2009, her overall pain rating decreased from 8 to 6.

Dr. Bucci assessed Burnette's postsurgical condition twice. First, on April 3, 2009, he completed a Physician's Statement for the Workers' Compensation Commission. In that document, he noted he had last seen Burnette on March 24, 2009, and she

sustained a 10% medical impairment to her cervical spine. In addition, he released her to return to work without restriction.

On August 6, 2009, Dr. Bucci revised his medical opinion when he filled out a more detailed questionnaire for Burnette's counsel. He stated Burnette suffered a 28% "permanent impairment . . . to the whole person as a result of her cervical spine injury of 6/16/07." He also acknowledged that when he completed the Physician's Statement, he was unaware of Burnette's disability retirement, 2003 lumbar spine injury, ongoing treatment for pain and depression/anxiety, or her limitations resulting from those conditions. Dr. Bucci concluded Burnette was not able to return to work without restriction.

In the meantime, on June 22, 2009, Dr. Satterthwaite completed a workers' compensation questionnaire stating Burnette had reached MMI with regard to her June 16, 2007 injuries. He assigned her a 72% impairment of the cervical spine, which translated to a 25% whole person impairment. In his treatment notes from July 1, 2009, he added that Burnette also had a 16% permanent impairment of the lumbar spine, which corresponded to a 12% whole person impairment. At that visit, Burnette rated her pain at 6 but complained it was in her neck, left arm to palm, back, and right leg.

IV. Workers' Compensation Claim

Burnette filed a Form 50, seeking total permanent disability for injuries to her neck, upper and lower back, and psyche from the June 2007 incident. The City admitted her neck and upper back injuries but denied her claims of injuries to the lower back and psyche. The City maintained Burnette had received medical treatment, had reached MMI, and needed no further care for injuries sustained in the June 2007 incident.

The parties submitted extensive medical and psychological records² for the single commissioner's consideration. In addition, Burnette supported her claims with opinions and reports from her treating physicians and Benson Hecker, Ph.D., an expert in vocational rehabilitation who evaluated her employment prospects. Dr. Hecker concluded Burnette would be "unable to perform any substantial gainful work activity which exists in significant numbers in open competition with others."

² A component of Burnette's care with Dr. Satterthwaite was psychological care from Dr. Tollison and his staff.

A. Hearing Testimony regarding Injuries

On September 3, 2009, the parties tried their case before the single commissioner. At that hearing, Burnette testified to the rigors and unpredictability of working as a police officer. She recalled wearing a uniform, duty belt, and bulletproof vest that together weighed approximately twenty-five pounds. According to Burnette, an officer's duties were physically demanding and "would vary from day to day, hour to hour." Burnette testified that after the August 2003 incident, she experienced pain in her middle and lower back and pain that radiated into her arms. At the time of the hearing, she claimed her pain went from her neck to her buttocks and, at times, radiated downward through a nerve into her leg.

Burnette also testified to suffering from depression. In addition, she claimed she experienced anxiety when riding in vehicles or being in crowds. She stated she could sit or stand comfortably for approximately twenty to thirty minutes at a time and could alternate sitting and standing for up to three hours at a time. Not only would pain prevent her from kneeling or walking more than a couple of blocks, she testified she had difficulty bending at the waist, twisting her back, squatting, or stooping.

B. Hearing Testimony regarding the Boat Cover Incident

On cross examination, Burnette acknowledged reporting to her doctors an incident that occurred in July 2009 when she and her friend were towing her parents' boat from Columbia to Greenville. According to the doctor's notes, Burnette "recite[d] an incident on the weekend in which the sun cover on the boat flew off and she and a friend had to pick it up and put it in their truck. Tuesday she start[ed] having increased lower back pain that radiates to her left and into her buttocks." Burnette stated the notes were incorrect, in that the boat belonged to her parents and the "cover" that blew off was a cushion.

Burnette further explained that the cover blew off the boat and flew onto the highway, clipping the corner of the car behind her. After Burnette pulled off the highway, her friend retrieved the cover from the road, and the two women "pushed it up in the truck." According to Burnette, her increased pain started while she was watering flowers on Tuesday following the Saturday incident.

C. Procedure and Appeals

On October 14, 2009, the single commissioner issued her order awarding Burnette seventy-five weeks of benefits for a 25% permanent partial disability to the spine.

She found the June 2007 incident resulted in injuries to Burnette's neck and upper back with psychological overlay. However, she also found the "greater weight of the evidence" did not support Burnette's claim of an injury to her lower back.

The single commissioner examined Burnette's 2004 and 2008 MRIs and found the latter showed "only a 'minimal' protrusion with no nerve root displacement or impingement, and comparatively, no greater pathology of any significance (if any) than the MRI of 2004" ³ In addition, the single commissioner accepted without question Dr. Satterthwaite's June 22, 2009 statement that Burnette had reached MMI from her cervical injury and awarded benefits based upon his determination of a 25% whole person impairment corresponding to the cervical spine injury. However, she ignored his contemporaneous determination of a 12% whole person impairment corresponding to the lumbar spine injury. Instead, the single commissioner found that "if [Burnette] aggravated her low back condition in the accident in issue, the aggravation was temporary, and her condition returned to baseline or is the result of an intervening accident," referring to either an unspecified event "in late 2008" or the boat cover incident.

She further stated she "strongly believe[d]" Burnette had "exaggerated her condition to various providers and to the undersigned in order to 'maximize' her case/award." Moreover, she stated Burnette struck her "as someone who simply [did] not wish to work (medical evidence as a whole; testimony of [Burnette], including but not limited to the issue of the amount of her monthly police disability income vis-à-vis her average weekly wage)." The single commissioner found Burnette was "conversant with various levels of the spine by name," but she dismissed much of Burnette's testimony as being "liberally laced with exaggeration." Four out of twenty-four findings of fact relied at least in part on Burnette's interaction with her parents' boat.

Both before and after the issuance of this order, Burnette sought leave to submit additional medical records in response to the boat cover incident. The single commissioner denied her motions.

On April 1, 2010, the Commission entered an order affirming and adopting verbatim the single commissioner's order. Burnette appealed to the circuit court, which affirmed in a modified Form 4 order. She then filed a motion to alter or amend the judgment, which was denied. This appeal followed.

³ The record does not reflect that any physician expressed this opinion.

STANDARD OF REVIEW

The Administrative Procedures Act ("APA") provides the standard for judicial review of decisions by the Commission. *Pierre v. Seaside Farms, Inc.*, 386 S.C. 534, 540, 689 S.E.2d 615, 618 (2010); *Lark v. Bi-Lo, Inc.*, 276 S.C. 130, 133-34, 276 S.E.2d 304, 306 (1981). Under the APA, this court can reverse or modify the decision of the Commission if the substantial rights of the appellant have been prejudiced because the decision is affected by an error of law or is clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record. S.C. Code Ann. § 1-23-380(5)(d), (e) (Supp. 2011); *Transp. Ins. Co. v. S.C. Second Injury Fund*, 389 S.C. 422, 427, 699 S.E.2d 687, 689-90 (2010).

The Commission is the ultimate factfinder in workers' compensation cases. *Shealy v. Aiken Cnty.*, 341 S.C. 448, 455, 535 S.E.2d 438, 442 (2000). As a general rule, this court must affirm the findings of fact made by the Commission if they are supported by substantial evidence. *Pierre*, 386 S.C. at 540, 689 S.E.2d at 618. "Substantial evidence is that evidence which, in considering the record as a whole, would allow reasonable minds to reach the conclusion the Commission reached." *Hill v. Eagle Motor Lines*, 373 S.C. 422, 436, 645 S.E.2d 424, 431 (2007). "The possibility of drawing two inconsistent conclusions from the evidence does not prevent the Commission's finding from being supported by substantial evidence." *Id.*

LAW/ANALYSIS

I. Injury to Lower Back

First, Burnette asserts substantial evidence does not support the finding she did not injure her lower back in the June 2007 incident. We agree.

An injured employee "who has a permanent physical impairment or preexisting condition" may receive benefits for a subsequent work-related disability if he establishes by a preponderance of the evidence that "the subsequent injury aggravated the preexisting condition or permanent physical impairment." S.C. Code Ann. § 42-9-35 (Supp. 2011); see also *Mullinax v. Winn-Dixie Stores, Inc.*, 318 S.C. 431, 436-37, 458 S.E.2d 76, 79 (Ct. App. 1995) (recognizing the "natural consequences flowing from a compensable injury, absent an independent intervening cause, are compensable," as well as the aggravation of "a [preexisting] condition, infirmity, or disease" by a work-related injury). Nonetheless, "an employee who suffers a subsequent injury which affects a single body part or

member injury set forth in Section 42-9-30 is limited to the recovery set forth in that section." § 42-9-35.

Although medical evidence "is entitled to great respect," the Commission is not bound by the opinions of medical experts and may disregard medical evidence in favor of other competent evidence in the record. *Potter v. Spartanburg Sch. Dist.* 7, 395 S.C. 17, 23, 716 S.E.2d 123, 126 (Ct. App. 2011). However, "[w]hile a finding of fact of the [C]ommission will normally be upheld, such a finding may not be based upon surmise, conjecture, or speculation, but must be founded on evidence of sufficient substance to afford a reasonable basis for it." *Edwards v. Pettit Constr. Co., Inc.*, 273 S.C. 576, 579, 257 S.E.2d 754, 755 (1979); *see also Grayson v. Carter Rhoad Furniture*, 317 S.C. 306, 309-10, 454 S.E.2d 320, 322 (1995) (affirming reversal of Commission's decision, which was supported by no evidence in the record).

We find the circuit court erred in affirming findings of fact that were unsupported by substantial evidence in the record. Particularly disturbing is the finding that the 2008 MRI showed "only a 'minimal' protrusion with no nerve root displacement or impingement, and comparatively, no greater pathology of any significance (if any) than the MRI of 2004" Because no evidence indicates this opinion originated from a medical provider, yet it appears in the single commissioner's order, we are forced to conclude it is the medical opinion of the single commissioner, adopted by the Commission.

Moreover, we find substantial evidence in the record does not support the Commission's findings that Burnette neither injured nor aggravated a preexisting injury to her lower back, or that any such injury or aggravation either "returned to baseline" or resulted from an independent intervening accident. *See Potter*, 395 S.C. at 23, 716 S.E.2d at 126 (permitting the Commission to disregard medical evidence only when other competent evidence exists in the record); *Edwards*, 273 S.C. at 579, 257 S.E.2d at 755 (holding a finding of fact by the Commission "may not be based upon surmise, conjecture, or speculation, but must be founded on evidence of sufficient substance to afford a reasonable basis for it"). The record contains Burnette's medical records and testimony, as well as written opinions by her treating physicians and a vocational rehabilitation expert. We find no evidence that challenges the conclusions of Burnette's doctors concerning her herniated disk at L5-S1, lower back pain, or development of radiculopathy. As a result, the record provides little or no support for the findings of the Commission holding that Burnette neither injured nor aggravated a prior injury to her lower back in the 2007 incident. Consequently, the circuit court erred in affirming the Commission's

factual findings concerning the existence, exacerbation, and possible causes of Burnette's lower back injury.

We reverse the circuit court's decision and remand this issue to the Commission. On remand, we specifically instruct the Commission to reconsider this issue and enter findings of fact concerning Burnette's lumbar injury that are supported by substantial evidence in the record.

II. Permanent and Total Disability

Next, considering the combined effects of her preexisting impairments with the injuries sustained in the June 2007 incident, Burnette argues substantial evidence does not support the finding that she is not permanently and totally disabled. We remand this issue as discussed below.

In a workers' compensation case, this court does not have the authority to find facts; that authority belongs to the Commission. *Sigmon v. Dayco Corp.*, 316 S.C. 260, 262, 449 S.E.2d 497, 498 (Ct. App. 1994). Moreover, the determination of an injured employee's impairment rating is more art than science, involving the consideration of evidence the Commission may gather from the injured employee, medical and vocational experts, and lay witnesses:

While an impairment rating may not rest on surmise, speculation or conjecture . . . it is not necessary that the percentage of disability or loss of use be shown with mathematical exactness. . . .

Further, the [Commission] is not bound by the opinion of medical experts and may find a degree of disability different from that suggested by expert testimony. Expert medical testimony is merely intended to aid the [Commission] in coming to the correct conclusion. Unless the question of the extent of partial loss of use under [section] 42-9-30 is so technically complicated as to require exclusively expert testimony, lay testimony is admissible.

Sanders v. MeadWestvaco Corp., 371 S.C. 284, 291-92, 638 S.E.2d 66, 70 (Ct. App. 2006) (citations and quotation marks omitted).

Any conclusion as to the degree or permanency of Burnette's disability must take into consideration her preexisting impairments, as well as factual findings not yet made with regard to her lumbar spine. In view of our determination that substantial evidence does not support the Commission's denial of a 2007 injury or aggravation of a prior injury to Burnette's lumbar spine, we remand this issue to the Commission for (1) the entry of findings of fact concerning the extent of Burnette's lumbar injury or aggravation, (2) a determination of the medical treatment or other benefits to which Burnette may be entitled for her lumbar injury or aggravation, and (3) a recalculation of Burnette's disability rating in view of the injury to the lumbar spine.

III. Credibility

Finally, Burnette contends the Commission's findings concerning her credibility are neither material nor supported by substantial evidence. Because our decisions on the two prior issues are dispositive of this appeal, we decline to reach this issue. *See Futch v. McAllister Towing of Georgetown, Inc.*, 335 S.C. 598, 613, 518 S.E.2d 591, 598 (1999) (ruling an appellate court need not review remaining issues when its determination of a prior issue is dispositive of the appeal).

CONCLUSION

We conclude the Commission's findings holding Burnette neither injured nor aggravated a prior injury to her lower back in the 2007 incident are not supported by substantial evidence. Consequently, we reverse the circuit court's decision affirming the Commission on this issue. Furthermore, we remand this issue to the Commission with instructions to reconsider this issue and enter findings of fact concerning Burnette's lumbar injury that are supported by substantial evidence in the record.

We further conclude the recognition of an injury or aggravation to an injury to Burnette's lower back affects the extent and permanency of Burnette's disability. Accordingly, we remand this issue to the Commission for reconsideration.

Because our determinations of the two other issues dispose of this appeal, we do not address the issue of credibility.

REVERSED AND REMANDED.

SHORT and LOCKEMY, JJ., concur.

THE STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

APPEAL FROM GREENVILLE COUNTY
COURT OF COMMON PLEAS

G. EDWARD WELMAKER, CIRCUIT COURT JUDGE

2010-CP-23-3442
CASE TRACKING NO. 2011198006

KELLIE N. BURNETTE,.....Appellant,

v.

CITY OF GREENVILLE
AND HEWITT COLEMAN & ASSOCIATES,.....Respondents.

RESPONDENTS' PETITION FOR REHEARING

The Respondents City of Greenville and Hewitt Coleman & Associates respectfully petition this court to rehear and reconsider its decision in the above-captioned matter issued on December 5, 2012 in Opinion No. 5059. The grounds for this petition are as follows:

When finding it difficult to define intelligibly what constitutes pornography in 1964, Justice Stewart of the United States Supreme Court famously said "I know it when I see it." Jacobellis v. Ohio, 378 U.S. 184, 197 (1964) (Stewart, J. concurring). Substantial evidence (in workers' compensation cases) is much like pornography. It is difficult to define but one knows it when one sees it. In the present case, the circuit court judge knew it when he saw it. Substantial evidence supports the Commission's findings

of fact and conclusions of law.

In its Opinion No. 5059, the Court of Appeals correctly recites the standard of review. The standard of review in Workers' Compensation Appeals is repeated so often that one may become desensitized as to what the standard really is. There are a few important characteristics in the standard of review which the Court of Appeals overlooked or misapprehended.

When reviewing findings of fact, an appellate court must defer to the Commission unless those findings are "*clearly erroneous* in view of the reliable, probative and substantial evidence on the whole record." S.C. Code Ann. §1-23-380 (5)(d),(e)(Supp. 2011)(emphasis added). Furthermore, if "*reasonable minds*" could reach the conclusion the Commission reached, substantial evidence supports the conclusion. Hill v. Eagle Motor Lines, 373 S.C. 422, 436, 645 S.E.2d. 424, 431 (2007)(emphasis added). To overturn a finding of fact made by the Commission, the appellate court must determine that it is clear that reasonable minds could not reach the conclusion reached by the Commission. It is not sufficient that the appellate court disagrees with the conclusion.

At least five reasonable minds¹ have all agreed that the Claimant in the present case failed to prove that she sustained a compensable permanent injury to her lumbar spine caused by the June 16, 2007 accident. In considering the substantial evidence in the present case, the Court of Appeals essentially ruled that the Claimant's credibility is irrelevant because other issues were "dispositive of the appeal." The credibility of the Claimant is a necessary cog in the wheel when determining the existence of substantial evidence related to an injury involving subjective complaints of pain.

¹ The hearing commissioner, the three member panel of the Worker's Compensation Commission and the circuit court judge all agreed).

The Claimant contends she injured her lumbar spine in the June 16, 2007 accident. The Commission found that she did not. *Could reasonable minds conclude that the Claimant did not sustain a permanent injury to her lumbar spine related to the June 16, 2007 accident?*

Because of the Claimant's long history of chronic back pain, any inquiry into what reasonable minds would conclude must necessarily start long before the alleged June 16, 2007 accident.

The Claimant had documented problems with her "low back" since as early as August of 2003. (ROA p. 305). She suffered from "persistent lumbar back pain" for years after the August 23, 2003 car accident. She underwent an MRI on May 11, 2004 which revealed a disc bulge at L5-S1 and L4-5 which resulted in her receiving an award of 17.5% permanent disability to her back from the Workers' Compensation Commission. (ROA p.297, 308).

The Claimant was treated by Drs. Kopera and Schwartz for well over a year starting in 2004. (ROA p. 135-149). A nerve conduction study ordered by Dr. Schwartz revealed "left L5 nerve root irritation" on July 18, 2005. (ROA App. p. 2-3). *Could reasonable minds conclude that the Claimant was suffering from a disc bulge that was impinging on her L5 nerve root in 2005 long before this new workers' compensation injury?*

With preexisting lumbar spine injury with objective evidence of nerve root irritation, the Claimant alleged a new injury by accident on June 16, 2007. During her first visit to a doctor after June 16, 2007, the Claimant complained of worsening depression. (ROA p. 268). She did not complain of any pain anywhere else in her body.

The first time the Claimant visited a doctor complaining of any pain after June 16, 2007 was her examination on August 28, 2007-two and a half months after the accident. (ROA p. 206). At that time, she was complaining of “persistent back and neck pain” that “started after being t-boned in MVC at work.” (ROA p. 206). The car accident in which the Claimant’s car was t-boned occurred on August 22, 2003. (acknowledged by Claimant in Final Brief of Appellant p. 2). As found by Dr. Hutcheson on August 28, 2007, the Claimant’s “new problems” were “cervical,” “thoracic” with “myofascial pain syndrome” and “depression.” (ROA p. 208). The Claimant did not have new lumbar pain or symptoms.

The Claimant continued to be seen by the Center for Advanced Management of Pain. On September 24, 2007, Dr. Satterthwaite confirmed that the Claimant told him that she “had an injury in June where she hurt her neck.” (ROA p. 198). The Claimant still enjoyed full range of motion in her lumbar spine and Straight Leg Raise and Patrick’s Test were both negative. (ROA p. 199).

The very first time the Claimant made any reference of any kind of any issues even arguably related to radiculopathy was on December 13, 2007-six months after the accident. On this date, the Claimant had decreased range of motion in the lumbar spine and the notes referenced right leg numbness. (ROA p. 192-193). Based upon this subjective complaint, the nurse practitioner – not a medical doctor – ordered an MRI of the lumbar spine. (ROA p.193).

The January 7, 2008 MRI revealed no disc protrusion at L4-5 and “very small minimal central disc protrusion” at L5-S1 with “no significant narrowing of the spinal canal or nerve root impingement.” (ROA p. 211). Compared to the 2004 MRI, the

Claimant actually had less severe objective findings at the L4-5 level and the same objective findings at L5-S1—minimal bulging or protrusion and no nerve root impingement.

Could reasonable minds conclude that, when she had no nerve root impingement in her lumbar spine in 2004 and no nerve root impingement in her lumbar spine in 2008, the Claimant had not suffered any worsening of her lumbar spine?

Three days after the lumbar MRI which revealed “no nerve root impingement,” the Claimant saw another nurse practitioner. Although there is no notation that the Claimant was complaining of pain in her legs on this date—and she had not complained of pain in her legs in the previous many months—the nurse practitioner noted “LUMBAR RADICULOPHY” in all caps on this date. (ROA p. 189-190).

“LUMBAR RADICULOPHY as unchanged Kimberly Parker FNPC “or” Monica Speak, FNP” appeared in the records from that date forward despite no evidence of radiculopathy. (ROA p. 176, 179, 182, 185).

Interestingly, the Claimant still did not complain of pain in her legs even after the diagnosis of lumbar radiculopathy by the nurse practitioners. Straight Leg Raise and Patrick's Test all continued to be negative on February 22, 2008 when she had a laundry list of complaints. (ROA p. 186-187). The Claimant did not complain of leg pain on March 13, 2008, April 10, 2008, June 18, 2008 or August 15, 2008 either. (ROA p. 175, 178, 181, 184).

When finally examined again by a medical doctor (who had been performing injections based upon the diagnoses of nurse practitioners), Dr. Satterthwaite noted “minimal leg pain” on September 4, 2008. (ROA p. 173). Doctor Satterthwaite noted that

the "lumbar radiculopathy had improved." (ROA p.174).

Could reasonable minds conclude that the Claimant did not have radiculopathy in her leg caused by the June 16, 2007 incident when the first reference by the Claimant of leg pain shows up almost fifteen months after the accident?

Despite the fact that Dr. Satterthwaite noted that the alleged lumbar radiculopathy had improved, the nurse practioners continued to find it was "unchanged" on October 1, 2008, November 18, 2008 and March 23, 2009. (ROA p. 166, 169, 171).

From September 4, 2008 until May 27, 2009, the Claimant experienced "no new paresthesia" and no pain radiating into her legs. (ROA p. 163, 164, 165, 168).

On July 1, 2009, Dr. Satterthwaite opined the Claimant had reached maxium medical improvement with a 25% impairment rating to the whole person related to the cervical spine and 12% impairment to the whole person related to the lumbar spine. Dr. Satterthwaite noted on July 1, 2009 that the Claimant had on going low back and left pain "from her previous back injury." (ROA p. 159). Long before this June 16, 2007 accident, the Claimant had already received an award of 17.5% permanent partial disability to the back. (ROA p. 308).

Could reasonable minds conclude that the Claimant sustained no permanent worsening of her lumbar spine given virtually identical objective findings in the 2004 and 2008 MRI's and the similar impairment to the lumbar spine existing both before and after the June 16, 2007 accident?

After being released by Dr. Satterthwaite on July 1, 2009, the Claimant injured her low back again. It is clear from the medical records and the testimony at trial that something happened in July of 2009 which exacerbated the Claimant's chronic low back

injury.

On July 23, 2009, the Claimant reported a new, non-employment accident which occurred the previous weekend. (July 18 or 19, 2009)(the "Boat Cover Incident"). For the very first time ever, the Claimant indicated she had "increased lower back pain that radiates to her left and into her buttocks." (ROA p. 256). Even on July 23, 2009, the Claimant did not indicate that she had any pain radiating down her legs!

Could reasonable minds conclude that the Claimant did not have radiating pain prior to July 2009 when the first time she personally complained of radicular pain was on July 23, 2009?

When the Claimant complained of radiating pain in buttocks to the nurse practitioner on July 23, 2009, she was instructed to increase her medication and return in one month if necessary. (ROA p. 256, 258).

The Claimant never returned to Dr. Satttherthwaite.

Instead, she sought a vocational opinion from Benson Hecker. (ROA p. 232). The Claimant did not reveal the Boat Cover Incident Benson Hecker and how it caused her new pain.

At trial, the Claimant's testimony was full of hyperbole if not outright lies. She claimed she felt a "shock" in her low back on June 16, 2007 despite no evidence of "shock" in the medical records. (ROA p. 101-102). She testified that she could only stand or sit comfortably for twenty to thirty minutes at a time and can only walk a block or two when the evidence revealed that she repeatedly works out a gym for an hour and half at time. (ROA p. 107-108, 125-126). The Claimant went to great effort to deflect questions (about the Boat Cover Incident. In fact, she actually created a new incident – the Flower

Watering Incident. Contrary to the explicit medical records relating the increased pain to Boat Cover Incident, the Claimant testified that she did not have “nerve pain” until the Flowering Watering Incident on Tuesday, July 21, 2009. (ROA p. 120, 121).

Could reasonable minds conclude that the Claimant’s “nerve pain” in her leg was caused by the Boat Cover Incident or the Flower Watering Incident when the Claimant went to great lengths to hide the records related to these incidents and, when caught, misrepresented the facts?

In Opinion No. 5059, this Court of Appeals mentions the “Boat Cover Incident” but essentially ignores it in the substantial evidence analysis. The existence of the Boat Cover Incident and the Claimant’s contorted efforts to hide and (explain away) the incident are very relevant in determining whether substantial evidence supports the findings of fact of the Commission.

Objective evidence of radiculopathy does not exist prior to June 17, 2007. The 2008 MRI revealed no nerve root impingement. The only evidence of radiculopathy comes from the mouth of the Claimant or from medical records repeating words from the mouth of the Claimant. Interestingly, it appears the Claimant did not tell her healthcare providers that she ever had pain in her legs. The most she ever said was she had pain in her “buttocks” which occurred *after* the Boat Cover/Flower Watering Incidents.

Despite never telling her healthcare providers about pain radiating “down a nerve of her leg,” the Claimant testified at trial that she had such pain and implied that she had had it since June of 2007. (ROA p. 103, 104).

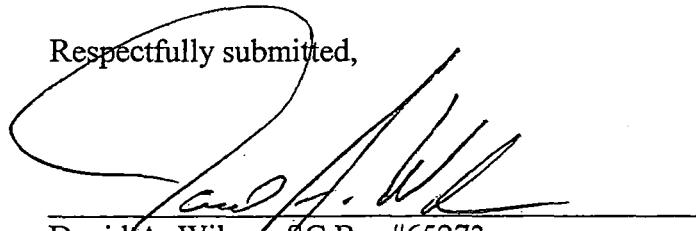
When no objective evidence of an injury exists and the symptoms are merely the Claimant’s subjective complaints of pain, is the Claimant’s credibility important in

determining the existence of substantial evidence?

If any of the above italicized questions can be answered in the affirmative, substantial evidence exists to support the findings and conclusions of the Commission. The Claimant did not sustain a new permanent injury to her lumbar spine or a permanent exacerbation of her preexisting lumbar spine injury. To find that substantial evidence does not exist to support the Commission's findings of fact, this Court of Appeals improperly weighed the evidence and substituted its judgment for the circuit court and the Workers' Compensation Commission. To not see substantial evidence supporting the findings of the Commission, this Court viewed the evidence blindly from the Claimant's side of the case.

BASED UPON THE FOREGOING, the Respondents City of Greenville and Hewitt Coleman & Associates respectfully petition this court to rehear and reconsider Opinion No. 5059 filed December 5, 2012 and affirm the Order of the circuit court.

Respectfully submitted,



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ATTORNEYS FOR RESPONDENTS

December 18, 2012

The South Carolina Court of Appeals

Kellie N. Burnette, Appellant,

v.

City of Greenville and Hewitt Coleman & Associates,
Respondents.

Appellate Case No. 2011-198006

ORDER

After careful consideration of the petition for rehearing, the Court is unable to discover that any material fact or principle of law has been either overlooked or disregarded, and hence, there is no basis for granting a rehearing. Accordingly, the petition for rehearing is denied.

Paul E. Spitz, Jr. J.

James E. Eckert J.

James W. Curator A. J.

Columbia, South Carolina

cc:

Michael Allen Farry
Douglas A. Churdar
David Alan Wilson

FILED

January 25, 2013

THE STATE OF SOUTH CAROLINA
IN THE SUPREME COURT

APPEAL FROM GREENVILLE COUNTY
COURT OF COMMON PLEAS

G. Edward Welmaker, Circuit Court Judge

CASE NO.: 2010CP2303442
Ct. App. Op. No. 5059
Filed December 5, 2012

RECEIVED
FEB 27 2013
S.C. Supreme Court

Kellie N. Burnett, ... Appellant,

v.

City of Greenville and Hewitt, Coleman & Associates, Inc., ... Respondents.

CERTIFICATE OF SERVICE

I, Michael A. Farry, hereby certify that on this 25th day of February, 2013, I served copy of Appendix to Petition for Writ of Certiorari on Appellant by placing same in the United States Mail, postage prepaid, addressed as follows:

Douglas A. Churdar
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