

22578

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

ORIGINAL

APPEAL FROM THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
APPELLATE PANEL
Commissioner Campbell, III, Chair

RECEIVED

APPELLATE CASE NO. 2015-002112

MAR 17 2016

Lettie Spencer, ... Employee, Appellant,

v.

NHC Parklane, Employer, and Premier Group Insurance Co., Inc.,
Carrier Respondents.

RECORD ON APPEAL

VOL 3 OF 4

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THE REHAB CENTER

2610 E. Seventh Street
Charlotte, NC 28204

PSYCHOLOGY PROGRESS NOTE

CLIENT: Lettie Spencer
CHART #: 12615
DATE: 9-12-2013

Ms. Spencer was seen in individual therapy today. She indicates continued success in her functional restoration program. She reported that she would be agreeable to an extension of the functional restoration program. We discussed her current lack of social support outside of the functional restoration program. We discussed the importance of social support in both physical and emotional healing. Ms. Spencer provided this writer with a brief overview of her work-related injury. Discussed the challenges of having to discontinue something that had been so meaningful to her, specifically her work with Alzheimer's patients, and discussed any potential opportunities she has, from either a vocational or social standpoint, to continue on with that work. Provided emotional support and supportive listening.

Electronically Signed by:

Darcy Alexander, Ph.D.
Psychologist

DA:dsb

CONFIDENTIAL



Daily Progress Note

Name: Lettie Spencer

Chart No: 12615

Days Tx: 16

Date: 9-12-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

MEDICINE

GOAL: To educate patients on the mechanism of injury, causes of chronic pain, diagnosis and management of chronic pain and general preventive health guidelines.

- ☒ Rounds
☐ Team Conference
☐ Patient Education

Comments: Team rounds were held today. We reviewed team conference treatment plans and goals. We discussed medical, psychological, physical therapy and vocational issues. She continues to put forth excellent effort. She is making gains in all areas. We talked to her about a possible extension; she is going to consider this. She is trying to consume more calories. She has improved her gait. She has decided she does not want to pursue the spinal cord stimulator. We will continue with our plan of care.

Electronically Signed by:

T. Kem Carlton, III, MD

Daily Progress Note



Name: Lette Spencer

MRN: 12615

Tx Day: 17

Date: 9/13/2013

DOB: [REDACTED]

Age At Visit: 65

Sex: F

Type of Program: Comprehensive Rehabilitation Program

Attendance Full Day

Notes

Patient performs bilateral shoulder horizontal abduction and diagonal patterns while walking, demonstrating good spinal alignment and upright posture. She does continue to state that she feels "exhausted". She states that she is looking forward to the weekend, hopefully to get some rest. /rh

BP @ 8:30 am 144/74 mm Hg

Pt. observed demonstrating improved upright posture t/o the day. Pt. states she is much more conscious of her posture now and really works hard to not allow the forward flexed posture she used to assume

Pt. is observed t/o the day moving at slower pace. Pt. stated she slept okay last evening other than waking up around 2 am. The previous night she was unable to get comfortable. Pt. was observed completing her side lying exercises and nodding off. Pt. stated she was "exhausted" and was ready for the weekend/ms

Pt demonstrated a noticeable decrease in pacing today with postural indicators of pain but remained on task with all activities. DP

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

Spinal Stabilization: 25 min. supine, standing

admitt
minutes: 12 MPH: 0.5 Distance: .12

Walking
Minutes: 20 Distance:

Weight Training: Demonstrated Good Technique, 5 exercises completed

Standing
Minutes: 20 Notes:

Physical Therapy - Goal: Improve Functional Status

Functional Lifting

Exercise	Pounds	Repetitions
Push Cart	40	3
Pull Cart	40	2

Circuit Exercise	Up & Down	Minutes	Description
Overhead Activities			Wand, 2 x 10
Kneeling		8	

Pain Behavior: Occasional verbal complaints of pain.

Signatory Name

primaryFlag

Signature

Daily Progress Note

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ROA 363

Name: Lettie Spencer

MRN: 12615

Tx Day: 17

Date: 9/13/2013

OB: 11/28/1947

Age At Visit: 65

Sex: F

☐	<i>Rayanne Higginman PT</i>
Dee Payne, P.T., M.S.	☐ <i>Dee Payne, P.T., M.S.</i>
Marisa T. Sheppard, LPTA	☐ <i>Marisa T. Sheppard, LPTA</i>



THE REHAB CENTER
INCORPORATED

Daily Progress Note

Name: Lettie Spencer

Chart No: 12815

Days Tx: 17

Date: 9-13-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

PSYCHOLOGY

GOAL: Improved emotional status with decreased distress and improved sleep.

- ☒ Relaxation: Progressive Muscle Relaxation was utilized, followed by controlled breathing.
Appeared visibly relaxed.

GOAL: Integrate Positive Coping Self-Statements and Coping Strategies to Address Pain-Related Beliefs

- ☒ Trade Secrets: This was a process-oriented group which provided patients with the opportunity to discuss topics of their choosing. Questions pertaining to the week's didactic lectures were answered as well as issues specific to patients' treatment.

Sitting Tolerance:	Sat through session without any pain behavior exhibited.
Participation:	Patient interacted moderately, but appeared to integrate material, at least moderately.
Pain Behavior	No verbal or nonverbal pain behavior exhibited.

Electronically Signed by:

Darcy Alexander, Ph.D.



Daily Progress Note

Name: Lettie Spencer

Chart No: 12615

Days Tx: 17

Date: 9-13-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

MEDICINE

GOAL: To educate patients on the mechanism of Injury, causes of chronic pain, diagnosis and management of chronic pain and general preventive health guidelines.

- ☒ Rounds
☐ Team Conference
☐ Patient Education

Comments: Lettie is seen on rounds today. She is in good spirits. She has had a good week, and she appears to be getting stronger. She says she can tell that she has better muscle definition. She is less fatigued at the end of the day. She is also tolerating the treadmill better. We are waiting to hear about authorization for her extension. Her mood continues to improve, her gait looks better and her movements are more fluid. She did get her refill on the Nuoynta. We are waiting for authorization for her TENS unit. I encouraged her to follow her exercise program over the weekend, and we will continue with our plan of care.

Electronically Signed by:

T. Kern Carlton, III, MD

Daily Progress Note



Name: Lette Spencer MRN: 12615 Tx Day: 18 Date: 9/16/2013
 DOB: [REDACTED] Age At Visit: 65 Sex: F

Type of Program: Comprehensive Rehabilitation Program

Attendance Full Day

Notes

BP @ 8:45 am 128/68 mm Hg

Pt reported over the weekend she attempted to run to multiple stores for groceries with out the use of her TENS unit. Stated she did not get that many items in each store but by the time she came home she had to call her son to unload the groceries and she applied her TENS unit and laid down in her chair/ms

Proper body mechanics demonstrated with activity performance but pt continues to transfer into a crouched position as a lumbar pain relieving measure. She continues to initiate and complete tasks with appropriate timing. Gait antalgia remains present. DP

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

Individual Exercises: Demonstrated Good Technique. 15 exercises completed

Spinal Stabilization: 25 min. supine, standing

Treadmill

Minutes: 15 MPH: .5 Distance: .11

Balance Training

Minutes: 5 Balance Type Dynamic Position: Standing Notes: beginner level activities

Standing

Minutes: 10+15 Notes:

Physical Therapy - Goal: Improve Functional Status

Circuit

Exercises	Up & Down	Minutes	Description
Stair Climbing	3	2X10	STICK OVERHEAD
Overhead Activities		8	
Kneeling Tall			

Pain Behavior: Occasional verbal complaints of pain.

Signatory Name	primaryFlag	Signature
Dee Payne, P.T., M.S.	☐	<i>Dee Payne, P.T., M.S.</i>
Mamta Patel, P.T.	☐	<i>Mamta Patel, P.T.</i>
Marisa T. Sheppard, LPTA	☐	<i>Marisa T. Sheppard, LPTA</i>



THE REHAB CENTER
INCORPORATED

Daily Progress Note

Name: Lettie Spencer

Chart No: 12815

Days Tx: 18

Date: 9-16-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

PSYCHOLOGY

GOAL: Improved emotional status with decreased distress and improved sleep.

☒ Relaxation: Progressive Muscle Relaxation was utilized, followed by controlled breathing.
Appeared visibly relaxed.

GOAL: Integrate Positive Coping Self-Statements and Coping Strategies to Address Pain-Related Beliefs

☒ Sleep and Sleep Hygiene: Normal sleep patterns, sleep disturbances attributable to pain and stress, and ways to obtain more effective sleep were discussed in this group. The effects of pain, stress, emotional upset, negative cognition, lack of exercise and weight gain were noted as having especially negative effects on sleep. Decreased caffeine/nicotine intake, maintaining a consistent exercise regimen, implementing a scheduled bedtime routine, utilizing relaxation exercises and a cognitive focus technique were introduced as ways of enhancing sleep.

Sitting Tolerance:	Sat through session without any pain behavior exhibited.
Participation:	Patient interacted moderately, but appeared to integrate material, at least moderately.
Pain Behavior	No verbal or nonverbal pain behavior exhibited.

Electronically Signed by:

Darcy Alexander, Ph.D.



Daily Progress Note

Name: Lettie Spencer

Chart No: 12615

Days Tx: 18

Date: 9-18-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

MEDICINE

GOAL: To educate patients on the mechanism of injury, causes of chronic pain, diagnosis and management of chronic pain and general preventive health guidelines.

- ☒ Rounds
☐ Team Conference
☐ Patient Education

Comments: Lettie is seen on rounds today. She says she feels like she is continuing to improve. She did have a flare-up over the weekend because, she said, she did some shopping and spent too much time on her feet. She rates her pain level a 6. The TENS unit continues to help her. She is very agreeable to an extension. Her gait is gradually improving. We will continue with our plan of treatment. There is no change neurologically.

Electronically Signed by:

T. Kern Carlton, III, MD.

Daily Progress Note



Name: Lette Spencer MRN: 12615 Tx Day: 19 Date: 9/17/2013
 DOB: [REDACTED] Age At Visit: 65 Sex: F

Type of Program: Comprehensive Rehabilitation Program

Attendance Full Day

Notes

BP @ 8:38 am 124/86 mm Hg

TUG Test: 9:09 seconds

Pt. observed completing core stabilization class on a mat on the floor. Pt. utilized good body mechanics transitioning from standing to supine and back. Noted improved LE strength and endurance with pt required fewer rest breaks/ms

Maximum lifting performed as listed below with c/o of pain with attempts to lift more than 4 lbs. Pt was able to increase pushing utilizing a cart to 41 lbs without body mechanics deterioration. DP

DC survey was completed by the pt. HEP was reviewed with the pt and she was able to properly verbalize understanding of her exercises. Pt will be given theraband on her final visit for home use. DP

Patient reports that she is doing well. She reports of sleeping a lot prior to the program. She reported that she was really very depressed. She is doing much better. She is working on her diet. She had a boost for breakfast, and small steak burger for lunch and said she will eat some nuts during break. Pt. reports "I don't think of food". Patient is working hard in therapy./MP

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

Individual Exercises: Demonstrated Good Technique. 11 exercises completed

Spinal Stabilization: 25 min. supine, standing

Treadmill

Minutes: 12:37 MPH: 1.5 Distance: .12
 Minutes: 15:00 MPH: 0.8 Distance:

Weight Training: Demonstrated Good Technique: 3 exercises completed

Balance Training

Minutes: 20 Balance Type Dynamic Position: Standing Notes: beginner level

Physical Therapy - Goal: Improve Functional Status

Functional Lifting

Exercise	Pounds	Repetitions
Knee To Waist	4	3
Waist To Shoulder	4	2
Level Lift	6	5
Push/Pull Cart	41*	2*

*Push Only - 12.2

Circuit

Exercise	Up & Down	Minutes	Description
Overhead Activities		2x10	
Reeling Tail		8	

Name: Lettie Spencer

MRN: 12615

Tx Day: 19

Date: 9/17/2013

3: 11/28/1947

Age At Visit: 65

Sex: F

Pain Behavior: Frequent nonverbal, mechanical, or postural indications of pain.

Signatory Name	primaryFlag	Signature
Dee Payne, P.T., M.S.	☐	<i>Dee Payne, P.T., M.S.</i>
Marisa T. Sheppard, LPTA	☐	<i>Marisa T. Sheppard, LPTA</i>
Mamta Patel, P.T.	☐	<i>Mamta Patel, P.T.</i>



Daily Progress Note

Name: Lettie Spencer

Chart No: 12815

Days Tx: 19

Date: 9-17-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

MEDICINE

GOAL: To educate patients on the mechanism of injury, causes of chronic pain, diagnosis and management of chronic pain and general preventive health guidelines.

- ☒ Rounds
☐ Team Conference
☐ Patient Education

Comments: Lettie is seen on rounds today. She is in good spirits. She says today is her best day. She says she hopes that she will get an extension. Her posture is more upright, and her gait is better. I am very pleased with her progress and effort. Hopefully, she will be approved for the extra time. We will continue with our plan of care. If she is not approved, then we will have a discharge conference tomorrow.

Electronically Signed by:

T. Kern Carlton, III, MD



Daily Progress Note

Name: Lettle Spencer

Chart No: 12815

Days Tx: 19

Date: 9-17-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

PSYCHOLOGY

GOAL: Improved emotional status with decreased distress and improved sleep.

☒ Relaxation: Progressive Muscle Relaxation was utilized, followed by controlled breathing.

Appeared visibly relaxed.

GOAL: Integrate Positive Coping Self-Statements and Coping Strategies to Address Pain-Related Beliefs

☒ Beliefs and Emotion: This group lecture introduced patients to the basic tenets of cognitive-behavioral therapy, and specifically to the notion that emotions are a product of thoughts and judgments which are themselves shaped by beliefs acquired from a variety of influences over the lifespan. We discussed some of the sources of these beliefs and pointed out that some of these are adaptive, while others are maladaptive, and that they can vary greatly in accuracy. It was noted that many of these beliefs are not fully conscious, but underlie emotional responses, and can be modified upon recognition of these and their maladaptive nature when this is the case. Applications to living with chronic pain were noted, and patients also had the opportunity to review handouts on common irrational beliefs and assessment measures used to identify these.

Sitting Tolerance: Sat through session without any pain behavior exhibited.

Participation: Patient interacted minimally but appeared to integrate material, at least moderately.

Pain Behavior: No verbal or nonverbal pain behavior exhibited.

Electronically Signed by:

Darcy Alexander, Ph.D.

Daily Progress Note



Name: Lettie Spencer MRN: 12615 Tx Day: 20 Date: 9/18/2013
 DOB: [REDACTED] Age At Visit: 65 Sex: F

Type of Program: Comprehensive Rehabilitation Program

Attendance Full Day

Notes

BP: 124/72 am

As last seen by this therapist on 9/8, Lettie is demonstrating improved gait and transitional movements that are markedly improved. She is able to transfer to the ground without problems. She is able to perform all spinal stabilization exercises without modifications. Her affect is positive and she is smiling throughout the sessions. She verbalized the improvements she has noticed including increased muscle strength and mass. She states she overall feels better. /KD

Patient instructed in ankle strengthening exercises using red theraband, for d.f., p.f., eversion, and inversion. She demonstrated all correctly. She states "I feel like my left ankle is weaker". Patient states that she feels her balance would be better if her ankles were stronger. /rh

Patient states that her balance is worse when she first gets up in the morning. She is instructed to try ankle pumps and pelvic tilts before getting out of bed in the morning to see if that helps. She is also instructed to have a light on when she gets up. /rh

Pt states that she will be walking at home for exercise and performing HEP as discussed. She was given theraband for home use. DP

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning stretches. Performed these in supine

Spinal Stabilization: performed in supine

admitt

utes: 12:33 MPH: 1.3 Distance:

Balance Training

Minutes: 2x Balance Type Dynamic Position: Standing Notes: tandem gait with blue foam

Physical Therapy - Goal: Improve Functional Status

Pain Behavior: Occasional verbal complaints of pain.

Signatory Name	primaryFlag	Signature
Kim Dunn, PT	☐	
Rayanne Hitzeman, P.T.	☐	Rayanne Hitzeman, P.T.
Dee Payne, P.T., M.S.	☐	Dee Payne, P.T., M.S.
Mamta Patel, P.T.	☐	Mamta Patel, P.T.



Daily Progress Note

Name: Little Spencer

Chart No: 12615

Days Tx: 20

Date: 9-18-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

PSYCHOLOGY

GOAL: Improved emotional status with decreased distress and improved sleep.

☒ Relaxation: Progressive Muscle Relaxation was utilized, followed by controlled breathing. Appeared visibly relaxed.

GOAL: Integrate Positive Coping Self-Statements and Coping Strategies to Address Pain-Related Beliefs

☒ Trade Secrets: This was a process-oriented group which provided patients with the opportunity to discuss topics of their choosing. Questions pertaining to the week's didactic lectures were answered as well as issues specific to patients' treatment.

Sitting Tolerance:	Sat through session without any pain behavior exhibited.
Participation:	Patient interacted minimally but appeared to integrate material, at least moderately.
Pain Behavior	No verbal or nonverbal pain behavior exhibited.

Electronically Signed by:

Darcy Alexander, Ph.D.

Daily Progress Note



Name: Lettie Spencer MRN: 12615 Tx Day: 21 Date: 9/23/2013
 DOB: [REDACTED] Age At Visit: 65 Sex: F

Type of Program: Comprehensive Rehabilitation Program

Attendance Full Day

Notes

PT arrived today with c/o lumbar pain and asked to have a TENS unit applied since it continues to assist with pain reduction. The unit was applied as listed below. DP

am 8:40 BP: 120/65

Patient reported that as she did decreased activities over the past four days she was a little tired today. Patient was reminded that she should plan activities for 8-10 hours during the day (after discharge) so she can continue to progress like she is doing in the program. She was also reminded to do balance activity on the mat this week and advance to balance beam next week./MP

Patient performed balance gait activity on mat with fair balance. With neuromuscular re-education using manual techniques, patient showed significant improvement./MP

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

Individual Exercises: Demonstrated Good Technique. pt needed demonstration and verbal cueing for ankle theraband. She compensated for ankle weakness with hip activation. Continue to instruct in ankle strengthening for balance improvement. 18 exercises performed.

Core Stabilization: 25 min, supine, standing

Treadmill

Minutes: 9 MPH: .6 Distance: .09
 Minutes: 11 MPH: 1.0 Distance: .11

Modalities

Minutes: PRN Modality: TENS, Modulated Mode, 4 electrodes, Variable mA Placement: Lumbar Position: Various

Balance Training

Minutes: 15 Balance Type Dynamic Position: Standing Notes:

Standing

Minutes: 15 Notes:

Physical Therapy - Goal: Improve Functional Status

Functional Lifting

Exercise	Pounds	Repetitions
Push/Pull Sled	41	3x/ 2 x

Circuit

Exercise	Up & Down	Minutes	Description
Stair Climbing	4		
Overhead Activities		2x10	stick
Kneeling Tall		9	

Pain Behavior: Occasional verbal complaints of pain.

Name: Lettie Spencer

MRN: 12615

Tx Day: 21

Date: 9/23/2013

DOB: 11/28/1947

Age At Visit: 65

Sex: F

Signatory Name	primaryFlag	Signature
Dee Payne, P.T., M.S.	☐	<i>Dee Payne, P.T., Ms.</i>
Kim Dunn, PT	☐	
Mamta Patel, P.T.	☐	<i>Mamta Patel, P.T.</i>
Marisa T. Sheppard, LPTA	☐	<i>Marisa T. Sheppard, LPTA</i>



THE REHAB CENTER
INCORPORATED

Daily Progress Note

Name: Lettie Spencer

Chart No: 12615

Days Tx: 21

Date: 9-23-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

MEDICINE

GOAL: To educate patients on the mechanism of injury, causes of chronic pain, diagnosis and management of chronic pain and general preventive health guidelines.

- ☒ Rounds
☐ Team Conference
☐ Patient Education

Comments: Lettie is seen on rounds today. She returns for her extension. She is pleased to be back. Her affect is brighter. Her gait still looks better. We reviewed with her her goals. I encouraged her to increase her intake of calories. I reexamined her, and there is no change neurologically. We will continue with our plan of care.

Electronically Signed by:

T. Kern Carlton, III, MD

Daily Progress Note



Name: Lette Spencer MRN: 12815 Tx Day: 22 Date: 9/24/2013
 DOB: 4/23/1947 Age At Visit: 85 Sex: F

Type of Program: Comprehensive Rehabilitation Program

Attendance Full Day

Notes

BP @ 8:35 am 104/70 mm Hg

Pt states that she feels fatigued but attributes it to her inactivity since last Thursday. She says that she is aware that her level of endurance has diminished. She was able to increase her treadmill duration by 1 minute today without signs of dyspnea, DP

PNF core stabilization prior to balance on mat. Noted significant improvement since last week. Patient is occasionally observed with flexed posture swaybacked posture and reminded of correction. Overall significant progress. Activity tolerance has improved. Patient is feeling good about her progress./MP

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

Indiv/dual Exercises: Demonstrated Good Technique. 13 exercises completed

Spinal Stabilization: 25 min. supine, standing

Treadmill

Minutes: 18:24 MPH: 1.2 Distance: .30

Balance Training

Minutes: 25 Balance Type Dynamic Position: Standing Notes: beginner/intermediate level activities

Standing

Minutes: 16 Notes:

Physical Therapy - Goal: Improve Functional Status

Functional Lifting

Exercise	Pounds	Repetitions
1 Hand Carry R.	8	3
1 Hand Carry L	8	3
2 Hand Carry	2	3
Push/Pull Cart	41	3

Circuit

Exercise	Up & Down	Minutes	Description
Stair Climbing	2		4 steps ascending/descending
Overhead Activities			Wand, 2 x 10 sec
Kneeling Tall		10	

Pain Behavior: Frequent nonverbal, mechanical, or postural indications of pain.

Signatory Name	primaryFlag	Signature
Dee Payne, P.T., M.S.	☐	Dee Payne, P.T., M.S.

Name: Lettie Spencer

MRN: 12015

Tx Day: 22

Date: 9/24/2018

B: 11/28/1947

Age At Visit: 65

Sex: F

Rayanne Hitzeman, P.T.	☐	<i>Rayanne Hitzeman, P.T.</i>
Marisa T. Sheppard, LPTA	☐	<i>Marisa T. Sheppard, LPTA</i>
Mamta Patel, P.T.	☐	<i>~~Mamta Patel, P.T.~~</i>



Daily Progress Note

Name: Lettie Spencer

Chart No: 12615

Days Tx: 22

Date: 9-24-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

PSYCHOLOGY

GOAL: Improved emotional status with decreased distress and improved sleep.

☒ Relaxation: Progressive Muscle Relaxation was utilized, followed by controlled breathing. Appeared visibly relaxed.

GOAL: Integrate Positive Coping Self-Statements and Coping Strategies to Address Pain-Related Beliefs

☒ Beliefs and Emotion: This group lecture introduced patients to the basic tenets of cognitive-behavioral therapy, and specifically to the notion that emotions are a product of thoughts and judgments which are themselves shaped by beliefs acquired from a variety of influences over the lifespan. We discussed some of the sources of these beliefs and pointed out that some of these are adaptive, while others are maladaptive, and that they can vary greatly in accuracy. It was noted that many of these beliefs are not fully conscious, but underlie emotional responses, and can be modified upon recognition of these and their maladaptive nature when this is the case. Applications to living with chronic pain were noted, and patients also had the opportunity to review handouts on common irrational beliefs and assessment measures used to identify these.

Sitting Tolerance:	Sat through session without any pain behavior exhibited.
Participation:	Patient interacted minimally but appeared to integrate material, at least moderately.
Pain Behavior	No verbal or nonverbal pain behavior exhibited.

Electronically Signed by:

Darcy Alexander, Ph.D.



Daily Progress Note

Name: Lettie Spencer

Chart No: 12816

Days Tx: 22

Date: 9-24-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

MEDICINE

GOAL: To educate patients on the mechanism of injury, causes of chronic pain, diagnosis and management of chronic pain and general preventive health guidelines.

- ☒ Rounds
☐ Team Conference
☐ Patient Education

Comments: Lettie is seen on rounds today. She is becoming more and more independent with her exercises. Her mood and affect continue to improve. She says she can tell that she is getting stronger. She also has cut back on her Nucynta. Over the weekend, she reduced the dose quite a bit. When she is in therapy, she says, she needs two or three doses per day. Hopefully, after she graduates, then she will be able to cut back on the Nucynta further. We will continue with our plan of care.

Electronically Signed by:

T. Kern Carlton, III, MD

Daily Progress Note



Name: LITTLE Spencer MRN: 12615 Tx Day: 23 Date: 9/25/2013
 DOB: [REDACTED] Age At Visit: 65 Sex: F

Type of Program: Comprehensive Rehabilitation Program

Attendance: Full Day

Notes

Patient continues to demonstrate improved, upright posture. She states that the TENS is very helpful in managing her pain./rh

Pt exhibited increased activity pacing today with fewer o/o fatigue. DP

am BP: at 8:40: 110/85

Pt. commended while performing pushing activities during functional lifting for her upright posture. Pt. stated she was much happier with it as well. Pt. tolerated increasing all weight by 1lb for each maneuver while maintaining neutral spine. Slight right lateral lean noted while performing 1-hand carry but was corrected by pt. and maintained/ms

Patient is noted to be taking large steps on the treadmill, with increased hip extension bilaterally. She states "I just wanted to try to see if I could do it". She is commended for her effort but advised to speak with one of the therapists before trying a new activity. She is agreeable. /rh

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

Individual Exercises: Demonstrated Good Technique. performed 4 + ankle exercises including BAPS board added. 5 exercises completed

Core Stabilization: Performed in standing

Treadmill

Minutes: 15:01 MPH: 1.5 Distance: .31

Balance Training

Minutes: 20 Balance Type Dynamic Position: Standing Notes: beginner level exercises completed

Standing

Minutes: 15 Notes:

Physical Therapy - Goal: Improve Functional Status

Functional Lifting

Exercise	Pounds	Repetitions
Knee To Waist	4	4
Waist To Shoulder	4	3
Level Lift	7	3
1 Hand Carry	7	2
1 Hand Carry	4	3
2 Hand Carry	3	2
Push/Pull Cart	42*	3

Push 12.0

Pull 13.6

Circuit

Exercise	Up & Down	Minutes	Description
Stair Climbing	4		4 steps
Wand Overhead	10		
Kneeling		15	

Name: Lettice Spencer

MRN: 12615

Tx Day: 23

Date: 9/25/2013

B: 11/28/1947

Age At Visit: 65

Sex: F

Pain Behavior: Occasional verbal, and nonverbal, mechanical or postural indications of pain.

Signatory Name	primaryFlag	Signature
Dee Payne, P.T., M.S.	☐	Dee Payne, P.T., M.S.
Mamta Patel, P.T.	☐	Mamta Patel, P.T.
Rayanne Hitzeman, P.T.	☐	Rayanne Hitzeman, P.T.
Marisa T. Sheppard, LPTA	☐	Marisa T. Sheppard, LPTA
Kim Dunn, P.T.	☐	

Daily Progress Note



Name: Lettie Spencer MRN: 12815 Tx Day: 24 Date: 9/26/2013
 DOB: [REDACTED] Age At Visit: 65 Sex: F

Type of Program: Comprehensive Rehabilitation Program

Attendance Full Day

Notes

Pt reporting that she is continuing to lose weight bc she is too tired to eat at home. Pt stating her calorie intake is not enough with her workouts. However, in the gym she is not lethargic with her activities.

BP @ 8:40 am 128/72 mm Hg

Patient states that her left shoulder has been bothering her lately. She is advised to eliminate any overhead activities. She is agreeable./rh

Pt reports continued fatigue with attempts to perform activities. As listed above, she reiterates that she is not consuming food consistently. Will again discuss the importance proper nutrition with the pt and program team during rounds today. DP

Patient demonstrates proper form with sidelying hip abduction and clams, remembering what we discussed yesterday./rh

Patient is excited that "my calf muscles are getting firm"/rh

Patient participated in 25 min. seated tai chi./rh

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

Individual Exercises: Demonstrated Good Technique: 3 exercises completed

Spinal Stabilization: 25 min. supine, standing

Bicycle

Minutes: MPH: Distance:

Balance Training

Minutes: 25 Balance Type Position: Notes:

Standing

Minutes: 15 Notes:

Physical Therapy - Goal: Improve Functional Status

Functional Lifting

Exercise	Pounds	Repetitions
1 Hand Carry	7	3R

Circuit

Exercise	Up & Down	Minutes	Description
Stair Climbing	4		4 steps
Kneeling Tall		10	

Pain Behavior: Frequent nonverbal, mechanical, or postural indications of pain.

Signatory Name

primaryFlag

Signature

Daily Progress Note

Page 1 of 2

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ROA 386



Daily Progress Note

Name: Lettie Spencer

Chart No: 12615

Days Tx: 23

Date: 9-25-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

PSYCHOLOGY

GOAL: Improved emotional status with decreased distress and improved sleep.

☒ Relaxation: Progressive Muscle Relaxation was utilized, followed by controlled breathing. Appeared visibly relaxed.

GOAL: Integrate Positive Coping Self-Statements and Coping Strategies to Address Pain-Related Beliefs

☒ Trade Secrets: This was a process-oriented group which provided patients with the opportunity to discuss topics of their choosing. Questions pertaining to the week's didactic lectures were answered as well as issues specific to patients' treatment.

Sitting Tolerance:	Sat through session without any pain behavior exhibited.
Participation:	Patient interacted minimally but appeared to integrate material, at least moderately.
Pain Behavior	No verbal or nonverbal pain behavior exhibited.

Electronically Signed by:

Darcy Alexander, Ph.D.

Name: Lettie Spencer

MRN: 12616

Tx Day: 24

Date: 9/26/2013

DOB: 11/28/1947

Age At Visit: 65

Sex: F

Dee Payne, P.T., M.S.	☐	<i>Dee Payne, P.T., M.S.</i>
Rayanne Hitzeman, P.T.	☐	<i>Rayanne Hitzeman, PT</i>
Marisa T. Sheppard, LPTA	☐	<i>Marisa T. Sheppard, LPTA</i>
Martha Patel, P.T.	☐	<i>Martha Patel, P.T.</i>
Kim Dunn, P.T.	☐	

THE REHAB CENTER

2610 E. Seventh Street
Charlotte, NC 28204

PSYCHOLOGY PROGRESS NOTE

CLIENT: Lettie Spencer
CHART #: 12615
DATE: 9-26-2013

Ms. Spencer was seen for individual therapy today. She reported a positive adjustment back to her functional restoration program after a four-day weekend. She reiterated that she believes the extension will be beneficial for her, as she has already noticed improvements in functioning since when she was in the program just last week. From an emotional standpoint, Ms. Spencer reported that her mood has been stable of late. She remains somewhat disappointed that the opportunity to volunteer with an Alzheimer's support group that seemed to materialize a week or two ago has since fallen through. She is able to report having backup ideas, including volunteering at a local hospice near her house. I reinforced her positive coping skills, including her efforts to stay socially engaged with other people. Her mood was slightly withdrawn. Affect, though, was mood-congruent. She stated that she feels her depression has significantly improved, and she believes that continuing on in her functional restoration program will continue to offer her both physical and emotional benefits.

Electronically Signed by:

Darcy Alexander, Ph.D.
Psychologist

DA:dah



Daily Progress Note

Name: Lettie Spencer

Chart No: 12615

Days Tx: 24

Date: 9-26-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

PSYCHOLOGY

GOAL: Improved emotional status with decreased distress and improved sleep.

☒ Relaxation: Progressive Muscle Relaxation was utilized, followed by controlled breathing.
Appeared visibly relaxed.

GOAL: Integrate Positive Coping Self-Statements and Coping Strategies to Address Pain-Related Beliefs

☒ The focus of today's session was to identify the best recession-proof jobs and careers with staying power. A video was viewed, and then we discussed the necessary skills for these jobs and how to transition into these jobs.

Sitting Tolerance:	Sat through session without any pain behavior exhibited.
Participation:	Patient interacted consistently and appropriately and integrated material.
Pain Behavior	Occasional nonverbal, mechanical or postural indications of pain.

Electronically Signed by:

Sabrina J. Bagby, M.Ed., CRC, CCM

Darcy Alexander, Ph.D.

Daily Progress Note



Name: Lettie Spencer MRN: 12615 Tx Day: 25 Date: 9/27/2013
 DOB: ~~12/12/1928~~ Age At Visit: 85 Sex: F

Type of Program: Comprehensive Rehabilitation Program

Attendance: Full Day

Notes

BP @ 8:38 am 132/68 mm Hg

Pt was placing a large mat under a table and stated: "A few weeks ago I could not even do this." Pt exhibited neutral trunk positioning and proper body mechanics with the task, no LOB. DP

Pt participated in 20 minutes of outdoor ambulation of even and uneven terrain. Pt. observed occasionally clutching her right hip. Pt. stated she sometimes feels like the joint is rubbing bone on bone/ms

Observed patient perform sidestepping on foam beam with slight LOB x two but significant improvement on stability. Patient is significantly happy with her achievement and reports that her balance is tremendously improved./MP

Affect and activity tolerance has significantly improved./MP

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

Individual Exercises: Demonstrated Good Technique. 4 exercises completed in AM

Spinal Stabilization: 25 minutes seated, standing

dmill
 Minutes: 29:44 MPH: 1.7 Distance: 0.75

Balance Training

Minutes: 25 Balance Type Dynamic Position: Standing Notes: beginner/intermediate level activities

Physical Therapy - Goal: Improve Functional Status

Functional Lifting

Exercise	Pounds	Repetitions
1 Hand Carry - R	7	1.5

Circuit

Exercise	Up & Down	Minutes	Description
Stair Climbing	6		4 steps
Kneeling Tall		15	

Pain Behavior: Frequent nonverbal, mechanical, or postural indications of pain.

Signatory Name	primaryFlag	Signature
Dee Payne, P.T., M.S.	☐	<i>Dee Payne, P.T., M.S.</i>
Marisa T. Sheppard, LPTA	☐	<i>Marisa T. Sheppard, LPTA</i>

Name: Lettie Spencer

MRN: 12616

Tx Day: 25

Date: 9/27/2013

DOB: 11/26/1947

Age At Visit: 65

Sex: F

Mamta Patel, P.T.





Daily Progress Note

Name: Lettle Spencer

Chart No: 12615

Days Tx: 25

Date: 9-27-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

PSYCHOLOGY

GOAL: Improved emotional status with decreased distress and improved sleep.

☒ Relaxation: Progressive Muscle Relaxation was utilized, followed by controlled breathing.
Appeared visibly relaxed.

GOAL: Integrate Positive Coping Self-Statements and Coping Strategies to Address Pain-Related Beliefs

☒ Stress Management: In this group lecture, stress was defined as a response to cognitive appraisal, emotional and physiological characteristics stemming from the perception of threat. Implications for the management of stress were reviewed, including recognition and reformulation of characteristic ways of perceiving and thinking, as well as ways of altering the physiological response of stress, including the use of relaxation and exercise. The effects of prolonged stress were described in terms of the adverse effects of the "fight or flight" response, in addition to behavioral and interpersonal consequences. A tripartite approach to stress management was outlined, including physiological regulation, cognitive-behavioral modification techniques and improved communication/assertion skills.

Sitting Tolerance:	Sat through session without any pain behavior exhibited.
Participation:	Patient interacted minimally but appeared to integrate material, at least moderately.
Pain Behavior	No verbal or nonverbal pain behavior exhibited.

Electronically Signed by:

Darcy Alexander, Ph.D.



Daily Progress Note

Name: Lettie Spencer

Chart No: 12615

Days Tx: 25

Date: 9-27-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

MEDICINE

GOAL: To educate patients on the mechanism of injury, causes of chronic pain, diagnosis and management of chronic pain and general preventive health guidelines.

- ☒ Rounds
☐ Team Conference
☐ Patient Education

Comments: Lettie is seen on rounds today. She is in good spirits. She continues to put forth excellent effort. Her endurance and strength continue to improve. Her posture has improved. She is pleased with her progress. There is no change neurologically. We will continue with our plan of care. We did talk about smoking cessation, but she does not plan to quit smoking.

Electronically Signed by:

T. Kern Carlton, III, MD

THE REHAB CENTER
2610 E. Seventh Street
Charlotte, NC 28204

PSYCHOLOGY PROGRESS NOTE

CLIENT: Lettie Spencer
CHART #: 12615
DATE: 9-30-2013

Ms. Spencer was seen in individual psychotherapy today. Ms. Spencer indicates that she believes she is progressing overall in her functional restoration program. She notes improvement in her overall physical status. She indicates she is not becoming fatigued as easily. She indicates that she recognizes that she requires fewer breaks in activity through the day. Ms. Spencer indicates that she is committed to continuing with her current exercise regimen to achieve further improvements in her physical status.

Ms. Spencer's nutritional status was discussed with her. She continues to struggle with the inability to gain weight. Specific strategies for augmenting her nutrition were discussed.

Ms. Spencer continues to consider vocational options. She has investigated opportunities to do volunteer work, with an emphasis on Alzheimer's disease. She expresses interest in returning to work in a paid position working with Alzheimer's patients.

Electronically Signed by:

W. Brian O'Malley, Ph.D.
Psychologist

WBO:dsh



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INCORPORATED

Daily Progress Note

Name: Lettie Spencer

Chart No: 12615

Days Tx: 26

Date: 9-30-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

PSYCHOLOGY

GOAL: Improved emotional status with decreased distress and improved sleep.

☒ Relaxation: Progressive Muscle Relaxation was utilized, followed by controlled breathing.
Appeared visibly relaxed.

GOAL: Integrate Positive Coping Self-Statements and Coping Strategies to Address Pain-Related Beliefs

☒ Psychology of Physical Symptoms: The nature of the interaction between physiological and psychological functioning was the focus of this group lecture. Issues addressed included the process by which decreased mental, physical and social activity lead to increased attention to somatic concerns, an exacerbation of perceived physical symptoms and heightened emotional distress. Common forms of patient resistance to the notion of managing pain via mental, physical and social distracters were discussed.

Sitting Tolerance: Sat through session without any pain behavior exhibited.

Participation: Patient interacted minimally but appeared to integrate material, at least moderately.

Pain Behavior: No verbal or nonverbal pain behavior exhibited.

Electronically Signed by:

Darcy Alexander, Ph.D.



Daily Progress Note

Name: Lettie Spender

Chart No: 12616

Days Tx: 28

Date: 9-30-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

MEDICINE

GOAL: To educate patients on the mechanism of injury, causes of chronic pain, diagnosis and management of chronic pain and general preventive health guidelines.

- ☒ Rounds
☐ Team Conference
☐ Patient Education

Comments: Lettie is seen on rounds today. She is in good spirits. Her affect is brighter than I have ever seen it. Her movements are more fluid. She says she had a great weekend. Her weight is up to 111 lbs, and she says she is eating more. This is the best that I have seen her. I encouraged her to continue to put forth her good effort, and we talked about a home program. We will continue with our plan of care.

Electronically Signed by:

T. Kern Carlton, III, MD

Daily Progress Note



Name: Lettie Spencer MRN: 12815 Tx Day: 27 Date: 10/1/2013
 DOB: [REDACTED] Age At Visit: 65 Sex: F

Type of Program: Comprehensive Rehabilitation Program

Attendance 8 - 11:15

Notes

Patient states that she has gained 5 lbs. She states that she has more energy and is not as tired in the evenings now. It is noted that she is taking longer strides on the treadmill. She is smiling more in the gym/rh

BP @ 8:38 am 136/70 mm Hg

Pt. observed through the morning noting improved upright posture with less breaks taken for lumbar stretching. Pt. ambulates with increased cadence through the gym and continues to challenge herself. Pt observed completing TM activities tolerating 2.3 mph compared to last week at 1.7 mph without increased pain indicators noted./ms

Pt. reports that she has gained 5lbs and has noted improved appetite. Pt. is observed t/o the day snacking more frequently and eating lunch. Pt. stated the shakes she has been drinking have been helping/ms

Pt observed ambulating on the treadmill with increased gait cadence and improved fluidity. DP

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

Individual Exercises: Demonstrated Good Technique. 3 exercises completed

Treadmill

utes: 32 MPH: 2.3 Distance:

Physical Therapy - Goal: Improve Functional Status

Pain Behavior: Occasional nonverbal, mechanical, or postural indications of pain.

Signatory Name	primaryFlag	Signature
Dee Payne, P.T., M.S.	☐	<i>Dee Payne, P.T., M.S.</i>
Rayanne Hitzeman, P.T.	☐	<i>Rayanne Hitzeman, PT</i>
Marisa T. Sheppard, LPTA	☐	<i>Marisa T. Sheppard, LPTA</i>

Daily Progress Note



Name: Lettie Spencer	MRN: 12815	Tx Day: 26	Date: 9/30/2013
DOB: [REDACTED]	Age At Visit: 65	Sex: F	[REDACTED]
Type of Program: Comprehensive Rehabilitation Program		Attendance: Full Day	

Notes

Patient reports that she had a good weekend. She did not try walking outdoors on uneven. Her posture and gait is significantly improved. She reports numbness in the LUE. Her functional lifting is modified for her and she did not have increased symptoms. She has been asked to hold off on 1 hand carry./MP

BP @ 132/72 mm Hg

Pt was given instructions on resuming sitting and standing exercises that eliminate the use of the L UE per c/o as listed above. She was able to complete her activities without c/o increased abnormal sensation. DP

While completed a floor to stand transfer, pt stated: "Look at how well I can do this now! My legs have gotten so much stronger." Pt then demonstrated the transfer again with proper stability, no use of UEs. DP

Pt. is observed lying supine on the low mat table prior to beginning morning warm-up. Pt. performs a series of bridging maneuvers at a moderate pace to place a pillow under her low back. Upon arrival to the program pt. was unable to perform the exercise. Pt. also noted to complete morning warm-up with requiring to sit down. Pt. maintains neutral upright spine through out the day/ms

Physical Therapy - Goal: Improve Physical Condition

Ability / ROM: Performed morning warm-up

Individual Exercises: Demonstrated Good Technique. 10 exercises completed.

Spinal Stabilization: 25 min. supine, standing

Treadmill

Minutes: 17:47 MPH: Distance: .45

Balance Training

Minutes: 20 Balance Type Dynamic Position: Standing Notes: beginner level activities

Standing

Minutes: 18 Notes:

Physical Therapy - Goal: Improve Functional Status

Functional Lifting

Exercise	Pounds	Repetitions
Level Lift	7	3
2 Hand Carry	5	5
Push Cart	25*	4

Push 12.

Circuit

Exercise	Up & Down	Minutes	Description
Overhead Activities	7		4 steps
Kneeling Tall		10	

Behavior: Occasional verbal complaints of pain.

Name: Lettie Spencer

MRN: 12815

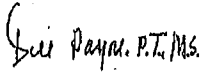
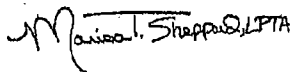
Tx Day: 26

Date: 9/30/2013

OB: ~~201047~~

Age At Visit: 65

Sex: F

Signatory Name	primaryFlag	Signature
Mamta Patel, P.T.	☐	
Dee Payne, P.T., M.S.	☐	
Marisa T. Sheppard, LPTA	☐	



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Daily Progress Note

Name: Lettie Spencer

Chart No: 12615

Days Tx: 27

Date: 10-1-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☐ Full Day ☐ Absent
☒ Half Day ☐ Other

PSYCHOLOGY

GOAL: Integrate Positive Coping Self-Statements and Coping Strategies to Address Pain-Related Beliefs

☒ **Learned Optimism:** This group lecture included a discussion of learned helplessness and how it influences depression and chronic pain. This discussion led into an exploration of the construct of learned optimism as something capable of cognitively and behaviorally counteracting the debilitating effects of learned helplessness. The goal of mastery over our environment was highlighted as a key construct in learned optimism and necessary to prevent and treat negative health outcomes. The differences in the explanatory styles between optimists and pessimists were presented. Strategies for promoting learned optimism were discussed.

Sitting Tolerance:	Sat through session without any pain behavior exhibited.
Participation:	Patient interacted minimally but appeared to integrate material, at least moderately.
Pain Behavior	No verbal or nonverbal pain behavior exhibited.

Electronically Signed by:

Darcy Alexander, Ph.D.

Daily Progress Note



Name: Lettie Spencer MRN: 12615 Tx Day: 28 Date: 10/2/2013
 DOB: [REDACTED] Age At Visit: 65 Sex: F

Type of Program: Comprehensive Rehabilitation Program Attendance Full Day

Notes

Pt demonstrates excellent dynamic standing balance. She was observed standing on the edge of the treadmill maintaining her balance and converging for approximately 20 seconds. DP

Patient is noted to be picking up and carrying the BAPS board across the gym and placing it on the floor. After she completes her balance activity, she lifts the BAPS from the floor and places it back in the corner of the gym. She demonstrates good body mechanics and no LOB. /rh

Pt. observed dragging 2 mats stacked side by side across the floor approximately 10-15' demonstrating upright neutral posture to begin balance activities. Pt. was observed ambulating over the two mats maintaining core stabilization demonstrating improved heel toe gait pattern/ms

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

Individual Exercises: Demonstrated Good Technique. 8 exercises completed

Spinal Stabilization: 25 min. supine, standing

Treadmill

Minutes: 22:28 MPH: 2.0 Distance: .63
 Minutes: 10 MPH: .5 Distance:

Balance Training

Minutes: 20 Balance Type Dynamic Position: Standing Notes: beginner/intermediate level activities

Standing

Minutes: 20 Notes:
 Minutes: 30 Notes:

Physical Therapy - Goal: Improve Functional Status

Functional Lifting

Exercise	Pounds	Repetitions
Level Lift	7	3
2 Hand Carry	5	5
Push Cart	25	4

Pain Behavior: Occasional verbal complaints of pain.

Signatory Name	primaryFlag	Signature
Dee Payne, P.T., M.S.	☐	<i>Dee Payne, P.T., M.S.</i>
Mamta Patel, P.T.	☐	<i>Mamta Patel, P.T.</i>

Name: Lettie Spencer

MRN: 12615

Tx Day: 26

Date: 10/2/2018

DOB: 11/28/1947

Age At Visit: 65

Sex: F

Rayanne Hitzeman, P.T.	☐	<i>Rayanne Hitzeman, PT</i>
Marisa T. Sheppard, LPTA	☐	<i>Marisa T. Sheppard, LPTA</i>



THE REHAB CENTER
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FUNCTIONAL STATUS REPORT

Name: Lettie Spencer
Chart Number: 12615
Discharge Date: 10-02-13

The functional status report is a compilation of information that illustrates a patient's baseline performance and progression during our comprehensive rehabilitation program. Information is gathered by clinician evaluation, weekly assessment and observation. Outcomes are based upon the patient's daily effort and performance. Repeat performance is an indicator of consistency of effort and is measured by bilateral manual isometric grip testing.

ASSESSMENT:

At the initial evaluation, Mrs. Spencer presented with the following deficits:

- Increased pain
- Decreased endurance
- Decreased lumbar active range of motion
- Decreased lumbar strength
- Decreased lower extremity strength
- Postural abnormality
- Poor body mechanics
- Balance abnormality
- Decreased positional tolerances
- Gait abnormality

When beginning the functional restoration program, Mrs. Spencer exhibited a lumbar flexed posture, demonstrating decreased cadence and antalgia with ambulation. She frequently assumed a crouched position during the day as a position of pain relief. She required occasional sessions of 20-30 minutes in supine on a treatment table as a pain relieving position per c/o increased lumbar pain. When beginning the program, she was only able to ambulate at in the physical therapy gym for 15 minutes with slow pacing.

Since entering the functional restoration program, she has made the following gains:

Mrs. Spencer is now ambulating with proper neutral trunk positioning, demonstrating the ability to assume and maintain proper neutral spine and standing posture without cueing. She assumes the crouched position as a pain relieving position only occasionally. She no longer requires any sessions during the program day that require her to lie down as a pain relieving measure. She participated in full body flexibility classes daily, performing activities independently with proper technique. The patient also participated in lumbar stabilization classes on a daily basis, also performing these activities independently with improved spinal positioning.

She is ambulating on the treadmill for 29 minutes at a 1.7 mph pace. She also demonstrates independence with community ambulation activities over even and uneven surface a normal cadence. She is performing intermediate level dynamic standing balance activities without LOB. She demonstrates the ability to perform stationary standing for 10 minutes with occasional weight shifting while performing work simulation activities. She demonstrates the ability to sit for 60 minutes with normal weight shifting.

She demonstrated excellent effort with functional tasks. Her manual isometric test revealed a CV of less than 15% in bilateral upper extremities, which is an indicator of full effort demonstrated.

Mrs. Spencer has demonstrated the ability to tolerate an 8-hr workday.

Functional Status Report
Page 2 of 2

ACTIVITY	ABILITIES
<u>Repetitive Hand Activity</u>	Able to perform manipulation of object at wall chain for 6 minutes, using bilateral hands.
<u>Reaching</u>	Able to hold bilateral arms at shoulder level for 6 minutes while performing work task.
<u>Manual Grip</u>	R side: Avg. Force, 57.6 lbs; L side: Avg. Force, 41.0 lbs. <i>Coefficient of Variation: R 2.7 %, L 1.3 % both consistent with full effort demonstrated. (Coefficient of variation of 15% or less is consistent with full effort demonstrated)</i>
<u>Rotate neck</u>	Moderate limitations noted
<u>Sit</u>	Observed sitting for 60 minutes at a time with occasional weight shifting.
<u>Stand</u>	Observed standing in one place for 10 minutes with occasional weight shifting. Observed dynamically standing for 29 minutes.
<u>Walk</u>	Able to ambulate on treadmill for 29 minutes at a 1.7 mph pace.
<u>Lift (floor to waist)</u>	Not tested per c/o cervical and shoulder pain.
<u>Lift (knee to waist)</u>	4 lbs occasionally
<u>Lift (waist to shoulder)</u>	4 lbs occasionally
<u>Lift (shoulder to overhead)</u>	Not tested per c/o cervical and shoulder pain.
<u>Lift (level)</u>	6 lbs frequently; 7 lbs occasionally
<u>1-hand carry (Right)</u>	6 lbs frequently; 7 lbs occasionally
<u>1-hand carry (Left)</u>	3 lbs frequently; 4 lbs occasionally
<u>2-hand carry</u>	
<u>Bend at waist</u>	No limitations noted. Able to demonstrate proper squatting technique.
<u>Twist at waist</u>	Not tested. Avoid twisting at the waist.
<u>Squat</u>	Observed performing 15 full squats in repetition.
<u>Climb stairs (# steps)</u>	Observed to ascend and descend 4 steps x 6 repetitions.
<u>Climb ladder (# rungs)</u>	Not tested. Unsafe maneuver for patient.
<u>Kneel</u>	Able to kneel for 15 minutes with proper posture and core stability.
<u>Foot control</u>	Able to ambulate on treadmill for 29 minutes with proper reciprocal foot pattern.
<u>Push (lbs & distance)</u>	Able to push 42 lbs (12.0 force lbs) x 50 ft
<u>Pull (lbs & distance)</u>	Able to pull 42 lbs (13.6 force lbs) x 50 ft

RECOMMENDATIONS:

When performing daily activities in her home and work environments, Mrs. Spencer has been reminded to do the following:

- Utilize proper body mechanics with lifting, carrying, pushing/pulling and ADLs.
- Maintain proper neutral lumbar spine posture with concurrent abdominal bracing while performing all activities.
- Use proper squatting techniques with all maneuvers that require lifting from lower levels.
- Change positions during the workday.

PLAN:

Mrs. Spencer has been instructed to continue with her present aerobic conditioning program at home to include a walking program. She is also to continue performing her individual exercises, flexibility exercises and lumbar stabilization exercises 3-4 times per week in order to maintain current level of function. She has been given Theraband resistive tubing for use with specified exercises. The patient has been instructed to utilize a TENS unit and ice PRN to assist with pain reduction.

Professionally,

Dee Payne, P.T., M.S.
Dee Payne, P.T., M.S.

Abbreviations used in this document are endorsed by the Institute of Physical Medicine and Rehabilitation



Daily Progress Note

Name: Lettie Spencer

Chart No: 12615

Days Tx: 28

Date: 10-2-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

PSYCHOLOGY

GOAL: Improved emotional status with decreased distress and improved sleep.

☒ Relaxation: Progressive Muscle Relaxation was utilized, followed by controlled breathing. Appeared visibly relaxed.

GOAL: Integrate Positive Coping Self-Statements and Coping Strategies to Address Pain-Related Beliefs

☒ Trade Secrets: This was a process-oriented group which provided patients with the opportunity to discuss topics of their choosing. Questions pertaining to the week's didactic lectures were answered as well as issues specific to patients' treatment.

Sitting Tolerance:	Sat through session without any pain behavior exhibited.
Participation:	Patient interacted minimally but appeared to integrate material, at least moderately.
Pain Behavior	No verbal or nonverbal pain behavior exhibited.

Electronically Signed by:

Darcy Alexander, Ph.D.

Daily Progress Note



Name: Lettie Spencer MRN: 12615 Tx Day: 29 Date: 10/3/2013
 DOB: [REDACTED] Age At Visit: 65 Sex: F

Type of Program: Comprehensive Rehabilitation Program

Attendance Full Day

Notes

TUG Test: 4:97 seconds

BP @ 9:27 am 124/88 mm Hg

Patient instructed in mechanics for squats with increased stability at ankles and spine and movement at hip and knee joint. Noted increased strength of quadriceps and gluteal muscles. /MP

Patient tolerated even and uneven ambulation surfaces at a normal pace for 25 minutes with one short restbreak./MP

Pt. observed ambulating through the gym demonstrating increased stride length, improved heel/toe gait pattern and increased cadence. Pt. reports she feels so much better since completing the program. She remembers how active she once was and is determined to stay this way./ms

Pt. observed transitioning from standing to supine demonstrating proper body mechanics utilizing her UE to slowly lower herself down on her side and rolling as a unit onto her back. Pt. performed bridging maneuver to positioning herself in the center of the mat./ms

Discharge conference completed with pt and program team (please see FBR for further details). She states that she will continue with a walking program and exercises at home. Pt was given theraband for home use last week. Her HEP was reviewed. She completed the DC survey on a previous visit. DP

Patient participated in 20 min. standing tai chi./rh

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

Individual Exercises: Demonstrated Good Technique. 7 exercises completed - required some verbal cueing for proper core stabilization

Spinal Stabilization: 25 min. supine, standing

Treadmill

Minutes: 21 MPH: 0.5-2.3 Distance: .38

Minutes: 10:31 MPH: .8 Distance:

Balance Training

Minutes: 30 Balance Type Dynamic Position: Standing Notes: Intermediate level activities

Physical Therapy - Goal: Improve Functional Status

Pain Behavior: Occasional nonverbal, mechanical, or postural indications of pain.

Signatory Name	primaryFlag	Signature
Dee Payne, P.T., M.S.	☐	<i>Dee Payne, P.T., M.S.</i>
Mamta Patel, P.T.	☐	<i>Mamta Patel, P.T.</i>

Name: Lettie Spencer

MRN: 12615

Tx Day: 29

Date: 10/3/2013

B: ~~REDACTED~~

Age At Visit: 68

Sex: F

Rayanne Hitzeman, P.T.	☐	<i>Rayanne Hitzeman, PT</i>
Marisa T. Sheppard, LPTA	☐	<i>Marisa T. Sheppard, LPTA</i>

THE REHAB CENTER

2610 East Seventh Street
Charlotte, NC 28204

DISCHARGE SUMMARY

NAME: Lettie Spencer
CHART#: 12615
DATE: 10-3-2013

Ms. Spencer completed a functional restoration program. During the course of treatment, she put forth excellent effort. She made gains in her strength, endurance, flexibility and balance. There was a marked reduction in her pain behavior and a marked improvement in her mood and affect. Her body mechanics and gait as well as her posture all improved. Her caloric intake increased, and she gained 6 lbs during the course of treatment. She used a TENS unit, which was beneficial, and was given a prescription for this. She was taking Nucynta 75 mg three times a day but was able to reduce this to twice a day, on occasion, and was encouraged to try to reduce her use of Nucynta, if possible. She was taking her other medications as prescribed by her primary care physician. Upon completing the program, she was placed at maximum medical improvement. She was given a rating of 8% of the back. She was placed in a sedentary work category. Please see her functional status report for details of her functional abilities. She was instructed on a home exercise program and a flare-up plan. She was told to call if there are any further questions, and I will recheck her in one month.

Electronically Signed by:

T. Kern Carlton, M.D., F.A.A.P.M. &R.
Medical Director

TKC:dsh

CONFIDENTIAL



THE REHAB CENTER
INCORPORATED

Daily Progress Note

Name: Little Spencer

Chart No: 12615

Days Tx: 29

Date: 10-3-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

PSYCHOLOGY

GOAL: Improved emotional status with decreased distress and improved sleep.

☒ Relaxation: Progressive Muscle Relaxation was utilized, followed by controlled breathing.
Appeared visibly relaxed.

GOAL: Integrate Positive Coping Self-Statements and Coping Strategies to Address Pain-Related Beliefs

☒ The focus of today's session was utilizing career exploration techniques such as self-assessments, books/databases, networking, volunteering, job fairs and other means to develop appropriate job goals and career plans.

Sitting Tolerance:	Sat through session without any pain behavior exhibited.
Participation:	Patient interacted consistently and appropriately and integrated material.
Pain Behavior	No verbal or nonverbal pain behavior exhibited.

Electronically Signed by:

Sabrina J. Bagby, M.Ed., CRC, CCM

Darcy Alexander, Ph.D.



Daily Progress Note

Name: Lettie Spencer

Chart No: 12615

Days Tx: 29

Date: 10-3-2013

Type of Program

- ☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance

- ☒ Full Day ☐ Absent
☐ Half Day ☐ Other

MEDICINE

GOAL: To educate patients on the mechanism of injury, causes of chronic pain, diagnosis and management of chronic pain and general preventive health guidelines.

- ☒ Rounds
☐ Team Conference
☐ Patient Education

Comments: Lettie is seen on rounds today. She is in good spirits. She is very pleased with her progress. We held a discharge conference. Please see my discharge summary for details.

Electronically Signed by:

T. Kern Carlton, III, MD



PHYSICAL THERAPY OUTPATIENT

Client Name: Lettie Spencer
Chart Number: 12615

Date: 10-14-2013

SUBJECTIVE: Patient reports that she has occasional cervical pain but that it is improving. She states that she is performing her exercises every other day and that she does perform some exercises to warm up before she gets out of bed. She states that, in her daily routine, she is taking her dogs for walks, and that allows her to get exercise as well. She reports that she is also walking in the mall for 10-15 minutes six days a week. She states that she is performing balance activities, including tai chi. She does report that she continues to have fatigue but is working on improving her endurance.

OBJECTIVE:

Strength:

Lumbar:	Flexion	4/5
	Extension	4/5
	Right lateral flexion	4/5
	Left lateral flexion	4/5

Hips:	<u>Right</u>	<u>Left</u>
Flexion	4/5	4/5
Abduction	4/5	4/5
Adduction	4/5	4/5
Internal rotation	4/5	4/5
External rotation	4/5	4/5

Balance: Single-limb stance on the right is 10 seconds and on the left is 12 seconds.

ASSESSMENT: Patient presents with a neutral posture. She has a normal gait cadence. She was able to properly verbalize understanding of TENS unit instructions given today. She is completing transfers and transitional movements with proper body mechanics.

PLAN: Patient is to continue with her home exercise program. She has a follow-up visit on the 31st. Will review TENS instruction again to see if she has any questions.

Electronically Signed by:

Dee Payne, P.T., M.S.

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THE REHAB CENTER

2610 E. Seventh Street
Charlotte, NC 28204

PSYCHOLOGY PROGRESS NOTE

CLIENT: Lettie Spencer
CHART #: 12615
DATE: 10-14-2013

Ms. Spencer was seen in psychological follow-up today. She reports stability in her status since completing the functional restoration program. She continues to follow through with her home exercise program. She did comment that she is not exercising as vigorously as she did during her program. She continues to use strategies for improving her balance. She describes herself as doing well overall.

Ms. Spencer continues to walk on a regular basis. She indicates that she is staying active most of the day at her home. She continues to look for both volunteer and paid opportunities.

Emotionally, Ms. Spencer describes her status as stable. She demonstrated significant improvement in her mood from her status at the time of admission to the functional restoration program.

Ms. Spencer was encouraged to persist with her present pain and stress management strategies. She will be seen in follow-up in two weeks.

Electronically Signed by:

W. Brian O'Malley, Ph.D.
Psychologist

WBO:dsh

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THE REHAB CENTER

2610 East Seventh Street
Charlotte, NC 28204

REEVALUATION

NAME: Lettie Spencer
CHART #: 12615
DATE: 10-31-2013

Ms. Spencer is seen today for a reevaluation. She says that she has been managing well. She has had an upper respiratory infection for the last few weeks and says this seems to have increased her pain a bit. She is using her TENS unit. She rates her pain level a 3. She says she is doing her exercises. She has been active, but not quite as active as she was before. She has not yet lined up any volunteer work but says she is working on it. She is still taking the Nucynta and says it continues to help her. She said she would prefer to see Dr. Nandahar for her pain medication, because he is more convenient to her home.

Medications: Nucynta 75 mg every 8 hours p.r.n. pain, usually 2-3 per day; she says this is helpful. She is on potassium 20 mEq per day, Norvasc 5 mg q.a.m., Aldactone 25 mg q.a.m., Viiibryd 40 mg once a day, which she says she has been on for two months and has been helpful, trazodone 100 mg at bedtime, Tapazole 10 mg q.h.s. and Klonopin 1 mg at bedtime.

PHYSICAL EXAM:

On physical exam, she is very pleasant and cooperative. She is awake, alert and fully oriented. She is coughing occasionally. There is lower lumbar tenderness. There is no change neurologically. Her weight is 111 lbs. Her affect is appropriate but not quite as bright as on the last visit.

IMPRESSION:

1. Lumbar strain, 6-22-2011.
2. Lumbar spondylosis with L4-5 disc protrusion.
3. Depression.
4. History of hypertension.
5. Hyperthyroidism.

PLAN:

I talked to her at length about her situation. I stressed to her the importance of getting involved in volunteer activity and staying active. I talked to her about the importance of increasing her exercise program. I reviewed with her her medications, and she says she is going to get these from Dr. Nandahar. She remains at maximum medical improvement, and there is no change in her rating or restrictions. I will see her back on an as-needed basis, and I told her to call if she has any further questions. Her case manager, Patti Chambers, R.N., joined us at the conclusion of the visit.

Electronically Signed by:

T. Kern Carlton, M.D., F.A.A.P.M.&R.
Medical Director

TKC:rdh

THE REHAB CENTER

2610 East Seventh Street
Charlotte, NC 28204

REEVALUATION

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CHART #: 12615
DATE: 10-31-2013

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Electronically Signed by:

T. Kern Carlton, M.D., F.A.A.P.M.&R.
Medical Director

TKC:dsh

CONFIDENTIAL



Bruce D. Filler, M Ed., P.T.
Director

www.crc rehab.com

January 21, 2014

Mr. Andrew Creech
Elrod Pops Law Firm
P.O. Box 11091
Rock Hill, S.C. 29731

Re: Lettie Spencer

Ms. Spencer was seen on January 21, 2014 for an impairment rating of her lumbar spine. Ms. Spencer sustained a work injury to her lumbar spine on June 22, 2011. A MRI of the lumbar spine dated July 22, 2011 indicated mild degenerative disc disease most prominent at L4-5. A CT of the lumbar spine dated September 11, 2012 indicated mild central canal stenosis at L4-5.

Ms. Spencer reports constant lumbar pain since her injury. She reports "weak legs" since her injury. She reports difficulty with shopping and prolonged sitting. She reports inability to garden or work since her injury.

The American Medical Association's Guides to the Evaluation of Permanent Impairment, fifth edition was utilized to determine her impairment. According to Table 15-3 on page 384, Ms. Spencer qualifies for a DRE (Diagnosis Related Estimates) Lumbar Category II. This whole person impairment rating is 8%. In order to convert a whole person impairment into a regional spine impairment, one must divide the whole person impairment by 0.75. Please refer to page 427 of the Guides. Therefore, 8% divided by 0.75 results in an 11% impairment of the lumbar spine.

Thank you for this referral. Please call me if you have any questions at (803) 799-7007.

Sincerely,

A handwritten signature in cursive script, appearing to read 'Tracy Hill', is written over the typed name.

Tracy Hill, P.T.

2382 Two Natch Road, Columbia, SC 29204, 799-7007
1 Wellness Blvd., Suite 204, Irmo, SC 29053, 749-0808
1177 Sunset Boulevard, West Columbia, SC 29169, 794-3440
115 Blarney Drive, Suite 202 Columbia, SC 29229, 736-4645



BLYTHEWOOD
PHYSICAL THERAPY

426-3 McNulty Road, PO Box 219, Blythewood, SC 29016, 728-0421

Page 000278



Bruce D. Miller, M.Ed., P.T.
January 21, 2014

www.crcrehab.com

Mr. Andrew Creech
Elrod Pope Law Firm
P.O. Box 11091
Rock Hill, S.C. 29731

Re: Lettie Spencer

Ms. Spencer was seen on January 21, 2014 for a Functional Capacity Evaluation.

Ms. Spencer is a 66 year old female who sustained a work injury to her lumbar spine on June 22, 2011. The patient reported an initial pain level of "7" on a "0-10" pain scale in which "0" represents no pain and "10" represents maximal emergency level pain. The highest reported pain level during today's evaluation was "8" and this occurred with pushing and attempted pulling.

The results of the Functional Capacity Evaluation performed on this date indicate that she can meet the demands of limited (less than) sedentary work. She tolerates occasional walking and squatting. She does not tolerate occasional stairclimbing, kneeling, bending, twisting, or reaching. She can lift from 3 to 6 pounds at various heights on an occasional basis. She can carry 7 pounds with 2 hands. She can carry 4 pounds in the right hand and 4 pounds in the left hand. She can push 14.2 foot pounds loaded in a sled. She was unable to pull 14.2 foot pounds loaded in a sled. She has a self-reported sitting and standing tolerance of 60 and 15 minutes respectively. She has a self reported walking tolerance of 60 minutes. She was observed to sit for a maximal time of 12 minutes and stand for a maximal time of 12 minutes. She was observed to stand/walk for a maximal time of 14 minutes.

The patient's lumbar range of motion is limited. Please refer to the enclosed forms for range of motion measurements.

The results of the treadmill test place Ms. Spencer in the average Classification of Aerobic Capacity. Ms. Spencer's Functional Aerobic Capacity qualifies her for light work.

Ms. Spencer put forth a consistent effort during the evaluation. She qualifies for limited sedentary (less than sedentary) work. Please refer to page 2 of the enclosed forms for specific lifting ability. She does not tolerate occasional kneeling, bending, twisting, stairclimbing, or reaching. Ms. Spencer reported medicating with Nucynta approximately one hour prior to testing.

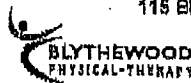
Thank you for this referral. If you have any questions, please call me at (803) 799-7007.

Sincerely,

A handwritten signature in black ink, appearing to read 'Tracy Hill', is written over the word 'Sincerely,'.

Tracy Hill, P.T.

2382 Two Notch Road, Columbia, SC 29204, 799-7007
1 Wellness Blvd., Suite 204, Irmo, SC 29063, 746-0808
1177 Sunset Boulevard, West Columbia, SC 29189, 794-3440
115 Blarney Drive, Suite 202 Columbia, SC 29223, 796-1845



426-3 McNulty Road, PO Box 219, Blythewood, SC 29016, 726-0421

Page 000279



PREPARED FOR:
Mr. Andrew Cressh
Eliel Pope Law Firm
P.O. Box 11091
Rock Hill, S.C. 29731

Tel: (803) 324-7574 Fax: (803) 324-7545

FUNCTIONAL ABILITIES EVALUATION



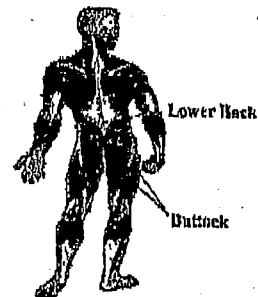
Client Information

Client Name: Ms. Lottie Spencer
Address: 2867 Greatfalls Highway
Richburg, S.C.
29729
Injury Date: June 22, 2011
Dominant Hand: Right Hand
SSN: 259-74-6627

Date of Birth: November 28, 1947
Gender: Female
Height: 62 inches
Weight: 107 lbs

Start & Finish Date: Jan 21, 2014
Evaluator: Tracy Hill, PT

Areas of Complaint



General Location	Specific Location	Plane	Side	Pain Type	Pain Scale
Buttock			Bilateral	Throbbing	7 - Low Intense
Lower Back (Lumbosacral)			Central	Throbbing	7 - Low Intense

Tracy Hill

Tracy Hill, PT
Physical Therapist

COLUMBIA REHABILITATION CLINIC, INC.
2362 TWO NOTCH ROAD COLUMBIA SC 29204 (803) 799-7007

All testing was completed using the FOCUS System. Data Management was completed through ODES products of BTE Technologies



Name Lettie SPENCER

Lift	Pounds	Job Demand Category
Floor to Waist	3	limited sedentary
12 Inch to Waist	6	
Waist to Shoulder	5	
Shoulder to Overhead	3	
Carry (2 Handed)	7	
Right Hand Carry	4	
Left Hand Carry	4	
Push	0 (14.2 lb.F)	limited light
Pull	unable	_____

Strength

Lower Extremity Manual Muscle Test

Jun 21, 2014 12:03:13 PM

Manual Muscle Testing of the lower extremities was performed and the results are as follows:

Hip Flexion: Bilat 4/5

Knee Extension: Bilat 4+/5

Dorsiflexion: Bilat 3/5

Extensor Hallucis Longi: Bilat 5/5

Eversion: Bilat 3/5

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2362 TWO NOTCH ROAD COLUMBIA SC 29204 (803) 799-7007

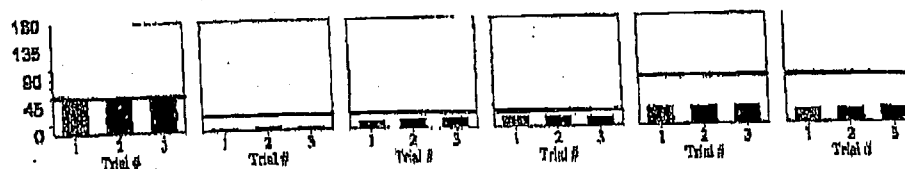
Mr. Little Spencer



Range of Motion **Lumbar Range of Motion**

Jan 21, 2014 11:55:00 AM

	True Lumbar Flexion	True Lumbar Extension	Left Lateral Flexion	Right Lateral Flexion	Left Straight Leg Raise	Right Straight Leg Raise
Normals:	60	28	25	25	80	80
Trial 1:	61	3	12	13	28	22
Trial 2:	58	6	14	15	30	24
Trial 3:	61	3	16	15	31	25
Average	60.0	4.0	14.0	13.0	29.7	23.7
Maximum	61.0	6.0	16.0	15.0	31.0	25.0
AMA Valid	YES	YES	YES	YES	YES	YES
% of Normal	100%	16%	56%	60%	37%	30%

Reference Information

American Medical Association Guides to the Evaluation of Permanent Impairment, Fifth Edition

COLUMBIA REHABILITATION CLINIC, INC.
2962 TWO NOTCH ROAD COLUMBIA SC 29204 (803) 799-7007

Ms. Lattie Spencer

Work Simulation - Dynamic Bending

Jan 21, 2014 12:16:56 PM

The patient was asked to bend forward at the waist 25 repetitions. The results are as follows:

dynamic bending: 12 repetitions

PRE HR 66 POST
HR 84

Evaluator Comments

Ms. Spencer was able to bend forward at the waist 11 repetitions. Testing was terminated at the request of the patient secondary to complaints of increased lumbar pain.

COLUMBIA REHABILITATION CLINIC, INC.
2362 TWO NOTCH ROAD COLUMBIA SC 29204 (803) 789-7007

Ms. Leticia Spencer



Work Simulation - Dynamic Rotation

Jan 21, 2014 12:20:23 PM

The patient was asked to rotate at the waist 25 repetitions. The results are as follows:

Dynamic rotation: 15 repetitions

PRE HR 64 POST
HR 80

Evaluator Comments

Ms. Spencer was able to rotate at the waist 15 repetitions. Testing was terminated at the request of the patient secondary to complaints of increased lumbar pain.

COLUMBIA REHABILITATION CLINIC, INC.
2352 TWO NOTCH ROAD COLUMBIA SC 29204 (803) 799-7007

Ms. Letitia Spencer



Work Simulation - Squatting

Jan 21, 2014 12:23:50 PM

The patient was asked to assume a squatting position for 2 minutes. The results of squatting are as follows:

squatting: 2 minutes

PRE HR 64 POST
HR 80

Evaluator Comments

Ms. Spencer was able to squat for 2 minutes. She was comfortable in the squatting position but was noted to have difficulty rising from the squatted position.

COLUMBIA REHABILITATION CLINIC, INC.
2362 TWO NOTCH ROAD COLUMBIA SC 29204 (803) 799-7007

Ms. Little Spencer

Work Simulation - Kneeling

Jan 21, 2014 12:28:10 PM

The patient was asked to assume a kneeling position for 2 minutes. The results are as follows:

Kneeling: 39 seconds

PRE HR 65 POST
HR 76

Evaluator Comments

Ms. Spencer was able to kneel for 39 seconds with difficulty noted staying upright. Testing was terminated at the request of the patient secondary to complaints of increased lumbar pain.

COLUMBIA REHABILITATION CLINIC, INC.
2362 TWO NOTCH ROAD COLUMBIA SC 29204 (803) 799-7007

Ms. Leslie Spencer

Work Simulation - Dynamic Reaching

Jan 21, 2014 12:42:31 PM

The patient was asked to transfer 1 lb weights from shoulder level to above head level for 5 minutes. The results are as follows:

Dynamic reaching: 3:49 minutes

PRE HR 72 POST
HR 89

Evaluator Comments

Ms. Spencer was able to reach for 3:49 minutes. Testing was terminated at the request of the patient secondary to complaints of increased lumbar pain.

COLUMBIA REHABILITATION CLINIC, INC.
2362 TWO NOTCH ROAD COLUMBIA SC 29204 (803) 799-7007

Mr. Leslie Spencer



Work Simulation ■ Stair Climbing

Jan 21, 2014 12:47:10 PM

The patient was asked to ascend/descend a series of 4 stairs for a total of 10 cycles. The results are as follows:

Time (min,secs)	Initial Heart Rate (bpm)	Final Heart Rate (bpm)	Stairs Ascended	Stairs Descended
3:28	74	94	24	24

Evaluator Comments

Ms. Spencer was able to ascend/descend a series of 4 stairs for a total of 6 cycles. She used a step over step gait pattern and used both handrails. Testing was terminated at the request of the patient secondary to complaints of increased lumbar pain.

COLUMBIA REHABILITATION CLINIC, INC.
2362 TWO NOTCH ROAD COLUMBIA SC 29204 (803) 759-7007

Ms. Lettie Spencer

F.10

Work Simulation Floor to waist lift

Jan 21, 2014 12:56:05 PM

Floor to waist lifting results are as follows:

Floor to waist: 3 pounds

Physical demand level: limited sedentary

MAX HR 90

Evaluator Comments

Ms. Spencer was able to lift 3 pounds with difficulty noted rising from the squatted position. She did not want to attempt additional weight secondary to complaints of increased lumbar pain.

COLUMBIA REHABILITATION CLINIC, INC.
2362 TWO NOTCH ROAD COLUMBIA SC 29204 (803) 799-7007

Ms. Letitia Spencer



Work Simulation - 12 inch to waist lift

Jan 21, 2014 1:03:00 PM

The patient was asked to lift from 12 inches off of the floor to waist height. The results are as follows:

12 inch to waist: 6 pounds

Physical demand level: limited sedentary

MAX HR 91

Evaluator Comments

Ms. Spencer was able to lift 6 pounds. She did not want to attempt additional weight secondary to complaints of increased lumbar pain.

COLUMBIA REHABILITATION CLINIC, INC.
2362 TWO NOTCH ROAD COLUMBIA SC 29204 (803) 799-7007

Ms. Lettie Spencer



Work Simulation - Waist to shoulder lift

Jan 21, 2014 1:09:52 PM

The patient was asked to lift from waist height to shoulder height. The results are as follows:

Waist to shoulder: 5 pounds

Physical demand level: limited sedentary

MAX HR 92

Evaluator Comments

Ms. Spencer was able to lift 5 pounds with difficulty noted. She did not want to attempt additional weight secondary to complaints of increased lumbar pain.

COLUMBIA REHABILITATION CLINIC, INC.
2362 TWO NOTCH ROAD COLUMBIA SC 29204 (803) 799-7007

Ms. Lettie Spencer



Work Simulation - Shoulder to overhead lift

Jan 21, 2014 1:18:46 PM

The patient was asked to lift from shoulder height to overhead height. The results are as follows:

Shoulder to overhead: 3 pounds

Physical demand level: limited sedentary

MAX HR 89

Evaluator Comments

Ms. Spencer was able to lift 3 pounds with difficulty noted. She did not want to attempt additional weight secondary to complaints of increased lumbar pain.

COLUMBIA REHABILITATION CLINIC, INC.
2362 TWO NOTCH ROAD COLUMBIA SC 29204 (803) 799-7007

Ms. Lottie Spencer



Work Simulation ~~is~~ Dynamic 2-handed carry

Jan 21, 2014 1:26:22 PM

The patient was asked to carry a box, using both hands, a distance of 30 feet. The results are as follows:

Dynamic 2-handed 7 pounds
carry

Physical demand level: limited sedentary

MAX HR 92

Evaluator Comments

Ms. Spencer was able to carry 7 pounds. Her speed of gait was noted to decrease and she did not want to attempt additional weight secondary to complaints of increased lumbar pain.

COLUMBIA REHABILITATION CLINIC, INC.
2362 TWO NOTCH ROAD COLUMBIA SC 29204 (803) 799-7007

Ms. Lettie Spencer



Work Simulation **Dynamic 1-handed carry**

Jan 21, 2014 1:35:00 PM

The patient was asked to carry a bucket, using 1 hand, a distance of 30 feet. The results are as follows:

Left-handed carry: 4 pounds

Right-handed carry: 4 pounds

MAX HR 93

Evaluator Comments

Ms. Spencer was able to carry 4 pounds in her left hand and 4 pounds in her right hand. Her speed of gait was noted to decrease and she did not want to attempt additional weight secondary to complaints of increased lumbar pain.

COLUMBIA REHABILITATION CLINIC, INC.
2362 TWO NOTCH ROAD COLUMBIA SC 29204 (803) 799-7007

Mr. Leslie Spencer



Work Simulation ➤ Dynamic Push/Pull

Jan 21, 2014 1:44:00 PM

The patient was asked to push and pull a sled a distance of 30 feet. The results are as follows:

Push: 14.2 lbs.

Pull: unable

MAX HR 93

Evaluator Comments

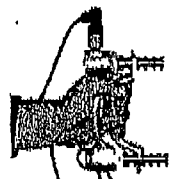
Ms. Spencer was able to push 14.2 foot pounds loaded in a sled with difficulty noted. She was unable to pull the sled secondary to complaints of increased lumbar pain when attempting to do so. She did not want to attempt additional weight secondary to complaints of increased lumbar pain.

Hand Grip Strength

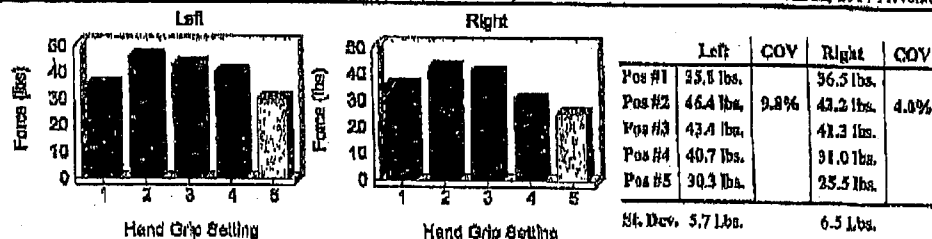
The JAMAR hand dynamometer was used in order to quantify grip strength and determine whether Ms. Lettie Spencer exerted consistent effort during grip strength testing. Ms. Lettie Spencer was tested using the modified maximum voluntary effort hand grip protocol. Ms. Lettie Spencer is right hand dominant. Normative data is based on the assumption that right and left hand dominant subjects, analyzed separately show little functional difference between their mean scores.^{1, 2}

Modified Maximum Voluntary Effort (MMVE)

Jan 21, 2014 11:48:26 AM



The hand dynamometer is set to each of the five available positions which vary the client's grip size. The results for each of the average maximum forces during each position are displayed by the corresponding bar graphs.



Using the Modified Maximum Voluntary Effort (MMVE) protocol over a range of five positions on the hand dynamometer, it is expected that the strength graphs obtained results in a bell-shaped curve^{3, 11, 12, 13}, even in a disabled population or if the client's hand is injured¹⁴, with the coefficients of variation at position 2 within the acceptable 15% or less limit.

The graph obtained for Ms. Lettie Spencer did demonstrate a bell shaped curve which may be an indicator of maximal effort and the coefficients of variation of the underlying data may be an indicator of consistent effort

¹ Stokes H. 1983. The normally uninjured hand - weakness of grip. J Occup Med 25(9):683-684.

¹¹ Niebuhr B, Marion R. 1990. Voluntary control of submaximal grip strength. Am J Phys Med Rehabil 69(2): 96-101.

¹² Matheson L, Carlson R, Mieseyer L. 1988. Grip strength in a disabled sample: reliability and normative standards. Ind Rehabil Q 1(3):9,17-23.

¹³ Hildebrand D, Brudenbach W, Lester G, Hodges A. 1989. Detection of submaximal effort by use of the rapid exchange grip. J Hand Surgery 14A(4): 742-745.

COLUMBIA REHABILITATION CLINIC, INC.
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Ms. Lettie Spencer



The Waddell Signs

Jan 21, 2014

Please read:

The following tests are recommended to test for non-organic physical signs in the case of lower back injuries. The Waddell's NOS should not be used in case situations where the injury involves multiple spinal segments.
Please check whether the patient's response is positive or negative.

1. Tenderness - Should be localized to a skeletal or neuromuscular structure.

Superficial Tenderness - provide light pinch to the skin over the lower back region. If there is widespread tenderness, this is considered non-physiological and is an indication of symptom magnification.

- ☒ Negative
☐ Positive

Non-Anatomic Tenderness - Perform deep palpation to the lumbar paraspinals. If there is tenderness which is widespread and not localized to any specific structures, then this is considered magnification of symptoms.

- ☒ Negative
☐ Positive

2. Simulation Tests - Give the patient the impression that a particular movement is being performed when it actually is not

Axial Loading - To perform this test apply a light downward pressure on the top of the patient's head while they are in the standing position. If increased lower back pain is reported then this is an indication of exaggeration of symptoms.

- ☒ Negative
☐ Positive

Simulated Rotation - With the patient in the stand position and feet together, rotate the pelvis and shoulders simultaneously by applying pressure at the level of the lower forearm. If the patient reports increased pain then this is considered symptom magnification.

- ☒ Negative
☐ Positive

3. Distraction Tests - Retesting of a positive finding in a way that the patient does not recognize or expect

Distraction Test - Perform a straight leg raise with the patient in the supine position. When the SLR shows marked improvement while performed on distraction (i.e. Patient seated) this is considered positive.

- ☒ Negative
☐ Positive

4. Regional Disturbances - Divergence from accepted neuroanatomy

Regional Disturbances - These are present as motor weakness or sensory loss involving widespread regions such as the entire leg or a quarter or half of the body.

- ☒ Negative
☐ Positive

5. Overreaction - Disproportionate verbalization, facial expression, muscular tension and/or tremor or sweating

Overreaction - A disproportionate response such as verbalizations, facial expressions, collapsing etc. can be indicative of symptom magnification.

- ☒ Negative
☐ Positive

If three or more of the categories are positive then the findings are clinically significant for non-organic low back pain.

Scoring: Clinically insignificant.

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Ms. Letitia Spencer



Sitting tolerance

Jan 21, 2014

The patient's self-reported sitting tolerance is as follows:

Evaluator Comments

Ms. Spencer has a self reported sitting tolerance of 60 minutes. She reports her sitting tolerance is limited secondary to complaints of increased lumbar pain.

Standing tolerance

Jan 21, 2014

The patient's self-reported standing tolerance is as follows:

Evaluator Comments

Ms. Spencer has a self reported standing tolerance of 15 minutes. She has a self reported walking (slow) tolerance of 60 minutes. She reports her standing/walking tolerance is limited secondary to complaints of increased lumbar pain and complaints of legs feeling weak. She was observed pacing a lot during today's evaluation.

Cardiovascular Intake Jan 21, 2014

	Resting Rate (Min)	Systolic (mm Hg)	Diastolic (mm Hg)
	58	140	72

Result	Slow Heart Rate	Borderline Hypertension	Normal Blood Pressure

Single Stage ▶ Pre-Testing Heart Disease Questions

Treadmill

Test Date: Jan 21, 2014 12:31:07 PM

1. Have you ever had a heart attack?..... ☐ Yes ☒ No
2. Have you ever had heart surgery?..... ☐ Yes ☒ No
3. Have you ever had an abnormal electrocardiogram?..... ☐ Yes ☒ No
4. Do you have heart disease?..... ☐ Yes ☒ No
5. Have you been told by a physician you have had angina?... ☐ Yes ☒ No
6. Have you been told by a physician you
have had palpitations?..... ☐ Yes ☒ No
7. Have you had a stroke (CVA)?..... ☐ Yes ☒ No
8. Is your blood pressure (BP) 159/100?..... ☐ Yes ☒ No
9. Are you pregnant?..... ☐ Yes ☒ No

Initial Heart Rate Initial Blood Pressure
58 BPM 140 / 72

Stage	Speed	Heart Rate	Blood Pressure	Grade
1. Warm-Up	0.5mph	82 BPM	0/0	0%
2. Exercise	0.6mph	87 BPM	0/0	5%
3. Recovery	0mph	0 BPM	0/0	0%
Predicted Maximum VO ₂	18 ml/Kg/min			
	7 ml/Kg/min			
Predicted Max Met Level	2 METS			
Functional Aerobic Capacity	Light work			
Classification of Aerobic Capacity	Average			

COLUMBIA REHABILITATION CLINIC, INC.
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Ms. Lettie Spencer



CURRICULUM VITAE
OF

TRACY L. MILL

PERSONAL INFORMATION

Home Address: 152 Saluda Avenue
Columbia, SC 29205

Date of Birth: January 20, 1962

Place of Birth: Columbia, South Carolina

EDUCATIONUndergraduate Coursework

Medical University of South Carolina June 1983 - May 1985
Allied Health Sciences Degree - B.S. Physical Therapy
Charleston, South Carolina

University Of South Carolina Sept. 1980 - May 1983
Columbia, South Carolina

PHYSICAL THERAPY PRACTICE EXPERIENCE

Columbia Rehabilitation Clinic May 1985 - Present
2362 Two Notch Road
Columbia, SC 29204
(803) 799-7007

Job Title: Clinic Supervisor
Supervisor: Bruce D. Miller, Owner
Job Description: Evaluate and treat orthopedic, sports medicine, and neuro patients.
Supervise approximately five staff members. Other duties include quality assurance,
instruction of student interns, functional capacity evaluations for the work hardening
program, performing Impairment Ratings.

Lexington Medical Center Fall 1990 - Fall 2000
2720 Sunset Blvd,
West Columbia, SC 29169
(803) 791-2000

Job Title: Weekend Staff Physical Therapist
Supervisor: Fred Valejo, RPT

Job Description: Evaluate and treat orthopedic, sports medicine, neuro, oncology and
open wound patients.

PROFESSIONAL LICENCES:

Page 2 (Cont.)

S.C. Physical Therapy License # 984

CONTINUING EDUCATION - 2005 TO PRESENT:

January 20-21, 2005 Clinical Applications in Functional Testing & Rehabilitation
Denver, CO (14 contact hours).

October 12, 2005 You Don't Have to be Crazy to Work Here
Columbia, SC (3 contact hours)

November 16, 2005 Gross Anatomy of the Extremities - A Review with Cadaveric
Specimens - Columbia, SC (3 hours)

February 23, 2006 Maximizing Upper Extremity Neurological Dysfunction Utilizing
Neuro-Developmental Treatment (NDT)
Columbia, SC (4 contact hours)

April 22-23, 2006 The Essentials of AMA Impairment Training
Birmingham, AL (16 contact hours)

October 19, 2006 Functional Capacity Evaluation: Practical Tools to Enhance Injury
Assessment and Rehabilitation
Columbia, SC (7 hours)

March 28, 2007 Effective Examination and Treatment Techniques for the Foot and
Ankle
Columbia, SC (7 hours)

May 16, 2007 Activities of Daily Living (ADLs): Assessment and Intervention in
the Clinic and at Home
Columbia, SC (7 hours)

September 6, 2007 Disease Progression, Prevention & Management
Columbia, SC (6 contact hours)

February 21, 2008 Strength Training and Exercise for the Aging Spine

August 22-23, 2008 Evaluation and Treatment of the Lumbar and Sacroiliac Spine:
A maitland approach (16 hours)

June 6, 2009 Practical Management of Lower Extremity Dysfunction
Columbia, SC (7 1/2 hours)

August 26, 2009 Coping with Cubital Tunnel Syndrome
(1 hour online)

Page 3 (Cont.)

December 3, 2009	ABC's of Physical Therapy Wound Management (1 hour online)
December 3, 2009	Yoga for the Child with Special Healthcare Needs (1 hour online)
December 5, 2009	Update in Orthopedic Sports Medicine Columbia, SC (8 hours)
January 13, 2010	Shoulder Disorders & Other Related Shoulder Injuries Columbia, SC (6 hours)
February 18, 2010	Understanding Distal Radius Fractures (1 hour online)
April 23-24, 2010	Hip & Upper/Lower Extremity Evaluation and Treatment (6 hours)
July 26, 2010	Overuse Injuries of Upper/Lower Extremity (8 hours)
August 1, 2010	Light at end of Carpal Tunnel (1 hour online)
August 1, 2010	Exercise & Fall Prevention in Seniors (1 hour online)
August 1, 2010	Treatment Strategies for Frozen Shoulder (1 hour online)
April 15, 2011	Effective Examination of the Shoulder Complex (6 hours)
May 5, 2011	12 Essential Clinical Tools for PT/OT Columbia, SC (6 hours)
October 28, 2011	The Lumbar Spine Columbia, SC (7.2 hours)
~~November 2, 2011~~	~~Degenerative Disc Disease Impairment Ratings (1 hour)~~

Page 4 (Cont.)

May 18, 2012

The Shoulder Girdle to the Hand
(7.5 hours)

May 24, 2012

New Concepts in the Management
of Soft Tissue Dysfunction
(4 hours)

POINSETT PSYCHIATRIC GROUP**PATRICK B. MULLEN, M.D., P.A.**

PROFESSIONAL PARK ON CLEVELAND

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GREENVILLE, SC 29607-2442

(864) 232-6216

FAX (864) 235-6369

PSYCHIATRIC EVALUATION

PATIENT NAME: Lettie Spencer
DATE OF BIRTH: 11/28/1947
DATE OF DICTATION: 02/28/2014

Mrs. Spencer is a 66-year-old female with chronic pain and depression.

The patient was well until June 2011 when she hurt her back at work. She was pushing a medication cart and had to overcome a transition from carpet to tile - the wheel stuck briefly, she pushed harder, and then she felt a sharp pain in her lower back. She continued to work with this pain and it gradually worsened. It began to radiate and ultimately it became severe enough to prevent her from working. This occurred in early 2012 - about six months after the initial accident. During this time the pain had been constant and disrupted her sleep. The only possible relief was occasional changes in her posture.

Early in the course of all of this she was diagnosed with lumbar strain and surgery was ruled out. She has had x-rays and MRIs. She has seen multiple doctors including a neurosurgeon, an orthopedic surgeon, and a spine specialist. She has had pain treatment, injections, and physical therapy. Nothing has given her lasting relief. She continues to have constant lumbar pain with occasional radiation into either leg.

She can sometimes relieve her pain very briefly by squatting or leaning over while seated. She did this several times during the interview.

Her depression began about six months after her initial injury. She had to quit working and stayed in bed a lot and the pain had grown worse. Her mood got depressed. She felt hopeless and helpless. She had crying spells, weight loss, difficulty sleeping, decreased libido. She felt worthless and got no pleasure from her surroundings - even her two little dogs she had had with her for many years.

Since that time, about two years ago, all of her symptoms have persisted and grown worse despite treatment. She has been to rehab. She has had injections, a TENS unit, physical therapy, a special rehab stay of about six weeks, pain medication - the only thing she has not had is surgery but none of these things have given her any lasting relief.

PAST MEDICAL HISTORY: Slightly increased blood pressure, a low potassium, hyperthyroid - all are stable and have been stable. She has had no hospitalizations. She did have interstitial cystitis diagnosed about six weeks ago with symptoms preceding by about six months. She has also had restless leg syndrome but her medical problems have all been fairly minor until the chronic pain and depression. She has never had any psychiatric care.

02/28/2014

Lettie Spencer

DOB: [REDACTED]

Page 2

CURRENT MEDICATIONS:

1. Tapazole for thyroid.
2. Norvasc for blood pressure.
3. Aldactone.
4. Neurontin.
5. Potassium.
6. Klonopin 1.0 at bedtime.
7. Trazodone 100 mg at bedtime.
8. Nucynta for pain.
9. Zanaflex for muscle spasm.
10. Multivitamin.

REVIEW OF SYSTEMS: Outside of her pain and depression, the only symptoms she has are weakness in her legs and occasional diarrhea. She has been pregnant twice and has two sons - age 49 and 46 - both are healthy.

FAMILY HISTORY: Her mother died in the 1970s of congestive heart failure - she was 84 years old. Her father died when he was 52 years old of a heart attack - the patient was only 8 years old. She had five brothers and four sisters. Four of the brothers are deceased and three of the sisters are deceased. There was no mental illness in the family.

PERSONAL AND SOCIAL HISTORY: The patient currently lives with her husband and is a truck driver and is not home very much. Her one son does try to spend a lot of time with her. He lives close by and tries to get her to come to his shop so he can see her every day or couple of days. She receives Social Security and Workers Comp. The Social Security is new - this is just since December 2013. The patient had a poor childhood but she thinks she was fairly happy during that time. Her education consists of the eighth grade when she quit and then later she got a GED and went to nursing school to get an LPN. She was raised in the Pentecostal church. She has not been a member of the church for many years. The patient used to enjoy gardening a lot. She says she raised beautiful flowers but she has not done any gardening since the accident.

The patient says her personality has changed. She used to be a lot happier and have a lot more energy. She was more extroverted and enjoyed people. Now she is much more socially withdrawn, has little energy, and stays depressed.

OCCUPATIONAL HISTORY: She has worked in textiles, in a convenience store and a drug store, and she has been an LPN for over 30 years.

CURRENT ACTIVITIES: The patient stays at home, trying to get comfortable. She also goes to her son's shop and sees him as well as trying to walk around the nice flat parking lot that goes along with his shop. She cannot do a whole lot of this but tries to do some.

MENTAL STATUS EXAMINATION: Psychomotor speed is slow. The patient moved around during the interview, getting into a squatting position on a couple of occasions and also leaning over to stretch her back two or three more times. Her affect was depressed and

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02/28/2014 Lette Spencer

DOB: 12/31/1947

Page 3

unhappy. She also seemed somewhat anxious and obviously in pain. Hygiene and dress were good. She does bathe every day. She is oriented and alert. Her memory is scattered and she says it is an effort for her to think. It is hard for her to concentrate. She says she can watch a short television show but otherwise she cannot concentrate to read or absorb any information. Her sensorium is clear. Thought process and content were very scattered. She rambled a bit and was somewhat irrelevant but it was hard for her to talk and seemed an effort for her to interact with the interviewer. The patient denies hallucinations. Her intelligence is fairly good.

REVIEW OF OLD RECORDS: The patient listed as symptoms crying spells, difficulty sleeping, depressed mood, low energy, chronic fatigue, anxiety attacks, trouble urinating, and chronic pain. On a self-rating panic and anxiety scale, her most prominent symptoms were feeling off-balance or unsteady, tingling or numbness in parts of her body, hot flashes or cold chills, and tension and inability to relax. She also feels tired, weak, and easily exhausted.

On a depression scale, she is losing weight, her mind is not as clear as it used to be, it is harder for her to do things, and she feels hopeless about the future. She is also irritable and she does not enjoy things like she used to.

On a pain scale, she rates herself as a 7 out of 10.

Her pain medications - Nuoynta and Zanaflex - give her about 40%-50% relief for a couple of hours but the pain interferes with her general activity, her mood, her walking ability, her normal work, her sleep, her enjoyment of life, her ability to concentrate, and her appetite.

Records sent by her attorney include records from Carolina Occupational Healthcare, Chester Regional Medical Center, Columbia Neurosurgical Associates, South Carolina Pain Associates, Select PT, Carolina Orthopedic Surgery Associates, PA, Springs Memorial Hospital, Sanjay Nandurkar, the Rehab Center (in Charlotte), and Tracy Hill Columbia Rehab Clinic, Inc. All of these records and summaries support the diagnosis of a chronic lumbar strain. There is also mention of disc impingement on her spinal cord. At Chester Regional Medical Center, there is an MRI that shows the L4-S level hypertrophic facet change and ligamentum flavum thickening combined with a broad-based disc bulge to cause a component of inferior neural foraminal narrowing bilaterally as well as a component of lateral recess narrowing - left greater than right. No central canal stenosis.

A Dr. Dye from Columbia Neurosurgical Associates indicated that he felt that she had a severe lumbar strain with mild degenerative disc disease and he did not think any neurosurgery was necessary - this was early on in her course with an examination done in August of 2011. Other records demonstrate an increase in the intensity of her interventions and the worsening of her symptoms - including a CT of the lumbar spine post myelogram done on 09/11/2012 which showed a mild central canal stenosis related to annular disc bulging and facet arthropathy, the thecal sac triangularly shaped with the AP diameter of the spinal cord in the region of maximal pathology at 9 mm. This was at Springs Memorial Hospital in Lancaster, South Carolina. She was also given a diagnosis of sacroiliac pain and had an injection for that from Dr. Tony Owens. There is a rather thick set of notes from Health and Rehabilitation Psychologists of Charlotte and then The Rehab Center in Charlotte.

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02/28/2014 ~~Lettie Spencer~~ Lettie SpencerDOB: ~~11/11/1947~~

Page 4

The psychologists saw her at the beginning of her stay there and diagnosed her with major depressive disorder and a pain disorder associated with psychological factors and a general medical condition secondary to her industrial accident of 06/22/2011. "Thus far, Mrs. Spencer's chronic low back pain and leg pain have been unresponsive to physical therapy, medication management, and interventional pain management. With the exception of a recent selective nerve root block, Mrs. Spencer's pain has been refractory to treatments thus far. Mrs. Spencer has demonstrated a pattern of progressive dysfunction with her now spending 18 to 20 hours a day in bed. This has further contributed to a decline in her overall physical status and a worsening of her depression...Mrs. Spencer's current depression is the direct consequence of her low back pain associated with her industrial injury of 06/22/2011. Mrs. Spencer has not reached maximum medical improvement from a psychological perspective." The rest consist of day-by-day records in The Rehab Center in Charlotte.

There are other records from Dr. Nandurkar detailing his treatment of her and finally a note from Tracy Hill, PT, at the Columbia Rehab Clinic who gave her a permanent impairment rating of whole person 8% and 11% impairment of the lumbar spine - exactly how she arrived at that was by applying a piece of Algebra to the whole person impairment - "please refer to page 427 of the guides."

DIAGNOSIS AND DISCUSSION:

- AXIS I Chronic pain, secondary to occupational injury.
Depression, major, secondary to chronic pain.
- AXIS II Some compulsive personality traits.
- AXIS III Status post back injury with abnormal imaging studies and no relief with intensive nonsurgical treatment.
- AXIS IV Stressors are severe - loss of job, etc.
- AXIS V Global Assessment of Function 45 to 50.

Mrs. Lettie Spencer hurt herself a lot worse than was initially apparent. Perhaps she did start off with a lumbar strain, but that strain got worse and worse and worse, and possibly it got worse because she continued to worsen. Whatever the exact reason, it progressed to the point of a disc bulging into her central spinal canal and some stenosis visible on CT scan. Her symptoms progressed accordingly as well and with the persistence of her symptoms she became depressed, adding a psychological/psychiatric component to her injuries.

It is not unusual for chronic pain and major depression to go hand-in-hand. The pain makes the depression worse and the depression makes the pain worse. They may have a common biochemistry - something to do with endogenous opioids and the natural pain-relieving mechanisms of your brain. Whatever the exact cause, they are often found together.

Mrs. Spencer has that exact situation. She has a major depression that is disabling. In and of itself it is affecting her cognitively as well as emotionally. She also has chronic pain with her back and legs almost completely dysfunctional.

02/28/2014

Lettie Spencer

DOB: [REDACTED]

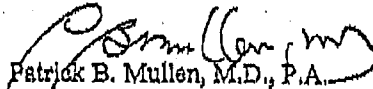
Page 5

She has not taken a lot of psychiatric medication and it is tempting to think that another kind of psychiatric intervention might get her more relief, but she informs me that she has had trials of Cymbalta and she is currently taking Vilbryd as well as the other medications that she mentioned to me at first. Her best hope is for some kind of review of her back situation with possibly a surgical intervention. The success of that, however, could not be guaranteed.

I believe that Mrs. Spencer is not a candidate for the active work force in any capacity. I would give her a much higher rating for permanent disability. Her depression and her pain together to me make her more than 50% or 60% disabled -- but even that may be a low estimate. However, if you want to measure it, she cannot work at all and she will remain permanently disabled for the rest of her life.

She could not maintain the persistence and pace necessary for any kind of gainful employment and her depression prevents her from learning anything new, plus her chronic pain is just worse and worse and prevents her from doing any kind of work at all.

The patient does continue to suffer from depressive symptoms. These symptoms are the result of her chronic pain and resultant functional limitations and she is impaired by her depression as well as her pain. The rating I would give is based on her ability to work. That is to a reasonable degree of medical certainty.


Patrick B. Mullen, M.D., P.A.
PBM/tf

LEANNA HOLLENBECK, MS, CLCP, CRC
Rehabilitation Consultant
Certified Life Care Planner

P.O. Box 97 ♦ Franklin, NC 28744 ♦ Office 704-877-4833 ♦ Fax 866-647-8147
Lhollenbeck23@aol.com

Confidential – For Professional Use Only

RE: Lettie Spencer
Date of Injury: June 22, 2011
Date of Birth: ~~11/23/56~~
Date of Interview: February 25, 2014
Date of Report: March 8, 2014

Attorney Andrew Creech has requested my professional opinion with regard to Ms. Spencer's ability to perform gainful employment and about the availability of suitable employment in or near the Richburg, SC area where Ms. Spencer resides.

I met with Ms. Spencer in a conference room at the Elrod Pope Law Firm in Rock Hill, SC. Ms. Spencer appeared to be a little unfocused during our meeting. She advised that she was in a lot of pain during our 1-1/2 hour interview. She stood and slowly paced around the room much of the time during our meeting.

Ms. Spencer is married to a long distance truck driver who is away from home days or weeks at a time. Her 50-year old son currently lives with her. She lives in Richburg, SC, population 332. The nearest towns are Lancaster, SC, 17 miles one way; Chester, SC 13.6 miles one way; and Rock Hill, 16.5 miles one way. Ms. Spencer currently receives Social Security Retirement benefits and Workers' Compensation payments.

RECORDS REVIEWED

Carolina Occupational Healthcare	08/17/11-10/14/11
Chester Regional Medical Center	07/22/11
Columbia Neurosurgical Associates, PA	08/31/11-09/21/11
SC Pain Associates	11/10/11-04/18/12
Select PT	03/12/12-04/18/12
Carolina Orthopaedic Surgery Associates, PA	04/04/12-04/02/13
Springs Memorial Hospital	09/11/12
Sanjay Nandurkar, MD - Piedmont Interventional Spine	01/28/13-1/09/13
The Rehab Center	03/07/13-10/31/13
Tracy Hill, PT, Columbia Rehabilitation Clinic - FCE Report	01/21/14
Sanjay Nandurkar, MD - Piedmont Interventional Spine - Correspondence	02/05/14
Patrick Mullins, MD - Poinsett Psychiatric Group	02/28/14

MEDICAL HISTORY

Ms. Spencer is a 66 year old right hand dominant woman who was working as an LPN in the Alzheimer's unit at National Health Care, Park Lane in Columbia, SC where she sustained a back injury. She was pushing a medication cart when the cart's wheels became caught on a strip on the floor. She was pushing the cart to free it from the strip when she had an immediate onset of low back and left leg pain. She was diagnosed with lumbar strain and possible radiculopathy, prescribed pain medication and referred to physical therapy. Her symptoms persisted, including both low back and left leg pain, and an MRI was performed, revealing mild degenerative disc disease of the lumbar spine, most prominent at L4-5. A consult was scheduled with neurosurgeon Dr. Dye, who examined Ms. Spencer and advised that she was not a surgical candidate. He recommended additional physical therapy and pain management.

Tony Owens, MD provided a sacroiliac joint injection and lateral branch radiofrequency ablation, neither of which provided significant relief. Ms. Spencer was noted to have become depressed and she had lost weight because of pain. She was referred to Dr. Lehman, who recommended pain management at Dr. Nandurkar's clinic.

Ms. Spencer was referred to the comprehensive pain rehabilitation program at The Rehab Center in Charlotte, NC. Psychologist Brian O'Malley evaluated Ms. Spencer and diagnosed major depressive disorder and a pain disorder associated with psychological factors as well as her general medical condition secondary to her industrial injury of 6/22/11. A course of psychotherapy was recommended. Kern Carlton, MD, Medical Director at The Rehab Center evaluated Mr. Spencer and diagnosed:

Lumbar strain
Lumbar spondylosis with L4-5 disc protrusion
Depression
History of hypertension
Hyperthyroidism

Ms. Spencer completed the program at The Rehab Center on 10/03/13 and was discharged from the full day program. Dr. Carlton reported that she made gains in her strength, endurance, flexibility and balance. Her body mechanics, gait and posture improved. Her pain behavior had decreased and she had gained 6 pounds. There was a marked improvement in her mood and affect. She was using a TENS unit, which was beneficial. She was placed at MMI with a rating of 8% of the back and she was placed in the sedentary work category.

A Functional Capacity Evaluation was performed on 02/21/14 by Tracy Hill, PT, who provided whole person impairment rating of 11%. During the FCE Ms. Spencer reported a pain level of 7-8/10. Ms. Hill reported that the results of the FCE indicate that Ms. Spencer can meet the demands of limited (less than) sedentary work. She can tolerate occasional walking and squatting but she does not tolerate occasional stair climbing, kneeling, bending, twisting or reaching. She can perform the following activities on an occasional (up to 1/3 of an 8-hour work day) basis:

Lifting

- 3 lbs. while reaching overhead.
- 3 lbs. floor to waist
- 6 lbs. 6" to waist
- 5 lbs. waist to shoulder

Carrying

- 7 lbs. with 2 hands.
- 4 lbs. in the right hand.
- 4 lbs. in the left hand.
- Pushing 14.2 foot pounds loaded on a sled.
- Unable to pull 14.2 foot lbs. loaded in a sled.
- Limited lumbar range of motion.

Ms. Spencer was observed:

- Alternating standing/walking for a maximum of 14 minutes.
- Sitting for a maximum of 12 minutes.
- Standing for a maximum of 12 minutes.

Dr. Nandurkar, MD responded to attorney Creech's 02/05/14 letter regarding Ms. Spencer with the following information:

Ms. Spencer is diagnosed with the following:

- Lumbar degenerative disc disease
- Lumbar radiculopathy, left leg
- Chronic pain
- Her whole person impairment is 13%.
- She is unable to return to work at her current employment
- She has a less than sedentary restriction
- Her future medical care and treatment will more likely than not include:
 - Pain management
 - Periodic spinal injections
 - Medications
 - Physical therapy
 - Spinal cord stimulator

Psychiatrist Patrick Mullen M.D. evaluated Ms. Spencer on 02/28/14. He diagnosed the following:

- Chronic pain secondary to occupational injury.
- Major depression secondary to chronic pain.
- Some compulsive personality traits.
- Status post back injury with abnormal imaging studies and no relief with intensive nonsurgical treatment.

- Severe stressors - loss of job, etc.
- Global Assessment of Function 45-50.
 Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting)
 OR any serious impairment in social, occupational, or school functioning (e.g., no friends,
 unable to keep a job). Definition quote from Global Assessment of Functioning (GAF) Scale
 (From DSM-IV-TR, p. 34.)

Dr. Mullen noted that Ms. Spencer has a major depression that is disabling. In and of itself it is affecting her cognitively as well as emotionally. She also has chronic pain with her back and legs almost completely dysfunctional. He added that Ms. Spencer is not a candidate for the active work force in any capacity. Her depression and her pain together make her more than 50% or 60% disabled, and maybe more than that. She cannot work at all and she will remain permanently disabled for the rest of her life. Regarding employability, Dr. Mullen advised that Ms. Spencer would have the following difficulties:

- Unable to maintain the persistence and pace necessary for any kind of gainful employment.
- Depression prevents her from learning anything new.
- Chronic pain is becoming worse and prevents her from doing any kind of work.

CURRENT MEDICAL STATUS

Ms. Spencer has been released by Dr. Carlton at The Rehab Center and continues to receive pain management treatment from Dr. Nandurkar. She takes pain medication and continues to receive some benefit from her TENS unit.

CURRENTLY PRESCRIBED MEDICATIONS

<u>MEDICATION</u>	<u>PRESCRIBED FOR</u>
Nucenta 75 mg.	Pain management
Zanaflex 4 mg.	Muscle relaxer
Vilbryd 40 mg.	Depression
Trazadone	Depression
Klonopin 1 mg.	Restless legs
Norvasc 5 mg.	Hypertension
Tapazole 10 mg.	Hyperthyroid
Potassium 20 mEq	Maintain health
Vitamins	Maintain health
Flomax 40 mg.	Bladder problems
Aldactone 25 mg.	Diuretic

Ms. Spencer also wears a TENS unit most of her waking hours.

PHYSICAL LIMITATIONS AND ABILITIES

She reports the following physical abilities and limitations:

Sitting/ Standing	Alternates between sitting and standing an estimated every 15-20 minutes.
Walking	Short distances.
Lifting/ Carrying	Less than 10 pounds. See FCE
Bending	Very painful
Climbing	Avoids
Balancing	Problem with balance. Uses a cane when outside the home.
Squatting	The most comfortable position is squatting on the floor with her knees tight to her chest, thus stretching her back, which Ms. Spencer demonstrated during our meeting.
Reaching	Other than overhead reaching, no problem reported.
Handling	No problem reported.
Fingering	No problem reported.
Driving	No problem operating foot controls. Drives short distances only.

CHIEF COMPLAINTS

Ms. Spencer voiced the following complaints with regard to her current medical status:

- She is never without pain. Pain level ranges from 5/10 on a good day (with medication) on a scale of 1-10, with 10 being the most severe pain imaginable. Any prolonged physical activity, including sitting and standing, will increase her pain level to 8/10.
- She reports being "in agony" by 5PM after a day at home with little or no physical activity during the day.
- Difficulty reaching over her head to wash and groom her hair.
- Muscle spasms in her back.
- Standing in one place is more painful than walking. She takes short walks outside, weather permitting.
- She uses a cane when she leaves her home and she has a Handicapped Parking tag for her car.
- Cold, wet and humid conditions increase her discomfort.
- Chronic pain causes increased irritability.
- Weakness in both legs seems to be getting worse.

- Knees feel as though they are going to give way.
- Pain radiates from the low back, down the left leg into the thigh.
- Severe chronic pain interferes with her ability to focus and maintain attention.
- Depression.
- Sleep is interrupted by back and left leg pain.
- Chronic fatigue prevents her from completing tasks around the house.
- Frustrated because she cannot work.

EDUCATION

Ms. Spencer quit school but obtained her GED in the 1980s. She completed LPN training and received her degree from Florida Hospital in 1982.

VOCATIONAL/EDUCATIONAL TESTING RESULTS

Ms. Spencer complained of being in a great deal of discomfort during our meeting and frequently changed positions from sitting to pacing the room. Given her long and successful work history as an LPN, I decided not to administer aptitude testing. The aptitude levels needed to perform her job were the same as those documented in the Dictionary of Occupational Titles.

WORK HISTORY

Employer:	National Health Care, Park Lane in Columbia, SC
Dates of Employment:	14 or 15 years
Work Performed:	LPN in the Alzheimer's units in both the Orlando and Columbia Facilities: Unit Supervisor at the Orlando, FL NHC facility; LPN at the Columbia, SC facility
Pay Rate:	Established average weekly wage, \$985.05, includes payment for frequent overtime work. Ms. Spencer reports that she worked an average of 85 hours in most two week pay periods.

She has worked as an LPN since she received her degree in 1982 and has no other significant work history.

VOCATIONAL STATUS

Ms. Spencer is not working at this time, primarily due to chronic pain and increased functional limitations. She returned to work but her pain level increased to the point that she could not perform her job duties and she was taken out of work. In November 2011, she has not returned to work in any capacity since then. Ms. Spencer mourns the loss of her ability to work with her residents and their families. She would like to do some type of volunteer work, perhaps teaching family members about the care and treatment needs of dementia and

Alzheimer's residents, but she is hesitant to attempt it due to her chronic pain, physical restrictions, effects of depression and difficulty driving long distance. It has been suggested that she would be a very effective part time speaker with CNA students with regard to treatment in facilities and home care of people with dementia/Alzheimer's, but there are no facilities, hospitals or clinics nearby and she would need to drive at least 30 miles round trip to reach any venue that may appreciate her talents.

TRANSFERABLE SKILLS ANALYSIS

Ms. Spencer reported the following work history:

<u>OCCUPATIONAL TITLE</u>	<u>D.O.T. CODE</u>	<u>SKILL LEVEL</u>	<u>STRENGTH LEVEL</u>
Licensed Practical Nurse (LPN)	079.374-014	Skilled	Medium

A transferable skills analysis was completed with the OASYS Job Match software and 12,761 occupations were examined to determine whether Ms. Spencer's skills and aptitudes would transfer to sedentary or less than sedentary occupations, given her functional limitations. There were no occupations in the sedentary category to which her skills would transfer.

EMPLOYABILITY

Ms. Spencer will not be able to return to her previous work, which is considered Medium. She has an average clerical aptitude based on her work history. This may qualify her for sedentary entry level unskilled jobs but she has a high level of pain with activity and a significant problem with depression, both of which affects her ability to focus and concentrate. These factors, along with her physical restrictions, present a severe impact on her employability. The Functional Status Report prepared at the conclusion of Ms. Spencer's rehab program at The Rehab Center indicates that she could work in the sedentary category of physical demands, however a later FCE concluded that she could work in less than sedentary occupations:

- Less than sedentary work.
- Alternating sitting for up to 12 minutes and standing up to 12 minutes.
- Occasionally lifting no more than 6 pounds at varying levels.
- Occasionally carrying 3-6 lbs.
- No stair climbing, kneeling, bending, twisting or reaching.

LABOR MARKET SURVEY

A transferable skills analysis revealed no sedentary occupations that would accommodate Ms. Spencer's restrictions, given her education and experience. Her occupational strengths are providing health care in a nursing home, supervising CNA's, record keeping, performing under stress and dealing with people. She would have difficulty qualifying for positions in other industries due to her lack of training and experience with occupations other than that of LPN. A survey of jobs listed with the South Carolina Employment Securities Commission

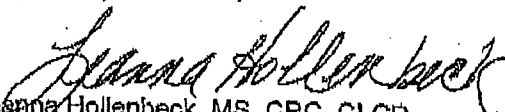
(SCESC) revealed no jobs for which Ms. Spencer would be able to qualify, given her lack of transferable skills and her functional limitations.

CONCLUSIONS

1. The FCE evaluator and Dr. Dr. Nandurkar both agree that Ms. Spencer functions in the less than sedentary category of physical demands, with lifting less than 10 lbs. and sitting less than 8 hours during an 8 hour day. She has significant issues that would preclude employment; namely her combined physical, mental and emotional status.
2. Ms. Spencer's elevated pain level with activity would result in her having difficulty focusing and concentrating on a job. This problem was apparent during our meeting. If she returned to work, she may experience slower work speed, reduced endurance and decline in attention, as well as frequent absences due to increased severe pain with any physical activity.
3. Dr. Mullen advised on 02/28/14 that that Ms. Spencer is not a candidate for the active work force in any capacity. Her depression and her pain together make her more than 50% or 60% disabled, and maybe more than that. She cannot work at all and she will remain permanently disabled for the rest of her life.
4. It is my professional opinion as a Vocational Rehabilitation Counselor with more than 35 years experience that Ms. Spencer is not employable now, nor will her employability increase in the future.
5. She has sustained a significant loss of wage earning potential due to her inability to continue working in her nursing career. Her established pre-injury average weekly wage is \$985.05.
6. Ms. Spencer would experience a 70% loss of wage earning capacity if she were able to perform an entry level unskilled job paying \$7.50 per hour. However, given her less than sedentary work restriction, combined with her age, chronic high pain level, emotional and cognitive instability and her lack of transferable skills, it is my professional opinion that she has experienced a 100% loss.

Thank you for giving me the opportunity to evaluate Ms. Spencer. Please call if you have any questions or need further clarification of any information in this report.

Respectfully submitted,


Leanna Hollenbeck, MS, CRC, CLCP
Certified Rehabilitation Consultant
Certified Life Care Planner

Enclosure: Ability Profile
Job Description: Licensed Practical Nurse

OCCUPATION LIST

DOT Code	DOT Title	Industry	SVP	Str	O*NET
079.374-014	Nurse, Licensed Practical	Medical Services	6	M	29-2061.00

ABILITY PROFILE

Name: Spencer, Lettie

SSN:
Case:

	Work History	Current Ability
Form Perception		
Clerical Aptitude	3 (34-66 Percentile)	3 (34-66 Percentile)
Motor Coordination	3 (34-66 Percentile)	3 (34-66 Percentile)
Finger Dexterity	3 (34-66 Percentile)	3 (34-66 Percentile)
Manual Dexterity	3 (34-66 Percentile)	3 (34-66 Percentile)
Eye-Hand-Foot Coordination	4 (11-33 Percentile)	3 (34-66 Percentile)
Color Discrimination	4 (11-33 Percentile)	4 (11-33 Percentile)
Work Situations (Temperaments)		
Directing, Controlling, Planning	No	No
Performing Repetitive Work	No	No
Influencing People	No	No
Performing a Variety of Duties	Yes	No
Expressing Personal Feelings	No	Yes
Working Alone or in Isolation	No	No
Performing Under Stress	Yes	No
Attaining Precise Limits/Tolerances	Yes	Yes
Following Specific Instructions	No	Yes
Dealing with People	Yes	No
Making Judgments and Decisions	No	Yes
		No
Work Functions - Data		
0 Synthesizing	No	No
1 Coordinating	No	No
2 Analyzing	No	No
3 Compiling	Yes	No
4 Computing	No	Yes
5 Copying	No	Unsure
6 Comparing	No	Unsure
		Unsure
Work Functions - People		
0 Mentoring	No	No
1 Negotiating	No	No
2 Instructing	No	No
3 Supervising	No	No
4 Directing	No	No
5 Persuading	No	No
6 Speaking-Signaling	No	No
7 Serving	Yes	No
8 Taking Instructions-Helping	No	Yes
		Unsure
Work Functions - Things		
0 Setting Up	No	No
1 Precision Working	No	No
2 Operating-Controlling	No	No
3 Driving-Operating	No	No
4 Manipulating	Yes	No
5 Tending	No	Yes
6 Feeding-Offbearing	No	Unsure
7 Handling	No	Unsure
		Unsure

Hollenbeck
03/02/2014

Page 2

OCCUPATIONAL DESCRIPTION

079.374-014 Nurse, Licensed Practical

Provides prescribed medical treatment and personal care services to ill, injured, convalescent, and handicapped persons in such settings as hospitals, clinics, private homes, schools, sanitariums, and similar institutions. Takes and records patients' vital signs. Dresses wounds, gives enemas, douches, alcohol rubs, and massages. Applies compresses, ice bags, and hot water bottles. Observes patients and reports adverse reactions to medication or treatment to medical personnel in charge. Administers specified medication, orally or by subcutaneous or intramuscular injection, and notes time and amount on patients' charts. Assembles and uses such equipment as catheters, tracheotomy tubes, and oxygen suppliers. Collects samples, such as urine, blood, and sputum, from patients for testing and performs routine laboratory tests on samples. Sterilizes equipment and supplies, using germicides, sterilizer, or autoclave. Prepares or examines food trays for prescribed diet and feeds patients. Records food and fluid intake and output. Bathes, dresses, and assists patients in walking and turning. Cleans rooms, makes beds, and answers patients' calls. Washes and dresses bodies of deceased persons. Must pass state board examination and be licensed. May assist in delivery, care, and feeding of infants. May inventory and requisition supplies. May provide medical treatment and personal care to patients in private home settings and be designated Home Health Nurse, Licensed Practical (medical ser.).

DLU: 1987

ABILITY PROFILE

Name: Spencer, Lattie

SSN:
Case:

	Work History	Current Ability
Specific Vocational Preparation		
Maximum	6 (1 to 2 years)	6 (1 to 2 years)
Minimum	6 (1 to 2 years)	1 (Short demo only)
General Educational Development		
Reasoning	4	4
Mathematics	3	3
Language	4	4
Physical Demands		
Strength	Maximum M Medium Minimum M Medium	S Sedentary S Sedentary
Climbing	Never	Never
Balancing	Never	Never
Stooping	Frequently	Never
Kneeling	Occasionally	Never
Crouching	Occasionally	Never
Crawling	Never	Occasionally
Reaching	Frequently	Never
Handling	Frequently	Never
Fingering	Frequently	Frequently
Feeling	Occasionally	Frequently
Talking	Frequently	Occasionally
Hearing	Frequently	Frequently
Tasting/Smelling	Never	Frequently
Near Acuity	Frequently	Never
Far Acuity	Never	Frequently
Depth Perception	Never	Never
Accommodation	Never	Never
Color Vision	Occasionally	Never
Field of Vision	Never	Occasionally Never
Environmental Conditions		
Exposure to Weather	Never	Never
Extreme Cold	Never	Never
Extreme Heat	Never	Never
Wet and/or Humid	Never	Never
Vibration	Never	Never
Atmospheric Conditions	Never	Never
Proximity to Moving Mechanical Parts	Never	Never
Exposure to Electrical Shock	Never	Never
Working in High Exposed Places	Never	Never
Exposure to Radiation	Never	Never
Working with Explosives	Never	Never
Exposure to Toxic or Caustic Chemicals	Never	Never
Other Environmental Conditions	Occasionally	Never
Noise Intensity Level	Moderate	Occasionally Moderate
DOT Aptitudes		
General Learning Ability	3 (34-66 Percentile)	3 (34-66 Percentile)
Verbal Aptitude	3 (34-66 Percentile)	3 (34-66 Percentile)
Numerical Aptitude	4 (11-33 Percentile)	4 (11-33 Percentile)
Spatial Aptitude	3 (34-66 Percentile)	3 (34-66 Percentile)

Hollenbeck
03/02/2014

Page 1

LEANNA HOLLENBECK, MS, CLCP, CRC

P.O. Box 97
Franklin, NC 28744
704-877-4833

lhollenbeck23@aol.com

CURRICULUM VITAE

EDUCATION

Florida State University, Tallahassee, Florida
Master of Science Degree, 1974
Major: Vocational Rehabilitation Counseling

University of Missouri, Columbia, Missouri
Bachelor of Arts Degree, 1984
Major: Merchandising

EMPLOYMENT

VOCATIONAL REHABILITATION & LIFE CARE PLANNING

1996-present

Hollenbeck & Associates, LLC

Fort Mill, SC/Franklin, NC

Providing life care plans and vocational rehabilitation services to physically and emotionally disabled individuals: job analyses, return to work coordination, job coaching, vocational testing, wage loss assessments, labor market surveys, transferable skills analyses and job placement.

Contract Review Officer for SC Retirement System 2005-2012.
Contract Vocational Expert for Office of Hearings & Appeals since 1996.

1992-1996

VOCATIONAL REHABILITATION SPECIALIST

The Rehab Center, Inc.

Charlotte, NC

Vocational Rehabilitation Specialist in an outpatient comprehensive rehabilitation facility: provided job site evaluations, return to work coordination, job seeking skills training, ergonomic consulting, vocational planning and counselling, vocational testing, evaluation and assessment.

1990-1992

MARKETING DIRECTOR/VOCATIONAL SERVICES SUPERVISOR

Rebound, Inc.

Lancaster, SC

Developed the Vocational Rehabilitation program for brain injured clients in an inpatient brain injury rehabilitation facility. Supervised four marketing Representatives in North and South Carolina. Assisted with Vocational Rehabilitation program. Developed and directed educational seminars for local rehabilitation providers.

1988-1990

DIRECTOR

The Physical Restoration Center

Tampa, FL

Director of an outpatient comprehensive rehabilitation facility offering physical and occupational therapy, psychological services, work hardening, reconditioning and job placement for injured workers.

1981-1988

MANAGER/REHABILITATION SPECIALIST

Intracorp

Tampa, FL

Rehabilitation Specialist providing consultation regarding full range of disability management services including medical care coordination, vocational services, vocational counseling and job placement. Manager of rehabilitation unit for four years, supervising ten rehabilitation providers.

1974-1981

VOCATIONAL REHABILITATION COUNSELOR

Florida Office of Vocational Rehabilitation

Pensacola, FL

Vocational Rehabilitation Counselor for State agency, providing services to individuals having disabilities which are a handicap to employment. Worked with clients with a variety of disabilities including spinal cord injuries, amputations, congenital disabilities, deafness and learning disabilities.

CERTIFICATES

Certified Life Care Planner (CLCP) #0245

Certified Rehabilitation Counselor (CRC) #17811

**PROFESSIONAL
MEMBERSHIPS**

International Association of Rehabilitation Professionals
International Academy of Life Care Planners

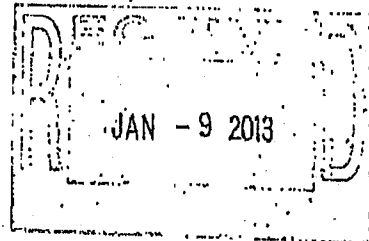
NANCE, McCANTS & MASSEY
ATTORNEYS & COUNSELORS AT LAW
218 NEWBERRY STREET, S.W.
AIKEN, SOUTH CAROLINA 29801

JAMES D. NANCE, L.L.C.
CLARKE W. McCANTS, III, P.C.
A. SEAN MASSEY, L.L.C.
AMY PATTERSON SHUMPERT

POST OFFICE BOX 2881
AIKEN, SC 29803-2881
TELEPHONE: (803) 649-6200
FAX: (803) 649-5566
E-MAIL: MCCANTS3RD@aol.com

January 7, 2013

The Honorable Avery B. Wilkerson
Commissioner
S.C. Workers' Compensation Commission
P. O. Box 1715
Columbia, SC 29202-1715



IN RE: Lettie L. Spencer v. NHC Parklane
SCWCC No.: 1120778
NHC File No.: WC18202011021728
Date of Accident: 6/22/11
Our File No.: MWC12-1203

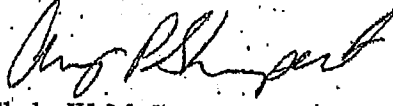
Dear Commissioner Wilkerson:

Please file in the above-referenced matter the enclosed Form 58, Notice of Submission of Evidence and Certificate of Filing and Service thereof upon opposing Counsel. By a copy of this letter, I am serving opposing Counsel with the Form 58 and Notice.

Thank you for your assistance in these regards.

With best regards, I remain

Very truly yours,


for Clarke W. McCants, III

CWMIII/aps
Enclosures

cc: Andrew W. Creech, Esquire (w.encls)

South Carolina Workers' Compensation Commission
P.O. Box 1715 · 1612 Marton Street
Columbia, South Carolina 29202-1715
(803) 737-5700

WCC File # 1120778
Carrier File # WC1820201102178
Carrier Code # 1100
Employer FEIN

Lettie L. Spencer
Claimant's Name

SSN

NHC Parklane
Employer's Name

Address

City

State

Zip

Address

City

State

Zip

Home Phone #

Work Phone #

Premier Group Insurance Company, Inc.
Insurance Carrier

Clarke W. McCants, III
Preparer's Name

Address

P. O. Box 2881, Aiken, SC 29802

((803) 649-6200
Phone #

Provide the information requested in the space provided. Use an additional sheet, if necessary. Type or print all information.

☒ Injury by Accident

☐ Occupational Disease

☐ Both Injury by Accident and Disease

☐ Other

1. Date of accident: June 22, 2011

2. AWW: \$ 985.05

Comp. Rate: \$ 656.73

3. Type of Injury and body part(s): Low back; alleged psychological overlay

4. Facts in controversy: Whether or not Claimant has reached MMI.

5. Legal issues involved: Liability of Defendants for additional medical treatment.

6. Unusual problems: None

7. Witnesses (designate if expert): Please see Notice of Submission of Evidence.

8. Exhibits: Please see Notice of Submission of Evidence.

9. Medical evidence: (Indicate report pursuant to R.67-812; deposition or appearance)
Please see Notice of Submission of Evidence.

10. Name, address, and specialty, if any, of the treating physician: William Louis Lehman, Jr., MD
Carolina Orthopaedic Surgery Associates, Rock Hill, SC

11. Impairment ratings body part(s); physician and date of opinion: None to date.

SIGNATURE Clarke W. McCants, III

DATE OF HEARING: 1/17/2013

On behalf of ☐ Claimant ☒ Employer

TIME OF HEARING: 10:00 a.m.

File this form and proof of service on the opposing party according to R.67-811 and R.67-212. Do not send medical reports.
* Commissioners reserve the right to admit expert witnesses at hearings.

SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

Lettie Spencer,
Claimant,

vs.

NHC Parklane,
Employer,

and

Premier Group Insurance Co., Inc.,
Carrier
Defendants.

) WCC File No: 1120778
) Carrier File No: WC1820201102178
) Carrier Code No: 1100
) Employer FEIN:
)

NOTICE OF SUBMISSION
OF EVIDENCE BY DEFENDANTS

PLEASE TAKE NOTICE that the Employer/Carrier, pursuant to the provisions of the South Carolina Workers' Compensation Law and S. C. Code Ann. Section 1-23-10 (1976), et. seq., submits the following documentary evidence to be included in the record for the above-captioned matter. Copies of the documents listed below are herewith served upon Counsel for the Claimant and will be offered at the hearing for this matter for inclusion in the record.

DOCUMENTARY EVIDENCE

1. Carolina Occupational Healthcare, LLC, 6/27/11 - 9/16/11, Pages 1 - 11;
2. Chester Regional Medical Center, 7/22/11, Pages 12 - 13;
3. Randall G. Drye, M.D., Columbia Neuorsurgical Associates, 8/31/11, Pages 14 - 15;
4. Tony Owens, M.D. S.C. Pain Associates, 11/10/11 - 4/18/12, Pages 16 - 35;
5. Select Physical Therapy, 3/12/12 - 4/24/12, Pages 36 - 46;
6. William L. Lehman, M.D., Carolina Orthopaedic Surgery Associates, P.A., 4/4/12 - 11/26/12, Pages 47 - 62;

7. Springs Memorial Hospital, 9/11/12, Pages 63 - 79.

PLEASE ALSO TAKE NOTICE THAT the Employer may call the following witnesses to testify at the hearing for this matter:

Melissa Argo

NHC Parklane

Patti Coates

" "

Pam Jackson

" "

Tasha Owens

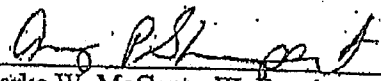
" "

Porter Nelms

Premier Group Insurance Co., Inc.

NANCE, McCANTS & MASSEY

By:

for 
Clarke W. McCants, III, Esquire
218 Newberry St., SW
P. O. Box 2881
Aiken, SC 29802-2881
(803) 649-6200 Ext. 21
Counsel for Employer/Carrier

Dated: January 7, 2013

SCANNED

CAROLINA OCCUPATIONAL HEALTHCARE, LLC

NAME Spencer, Leticia

DATE 6/27/11 TIME 3:00

TECH 88

HEIGHT 62 inches

WEIGHT 138 lbs.

PULSE 74

BP 139/72

CC Pushing MED Cart into Felt Sharp Pain in Lower Back

HPI 5 days ago pushing med cart

felt pop in (L) low back

trailing into (L) L.E. to calf.

Never had before. (has worsened)

movement. 200 B/B.

ROS: ☐ Reviewed ☐ Non-Contributory

PH: ☐ Reviewed ☐ Non-Contributory

FISH: ☐ Reviewed ☐ Non-Contributory

PHYSICAL EXAMINATION Per: DLSR but D intensification of

(L) low back pain/guarded = (L) SLR

(R) SLR/interfered color

pt has pulse +2/4

Horton's 5-Tone and palp

Low Back Strain, but likely radiculopathy (will try

steroids for benefit)

ASSESSMENT & PLAN: SEE RETURN TO WORK STATUS FORM ☐

NEXT VISIT IN 7 DAYS OR PRN

PHYSICIAN'S SIGNATURE

DATE 6.27.11

☐ MITCHELL H. HEGQUIST, MD

☐ JAMES WRIGHT, MD

☐ H.W. BLEDSOE, MD

☐ CHARLES BOYTER, MD

☒ THOMAS MOTYCKA, MD

☐

SCANNED

CAROLINA OCCUPATIONAL HEALTHCARE, LLC
1715 BLANDING ST.
COLUMBIA, SC 29201
PHONE (803) 799-3926, FAX (803) 256-7896

☐ SC VOC	NHC	(Company name)
☐ PRIVATE		
☐ Employment		(Company Name)
☐ Asbestos - NIOSH FORM NEEDED - RADIOLOGIST READS		

X-Ray No. 19060 Patient Name Spencer, Lettie M ☒ (P)
Date 6-27-11 SSN [REDACTED] DOB [REDACTED] Age [REDACTED] *Pregnancy statement

Requesting Physician: ☐ WRIGHT ☐ HEGQUIST ☒ MOTYCKA ☐ BLEDSOE ☐

History: WC Injury

X-Ray Technician's Signature/Name: E. Bortwell R.T. (R)

- | | | | |
|---|---|---|---|
| ☐ Abdomen, IV, 74000 | ☐ Finger, 3V, 73140 | ☐ Knee & Tun, 3+1, 73564 | ☐ Shoulder, 2V, 73030 |
| ☐ Abdomen, 3V, 74022 | ☐ Foot, 2V, 73620 | ☒ L-Spine, 3V, 72100 | ☐ Sinuses, 2V, 70210 |
| ☐ Ankle, 3V, 73610 | ☐ Foot, 3V, 73630 | ☒ Mandible, 3V, 70100 | ☐ Sinuses, 3V, 70220 |
| ☐ C-Spine, 3V, 72040 | ☐ Foot-FB, 2V, 73620 | ☐ Nasal, 3V, 70160 | ☐ Skull, 2V, 70250 |
| ☐ C-Spine, 5V, 72050 | ☐ Forearm, 2V, 73090 | ☐ Neck-ST, 2V, 70360 | ☐ Skull, 4V, 70280 |
| ☐ Chest, 1V, 71010 | ☐ Hand, 3V, 73130 | ☐ Osgood, 2V, 73650 | ☐ T-Spine, 2V, 72070 |
| ☐ Chest, 2V, 71020 | ☐ Hand, 2V, 73120 | ☐ Pelvis, 1V, 72170 | ☐ Thumb, 3V, 73140 |
| ☐ Clav, 2V, 73000 | ☐ Hip, 2V, 73510 | ☐ Ribs, 4V, 71101 | ☐ Tib & Fib, 2V, 73590 |
| ☐ Coccyx & Sacrum 2V 72220 | ☐ Humerus, 2V, 73060 | ☐ Ribs-Bilat, 4-5V, 71111 | ☐ Toes, 3V, 73660 |
| ☐ Elbow, 2V, 73070 | ☐ Knee, 2V, 73580 | ☐ SI Joint, 3V, 72202 | ☐ Wrist, 2V, 73100 |
| ☐ Elbow, 4V, 73080 | ☐ Knee, 3V, 73562 | ☐ Scapula, 2V, 73010 | ☐ Wrist w/Nav, 3-5V, 73110 |
| ☐ Femur, 2V, 73550 | ☐ Knee & Sun, 3+1, 73564 | ☐ Shoulder, AC, 2V, 73050 | ☐ Add View, 1V, 70001 |
| ☐ Sternum, 71120 | | | |

INITIAL IMPRESSION

5/51 fracture of right tibia

SIGNATURE ON FILE: ☐ JAMES A. WRIGHT, MD ☐ MITCHELL H. HEGQUIST, MD ☒ THOMAS MOTYCKA, MD
☐ H.W. BLEDSOE, MD ☐ CHARLES BOYTER, MD ☐ _____, MD

☐ 78140 REQUEST RADIOLOGIST CONSULT

- ☐ Normal Examination
☐ I agree with the Initial Impression stated above
☐ I disagree with the Initial Impression; see comments:
☐ Radiologist please review the following area of concern _____

Radiologist

Date

ROA 469

2

SCANNED

CAROLINA OCCUPATIONAL HEALTHCARE, LLC
1715 BLANDING ST, COLUMBIA, SC 29201
PHONE (803) 799-3926 • FAX (803) 256-7896

RETURN TO WORK STATUS

PATIENT INFORMATION:

NAME

Spencer, Little

COMPANY INFORMATION:

COMPANY NAME

NHC

CONTACT PERSONS NAME

Patty Coates

OCCUPATION / JOB DESCRIPTIONS

Nurse

INJURY INFORMATION:

DATE OF INJURY

6, 22, 11

TIME OF INJURY

730

AM / PM

DIAGNOSIS:

Low Back Strain (also Radiculopathy, likely)

TREATMENT PLAN

- (1) Warm compresses
- (2) Cyclobenzaprine at bedtime
- (3) Tramadol for pain
- (4) (Steroid) Steroid-Taper

INSTRUCTION SHEET GIVEN

RETURN TO WORK STATUS:

- ☐ RETURN TO WORK WITH NO LIMITATIONS
- ☐ RETURN TO WORK WITH NO LIMITATIONS AS A
- ☐ UNABLE TO RETURN TO WORK UNTIL
- ☐ RELEASED FROM CARE
- ☐ REFERRED FOR SPECIALTY EVALUATION TO
- ☒ RETURN TO WORK WITH THE FOLLOWING LIMITATIONS:

LIMITATIONS:

- ☐ NO OPERATING OF HEAVY EQUIPMENT, MACHINERY, DRIVING
- ☐ NO PROLONGED BENDING, STOOPING, SQUATTING
- ☒ NO LIFTING MORE THAN 10 POUNDS
- ☐ NO USE OF
- ☐ SIT FOR NO LONGER THAN HOURS PER 8 HOUR WORKDAY
- ☐ STAND FOR NO LONGER THAN HOURS PER 8 HOUR WORKDAY
- ☐ WALK FOR NO LONGER THAN HOURS PER 8 HOUR WORKDAY
- ☐ RECOMMENDATIONS
- ☒ ALTERNATE SITTING, STANDING & WALKING
- ☐ OTHER RESTRICTIONS

AVOID PILL CRUSHER IF IT CAUSES BACK PAIN

PHYSICIAN'S SIGNATURE

DATE

6, 27, 11

PHYSICIAN'S NAME:

- ☐ MITCHELL H. HEZOMIST, MD
- ☐ H.W. BLEDSOE, MD
- ☐ CHARLES BOYTER, MD

- ☐ JAMES WRIGHT, MD
- ☒ THOMAS MOTYCKA, MD

NEXT APPOINTMENT

07, 05, 11 @ 200

CHECK OUT TIME:

5:15

INITIALS

OK

* IF LESS THAN 7 DAYS, NEED AUTHORIZATION

3

Carolina Occupational Healthcare, LLC

1715 BLANDING STREET, COLUMBIA, SC 29201
PHONE (803) 798-3926 FAX (803) 258-7886

SCANNED

Patient: SPENCER, LETTIE L DATE: 7-5-11 TIME: 2:00 TECH: Wright
SS#: 743627 DOB: 1-19-41 DOI: 6/22/2011

HEIGHT: 62 inches WEIGHT: 138 lbs PULSE: 80 BP: 168 / 70 BP: 1

CO: L4/L5 Lumbar Sprain
HPI: Not only better, might even be worse
is on Day 7 of 12 Day Steroid
taper. Using cyclobenzaprine during day, it
makes me drowsy &
Oscarate & Radiation
Pill crushing still hurts my back

ROS: ☐ Reviewed ☐ Non-Contributory

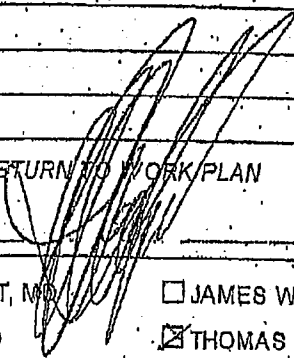
PH: ☐ Reviewed ☐ Non-Contributory

F/S/H: ☐ Reviewed ☐ Non-Contributory

PHYSICAL EXAM: Very uncomfortable - appearing - sitting as much as possible
flexion & standing - bent over posture - pain
OSLR but did intensify back pain
mild palp repro pain

ASSESSMENT & PLAN: SEE RETURN TO WORK PLAN

NEXT VISIT IN after MRI DAYS OR PRN

PHYSICIAN SIGNATURE: 

DATE: 7-5-11

☐ MITCHELL H. HEGQUIST, MD

☐ JAMES WRIGHT, MD

☐ CHARLES BOYTER, MD

☒ THOMAS J. MOTYCKA, MD

☐

4

SCANNED

Carolina Occupational Healthcare, LLC

1715 BLANDING STREET, COLUMBIA, SC 29201
PHONE (803) 799-3926 FAX (803) 258-7896

RETURN TO WORK STATUS

Patient: SPENCER, LETTIE L

Employer: NHC HEALTHCARE - PARK LANE

EMPLOYER CONTACT:

OCCUPATION / JOB DESCRIPTION: NURSE

SS#: 4627

DOB: 6/22/1947

INJURY INFORMATION:

DATE OF INJURY: 6/22/2011

Diagnosis: 847.2 SPRAIN LUMBAR REGION

ADDITIONAL DIAGNOSIS INFORMATION:

TREATMENT PLAN:

① TRAMADOL for Daytime Pain
② CYCLOBENZAPRINE AT BEDTIME
③ Heating Pad after Days Activities
④ MRI Low Back

INSTRUCTION SHEET GIVEN:

⑤ Continue Steroid Taper

RETURN TO WORK STATUS:

- ☐ RETURN TO WORK WITH NO LIMITATIONS
☐ RETURN TO WORK WITH NO LIMITATIONS AS A _____
☐ UNABLE TO RETURN TO WORK UNTIL: 1/1/11
☐ RELEASED FROM CARE
☐ REFERRED FOR SPECIALTY EVALUATION TO _____
☒ RETURN TO WORK WITH THE FOLLOWING LIMITATIONS (see below)

LIMITATIONS:

- ☐ NO OPERATING OF HEAVY EQUIPMENT, MACHINERY, DRIVING
☐ NO PROLONGED BENDING, STOOPING, SQUATTING
☒ NO LIFTING MORE THAN 10 POUNDS
☐ NO USE OF _____
☐ SIT FOR NO LONGER THAN _____ HOURS PER 8 HOUR WORKDAY
☐ STAND FOR NO LONGER THAN _____ HOURS PER 8 HOUR WORKDAY
☐ WALK FOR NO LONGER THAN _____ HOURS PER 8 HOUR WORKDAY
☐ RECOMMENDATIONS
☐ ALTERNATE SITTING, STANDING & WALKING
☒ OTHER RESTRICTIONS:

Avoid Pill-Cushing if it causes low back pain

PHYSICIAN SIGNATURE:

DATE 7-5-11

☐ MITCHELL H. HEGQUIST, MD

☐ JAMES WRIGHT, MD

☐ CHARLES BOYTER, MD

☒ THOMAS J. MOTYCKA, MD

Check out TIME: _____ Initials: _____

NEXT APPOINTMENT DATE/TIME: _____ @ _____

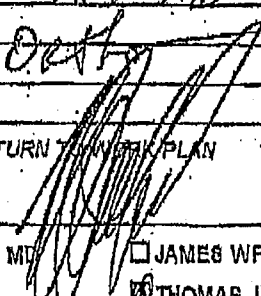
*If less than 7 days. Need AUTHORIZATION

ROA 472

Carolina Occupational Healthcare, LLC

1715 BLANDING STREET, COLUMBIA, SC 29201

PHONE (803) 789-3828 FAX (803) 288-7888

Patient: SPENCER, LETTIE L DATE: 7-29-11 TIME: 2:00 TECH: BSDOB: 8/22/2011HEIGHT: 52 inches WEIGHT: 138 lbs PULSE: 60 BP: 110/70CC: Flu on MRI - of LS-spineHPI: Still have (C) low back pain L & R and (C)
buttock/potterolateral thigh radiation
Out of tripod
with seconds of pain passing from disc bridge
at L4/5ROB: ☐ Reviewed ☐ Non-ContributoryPHI: ☐ Reviewed ☐ Non-ContributoryF/SH: ☐ Reviewed ☐ Non-ContributoryPHYSICAL EXAM: Very uncomfortable - appear lying to knee right
(C) (C) just to (C) of middle
at LS. (C) (C) (C)
Can't walking, sitting, due to (C) low back/hipAs low back pain (C) (C) L4/5 - narrowing
P. to OrthoASSESSMENT & PLAN: SEE RETURN TO WORK PLANNEXT VISIT IN 01/20/12 DAYS OR PRNPHYSICIAN SIGNATURE: DATE: 7-29-2011☐ MITCHELL H. HEGQUIST, MD☐ JAMES WRIGHT, MD☐ CHARLES BOYTER, MD☒ THOMAS J MOTYCKA, MD☐

Carolina Occupational Healthcare, LLC

1715 BLANDING STREET, COLUMBIA, SC 29201

PHONE (803) 798-3928 FAX (803) 258-7888

RETURN TO WORK STATUS

Patient: SPENCER, LETTIE L

Employer: NHO HEALTHCARE - PARKLANE

EMPLOYER CONTACT

OCCUPATION / JOB DESCRIPTION: NURSE

SSN: [REDACTED]

DOB: [REDACTED]

INJURY INFORMATION:

DATE OF INJURY: 8/22/2011

Diagnosis: 847.2 SPRAIN LUMBAR REGION

ADDITIONAL DIAGNOSIS INFORMATION:

TREATMENT PLAN:

1. Warm Compresses make of the relief

2. Ortho Referral

3. Refill by doctor signature - Tramadol

INSTRUCTION SHEET GIVEN:

RETURN TO WORK STATUS:

- ☐ RETURN TO WORK WITH NO LIMITATIONS
- ☐ RETURN TO WORK WITH NO LIMITATIONS AS A
- ☐ UNABLE TO RETURN TO WORK UNTIL 1/1
- ☐ RELEASED FROM CARE
- ☐ REFERRED FOR SPECIALTY EVALUATION TO
- ☒ RETURN TO WORK WITH THE FOLLOWING LIMITATIONS (see below)

LIMITATIONS:

- ☐ NO OPERATING OF HEAVY EQUIPMENT, MACHINERY, DRIVING
- ☐ NO PROLONGED BENDING, SQUATTING, SQUATTING
- ☐ NO LIFTING MORE THAN _____ POUNDS
- ☐ NO USE OF _____
- ☐ SIT FOR NO LONGER THAN _____ HOURS PER 8 HOUR WORKDAY
- ☐ STAND FOR NO LONGER THAN _____ HOURS PER 8 HOUR WORKDAY
- ☐ WALK FOR NO LONGER THAN _____ HOURS PER 8 HOUR WORKDAY
- ☐ RECOMMENDATIONS
- ☐ ALTERNATE SITTING, STANDING & WALKING
- ☒ OTHER RESTRICTIONS:

AVOID PILL-CRUSHING
IF IT CHUNTS BACK

PHYSICIAN SIGNATURE:

DATE

7-29-2011

☐ MITCHELL H. HEGQUIST, MD☐ JAMES WRIGHT, MD☒ CHARLES BOYTER, MD☐ THOMAS J. MOTYOKA, MD

Check out TIME 4:30 Initials: SL

NEXT APPOINTMENT DATE/TIME: 08/30/11

*If less than 7 days, Need AUTHORIZATION

CAROLINA OCCUPATIONAL HEALTHCARE, LLC

BLANDING STREET
181A, RD 22501
1 (800) 788-3888
001 808-7888

MITCHELL H. HEDQUIST, MD BHE271714
CHARLES W. BOYTER, JR., MD B81518877
JAMES W. WRIGHT, MD B81518877
THOMAS J. MOTYKA, MD BMS048888

and: SPENCER, Lethe

Dr. Ho Referral

Date: 7-29-2011

DMR
L4/L5 Disc Bulge
Discoid

select label with drug name

does (No fill unless indicated)

WRITTEN

M.D.

RESTITUTION PERMITTED

Carolina Occupational Healthcare, LLC

1716 BLANDING STREET, COLUMBIA, SC 29201

PHONE (803) 799-3926 FAX (803) 256-7896

RETURN TO WORK STATUS

Patient: **SPENCER, LETTIE L**

Employer: **NHO HEALTHCARE - PARKLANE**

EMPLOYER CONTACT

OCCUPATION / JOB DESCRIPTION: **NURSE**

SS# **22-0000000**

DOB **02/27/67**

INJURY INFORMATION:

DATE OF INJURY: **8/22/2011**

Diagnosis **847.2 SPRAIN LUMBAR REGION**

ADDITIONAL DIAGNOSIS INFORMATION:

TREATMENT PLAN:

- (1) **PT. continued**
- (2) **Tramadol & Cyclobenzaprine**
- (3) **TENS UNIT**

INSTRUCTION SHEET GIVEN:

RETURN TO WORK STATUS:

- ☐ RETURN TO WORK WITH NO LIMITATIONS
- ☐ RETURN TO WORK WITH NO LIMITATIONS AS A _____
- ☐ UNABLE TO RETURN TO WORK UNTIL _____
- ☐ RELEASED FROM CARE
- ☐ REFERRED FOR SPECIALTY EVALUATION TO _____
- ☒ RETURN TO WORK WITH THE FOLLOWING LIMITATIONS (see below)

LIMITATIONS:

- ☐ NO OPERATING OF HEAVY EQUIPMENT, MACHINERY, DRIVING
- ☐ NO PROLONGED BENDING, STOOPING, SQUATTING
- ☐ NO LIFTING MORE THAN _____ POUNDS
- ☐ NO USE OF _____
- ☐ SIT FOR NO LONGER THAN _____ HOURS PER 8 HOUR WORKDAY
- ☐ STAND FOR NO LONGER THAN _____ HOURS PER 8 HOUR WORKDAY
- ☐ WALK FOR NO LONGER THAN _____ HOURS PER 8 HOUR WORKDAY
- ☐ RECOMMENDATIONS _____
- ☐ ALTERNATE SITTING, STANDING & WALKING _____
- ☒ OTHER RESTRICTIONS: **Avoid Pill-Crushing**

PHYSICIAN SIGNATURE: _____

DATE: **9-16-11**

☐ MITCHELL H. HEGQUIST, MD

☐ JAMES WRIGHT, MD

☐ CHARLES BOYTER, MD

☐ THOMAS, MOTYCKA, MD

Check out TIME **3:52 PM** Initials: **BR**

NEXT APPOINTMENT DATE/TIME: **10-14-2011 3:00pm**

*If less than 7 days, Need AUTHORIZATION

Carolina Occupational Healthcare, LLC

1716 BLANDING STREET, COLUMBIA, SC 29201
PHONE (803) 789-3926 FAX (803) 258-7896

Patient: SPENCER, LETTIE L DATE: 9-16-11 TIME: 3:05 TECH: MWC

SSN: [REDACTED] DOB: [REDACTED] DOI: 6/22/2011

HEIGHT: 62 inches WEIGHT: 138 lbs PULSE: 80 BP 156 / 62 BP

OC: f/u 1st

HPI: Retires a NEURO Surg report that nothing surgical
and present a Ad report & both state that
PIT, said Benet moved from TX
still all crushing with body parts my low back
of sciatica

ROS: ☐ Reviewed ☐ Non-Contributory

PH: ☐ Reviewed ☐ Non-Contributory

F/S: ☐ Reviewed ☐ Non-Contributory

PHYSICAL EXAM PE of Spine

Tender at the L5 S1 area - nothing
more lateral & nothing more superior
The S1 is not tender

McDonald Low back Pain (Overexertion)
f: see dx

ASSESSMENT & PLAN: SEE RETURN TO WORK PLAN

NEXT VISIT IN 4 weeks DAYS OR PRN

PHYSICIAN SIGNATURE: [Signature]

DATE: 9-16-11

☐ MITCHELL H. HEGQUIST, MD

☐ JAMES WRIGHT, MD

☐ CHARLES BOYTER, MD

☒ M. W. Wright, MD

CAROLINA OCCUPATIONAL HEALTHCARE, LLC

1718 BLANDING STREET
COLUMBIA, SC 29201
PHONE: (803) 768-9928
FAX: (803) 266-7888

MITCHELL H. HEGQUIST, MD BH2271714
CHARLES W. BOYTER, JR., MD BS1618377
JAMES WRIGHT, MD AW2892375
THOMAS J. MISTYCKA, MD BM3042885

Patient Name:

Bettie Spencer

Address:

Date:

9-16-2011

R TENS Unit

AS directed

☐ unless checked, label with drug name

Refill 0 times (No refill unless indicated)

DISPENSE AS WRITTEN

M.D.

M.D.

SUBSTITUTION PERMITTED

FROM

(FAX) JUL 28 2011 0145/ST. 0144/HQ. 0012078004 P 1

CHESTER REGIONAL MEDICAL CENTER

1 MEDICAL PARK DRIVE

CHESTER SC 29706

RADIOLOGICAL INTERPRETATION

PATIENT NAME: SPENCER, LENTIN
 ACCOUNT #: 3102226
 EXAM DATE: 7/22/2011
 ORDERING: STAFF NON, MD

RM: RAD MR#: 107577
 X-RAY#: 17750
 D.O.B.: 11/28/1947

ATTENDING:

CONSULTING:

MRI
 LOW BACK PAIN

7489861 72148 MRI L-SPINE WO CONT

MRI OF THE LUMBAR SPINE, 07/22/11:

HISTORY: 63-year-old with history of lower back pain.
 TECHNIQUE: Sagittal and axial T1 and T2 and sagittal STIR weighted Mr images of the lumbar spine were performed without the use of radiologic contrast material.

FINDINGS: The vertebral body heights of the lumbar spine are preserved and anatomic alignment maintained. No abnormal marrow signal is identified. The spinal cord cone ends appropriately at T12-L1 disc space level with no evidence of intrathecal mass. Visualized portions of the retroperitoneum are unremarkable.

At the T11-12, T12-L1 and L1-2 levels no disc herniation or significant neural foraminal narrowing is identified.

At the L2-3 level, no disc herniation or neural foraminal narrowing is identified.

At the L3-4 level, hypertrophic facet changes are identified, however, disc herniation or neural foraminal narrowing is identified.

At the L4-5 level, hypertrophic facet change and ligamentum flavum thickening are identified and combined with a broad-based disc bulge to cause a component of inferior neural foraminal narrowing bilaterally as well as a component of lateral recess narrowing, left greater than right. No central canal stenosis

CONTINUED ON PAGE 2

STAFF NON, MD

Carolina
 Occ Health

787-3028

fax 803-258-7896
 256

12

CHESTER REGIONAL MEDICAL CENTER

1 MEDICAL PARK DRIVE
CHESTER SC 29706
RADIOLOGICAL INTERPRETATION

PATIENT NAME: SPENCER, LETTIE
ACCOUNT #: 3102226
EXAM DATE: 7/22/2011
ORDERING: STAFF NON, MD

RM: RAD MR#: 107577
X-RAY#: 17750
D.O.B.: 11/28/1947

ATTENDING:

CONSULTING:

MRI
LOW BACK PAIN

7489861 72148 MRI L-SPINE WO CONT

is identified.

At the L5-S1 level, no disc herniation or neural foraminal narrowing is identified.

IMPRESSION: MILD DEGENERATIVE DISC DISEASE OF THE LUMBAR SPINE
MOST PROMINENT AT L4-5 AS DESCRIBED ABOVE.

DB: 07/22/2011 00:00
DT: 07/22/2011 19:07 MPS

Dictated By: REUTER, MD, ROBERT
Signed By: REUTER, MD, ROBERT

ROBERT REUTER, MD
DICTATED BY
DATE DICTATED: 7/22/2011
DATE TRANSCRIBED: 7/22/2011 19:07
TRNG: MPS TECH: GENERIC TECH
7489851 STAFF NON, MD

REVIEWED AND SIGNED
ROBERT REUTER, MD
RADIOLOGIST
7/25/2011 15:34:52
PAGE 2 OF 2

8/6/2011 8:30 PM FROM: FAX TO: 18664406782 PAGE: 001 OF 002

COLUMBIA NEUROSURGICAL ASSOCIATES, P.A.

www.columbianeurosurgical.com

Spine & Neurological Surgery

Thomas J. Holbrook, Jr., MD Scott B. Boyd, MD
William M. Rambo, Jr., MD Brett C. Gunter, MD
Randall G. Drye, MD Karl A. Lozanne, MD

720 Rabon Road
Columbia, SC 29208
(803) 462-0423 - (F) 462-0432

Pain/Medicine
Steven B. Siperick, MD
Eva J. Rawl, MD

132 Sunset Court
W. Columbia, SC 29169
(803) 784-8700 - (F) 784-0922

OFFICE CONSULTATION

Patient: Lettie F. Spencer
Chart: 130062 WC
Date: 8/31/11

CHIEF COMPLAINT: Onset of severe back pain with some left leg symptoms on 6/22/11.

HISTORY OF PRESENT ILLNESS: The patient is a 63-year-old female who works as a nurse at a local nursing home facility. She reports no prior history of low back or leg problems and was doing well when, on 6/22/11 she was at work. She was apparently pushing a medication cart when she was transitioning from carpet to a tile threshold. The cart became stuck and required a great deal of force and as it freed she was thrown forward. She had an immediate onset of sharp pain in her back. The patient states that this failed to improve and over time has worsened in terms of stiffness and pain. In addition, she has some left leg symptoms that travel across the buttock, lateral thigh into the portion of the lateral calf. She has no symptoms in the foot or toes. The patient has been back at work with some restrictions but her pain persists. She describes it as being in the lower lumbar area with the above leg symptoms. She has no similar symptoms in the right leg and no symptoms in the foot or toes. She denies any bowel or bladder incontinence or retention. Her treatment has included various medications and she did undergo an MRI. She arrives today at the request of workman's comp seeking neurosurgical input.

HISTORIES: Allergies: PENICILLIN, DEMEROL, CODEINE. Medications: Potassium, Norvasc, Aldactone, vitamin D, calcium, magnesium, trazodone, Crestor, methimazole, Tricor, Klonopin, and Ultram p.r.n. Illnesses: Hypertension, history of a cervical radiculopathy. Surgeries: Left foot, hysterectomy. Family history and review of systems are well documented in the intake sheet of 8/31/11 and have been reviewed and signed. The information contained is noncontributory except for that in the HPI. Social history: She smokes 1/2 pack/day, does not drink alcohol, is married with two adult children, and is employed and working light duty.

PHYSICAL EXAMINATION: VITALS: HT 5'2", WT 137

GENERAL: The patient is a well-developed individual who is awake, alert and oriented x3. Speech pattern is normal in form and content with mentation and memory appropriate for age. **HEENT:** Normocephalic, atraumatic. Neck: Supple without masses. Eyes: Conjugate without scleral injection or icterus. Vision: Grossly intact bilaterally. Hearing: Present in both ears with normal-appearing ears, nose and throat. **LUNGS:** Clear to auscultation and percussion. **HEART:** RR. **ABDOMEN:** Soft, nondistended, nontender with bowel sounds present. **EXTREMITIES:** No cyanosis, clubbing or edema. Distal pulses are present. **SKIN:** No rashes or gross abnormalities noted. **MUSCULOSKELETAL:** Normal ROM of the cervical spine without tenderness, rigidity or step-off deformity. Lhermitte's sign is absent. Spurling's maneuver is negative. Shoulder ROM is normal without pain, tenderness or crepitus. She has very restricted flexion at the waist. SLR reproduces back pain only bilaterally. Patrick's maneuver increases the pain in her back but it does not produce hip discomfort. Hip ROM is full and nonpainful. She is extremely tender to palpation over the lumbar paraspinal muscles and does have some tension if not spasm. No active spasm, kyphosis or scoliosis present. **NEUROLOGICAL:** Cranial nerve exam: II - Vision is normal to finger recognition and tracks the examiner without difficulty. III, IV, VI - EOMI. V - Sensation on the face is intact to light touch. VII - Muscles of facial expression are normal and symmetric. VIII - Hearing is present in both ears. IX, X - Oropharynx elevates symmetrically in the midline. XI - Strength in the sternocleidomastoid and trapezius is intact. XII - Tongue protrudes normally in the midline. Face is symmetric. Strength is 5/5 bilaterally throughout. DTRs are normal and symmetric

14

9/8/2011 5:30 PM FROM: FAK TO: 18664405782 PAGE: 002 OF 002

COLUMBIA NEUROSURGICAL ASSOCIATES, P.A.

Page 2

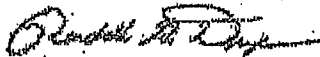
Re: Lettie F. Spencer

8/31/11

throughout. Toes are downgoing. Clonus is absent. Hoffmann's sign is negative. Touch and pinprick are subjectively and slightly diminished in the left lateral thigh and superior calf compared to the right. Cerebellar function is intact with normal station, gait, finger-to-nose and heel-to-shin exams.

IMAGING STUDIES: MRI of the lumbar spine done at Chester Regional Medical Center demonstrates no significant pathologic findings. She has a very mild degenerative disc at L4-5 with nonpathologic bulge and slight desiccation. The disc height is however, fairly well maintained. The other discs show retention of normal fluid and position and she has no evidence of severe spondylosis, stenosis, instability or fracture.

IMPRESSION/PLAN: Ms. Spencer presents with a very intact and relatively healthy lumbar spine that appears younger than her stated age. I have spent approximately 45 minutes with her reviewing the actual images, discussing the findings and the positive nature of those findings. I think that her symptoms are emanating from a severe lumbar strain given the mechanism of injury and her symptom complex. There is certainly no place for any neurosurgical intervention. She seemed to relieve to hear this. I think that she would best be treated with physical therapy. At the end of the session we met with the caseworker and discussed the above. She has agreed that if I order the physical therapy that the patient can be seen, monitored, and managed by Dr. Rawl with our pain department. I think this would be more appropriate than to have continuous neurosurgical surveillance. The patient may return to her current work duties with restrictions and we will make arrangements for physical therapy with a formal consultation with Dr. Rawl.



Randall G. Drye, MD

THIS DOCUMENT HAS BEEN ELECTRONICALLY SIGNED

RGD / MEH

CNAWT: 4021

Faxed To: Patty Chambers, RN

15

Spencer, Lettie L. 11/28/1947

Office/Outpatient Visit

Visit Date: Thu, Nov 10, 2011 01:00 pm

Provider: Tony Owens, MD (Supervisor: Tony Owens, MD; Assistant: Lisa Shealy, MA)

Location: South Carolina Internal Medicine

1 of 2

Electronically signed by Tony Owens, MD on 11/16/2011 11:45:16 AM
Printed on 11/28/2011 at 3:03 pm.**SUBJECTIVE:****CC:** Pt complains of Low back pain.

HPI: Ms. Spencer is a pleasant 63-year-old female with a history lumbar back pain which began in June of this year. She describes this pain as 8 out of 10 on the NRS with a dull, stabbing, constant and nauseating sensation. Pain is along the lumbosacral spine with radiation in the posterior aspect of the left lower extremity to the left lateral malleolus. Crushing pills at work and utilizing a vacuum cleaner tends to exacerbate her pain while utilizing a TENS unit has alleviated this pain to some extent. She reports her pain is associated with some weakness in the left leg.

Regarding management this condition, she reports no previous surgeries or interventions in effort to control his pain symptoms. She does report participation in physical therapy with modest results. Regarding medication management, she reports previous trials of Ultram and Flexeril. She is currently on a medication regimen of Trazodone and Klonopin.

ROS:

CONSTITUTIONAL: Negative for chills, fatigue, fever and weight change.
EYES: Negative for double vision, blurred vision, redness, eye pain and discharge.
ENT/MOUTH: Negative for bleeding, throat swelling, ulcers, lip lesions and mouth dryness.
RESPIRATORY: Negative for shortness of breath, wheezing, chest tightness and coughing up blood/puss.
CARDIOVASCULAR: Negative for chest pain, palpitations, passing out and extremity swelling.
GASTROINTESTINAL: Positive for nausea, Negative for vomiting, heartburn, bleeding or constipation.
GENITOURINARY: Negative for incontinence, impotence, genital burn, difficult urination and discharge.
MUSCULOSKELETAL: Positive for pain. Negative for cramps, weakness, joint pain or muscle loss.
NEUROLOGICAL: Negative for headache, seizures, vertigo, memory loss and concentration difficulty.
PSYCHIATRIC: Negative for anxiety, depression, insomnia and homicidal/suicidal thoughts.

Current Medications:

Tramadol 50mg Tablet 1-2 q8h prn

OBJECTIVE:**Vitals:**

Current: 11/10/2011 8:19:12 PM
Ht: 5 ft, 2 in; Wt: 130 lbs; BMI: 23.0
BP: 120/70 mm Hg; P: 72 bpm; R: 16 bpm
O2 Sat: 98 %
Pain Index: 8

Exams:**CONSTITUTIONAL:** Well-nourished and in no apparent distress.**EYES:** Negative for PERRL; non-loteric sclera.**ENT/MOUTH:** No ear lesions present. Mucous membranes moist.**RESPIRATORY:** Clear to auscultation bilaterally.**CARDIOVASCULAR:** Normal rate and rhythm. No murmurs, gallops, or rubs.**ABDOMEN:** Negative for tenderness. No present masses or lesions.

Spencer, Lettie L. 11/28/2011

2 of 2

Office/Outpatient Visit

Visit Date: Thu, Nov 10, 2011 01:00 pm

Provider: Tony Owens, MD (Supervisor: Tony Owens, MD; Assistant: Lisa Shealy, MA)

Location: South Carolina Internal Medicine

Electronically signed by Tony Owens, MD on 11/18/2011 11:49:18 AM

Printed on 11/28/2011 at 3:03 pm.

NEUROLOGICAL:

Cranial Nerves: II - XII Intact.

Reflex Exam: Right bicep 3+, Right tricep 3+, Right patella 3+, Right achilles 3+, Left bicep 3+, Left tricep 3+, Left patella 3+, and Left achilles 3+.

Hoffmann's Sign: Negative bilaterally.

Clonus: None present.

Sensory Exam: No gross deficits noted.

Patrick's Test: Positive on the left side.

Forn's Point: Positive on the left side.

Straight Leg Test: Negative bilaterally.

Tenderness to palpation: L-spine.

MUSCULOSKELETAL:

Gait: Non-antalgic.

Muscle Atrophy: None noted.

Right Motor Exam: 5/5 strength in shoulder, arm, hand grip, hip, leg, dorsiflexion and plantarflexion muscles.

Left Motor Exam: 5/5 strength in shoulder, arm, hand grip, hip, leg, dorsiflexion and plantarflexion muscles.

PSYCHIATRIC: Alert and oriented to person, place and time. Cognition Intact. Non-pressured speech. Normal affect.**Lab/Test Results:** MRI of L-spine 07/22/11

Impression: No significant pathologic findings. She has a very mild degenerative disc at L4-5 with nonpathologic bulge and slight discoloration. The disc height is however, fairly well maintained. The other discs show retention of normal fluid and position and she has no evidence of severe spondylosis, stenosis, instability or fracture.

SC Pharmacy query was evaluated today and reflected adherence to the prescribed regimen.

ASSESSMENT:724.8 Sacroiliac pain
838.4 Chronic pain syndrome
724.2 Low back pain**PLAN:** 1. Due to the distribution of Ms. Spencer's pain as well as physical exam findings, she was scheduled for a left sacroiliac joint injection.
2. I did initiate her on Tramadol today in effort to gain better control of her breakthrough pain for the time being.
3. She will follow up in clinic in 4 weeks assess the effectiveness of the intervention and medication changes mentioned above and make additional treatment recommendations as necessary.

Patient: Sponcer, Lettie L
DOB: 11/28/1947
Date of Exam: 11/21/2011



Dr. Tony Owens
SC Pain Associates
Phone: (803) 457-7246
Fax: (803) 454-6544

Left Sacroiliac Joint Injection with Sedation

Procedure:

- 1) Left Sacroiliac Joint Injection:
- 2) Fluoroscopy
- 3) IV sedation

The patient was identified in the holding room. Written informed consent was obtained including a discussion of the risks, benefits and alternatives to the procedure. An IV was placed and the patient was positioned prone on the fluoroscopic table. IV access was confirmed, monitors applied and mild IV sedation was initiated by the sedation nurse. A/P fluoroscopy with a slight oblique tilt was utilized to identify the left SI joint at its most posterior and inferior aspect. 4cc of 0.5% Lidocaine was used for skin anesthesia. Then a 22 gauge spinal needle was placed into the SI joint utilizing intermittent fluoroscopic guidance. After negative aspiration for blood or CSF, 3 cc of a solution containing 0.25% bupivacaine and 40 mg of Kenalog was injected into the joint. The needle was removed intact and hemostasis was appreciated. Meaningful verbal contact was maintained with the patient throughout the entire procedure. The patient was allowed to recover in a monitored setting for 30 minutes prior to discharge. No complications were noted.

This document has been electronically verified and signed by Tony Owens, M.D., 11/21/2011



SOUTH CAROLINA PAIN ASSOCIATES
TONY OWENS, M.D.
1 WELLNESS BOULEVARD, SUITE 200
IRMO, SOUTH CAROLINA 29063
PHONE: (803) 457-7246
FAX: (803) 454-6544

November 21, 2011

RE: Return to Work Notice for Lettie Spencer

To Whom It May Concern,

Please be advised that Ms. Spencer is currently under my medical care. Please excuse her from work until 12/9/11; she has a follow-up appointment scheduled with me at that time.

If you should have any questions or concerns, please do not hesitate to contact me.

Sincerely,

Tony Owens, M.D.

Dec. 14, 2011 8:25AM Billing

No: 7377 P. 2

Spencer, Lettie L. 11/28/1947

1 of 2

Office/Outpatient Visit

Visit Date: Fri, Dec 9, 2011 01:00 pm

Provider: Tony Owens, MD (Supervisor: Tony Owens, MD; Assistant: Lisa Shealy, MA)

Location: SC Pain Associates, Dr. Tony Owens

Electronically signed by Tony Owens, MD on 12/13/2011 10:44:33 AM

Printed on 12/14/2011 at 8:23 am.

SUBJECTIVE:**CC:** Follow up Low back pain.**HPI:** Ms. Spencer is a pleasant 63-year-old female with a history of lumbar back pain. She is currently on a medication regimen of Norco, trazodone and Klonopin. Previous medication trials include tramadol and Flexeril.

She has undergone the following interventions with the indicated benefit

1. November 2011, left sacroiliac joint injection, which decreased her pain approximate 80% for about an 18 hour period.

She is describing her pain today as 8-9 out of 10 on the NRS with an aching, dull, shooting and constant sensation. The pain is in the lumbosacral spine with radiation down the posterior aspect of the left lower extremity to the superior aspect of her left hamstring.

ROS:**CONSTITUTIONAL:** Positive for weight loss and general weakness. Negative for fatigue, fever, sweats or weight gain.**EYES:** Negative for double vision, blurred vision, redness, eye pain and discharge.**ENT/MOUTH:** Negative for bleeding, throat swelling, ulcers, lip lesions and mouth dryness.**RESPIRATORY:** Negative for shortness of breath, wheezing, chest tightness and coughing up blood/pus.**CARDIOVASCULAR:** Negative for chest pain, palpitations, passing out and extremity swelling.**GASTROINTESTINAL:** Positive for nausea. Negative for vomiting, heartburn, bleeding or constipation.**GENTOURINARY:** Negative for incontinence, impotence, genital burn, difficult urination and discharge.**MUSCULOSKELETAL:** Positive for pain. Negative for cramps, weakness, joint pain or muscle loss.**NEUROLOGICAL:** Negative for headache, seizures, vertigo, memory loss and concentration difficulty.**PSYCHIATRIC:** Negative for anxiety, depression, insomnia and homicidal/suicidal thoughts.**Current Medications:**

Norco 5mg/325mg Tablet one po tid prn

Tramadol 50mg Tablet 1-2 q8h prn

OBJECTIVE:**Vitals:**

Current 12/9/2011 4:50:16 PM

Ht: 5 ft; 2 in

BP: 122/70 mm Hg; P: 71 bpm; R: 16 bpm

O2 Sat 98 %

Pain Index: 9

Exams:**CONSTITUTIONAL:** Well-nourished and in no apparent distress.**EYES:** Negative for PERRL; non-icteric sclera.**RESPIRATORY:** Clear to auscultation bilaterally.**CARDIOVASCULAR:** Normal rate and rhythm. No murmurs, gallops, or rubs.**NEUROLOGICAL:**

Cranial Nerves: II - XII Intact.

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Dec. 14, 2011 8:25AM Billing

No. 7377 P: 3

2 of 2

Spencer, Lettie L. 11/28/1947

Office/Outpatient Visit

Visit Date: Fri, Dec 9, 2011 01:00 pm

Provider: Tony Owens, MD (Supervisor: Tony Owens, MD; Assistant: Lisa Shealy, MA)

Location: SC Pain Associates, Dr. Tony Owens

Electronically signed by Tony Owens, MD on 12/13/2011 10:44:33 AM
Printed on 12/14/2011 at 8:23 am.

Fortin's Point: **Positive on the left side.**

PSYCHIATRIC: Alert and oriented to person, place and time. Cognition intact. Non-pressured speech. Normal affect.

Lab/Test Results:

MRI of L-spine 07/22/11

Impression: No significant pathologic findings. She has a very mild degenerative disc at L4-5 with nonpathologic bulge and slight desiccation. The disc height is, however, fairly well maintained. The other discs show retention of normal fluid and position and she has no evidence of severe spondylosis, stenosis, instability or fracture.

ASSESSMENT:

724.8 Sacroiliac pain
338.4 Chronic pain syndrome
724.2 Low back pain

PLAN: Plan

1. Due to the short-lived benefit she received from the left sacroiliac joint injection, I scheduled her for a left L5-S2 lateral branch radiofrequency ablation.
2. She will continue her Norco as previously prescribed due to positive benefit.
3. She will follow up in clinic in 6-8 weeks to assess her response to the intervention mentioned above and to make additional treatment recommendations as necessary.



SOUTH CAROLINA INTERNAL MEDICINE ASSOCIATES & REHABILITATION, L.L.C.
1 WELLNESS BOULEVARD, SUITE 200
IRMO, SOUTH CAROLINA 29063
PHONE: (803) 749-1111 • FAX: (803) 749-0080

Friday, December 09, 2011

RE: Return to Work Notice for Lettie Spencer

To Whom It May Concern,

Please be advised that Ms. Spencer is currently under my medical care. She will be released to return to work effective 01/14/2012.

If you should have any questions or concerns, please do not hesitate to contact me.

Sincerely,

Choose provider

South Carolina Internal Medicine Associates and Rehabilitation, L.L.C.

Spencer, Lettie L. 11/28/1947

1 of 3

Office/Outpatient Visit

Visit Date: Fri, Jan 13, 2012 05:45 am

Provider: Tony Owens, MD (Supervisor: Tony Owens, MD; Assistant: Lisa Shealy, MA)

Location: SC Pain Associates, Dr. Tony Owens

Electronically signed by Tony Owens, MD on 01/20/2012 02:17:04 PM
Printed on 02/27/2012 at 10:03 am.**SUBJECTIVE:****CC:** Follow up low back pain.**HPI:** Ms. Spencer is a pleasant 63-year-old female with a history of lumbar back pain. She is currently on a medication regimen of Norco, trazodone and Klonopin. Previous medication trials include tramadol and Flexeril.

She has undergone the following interventions with the indicated benefit

1. November 2011: left sacroiliac joint injection, which decreased her pain approximately 80% for about an 18 hour period.
2. December 2011: left L5-S2 lateral branch radiofrequency ablation, which decreased her pain for a 2 day time period

Lettie describes her pain today as 8/10 on the NRS with a throbbing, shooting and frequent sensation. She reports the majority of her pain is actually in the lumbar spine, although she still reports tenderness along the left sacroiliac joint.

ROS:**CONSTITUTIONAL:** Positive for weight loss. Negative for fatigue, fever, sweats, weight gain or general weakness.**EYES:** Negative for double vision, blurred vision, redness, eye pain and discharge.**ENT/MOUTH:** Negative for bleeding, throat swelling, ulcers, lip lesions and mouth dryness.**RESPIRATORY:** Negative for shortness of breath, wheezing, chest tightness and coughing up blood/pus.**CARDIOVASCULAR:** Negative for chest pain, palpitations, passing out and extremity swelling.**GASTROINTESTINAL:** Positive for nausea and vomiting. Negative for heartburn, bleeding or constipation.**GENITOURINARY:** Negative for incontinence, impotence, genital burn, difficult urination and discharge.**MUSCULOSKELETAL:** Negative for cramps, pain, weakness, joint pain and muscle loss.**NEUROLOGICAL:** Negative for headache, seizures, vertigo, memory loss and concentration difficulty.**PSYCHIATRIC:** Negative for anxiety, depression, insomnia and homicidal/suicidal thoughts.**Past Medical History / Family History / Social History:**

... Last Reviewed on 1/13/2012 11:32:26 AM by Shealy, Lisa

Past Medical History:

Hyperlipidemia

Hypertension

Hypothyroidism

Family History: No Family HX of Pain.**Tobacco/Alcohol/Supplements:**

... Last Reviewed on 1/13/2012 11:33:08 AM by Shealy, Lisa

Tobacco: Currently smokes 1-5 cigarettes per day. Non-drinker

Substance Abuse History:

... Last Reviewed on 1/13/2012 11:33:16 AM by Shealy, Lisa

None

Current Problems:

... Last Reviewed on 1/13/2012 11:30:18 AM by Shealy, Lisa

Acquired hypothyroidism, other specified cause

HTN

Low back pain

Other hyperlipidemia

Allergies:

... Last Reviewed on 1/13/2012 11:31:24 AM by Shealy, Lisa

Spencer, Lettie L. 1/28/1947

Office/Outpatient Visit

Visit Date: Fri, Jan 13, 2012 08:45 am

Provider: Tony Owens, MD (Supervisor: Tony Owens, MD; Assistant Lisa Sheehy, MA)

Location: SC Pain Associates, Dr. Tony Owens

Electronically signed by Tony Owens, MD on 01/20/2012 02:17:04 PM
Printed on 02/27/2012 at 10:03 am.

surgical evaluation. She declined this treatment option at this time.

2. I will discontinue hydrocodone today due to lack of benefit and I initiated her on a trial of OxyContin due to the consistent nature of her pain.

3. I plan to enroll her into hydrotherapy as soon as her pain is better controlled.

4. I also initiate her on a trial of Neurontin to address what I believe is likely neuropathic pain.

5. She will follow up in clinic with me in 4 weeks for further evaluation.

8 of 8

Spencer, Lettie L. 11/28/1947

Office/Outpatient Visit

Visit Date: Thu, Feb 9, 2012 01:15 pm

Provider: Tony Owens, MD (Supervisor: Tony Owens, MD; Assistant: Lisa Shealy, MA)

Location: SC Pain Associates, Dr. Tony Owens

Electronically signed by Tony Owens, MD on 02/22/2012 05:42:49 PM
Printed on 02/27/2012 at 10:03 am.

1 of 3

SUBJECTIVE:CC: Follow up Low back pain.

HPI: Ms. Spencer is a pleasant 63-year-old female with a history of lumbar back pain. She is currently on a medication regimen of trazodone, Klonopin, OxyContin and Neurontin. Previous medication trials include tramadol, Norco and Flexeril.

She has undergone the following interventions with the indicated benefit:

1. November 2011: left sacrospinous joint injection, which decreased her pain approximately 80% for about an 18 hour period.
2. December 2011: left L5-S2 lateral branch radiofrequency ablation, which decreased her pain for a 2 day time period.

Lettie reports to me today that she suffered nausea which started shortly after our last visit and has progressively gotten worse. When she stopped the OxyContin and Neurontin she reports that this eased up for a few days, but now has gotten worse and she has not been able to hold down any food. She reports that the OxyContin did control her pain well, but the nausea was more than she was able to tolerate. She reports her pain today as 8/10 on the NRS with an aching and constant sensation. The pain is in the lumbosacral spine with no radiation to the lower extremities.

ROS:

CONSTITUTIONAL: Positive for fatigue, fever, sweats and weight loss. Negative for weight gain or general weakness.

EYES: Negative for double vision, blurred vision, redness, eye pain and discharge.

ENT/MOUTH: Negative for bleeding, throat swelling, ulcers, lip lesions and mouth dryness.

RESPIRATORY: Negative for shortness of breath, wheezing, chest tightness and coughing up blood/pus.

CARDIOVASCULAR: Negative for chest pain, palpitations, passing out and extremity swelling.

GASTROINTESTINAL: Positive for nausea and vomiting. Negative for heartburn, bleeding or constipation.

GENITOURINARY: Negative for incontinence, impotence, genital burn, difficult urination and discharge.

MUSCULOSKELETAL: Negative for cramps, pain, weakness, joint pain and muscle loss.

NEUROLOGICAL: Negative for headache, seizures, vertigo, memory loss and concentration difficulty.

PSYCHIATRIC: Positive for depression. Negative for anxiety, insomnia or homicidal or suicidal thoughts.

Past Medical History / Family History / Social History

... Last Reviewed on 1/13/2012 11:32:28 AM by Shealy, Lisa

Past Medical History:

Hyperlipidemia

Hypertension

Hypothyroidism

Family History: No Family Hx of Pain.Tobacco/Alcohol/Supplements:

... Last Reviewed on 1/13/2012 11:33:08 AM by Shealy, Lisa

Tobacco: Currently smokes 1-2 cigarettes per day. Non-drinker

Substance Abuse History:

... Last Reviewed on 1/13/2012 11:33:16 AM by Shealy, Lisa

None

Allergies:

Last Reviewed on 1/13/2012 11:31:24 AM by Shealy, Lisa

Demerol HCl

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Spencer, Lettie L. 1/28/1947

Office/Outpatient Visit

2 of 3

Visit Date: Thu, Feb 9, 2012 01:15 pm

Provider: Tony Owens, MD (Supervisor: Tony Owens, MD; Assistant: Lisa Shealy, MA)

Location: SC Pain Associates, Dr. Tony Owens

Electronically signed by Tony Owens, MD on 02/22/2012 06:42:49 PM

Printed on 02/27/2012 at 10:03 am.

Codeine Sulfate:

Pericillina:

Current Medications:

Nucynta ER 50mg Tablets, Extended Release One tablet by mouth BID. May increase to two tabs BID after three days if necessary

Phenergan 25mg Suppository Insert one rectally q8hr prn nausea

Neurontin 300mg Capsules qhs x 5, then two qhs x 5, then one am and two qhs x 5, then two bid x 5, then two am, one noon and two qhs x 5, then two bid thereafter

Oxycontin 10mg Tablets, Controlled Release One po BID

OBJECTIVE:Vitals:

Current: 2/10/2012 12:43:31 PM

Ht: 5 ft, 2 in

BP: 118/72 mm Hg; P: 76 bpm; R: 20 bpm

O2 Sat: 98 %

Pain Index: 3

Exams:

CONSTITUTIONAL: Well-nourished and in no apparent distress.

EYES: Negative for PERRL; non-icteric sclera.

RESPIRATORY: Clear to auscultation bilaterally.

CARDIOVASCULAR: Normal rate and rhythm. No murmurs, gallops, or rubs.

NEUROLOGICAL:

Cranial Nerves: II - XII Intact.

PSYCHIATRIC: Alert and oriented to person, place and time. Cognition intact. Non-pressured speech. Normal affect.

Lab/Test Results:

MRI of L-spine 07/22/11

Impression: No significant pathologic findings. She has a very mild degenerative disc at L4-5 with nonpathologic bulge and slight desiccation. The disc height is however, fairly well maintained. The other discs show retention of normal fluid and position and she has no evidence of severe spondylosis, stenosis, instability or fracture.

ASSESSMENT:724.5 Sacroiliac pain
888.4 Chronic pain syndrome
724.2 Low back pain**PLAN:** 1. I believe Lettie initially was having a reaction to the OxyContin, but is likely now suffering from withdrawal symptoms. I will discontinue her OxyContin and Neurontin and I initiated her on extended release Nucynta which I believe will help with her pain and will be less likely to cause GI distress.

02/27/2012 10:08

Received by CorVel Corporation 2/27/2012, 7:11:18 AM Pacific Time, 8782, Page 4 of 7
(FAX)

P.004/007

Spencer, Lettie L. 11/28/1947

Office/Outpatient Visit

Visit Date: Thu, Feb 9, 2012 01:16 pm

Provider: Tony Owens, MD (Supervisor: Tony Owens, MD; Assistant: Lisa Shealy, MA)

Location: SD Pain Associates, Dr. Tony Owens

3 of 3

Electronically signed by Tony Owens, MD on 02/22/2012 05:42:49 PM

Printed on 02/27/2012 at 10:03 am

2. She will also utilize Phenergan suppositories for nausea as needed.
3. She will follow up in clinic with me in four weeks for further evaluation.

Spencer, Lottie L. 11/28/1947

1 of 3

Office/Outpatient Visit

Visit Date: Wed, Mar 7, 2012 01:16 pm

Provider: Tony Owens, MD (Supervisor: Tony Owens, MD; Assistant: April Smith, RN)

Location: SC Pain Associates, Dr. Tony Owens

Electronically signed by Tony Owens, MD on 03/08/2012 01:11:21 PM

Printed on 03/08/2012 at 1:38 pm.

SUBJECTIVE:

CC:

Mrs. Spencer, a pleasant 64 year old White female, returns to the office today to follow up regarding pain management.

HPI:

Mrs. Spencer presents today with back pain.

The following interventions have been performed with the indicated benefit:

1. November 2011: Left SI Injection, decreased pain approximately 80% for < 1 day
2. December 2011: Left L5-S2 LB RFA, decreased pain for approximately 2 days.

Mrs. Spencer is currently on a medication regimen of Neurontin, Nucynta ER, Trazodone, Klonopin, and Phenergan. She reports previous medication trials of Oxycontin, Tramadol, Norco, and Flexeril.

She describes this pain as 5/10 on the NRS with a(n) aching, dull, and frequent sensation. This pain is located in the lumbosacral spine with no radiation.

ROS:

CONSTITUTIONAL: Negative for chills, fatigue, fever and weight change.

EYES: Negative for double vision, blurred vision, redness, eye pain and discharge.

ENT/MOUTH: Negative for bleeding, throat swelling, ulcers, lip lesions and mouth dryness.

RESPIRATORY: Negative for shortness of breath, wheezing, chest tightness and coughing up blood/pus.

CARDIOVASCULAR: Negative for chest pain, palpitations, passing out and extremity swelling.

GASTROINTESTINAL: Negative for nausea, vomiting, heartburn, bleeding and constipation.

GENITOURINARY: Negative for incontinence, impotence, genital burn, difficult urination and discharge.

MUSCULOSKELETAL: Positive for pain. Negative for cramps, weakness, joint pain or muscle loss.

NEUROLOGICAL: Negative for headache, seizures, vertigo, memory loss and concentration difficulty.

PSYCHIATRIC: Negative for anxiety, depression, insomnia and homicidal/suicidal thoughts.

Past Medical History / Family History / Social History:

... Last Reviewed on 3/7/2012 1:51:54 PM by Owens, Tony L.

Past Medical History:

Hyperlipidemia

Hypertension

Hypothyroidism

Family History: No Family HX of Pain.

Tobacco/Alcohol/Supplements:

... Last Reviewed on 3/7/2012 1:51:55 PM by Owens, Tony L.

Tobacco: Currently smokes 1-5 cigarettes per day. Non-drinker

Substance Abuse History:

... Last Reviewed on 1/13/2012 11:33:16 AM by Shealy, Lisa

None.

Current Problems:

Last Reviewed on 3/7/2012 1:51:48 PM by Owens, Tony L.

Acquired hypothyroidism, other specified cause

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Spencer, Leticia L. 11/28/1947

2 of 3

Office/Outpatient Visit

Visit Date: Wed, Mar 7, 2012 01:15 pm

Provider: Tony Owens, MD (Supervisor: Tony Owens, MD; Assistant: April Smith, RN)

Location: SC Pain Associates, Dr. Tony Owens

Electronically signed by Tony Owens, MD on 03/08/2012 01:11:21 PM

Printed on 03/08/2012 at 1:38 pm.

Chronic pain syndrome

HTN

Low back pain

Other hyperlipidemia

Sacroiliac pain

Allergies:

Last Reviewed on 3/7/2012 1:51:49 PM by Owens, Tony L.

Demerol HCl:

Codaine Sulfate:

Penicillins:

Current Medications:

Last Reviewed on 3/7/2012 1:51:50 PM by Owens, Tony L.

Nucynta 50mg Tablet take one or two tablets every four to six hours as needed for pain pain

Phenergen 25mg Suppository Insert one rectally q6hr prn nausea

OBJECTIVE:

Vitals:

Current: 3/8/2012 9:10:09 AM

Ht: 5 ft, 2 in; Wt: 125 lbs; BMI: 22.9

BP: 128/72 mm Hg; P: 68 bpm; R: 16 bpm

O2 Sat: 97 %

Exams:

CONSTITUTIONAL: Well-nourished and in no apparent distress.

EYES: Negative for PERRL; non-icteric sclera.

RESPIRATORY: Clear to auscultation bilaterally.

CARDIOVASCULAR: Normal rate and rhythm. No murmurs, gallops, or rubs.

NEUROLOGICAL:

Cranial Nerves: II - XII intact.

PSYCHIATRIC: Alert and oriented to person, place and time. Cognition intact. Non-pressured speech. Normal affect.

Lab/Test Results:

SC Pharmacy query was evaluated today and reflected adherence to the prescribed regimen. The following radiology test(s) have been performed with the indicated benefit:

7/22/2011 - MRI of Lumbar Spine: No significant pathologic findings. She has a very mild degenerative disc at L4-5 with nonpathologic bulge and slight desiccation. The disc height is however, fairly well maintained. The other discs show retention of normal fluid and position and she has no evidence of severe spondylosis, stenosis, instability or fracture.

ASSESSMENT:

338.4 Chronic pain syndrome

724.6 Sacroiliac pain

30

Spencer, Lettie L. 11/28/1947

3 of 3

Office/Outpatient Visit

Visit Date: Wed, Mar 7, 2012 01:15 pm

Provider: Tony Owens, MD (Supervisor; Tony Owens, MD; Assistant: April Smith, RN)

Location: SC Pain Associates, Dr. Tony Owens

Electronically signed by Tony Owens, MD on 03/08/2012 01:11:21 PM

Printed on 03/08/2012 at 1:39 pm.

724.2 Low back pain

PLAN:

Chronic pain syndrome

- A referral was made to Columbia Rehabilitation Clinic for hydrotherapy.
- The pain is currently reasonably controlled and no changes in management will be made today.
- Nucynta is working quite well for Ma. Spencer
- She will follow-up in clinic in 6-8 weeks for further evaluation.

Orders:

Office/outpatient visit: established patient, level 3

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Spencer, Lettie L. 11/28/1947

Office/Outpatient Visit

Visit Date: Wed, Apr 18, 2012 12:05 pm

Provider: Tony Owens, MD (Supervisor: Tony Owens, MD; Assistant: April Smith, RN)

Location: South Carolina Internal Medicine

1 of 3

Electronically signed by Tony Owens, MD on 04/18/2012 05:27:18 PM

Printed on 04/18/2012 at 5:27 pm.

SUBJECTIVE:

CC:

Mrs. Spencer, a pleasant 64 year old White female, returns to the office today for a follow-up visit regarding pain management.

HPI:

Mrs. Spencer presents today with back pain.

The following interventions have been performed with the indicated benefit:

1. November 2011: Left SI Injection. 80% pain relief for < 1 day
2. December 2011: Left L5-S2 LB PFA, provided pain relief for 2 days

Regarding management, she is currently on a medication regimen of Neurontin, Nucynta ER, Trazodone, Klonopin, and Phenergan. She reports previous medication trials of Oxycontin, Tramadol, Norco, and Flexeril. No other treatment modalities are noted.

She describes her pain today as 8/10 on the NRS with a(n) aching, constant, dull, sharp, and shooting sensation. This pain is located in the lumbar spine with radiation to the posterior aspect of the left lower extremity.

ROS:

CONSTITUTIONAL: Negative for chills, fatigue, fever and weight change.

EYES: Negative for double vision, blurred vision, redness, eye pain and discharge.

ENT/MOUTH: Negative for bleeding, throat swelling, ulcers, lip lesions and mouth dryness.

RESPIRATORY: Negative for shortness of breath, wheezing, chest tightness and coughing up blood/pus.

CARDIOVASCULAR: Negative for chest pain, palpitations, passing out and extremity swelling.

GASTROINTESTINAL: Negative for nausea, vomiting, heartburn, bleeding and constipation.

GENITOURINARY: Negative for incontinence, impotence, genital burn, difficult urination and discharge.

MUSCULOSKELETAL: Positive for pain. Negative for cramps, weakness, joint pain or muscle loss.

NEUROLOGICAL: Negative for headache, seizures, vertigo, memory loss and concentration difficulty.

PSYCHIATRIC: Positive for depression. Negative for anxiety, insomnia or homicidal or suicidal thoughts.

Past Medical History / Family History / Social History:

... Last Reviewed on 4/18/2012 12:05:27 PM by James, Whitney A

Past Medical History:

Hypertension

Hypertension

Hypothyroidism

Family History: No Family HX of Pain.

Tobacco/Alcohol/Supplements:

... Last Reviewed on 4/18/2012 12:05:32 PM by James, Whitney A

Tobacco: Currently smokes 1-5 cigarettes per day. Non-drinker

Substance Abuse History:

... Last Reviewed on 1/13/2012 11:33:16 AM by Shealy, Lisa

None

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Spencer, Lettie L. 11/28/1947

2 of 3

Office/Outpatient Visit

Visit Date: Wed, Apr 18, 2012 12:05 pm

Provider: Tony Owens, MD (Supervisor: Tony Owens, MD; Assistant: April Smith, RN)

Location: South Carolina Internal Medicine

Electronically signed by Tony Owens, MD on: 04/18/2012 05:27:16 PM

Printed on 04/18/2012 at 5:27 pm.

Current Problems:

Last Reviewed on 4/18/2012 12:05:24 PM by James, Whitney A

Acquired hypothyroidism, other specified cause

HTN

Low back pain

Other hyperlipidemia

Allergies:

Last Reviewed on 4/18/2012 12:05:25 PM by James, Whitney A

Demerol HCl;

Codaine Sulfate;

Penicillins;

Current Medications:

Last Reviewed on 4/18/2012 12:05:26 PM by James, Whitney A

None

OBJECTIVE:

Vitals:

Current: 4/18/2012 1:49:36 PM

Ht: 5 ft 2 in; Wt: 129 lbs; BMI: 23.6

BP: 142/72 mm Hg P: 92 bpm; R: 20 bpm

O2 Sat: 98 %

Exams:

CONSTITUTIONAL: Well-nourished and in no apparent distress.

EYES: Negative for PERRL; non-icteric sclera.

RESPIRATORY: Clear to auscultation bilaterally.

CARDIOVASCULAR: Normal rate and rhythm. No murmurs, gallops, or rubs.

NEUROLOGICAL:

Cranial Nerves: II - XII intact.

Sensory Exam: No gross deficits noted.

Forlin's Point: Positive on the left side.

PSYCHIATRIC: Alert and oriented to person, place and time. Cognition intact. Non-pressured speech. Normal affect.

Lab/Test Results:

The following radiology test(s) have been performed with the indicated benefit:

7/22/2011 - MRI of Lumbar Spine: No significant pathologic findings. She has a very mild degenerative disc at L4-5 with nonpathologic bulge and slight desiccation. The disc height is however, fairly well maintained. The other discs show retention of normal fluid and position and she has no evidence of severe spondylosis, stenosis, instability or fracture.

SC Pharmacy query was evaluated today and reflected adherence to the prescribed regimen.

ASSESSMENT:

33

4/18/2012 5:27 PM FROM: Pam TO: 18664406782 PAGE: 004 OF 004

Spencer, Lettie L. 11/28/1947

3 of 3

Office/Outpatient Visit

Visit Date: Wed, Apr 18, 2012 12:05 pm

Provider: Tony Owens, MD (Supervisor: Tony Owens, MD; Assistant: April Smith, RN)

Location: South Carolina Internal Medicine

Electronically signed by Tony Owens, MD on 04/18/2012 05:27:18 PM
Printed on 04/18/2012 at 5:27 pm.

338.4 Chronic pain syndrome
724.6 Sacroiliac pain
724.2 Low back pain

PLAN:

Chronic pain syndrome

- I continued her current medication regimen without change due to positive benefit.
- A referral was made to orthopedist for further evaluation of chronic low back pain.

Low back pain

Patient Education Handouts:
Acute Low Back Pain

34



SOUTH CAROLINA PAIN ASSOCIATES
TONY OWENS, M.D.
1 WELLNESS BOULEVARD, SUITE 200
IRMO, SOUTH CAROLINA 29063
PHONE: (803) 457-7246
FAX: (803) 454-6544

Wednesday, April 18, 2012

RE: Lettie Spencer
DOB: 11/28/1947

To Whom It May Concern,

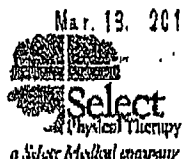
Please be advised that Ms. Spencer was seen in my office today. I have ordered her to remain out of work until she sees a specialist.

If you should have any questions or concerns, please do not hesitate to contact me.

Sincerely,



Tony Owens, M.D.
South Carolina Pain Associates



Mar. 13, 2012 9:59AM
 Select Physical Therapy
 154-101 Amendment Ave...
 Rock Hill, SC USA 29732
 Phone: (803) 366-9990
 Fax: (803) 366-9960

Session: Physical Therapy
 Patient: LARRY SPENCER
 Acct #: 013-010302198
 DOB: Nov 28, 1947
 Clinician: Judith E. Kiser, MPT
 Print Phys: Tony Owens
 Phy Phone: (803) 749-1111
 Phy Fax: (803) 749-0030
 Sec Phys: Not Specified
 Inj. Date: 7/22/2011
 Surg. Date: Not Specified

No. 5468 P. 4

Visit Date: Mar 12, 2012
 FSC: Workers Compensation
 Payor: WC OF SC
 Pol/Claim#: Not Specified
 Insured: Not Specified
 Employer: NHC Parklane
 Case Mgr: Not Specified
 Visits: 1
 Ctl/Na: 0

Initial Evaluation

Diagnosis Spine: 7242 LUMBAGO

Subjective Examination

The patient's medical history has been verbally reviewed with the patient by the evaluating therapist. The medical history questionnaire has been completed and signed by the patient, reviewed by the evaluating therapist, and is on file.

ADL / Functional Status:

• Premorbid status:

- Basic care: Independent without difficulty. Work status: Full time / Full duty.

• Current status:

- Work status: Unable to work secondary to dysfunction. Basic care: Modified Independence: Requires prolonged time. can not get clothes out of washing machine, vacuum, change sheets
- Occupation: LPN at skilled nursing facility

Chief Complaint:

• Pain: Aggravating Factors: Activities:

- Standing: 20 min Walking: 60 min Sitting: < 30 min

• Pain: Location: Lumbosacral Area: center of low back

Mechanism of Injury:

- 6-22-11 Pushing a med chart, had to give it a shove to get over trim at door felt immediate sharp pain in back

Medical Management:

- Originally saw urgent care MD had x-rays and MRI and PT. Was then referred to neurosurgeon who referred her to pain Medicine. Had injections 11-20-11, then 12-20-11 had radio frequency ablation. Medications: Prescription: Pain Medication/Analgesics.

Questionnaires: Disability Index:

• Test Name

Oswestry Disability Index

• Date

03/13/2012

• Assessment

Initial

• Percentage

50.00%

Rehabilitation Expectations/Goals:

- to get better and get stronger

Objective Examination

Muscle Testing: Lower Extremity MMT:

• Hip Flexion

Left

Right

+4/5

+4/5

• Knee Extension

+4/5

+4/5

• Knee Flexion

+4/5

+4/5

• Ankle Dorsiflexion

-5/5

-5/5

Range of Motion: Spine: Active Lumbosacral

• Extension(Bilateral - Pain Provoked)

10%

• Flexion(Bilateral - Pain Provoked)

20%

• Side Bending Left(Bilateral - Pain Provoked)

20%

• Side Bending Right(Bilateral - Pain Provoked)

20%

Treatments

PT/Pain By Education:

• Patient Education 1

Time Elapsed: 5 Minutes, Description: benefits of aquatic therapy then progress to clinic; Charge As: Self Care / Home Mgt-Training

Therapy Session Time

• Therapy Session Start Time

12:03 PM

• Therapy Session Stop Time

12:35 PM

Documented Procedural Code Summary:

Description	Code	Units	Minutes
• Physical Therapy Evaluation	97001	1	n/a

36

Mar. 13, 2012 9:59AM

Service: Physical Therapy

No. 5468 P. 5


 Patient: Letitia Spencer
 Acct #: 013-610302198

Visit Date: Mar 12, 2012

Self Care/Home Management Training 07535 1 5

Assessment

The patient requires skilled physical therapy to address the problems identified, and to achieve the individualized patient goals as outlined in the problems and goals section of this evaluation. Overall rehabilitation potential is good. The patient was educated regarding their diagnosis, prognosis, related pathology & plan of care. The patient demonstrates a good understanding of the risks, benefits, precautions/contraindications, & prognosis of their skilled rehabilitation program.

Recommendations: Skilled Intervention: Required To:

- Decrease Pain. Improve Function. Increase Range of Motion. Increase Strength.

Problems & Goals

Problem #1 Chief Complaint: Pain: Aggravating Factors: Activities: Standing: 20 min

LTG Achieve by May 11, 2012.

Functional Improvements In:

- Pt able to tolerate standing for 1 hr

Problem #2 Chief Complaint: Pain: Aggravating Factors: Activities: Sitting: < 30 min

LTG Achieve by May 11, 2012.

Functional Improvements In:

- Pt able to tolerate sitting up to 1 hr

Problem #3 Range of Motion: Spine: Active Lumbosacral.

LTG Achieve by May 11, 2012.

Range of Motion Improvements for Active Lumbosacral:

- | | |
|-----------------------|-----|
| • Extension. | 80% |
| • Flexion. | 80% |
| • Side Bending Left. | 80% |
| • Side Bending Right. | 80% |

Problem #4 Muscle Testing: Lower Extremity MMT.

LTG Achieve by May 11, 2012.

Musculoskeletal Improvements In: Lower**Extremity Strength to:**

- | | Left | Right |
|------------------|------|-------|
| • Hip Flexion | -5/5 | -5/5 |
| • Knee Extension | -5/5 | -5/5 |
| • Knee Flexion | -5/5 | -5/5 |

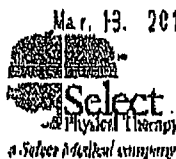
Plan**Amount, Frequency and Duration:**

- Frequency and Duration: It is recommended that the patient attend rehabilitative therapy for 2 visits a week with an expected duration of 8 weeks. The outlined therapeutic procedures and services in the plan of care will address the problems and goals identified.

Therapeutic Contents:

- Active Assistive Range of Motion Activities. Active Range of Motion Activities. Aquatics/Pool. Client Education.

Judith E. Kiser, MPT, MPT(SC Lic: 4150)



Mar. 13, 2012 9:00AM
Select Physical Therapy
154-101 Amendment Ave.
Rock Hill, SC USA 29732
Phone: (803) 366-9990
Fax: (803) 366-9960

Physical Therapy
Acct #: 013-810302193
DOB: Nov 28, 1947
Clinician: Judith E. Klear, MPT
Prim Phy: Tony Owens
Phy Phone: (803) 749-1111
Phy Fax: (803) 749-0050
Sec Phy: Not Specified
Inj. Date: 7/22/2011
Surf. Date: Not Specified

No. 5468 P. 6

Visit Date: Mar. 12, 2012
FEC: Workers Compensation
Payor: WC OR SC
Pol/Claim#: Not Specified
Insured: Not Specified
Employer: WNC Parklane
Case Mgr: Not Specified
Visits: 1
Cd/No: 0

Plan of Care

Diagnosis Spine 7242 LUMBAGO

Subjective Examination

The medical history questionnaire has been completed and signed by the patient, reviewed by the evaluating therapist, and is on file.

ADL / Functional Status:

• Premorbid status: Work status: Full time / Full duty.

Rehabilitation Expectations/Goals:

• to get better and get stronger

ADL / Functional Status:

• Current status: Work status: Unable to work secondary to dysfunction, Occupation: LPN at skilled nursing facility

Chief Complaints:

• Pain: Aggravating Factors: Activities:

• Standing: 20 min Walking: 60 min Sitting: < 30 min

• Pain: Location: Lumbosacral Area: center of low back

Mechanism of Injury:

• 6-22-11 Pushing a mad cart, had to give it a shove to get over rim at door left immediate sharp pain in back

Questionnaire: Disability Index:

• Test Name:

Oswestry Disability Index

• Date:

03/13/2012

• Assessment:

Initial

• Percentage:

50.00%

Assessment

The patient requires skilled physical therapy to address the problems identified, and to achieve the individualized patient goals as outlined in the problems and goals section of this evaluation. Overall rehabilitation potential is good. The patient was educated regarding their diagnosis, prognosis, related pathology & plan of care. The patient demonstrates a good understanding of the risks, benefits, precautions/contraindications, & prognosis of their skilled rehabilitation program.

Recommendations: Skilled Intervention: Required To:

• Decrease Pain. Improve Function. Increase Range of Motion. Increase Strength.

Problems & Goals

Problem #1 Chief Complaints: Pain: Aggravating Factors: Activities: Standing: 20 min

LTG Achieve by May 11, 2012.

Functional Improvements In:

• Pt able to tolerate standing for 1 hr

Problem #2 Chief Complaints: Pain: Aggravating Factors: Activities: Sitting: < 30 min

LTG Achieve by May 11, 2012.

Functional Improvements In:

• Pt able to tolerate sitting up to 1 hr

Problem #3 Range of Motion: Spine: Active Lumbosacral.

• Extension(Bilateral - Pain Provoked) 10%

• Flexion(Bilateral - Pain Provoked) 20%

• Side Bending Left(Bilateral - Pain Provoked) 20%

• Side Bending Right(Bilateral - Pain Provoked) 20%

LTG Achieve by May 11, 2012.

Range of Motion Improvements to: Active Lumbosacral:

• Extension 80%

• Flexion 80%

• Side Bending Left 80%

• Side Bending Right 80%

Problem #4 Muscle Testing: Lower Extremity MMT.

Left

Right



Mar. 13, 2012 9:00AM

 Service: Physical Therapy
 Patient: Laura Spencer
 Acct #: 013-810302198

No. 5468 P. 7

Alt Date: Mar 12, 2012

• Ankle Dorsiflexion	-5/5	-5/5
• Hip Flexion	-4/5	-4/5
• Knee Extension	-5/5	-4/5
• Knee Flexion	+4/5	+4/5
LTG Achieve by May 11, 2012.		
Musculoskeletal Improvements In: Lower		
Extremity Strength to:	Left	Right
• Hip Flexion	-5/5	-5/5
• Knee Extension	-5/5	-5/5
• Knee Flexion	-5/5	-5/5

Plan**Amount, Frequency and Duration:**

- Frequency and Duration: It is recommended that the patient attend rehabilitative therapy for 2 visits a week with an expected duration of 8 weeks. The outlined therapeutic procedures and services in the plan of care will address the problems and goals identified.

Therapeutic Contents:

- Active Assistive Range of Motion Activities. Active Range of Motion Activities. Aquatics/Pool. Client Education.

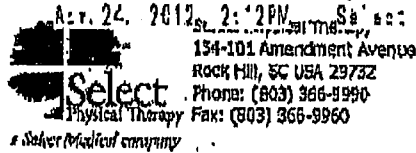
Judith E. Kiser, MPT, MPT(SC Lic: 4150)

Please Sign and Return

I have reviewed the Plan of Care established for skilled therapy services and certify that the services are required and that they will be provided while this patient is under my care.

Comments/RevisionsPhysician Signature Therapy Owens, M.D.

Date _____



Select Medical Company

Physical Therapy

Acct #: 013-610302198
DOB: Nov 28, 1947
Clinician: Judith E. Klear, MPT
Prim Phys: Tony Owens
Phy Phone: (803) 457-7246
Phy Fax: (803) 454-6544
Sec Phys: Not Specified
Inj. Date: 7/22/2011
Surg. Date: Not Specified

No. 7594 P. 3

Note Dates: Apr 24, 2012
FSC: Workers Compensation
Payor: WC of SC
Pol/Claim#: Not Specified
Insured: Not Specified
Employer: NHC Partners
Case Mgr: Not Specified
Visits: 11
Cd/Nst: 0

Discharge Summary

Diagnosis: Spine 7242 LUMBAGO

Subjective Examination

ADL / Functional Status:

Current status:

- Work status: Unable to work secondary to dysfunction. Basic care: Modified Independence; Requires prolonged time; can not get clothes out of washing machine, vacuum, change sheets

Occupation: LPN at skilled nursing facility

Chief Complaint:

Pain Aggravating Factors: Activities:

- Standing: no more than 30 min Walking: 60 min Sitting: about an hour with pain meds

Pain Location: Lumbosacral Area: center of low back

Daily Comments:

- Perceived Improvement: Reports that she has not noticed much difference in her symptoms yet. Usually curls up in bed the rest of the day after aquatic therapy.

Mechanism of Injury:

- 6-22-11 Pushing a med chart, had to give it a shove to get over trim at door felt immediate sharp pain in back

Medical Management:

- Originally saw urgent care MD had x-rays and MRI and PT. Was then referred to neurosurgeon who referred her to pain Medicine. Had injections 11-20-11, then 12-20-11 had radio frequency ablation. Medications: Prescription: Pain Medication/Analgesics.

Questionnaire Disability Index:

Test Name:

Date:

Assessment:

Percentage:

Oswestry Disability Index

04/17/2012

Reassessment

70.00%

Objective Examination

OBJECTIVE NOTED - 04/17/12

Muscle Testing: Lower Extremity NMT:

• Hip Flexion:

• Knee Extension:

• Knee Flexion:

• Ankle Dorsiflexion:

Range of Motion: Spinal Active Lumbosacral:

• Extension (Bilateral - Pain Provoked):

• Flexion:

• Side Bending Left (Bilateral - Pain Provoked):

• Side Bending Right (Bilateral - Pain Provoked):

Mar 12, 2012

Apr 17, 2012

Left

Right

Left

Right

4/5

4/5

4/5

4/5

4/5

4/5

4/5

4/5

4/5

4/5

4/5

4/5

5/5

5/5

5/5

5/5

5/5

5/5

5/5

5/5

20%

20%

20%

20%

20%

20%

20%

20%

20%

20%

20%

20%

20%

20%

20%

20%

Assessment

Ms Spencer has been participating in aquatic therapy for 4 weeks with fair tolerance for the activity. She reports good pain relief when she is able to unweight completely with the use of noodles, but increased pain with leg kicks and retro walking. She demonstrates decreased lumbar active ROM today, but increased in LE strength. Her Oswestry score went 20 points in the wrong direction on upon her re-evaluation from a 50% disability score to 70% disability.

Based on this patient's clinical presentation, it is my professional opinion that the patient's prognosis at time of discharge is fair. The patient was educated regarding their discharge prognosis and related pathology. The patient demonstrates fair understanding of their home program instructions.

Problems & Goals

Document ID: 18A0132E-014
Judith E. Klear, MPT, MPT (SC Lic: 4150)

Status: Signed off (secure electronic signature)

Page 1 of 2

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Apr. 24, 2012 2:22 PM

Session: Physical Therapy

Patient: Letitia Spencer

No. 7534 P. 4

Acct #: 013-610302198

Note Date: Apr 24, 2012

Problem #1 Chief Complaint: Pain; Aggravating Factors: Activities; Standing; no more than 30 min

Goal Abandoned Apr 24, 2012, 25 % of Goal Met

Functional Improvements In:

- Pt able to tolerate standing for 1 hr

Problem #2 Chief Complaint: Pain; Aggravating Factors: Activities; Sitting; about an hour with pain meds

Goal Abandoned Apr 24, 2012, 90 % of Goal Met

Functional Improvements In:

- Pt able to tolerate sitting up to 1 hr

Problem #3 Range of Motion: Spinal Active Lumbosacral

Goal Abandoned Apr 24, 2012, due to increased pain

Range of Motion Improvements to: Active Lumbosacral

Extension: 80%

Flexion: 80%

Side Bending Left: 80%

Side Bending Right: 80%

Problem #4 Muscle Testing: Lower Extremity MMT

Goal Abandoned Apr 24, 2012, 50 % of Goal Met

Musculoskeletal Improvements In: Lower

Extremity Strength to:

Hip Flexion: 5/5

Knee Extension: 5/5

Knee Flexion: 5/5

Plan

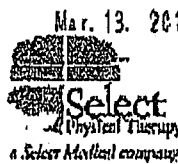
Discharge due to:

- per phone call from patient, MD said O/C

Judith E. Kizer MPT

Judith E. Kizer, MPT, MPT(SC Lic: 4150)
Signed on Apr 24, 2012 13:49:33

44



Physical Therapy
154-101 Amendment Ave.,
Rock Hill, SC USA 29732
Phone: (803) 366-9990
Fax: (803) 366-9960

Physical Therapy
Patient: **Spencer**
Acct #: **013-810302198**
DOB: **Nov 28, 1947**
Clinician: **Judith E. Kiser, MPT**
Prim Phys: **Tony Owens**
Phy Phone: **(803) 749-1111**
Phy Fax: **(803) 749-0050**
Sec Phys: **Not Specified**
Inj. Date: **7/22/2011**
Surg. Date: **Not Specified**

No. 5468 P. 4

Visit Date: **May 12, 2012**
PSC: **Workers Compensation**
Payor: **WQ OF SC**
Pol/Claim#: **Not Specified**
Insured: **Not Specified**
Employer: **NHC Parklane**
Case Mgr: **Not Specified**
Visits: **1**
Cxl/Hst: **0**

Initial Evaluation

Diagnosis Spine 7242 LUMBAGO

Subjective Examination

The patient's medical history has been verbally reviewed with the patient by the evaluating therapist. The medical history questionnaire has been completed and signed by the patient, reviewed by the evaluating therapist, and is on file.

ADL / Functional Status:

* Premorbid status:

* Basic care: Independent without difficulty. Work status: Full time / Full duty.

* Current status:

* Work status: Unable to work secondary to dysfunction. Basic care: Modified Independence: Requires prolonged time. can not get clothes out of washing machine, vacuum, change sheets

* Occupation: LPN at skilled nursing facility

Chief Complaint:

* Pain: Aggravating Factors: Activities:

* Standing: 20 min Walking: 60 min Sitting: < 30 min

* Pain: Location: Lumbosacral Area: center of low back

Mechanism of Injury:

* 6-22-11 Pushing a med chart, had to give it a shove to get over him at door felt immediate sharp pain in back

Medical Management:

* Originally saw urgent care MD had x-rays and MRI and PT. Was then referred to neurosurgeon who referred her to pain Medicine. Had injections 11-20-11, then 12-20-11 had radio frequency ablation. Medications: Prescription: Pain Medication/Analgesics.

Questionnaires: Disability Index

* Test Name

* Date

* Assessment:

* Percentage

Oswestry Disability Index

03/13/2012

Initial

50.00%

Rehabilitation Expectations/Goals:

* to get better and get stronger

Objective Examination**Muscle Testing: Lower Extremity MMT:**

* Hip Flexion

Left

+4/5

Right

+4/5

* Knee Extension

+4/5

+4/5

* Knee Flexion

+4/5

+4/5

* Ankle Dorsiflexion

-5/5

-5/5

Range of Motion: Spine: Active Lumbosacral:

* Extension(Bilateral - Pain Provoked)

10%

* Flexion(Bilateral - Pain Provoked)

20%

* Side Bending Left(Bilateral - Pain Provoked)

20%

* Side Bending Right(Bilateral - Pain Provoked)

20%

Treatments**Pt./Family Education:**

* Patient Education 1

Time Elapsed: 5 Minutes, Description: benefits of aquatic therapy then progress to clinic, Charge As: Self Care / Home Mgt-Training

Therapy Session Time

* Therapy Session Start Time

12:03 PM

* Therapy Session Stop Time

12:35 PM

Documented Procedural Code Summary:

Description	Code	Units	Minutes
* Physical Therapy, Evaluation	97001	1	n/a



Mar. 13. 2012 9:59AM

Received by CorVel Corporation 3/13/2012, 6:59:54 AM Pacific Time, 2012, Page 6 of 7

Session: Physical Therapy

Patient: LARRY SPENCER

Acct #: 013-610302198

No. 5468 P. 5

Visit Date: Mar 12, 2012

Self Care/Home Management Training 97535 1 5

Assessment

The patient requires skilled physical therapy to address the problems identified, and to achieve the individualized patient goals as outlined in the problems and goals section of this evaluation. Overall rehabilitation potential is good. The patient was educated regarding their diagnosis, prognosis, related pathology & plan of care. The patient demonstrates a good understanding of the risks, benefits, precautions/contraindications, & prognosis of their skilled rehabilitation program.

Recommendations: Skilled Intervention: Required To:

- Decrease Pain, Improve Function, Increase Range of Motion, Increase Strength.

Problems & Goals

Problem #1 Chief Complaint: Pain; **Aggravating Factors:** Activities; **Standing:** 20 min

LTG Achieve by May 11, 2012.

Functional Improvements In:

- Pt able to tolerate standing for 1 hr

Problem #2 Chief Complaint: Pain; **Aggravating Factors:** Activities; **Sitting:** < 30 min

LTG Achieve by May 11, 2012.

Functional Improvements In:

- Pt able to tolerate sitting up to 1 hr

Problem #3 Range of Motion: Spine; **Active Lumbosacral.**

LTG Achieve by May 11, 2012.

Range of Motion Improvements to: Active Lumbosacral:

- | | |
|----------------------|-----|
| • Extension | 80% |
| • Flexion | 80% |
| • Side Bending Left | 80% |
| • Side Bending Right | 80% |

Problem #4 Muscle Testing: Lower Extremity MMT.

LTG Achieve by May 11, 2012.

Musculoskeletal Improvements In: Lower

Extremity Strength to:

- | | Left | Right |
|------------------|------|-------|
| • Hip Flexion | -5/5 | -5/5 |
| • Knee Extension | -5/5 | -5/5 |
| • Knee Flexion | -5/5 | -5/5 |

Plan

Amount, Frequency and Durations

- Frequency and Duration: It is recommended that the patient attend rehabilitative therapy for 2 visits a week with an expected duration of 6 weeks. The outlined therapeutic procedures and services in the plan of care will address the problems and goals identified.

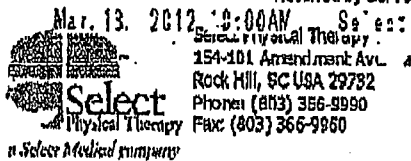
Therapeutic Contents:

- Active Assistive Range of Motion Activities, Active Range of Motion Activities, Aquatics/Pool, Client Education.

Judith E. Kiser MPT

Judith E. Kiser, MPT, MPT(SC Lic: 4150)

43



Acct #: 013-510302108
DOB: Nov 28, 1947
Clinician: Judith E. Kleer, MPT
Prim Phy: Tony Owens
Phy Phone: (803) 749-1111
Phy Fax: (803) 749-0050
Sec Phy: Not Specified
Inj. Date: 7/22/2011
Surg. Date: Not Specified

No. 5468 P. 6

Visit Date: Mar. 12, 2012
FIC: Workers Compensation
Payor: WC of SC
Pol/Claim#: Not Specified
Insured: Not Specified
Employer: NRC Parklane
Case Mgr: Not Specified
Visits: 1
Cd/Nst: 0

Plan of Care

Diagnosis spine 7242 LUMBARO

Subjective Examination

The medical history questionnaire has been completed and signed by the patient, reviewed by the evaluating therapist, and is on file.

ADL / Functional Status:

- Premorbid status: Work status: Full time / Full duty.

Rehabilitation Expectations/Goals:

- to get better and get stronger

ADL / Functional Status:

- Current status: Work status: Unable to work secondary to dysfunction, Occupation: LPN at skilled nursing facility

Chief Complaints:

- Pain: Aggravating Factors: Activities:
 - Standing: 20 min Walking: 60 min Sitting: < 30 min
- Pain: Location: Lumbosacral Area: center of low back

Mechanism of Injury:

- 6-22-11 Pushing a med chart, had to give it a shove to get over trim at door felt immediate sharp pain in back

Questionnaires: Disability Index:

- Test Name: Oswestry Disability Index
- Date: 03/13/2012
- Assessment: Initial
- Percentage: 50.00%

Assessment

The patient requires skilled physical therapy to address the problems identified, and to achieve the individualized patient goals as outlined in the problems and goals section of this evaluation. Overall rehabilitation potential is good. The patient was educated regarding their diagnosis, prognosis, related pathology & plan of care. The patient demonstrates a good understanding of the risks, benefits, precautions/contraindications, & prognosis of their skilled rehabilitation program.

Recommendations: Skilled Intervention: Required To:

- Decrease Pain, Improve Function, Increase Range of Motion, Increase Strength.

Problems & Goals

Problem #1 Chief Complaints: Pain: Aggravating Factors: Activities: Standing: 20 min

LTG Achieve by May 11, 2012.

Functional Improvements In:

- Pt able to tolerate standing for 1 hr

Problem #2 Chief Complaints: Pain: Aggravating Factors: Activities: Sitting: < 30 min

LTG Achieve by May 11, 2012.

Functional Improvements In:

- Pt able to tolerate sitting up to 1 hr

Problem #3 Range of Motion: Spine: Active Lumbosacral.

- Extension(Bilateral - Pain Provoked) 10%
- Flexion(Bilateral - Pain Provoked) 20%
- Side Bending Left(Bilateral - Pain Provoked) 20%
- Side Bending Right(Bilateral - Pain Provoked) 20%

LTG Achieve by May 11, 2012.

Range of Motion Improvements to: Active Lumbosacral:

- Extension 80%
- Flexion 80%
- Side Bending Left 80%
- Side Bending Right 80%

Problem #4 Muscle Testing: Lower Extremity NMT.

Left

Right



Mar. 13, 2012 0:00AM

 Service: Physical Therapy
 Patient: Linda Spencer
 Acct #1 013-61030219R

No. 5468 P. 7

Visit Date: Mar 12, 2012

• Ankle Dorsiflexion	-5/5	-5/5
• Hip Flexion	-4/5	-4/5
• Knee Extension	-4/5	-4/5
• Knee Flexion	+4/5	+4/5
LTG Achieve by May 11, 2012.		
Musculoskeletal Improvements In: Lower	Left	Right
Extremity Strength for		
• Hip Flexion	-5/5	-5/5
• Knee Extension	-5/5	-5/5
• Knee Flexion	-5/5	-5/5

Plan**Amount, Frequency and Duration:**

- Frequency and Duration: It is recommended that the patient attend rehabilitative therapy for 2 visits a week with an expected duration of 8 weeks. The outlined therapeutic procedures and services in the plan of care will address the problems and goals identified.

Therapeutic Contents:

- Active Assistive Range of Motion Activities, Active Range of Motion Activities, Aquatics/Pool, Client Education.

Judith E. Kiser, MPT, MPT(SC Lic: 4150)

Please Sign and Return

I have reviewed the Plan of Care established for skilled therapy services and certify that the services are required and that they will be provided while the patient is under my care.

Comments/Revisions

Physician Signature Tony Owens, M.D.

Date

45

Select Physical Therapy
 154-101 Amendment Avenue
 Rock Hill, SC 29732
 Phone: (803) 366-9990
 Fax: (803) 366-9960

Appointment List for Spencer, Leticia

Thank you for visiting Select Physical Therapy. If we can be of any further assistance, please let us know.

Date	Time	Appointment Type	Physician	Copay
Thu, Mar 15, 2012	11:00 AM	Aquatics	Bragg, PTA, Rochelle	0.00
Tue, Mar 20, 2012	11:00 AM	Aquatics	Bragg, PTA, Rochelle	0.00
Thu, Mar 22, 2012	11:00 AM	Aquatics	Bragg, PTA, Rochelle	0.00
Tue, Mar 27, 2012	11:00 AM	Aquatics	Bragg, PTA, Rochelle	0.00
Thu, Mar 29, 2012	11:00 AM	Aquatics	Bragg, PTA, Rochelle	0.00

Additional Instructions:

4-3-12 11:00
 4-5-12 11:00
 4-10-12 11:00
 4-12-12 11:00
 Thank you,
 Select Physical Therapy
 4-18-12 11:00

73

SCANNED

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CAROLINA ORTHOPAEDIC SURGERY ASSOCIATES, P.A. (COSA)
PATIENT UPDATE AND REGISTRATION

PATIENT INFO:		SSN: 259-74-6527	DOB: 11/28/1947	SEX: Female
Name: LETTIE SPENCER		PHONE Home: (407) 497-0358		
Address: 2867 GREAT FALLS HWY		PHONE Cell: 803 581-5919		
RICHMOND, SC 29229		PHONE Work:		
EMPLOYER: NHC Park Lane Columbia SC				
RESPONSIBLE PARTY:		SSN:	DOB:	
Name: <u>See</u>		PHONE Home:		
Address:		PHONE Cell:		
		PHONE Work:		
EMPLOYER:				

The following questions MUST BE ANSWERED prior to seeing the physician.

What are we seeing you for today? Back pain

1) WHEN DID THIS PROBLEM BEGIN? (date) 6-22-11

2) If Accident - Check the appropriate type

Accident? ☒ YES ☐ NO	
Auto Accident ☐ Other ☐	State where accident occurred: <u>S.C.</u>
☒ Work Related Injury	Did someone else cause this injury? ☐ YES ☒ NO

3) Who referred you to our office?

Referred by: Parents

Notes: If referred notes are sent

4) INSURANCE INFORMATION:

Insurance to be filed 1st: R&BS

Person Insured: <u>Lettie Spencer</u>	Employer: <u>Went to file BC</u>
DOB: <u>11-28-47</u>	Relation: <u>Went today</u>

Insurance to be filed 2nd:

Person Insured:	Employer:
DOB:	Relation:

Cons may be made to you for reminders regarding appointments. We may also leave messages for you to contact us regarding billing questions or other information. If we are unable to reach you may we leave a message? Please INITIAL beside each that you would like us to leave message etc.

HOME ☐ CELL ☒ WORK ☐
VIA EMAIL ☐ email address: _____

LETTIE SPENCER

Patient ID: 128571-45

DOB: 11/28/1947 (64 years)

04/17/2012 10:09 am

LETTIE B SPENCER DOB 11/28/1947

SCANNED 47

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Printed with PrintDirect from printing. Attachment of image file: printout.com.

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ELROD POPE LAW FIRM

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**Carolina Orthopaedic Surgery Associates, P.A.
Consent and Financial Responsibility**

Thank you for choosing COSA as your healthcare provider.

MEDICAL CONSENT: The undersigned consents for treatment by the physicians and staff of Carolina Orthopaedic Surgery Associates, P.A. This treatment may include office visits, laboratory testing, x-rays, physical therapy, MRIs or other medical treatment directly related to the patient's care.

The undersigned understands that medicine is not an exact science and diagnosis and treatment may involve risk. The undersigned also acknowledges that no guarantees have been made as to the results of examinations and/or treatment.

FINANCIAL RESPONSIBILITY: The undersigned acknowledges full responsibility for services rendered and agrees to make a definite financial arrangement for services rendered and understands that the charges made for professional services and supplies may not be covered by health insurance and therefore they are solely responsible for payment of all uncovered services. The undersigned understands that payment is expected at the time of service for all office visits, testing, supplies and services not covered by insurance including co-pay, deductibles and co-insurance.

Patients who are not covered by insurance are required to pay a minimum deposit established by the practice. This is a deposit and not to be considered as the total for services rendered. Balances are due at the time of treatment unless other arrangements have been made.

CONTACT FROM PRACTICE/AGENTS: When you provide us with a wireless telephone or land line number you are giving us and our representatives/agents your prior express consent to call that number.**LIABILITY CLAIMS:** The undersigned acknowledges that COSA does not accept third party liability as the sole means of payment for services. Payment is expected in full at the time of service unless other arrangements have been made. In the event of other medical insurance, all claim forms and subrogation forms must be completed prior to services being rendered. The undersigned authorizes COSA to establish a valid lien against any settlement, liability judgment or verdict as a result of said claim, for the full amount of services rendered and not previously paid by the patient.

The undersigned further authorizes and directs all Attorneys and Third Party Payers to pay directly to COSA any sums owing, including payments and adjustments from insurance carriers, prior to sums being distributed to the patient and within 15 days of settlement of said liability claim. COSA will, as required by contracts, refund insurance carriers for amounts previously paid on liability claims.

MEDICAL RECORDS: The undersigned authorizes COSA to release medical records, according to HIPAA guidelines, which relate to treatment rendered to insurance carriers, including workers compensation employees and some case managers for the purpose of payment of claims. This may include but is not limited to medical records, medical opinions and test results.**MEDICARE, MEDICAID, and GOVERNMENT AUTHORIZATIONS:** The undersigned certifies the information given in applying for payment of services provided under TITLE XVIII and XIX of the Social Security Act is correct and request payment to be made in their behalf. The undersigned states they do not have:

-Other group/private insurance that should be filed primary and has provided COSA with all insurance information

-Has not been involved in a third party liability claim for which another party is liable and if so, has provided COSA with detailed billing information as required

The undersigned further authorizes COSA to release information about treatment to the utilization and quality control peer review organization responsible for reviewing medical care.

ASSIGNMENT OF BENEFITS: The undersigned authorizes payment of medical, surgical, and all associated charges for services provided directly to Carolina Orthopaedic Surgery Associates, P.A.

A PHOTOSTATIC COPY OF THIS CONSENT SHALL BE AS VALID AS THE ORIGINAL. I/WE AGREE THIS AUTHORIZATION SHALL BE VALID FOR TWO YEARS.


Signature Patient/Primary Insured
Signature Patient/Spouse/Guardian4/4/12
Date

LETTIE SPENCER

Printed # 17221148

DOB: 11/28/1947 (64 years)

04/17/2012 10:09 AM

LETTIE B SPENCER DOB 11/28/1947

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dated with ElmDent trial version purchased at www.finnprint.com

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ELROD POPE LAW FIRM

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134 Professional Park Drive
Rock Hill, SC 29732
Phone: (803) 329-3130
Fax: (803) 329-2811LETTIE B SPENCER
04/04/2012 02:00 PM
Patient #: 179171-LS
DOB: 11/28/1947**History of Present Illness**

The patient is a 64 year old female who presents with a complaint of LUMBAR SPINE PAIN. The onset of the pain has been sudden and has been occurring in a persistent pattern for 9 months. The course has been constant. The pain is described as severe. Note for "LUMBAR SPINE PAIN".

CHIEF COMPLAINT: low back pain**REFERRING PHYSICIAN:** Dr Robert Bradley**PRIMARY CARE PHYSICIAN:** same**ACCOMPANIED BY:** spouse**WOULD YOU LIKE FOR THEM TO RECEIVE A COPY OF TODAY'S OFFICE NOTE?** yes

Patient states she was pushing a cart at work through a doorway the wheels got caught on the carpet/tile and she felt a sharp pain in her back. Patient states she has seen the company doctor and several other doctor's for this problem. Patient states she is wanting a 2nd opinion for this problem.

Subjective Transcription

She has been an LPN at a nursing home for about four years, employed by NHC Long Term Care. She was working for this company for 9 years when in Orlando, FL, but has been working for four years in this area. On 6/26/11, she was pushing a cart at work through the doorway and the wheel got caught on the carpet or tile, and she felt a sharp pain in her back. Symptoms extend from the back into the left leg towards the calf. She denies any bowel or bladder difficulties. She tried to pursue her regular duties but eventually had to go out of work and has not been naturally working since November 2011. She has been using a TENS unit. No specific light duty is available. She initially saw the company doctor and was then sent to a neurologist who felt that there is nothing really to do other than send it to a pain management program. She thus has been referred to Terry Owens, M.D., at South Carolina Pain Associates in Irmo, SC. She has been traveling back and forth from Richburg, SC near Rock Hill down to Irmo. She received ESI X 1 on 11/21/11, but this offered no relief. On 12/21/11, she apparently underwent lumbar medial branch radiofrequency blocks with no improvement. This apparently was dealing with a facet arthropathy seen on scans. Physical therapy was also initiated but this made matters worse. She is potentially released to return back to work on 4/19/12 but feels that she cannot really do this. She is extremely uncomfortable with her back difficulties, still having pain down the left leg. She cannot bend over. She cannot vacuum, use the dishwasher or do anything that requires any bending, leaning, stooping or twisting. She has been taking Nucynta 50 mg which really has not offered that much relief.

Health History Form is on the chart and reviewed with her, including medications and allergies.

SPENCER, LETTIE

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Allergies

PENICILLIN; rash swelling
DEMEROL; rash swelling

Past Medical History

No reported breathing problems
Hypertension
Thyroid Problem
None - Liver/Kidney
None - Neurologic
None - Blood
Hysterectomy
Crowns
Dentures
Vision Problems; glasses
General Anesthesia

Family History

Myocardial Infarction: Father
Hypertension: Mother

Social History

No Drug Use
Non Drinker/No Alcohol Use
Tobacco Use; 1/2 pack per day
Living Situation; spouse
Current Work/Study Status; Full-time

Medication History

potassium 20 mg (1 daily) Active.
Magnesium Oxide (400MG Tablet 1 Oral daily) Active.
Aldactone (25MG Tablet 1 Oral daily) Active.
Norvasc (10MG Tablet 1 Oral daily) Active.
Calcium Carbonate (600MG Tablet 1 Oral daily) Active.
Trazodone HCl (100MG Tablet 1 Oral daily) Active.
Klonopin (0.5MG Tablet 1 Oral daily) Active.
Crestor (20MG Tablet 1 Oral daily) Active.
Tapazole (10MG Tablet 1 Oral daily) Active.
Tricor (145MG Tablet 1 Oral daily) Active.
Fish Oil Concentrate (300MG Capsule 1 Oral daily) Active.
Nucynta ER (50MG Tablet ER 12HR 1 Oral every four-six hours with food, as needed for pain) Active.

Past Surgical

Hysterectomy
Cervical Dissection

Review of Systems

General: Not Present- Fever, Weight Gain and Weight Loss.
Skin: Not Present- New Lesions and Ulcers.
HEENT: Not Present- Visual Loss, Hearing Loss, Sleep Apnea, Hoarseness, Sore Throat and Voice Changes.
Respiratory: Not Present- Cough, Difficulty Breathing, Hemoptysis and Wheezing.
Cardiovascular: Present- Hypertension. Not Present- Chest Pain, Edema, Elevated Blood Pressure and Palpitations.
Gastrointestinal: Not Present- Abdominal Pain, Change in Bowel Habits, Difficulty Swallowing and Heartburn.
Neurological: Not Present- Difficulty Speaking and Visual Changes.
Psychiatric: Not Present- Change in Sleep Pattern and Mood changes.
Endocrine: Not Present- Appetite Changes, Cold Intolerance, Excessive Thirst, Excessive Urination and Hair Changes.
Hematology: Not Present- Abnormal Bleeding and Easy Bruising.

SPENCER, LETTIE

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04/04/2012 02:12 PM

Weight: 128 lb Height: 62 in

Body Surface Area: 1.59 m² Body Mass Index: 23.41 kg/m²

Pulse: 64 (Regular) P.OX: 95% (Room air)

Objective Transcription

Ms. Spencer is alert and conversant, oriented X 3. Vital signs are noted and recorded. She is accompanied by her husband. She obviously is severely uncomfortable and has to change positions frequently because of increasing back and left leg symptoms. There is very limited mobility at the lumbar spine. There is no specific motor, sensory or reflex deficit involving the left lower extremity with no pathologic reflexes. Peripheral pulses are normal. There is mild edema in both legs.

X-RAY: Personal review of the MR of the lumbar spine obtained at Chester Regional Medical Center on 7/22/11 did show hypertrophic facet arthropathy at the L3-4 level. At the L4-5 level, there were hypertrophic facet changes but also ligamentum thickening and a disc bulge extending into the inferior foramen at L4-5 bilaterally, with lateral recess narrowing, left greater than right. This would be consistent with symptoms.

Assessment & Plan**Unspecified Diagnosis****Current Plans:**

- Nucynta 75MG, 1-2 Tablet every six hours, as needed for pain, #40, 04/04/2012, No Refill. Active.

Assessments Transcription

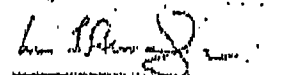
WORK INJURY 6/22/11 WITH PERSISTENT LOW BACK AND LEFT LEG RADICULAR SYMPTOMS, PROBABLY RELATED TO THE L4-5 LEVEL WITH EVIDENCE OF FORAMINAL STENOSIS AND LATERAL RECESS NARROWING LEFT GREATER THAN RIGHT.

Plan Transcription

I recommended further evaluation and treatment. She probably needs a CT myelogram to determine the extent of impingement at the L4-5 level. I increased Nucynta to 75 mg one to two every six hours as needed for pain and she hopefully would respond to perhaps a selective nerve root block prior to considering any surgical intervention. She has had Prednisone in the past and does not want to continue this. It does appear that she would be extremely limited in return back to work and would have to include sedentary work only with ability to change positions frequently. She will contact her attorney, Mr. Elrod, regarding transfer of her care so that I can evaluate her further and provide more effective treatment for this unfortunate woman.

William L. Lehman, Jr., M.D. / as 20083

c: Robert Bradley, M.D., Chester Internal Medicine, One Medical Park Drive, Bldg. 1, Ste. D, Chester, SC 29706 (fax: 803-581-0827)



Electronically signed by William L. Lehman

SPENCER, LETTIE

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134 Professional Park Drive
Rock Hill, SC 29732
Phone: 803-329-3130
Fax: 803-329-2811

Patient Name: LETTIE B SPENCER

Date of Birth: [REDACTED]

Account: 179171-LS

Date: 04/12/2012

To Whom It May Concern:

LETTIE B SPENCER was treated in our office on 04/12/2012. She was discharged at 05:22:54 PM. Please excuse LETTIE for this appointment.

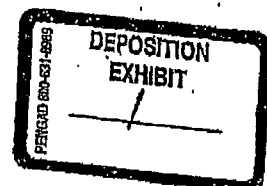
Work Restrictions / Additional Instructions

Sit Down Work Only WITH ABILITY TO CHANGE POSITIONS

If unable to accommodate restrictions patient should be out of work until next scheduled appointment.

If you have further questions regarding the patient's work status you must talk with the patient and have them contact our office. Due to HIPAA regulations we are unable to verbally confirm the appointment, work note or the work status of the patient without their signed consent unless they are covered under workers compensation.

William L. Lehman



SPENCER, LETTIE

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134 Professional Park Drive
Rock Hill, SC 29732
Phone: 803-329-3130
Fax: 803-329-3611

LETTIE B SPENCER

04/12/2012 05:20 PM

Patient #: 179171-LS

DOB: [REDACTED]

History of Present Illness

Assessment & Plan
Unspecified Diagnosis
Current Plans:

- * Sit Down Work Only WITH ABILITY TO CHANGE POSITIONS

Electronically signed by William L. Lehman

SPENCER, LETTIE

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SCANNED

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6237 Suite 313 Carolina Commons Drive
Indian Land, SC 29707
Phone: (803) 329-3130
Fax: (803) 329-2611

LETTIE B SPENCER
09/17/2012
Patient #: 179171-LS
DOB: ~~11-28-1947~~

History of Present Illness

The patient is a 64 year old female who is in today for TEST RESULTS. Note for "TEST RESULTS": ct lumbar myelogram

Subjective Transcription

She presents for further follow up regarding her work injury of 6/22/11, with back pain and left leg radicular symptoms. MR showing hypertrophic facet arthropathy L3-4, ligamentum thickening and disc bulging at L4-5. I had suggested a CT myelogram in my note of 4/4/2012. This has finally been completed. She has been to physical therapy which only made matters worse.

Previous Health History Form is reviewed and updated from 4/4/12.

Objective Transcription

Ms. Spencer is alert and conversant, oriented X3. Vital signs: Temperature - 98.2; Pulse - 75; Respiration - 15. There is satisfactory range of motion of the lumbar spine, though somewhat limited in flexion. There are radicular symptoms but no definite neurologic deficit.

X-RAY: Personal review of the CT myelogram lumbar spine did show interestingly no problem whatsoever other than the L4-5 level which did show mild central stenosis. No abnormality otherwise.

Assessment & Plan

Unspecified Diagnosis

Current Plans:

- Sit Down Work Only

Low Back Pain (724.2)

Current Plans:

THORACIC OR LUMBOSACRAL NEURITIS OR RADICULITIS, UNSPECIFIED (724.4)

Current Plans:

- REFERRAL / CONSULT (ADD COMMENTS); Routine (refer to Dr. Nandurkar for pain management/snrh left L-5).
- Nucynta 75MG, 1-2 Tablet every six hours, as needed for pain, #40, 09/17/2012, No Refill. Active.
- Neurontin 300MG, 1 Capsule three times daily, #60, 09/17/2012, No Refill. Active.
- Follow up in 3 - 4 weeks

SPENCER, LETTIE

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ROA 527

Assessments Transcription

WORK INJURY 6/22/11 WITH PERSISTENT BACK AND LEFT LEG RADICULAR SYMPTOMS.

Plan Transcription

I suggested a selective nerve root block on the left at L5 as this is the most likely nerve that is irritated from the L4-5 level. I recommended ongoing pain management, possibly by Dr. Nandurkar or someone in Charlotte. I also placed her on Neurontin 300 mg at bedtime gradually increasing to 300 mg tid. I refilled Nucynta 75 mg. Hopefully, we will be able to get her to pain management through Dr. Nandurkar which would be much more direct. I will be glad to see her back if she has any further difficulties, but will follow along to see if she receives authorization for these suggestions as outlined above.

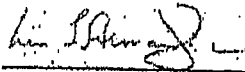
Ms. Pat Chambers, RN, CCM, Corvel Corporation, was available after examination for clarification and facilitation of care on behalf of Ms. Spencer.

She is able to work at light duty, though such apparently is not available. Her previous pain doctor, Tony Owens, M.D. at South Carolina Pain Associates in Columbia, SC, did recommend continued protective mobility, numbness and tingling of the right arm and hand. Electrical studies were to be helpful in this regard.

William L. Lehman, Jr., M.D. / as 801_1101

c: Robert Bradley, M.D., Chester Internal Medicine, One Medical Park Drive, Bldg. 1, Ste. D, Chester, SC 29706 (fax: 803-581-0827)

Pat Chambers, NCM, Corvel - fax: 866-440-6782



Electronically signed by William Lehman MD

SPENCER, LETTIE

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ROA 528



6237 Suite 313 Carolina Commons Drive
Indian Land, SC 29707
Phone: (803) 329-3130
Fax: (803) 329-2611

Procedure Order

Ordering Site

INDIAN LAND OFFICE
6237 Suite 313 Carolina Commons Drive
Indian Land, SC 29707
(803) 329-3130 X 206 Delores
Fax: (803) 329-2611
985-4580

Report Date: 10/29/2012

Patient Information

LETTIE B SPENCER
2867 GREAT FALLS HWY
RICHBURG, SC 29729
(407) 497-0358

Gender: Female Date of Birth: 11/28/1947 SSN (last 4 digits): 6627

Patient Insurance Information

PREMIER GROUP INS (866) 414-7442
Group #NONE
Plan #WC18202011021728

Procedures Ordered

REFERRAL / CONSULT (ADD COMMENTS)

Note: refer to Dr. Nandurkar for eval 7 SNRB LEFT L.S and pain management
Diagnosis: Radioulnitis (729.2)
Ordered by: William Lehman, MD

End of Procedures Ordered

Electronically signed by William Lehman MD

LETTIE B SPENCER

Patient #: 179171-15

DOB: 11/28/1947 (64 years)

Monday, October 29, 2012

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2012-10-30 15:14

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ROA 529



6287 Suite 313 Carolina Commons Drive
Indian Land, SC 29707
Phone: (803) 329-3130
Fax: (803) 329-2611

LETTIE B SPENCER
10/25/2012
Patient #: 179171-LS
DOB: ~~11/28/1947~~

History of Present Illness

The patient is a 64 year old female who presents for a recheck of Back pain.

Subjective Transcription

64 year old woman presents for further follow up regarding her work related injury which occurred on 6/12/11 when functioning as an LPN at National Health Care for approximately 3-1/2 years. I had been provided with extensive records from Columbia Neurosurgical Associates, Randall Dye, M.D. who saw her once upon referral from the company physician who saw her initially after the injury. She was referred for pain management to Tony Owens, M.D. at South Carolina Pain Associates in Columbia, SC. undergoing left sacroiliac joint injection on one occasion, radiofrequency ablation on the left at L3, S1 and S2, performed November and December 2011 with no relief. She has also undergone physical therapy which offered no relief.

She was on light duty until November 2011, but then her progressive symptoms required that she be out of work and has not been able to return to work since. She was referred for my evaluation in 9/17/2011, and she apparently paid for the appointment through her attorney since I was not the approved treating physician.

I had suggested a lumbar CT myelogram, as well as pain management through Dr. Nandurkar. The CT myelogram was finally approved and performed on 9/11/2012.

She continues to be out of work and is quite depressed, and has lost a considerable amount of weight because of the pain. She continues to have left leg pain extending to the calf, only moderately relieved by Nucynta 75 mg, as well as Neurontin 300 mg tid. She is becoming progressively more debilitated and depressed.

Previous Health History Form is reviewed and updated from 9/17/12.

SPENCER, LETTIE

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2012-10-30 15:14

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ROA 530

Objective Transcription

Ms. Spencer is alert and conversant, obviously quite depressed and very thin. Vital signs: Temperature - 98.4, Pulse - 78, Respiration - 15, General exam is otherwise unremarkable.

At the lower back, there is extreme tenderness to palpation over the lumbar paraspinal muscles with some paraspinal tension, no active spasm, kyphosis or scoliosis.

Patrick's maneuver increases pain in the back. This does appear to be consistent with SI joint pain and Faber does appear to be positive. There is very restricted motion diffusely about the lumbar spine created by pain. Bilateral hip range of motion is normal. Neurologic function to the cranial nerves is normal. Deep tendon reflexes are normal, and there is no clonus. There are no pathologic reflexes. There is decreased touch and pin prick sensation at the left lateral thigh and superior calf as compared to the opposite side. Peripheral pulses are normal. Gait is quite slow and deliberate but is reciprocal heel to toe.

X-RAY: Personal review of the CT myelogram of the lumbar spine, performed at Springs Hospital 9/11/12 shows a very poor study. There was considerable extra dural injection with paraspinal contrast at the L2-3 through L4-5 levels. This study is unlikely to be completely accurate. It does demonstrate, however, that there was significant but relatively mild changes of central canal stenosis at L4-5 with pathology at 9 mm diameter at the L4-5 level.

Assessment & Plan

Radiculitis (729.2)

Current Plans:

- REFERRAL / CONSULT (ADD COMMENTS); Routine (refer to Dr. Nandurkar for esi 7 ENRB LEFT L-5 and pain management)
- Neurontin 600MG, 1 Tablet three times daily, #90, 10/25/2012, No Refill. Active.
- Nucynta 75MG, 1-2 Tablet every six hours, as needed for pain, #40, 10/25/2012, No Refill. Active.
- Sit Down Work Only
- Follow up in 1 month or as needed

Assessments Transcription

WORK INJURY 6/12/11 WITH ONGOING BACK PAIN AND LEFT LEG RADICULAR SYMPTOMS, PROGRESSIVE WEIGHT LOSS AND DEPRESSION.

Plan Transcription

I recommended increasing Neurontin to 600 mg tid on a trial basis. I refilled Nucynta #40. Her condition appears to be deteriorating consistent and severely, to the point that I think that maybe it may be physically impossible for her to return back to her date of injury job or any suitable gainful employment. I believe it is of paramount importance to provide more effective treatment for this unfortunate woman.

I met with the case manager, Ms. Patty Chambers, RN, CCM, who thinks that Dr. Owens' rationale for the left SI joint and injection, as well as the facet blocks on the left side, may have occurred because the primary problem at that point was back pain. The leg symptoms are now seemingly more prominent, and I would recommend a trial of epidural steroid injection or selective nerve root block at the L5 level, even though the CT myelogram is not particularly useful. Pain management also appears to be appropriate.

If she does not respond to these treatments, a trial of a spinal cord dorsal column stimulator might be considered as well. I feel strongly that such referral to Dr. Nandurkar would be essential to further treatment of this unfortunate woman and does have the propensity to lessen the current level of disability. Ultimately, it is likely that there will be sufficient residual symptoms that Ms. Spencer will require alternative work activities, ideally based on MPE.

William L. Lehman, Jr., M.D. / as 801 1950

SPENCER, LETTIE

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1 >> Fvel Corporation P 3/4

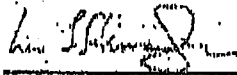
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2012-10-30 15:15

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ROA 531

c: Robert Bradley, M.D., Chester Internal Medicine, One Medical Park Drive, Bldg. 1, Ste. D,
Chester, SC 29706 (fax: 803-581-0827)
Patty Chambers, RN, CCM, nurse case manager, Corvel Corporation - fax: 866-440-6782
Premier Group Insurance, Claim #WC18202011021728, P.O. Box 1122, Murfreesboro, TN 37133



Electronically signed by William Lehman MD

SPENCER, LETTIE

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2012-10-30 15:15

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ROA 532

LETTIE B SPENCER

11/26/2012

Patient #: 179171-LS

DOB: ~~REDACTED~~

History of Present Illness

The patient is a 64 year old female who is in today for TEST RESULTS. Note for "TEST RESULTS": ct lumbar myelogram

Subjective Transcription

She presents for further follow up regarding work related injury to her lower back which occurred on 6/12/11 while functioning as an LPN, National Health Care, just previously being treated by Randall Drye, M.D., Columbia Neurosurgical Associates, then Tony Owens, M.D., Pain Management at South Carolina Pain Associates, Columbia, SC. She has undergone left SI joint injection as well as RF ablation on the left at L5-S1 and S2. She has been out of work since November 2011.

She has remained quite depressed and continues to lose weight to some extent, responding to some extent to Neurontin and Nucynta. A CT myelogram has been performed as of 9/11/11, which again, was a very poor study, showing some mild central stenosis L4-5 with 9 mm diameter centrally. She has responded a little bit to Neurontin, which was increased to 600 mg tid. She continues to require Nucynta. She still has mainly back pain but occasionally does have symptoms that extend into the left calf. I had recommended a left L5 selective nerve root block versus a spinal cord stimulator, but the referral has not been authorized as yet.

Previous Health History Form is reviewed and updated from 10/25/12.

Objective Transcription

Ms. Spencer is alert and conversant, oriented X 3. Vital signs are unchanged. She still has the appearance of someone who is very depressed and chronically ill. She apparently is only taking Trazodone which is mainly used for sleep. Her weight is 109 pounds. She does have radicular symptoms extending into the left calf. There is seemingly improved straight leg raise, but with continued decreased touch and pinprick sensation on the left lateral thigh and upper portion of the left calf as compared to the opposite side. Gait remains slow, deliberate, reciprocal heel to toe.

Assessment & Plan

Low back pain (724.2)

Current Plans:

- Neurontin 600MG, 1 Tablet three times daily, #60, 11/26/2012, No Refill. Active.
- Nucynta 75MG, 1-2 Tablet every six hours, as needed for pain, #40, 11/26/2012, No Refill. Active.
- Sit Down Work Only
- Follow up in 6 weeks or as needed

Chronic back pain (724.5)

Current Plans:

Stenosis of lumbosacral spine (724.02)

Current Plans:

Assessments Transcription

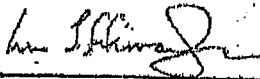
WORK INJURY 6/12/11 WITH ONGOING BACK AND LEFT LEG RADICULAR SYMPTOMS, MILD STENOSIS L4-5 CONSISTENT WITH SYMPTOMS, SEVERE DEPRESSIVE SYMPTOMATOLOGY.

Plan Transcription

She continues to require referral to Dr. Nandurkar requiring possible L5 selective nerve root block versus bone growth stimulator. I think she needs the decompression controlled before considering any more aggressive treatment. I continued Neurontin at 600 mg tid; and if she needs something more, such as Celexa, or otherwise. I refilled Nucynta 75 mg. I will see her back in three to four weeks for further follow up hoping that something will have happened at that point to treat her ongoing difficulties. It is obvious that she can pursue only sedentary work activity and this will likely per a work capacity for an extended period of time.
William L. Lehman, Jr., M.D. / as 801-2580

cc: Robert Bradley, M.D., Chester Internal Medicine, One Medical Park Drive, Bldg. 1, Ste. D, Chester, SC 29706 (fax: 803-581-0827)

Patty Chambers, RN, CCM, nurse case manager, Corvel Corporation - fax: 866-440-6782
Premier Group Insurance, Claim #WC18202011021728, P.O. Box 1122, Murfreesboro, TN 37133



Electronically signed by William Lehman MD

SPENCER, LETTIE

Page 2 / 2

SCANNED ⁶²

ROA 534

SPENCER, LETTIE F

Lehman, William L. MD

Lehman, William L. MD

REG SDC OPS

11/28/1947 64

09/11/2012

D006334539

M000594470

EXAM#	TYPE/EXAM	RESULT
000748585	RAD/MYELOGRAM-LUMBAR	

CLINICAL HISTORY: Back pain

EXAMINATION: Myelogram of the lumbar spine.

REPORT:

After informed signed consent and with procedure and risk explained to the patient and questions answered, lumbar myelogram performed using fluoroscopic guidance. Using sterile technique and 1% Xylocaine anesthesia, a 22-gauge spinal needle was used to gain access to the CSF space at the L4-L5 level and 12 mL of Isovue-M 200 contrast administered.

There were no immediate post procedure complications.

The exam documents mild spinal stenosis at the L4-L5 level. The exam does not demonstrate myelographic findings to suggest a focal disc herniation. Bony structures are intact.

IMPRESSION:

Findings of mild central canal stenosis at L4-L5, lumbar myelogram otherwise unremarkable.

** REPORT SIGNED IN OTHER VENDOR SYSTEM 09/11/2012 **
Reported By: TOMMY L. WEAVER, MD

CC: William L. Lehman MD

Technologist: JO C. TUCKER, RT
Transcribed Date/Time: 09/11/2012 (1257)
Transcriptionist: RAD.HAYVI
Printed Date/Time: 09/27/2012 (0854)

PAGE 1

Signed Report Printed From PCI

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ROA 536

SPENCER, LETTIE, F

F

D006334539

Lehman, William L. MD

REG SDC OPS

M000594470

Lehman, William L. MD

11/28/1947 64

09/11/2012

EXAM#	TYPE/EXAM	RESULT
000748584	CT/LUMBAR SPINE WITHOUT CONTRAS	

CLINICAL HISTORY: Back pain.

EXAMINATION: CT of the lumbar spine, post myelogram.

REPORT:

In this patient in which access to the CSF space was obtained fluoroscopically at the L4-L5 level, the injection in part was extradural in that there is some contrast about the paraspinal soft tissues at the L4-L5, L3-L4 and L2-L3 levels. The injection also had to breach the venous system at some time given the fact that there is some minimal contrast seen within the intrarenal collecting systems.

The field-of-view visualized from the upper endplate of T11 through the lower sacrum. Preserved vertebral body heights and alignment.

Distal cord and conus are of normal size and signal, conus ends L1.

The T11-T12 level is unremarkable.

The T12-L1 level is unremarkable.

The L1-L2 level is unremarkable.

The L2-L3 level is unremarkable.

The L3-L4 level is unremarkable.

The L4-L5 level demonstrates mild central canal stenosis related to annular disc bulging and facet arthropathy; the thecal sac triangularly shaped with the AP diameter of the spinal canal in the region of maximum pathology at about 9 mm.

The L5-S1 level is unremarkable

IMPRESSION:

Mild acquired central canal stenosis at the L4-L5 level as described.

PAGE 1

Signed Report Printed From PCI (CONTINUED)

ROA 537

SPENCER, LETTIE F

F

D006334539

Lehman, William L. MD

REG SDC OPS

M000594470

Lehman, William L. MD

11/28/1947 64.

09/11/2012

EXAM#	TYPE/EXAM	RESULT
000748584	CT/LUMBAR SPINE WITHOUT CONTRAS	
	<Continued>	

Remaining lumbar disc space levels without significant findings.

** REPORT SIGNED IN OTHER VENDOR SYSTEM 09/11/2012 **
Reported By: TOMMY L. WEAVER, MD

CC: William L. Lehman MD

Technologist: JULIE H. COX, RT(R)
Transcribed Date/Time: 09/11/2012 (1257)
Transcriptionist: RAD.HAYVI
Printed Date/Time: 09/27/2012 (0854)

PAGE 2

Signed Report Printed From PCI

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ROA 538



To: Leisa E. Smith Date Completed: 11/28/12
 From: Joanne Requestor's Extension: 1488
 Date Requested: 11/28/12 Hospital Service Code/Department: 138
 Patient Name: Leisa E. Spencer Admit/Discharge Dates: 9/11/12
 Account Number: [REDACTED] Medical Record Number: M594470 500
 Account Balance: 8644.13 DOB 11/28/47 ✓

Medical Record Copy Request

Check Appropriate Request

Emergency Department Record: _____

☒ 1st Request

Medical Records:

☐ 2nd Request

Abstract Only: X _____

☐ 3rd Request

Entire Chart: _____

Other: _____

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OCT 01 2012

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Please send to:

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 Address: PO Box 1122 Murfreesboro, TN 37133
Premier Group
P.O. Box 1122 murfreesboro TN 37133
 Attention: _____

Notes: _____

Explain Inquiry in Detail: _____

Date Shipped: _____ Tracking Number or Label: _____

HP
 9-27-12
 cm

70636962 ① 66

SPRINGS MEMORIAL HOSPITAL

800 West Meeting Street
Lancaster, SC 29720
REGISTRATION FORM

PATIENT DEMOGRAPHICS

ACCOUNT NO. ~~0000000000~~ ADMISSION DATE 09/11/12 MEDICAL RECORD NO. M000594470
ROOM/BED ~~0000000000~~ ADMISSION TIME 0803 FINANCIAL CLASS WORKERS COMPENSATI
TYPE ~~0000000000~~ DISCH DATE DISCH TIME SSN ~~0000000000~~ LOC/SVC OPS
PRIM LANGUAGE ENGLISH INTERP. PHONE

PATIENT NAME SPENCER, LETTIE F DOB 11/28/47 AGE 64 SEX F RACE W
STREET 2867 GREAT FALLS HWY HOME PHONE (803)581-2919
CITY/STATE/ZIP ~~0000000000~~ COUNTY
RELIGION MARITAL STATUS LEGALLY SEPARATED

PATIENT EMPLOYER PERSON TO NOTIFY
NAME DISABLED NAME NEENEY, GEORGIA
STREET STREET 2867 GREAT FALLS HWY
CITY/STATE/ZIP CITY/STATE/ZIP ~~0000000000~~
PHONE PHONE (803)581-2919 RELATIONSHIP CHILD

GUARANTOR/RESPONSIBLE PARTY NEXT OF KIN
NAME SPENCER, LETTIE NAME
STREET 2867 GREAT FALLS HWY STREET
CITY/STATE/ZIP RICHBURG, SC 29729-9286 CITY/STATE/ZIP
PHONE (803)581-2919 SOCIAL SECURITY # ~~0000000000~~ PHONE RELATIONSHIP

GUARANTOR EMPLOYER ACCIDENT/ARRIVAL/PHYSICIAN DATA
NAME DISABLED ACCIDENT DATE 06/22/11 TIME
STREET ARRIVAL MODE
CITY/STATE/ZIP ATTEND DR. Lehman, William L. MD
PHONE ADM/PAM DR. Lehman, William L. MD

INSURANCE PORTAL GROUP SUBSCRIBER
ADDRESS CITY STATE ZIP CODE PHONE

WORKMENS COMPENSATION WC18202011021728 SPENCER, LETTIE

REASON FOR VISIT SCIATICA, 724.2 ADMIT CLERK BUS.MOSTE
ACCIDENT TYPE EMPLOYMENT RELATED COMMENT PSNDT/TM

PATIENT DIAGNOSIS PATIENT PROCEDURES

CONSULTATIONS

PHYSICIAN'S SIGNATURE