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ORIGINAL

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM THE SOUTH CAROLINA WORKERS'
COMPENSATION COMMISSION APPELLATE PANEL

Gene McCaskill, Commissioner
Melody L. James, Commissioner
R. Michael Campbell, Commissioner

W.C.C. File No. 0802605
Appellate Case No.2015-002120

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peals

Tommy G. Houston, Employee, ... Respondent,

v.

Garda World Security, Employer, and Gallagher Bassett Services, Inc., Carrier, ... Appellants.

RECORD ON APPEAL – Vol. II

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(864) 235-6254
Attorney for Respondent

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Melody L. James, Commissioner
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W.C.C. File No. 0802605
Appellate Case No.2015-002120

Tommy G. Houston, ... Claimant,

v.

Garda World Security, ... Employer/Defendant,

and

Gallagher Bassett Services, Inc., ... Carrier/Defendant,

Of Whom

Defendants are Appellants,

and

Claimant is Respondent.

RECORD ON APPEAL – Vol. II

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(864) 235-6254
Attorney for Respondent

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Claimant's Name:	Tommy G. Houston	Employer's Name:	Garda World Security
Address:	204 Barton Street	Address:	2320 Presidential Dr.
City:	Easley State: SC Zip: 29640	City:	Durham State: NC ZIP: 27703
Home Phone:	(864) 855-0437	Work Phone:	
Carrier:		Carrier:	Gallagher Bassett Services Inc
Preparer's Name:	R. Daniel Addison	Preparer's Phone #:	(803) 727-1200

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

☒ Injury ☐ Illness ☐ Repetitive Trauma

1. Compensation Rate: \$411.32 2. AWW: \$616.96 Date of Injury: March 11, 2008
3. Type of injury and body part(s): Per prior consent order, admitted change of condition to right shoulder and low back. Alleged right shoulder, back, ribs, right knee, right hand, left hip, and left leg.
4. Facts in controversy: Scope and extent of compensable injuries. Whether Claimant has compensable injury to right knee? Whether Claimant is entitled to additional medical treatment for right knee? Defendants' liability for additional medical treatment.
5. Legal issues involved: S.C. Code § 42-15-60;
6. Unusual aspects: None
7. Witnesses (designate if expert)* Claimant; anyone called by Claimant; Dr. John Paylor (via deposition); Dr. Jyoti Math (via deposition); Dr. Phillip Wessinger (via deposition – to be submitted upon receipt, deposition currently scheduled for October **, 2014. Defendants request record be held open)
8. Exhibits: None
9. Medical evidence: (indicate report pursuant to R.67-612; deposition or appearance): See Attached APA.

10. Name, address, and specialty, if any, of the treating physician: Dr. Phillip Wessinger, Steadman Hawkins, 727 SE Main St. Suite 220, Simpsonville, S.C. Dr. Michael Bucci, Piedmont Spine and Neurosurgical Group, 3 St. Francis Dr., Suite 490, Greenville, S.C.; Dr. Charles Kanos, S.E. Neurosurgery, 109 Doctors Dr., Greenville, S.C.

11. Impairment rating(s); body part(s); physician and date of opinion: 25% lumbar spine, Dr. Kanos, April 24, 2013

12. I am amending my Form 50/51 in the following manner N/A

☐ **Mediation**

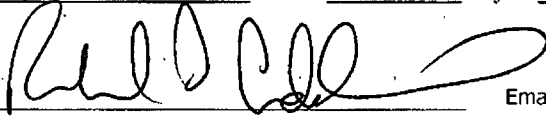
- ☐ a. Mediation is requested to be ordered pursuant to Reg. 67-1801 B
- ☐ b. Mediation is required pursuant to Reg. 67-1802.
- ☐ c. Mediation is requested by consent of the Parties pursuant to Reg. 67-1803.
- ☐ d. Mediation has been conducted by a duly qualified mediator and resulted in impasse.

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

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

I certify I have served this document pursuant to Reg. 67-211 by delivering a copy to Kathryn Williams

Address P.O. Box 10693, Greenville, SC 29603 on the 19th day of September, 2014, by ☒ first class postage ☐ certified mail ☐ personal service

Signature:  Email: daddison@hedrickgardner.com

Date of Hearing October 1, 2014 Time needed for hearing: 1 hour

On behalf of ☐ Claimant ☒ Employer

Questions about the use of this form should be directed to the Jurisdictional Commissioner. Refer to Regulations 57-204 through 67-211 and Regulations 67-601 through 67-615; as well as Regulation 67-1801. File this form and proof of service on the opposing party according to R.67-611 and R.67-212. Do not send medical reports. * Commissioners reserve the right to admit expert witnesses at hearings.

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
WCC NO. 0802605

TOMMY G. HOUSTON,

Claimant,

vs.

GARDA WORLD SECURITY,

Employer,

and

GALLAGHER BASSETT SERVICES INC,

Carrier.

**NOTICE OF WITNESSES AND
WRITTEN REPORT(S) PHYSICIAN OR
OTHER EVIDENCE TO BE
INTRODUCED ON BEHALF OF THE
EMPLOYER/CARRIER**

**TO: SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION AND
KATHRYN WILLIAMS, ATTORNEY FOR CLAIMANT:**

YOU ARE HEREBY NOTIFIED THAT THE employer/carrier, pursuant to the provisions of the South Carolina Workers' Compensation Act and South Carolina Code §1-23-330 (1976, as amended), herewith submits the following reports/physicians or other evidence on behalf of the employer/carrier, to wit:

TAB	NAME OF PHYSICIAN/OTHER	DATE OF REPORTS	NO.
13	Dr. Phillip Wessinger	4/30/08-11/3/10	192-238
14	Piedmont Spine and Neurosurgical Group	4/21/11-6/28/11	239-249
15	Dr. Jyoti Math	8/18/11-12/16/13	250-291
16	Dr. Charles Kanos	8/1/12-4/24/13	292-308
17	Upstate Medical Rehabilitation	1/4/12-4/15/14	309-370
18	Dr. John Paylor	10/28/13-12/18/13	371-379
19	Bon Secours/St. Francis Hospital	1/21/13-4/10/13	380-402
20	Greenville Hospital System	3/11/08	403-405
21	Diagnostic Health	5/14/08	406-407
22	Innervisions	9/8/10-8/20/12	408-415
23	SC Diagnostic Imaging	6/25/13	416
24	Greenville Memorial Hospital	12/12/12	417-419

YOU ARE FURTHER HEREBY NOTIFIED that you have the right to cross-examination; and, should you desire to exercise said right, you are to forthwith schedule the deposition(s) of any of the physicians or other person(s), whose reports are submitted, for the purposes of cross-examination.

YOU ARE FURTHER HEREBY NOTIFIED that the originals of the documents referred herein, or photocopies received from said physicians/others, are being herewith forwarded to the South Carolina Workers' Compensation Commission, for insertion in the file of the South Carolina Workers' Compensation Commission and inclusion into evidence on behalf of the employer.

YOU ARE FURTHER NOTIFIED that the following witnesses may be called on behalf of the employer/carrier:

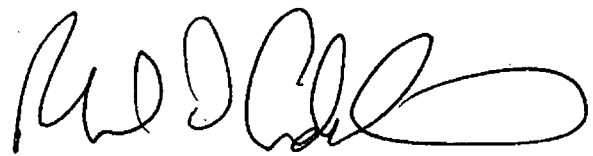
Claimant

Anyone named by Claimant

Dr. John Paylor (via deposition)

Dr. Jyoti Math (via deposition)

Dr. Phillip Wessinger (via deposition)



R. Daniel Addison
HEDRICK GARDNER KINCHELOE &
GAROFALO, LLP
P.O. Box 11267
Columbia, SC 29211
(803) 727-1200
Attorneys for Defendant(s)

September 19, 2014

TOMMY G. HOUSTON v. GARDA WORLD SECURITY

WCC No. : 0802605

DOI: March 11, 2008

APA COVERSHEET

TAB	NAME OF PHYSICIAN/OTHER	DATE OF REPORTS	NO.
13	Dr. Phillip Wessinger	4/30/08-11/3/10	192-238
14	Piedmont Spine and Neurosurgical Group	4/21/11-6/28/11	239-249
15	Dr. Jyoti Math	8/18/11-12/16/13	250-291
16	Dr. Charles Kanos	8/1/12-4/24/13	292-308
17	Upstate Medical Rehabilitation	1/4/12-4/15/14	309-370
18	Dr. John Paylor	10/28/13-12/18/13	371-379
19	Bon Secours/St. Francis Hospital	1/21/13-4/10/13	380-402
20	Greenville Hospital System	3/11/08	403-405
21	Diagnostic Health	5/14/08	406-407
22	Innervisions	9/8/10-8/20/12	408-415
23	SC Diagnostic Imaging	6/25/13	416
24	Greenville Memorial Hospital	12/12/12	417-419

Progress Notes

Patient: HOUSTON, TOMMY GREGORY
DOB: 02/18/1956 **Age:** 52 Y **Sex:** Male
Phone: 864-855-0437
Address: 204 BARTON ST, PO BOX 1099, EASLEY, SC-29640

Provider: Philip Wessinger, M.D.
Date: 04/30/2008

Subjective:

CC:

1. RIGHT SHOULDER PAIN. 2. W/C.

HPI:

History of Present Illness:

This is a 52-year-old who comes in. Worked for AT Systems in an armored car service where, on 03/11, his partner, the driver, pulled out and their armored car was hit. He was bouncing around in the back like a pinball in a pinball machine, as he says. He states he had several rib fractures on the right. He initially had right knee pain. Those have improved. However, he since has continued to have increased problems with left shoulder pain that is difficult with overhead activities. The patient also has developed a left hip pain that radiates down to the knee. He states that this is intermittent and comes and goes; however, his shoulder has continued to be more persistent.

What: Right shoulder, left hip. When: 03.11.08. How: MVC. Pain: Severity: pain = 2/10 aching pain.

ROS:

CONSTITUTIONAL:

Fever no. Weight Loss no. Weight Gain no. Fatigue no. Chills no. Night Sweats no.

CARDIOVASCULAR:

Chest Pain no. Irregular Heart Beat no. Poor Circulation no. Leg/feet swelling no. Leg/foot ulcer no.

GENITOURINARY:

Blood in urine no. Pain in urinating no. Unable to urinate no. Bladder Infection no. Frequent Urination no. Difficulty with urination no.

NEUROLOGICAL:

Paralysis no. Frequent Headaches no. Seizures no. CVA/ITA no. Syncope no. Anxiety/Depression no. Tremors no. Speech Problems no. Feeling of hopelessness no. Sleep disturbance no. Vision Changes no.

EYES:

Decreased Vision no. Cataracts no.

RESPIRATORY:

COPD no. Asthma no. Persistent Cough no. Shortness of Breath no. Wheezing no. Pneumonia no.

ENT:

Loss of Hearing no. Sinusitis **yes**. Headache no.

GASTROINTESTINAL:

GERD no. PUD/Gastritis no. Liver Problems no. Stomach Pain no. Diarrhea no. Abdominal Pain no. Nausea/Vomiting no. Black tar-like or bloody stool no.

SKIN:

no Rash, no. Dryness of Skin no. Ulcer no. Cancer no. Open sores no. New Moles no. Poor Healing no. Skin Infection no.

PSYCHIATRIC:

Depression no. Bipolar Disease no.

ENDOCRINE:

Diabetes no. Thyroid no. Heat intolerance no. Cold intolerance no.

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Philip Wessinger,
M.D. 04/30/2008

HEME/LYMP:

Anemia no. Bleeding Problems no. Blood Transfusion no. Bruises no.

ALLERGIC/IMMUNOLOGIC:

Seasonal **yes**. Iodine no. Food Allergies no.

MUSCULOSKELETAL:

Joint Swelling no. Muscle aches no. Joint Pain no. Pain in multiple joints no. Weakness no.

Medical History: Hypertension.

Family History:

Social History:

Medications: metoprolol 25 mg 1 tab(s) once a day, clonidine 0.1 mg 0.5 tab (0.05mg) QHS

Allergies: Codeine.

Objective:

Examination:

General

General Appearance: Well and in no acute distress. Cardiovascular: Regular rhythm by palpation of distal pulse, normal color and temperature, no concerning varicosities on symptomatic side. Lungs: Breathing easily. Psychiatric: Well-oriented with a normal mood and affect.

Examination

On physical examination, this is a well-appearing white male in no apparent distress. He does have mild-to-moderate pain through his shoulder, particularly with overhead activity. He has a positive Hawkins test and Neer test.

Assessment:

Assessment:

1. Subacromial Impingement - 726.19 (Primary)

2. Bursitis of hip - 726.5

; X-rays demonstrate no fracture, subluxation, or dislocation. His left hip demonstrates tenderness to palpation, but the hip x-ray, pelvis x-rays demonstrate no fracture. He thinks that the hip is much better than it has been. Impression: Subacromial impingement on the right and traumatic bursitis. Possible traumatic bursitis of the left greater trochanter.

Plan:

1. Others

We will go ahead and inject the right shoulder today. Have him come back to see me in a week. bi

Immunizations:

Diagnostic Imaging: Hip, 1 view Brainin,Fay 04/30/2008 04:11:46 PM EDT > Left hip lateral only., Shoulder, 3 views Brainin,Fay 04/30/2008 04:12:26 PM EDT > Right shoulder ap /outlet /axillary.

Procedure Codes: HIP (1 VIEW) X-RAY, SHOULDER (2 OR MORE VIEWS) X-RAY

Preventive:

Follow Up: 1 Week

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Philip Wessinger,
M.D. 04/30/2008

Provider: Philip Wessinger, M.D.
Patient: HOUSTON, TOMMY GREGORY **DOB:** 02/18/1956 **Date:** 04/30/2008

Provider: Philip Wessinger, M.D.
Patient: HOUSTON, TOMMY GREGORY **DOB:** 02/18/1956 **Date:** 04/30/2008

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Philip Wessinger,
M.D. 04/30/2008

Progress Notes

Patient: HOUSTON, TOMMY GREGORY
DOB: 02/18/1956 **Age:** 52 Y **Sex:** Male **EncId:** 1376191
Phone: 864-855-0437
Address: 204 BARTON ST, PO BOX 1099, EASLEY, SC-29640

Provider: Philip Wessinger, M.D.
Date: 05/07/2008

Subjective:**CC:**

1. SHC 1 WK RECK RT SHOULDER.

HPI:Interim History:

Prior Assessment(s): Subacromial Impingement, Bursitis of hip . Treatment to Date: Steroid Injection 04.30.08. Response to treatment: patient states feeling the same since last visit. Pain: Severity: pain = 4/10 constant stabbing , aching pain, not satisfactorily controlled, pt resorts no relief from previous injection.

HPI:

The patient comes in today. He states that the subacromial injection we gave him at his last visit did not improve his symptoms at this point. He actually had 2 or 3 days where he felt worse. He states he also developed significant sciatica that ran down the back of his left leg and ran halfway through the calf.

ROS:

Pt reports no change in review of system since 04.30.08

Medical History: Hypertension.

Surgical History: left wrist 1978, right knee 1974, hernia 9/07.

Family History: Family: diabetes

Social History:

Medications: metoprolol 25 mg 1 tab(s) once a day, clonidine 0.1 mg 0.5 tab (0.05mg) QHS

Allergies: Codeine.

Objective:**Examination:**Examination

On physical examination, the patient continues to have decreased range of motion of the shoulder. Positive Neer sign, Hawkins' sign. Rotator cuff strength is marginal. Does have pain through the sciatic notch but also there is tenderness over the greater trochanteric bursa.

Therapeutic Interventions:**Assessment:****Assessment:**

1. Subacromial Impingement - 726.19 (Primary)
 2. Bursitis of hip - 726.5
- ; Impression is peritrochanteric bursitis, sciatica, shoulder possible rotator cuff tear. .

Plan:

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Philip Wessinger,
M.D. 05/07/2008

1. Subacromial Impingement Start Medrol Dose Pack tablet, orally, 1 pack, as directed, Refills 0 .

2. Others

Plan will be to go ahead and get a MRI for his rotator cuff. Give him Medrol Dosepak for his sciatica. Did not inject his bursa at this point. le

Immunizations:

Preventive:

Follow Up: mri

Provider: Philip Wessinger, M.D.

Patient: HOUSTON, TOMMY GREGORY **DOB:** 02/18/1956 **Date:** 05/07/2008

Patient: HOUSTON, TOMMY GREGORY **DOB:** 02/18/1956 **Progress Note:** Philip Wessinger,
M.D. 05/07/2008

Progress Notes

Patient: HOUSTON, TOMMY GREGORY
DOB: 02/18/1956 **Age:** 52 Y **Sex:** Male
Phone: 864-655-0437
Address: 204 BARTON ST, PO BOX 1099, EASLEY, SC-29640

Provider: Philip Wessinger, M.D.
Date: 05/21/2008

Subjective:

CC:

1. RECHECK.

HPI:

Interim History:

The patient comes in today, he is doing fairly well. He is 52 years old. He has tenderness along the lateral aspect of his greater trochanteric bursa. Did do better after Medrol Dose Pak. His right shoulder has MRI which demonstrates he has a rotator cuff tear of the supraspinatus tendon, either near full or full-thickness in nature.

Prior Assessment(s): Right shoulder recheck. Treatment to Date: MRI.

ROS:

no changes since last visit

Medical History: Hypertension.

Surgical History: left wrist 1978, right knee 1974, hernia 9/07.

Family History: Family: diabetes

Social History:

Medications: Medrol Dose Pack as directed, metoprolol 25 mg 1 tab(s) once a day, clonidine 0.1 mg 0.5 tab (0.05mg) QHS

Allergies: Codeine.

Objective:

Examination:

General

General Appearance: Well and in no acute distress. Cardiovascular: Regular rhythm by palpation of distal pulse, normal color and temperature, no concerning varicosities on symptomatic side. Lungs: Breathing easily. Psychiatric: Well-oriented with a normal mood and affect.

Physical Examination:

Has weakness in abduction, has tenderness over his greater trochanter.

Therapeutic Interventions:

Assessment:

Assessment:

1. Rotator cuff tear - 727.61 (Primary)
2. Bursitis of hip - 726.5 (Primary)

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Philip Wessinger,
M.D. 05/21/2008

Plan:

1. Rotator cuff tear

Go ahead and inject his left greater trochanteric bursa. Will also go ahead and schedule him for an arthroscopic rotator cuff repair.

Immunizations:

Preventive:

Follow Up: sx

Provider: Philip Wessinger, M.D.

Patient: HOUSTON, TOMMY GREGORY **DOB:** 02/18/1956 **Date:** 05/21/2008

Patient: HOUSTON, TOMMY GREGORY **DOB:** 02/18/1956 **Progress Note:** Philip Wessinger,
M.D. 05/21/2008

Progress Notes

Patient: HOUSTON, TOMMY G
DOB: 02/18/1956 **Age:** 52 Y **Sex:** Male
Phone: 864-855-0437
Address: 204 BARTON ST, PO BOX 1099, EASLEY, SC-29640

Provider: Philip Wessinger, M.D.
Date: 06/25/2008

Subjective:**CC:**

1. RIGHT SHOULDER PAIN.

HPI:Interim History:

The patient was scheduled for rotator cuff repair that we will do on July 7. However, he states he had good improvement from his greater trochanteric bursal injection until last week. He had a re-flare with regard to it and would like to repeat that injection, particularly pending his upcoming surgery.

Prior Assessment Rotator cuff tear, Bursitis of hip. Treatment to Date: MRI. Response to treatment: patient states feeling the same since last visit. Pain: Severity: pain = 5/10 intermittent dull, aching, burning.

ROS:CONSTITUTIONAL:

Fever no. Weight Loss no. Weight Gain no. Fatigue no. Chills no. Night Sweats no.

CARDIOVASCULAR:

Chest Pain no. Irregular Heart Beat no. Poor Circulation no. Leg/feet swelling no. Leg/foot ulcer no.

GENITOURINARY:

Blood in urine no. Pain in urinating no. Unable to urinate no. Bladder Infection no. Frequent Urination no. Difficulty with urination no.

NEUROLOGICAL:

Paralysis no. Frequent Headaches no. Seizures no. CVA/ITA no. Syncope no. Anxiety/Depression no. Tremors no. Speech Problems no. Feeling of hopelessness no. Sleep disturbance no. Vision Changes no.

EYES:

Decreased Vision no. Cataracts no.

RESPIRATORY:

COPD no. Asthma no. Persistent Cough no. Shortness of Breath no. Wheezing no. Pneumonia no.

ENT:

Loss of Hearing no. Sinusitis no. Headache no.

GASTROINTESTINAL:

GERD no. PUD/Gastritis no. Liver Problems no. Stomach Pain no. Diarrhea no. Abdominal Pain no. Nausea/Vomiting no. Black tar-like or bloody stool no.

SKIN:

no Rash, no. Dryness of Skin no. Ulcer no. Cancer no. Open sores no. New Moles no. Poor Healing no. Skin Infection no.

PSYCHIATRIC:

Depression no. Bipolar Disease no.

ENDOCRINE:

Diabetes no. Thyroid no. Heat intolerance no. Cold intolerance no.

HEME/LYMP:

Anemia no. Bleeding Problems no. Blood Transfusion no. Bruises no.

ALLERGIC/IMMUNOLOGIC:

Seasonal no. Iodine no. Food Allergies no.

Patient: HOUSTON, TOMMY G DOB: 02/18/1956 Progress Note: Philip Wessinger, M.D. 06/25/2008

MUSCULOSKELETAL:

Joint Swelling no. Muscle aches no. Joint Pain no. Pain in multiple joints no. Weakness no.

Medical History: Hypertension.

Surgical History: left wrist 1978, right knee 1974, hernia 9/07.

Family History: Family: diabetes

Social History:

Medications: Medrol Dose Pack as directed, metoprolol 25 mg 1 tab(s) once a day, clonidine 0.1 mg 0.5 tab (0.05mg) QHS

Allergies: Codeine.

Objective:

Examination:

General

General Appearance: Well and in no acute distress. Cardiovascular: Regular rhythm by palpation of distal pulse, normal color and temperature, no concerning varicosities on symptomatic side.

Lungs: Breathing easily. Psychiatric: Well-oriented with a normal mood and affect.

~~On physical exam, the patient has tenderness over the greater trochanter, tenderness with range of motion of the hip.~~

Therapeutic Interventions:

Assessment:

Assessment:

1. Rotator cuff tear - 727.61 (Primary)
2. Bursitis of hip - 726.5 (Primary)

Plan:

1. Rotator cuff tear

The plan will be to go ahead and inject left greater trochanter. He will come back to see me here after surgery.

Immunizations:

Preventive:

Follow Up: p op

Provider: Philip Wessinger, M.D.

Patient: HOUSTON, TOMMY G **DOB:** 02/18/1956 **Date:** 06/25/2008

Patient: HOUSTON, TOMMY G DOB: 02/18/1956 Progress Note: Philip Wessinger, M.D. 06/25/2008

Progress Notes

Patient: HOUSTON, TOMMY G
DOB: 02/18/1956 **Age:** 52 Y **Sex:** Male
Phone: 864-855-0437
Address: 204 BARTON ST, PO BOX 1099, EASLEY, SC-29640

Provider: Philip Wessinger, M.D.
Date: 07/23/2008

Subjective:

CC:

1. SHC: RT SHOULDER, GLOBAL 10.9.08.

HPI:

Interim History:

Prior Assessment Subacromial Impingement, Bursitis of hip. Date of Surgery: 07.11.08 RT SHOULDER SCOPE, ROTATOR CUFF REPAIR. Treatment to Date: Steroid Injection 04.30.08. Response to treatment: patient states feeling better since last visit. Pain: Severity: pain = 5/10 dull pain.

HPI:

The patient comes in today, a 52-year-old who is doing fairly well status post rotator cuff repair. It turned out he had a 3-cm tear that required a repair. He is tolerating this well. He is in physical therapy.

ROS:

CONSTITUTIONAL:

Fever no. Weight Loss no. Weight Gain no. Fatigue no. Chills no. Night Sweats no.

CARDIOVASCULAR:

Chest Pain no. Irregular Heart Beat no. Poor Circulation no. Leg/feet swelling no. Leg/foot ulcer no.

GENITOURINARY:

Blood in urine no. Pain in urinating no. Unable to urinate no. Bladder Infection no. Frequent Urination no. Difficulty with urination no.

NEUROLOGICAL:

Paralysis no. Frequent Headaches no. Seizures no. CVA/ITA no. Syncope no. Anxiety/Depression no. Tremors no. Speech Problems no. Feeling of hopelessness no. Sleep disturbance no. Vision Changes no.

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Decreased Vision no. Cataracts no.

RESPIRATORY:

COPD no. Asthma no. Persistent Cough no. Shortness of Breath no. Wheezing no. Pneumonia no.

ENT:

Loss of Hearing no. Sinusitis no. Headache no.

GASTROINTESTINAL:

GERD no. PUD/Gastritis no. Liver Problems no. Stomach Pain no. Diarrhea no. Abdominal Pain no. Nausea/Vomiting no. Black tar-like or bloody stool no.

SKIN:

no Rash, no. Dryness of Skin no. Ulcer no. Cancer no. Open sores no. New Moles no. Poor Healing no. Skin Infection no.

PSYCHIATRIC:

Depression no. Bipolar Disease no.

ENDOCRINE:

Diabetes no. Thyroid no. Heat intolerance no. Cold intolerance no.

HEME/LYMP:

Anemia no. Bleeding Problems no. Blood Transfusion no. Bruises no.

ALLERGIC/IMMUNOLOGIC:

Patient: HOUSTON, TOMMY G **DOB:** 02/18/1956 **Progress Note:** Philip Wessinger, M.D. 07/23/2008

Seasonal no. Iodine no. Food Allergies no.
MUSCULOSKELETAL:

Joint Swelling no. Muscle aches no. Joint Pain no. Pain in multiple joints no. Weakness no.

Medical History: Hypertension.

Surgical History: left wrist 1978, right knee 1974, hernia 9/07.

Family History: Family: diabetes

Social History: no Alcohol. no Smoking. no Recreational drug use. no Use of marijuana, cocaine, or similar drugs.

Medications: metoprolol 25 mg 1 tab(s) once a day, clonidine 0.1 mg 2.5 tab (0.05mg) QHS

Allergies: Codeine.

Objective:

Examination:

General

General Appearance: Well and in no acute distress. Cardiovascular: Regular rhythm by palpation of distal pulse, normal color and temperature, no concerning varicosities on symptomatic side.
Lungs: Breathing easily. Psychiatric: Well-oriented with a normal mood and affect.

Therapeutic Interventions:

Assessment:

Assessment:

1. Subacromial Impingement - 726.19 (Primary)
2. Bursitis of hip - 726.5
3. Rotator cuff tear - 727.61

Plan:

1. Others

He is to come back to see me here in 4 weeks. We have gone ahead and removed his sutures. The wound has healed nicely. Have written for some more oxycodone, if he needs it. He is to come back to see me here in 4 weeks. kds

Immunizations:

Preventive:

Follow Up: 6 Weeks, 4 Weeks

Provider: Philip Wessinger, M.D.

Patient: HOUSTON, TOMMY G **DOB:** 02/18/1956 **Date:** 07/23/2008

Patient: HOUSTON, TOMMY G **DOB:** 02/18/1956 **Progress Note:** Philip Wessinger, M.D. 07/23/2008

Progress Notes

Patient: HOUSTON, TOMMY G
DOB: 02/18/1956 **Age:** 52 Y **Sex:** Male
Phone: 864-855-0437
Address: 204 BARTON ST, PO BOX 1099, EASLEY, SC-29640

Provider: Philip Wessinger, M.D.
Date: 07/11/2008

Subjective:

CC:

1. SHC:RT SHOULDER SCOPE, ROTATOR CUFF REPAIR ssu.

HPI:

Medical History: Hypertension.

Family History:

Social History:

Medications: None

Allergies: Codeine.

Objective:

Examination:

Therapeutic Interventions:

Assessment:

Assessment:

1. Rotator cuff tear - 727.61 (Primary)
2. Subacromial Impingement - 726.19

Plan:

1. Rotator cuff tear
29827

2. Subacromial Impingement
29826

Immunizations:

Preventive:

Follow Up: 2 Weeks

Provider: Philip Wessinger, M.D.

Patient: HOUSTON, TOMMY G **DOB:** 02/18/1956 **Date:** 07/11/2008

Patient: HOUSTON, TOMMY G **DOB:** 02/18/1956 **Progress Note:** Philip Wessinger, M.D. **07/11/2008**

Progress Notes

Patient: HOUSTON, TOMMY G
DOB: 02/18/1956 **Age:** 52 Y **Sex:** Male **EncId:** 1553393
Phone: 864-855-0437
Address: 204 BARTON ST, PO BOX 1099, EASLEY, SC-29640

Provider: Philip Wessinger, M.D.
Date: 09/03/2008

Subjective:

CC:

1. RIGHT SHOULDER PAIN.

HPI:

Interim History:

Prior Assessment Subacromial Impingement, Bursitis of hip, Rotator cuff tear. Date of Surgery: 07.11.08 RT SHOULDER SCOPE, ROTATOR CUFF REPAIR. Treatment to Date: Steroid Injection 04.30.08. Response to treatment: patient states feeling better since last visit. Pain: Severity: pain = 5/10 shoulder pain aching, and burning, left hip pain sharp, stabbing pain.

HPI:

This is a 52-year-old who comes in status post large rotator cuff repair. However, he is complaining primarily of hip pain today. We have injected this in the past with good results. He would like to have another injection today. He is making progress in his physical therapy.

ROS:

Pt reports no change in review of system since 07.23.08

Medical History: Hypertension.

Surgical History: left wrist 1978, right knee 1974, hernia 9/07.

Family History: Family: diabetes

Social History: no Alcohol. no Smoking. no Recreational drug use. no Use of marijuana, cocaine, or similar drugs.

Medications: metoprolol 25 mg 1 tab(s) once a day, clonidine 0.1 mg 0.5 tab (0.05mg) QHS

Allergies: Codeine.

Objective:

Examination:

General

General Appearance: Well and in no acute distress Cardiovascular: Regular rhythm by palpation of distal pulse, normal color and temperature, no concerning varicosities on symptomatic side
Lungs: Breathing easily Psychiatric: Well-oriented with a normal mood and affect

Examination

Has a well-healed surgical scar. Good range of motion of the shoulder. Tenderness over the greater trochanter.

Therapeutic Interventions:

Assessment:

Assessment:

1. Subacromial Impingement - 726.19 (Primary)
2. Bursitis of hip - 726.5

Patient: HOUSTON, TOMMY G DOB: 02/18/1956 Progress Note: Philip Wessinger, M.D. 09/03/2008

3. Rotator cuff tear - 727.61
; Recurrent bursitis of the hip as well as rotator cuff tear. .

Plan:

1. Subacromial Impingement Start oxycodone capsule, 5 mg, orally, 30, 1 cap(s), Q6H, Refills 0 .

2. Others

Continue physical therapy. We will go ahead with an injection of his hip. He has tolerated this well. Come back to see me here in 4 weeks.

Immunizations:

Preventive:

Follow Up: 4 Weeks

Provider: Philip Wessinger, M.D.

Patient: HOUSTON, TOMMY G **DOB:** 02/18/1956 **Date:** 09/03/2008

Patient: HOUSTON, TOMMY G DOB: 02/18/1956 Progress Note: Philip Wessinger, M.D. 09/03/2008



UNIVERSITY MEDICAL GROUP
Woodman Institute, Clinic of the Carolinas

HOUSTON, TOMMY G

52 Y old Male, DOB: 02/18/1956
204 BARTON ST, PO BOX 1099, EASLEY, SC-29640
Home: 864-855-0437

Guarantor: HOUSTON, TOMMY G Insurance: UNITED HEALTHCARE

10/01/2008

Progress Notes: Philip Wessinger, M.D.

Current Medications

metoprolol 25 mg 1 tab(s) once a day
clonidine 0.1 mg 0.5 tab (0.05mg) QHS

Past Medical History

Hypertension

Surgical History

left wrist 1978
right knee 1974
hernia 9/07

Family History

Family: diabetes

Social History

no Alcohol.
no Smoking.
no Recreational drug use.
no Use of marijuana, cocaine, or similar drugs.

Allergies

codeine

Review of Systems

Pt reports no change in review of system since 07.23.08

Reason for Appointment

1. RIGHT SHOULDER PAIN

History of Present Illness

Interim History:

Prior Assessment Subacromial Impingement, Bursitis of hip, Rotator cuff tear. Date of Surgery: 07.11.08 RT SHOULDER SCOPE, ROTATOR CUFF REPAIR. Treatment to Date: Steroid Injection 04.30.08, Physical Therapy, Steroid Injection Hip 9.03.08. Response to treatment: patient states feeling better since last visit. Pain: Severity: pain = 2/10 intermittent aching, burning pain.

HPI:

The patient comes in today status post large rotator cuff tear. He is doing well from physical therapy. He states his steroid injection in his left hip did not help him as much as he would have liked it to at that point. He states he has some tenderness primarily around his posterior aspect of his SI joint. Felt this may be the reason why the injection of his greater trochanter did not particularly help at that point. The patient does continue to have burning pain.

Examination

General:

General Appearance: Well and in no acute distress. Cardiovascular: Regular rhythm by palpation of distal pulse, normal color and temperature, no concerning varicosities on symptomatic side. Lungs: Breathing easily. Psychiatric: Well-oriented with a normal mood and affect.

Assessments

1. Subacromial Impingement - 726.19 (Primary)
2. Bursitis of hip - 726.5
3. Rotator cuff tear - 727.61

Treatment

1. Subacromial Impingement

Start Ultram ER tablet, extended release, 300 mg, orally, 30, 1 tab(s),

Patient: HOUSTON, TOMMY G DOB: 02/18/1956 Progress Note: Philip Wessinger, M.D. 10/01/2008
Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

once a day, 30 day(s), Refills 0
Start oxycodone capsule, 5 mg, orally, 25, 1 cap(s), as needed after
physical therapy, Refills 0

2. Others

We will go ahead and try him on Ultram ER. Allow him to augment this
with Lortab as an addition. The patient is to come back to see me here
in 3 weeks.

Follow Up

3 Weeks

Electronically signed by Philip Wessinger on 10/08/2008 at
04:56 PM EDT

Sign off status: Completed

Steadman Hawkins-Greenville (SHCP)
200 Patewood Dr
Greenville, SC 29615
Tel: 864-454-7422
Fax: 864-454-8265

Patient: HOUSTON, TOMMY G DOB: 02/18/1956 Progress Note: Philip Wessinger, M.D. 10/01/2008

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



UNIVERSITY MEDICAL GROUP
Steadman Hawkins Clinic of the Carolinas

HOUSTON, TOMMY G

52 Y old Male, DOB: 02/18/1956
204 BARTON ST, PO BOX 1099, EASLEY, SC-29640
Home: 864-855-0437

Guarantor: HOUSTON, TOMMY G Insurance: UNITED HEALTHCARE

10/22/2008

Progress Notes: Philip Wessinger, M.D.

Current Medications

metoprolol 25 mg 1 tab(s) once a day
clonidine 0.1 mg 0.5 tab (0.05mg) QHS

Past Medical History

Hypertension

Surgical History

left wrist 1978
right knee 1974
hernia 9/07

Family History

Family: diabetes

Social History

no Alcohol.
no Smoking.
no Recreational drug use.
no Use of marijuana, cocaine, or similar drugs.

Allergies

codeine

Review of Systems

CONSTITUTIONAL:

Fever NO. Weight Loss NO. Weight Gain NO. Fatigue NO. Chills NO. Night Sweats NO.

CARDIOVASCULAR:

Chest Pain NO. Irregular Heart Beat NO. Poor Circulation NO. Leg/feet swelling NO. Leg/foot ulcer NO.

GENITOURINARY:

Blood in urine NO. Pain in urinating NO. Unable to urinate NO. Bladder Infection NO. Frequent Urination NO. Difficulty with urination NO.

NEUROLOGICAL:

Paralysis NO. Frequent Headaches NO. Seizures NO. CVA/ITA NO. Syncope NO. Anxiety/Depression NO. Tremors NO. Speech Problems NO. Feeling of hopelessness NO. Sleep disturbance NO. Vision Changes NO.

EYES:

Reason for Appointment

1. RIGHT SHOULDER PAIN

History of Present Illness

Interim History:

Prior Assessment Subacromial Impingement, Bursitis of hip, Rotator cuff tear. Date of Injury: 3.11.08. Date of Surgery: 07.11.08 RT SHOULDER SCOPE, ROTATOR CUFF REPAIR. Treatment to Date: Steroid Injection 04.30.08; Physical Therapy; Steroid Injection Hip 9.03.08. Response to treatment: patient states feeling better since last visit. Pain: Severity: pain = 3/10 intermittent dull, aching pain, satisfactorily controlled.

HPI:

The patient comes in today status post a rotator cuff repair. Is much better with regard to his pain and has improved in his range of motion. Has a fairly easy range of motion through functional range. However, still is, as would be expected, fairly weak with regard to overhead lift and activity. He is only working with 3 pounds in physical therapy. We would need to continue physical therapy and improve that, particularly since his primary job activity involves him loading anywhere from 35-70 pounds overhead, by his report. The patient states that his hip and low back have responded well to physical therapy as well.

Examination

General:

General Appearance: Well and in no acute distress. Cardiovascular: Regular rhythm by palpation of distal pulse, normal color and temperature, no concerning varicosities on symptomatic side. Lungs: Breathing easily. Psychiatric: Well-oriented with a normal mood and affect.

Examination:

The patient has easy midrange range of motion. Lacks 5-10 degrees from full external rotation and internal rotation. Still remains weak primarily in straight abduction and has a little pseudoparalytic move as he goes overhead. However, I feel that his rotator cuff is intact, primarily related to strength. Low back is much less tender. He has no pain with external rotation.

Assessments

1. Subacromial Impingement - 726.19 (Primary)

Patient: HOUSTON, TOMMY G DOB: 02/18/1956 Progress Note: Philip Wessinger, M.D. 10/22/2008
Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Decreased Vision NO. Cataracts NO.
RESPIRATORY:

COPD NO. Asthma NO. Persistent
Cough NO. Shortness of Breath NO.
Wheezing NO. Pneumonia NO.
ENT:

Loss of Hearing NO. Sinusitis NO.
Headache NO.

GASTROINTESTINAL:

GERD NO. PUD/Gastritis NO. Liver
Problems NO. Stomach Pain NO.
Diarrhea NO. Abdominal Pain NO.
Nausea/Vomiting NO. Black tar-like or
bloody stool NO.

SKIN:

no Rash, NO. Dryness of Skin NO.
Ulcer NO. Cancer NO. Open sores NO. New
Moles NO. Poor Healing NO. Skin
Infection NO.

PSYCHIATRIC:

Depression NO. Bipolar Disease NO.

ENDOCRINE:

Diabetes NO. Thyroid NO. Heat
intolerance NO. Cold intolerance NO.

HEME/LYMP:

Anemia NO. Bleeding Problems NO.
Blood Transfusion NO. Bruises NO.

ALLERGIC/IMMUNOLOGIC:

Seasonal NO. Iodine NO. Food
Allergies NO.

MUSCULOSKELETAL:

Joint Swelling NO. Muscle aches NO.
Joint Pain NO. Pain in multiple joints NO.
Weakness NO.

2. Bursitis of hip - 726.5
3. Rotator cuff tear - 727.61

Treatment

1. Others

Will be for him to continue with physical therapy. He is not ready to return to work, since they would not allow him to return without restrictions. Anticipate unless he can get an assistant on the job, that he may be several more months before he would be able to obtain strength that would allow him to work overhead for extended periods of time with as much weight as he is describing.

Follow Up

4 Weeks

Electronically signed by Philip Wessinger on 11/03/2008 at
12:16 PM EST

Sign off status: Completed

Steadman Hawkins-Greenville (SHCP)
200 Patewood Dr
Greenville, SC 29615
Tel: 864-454-7422
Fax: 864-454-8265

Patient: HOUSTON, TOMMY G DOB: 02/18/1956 Progress Note: Philip Wessinger, M.D. 10/22/2008

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Progress Notes

Patient: HOUSTON, TOMMY G
DOB: 02/18/1956 **Age:** 52 Y **Sex:** Male
Phone: 864-555-0437
Address: 204 BARTON ST, PO BOX 1099, EASLEY, SC-29640

Provider: Philip Wessinger, M.D.
Date: 11/19/2008

Subjective:

CC:

1. RIGHT SHOULDER PAIN.

HPI:

Interim History:

Prior Assessment Subacromial Impingement, Bursitis of hip, Rotator cuff tear. Date of Injury: 3.11.08. Date of Surgery: 07.11.08 RT SHOULDER SCOPE, ROTATOR CUFF REPAIR. Treatment to Date: Steroid Injection 04.30.08, Physical Therapy, Steroid Injection Hip 9.03.08.

ROS:

CONSTITUTIONAL:

Fever no. Weight Loss no. Weight Gain no. Fatigue no. Chills no. Night Sweats no.

CARDIOVASCULAR:

Chest Pain no. Irregular Heart Beat no. Poor Circulation no. Leg/feet swelling no. Leg/foot ulcer no.

GENITOURINARY:

Blood in urine no. Pain in urinating no. Unable to urinate no. Bladder Infection no. Frequent Urination no. Difficulty with urination no.

NEUROLOGICAL:

Paralysis no. Frequent Headaches no. Seizures no. CVA/ITA no. Syncope no. Anxiety/Depression no. Tremors no. Speech Problems no. Feeling of hopelessness no. Sleep disturbance no. Vision Changes no.

EYES:

Decreased Vision no. Cataracts no.

RESPIRATORY:

COPD no. Asthma no. Persistent Cough no. Shortness of Breath no. Wheezing no. Pneumonia no.

ENT:

Loss of Hearing no. Sinusitis no. Headache no.

GASTROINTESTINAL:

GERD no. PUD/Gastritis no. Liver Problems no. Stomach Pain no. Diarrhea no. Abdominal Pain no. Nausea/Vomiting no. Black Tar-like or bloody stool no.

SKIN:

no Rash, no. Dryness of Skin no. Ulcer no. Cancer no. Open sores no. New Moles no. Poor Healing no. Skin Infection no.

PSYCHIATRIC:

Depression no. Bipolar Disease no.

ENDOCRINE:

Diabetes no. Thyroid no. Heat intolerance no. Cold intolerance no.

HEME/LYMP:

Anemia no. Bleeding Problems no. Blood Transfusion no. Bruises no.

ALLERGIC/IMMUNOLOGIC:

Seasonal no. Iodine no. Food Allergies no.

MUSCULOSKELETAL:

Joint Swelling no. Muscle aches no. Joint Pain no. Pain in multiple joints no. Weakness no.

Medical History: Hypertension.

Surgical History: left wrist 1978, right knee 1974, hernia 9/07.

Family History: Family: diabetes

Social History: no Alcohol. no Smoking. no Recreational drug use. no Use of marijuana, cocaine, or similar

drugs.

Medications: metoprolol 25 mg 1 tab(s) once a day, clonidine 0.1 mg 2.5 tab (0.05mg) QHS

Allergies: Codeine.

Objective:

Examination:

General:

General Appearance: Well and in no acute distress. Cardiovascular: Regular rhythm by palpation of distal pulse, normal color and temperature, no concerning varicosities on symptomatic side. Lungs: Breathing easily. Psychiatric: Well-oriented with a normal mood and affect.

Therapeutic Interventions:

Assessment:

Assessment:

1. Subacromial Impingement - 726.19 (Primary)
2. Bursitis of hip - 726.5
3. Rotator cuff tear - 727.61

Plan:

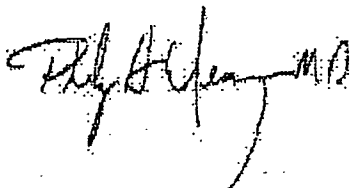
Immunizations:

Labs:

Preventive:

Provider: Phillip Wessinger, M.D.

Patient: HOUSTON, TOMMY G **DOB:** 02/18/1956 **Date:** 11/19/2008



Electronically signed by Philip Wessinger on 12/09/2009 at 01:37 PM EST
Sign off status: Pending



UNIVERSITY MEDICAL GROUP

HOUSTON, TOMMY G

52 Y old Male, DOB: 02/18/1956
204 BARTON ST, PO BOX 1009, EASLEY, SC-29640
Home: 864-855-0437

Guarantor: HOUSTON, TOMMY G Insurance: UNITED HEALTHCARE

12/03/2008

Progress Notes: Philip Wessinger, M.D.

Current Medications

metoprolol 25 mg 1 tab(s) once a day
Plavix 75 mg 1 tab(s) once a day
ASA 325 mgm 1 q am
clonidine 0.2 mg 1 tab(s) BID
Imdur 30 mg 1 tab qd
trimethoprim 100 mg 1 tab(s) Q12H
labetalol 200 mg 1 tab(s) BID
Lorazepam 0.5 mg 1 tab(s) TID
lisino-hctz 20-25mg 1 q day
pravastatin 80 mg 1 tab(s) once a day (at bedtime)

Past Medical History

Hypertension

Surgical History

left wrist 1978
right knee 1974
hernia 9/07
heart surgery 11/23

Allergies

codeine

Review of Systems

Angioplasty last week, hospitalized for 1 week, 40% and 80% blockage, home on Thanksgiving

CC

1. SHC RCK RIGHT SHOULDER

HPI

Interim History:

Prior Assessment

1. Subacromial Impingement - 726.19 (Primary)
2. Bursitis of hip - 726.5
3. Rotator cuff tear - 727.61

Date of Injury: 03/11/08. Date of Surgery: 07/11/08. Treatment to Date: RT SHOULDER SCOPE, ROTATOR CUFF REPAIR ssu.

Response to treatment: patient states feeling the same since last visit. Pain: Severity: pain = 3 satisfactorily controlled with medication, aching, intermittent-start physical therapy on 12/05/08.

The patient comes in today after a right shoulder rotator cuff repair as well as left SI joint with greater trochanteric bursitis. He has been treated in physical therapy; however, workman's comp insurance cut him off and he has only been doing home exercises for the last 2-3 weeks. The patient has now been cleared to go back for more physical therapy.

Vital Signs

Ht: 70, Wt lbs: 203, BMI: 29.12.

Examination

General:

General Appearance: Well and in no acute distress.

Cardiovascular: Regular rhythm by palpation of distal pulse, normal color and temperature, no concerning varicosities on symptomatic side. Lungs: Breathing easily. Psychiatric: Well-oriented with a normal mood and affect.

The patient has external rotation to approximately 45 to 50 degrees and internal rotation to 60 degrees. Good abduction, within normal limits, and good forward flexion. He still has some tenderness over the bursa and SI joint.

Assessments

1. Rotator cuff tear - 727.61 (Primary)

Patient: HOUSTON, TOMMY G DOB: 02/18/1956 Progress Note: Philip Wessinger, M.D. 12/03/2008
Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

2. Subacromial Impingement - 726.19
3. Bursitis of hip - 726.5

Treatment

1. Rotator cuff tear

I have sent him back to physical therapy. Since there is no light duty at his work and he has to lift up to 70 to 80 lbs with regard to coins and moving money on and off the truck, he is not able to return to work at this point. He is to come back to see me here in about 4-6 weeks.

Follow Up

4 Weeks, 6 Weeks

Electronically signed by Philip Wessinger on 12/05/2008 at 01:13 PM EST

Sign off status: Completed

Steadman Hawkins-HillCrest (SH)
727 S.E. Main Street
Simpsonville, SC 29681
Tel: 864-454-7422
Fax: 864-454-0005

Patient: HOUSTON, TOMMY G DOB: 02/18/1956 Progress Note: Philip Wessinger, M.D. 12/03/2008

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



UNIVERSITY MEDICAL GROUP
Leadman Island, Clark of the Carolina

HOUSTON, TOMMY G

52 Y old Male, DOB: 02/18/1956
204 BARTON ST, PO BOX 1099, EASLEY, SC-29640
Home: 864-855-0437

Guarantor: HOUSTON, TOMMY G Insurance: UNITED HEALTHCARE

01/07/2009

PROGRESS NOTES: Philip Wessinger, M.D.

Current Medications

metoprolol 25 mg 1 tab(s) once a day
Plavix 75 mg 1 tab(s) once a day
ASA 325 mgm 1 q am
clonidine 0.2 mg 1 tab(s) BID
Imdur 30 mg 1 tab qd
trimethoprim 100 mg 1 tab(s) Q12H
labetalol 200 mg 1 tab(s) BID
Lorazepam 0.5 mg 1 tab(s) TID
lisino-hetz 20-25mg 1 q day
pravastatin 80 mg 1 tab(s) once a day (at bedtime)

Past Medical History

Hypertension

Surgical History

left wrist 1978
right knee 1974
hernia 9/07
heart surgery 11/23

Allergies

codeine

Review of Systems

Review of systems from 12.03.08
reviewed with patient and no changes found.
Angioplasty last week, hospitalized for 1
week, 40% and 80% blockage, home on
Thanksgiving

Reason for Appointment

1. SHC:RT SHOULDER WKCP RCK

History of Present Illness

Interim History:

Prior Assessment

Subacromial Impingement, Bursitis of hip, Rotator cuff tear

. Date of Injury: 03/11/08.. Date of Surgery: 07/11/08. Treatment to
Date: RT SHOULDER SCOPE, ROTATOR CUFF REPAIR ssu. .

Response to treatment: patient states feeling the same since last visit.

Pain: Severity: pain = 7/10 intermittent sharp, stabbing pain, not
satisfactorily controlled.

This 52 year-old comes in today and is doing fairly well with regard
to his right shoulder. He is still having some back and leg pain. He
states that he has some difficulty with pain running around to the front.
I previously evaluated him and realized he has some lumbar spine
issues.

Vital Signs

Ht: 70, Wt lbs: 203, BMI: 29.12.

Examination

General:

General Appearance: Well and in no acute distress.

Cardiovascular: Regular rhythm by palpation of distal pulse, normal
color and temperature, no concerning varicosities on symptomatic
side. Lungs: Breathing easily. Psychiatric: Well-oriented with a
normal mood and affect.

Assessments

1. Rotator cuff tear - 727.61 (Primary)
2. Subacromial Impingement-- 726.19
3. Bursitis of hip - 726.5

Treatment

1. Rotator cuff tear

Start Oxycodone capsule, 5 mg, orally, 30, 1 cap(s), Q6H, as needed,
Refills 0

Start Medrol Dose Pack tablet, orally, 1 pack, as directed, Refills 0

We will get him started on a Medrol Dose Pack. Continue with P.T. He
will come back to see me here in 3-4 weeks. He is not ready to go back
to work since he needs to be able to lift up to 70 lbs in order to do his
work activities.

Patient: HOUSTON, TOMMY G DOB: 02/18/1956 Progress Note: Philip Wessinger, M.D. 01/07/2009
Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Preventive Medicine

Forms/Handouts Given: Medication Reconciliation form provided: .

Follow Up

3 Weeks, 4 Weeks

Electronically signed by Philip Wessinger on 01/13/2009 at
01:40 PM EST

Sign off status: Completed

Steadman Hawkins-Greenville (SHCP)

200 Patwood Dr

Greenville, SC 29615

Tel: 864-454-7422

Fax: 864-454-8265

Patient: HOUSTON, TOMMY G DOB: 02/18/1956 Progress Note: Philip Wessinger, M.D. 01/07/2009

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



HOUSTON, TOMMY G

52 Y old Male, DOB: 02/18/1956
204 BARTON ST, PO BOX 1009, EASLEY, SC-29640
Home: 864-855-0437

Guarantor: HOUSTON, TOMMY G Insurance: UNITED HEALTHCARE

PROGRESS NOTES: Philip Wessinger, M.D.

02/04/2009

Current Medications

metoprolol 25 mg 1 tab(s) once a day
Plavix 75 mg 1 tab(s) once a day
ASA 325 mg m 1 q am
clonidine 0.2 mg 1 tab(s) BID
Imdur 30 mg 1 tab qd
trimethoprim 100 mg 1 tab(s) Q12H
labetalol 200 mg 1 tab(s) BID
Lorazepam 0.5 mg 1 tab(s) TID
lisino-hctz 20-25mg 1 q-day
pravastatin 80 mg 1 tab(s) once a day (at bedtime)

Past Medical History

Hypertension

Surgical History

left wrist 1978
right knee 1974
hernia 9/07
heart surgery 11/23

Family History

Family: diabetes

Social History

no Alcohol.
no Smoking.
no Recreational drug use.
no Use of marijuana, cocaine, or similar drugs.

Allergies

codeine

Review of Systems

CONSTITUTIONAL:

Fever NO. Weight Loss NO. Weight Gain NO. Fatigue NO. Chills NO. Night Sweats NO.

CARDIOVASCULAR:

Chest Pain NO. Irregular Heart Beat NO. Poor Circulation NO. Leg/feet swelling NO. Leg/foot ulcer NO.

GENITOURINARY:

Blood in urine NO. Pain in urinating NO. Unable to urinate NO. Bladder Infection NO. Frequent Urination NO. Difficulty with

Reason for Appointment

1. SHR RT SHOULDER AND BACK

History of Present Illness

Interim History:

Prior Assessment Rotator cuff tear, Subacromial Impingement, Bursitis of hip

. Date of Injury: 03/11/08. Date of Surgery: 07/11/08 RT SHOULDER SCOPE, ROTATOR CUFF REPAIR. Response to treatment: patient states feeling better since last visit. Pain: Severity: pain = 2/10 intermittent.

The patient comes in today and is doing fairly well S/P rotator cuff tear on the right. He is making progress in PT and actually feels that if he does some general conditioning and finishes out the therapy that we've approved at this point that he may be ready to return to work on his next visit.

Vital Signs

Ht: 70, Wt lbs: 203, BMI: 29.12.

Examination

General:

General Appearance: Well and in no acute distress. Cardiovascular: Regular rhythm by palpation of distal pulse, normal color and temperature, no concerning varicosities on symptomatic side. Lungs: Breathing easily. Psychiatric: Well-oriented with a normal mood and affect.

He does have improved strength with regard to his rotator cuff. He has maintained his ROM with regard to his shoulder. His back continues to be better with good ROM and he states he is able to walk 2-3 hours without the pain that he was experiencing at 5 minutes previously.

Assessments

1. Rotator cuff tear - 727.61 (Primary)
2. Subacromial Impingement - 726.19
3. Bursitis of hip - 726.5

Treatment

1. Rotator cuff tear

We will see him back in 3-4 weeks.

Patient: HOUSTON, TOMMY G DOB: 02/18/1956 Progress Note: Philip Wessinger, M.D. 02/04/2009
Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

urination NO.

NEUROLOGICAL:

Paralysis NO. Frequent Headaches NO.
Seizures NO. CVA/ITA NO. Syncope NO.
Anxiety/Depression NO. Tremors NO.
Speech Problems NO. Feeling of
hopelessness NO. Sleep disturbance NO.
Vision Changes NO.

EYES:

Decreased Vision NO. Cataracts NO.

RESPIRATORY:

COPD NO. Asthma NO. Persistent
Cough NO. Shortness of Breath NO.
Wheezing NO. Pneumonia NO.

ENT:

Loss of Hearing NO. Sinusitis NO.
Headache NO.

GASTROINTESTINAL:

GERD NO. PUD/Gastritis NO. Liver
Problems NO. Stomach Pain NO.
Diarrhea NO. Abdominal Pain NO.
Nausea/Vomiting NO. Black tar-like or
bloody stool NO.

SKIN:

no Rash, NO. Dryness of Skin NO.
Ulcer NO. Cancer NO. Open sores NO. New
Moles NO. Poor Healing NO. Skin
Infection NO.

PSYCHIATRIC:

Depression NO. Bipolar Disease NO.

ENDOCRINE:

Diabetes NO. Thyroid NO. Heat
intolerance NO. Cold intolerance NO.

HEME/LYMP:

Anemia NO. Bleeding Problems NO.
Blood Transfusion NO. Bruises NO.

ALLERGIC/IMMUNOLOGIC:

Seasonal NO. Iodine NO. Food
Allergies NO.

MUSCULOSKELETAL:

Joint Swelling NO. Muscle aches NO.
Joint Pain NO. Pain in multiple joints NO.
Weakness NO.

Follow Up
3 Weeks, 4 Weeks

**Electronically signed by Philip Wessinger on 02/10/2009 at
02:08 PM EST**

Sign off status: Completed

Steadman Hawkins-Greenville (SHCP)
200 Patewood Dr
Greenville, SC 29615
Tel: 864-454-7422
Fax: 864-454-8265

Patient: HOUSTON, TOMMY G DOB: 02/18/1956 Progress Note: Philip Wessinger, M.D. 02/04/2009

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



UNIVERSITY MEDICAL GROUP
Steadman Hawkins Clinic of the Carolinas

HOUSTON, TOMMY G

53 Y old Male, DOB: 02/18/1956
204 BARTON ST, PO BOX 1099, EASLEY, SC-29640
Home: 864-855-0437

Guarantor: HOUSTON, TOMMY G Insurance: UNITED HEALTHCARE

04/15/2009

PROGRESS NOTES: Philip Wessinger, M.D.

Current Medications

metoprolol 25 mg 1 tab(s) once a day
Plavix 75 mg 1 tab(s) once a day
ASA 325 mgm 1 q am
clonidine 0.2 mg 1 tab(s) BID
Imdur 30 mg 1 tab qd
trimethoprim 100 mg 1 tab(s) Q12H
labetalol 200 mg 1 tab(s) BID
Lorazepam 0.5 mg 1 tab(s) TID
lisino-hctz 20-25mg 1 q day
pravastatin 80 mg 1 tab(s) once a day (at bedtime)

Past Medical History

Hypertension

Surgical History

left wrist 1978
right knee 1974
hernia 9/07
heart surgery 11/23

Family History

Family: diabetes

Social History

no Alcohol.
no Smoking.
no Recreational drug use.
no Use of marijuana, cocaine, or similar drugs.

Allergies

codeine

Review of Systems

Review of systems from 02.04.09
reviewed with patient and no changes found.

Reason for Appointment

1. WCR RT SHOULDER/BACK PAIN
2. Case Manager: Darlene Ligon, RN

History of Present Illness

Interim History:

Prior Assessment Rotator cuff tear, Subacromial Impingement, Bursitis of hip

Date of Injury: 03/11/08. Date of Surgery: 07/11/08 RT SHOULDER SCOPE, ROTATOR CUFF REPAIR. Response to treatment: patient states feeling better since last visit. Pain: Severity: pain = 3/10 intermittetn dull, aching pain, satisfactorily controlled.

Right Shoulder/Arm:

The patient comes in today. He is scheduled for his FCE next week. He is doing well and was able to cut his grass the other day.

Vital Signs

Ht: 70, Wt lbs: 203, BMI: 29.12, HR: 78.

Examination

General:

General Appearance: Well and in no acute distress.
Cardiovascular: Regular rhythm by palpation of distal pulse, normal color and temperature, no concerning varicosities on symptomatic side. Lungs: Breathing easily. Psychiatric: Well-oriented with a normal mood and affect.

Right Shoulder/Arm:

He has some pain and tenderness. He has FROM of his shoulder with some clicking. ROM of his hip is also better.

Assessments

1. Rotator cuff tear - 727.61 (Primary)
2. Subacromial Impingement - 726.19
3. Bursitis of hip - 726.5

Treatment

1. Rotator cuff tear

Start Ultram tablet, 50 mg, orally, 60, 1 tab(s), Q4H, 10 days, Refills 0
He has been using Ultram for pain. He is to come back to see me here in two weeks and we will assess whether he can go back to work based on his FCE findings.

Patient: HOUSTON, TOMMY G DOB: 02/18/1956 Progress Note: Philip Wessinger, M.D. 04/15/2009
Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Preventive Medicine

Forms/Handouts Given: Medication Reconciliation form provided: .

Procedure Codes

99499 Work Comp Case Manager

Follow Up

2 Weeks

Electronically signed by Philip Wessinger on 04/16/2009 at
11:50 AM EDT

Sign off status: Completed

Steadman Hawkins-Greenville (SHCP)

200 Patewood Dr
Greenville, SC 29615
Tel: 864-454-7422
Fax: 864-454-8265

Patient: HOUSTON, TOMMY G DOB: 02/18/1956 Progress Note: Philip Wessinger, M.D. 04/15/2009

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



UNIVERSITY MEDICAL GROUP

HOUSTON, TOMMY G

53 Y old Male, DOB: 02/18/1956
204 BARTON ST, PO BOX 1099, EASLEY, SC-29640
Home: 864-855-0437

Guarantor: HOUSTON, TOMMY G Insurance: UNITED
HEALTHCARE

External Visit ID: 85615961

04/29/2009

PROGRESS NOTES: Philip Wessinger, M.D.

Current Medications

metoprolol 25 mg 1 tab(s) once a day
Plavix 75 mg 1 tab(s) once a day
ASA 325 mgm 1 q am
clonidine 0.2 mg 1 tab(s) BID
Imdur 30 mg 1 tab qd
trimethoprim 100 mg 1 tab(s) Q12H
labetalol 200 mg 1 tab(s) BID
Lorazepam 0.5 mg 1 tab(s) TID
lisino-hctz 20-25mg 1 q day
pravastatin 80 mg 1 tab(s) once a day (at
bedtime)

Past Medical History

Hypertension

Surgical History

left wrist 1978
right knee 1974
hernia 9/07
heart surgery 11/23

Family History

Family: diabetes

Social History

no Alcohol.
no Smoking.
no Recreational drug use.
no Use of marijuana, cocaine, or similar
drugs.

Allergies

codeine

Review of Systems

CONSTITUTIONAL:

Fever NO. Weight Loss NO. Weight
Gain NO. Fatigue no. Chills no. Night
Sweats NO.

CARDIOVASCULAR:

Chest Pain NO. Irregular Heart Beat NO.
Poor Circulation NO. Leg/feet swelling NO.
Leg/foot ulcer no.

GENITOURINARY:

Blood in urine NO. Pain in urinating no.
Unable to urinate NO. Bladder Infection no.

Reason for Appointment

1. WCR RT SHLDR

History of Present Illness

Interim History:

Prior Assessment Rotator cuff tear, Subacromial Impingement,
Bursitis of hip

Date of Injury: 03/11/08. Date of Surgery: 07/11/08 RT SHOULDER
SCOPE, ROTATOR CUFF REPAIR. Response to treatment: patient
states feeling the same since last visit. Pain: Severity: pain = 2/10
intermittent aching pain, satisfactorily controlled.

Right Shoulder/Arm:

The patient comes in today S/P FCE with regard to his rotator cuff.
He was actually approved to go forward with heavy activity with the
exception of overhead more than 70 lbs which he does not need to do.

Right Wrist/Hand:

He points out that on the back of his right hand he has had a place
that will periodically break down and ooze. This has been since back
when he was in the ambulance on the way to surgery. He states he had
never had this problem before, and that it is related to an IV stick at
that point in time. This is the first time he has mentioned this to me.
He states that he can feel something just proximal to that.

Vital Signs

Ht 70, Wt lbs 203, BMI 29.12, HR 78.

Examination

General:

General Appearance: Well and in no acute distress.
Cardiovascular: Regular rhythm by palpation of distal pulse, normal
color and temperature, no concerning varicosities on symptomatic
side. Lungs: Breathing easily. Psychiatric: Well-oriented with a
normal mood and affect.

Right Wrist/Hand:

He does have an area of scab or eschar over the dorsal part of his
hand.

Assessments

1. Rotator cuff tear - 727.61 (Primary)
2. Subacromial Impingement - 726.19

Patient: HOUSTON, TOMMY G DOB: 02/18/1956 Progress Note: Philip Wessinger, M.D. 04/29/2009
Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Frequent Urination NO. Difficulty with urination NO.

NEUROLOGICAL:

Paralysis NO. Frequent Headaches NO.
Seizures NO. CVA/ITA NO. Syncope NO.
Anxiety/Depression NO. Tremors NO.
Speech Problems NO. Feeling of hopelessness NO. Sleep disturbance NO.
Vision Changes NO.

EYES:

Decreased Vision NO. Cataracts NO.

RESPIRATORY:

COPD NO. Asthma NO. Persistent Cough NO. Shortness of Breath NO.
Wheezing NO. Pneumonia NO.

ENT:

Loss of Hearing NO. Sinusitis NO.
Headache NO.

GASTROINTESTINAL:

GERD NO. PUD/Gastritis NO. Liver Problems NO. Stomach Pain NO.
Diarrhea NO. Abdominal Pain NO.
Nausea/Vomiting NO. Black tar-like or bloody stool NO.

SKIN:

Rash NO. Dryness of Skin NO. Ulcer NO.
Cancer NO. Open sores NO. New Moles NO.
Poor Healing NO. Skin Infection NO.

PSYCHIATRIC:

Depression NO. Bipolar Disease NO.

ENDOCRINE:

Diabetes NO. Thyroid NO. Heat intolerance NO. Cold intolerance NO.

HEME/LYMP:

Anemia NO. Bleeding Problems NO.
Blood Transfusion NO. Bruises NO.

ALLERGIC/IMMUNOLOGIC:

Seasonal NO. Iodine NO. Food Allergies NO.

MUSCULOSKELETAL:

Joint Swelling NO. Muscle aches NO.
Joint Pain NO. Pain in multiple joints NO.
Weakness NO.

3. Bursitis of hip - 726.5

Treatment

1. Rotator cuff tear

We will return him to work at this point.

2. Others

With regard to his right hand, certainly a foreign body could behave this way as could a skin lesion of some sort. It is difficult for me to tell what this is. He wishes to have this removed and have an excisional biopsy. We will go ahead and schedule this.

Follow Up

SX

Electronically signed by Philip Wessinger on 06/04/2009 at 11:48 AM EDT

Sign-off status: Completed

Steadman Hawkins-Greenville (SHCP)
200 Patewood Dr
Greenville, SC 29615
Tel: 864-454-7422
Fax: 864-454-8265

Patient: HOUSTON, TOMMY G DOB: 02/18/1956 Progress Note: Philip Wessinger, M.D. 04/29/2009

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



UNIVERSITY MEDICAL GROUP

HOUSTON, TOMMY G

53 Y old Male, DOB: 02/18/1956
204 BARTON ST, PO BOX 1099, EASLEY, SC 29640
Home: 864-855-0437
Provider: Wessinger, Philip

Telephone
Encounter

Date: 04/22/2009
Time: 04:55 PM

Answered by Ramos, Melissa

Caller Rita Bracy/nurse case manager

Reason work status and restrictions

Message I received a call from nurse case manager, requesting work status and restrictions-- if the patient has any... please fax to 4.7494. This is for date of service 04.15.09.

Action Taken Anstee, Linda 04/23/2009 01:00:24 PM EDT > Per office note for that day, patient is out of work. When we see him back, Dr Wessinger will review FCE to see if he can go back to work at that time
Ramos, Melissa 04/23/2009 04:22:23 PM EDT > wrote up oow note for dos 04.15.09, faxed to nurse case manager.

Patient: HOUSTON, TOMMY G DOB: 02/18/1956 Provider: Wessinger, Philip 04/22/2009

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



UNIVERSITY MEDICAL GROUP

HOUSTON, TOMMY G

53 Y old Male, DOB: 02/18/1956
 204 BARTON ST, PO BOX 1099, EASLEY, SC-29640
 Home: 864-855-0437

Guarantor: HOUSTON, TOMMY G Insurance: UNITED
 HEALTHCARE

06/01/2009

Progress Notes: Philip Wessinger, M.D.

Current Medications

metoprolol 25 mg 1 tab(s) once a day
 Plavix 75 mg 1 tab(s) once a day
 ASA 325 mgm 1 q am
 clonidine 0.2 mg 1 tab(s) BID
 Imdur 30 mg 1 tab qd
 trimethoprim 100 mg 1 tab(s) Q12H
 labetalol 200 mg 1 tab(s) BID
 Lorazepam 0.5 mg 1 tab(s) TID
 lisino-hctz 20-25mg 1 q day
 pravastatin 80 mg 1 tab(s) once a day (at
 bedtime)

Past Medical History

Hypertension

Surgical History

left wrist 1978
 right knee 1974
 hernia 9/07
 heart surgery 11/23
 EXPLORATION AND REMOVAL OF
 FOREIGN BODY, RT HAND. 06/01/09

Allergies

codeine

Reason for Appointment

1. SHC: EXPLORATION AND REMOVAL OF FOREIGN BODY, RT
 HAND

Assessments

1. Benign neoplasm of skin of lip - 216.0 (Primary)
 2. Localized superficial swelling, mass, or lump - 782.2

Treatment

1. Localized superficial swelling, mass, or lump
 11421

Follow Up

2 Weeks

Electronically signed by Philip Wessinger on 06/04/2009 at
 11:47 AM EDT

Sign off status: Completed

Steadman Hawkins-HillCrest (SH)
 727 S.E. Main Street
 Simpsonville, SC 29681
 Tel: 864-454-7422
 Fax: 864-454-6605

Patient: HOUSTON, TOMMY G DOB: 02/18/1956 Progress Note: Philip Wessinger, M.D. 06/01/2009

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



UNIVERSITY MEDICAL GROUP

HOUSTON, TOMMY G

53 Y old Male, DOB: 02/18/1956
204 BARTON ST, PO BOX 1099, EASLEY, SC-29640
Home: 864-855-0437

Guarantor: HOUSTON, TOMMY G Insurance: UNITED
HEALTHCARE

External Visit ID: 86061314

05/27/2009

PROGRESS NOTES: Philip Wessinger, M.D.

Current Medications

metoprolol 25 mg 1 tab(s) once a day
Plavix 75 mg 1 tab(s) once a day
ASA 325 mgm 1 q am
clonidine 0.2 mg 1 tab(s) BID
Imdur 30 mg 1 tab qd
trimethoprim 100 mg 1 tab(s) Q12H
labetalol 200 mg 1 tab(s) BID
Lorazepam 0.5 mg 1 tab(s) TID
lisin-hctz 20-25mg 1 q day
pravastatin 80 mg 1 tab(s) once a day (at
bedtime)

Past Medical History

Hypertension

Surgical History

left wrist 1978
right knee 1974
hernia 9/07
heart surgery 11/23

Family History

Family: diabetes

Social History

no Alcohol.
no Smoking.
no Recreational drug use.
no Use of marijuana, cocaine, or similar
drugs.

Allergies

codeine

Review of Systems

CONSTITUTIONAL:

no Fever, NO. no Weight Loss, NO.
no Weight Gain, NO. no Fatigue, NO.
no Chills, NO. no Night Sweats, NO.

CARDIOVASCULAR:

no Chest Pain, NO. no Irregular Heart
Beat, NO. no Poor Circulation, NO.
no Leg/feet swelling, NO. no Leg/foot
ulcer, NO.

GENITOURINARY:

no Blood in urine, NO. no Pain in.

Reason for Appointment

1. WCR RT SHOULDER AND BACK

History of Present Illness

Interim History:

Prior Assessment Rotator cuff tear, Subacromial Impingement,

Bursitis of hip

. Date of Injury: 03/11/08. Date of Surgery: 07/11/08 RT SHOULDER
SCOPE, ROTATOR CUFF REPAIR. Response to treatment: patient
states feeling the same since last visit. Pain: Severity: pain = 2/10
intermittent dull, aching pain, satisfactorily controlled.

Right Shoulder/Arm:

HPI:

This 53 year-old comes in today and is doing fairly well. He still has
the area on the back of his right hand. He has been approved for
exploration and excision of this wound.

Vital Signs

Ht 70, Wt lbs 203, BMI 29.12, HR 70.

Examination

General:

General Appearance: Well and in no acute distress.
Cardiovascular: Regular rhythm by palpation of distal pulse, normal
color and temperature, no concerning varicosities on symptomatic
side. Lungs: Breathing easily. Psychiatric: Well-oriented with a
normal mood and affect.

Assessments

1. Localized superficial swelling, mass, or lump - 782.2 (Primary)
2. Rotator cuff tear - 727.61
3. Subacromial Impingement - 726.19
4. Bursitis of hip - 726.5

Treatment

1. Rotator cuff tear

He will come back to see me here after surgery.

Follow Up

after Sx

Patient: HOUSTON, TOMMY G DOB: 02/18/1956 Progress Note: Philip Wessinger, M.D. 05/27/2009
Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

urinating, NO. no Unable to urinate, NO.
no Bladder Infection, NO. no Frequent
Urination, NO. no Difficulty with
urination, NO.

NEUROLOGICAL:

no Paralysis, NO. no Frequent
Headaches, NO. no Seizures, NO.
no CVA/ITA, NO. no Syncope, NO.
no Anxiety/Depression, NO.
no Tremors, NO. no Speech Problems, NO.
no Feeling of hopelessness, NO. no Sleep
disturbance, NO. no Vision Changes, NO.
EYES:

no Decreased Vision, NO.
no Cataracts, NO.

RESPIRATORY:

no COPD, NO. no Asthma, NO.
no Persistent Cough, NO. no Shortness of
Breath, NO. no Wheezing, NO.
no Pneumonia, NO.

ENT:

no Loss of Hearing, NO.
no Sinusitis, NO. no Headache, NO.

GASTROINTESTINAL:

no GERD, NO. no PUD/Gastritis, NO.
no Liver Problems, NO. no Stomach
Pain, NO. no Diarrhea, NO. no Abdominal
Pain, NO. no Nausea/Vomiting, NO.
no Black tar-like or bloody stool, NO.

SKIN:

no Rash, NO. no Dryness of Skin, NO.
no Ulcer, NO. no Cancer, NO. no Open
sores, NO. no New Moles, NO. no Poor
Healing, NO. no Skin Infection, NO.

PSYCHIATRIC:

no Depression, NO. no Bipolar
Disease, NO.

ENDOCRINE:

no Diabetes, NO. no Thyroid, NO.
no Heat intolerance, NO. no Cold
intolerance, NO.

HEMB/LYMP:

no Anemia, NO. no Bleeding
Problems, NO. no Blood Transfusion, NO.
no Bruises, NO.

ALLERGIC/IMMUNOLOGIC:

no Seasonal, NO. no Iodine, NO. no Food
Allergies, NO.

MUSCULOSKELETAL:

no Joint Swelling, NO. no Muscle
aches, NO. no Joint Pain, NO. no Pain in
multiple joints, NO. no Weakness, NO.

Electronically signed by Philip Wessinger on 05/28/2009 at
01:27 PM EDT

Sign off status: Completed

Steadman Hawkins-Greenville (SHCP)
200 Patewood Dr
Greenville, SC 29615
Tel: 864-454-7422
Fax: 864-454-8265

Patient: HOUSTON, TOMMY G DOB: 02/18/1956 Progress Note: Philip Wessinger, M.D. 05/27/2009

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



UNIVERSITY MEDICAL GROUP

HOUSTON, TOMMY G

53 Y old Male, DOB: 02/18/1956
204 BARTON ST, PO BOX 1099, EASLEY, SC-29640
Home: 864-855-0437

Guarantor: HOUSTON, TOMMY G Insurance: UNITED
HEALTHCARE

External Visit ID: 86545399

06/10/2009

PROGRESS NOTES: Philip Wessinger, M.D.

Current Medications

metoprolol 25 mg 1 tab(s) once a day
Plavix 75 mg 1 tab(s) once a day
ASA 325 mgm 1 q am
clonidine 0.2 mg 1 tab(s) BID
Imdur 30 mg 1 tab qd
trimethoprim 100 mg 1 tab(s) Q12H
labetalol 200 mg 1 tab(s) BID
Lorazepam 0.5 mg 1 tab(s) TID
lisino-hctz 20-25mg 1 q day
pravastatin 80 mg 1 tab(s) once a day (at
bedtime)

Past Medical History

Hypertension

Surgical History

left wrist 1978
right knee 1974
hernia 9/07
heart surgery 11/23

Family History

Family: diabetes

Social History

no Alcohol.
no Smoking.
no Recreational drug use.
no Use of marijuana, cocaine, or similar
drugs.

Allergies

codeine

Reason for Appointment

1. POST OP RT HAND

History of Present Illness

Interim History:

Prior Assessment Benign neoplasm of skin of lip, Localized
superficial swelling, mass, or lump. Date of Injury: 03/11/08. Date of
Surgery: 06.01.09 EXPLORATION AND REMOVAL OF FOREIGN
BODY, RT HAND, 07/11/08 RT SHOULDER SCOPE, ROTATOR CUFF
REPAIR. Response to treatment: patient states feeling better since last
visit. Pain: Severity: pain = 2/10 intermittent, satisfactorily
controlled.

HPI:

The patient is a 53 year-old who comes in S/P lesion removal from
the back of his hand. Pathology came back as a squamous cell that did
not extend to the margins of the excision and is not deep into the hand
and therefore he has had complete resection. The patient is aware this
was malignant.

Vital Signs

Ht 70, Wt lbs 203, BMI 29.12, HR 76.

Examination

General:

General Appearance: Well and in no acute distress.
Cardiovascular: Regular rhythm by palpation of distal pulse, normal
color and temperature, no concerning varicosities on symptomatic
side. Lungs: Breathing easily. Psychiatric: Well-oriented with a
normal mood and affect.

Right Wrist/Hand:

The patient does have some erythema around his wound.

Assessments

1. Benign neoplasm of skin of lip - 216.0 (Primary)
2. Localized superficial swelling, mass, or lump - 782.2

Treatment

1. Benign neoplasm of skin of lip
Start Duricef capsule, 500 mg, orally, 20, 1 cap(s), every 12 hours, 10
day(s), Refills 0

Patient: HOUSTON, TOMMY G DOB: 02/18/1956 Progress Note: Philip Wessinger, M.D. 06/10/2009
Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

2. Others

We will place him on some oral antibiotics. I do not feel that he is ready to have his sutures removed. He will need to come back for that in 7-10 days.

Preventive Medicine

Forms/Handouts Given: Medication Reconciliation form provided: .

Follow Up

1 Week, 10 days

Electronically signed by Philip Wessinger on 06/15/2009 at 04:36 PM EDT

Sign off status: Completed

Steadman Hawkins-Greenville (SHCP)
200 Patewood Dr
Greenville, SC 29615
Tel: 864-454-7422
Fax: 864-454-8265

Patient: HOUSTON, TOMMY G DOB: 02/18/1956 Progress Note: Philip Wessinger, M.D. 06/10/2009

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

PROGRESS NOTES

Patient: HOUSTON, TOMMY G
DOB: 02/18/1956 **Age:** 53 Y **Sex:** Male
Phone: 864-855-0437
Address: 204 BARTON ST, PO BOX 1099, EASLEY, SC-29640

Provider: Philip Wessinger, M.D.
Date: 06/24/2009

Subjective:

CC:

1. WCR SR RT HAND.

HPI:

Interim History:

Prior Assessment Benign neoplasm of skin of lip, Localized superficial swelling, mass, or lump.
Date of Injury: 03/11/08. Date of Surgery: 06.01.09 EXPLORATION AND REMOVAL OF FORIEGN BODY, RT HAND, 07/11/08 RT SHOULDER SCOPE, ROTATOR CUFF REPAIR.

ROS:

Review of systems from 06.10.09 reviewed with patient and no changes found.

Medical History:

Hypertension.

Surgical History: left wrist 1978, right knee 1974, hernia 9/07, heart surgery 11/23.

Family History: Family: diabetes

Social History: no Alcohol. no Smoking. no Recreational drug use. no Use of marijuana, cocaine, or similar drugs.

Medications: metoprolol 25 mg 1 tab(s) once a day, Plavix 75 mg 1 tab(s) once a day, ASA 325 mgm 1 q am, clonidine 0.2 mg 1 tab(s) BID, Imdur 30 mg 1 tab qd, trimethoprim 100 mg 1 tab(s) Q12H, labetalol 200 mg 1 tab(s) BID, Lorazepam 0.5 mg 1 tab(s) TID, lisino-hctz 20-25mg 1 q day, pravastatin 80 mg 1 tab (s) once a day (at bedtime), Duricef 500 mg 1 cap(s) every 12 hours

Allergies: Codeine.

Objective:

Vitals: Ht 70, Wt lbs 203, BMI 29.12, HR 70.

Examination:

General:

General Appearance: Well and in no acute distress. Cardiovascular: Regular rhythm by palpation of distal pulse, normal color and temperature, no concerning varicosities on symptomatic side.
Lungs: Breathing easily. Psychiatric: Well-oriented with a normal mood and affect.

Assessment:

Assessment:

1. Benign neoplasm of skin of lip - 216.0 (Primary)
2. Localized superficial swelling, mass, or lump - 782.2

Plan:

Immunizations:

Labs:

Preventive:

Provider: Philip Wessinger, M.D.

Patient: HOUSTON, TOMMY G DOB: 02/18/1956 Date: 06/24/2009

Philip Wessinger MD

Electronically signed by Philip Wessinger on 12/09/2009 at 01:38 PM EST
Sign off status: Pending



UNIVERSITY MEDICAL GROUP

HOUSTON, TOMMY G

53 Y old Male, DOB: 02/18/1956
204 BARTON ST, PO BOX 1099, EASLEY, SC-29640
Home: 864-855-0437

Guarantor: HOUSTON, TOMMY G Insurance: UNITED
HEALTHCARE

External Visit ID: 87980702

07/01/2009

PROGRESS NOTES: Philip Wessinger, M.D.

Current Medications

Plavix 75 mg 1 tab(s) once a day
ASA 325 mgm 1 daily
Imdur 30 mg 1 tab daily
Lorazepam 0.5 mg 1 tab(s) TID
pravastatin 80 mg 1 tab(s) once a day (at
bedtime)
Bystolic 40 mg Oral-tablet

Past Medical History

Hypertension

Family History

Family: diabetes

Social History

no Alcohol.
no Smoking.
no Recreational drug use.
no Use of marijuana, cocaine, or similar
drugs.

Allergies

codeine

Review of Systems

No changes found in review of system
since last checked on 06/10/09

Reason for Appointment

1. SHG/WCR: RT HAND/REMOVE STITCHES, GLOBAL 8.30.09

History of Present Illness

Interim History:

Prior Assessment Benign neoplasm of skin of lip, Localized
superficial swelling, mass, or lump. Date of Injury: 03/11/08. Date of
Surgery: 06.01.09 EXPLORATION AND REMOVAL OF FORIEGN
BODY, RT HAND, 07/11/08 RT SHOULDER SCOPE, ROTATOR CUFF
REPAIR. Treatment to Date: duricef. Response to treatment: patient
states feeling better since last visit. Pain: Severity: pain = 1
satisfactorily controlled dull aching intermittent.

HPI:

The patient is a 53 year-old who comes in today.

Vital Signs

Ht 70, Wt lbs 203, BMI 29.12, HR 76.

Examination

General:

General Appearance: Well and in no acute distress.
Cardiovascular: Regular rhythm by palpation of distal pulse, normal
color and temperature, no concerning varicosities on symptomatic
side. Lungs: Breathing easily. Psychiatric: Well-oriented with a
normal mood and affect.

Right Wrist/Hand:

His wound has healed nicely. We have removed his sutures here
today.

Assessments

1. Benign neoplasm of skin of lip - 216.0 (Primary)
2. Localized superficial swelling, mass, or lump - 782.2

Treatment

1. Others

I do feel that from his shoulder and back perspective from his injury
that he is at MMI. I feel that from his shoulder and massive rotator cuff
repair and with continuing to have some weakness, we are dealing with
a 15% impairment of the shoulder based on AMA Guides for Permanent
Impairment. From his low back and with pain with regard to the

Patient: HOUSTON, TOMMY G DOB: 02/18/1956 Progress Note: Philip Wessinger, M.D. 07/01/2009
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lumbar spine, I feel that we are dealing with a 7% impairment. The patient is to come back to see me on a PRN basis. He is released from care and he is back at work.

Follow Up
prn

Electronically signed by Philip Wessinger on 07/06/2009 at 09:31 AM EDT

Sign off status: Completed

Steadman Hawkins-HillCrest (SH)
727 S.E. Main Street
Simpsonville, SC 29681
Tel: 864-454-7422
Fax: 864-454-6605

Patient: HOUSTON, TOMMY G DOB: 02/18/1956 Progress Note: Philip Wessinger, M.D. 07/01/2009

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



GREENVILLE HEALTH SYSTEM

HOUSTON, TOMMY G

54 Y old Male, DOB: 02/18/1956
204 BARTON ST, PO BOX 1099, EASLEY, SC-29640

Home: 864-855-0437

Guarantor: HOUSTON, TOMMY G Insurance: UNITED
HEALTHCARE

PCP: Richard Curry, MD External Visit ID: 103409942

09/01/2010

Progress Notes: Philip Wessinger, M.D.

Current Medications

ASA 325 mgm 1 q am
Indur 30 mg 1 tab qd
labetalol 200 mg 1 tab(s) BID
Lorazepam 0.5 mg 1 tab(s) TID
pravastatin 80 mg 1 tab(s) once a day (at
bedtime)

Past Medical History

Hypertension

Surgical History

left wrist 1978
right knee 1971
hernia 9/07
heart surgery 11/23

Family History

Family: diabetes, Hypertension

Social History

no Alcohol.
Smoking: yes, PPD: , years.
no Recreational drug use.
no Use of marijuana, cocaine, or similar
drugs

Allergies

codeine

Review of Systems

Osteoporosis:

Lifestyle Factors Pt currently
smokes.

CONSTITUTIONAL:

Fever NO. Weight Loss NO. Weight
Gain NO. Fatigue NO. Chills NO. Night
Sweats NO.

CARDIOVASCULAR:

Chest Pain NO. Irregular Heart Beat NO.
Poor Circulation NO. Leg/feet swelling NO.
Leg/foot ulcer NO.

GENITOURINARY:

Blood in urine NO. Pain in urinating NO.
Unable to urinate NO. Bladder Infection NO.
Frequent Urination NO. Difficulty with
urination NO.

Reason for Appointment

1. ENP RT SHOULDER RE EVAL W/C PER MELISSA

History of Present Illness

Interim History:

Prior Assessment Rotator cuff tear, Subacromial Impingement,
Bursitis of hip. Date of Injury: 03/11/08. Date of Surgery: 07/11/08
RT SHOULDER SCOPE, ROTATOR CUFF REPAIR. Response to
treatment: patient states feeling worse since last visit. Pain: Severity:
pain = 9/10, sharp, stabbing, burning, constant, **not satisfactorily
controlled**, Associated Symptoms: numbness, stiffness, locking,
catching, giving away, Aggravated by: physical activity.

IIPI:

The patient comes in today. He states he has gradually had an
increase of pain in his right shoulder to the point where he is having a
lot of difficulty. It feels very much like a rotator cuff tear at this point.
He states it has made it very difficult for him to participate in activities.

He is complaining of left leg pain as well and low back pain.

Vital Signs

Ht 70, Wt lbs 200, BMI 28.69, RR 16.

Examination

General:

General Appearance: Well and in no acute distress.
Cardiovascular: Regular rhythm by palpation of distal pulse, normal
color and temperature, no concerning varicosities on symptomatic
side. Lungs: Breathing easily. Psychiatric: Well-oriented with a
normal mood and affect.

Right Shoulder/Arm:

Positive impingement signs. There is some weakness in abduction.

SM Spine:

He has some soreness into both hips. No pain down the leg.

Imaging Studies:

X-rays demonstrate no significant osteoarthritis. No disc space
narrowing.

Assessments

Patient: HOUSTON, TOMMY G DOB: 02/18/1956 Progress Note: Philip Wessinger, M.D. 09/01/2010

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

NEUROLOGICAL:

Paralysis **NO**. Frequent Headaches **NO**
Seizures **NO**. CVA/ITA **YES**. Syncope **NO**.
Anxiety/Depression **NO**. Tremors **NO**.
Speech Problems **NO**. Feeling of
hopelessness **NO**. Sleep disturbance **NO**.
Vision Changes **NO**.

EYES:

Decreased Vision **NO**. Cataracts **NO**.

RESPIRATORY:

COPD **NO**. Asthma **NO**. Persistent
Cough **NO**. Shortness of Breath **NO**.
Wheezing **NO**. Pneumonia **NO**.

ENT:

Loss of Hearing **NO**. Sinusitis **YES**.
Headache **NO**.

GASTROINTESTINAL:

GERD **NO**. PUD/Gastritis **NO**. Liver
Problems **NO**. Stomach Pain **NO**.
Diarrhea **NO**. Abdominal Pain **NO**.
Nausea/Vomiting **NO**. Black tar-like or
bloody stool **NO**.

SKIN:

Rash **NO**. Dryness of Skin **NO**. Ulcer **NO**.
Cancer **NO**. Open sores **NO**. New Moles **NO**.
Poor Healing **NO**. Skin Infection **NO**.

PSYCHIATRIC:

Depression **NO**. Bipolar Disease **NO**.

ENDOCRINE:

Diabetes **NO**. Thyroid **NO**. Heat
intolerance **NO**. Cold intolerance **NO**.

HEME/LYMP:

Anemia **NO**. Bleeding Problems **NO**.
Blood Transfusion **NO**. Bruises **NO**.

ALLERGIC/IMMUNOLOGIC:

Seasonal **YES**. Iodine **NO**. Food
Allergies **NO**.

MUSCULOSKELETAL:

Joint Swelling **NO**. Muscle aches **NO**.
Joint Pain **NO**. Pain in multiple joints **NO**.
Weakness **NO**.

1. Localized superficial swelling, mass, or lump - 782.2 (Primary)
2. Rotator cuff tear - 727.61
3. Subacromial Impingement - 726.19
4. Low back pain - 724.2

Treatment

1. Localized superficial swelling, mass, or lump

Start Medrol dose pack, 1, as directed, Refills 0

OOW note given: out of work until he comes back for MRI results

2. Subacromial Impingement

We will get an MRI of his shoulder to evaluate. We will get him on a
Medrol Dosepak in an effort to control his back symptoms. If it is no
better when he returns, he may need an MRI of his lumbar spine.

PHW/pam

Diagnostic Imaging

Lumbar Spine, 2 or 3 views, Shoulder, 2 or more views, right

Preventive Medicine

MED RECONCILIATION: Handout given: Complete and current
medication list reviewed, printed, and handed to the patient today.

Procedure Codes

73030 SHOULDER (2 OR MORE VIEWS) X-RAY

72100 LS SPINE (2-3 VIEW) X-RAY

Follow Up

after MRI

Electronically signed by Philip Wessinger on 09/02/2010 at
01:03 PM EDT

Sign off status: Completed

Steadman Hawkins-Greenville (SHCP)
200 Patewood Dr
Greenville, SC 29615
Tel: 864-454-7422
Fax: 864-454-6605

Patient: HOUSTON, TOMMY G DOB: 02/18/1956 Progress Note: Philip Wessinger, M.D. 09/01/2010

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



UNIVERSITY MEDICAL GROUP

HOUSTON, TOMMY G

54 Y old Male, DOB: 02/18/1956
204 BARTON ST, PO BOX 1099, EASLEY, SC-29640
Home: 864-855-0437

Guarantor: HOUSTON, TOMMY G Insurance: UNITED
HEALTHCARE

PCP: Richard Curry, MD External Visit ID: 105000780

10/06/2010

PROGRESS NOTES: Philip Wessinger, M.D.

Current Medications

ASA 325 mgm 1 q am
Imdur 30 mg 1 tab qd
labetalol 200 mg 1 tab(s) BID
Lorazepam 0.5 mg 1 tab(s) TID
pravastatin 80 mg 1 tab(s) once a day (at
bedtime)
Medrol dose pack as directed

Past Medical History

Hypertension

Surgical History

left wrist 1978
right knee 1974
hernia 9/07
heart surgery 11/23

Family History

Family: diabetes, Hypertension

Allergies

codeine

Review of Systems

Osteoporosis:

Lifestyle Factors Pt currently

smokes.

CONSTITUTIONAL:

Fever NO. Weight Loss NO. Weight

Gain NO. Fatigue NO. Chills NO. Night

Sweats NO.

CARDIOVASCULAR:

Chest Pain NO. Irregular Heart Beat NO.

Poor Circulation NO. Leg/feet swelling NO.

Leg/foot ulcer NO.

GENITOURINARY:

Blood in urine NO. Pain in urinating NO.

Unable to urinate NO. Bladder Infection NO.

Frequent Urination NO. Difficulty with
urination NO.

NEUROLOGICAL:

Paralysis NO. Frequent Headaches NO.

Seizures NO. CVA/ITA yes. Syncope NO.

Anxiety/Depression NO. Tremors NO.

Reason for Appointment

1. SHT, MRI RESULTS, RT SHOULDER

History of Present Illness

Interim History:

Prior Assessment Rotator cuff tear, Subacromial Impingement,
Bursitis of hip. Date of Injury: 03/11/08. Date of Surgery: 07/11/08
RT SHOULDER SCOPE, ROTATOR CUFF REPAIR. Response to
treatment: patient states feeling the same since last visit.

Pain: Severity: pain = 5/10 constant aching, burning pain, not
satisfactorily controlled.

HPI:

This is a 54 year-old who comes in. MRI that he had back on
09/08/10 shows that he has some tendonitis in his rotator cuff, but
does not have a full thickness tear. He has some AC arthritis, fraying of
the labrum, but no obvious tear. I agree with the reading.

He states he is still having back and hip problems, primarily on
the left side. He states they have been present since the accident as
well. They are getting apparently worse. He states he can only walk for
10-15 minutes before he starts to have pain in the left leg. He can sit on
something hard and relieve this.

Vital Signs

Ht 70, Wt lbs 200, BMI 28.69, RR 16.

Examination

General:

General Appearance: Well and in no acute distress.

Cardiovascular: Regular rhythm by palpation of distal pulse, normal
color and temperature, no concerning varicosities on symptomatic
side. Lungs: Breathing easily. Psychiatric: Well-oriented with a
normal mood and affect.

Imaging Studies:

X-rays from last were reviewed and show no significant disc space
loss, maybe some mild L4/5 spondylolisthesis.

Assessments

1. Localized superficial swelling, mass, or lump - 782.2 (Primary)
2. Rotator cuff tear - 727.61
3. Subacromial Impingement - 726.19

Patient: HOUSTON, TOMMY G DOB: 02/18/1956 Progress Note: Philip Wessinger, M.D. 10/06/2010

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Speech Problems no. Feeling of
hopelessness no. Sleep disturbance no.
Vision Changes no.
-YES:

Decreased Vision no. Cataracts no.
RESPIRATORY:

COPD no. Asthma no. Persistent
Cough no. Shortness of Breath no.
Wheezing no. Pneumonia no.

ENT:

Recent loss of hearing no.
Sinusitis yes. Headache no.

GASTROINTESTINAL:

GERD no. PUD/Gastritis no. Liver
Problems no. Stomach Pain no.
Diarrhea no. Abdominal Pain no.
Nausea/Vomiting no. Black tar-like or
bloody stool no.

SKIN:

Rash or itching no. Dryness of Skin no.
Ulcer no. Cancer no. Open sores no. New
Moles no. Poor wound healing no. Skin
Infection no.

PSYCHIATRIC:

Depression no. Bipolar Disease no.
ENDOCRINE:

Diabetes no. Thyroid disease no. Heat
intolerance no. Cold intolerance no.
HEME/LYMP:

Anemia no. Bleeding Problems no.
Blood Transfusion no. Bruises no.

ALLERGIC/IMMUNOLOGIC:

Seasonal yes. Iodine no. Food
Allergies no.

MUSCULOSKELETAL:

Joint Swelling or Stiffness no. Muscle
aches no. Joint Pain no. Pain in multiple
joints no. Weakness no.

4. Low back pain - 724.2

Treatment

1. Localized superficial swelling, mass, or lump

We will go ahead and get MRI. We will have her come back to see me
here after MRI. PHW/gsl

Follow Up

p mri

Electronically signed by Philip Wessinger on 10/12/2010 at
02:19 PM EDT

Sign off status: Completed

Steadman Hawkins-Greenville (SHCP)
200 Patewood Dr
Greenville, SC 29615
Tel: 864-454-7422
Fax: 864-454-6605

Patient: HOUSTON, TOMMY G DOB: 02/18/1956 Progress Note: Philip Wessinger, M.D. 10/06/2010

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



UNIVERSITY MEDICAL GROUP

HOUSTON, TOMMY G

54 Y old Male, DOB: 02/18/1956
204 BARTON ST, PO BOX 1099, EASLEY, SC-29640
Home: 864-855-0437

Guarantor: HOUSTON, TOMMY G Insurance: UNITED HEALTHCARE

PCP: Richard Curry, MD External Visit ID: 106268808

10/27/2010

PROGRESS NOTES: Philip Wessinger, M.D.

Current Medications

ASA 325 mg q 1 q am
Imdur 30 mg 1 tab qd
labetalol 200 mg 1 tab(s) BID
Lorazepam 0.5 mg 1 tab(s) TID
pravastatin 80 mg 1 tab(s) once a day (at bedtime)
Medrol dose pack as directed

Past Medical History

Hypertension

Surgical History

left wrist 1978
right knee 1974
hernia 9/07
heart surgery 11/23

Family History

Family: diabetes, Hypertension

Allergies

codeine

Review of Systems

Osteoporosis:

Lifestyle Factors Pt currently smokes.

CONSTITUTIONAL:

Fever NO. Weight Loss NO. Weight Gain NO. Fatigue NO. Chills NO. Night Sweats NO.

CARDIOVASCULAR:

Chest Pain NO. Irregular Heart Beat NO. Poor Circulation NO. Leg/feet swelling NO. Leg/foot ulcer NO.

GENITOURINARY:

Blood in urine NO. Pain in urinating NO. Unable to urinate NO. Bladder Infection NO. Frequent Urination NO. Difficulty with urination NO.

NEUROLOGICAL:

Paralysis NO. Frequent Headaches NO. Seizures NO. CVA/ITA yes. Syncope NO. Anxiety/Depression NO. Tremors NO.

Reason for Appointment

1. SHR-MRI LUMBAR

History of Present Illness

Interim History:

Prior Assessment Rotator cuff tear, Subacromial Impingement, Bursitis of hip. Date of Injury: 03/11/08. Date of Surgery: 07/11/08. RT SHOULDER SCOPE, ROTATOR CUFF REPAIR. Response to treatment: patient states feeling the same since last visit. Pain: Severity: pain = 7/10 constant sharp, stabbing, burning pain, not satisfactorily controlled.

HPI:

This 54 year-old comes in today with his MRI.

Vital Signs

Ht 70, Wt lbs 200, BMI 28.69, RR 16.

Examination

General:

General Appearance: Well and in no acute distress. Cardiovascular: Regular rhythm by palpation of distal pulse, normal color and temperature, no concerning varicosities on symptomatic side. Lungs: Breathing easily. Psychiatric: Well-oriented with a normal mood and affect.

Imaging Studies:

MRI demonstrates L4-5 severe facet arthritis and some lateral recess stenosis. He has some mild disc space narrowing, but nothing that is putting pressure on the nerve root currently.

Assessments

1. Localized superficial swelling, mass, or lump - 782.2 (Primary)
2. Rotator cuff tear - 727.61
3. Subacromial Impingement - 726.19
4. Low back pain - 724.2

Treatment

1. Subacromial Impingement

I feel that his shoulder is at maximum medical improvement and he is ready for discharge with regard to this.

Patient: HOUSTON, TOMMY G DOB: 02/18/1956 Progress Note: Philip Wessinger, M.D. 10/27/2010

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Speech Problems **no**. Feeling of hopelessness **no**. Sleep disturbance **no**. Vision Changes **no**.

-EYES:

Decreased Vision **no**. Cataracts **no**.

RESPIRATORY:

COPD **no**. Asthma **no**. Persistent

Cough **no**. Shortness of Breath **no**.

Wheezing **no**. Pneumonia **no**.

ENT:

Recent loss of hearing **no**.

Sinusitis **yes**. Headache **no**.

GASTROINTESTINAL:

GERD **no**. PUD/Gastritis **no**. Liver Problems **no**. Stomach Pain **no**.

Diarrhea **no**. Abdominal Pain **no**.

Nausea/Vomiting **no**. Black tar-like or bloody stool **no**.

SKIN:

Rash or itching **no**. Dryness of Skin **no**.

Ulcer **no**. Cancer **no**. Open sores **no**. New

Moles **no**. Poor wound healing **no**. Skin

Infection **no**.

PSYCHIATRIC:

Depression **no**. Bipolar Disease **no**.

ENDOCRINE:

Diabetes **no**. Thyroid disease **no**. Heat intolerance **no**. Cold intolerance **no**.

HEME/LYMP:

Anemia **no**. Bleeding Problems **no**.

Blood Transfusion **no**. Bruises **no**.

ALLERGIC/IMMUNOLOGIC:

Seasonal **yes**. Iodine **no**. Food

Allergies **no**.

MUSCULOSKELETAL:

Joint Swelling or Stiffness **no**. Muscle aches **no**. Joint Pain **no**. Pain in multiple joints **no**. Weakness **no**.

2. Low back pain

He has mostly osteoarthritic problems that, again, could have been aggravated by his accident, but certainly were not caused by the accident. He has asked about what can be done and if there is anything surgical. We need to get a surgical opinion. We will send him for evaluation with regard to this. PHW/pan

3. Others

Out of work until appt. with spine center. COPY: Dr. Curry

Follow Up

Spine Center

Electronically signed by Philip Wessinger on 10/29/2010 at 12:10 PM EDT

Sign off status: Completed

Steadman Hawkins-Greenville (SHCP)
200 Patewood Dr
Greenville, SC 29615
Tel: 864-454-7422
Fax: 864-454-6605

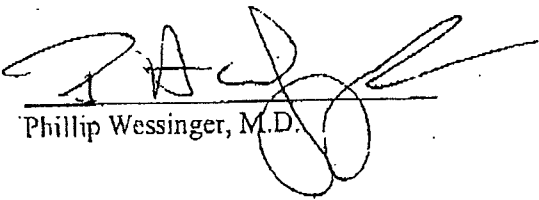
Patient: HOUSTON, TOMMY G DOB: 02/18/1956 Progress Note: Philip Wessinger, M.D. 10/27/2010

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Re: Patient/Client : Tommy G. Houston
Date of Injury : March 11, 2008
Social Security No. : 250-06-6278
Date of Birth : 2/18/56

 Tommy G. Houston has sustained a change of condition for the worse since I released him on July 1, 2009.

 Tommy G. Houston has not sustained a change of condition for the worse since I released him on July 1, 2009.


Phillip Wessinger, M.D.

11/3/10
Date

Piedmont Spine and Neurosurgical Group, P.A.

3 St. Francis Dr. Suite 490
Greenville, SC 29601
Phone: (864) 220-4263
Fax: (864) 220-5836

HISTORY AND PHYSICAL REPORT

Tommy G Houston

ID: 171100

DOB: 02/18/1956 (55 years)

Date of Encounter: 04/21/2011 03:33 PM

History of Present Illness

Patient words: History of Present Illness (Janice W Blackwell; 4/21/2011 9:53 AM)

Patient words: Patient complains of low back pain radiating to the left buttock, down the back of the left leg to the foot. He also complains of numbness down the outside of his left leg. He occasionally has symptoms in the right groin region and leg. Standing, walking or riding in a truck aggravates his symptoms which have been present since 3/18/2008 when he was involved in a MVA at work. MRI of the lumbar spine in October 2010 did show severe left foraminal stenosis at L4-5 however the sagittal views show a possible grade 1 spondylolisthesis as well. The patient is a 54 year old male

Problem List/Past Medical (Janice W Blackwell; 4/21/2011 9:54 AM)

Conservative Treatment. Prescription Medications, Physical Therapy, Injections.
Glucose intolerance
Claustrophobia
High blood pressure
Stroke
Coronary artery disease
Placement of cardiac stent
Right shoulder surgery
Right hand surgery
Hernia repair
Right knee surgery
Left wrist surgery

Allergies (Janice W Blackwell; 4/21/2011 9:54 AM)
Codeine/Codeine Derivatives

Family History (Janice W Blackwell; 4/21/2011 9:55 AM)
Heart Disease
Diabetes

Social History (Janice W Blackwell; 4/21/2011 9:55 AM)
No alcohol use
Tobacco use. Has been smoking for 25 years, Smokes < 1 pack of cigarettes per day.
Current Work/Study Status. Full-time.

Review of Systems (Janice W Blackwell; 4/21/2011 9:53 AM)
Respiratory: Present- Wheezing.
Musculoskeletal: Present- Leg Cramps and Muscle Pain.
Psychiatric: Present- Insomnia (Pain).

Vitals (Janice W Blackwell; 4/21/2011 9:56 AM)
4/21/2011 9:55 AM
Weight: 198 lb Height: 70 in
Weight was reported by patient.
Height was reported by patient.
Body Surface Area: 2.11 m² Body Mass Index: 28.41 kg/m²

Tommy G Houston

Patient #: 171100

DOB: 02/18/1956 (55 years)

Friday, June 24, 2011

Page 1 / 3

Patient reports pain level ranges 5/10 to 10/10. Medication History (Janice W Blackwell; 4/21/2011 3:30 PM)
Amlodipine/benazepril 10/40 Active.
Bystolic 10 mg Active.
Isosorbide 60 mg Active.
Pravastatin 40 mg Active.
Ecotrin Active. (325)
Niacin Active.

The patient is a 55 year old male

History

There is no documented history at this time.

Physical Exam

The physical exam findings are as follows:

General

Mental Status - Alert. **General Appearance** - Cooperative.

Eye

Fundi - **Bilateral** - Normal.

Chest and Lung Exam

Chest and lung exam reveals - on auscultation, normal breath sounds, no adventitious sounds and normal vocal resonance.

Cardiovascular

Cardiovascular examination reveals - normal heart sounds, regular rate and rhythm with no murmurs.

Abdomen

Palpation/Percussion: Palpation and Percussion of the abdomen reveal - Non Tender and No Rigidity (guarding).

Auscultation: Auscultation of the abdomen reveals - Bowel sounds normal.

Neurologic

Mental Status: **Affect** - normal and appropriate. **Speech** - Normal. **Thought content/perception** - Normal. **Cognitive function** - Normal.

Cranial Nerves: I Olfactory - Normal.

II Optic: - Normal Bilaterally.

III Oculomotor: - Normal Bilaterally.

IV Trochlear - **Bilateral** - Normal.

V Trigeminal: - Normal Bilaterally.

VI Abducens - **Bilateral** - Normal.

VII Facial: - Normal Bilaterally.

VIII Acoustic - **Bilateral** - Hearing normal. **IX Glossopharyngeal / X Vagus** - Normal.

XI Accessory: - Normal Bilaterally.

XII Hypoglossal - **Bilateral** - Normal.

Eye Movements: **Gaze** - **Bilateral** - Extraocular muscles intact. **Nystagmus** - **Bilateral** - None.

Sensory:

Pain: Intact - Globally.

Motor:

Tone: - Normal.

Strength: 5/5 normal muscle strength - All Muscles.

Reflexes (Dermatomes): 2/2 Normal - All.

Plantar Reflexes (L4-S2) - **Bilateral** - Flexion. **Coordination** - Normal. **Gait** - Normal.

Neuropsychiatric

Thought Processes/Cognitive Function - appropriate fund of knowledge. no attention deficit, no impairment of concentration, no impairment of global orientation, no impairment of long term memory and no impairment of short term memory.

Assessments

- LUMBAR STENOSIS (724.02)
- rule out spondylolisthesis
- REVIEW OF FILMS (V72.5)

Flex/Ext Lumbar Spine (72120) (1 Units)
MYELOGRAM / LUMBAR (72265) (1 Units)
Follow up in 2 weeks Follow up in 2 weeks or as needed

Michael N. Bucci MD

Michael N Bucci MD

Tommy G Houston

Patient #: 171100

DOB: 02/18/1956 (55 years)

Friday, June 24, 2011

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R. 494

Piedmont Spine and Neurosurgical Group, P.A.

3 St. Francis Dr. Suite 490
Greenville, SC 29601
Phone: (864) 220-4263
Fax: (864) 220-5836

HISTORY AND PHYSICAL REPORT

Tommy G Houston

ID: 171100

DOB: 02/18/1956 (55 years)

Date of Encounter: 04/21/2011 03:29 PM

History of Present Illness

History

Medications

Amlodipine/benazepril 10/40 Active.
Bystolic 10 mg Active.
Isosorbide 60 mg Active.
Pravastatin 40 mg Active.
Ecotrin Active. (325)
Niacin Active.

Janice W Blackwell

Tommy G Houston

Patient #: 171100

DOB: 02/18/1956 (55 years)

Friday, June 24, 2011

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R. 495

Piedmont Spine and Neurosurgical Group, P.A.

3 St. Francis Dr. Suite 490
Greenville, SC 29601
Phone: (864) 220-4263
Fax: (864) 220-5836

HISTORY AND PHYSICAL REPORT

Tommy G Houston

ID: 171100

DOB: 02/18/1956 (55 years)

Date of Encounter: 04/21/2011 09:49 AM

History of Present Illness

Patient words: Patient complains of low back pain radiating to the left buttock, down the back of the left leg to the foot. He also complains of numbness down the outside of his left leg. He occasionally has symptoms in the right groin region and leg. Standing, walking or riding in a truck aggravates his symptoms which have been present since 3/18/2008 when he was involved in a MVA at work.
The patient is a 54 year old male

History

Allergy

Codeine/Codeine Derivatives

Past Medical

Conservative Treatment

Glucose intolerance

Claustrophobia

High blood pressure

Stroke

Coronary artery disease

Placement of cardiac stent

Right shoulder surgery

Right hand surgery

Hernia repair

Right knee surgery

Left wrist surgery

Social

No alcohol use

Tobacco use

Current Work/Study Status

Family

Heart Disease

Diabetes

Review of Systems

Respiratory: Present- Wheezing.

Musculoskeletal: Present- Leg Cramps and Muscle Pain.

Psychiatric: Present- Insomnia (Pain).

Vitals

04/21/2011 09:55 AM

Weight: 198 lb Height: 70 in

Body Surface Area: 2.08 m² Body Mass Index: 28.44 kg/m²

Patient reports pain level ranges 5/10 to 10/10.

Tommy G Houston

Patient #: 171100

DOB: 02/18/1956 (55 years)

Friday, June 24, 2011

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Janice W Blackwell

Tommy G Houston

Patient #: 171100

DOB: 02/18/1956 (55 years)

Friday, June 24, 2011

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R. 497

Piedmont Spine and Neurosurgical Group, P.A.

3 St. Francis Dr. Suite 490
Greenville, SC 29601
Phone: (864) 220-4263
Fax: (864) 220-5836

HISTORY AND PHYSICAL REPORT**Tommy G Houston****ID: 171100****DOB: 02/18/1956 (55 years)****Date of Encounter: 06/28/2011 02:22 PM****History of Present Illness**

Patient words: CT myelography shows a wide open spinal canal without stenosis. There are no pars defects. The report mentions a grade 1 spondylolisthesis however to me the spinal alignment is normal.
The patient is a 55 year old male

History

There is no documented history at this time.

Physical Exam

The physical exam findings are as follows:

General

Mental Status - Alert. **General Appearance** - Cooperative.

Eye

Fundi - **Bilateral** - Normal.

Chest and Lung Exam

Chest and lung exam reveals - on auscultation, normal breath sounds, no adventitious sounds and normal vocal resonance.

Cardiovascular

Cardiovascular examination reveals - normal heart sounds, regular rate and rhythm with no murmurs.

Abdomen

Palpation/Percussion: Palpation and Percussion of the abdomen reveal - Non Tender and No Rigidity (guarding).

Auscultation: Auscultation of the abdomen reveals - Bowel sounds normal.

Neurologic

Mental Status: Affect - normal and appropriate. **Speech** - Normal. **Thought content/perception** - Normal. **Cognitive function** - Normal.

Cranial Nerves: I Olfactory - Normal.

II Optic: - Normal Bilaterally.

III Oculomotor: - Normal Bilaterally.

IV Trochlear - **Bilateral** - Normal.

V Trigeminal: - Normal Bilaterally.

VI Abducens - **Bilateral** - Normal.

VII Facial: - Normal Bilaterally.

VIII Acoustic - **Bilateral** - Hearing normal. **IX Glossopharyngeal / X Vagus** - Normal.

XI Accessory: - Normal Bilaterally.

XII Hypoglossal - **Bilateral** - Normal.

Eye Movements: Gaze - **Bilateral** - Extraocular muscles intact. **Nystagmus** - **Bilateral** - None.

Sensory:

Pain: Intact - Globally.

Motor:

Tone: - Normal.

Strength: 5/5 normal muscle strength - All Muscles.

Reflexes (Dermatomes): 2/2 Normal - All.

Plantar Reflexes (L4-S2) - **Bilateral** - Flexion. **Coordination** - Normal. **Gait** - Normal.

Tommy G Houston

Patient #: 171100

DOB: 02/18/1956 (55 years)

Friday, July 1, 2011

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Neuropsychiatric

Thought Processes/Cognitive Function - appropriate fund of knowledge, no attention deficit, no impairment of concentration, no impairment of global orientation, no impairment of long term memory and no impairment of short term memory.

Assessments

- LOW BACK PAIN - LUMBAGO (724.2)
- LIGAMENT STRAIN OR SPRAIN (848.8)
- LUMBAR DDD (722.52)
- REVIEW OF FILMS (V72.5)

FOLLOW UP AS NEEDED FOLLOW-UP AS NEEDED
Referred to: Grler, Michael T MD (Undefined)

Michael N. Buccì

Michael N Buccì MD

Tommy G Houston

Patient #: 171100

DOB: 02/18/1956 (55 years)

Friday, July 1, 2011

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Piedmont Spine and Neurosurgical Group, P.A.

3 St. Francis Dr. Suite 490
Greenville, SC 29601
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*Michael N. Bucci, M.D., F.A.C.S.
Aaron C. MacDonald, M.D., F.A.C.S.
Christie B. Mina, M.D.
D. Mark Melton, M.D.*

06/28/2011 02:22 PM

RE: Consultation for Tommy G Houston

It was a pleasure to see your patient, Tommy G Houston for a consultation in my office. After my examination of the patient, here are my findings and recommendations:

Assessments

- **LOW BACK PAIN - LUMBAGO (724.2)**
 - **LIGAMENT STRAIN OR SPRAIN (848.8)**
 - **LUMBAR DDD (722.52)**
 - **REVIEW OF FILMS (V72.5)**
- FOLLOW UP AS NEEDED FOLLOW-UP AS NEEDED
Referred to: Grier, Michael T MD (Undefined)

It is a pleasure participating in the care of Tommy G Houston. Please let me know if you have any questions.

Sincerely,



Michael N Bucci, MD

Piedmont Spine and Neurosurgical Group, P.A.

3 St. Francis Dr. Suite 490
Greenville, SC 29601
Phone: (864) 220-4263
Fax: (864) 220-5836

HISTORY AND PHYSICAL REPORT

Tommy G Houston

ID: 171100

DOB: 02/18/1956 (55 years)

Date of Encounter: 06/28/2011 02:22 PM

History of Present Illness

Patient words: CT myelography shows a wide open spinal canal without stenosis. There are no pars defects. The report mentions a grade 1 spondylolisthesis however to me the spinal alignment is normal. The patient is a 55 year old male

History

There is no documented history at this time.

Physical Exam

The physical exam findings are as follows:

General

Mental Status - Alert. **General Appearance** - Cooperative.

Eye

Fundi - Bilateral - Normal.

Chest and Lung Exam

Chest and lung exam reveals - on auscultation, normal breath sounds, no adventitious sounds and normal vocal resonance.

Cardiovascular

Cardiovascular examination reveals - normal heart sounds, regular rate and rhythm with no murmurs.

Abdomen

Palpation/Percussion: Palpation and Percussion of the abdomen reveal - Non Tender and No Rigidity (guarding).

Auscultation: Auscultation of the abdomen reveals - Bowel sounds normal.

Neurologic

Mental Status: **Affect** - normal and appropriate. **Speech** - Normal. **Thought content/perception** - Normal.

Cognitive function - Normal.

Cranial Nerves: I Olfactory - Normal.

II Optic: - Normal Bilaterally.

III Oculomotor: - Normal Bilaterally.

IV Trochlear - Bilateral - Normal.

V Trigeminal: - Normal Bilaterally.

VI Abducens - Bilateral - Normal.

VII Facial: - Normal Bilaterally.

VIII Acoustic - Bilateral - Hearing normal. **IX Glossopharyngeal / X Vagus** - Normal.

XI Accessory: - Normal Bilaterally.

XII Hypoglossal - Bilateral - Normal.

Eye Movements: **Gaze** - Bilateral - Extraocular muscles intact. **Nystagmus** - Bilateral - None.

Sensory:

Pain: Intact - Globally.

Motor:

Tone: - Normal.

Strength: 5/5 normal muscle strength - All Muscles.

Reflexes (Dermatomes): 2/2 Normal - All.

Plantar Reflexes (L4-S2) - Bilateral - Flexion. **Coordination** - Normal. **Gait** - Normal.

Neuropsychiatric

Thought Processes/Cognitive Function - appropriate fund of knowledge. no attention deficit, no impairment of concentration, no impairment of global orientation, no impairment of long term memory and no impairment of short term memory.

Assessments

LOW BACK PAIN - LUMBAGO (724.2)

LIGAMENT STRAIN OR SPRAIN (848.8)

LUMBAR DDD (722.52)

REVIEW OF FILMS (V72.5)

Additional Instructions

FOLLOW-UP AS NEEDED

Referrals

Referred to: Grier, Michael T MD (Undefined)



UNIVERSITY MEDICAL GROUP

HOUSTON, TOMMY GREGORY

55 Y old Male, DOB: 02/18/1956
204 BARTON ST, PO BOX 1099, EASLEY, SC-29640

Home: 864-855-0437

Guarantor: HOUSTON, TOMMY GREGORY

Insurance: UNITED HEALTHCARE

PCP: Richard Curry, MD External Visit ID: 119145332

Appointment Facility: Upstate Medical Rehabilitation

08/18/2011

Progress Notes: Jyoti Math, MD

Current Medications

pravastatin tablet 80 mg 1 tab(s) once a day (at bedtime)
amlodipine-benazepril capsule 10-mg-40-mg 1 cap(s) once a day
Bystolic tablet 10 mg 1 tab(s) twice a day
isosorbide mononitrate tablet, extended release 60 mg 1 tab(s) once a day (in the morning)
Ecotrin enteric coated tablet 325 mg 1 tab(s) once a day
niacin tablet, extended release 1000 mg 1 tab(s) once a day (at bedtime)
Medication List reviewed and reconciled with the patient

Past Medical History

Hypertension
High Cholesterol
Heart disease
Heart Attack
Fracture

Surgical History

left wrist 1978
right knee 1974
hernia 9/07
heart surgery 11/23
EXPLORATION AND REMOVAL OF FOREIGN BODY, RT HAND. 06/01/09

Family History

Family: diabetes, Hypertension, Heart Disease

Social History

Interpersonal/family relationships: Divorced.

Occupation: Employed, but currently not working.
no Alcohol
Smoking: yes PPD: , years:.
no Recreational drug use.
no Use of marijuana, cocaine, or similar drugs.

Reason for Appointment

1. New W/C shoulder

History of Present Illness**Worker's Comp:****Interim History:**

1. MRI L-Spine 10/14/10: (a) there is increased stress at the lumbosacral junction. (b) severe bilateral L5-S1 facet arthritis. mild non-compressive L5-S1 disc bulge. mild L4-5 disc bulge (c) moderate left and milder right S1 lateral recess narrowing (d) moderate right and severe left L5 bony neural foraminal stenosis

2. CT L-Spine 6/2/11: (a) transitional vertebral bodies. there is grade 1 anterolisthesis of L5 appreciated secondary to facet degenerative changes. (b) no pars fractures are appreciated. there are multilevel degenerative changes from L4-5 through S1-2

3. FL-Lumbar Myelogram 6/2/11: (a) minimal anterolisthesis of L5. endplate degenerative changes noted. vertebral body heights maintained (b) fluoroscopically guided lumbar myelogram.

Date of Injury: 3/11/08 2:30 pm . Work Status: Out of work, WC leave. Current treatment: PT No PT in past , Injections:

No. Location: Lumbar region bilaterally, shoulders, hips . Quality: radiating, numbness, burning, constant cramp. Severity: Pain score (on a scale of 1-10): 10 (unbearable). Qualitative intensity: moderate-to-severe. Functional impairment is very severe - when present the patient is unable to carry out any daily activities. Effect of pain on sleeping: interferes with sleep. Trend in severity since onset: slightly increased. Investigations: MRI scan, Myelogram.

General:

Patient is a 55 year-old male, seen at the request of Dr. Bucci for pain management for low back. Patient sustained a work injury on 3/11/2008. He worked for AT Systems in an armored car service when on 3/11 his partner pulled out and their armored car was hit. He injured his left shoulder and had multiple broken ribs and kidney puncture. He never had back pain before and his back pain started on the day of the injury. He has been evaluated by Dr. Wessinger. He is status post right shoulder scope and rotator cuff repair on 7/11/2008.

Regarding his back pain and knee pain, he is status post physical therapy and he was in physical therapy from 2008 to 2009, and he got a little better and he was stable. In June 2009, he went back to work

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Jyoti Math, MD 08/18/2011

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Allergies

codeine
penicillin
contrast dye: rash: Side Effects

**Hospitalization/Major
Diagnostic Procedure**

see surgery list

and he worked until August 2010, but his job is physically demanding and requires heavy lifting, and that aggravated his shoulder pain, as well as back pain. Back pain is worse with prolonged standing. It is in the back of the thigh on the left side and occasionally up to the heel. He has numbness in the L5 distribution. He has some weakness secondary to the pain, but no true weakness. He denies any fall, but occasionally he had some near-fall events.

Regarding his workers' comp, the case was settled in August 2010 and he was put at MMI by Dr. Wessinger, but it was reopened because of aggravation of his symptoms. Currently, his medical expenses are covered by workers' comp. He has recently been evaluated by Dr. Bucci and he does not feel that he is a surgical candidate. Dr. Bucci had ordered lumbar myelogram and as per his note, patient's spinal canal is wide open without any impingement and he does not require any surgery. I have reviewed the CT myelogram report. I have also reviewed his functional capacity evaluation done at ProAxis in May 2009.

Referring Provider: Michael N. Bucci, MD.

Vital Signs

Temp (F) 97.8, HR 89, BP 148/82, O2 Sat 95%, Pain score 8.

ExaminationGeneral Exam:

Patient is obese, awake, alert and oriented. His gait is normal. He is able to stand on his toes, but not on his heels. General Appearance: No apparent acute or chronic distress. Communicates normally. Alert. Affect: Normal. Head: Atraumatic. Cardiovascular: Normal, 2+ peripheral vascular pulses (rhythm, amplitude). Chest: Respiratory effort normal. Abdomen: Normal without tenderness. Skin: No significant lesions, normal. Extremities: No edema, no cyanosis, no ulcerations. Neurological and musculoskeletal assessment: On inspection, there is no swelling or edema on his lower back. On palpation, he has tenderness over the lumbar paraspinal muscles, as well as left posterosuperior iliac spine. No tenderness over the piriformis muscle or greater trochanter. Strength in bilateral lower extremities is 5/5 in myotomal distribution. No sensory deficits noted, except in left L5 distribution he has some numbness and impaired sensation. Reflexes are 1+ and symmetrical at bilateral knee and ankle. Straight leg test is negative. Hip range of motion is full and pain free. FABER test is positive on the left. No pelvic obliquity.

Assessments

1. Lumbar and sacral arthritis - 721.3 (Primary)
2. Spondylolisthesis - 756.12
3. DISORDERS SACRUM - 724.6
4. Pain, myofascial - 729.1
5. Lumbar Radiculopathy - 724.4

Treatment**1. Lumbar and sacral arthritis**

Start Percocet 7.5/325 tablet, 325 mg-7.5 mg, 1 tab(s), orally, every 6 hours, 30 days, 120

Start Flexeril tablet, 10 mg, 1 tab(s), orally, 3 times a day, 30 days, 90

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Jyoti Math, MD 08/18/2011
Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

<http://ecw.ghs.org:8080/mobiledoc/jsp/catalog/xml/printMultipleChartOptions.jsp?encount...> 9/29/2011

2. Others

I think his pain is multifactorial in origin due to above. We will start him with physical therapy for SI joint mobilization and myofascial release. If it does not improve his pain, I will consider lumbar paraspinal and ilioinguinal ligament trigger point injection. He also may benefit from facet injections, including medial branch block and rhizotomy in the future. We will reassess him as the treatment progresses and decide the future plans. We will also get flexion and extension x-rays for spondylolisthesis to make sure that it is not unstable. Patient is out of work, as per Dr. Bucci's recommendations. Also, if he does not improve with the physical therapy, we will consider SI joint injection. The patient was advised to continue all other medications as prescribed by other treating physicians/providers. JM/jp/081811.

Referral To:

Reason: PT: For SI mobilization and myofascial release, [Lumbar TPI: Ilioinguinal lig and lumbar paraspinal muscles.

Referral To:

Reason: L spine X ray Flexion/extension views: Dx Spondylolisthesis

Preventive Medicine

MED RECONCILIATION: Pt. Ed: Current Meds Verified: Current meds/immunizations reviewed, including purpose with pt. Med Recon list given to pt/family. Pt advised to discard old med lists and provide all providers with current list at each visit and carry list with them in case of emergency.

Follow Up

4 Weeks (Reason: lumbar TPI)

Jmath

Electronically signed by Jyoti Math on 08/23/2011 at 09:40 AM EDT

Sign off status: Completed

Upstate Medical Rehabilitation

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Jyoti Math, MD 08/18/2011
Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

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111 Doctors Drive
Greenville, SC 29605
Tel: 864-797-7100
Fax: 864-241-9229

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Jyoti Math, MD 08/18/2011

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UNIVERSITY MEDICAL GROUP

HOUSTON, TOMMY GREGORY

55 Y old Male, DOB: 02/18/1956
204 BARTON ST, PO BOX 1099, EASLEY, SC-29640
Home: 864-855-0437

Guarantor: HOUSTON, TOMMY GREGORY
Insurance: UNITED HEALTHCARE

PCP: Richard Curry, MD External Visit ID: 121028898
Appointment Facility: Upstate Medical Rehabilitation

09/12/2011

PROGRESS NOTES: Jyoti Math, MD

Current Medications

niacin tablet, extended release 1000 mg 1 tab (s) once a day (at bedtime)
Ecotrin enteric coated-tablet 325-mg-1-tab(s) once a day
isosorbide mononitrate tablet, extended release 60 mg 1 tab(s) once a day (in the morning)
Bystolic tablet 10 mg 1 tab(s) twice a day
amlodipine-benazepril capsule 10 mg-40 mg 1 cap(s) once a day
Flexeril tablet 10 mg 1 tab(s) 3 times a day
pravastatin tablet 80 mg 1 tab(s) once a day (at bedtime)
Percocet 7.5/325 tablet 325 mg-7.5 mg 1 tab (s) every 6 hours
Medication List reviewed and reconciled with the patient

Past Medical History

Hypertension
High Cholesterol
Heart disease
Heart Attack
Fracture

Surgical History

left wrist 1978
right knee 1974
hernia 9/07
heart surgery 11/23
EXPLORATION AND REMOVAL OF
FOREIGN BODY, RT HAND. 06/01/09

Family History

Family: diabetes, Hypertension, Heart Disease

Social History

Interpersonal/family relationships: Divorced.
Occupation: Employed, but currently not working.
no Alcohol
Smoking: yes PPD: , years:
no Recreational drug use.

Reason for Appointment

1. LUMBAR UMR Trigger Point Injection JM

History of Present IllnessWorker's Comp:Interim History:

1. MRI L-Spine 10/14/10: (a) there is increased stress at the lumbosacral junction. (b) severe bilateral L5-S1 facet arthritis. mild non-compressive L5-S1 disc bulge. mild L4-5 disc bulge (c) moderate left and milder right S1 lateral recess narrowing (d) moderate right and severe left L5 bony neural foraminal stenosis

2. CT L-Spine 6/2/11: (a) transitional vertebral bodies. there is grade 1 anterolisthesis of L5 appreciated secondary to facet degenerative changes. (b) no pars fractures are appreciated. there are multilevel degenerative changes from L4-5 through S1-2

3. FL-Lumbar Myelogram 6/2/11: (a) minimal anterolisthesis of L5. endplate degenerative changes noted. vertebral body heights maintained (b) fluoroscopically guided lumbar myelogram.

Date of Injury: 3/11/08 2:30 pm . Work Status: Out of work, WC leave. Current treatment: PT No PT in past , Injections: No. Location: Lumbar region bilaterally, shoulders, hips . Quality: radiating, numbness, burning, constant cramp. Severity: Pain score (on a scale of 1-10): 10 (unbearable). Qualitative intensity: moderate-to-severe. Functional impairment is very severe - when present the patient is unable to carry out any daily activities. Effect of pain on sleeping: interferes with sleep. Trend in severity since onset: slightly increased. Investigations: MRI scan, Myelogram.

Assessments

1. Pain, myofascial - 729.1 (Primary)
2. Pain, Back - 724.5

Treatment

1. Pain, myofascial
Refill Flexeril tablet, 10 mg, 1 tab(s), orally, 3 times a day, 30 days, 90
Refill Percocet 7.5/325 tablet, 325 mg-7.5 mg, 1 tab(s), orally, every 6 hours, 30 days, 120
release date 9/16/11
I have shown him stretches for lumbar paraspinal muscles.

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Jyoti Math, MD 09/12/2011
Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

<http://ecw.ghs.org:8080/mobile/doc/jsp/catalog/xml/printMultipleChartOptions.jsp?encount...> 9/29/2011

no Use of marijuana, cocaine, or similar drugs.

Allergies

codeine
penicillin
contrast dye: rash: Side Effects

Hospitalization/Major

Diagnostic Procedure

see surgery list

2. Pain, Back

Diagnostic Imaging:Lumbar Spine, 2 or 3 views

Procedures

Generic Procedure Note:

Procedure Type: Trigger Point Injection.

The patient presented for Trigger Point Injections. Patient is awake, alert and oriented. , The patient was advised as to risk and benefits of the procedure, .

Indications Myofascial pain with trigger point(s) .

Consent Informed consent was obtained. The patient was advised as to risks and benefits of the procedure. .

Prep The triggers point(s) was/were identified and marked with a pen. The skin was prepped with Betadine/Alcohol. .

Timeout Performed for correct injection site., Identification and confirmation were performed using written consent and history and physical exam..

Procedure Aspiration was negative. The trigger points (s) was/were injected in Lt iliolumbar lig and paraspinal muscles. and the 25 gauge 1 1/2 inch needle was used to distribute the injectate in a fan-like manner infiltrating the trigger point., A total of of (3) trigger points were injected with approximately (0.5/1/2) cc's of injectate per trigger point. , The injectate utilized in this procedure consisted of 2 cc's of 1% Lidocaine and 1 cc's of Kenalog 10/ mg/ml. The needle was removed. The Betadine was cleansed off. All bleeding was controlled. A Band-Aid was applied. There were no immediate complications. .

Complications None noted .

Post-Procedure The patient tolerated the procedure well. Post procedure instructions were explained and given to the patient., The patient is invited to contact us at any time should they have any questions and/ or problems. .

Preventive Medicine

MED RECONCILIATION: Pt. Ed: Current Meds Verified: Current meds/immunizations reviewed, including purpose with pt. Med Recon list given to pt/family. Pt advised to discard old med lists and provide all providers with current list at each visit and carry list with them in case of emergency.

Procedure Codes

20552 INJECT TRIGGER POINT, 1 OR 2

J3301 Kenalog

72100 LS SPINE (2-3 VIEW) X-RAY

Follow Up

4 Weeks

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Jyoti Math, MD 09/12/2011

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Jmath

Electronically signed by Jyoti Math on 09/15/2011 at 11:57 AM
EDT

Sign off status: Completed

Upstate Medical Rehabilitation
111 Doctors Drive
Greenville, SC 29605
Tel: 864-797-7100
Fax: 864-241-9229

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Jyoti Math, MD 09/12/2011

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



UNIVERSITY MEDICAL GROUP

HOUSTON, TOMMY GREGORY

55 Y old Male, DOB: 02/18/1956
204 BARTON ST, PO BOX 1099, EASLEY, SC-29640
Home: 864-855-0437

Guarantor: HOUSTON, TOMMY GREGORY
Insurance: UNITED HEALTHCARE
PCP: Richard Curry, MD External Visit ID: 122371685
Appointment Facility: Upstate Medical Rehabilitation

10/10/2011

Progress Notes: Jyoti Math, MD

Current Medications

niacin tablet, extended release 1000 mg 1 tab (s) once a day (at bedtime)
Ecotrin enteric coated tablet 325 mg 1 tab(s) once a day
isosorbide mononitrate tablet, extended release 60 mg 1 tab(s) once a day (in the morning)
Bystolic tablet 10 mg 1 tab(s) twice a day
amlodipine-benazepril capsule 10 mg-40 mg 1 cap(s) once a day
pravastatin tablet 80 mg 1 tab(s) once a day (at bedtime)
Flexeril tablet 10 mg 1 tab(s) 3 times a day
Percocet 7.5/325 tablet 325 mg-7.5 mg 1 tab (s) every 6 hours
Medication List reviewed and reconciled with the patient

Past Medical History

Hypertension
High Cholesterol
Heart disease
Heart Attack
Fracture

Surgical History

left wrist 1978
right knee 1974
hernia 9/07
heart surgery 11/23
EXPLORATION AND REMOVAL OF FOREIGN BODY, RT HAND. 06/01/09

Family History

Family: diabetes, Hypertension, Heart Disease

Social History

Interpersonal/family relationships: Divorced.

Occupation: Employed, but currently not working.
no Alcohol
Smoking: yes PPD: , years:
no Recreational drug use.

Reason for Appointment

1. FOLLOW UP

History of Present IllnessWorker's Comp:Interim History:

1. The patient is a 55 y/o male seen at the request of Dr. Bucci. He sustained a work injury on 3/11/08 requiring right shoulder scope and rotator cuff repair on 7/11/08 by Dr. Wessinger. Dr. Bucci does not think that his low back requires surgical intervention. The CT myelogram shows wide open canal. The case was closed in August 2010 and was put at MMI by Dr. Wessinger but was reopened because of aggravation of the symptoms.

2. Low back pain, mainly secondary to facet and SI problem as well as myofascial in origin S/P trigger point injection by me on 9/12/11. The patient reports partial relief. The patient is in physical therapy.

3. Spondylolisthesis S/P x-ray.

The patient returns today for followup. He has been doing well. He says the trigger point injection partially helped him. He is in physical therapy and progressing very well but he continues to have low back pain. He denies any progression of symptoms to the feet. No change in bowel or bladder habit. No fever or weight loss.

Date of Injury: 3/11/08 2:30 pm. Work Status: Out of work, WC leave. Current treatment: PT No PT in past, Injections:

No. Location: Lumbar region bilaterally, shoulders, hips. Quality: radiating, numbness, burning, constant cramp. Severity: Pain score (on a scale of 1-10): 10 (unbearable) pain is currently 8...pt just left PT, pt took percocet this morning. Qualitative intensity: moderate-to-severe. Functional impairment is very severe - when present the patient is unable to carry out any daily activities. Effect of pain on sleeping: interferes with sleep. Trend in severity since onset: slightly increased. Investigations: MRI scan, Myelogram.

General:

Diagnostic Imaging Studies: 1. MRI L-Spine 10/14/10: (a) there is increased stress at the lumbosacral junction. (b) severe bilateral L5-S1 facet arthritis. mild non-compressive L5-S1 disc bulge. mild L4-5 disc bulge (c) moderate left and milder right S1 lateral recess narrowing (d) moderate right and severe left L5 bony neural foraminal stenosis

2. CT L-Spine 6/2/11: (a) transitional vertebral bodies. there is

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Jyoti Math, MD 10/10/2011

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

no Use of marijuana, cocaine, or similar drugs.

Allergies

codeine
penicillin
contrast dye: rash: Side Effects

Hospitalization/Major Diagnostic Procedure

see surgery list

grade 1 anterolisthesis of L5 appreciated secondary to facet degenerative changes. (b) no pars fractures are appreciated. there are multilevel degenerative changes from L4-5 through S1-2

3. FL-Lumbar Myelogram 6/2/11: (a) minimal anterolisthesis of L5. endplate degenerative changes noted. vertebral body heights maintained (b) fluoroscopically guided lumbar myelogram.

4. Lumbosacral Spine X-ray 9/12/11- Transitional vertebra at the lumbosacral junction. Facet degenerative changes in the lower lumbar spine and at the lumbosacral junction. Old right posterior rib fractures. No other acute injury identified.

Examination

General Exam:

On examination, he is awake, alert, oriented. He communicates appropriately. He is able to transfer independently from sitting to standing position. On inspection, there is no swelling or erythema. On palpation, there is tenderness in the lumbar facets as well as left posterior/superior iliac spine. Faber test is positive on the left side. Strength in bilateral lower extremities is 5/5.

Assessments

1. Lumbar and sacral arthritis - 721.3 (Primary)
2. DISORDERS SACRUM - 724.6
3. Spondylolisthesis - 756.12
4. Pain, myofascial - 729.1
5. Lumbar Radiculopathy - 724.4
6. Pain, Back - 724.5

Treatment

1. Lumbar and sacral arthritis

Refill Flexeril tablet, 10 mg, 1 tab(s), orally, 3 times a day, 30 days, 90
Refill Percocet 7.5/325 tablet, 325 mg-7.5 mg, 1 tab(s), orally, every 6 hours, 30 days, 120

2. Others

I think most of his pain is secondary to underlying SI joint and facet problem. In physical therapy they are working on SI joint mobilization but he is not progressing enough so we will go ahead and schedule him for left SI injection under fluoroscope. He also has a component of facet pain so after SI injection we will consider medial branch block and rhizotomy depending on the results of the SI joint. For the spondylolisthesis I had ordered flexion/extension view but the technician has done only standing view so we need to get the flexion and extension views. I have refilled his prescription for Percocet and Flexeril. Followup for left SI injection. The patient was advised to continue all other medications as prescribed by other treating physicians/providers.

JM/mat/101011.

Referral To:

Reason: Lt SI inj

Preventive Medicine

MED RECONCILIATION: Pt. Ed: Current Meds Verified: Current

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Jyoti Math, MD 10/10/2011

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<http://ecw.ghs.org:8080/mobiledoc/jsp/catalog/xml/printMultipleChartOptions.jsp?encou...> 12/29/2011

meds/immunizations reviewed, including purpose with pt. Med Recon list given to pt/family. Pt advised to discard old med lists and provide all providers with current list at each visit and carry list with them in case of emergency.

Follow Up

4 Weeks (Reason: Lt SI inj WC)

Jmath

Electronically signed by Jyoti Math on 10/13/2011 at 04:06 PM EDT

Sign off status: Completed

Upstate Medical Rehabilitation
111 Doctors Drive
Greenville, SC 29605
Tel: 864-797-7100
Fax: 864-241-9229

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Jyoti Math, MD 10/10/2011

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



UNIVERSITY MEDICAL GROUP

HOUSTON, TOMMY GREGORY

55 Y old Male, DOB: 02/18/1956
204 BARTON ST, PO BOX 1099, EASLEY, SC-29640

Home: 864-855-0437

Guarantor: HOUSTON, TOMMY GREGORY

Insurance: UNITED HEALTHCARE

PCP: Richard Curry, MD External Visit ID: 124126467

Appointment Facility: Upstate Medical Rehabilitation

10/31/2011

Progress Note: Jyoti Math, MD

Current Medications

niacin tablet, extended release 1000 mg 1 tab (s) once a day (at bedtime)
Ecotrin enteric coated tablet 325 mg 1 tab(s) once a day
isosorbide mononitrate tablet, extended release 60 mg 1 tab(s) once a day (in the morning)
Bystolic tablet 10 mg 1 tab(s) twice a day
amlodipine-benazepril capsule 10 mg-40 mg 1 cap(s) once a day
pravastatin tablet 80 mg 1 tab(s) once a day (at bedtime)
Flexeril tablet 10 mg 1 tab(s) 3 times a day
Percocet 7.5/325 tablet 325 mg-7.5 mg 1 tab (s) every 6 hours
Medication List reviewed and reconciled with the patient

Past Medical History

Hypertension
High Cholesterol
Heart disease
Heart Attack
Fracture

Surgical History

left wrist 1978
right knee 1974
hernia 9/07
heart surgery 11/23
EXPLORATION AND REMOVAL OF
FORIEGN BODY, RT HAND. 06/01/09

Family History

Family: diabetes, Hypertension, Heart Disease

Social History

Interpersonal/family relationships: Divorced.
Occupation: Employed, but currently not working.
no Alcohol
Smoking: yes PPD: , years:
no Recreational drug use.

Reason for Appointment

1. LT SLJ

History of Present Illness

General:

Worker's Comp:

Interim History:

1. The patient is a 55 y/o male seen at the request of Dr. Buccu. He sustained a work injury on 3/11/08 requiring right shoulder scope and rotator cuff repair on 7/11/08 by Dr. Wessinger. Dr. Buccu does not think that his low back requires surgical intervention. The CT myelogram shows wide open canal. The case was closed in August 2010 and was put at MMI by Dr. Wessinger but was reopened because of aggravation of the symptoms.

2. Low back pain, mainly secondary to facet and SI problem as well as myofascial in origin S/P trigger point injection by me on 9/12/11. The patient reports partial relief. The patient is in physical therapy.

3. Spondylolisthesis S/P x-ray.

Pain Any pain at this time? Yes, chronic pain, Does your current medication impair your judgement, coordination or your ability to drive? No, Rate the pain you had before you began treatment (on a scale of 0-10): 7, Rate your pain since you began treatment (on a scale of 0-10): 5, Is the current treatment working? Yes, Current treatment includes: PT, Medication(s) 4am today, Are you experiencing any side effects from the medications prescribed by your Physician at UMR? No, Are you satisfied with the treatment? Yes.

Vital Signs

Temp (F) 98.8, HR 99, BP 140/80, RR 18, O2 Sat 96
Blood sugar 110.

Assessments

1. DISORDERS SACRUM - 724.6 (Primary)
2. Pain, Back - 724.5

Treatment

1. DISORDERS SACRUM

Refill Flexeril tablet, 10 mg, 1 tab(s), orally, 3 times a day, 30 days, 90
Refill Percocet 7.5/325 tablet, 325 mg-7.5 mg, 1 tab(s), orally, every 6

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Jyoti Math, MD 10/31/2011
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no Use of marijuana, cocaine, or similar drugs.

Allergies

codeine
penicillin
contrast dye: rash: Side Effects

Hospitalization/Major

Diagnostic Procedure

see surgery list

hours, 30 days, 120

Procedures

Sacroiliac Joint Injection:

Consent Informed consent obtained, After reviewing the risks, benefits, likely outcome and potential complications of the procedure, pre-injection verbal and written consents were obtained, The procedure and post-procedure course were discussed with the patient in detail, All questions were answered.

Prep The patient was transported to the procedure room and placed in the prone position on the pain-management fluoroscopy table, Sterile prep and drape were performed, Scout film of the pertinent anatomy was taken, The anterior and posterior projections of the ___ Lt ___ sacroiliac joint were noted, Prior to the procedure the patient was reassessed. The patient reported no new complaints, medical problems or medications since our last office visits. Physical exam was performed and was within normal limits..

Time Out performed for correct injection site, Identification and confirmation were performed using written consent and history and physical exam.

Procedure Local anesthesia of the skin and subcutaneous tissues was accomplished utilizing a 25-gauge 1.5-inch needle injecting lidocaine 1% X 2mls., A #22-gauge 3.5-inch Quincke-tip spinal needle was placed in the posterior portion of the sacroiliac joint under fluoroscopic guidance, A distinct pop through the joint capsule was noted, A mixture of 1 cc of marcain 0.5% and kenolog 40 mg /cc were injected into the joint space, The patient had no complaints of pain or paresthesia during the injection.

Post Procedure The patient tolerated the procedure well and was transported to the recovery room in stable condition, Post procedural education was performed in recovery area, The patient was discharged ambulating without difficulty, We will follow up with the patient via telephone within one week's time, We will be happy to see the patient again on a prn basis.

Preventive Medicine

MED RECONCILIATION: Pt. Ed: Current Meds Verified: Current meds/immunizations reviewed, including purpose with pt. Med Recon list given to pt/family. Pt advised to discard old med lists and provide all providers with current list at each visit and carry list with them in case of emergency.

Procedure Codes

J3301 Kenalog
77003 FLUOROGUIDE FOR SPINE INJECT
27096 INJECT SACROILIAC JOINT

Follow Up

5W

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Jyoti Math, MD 10/31/2011
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Jmath

Electronically signed by Jyoti Math on 11/09/2011 at 12:55 PM
EST

Sign off status: Completed

Upstate Medical Rehabilitation
111 Doctors Drive
Greenville, SC 29605
Tel: 864-797-7100
Fax: 864-241-9229

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Jyoti Math, MD 10/31/2011

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UNIVERSITY MEDICAL GROUP

HOUSTON, TOMMY GREGORY

55 Y old Male, DOB: 02/18/1956
204 BARTON ST, PO BOX 1099, EASLEY, SC-29640
Home: 864-855-0437

Guarantor: HOUSTON, TOMMY GREGORY
Insurance: UNITED HEALTHCARE

PCP: Richard Curry, MD External Visit ID: 125394452
Appointment Facility: Upstate Medical Rehabilitation

12/05/2011

Progress Notes: Jyoti Math, MD

Current Medications

niacin tablet, extended release 1000 mg 1 tab (s) once a day (at bedtime)
Ecotrin enteric coated tablet 325 mg 1 tab(s) once a day
isosorbide mononitrate tablet, extended release 60 mg 1 tab(s) once a day (in the morning)
Bystolic tablet 10 mg 1 tab(s) twice a day
amlodipine-benazepril capsule 10 mg-40 mg 1 cap(s) once a day
pravastatin tablet 80 mg 1 tab(s) once a day (at bedtime)
Flexeril tablet 10 mg 1 tab(s) 3 times a day
Percocet 7.5/325 tablet 325 mg-7.5 mg 1 tab (s) every 6 hours
Medication List reviewed and reconciled with the patient

Past Medical History

Hypertension
High Cholesterol
Heart disease
Heart Attack
Fracture

Surgical History

left wrist 1978
right knee 1974
hernia 9/07
heart surgery 11/23
EXPLORATION AND REMOVAL OF
FOREIGN BODY, RT HAND. 06/01/09

Family History

Family: diabetes, Hypertension, Heart Disease

Social History

Interpersonal/family relationships: Divorced.

Occupation: Employed, but currently not working.
no Alcohol
Smoking: yes PPD: , years:.
no Recreational drug use.

Reason for Appointment

1. FOLLOW UP FROM SIJ

History of Present Illness**Worker's Comp:****Interim History:**

1. The patient is a 55 y/o male seen at the request of Dr. Bucci. He sustained a work injury on 3/11/08 requiring right shoulder scope and rotator cuff repair on 7/11/08 by Dr. Wessinger. Dr. Bucci does not think that his low back requires surgical intervention. The CT myelogram shows wide open canal. The case was closed in August 2010 and was put at MMI by Dr. Wessinger but was reopened because of aggravation of the symptoms. The patient has been out of work since his injury.

2. Low back pain, mainly secondary to facet and SI problem as well as myofascial in origin S/P trigger point injection by me on 9/12/11. The patient reports partial relief. The patient is in physical therapy. The patient is S/P SI injection with no significant improvement. Pain relief lasted for only one to two days.

3. Spondylolisthesis S/P x-ray.

4. The patient is in physical therapy. He feels that he is plateauing at the physical therapy. Initially it helped but now he has plateaued. The patient returns today for followup. He continues to have back pain which shoots down the left leg up to the knee. It never goes beyond the knee. Prolonged standing exacerbates his pain. He can stand up to 15 to 20 minutes and then the pain gets worse. He denies any weakness in his lower extremities. No change in bowel or bladder habit. Fever or weight loss.

Date of Injury: 3/11/08 2:30 pm . Work Status: Out of work, WC leave. Current treatment: PT No PT in past , Injections: No. Location: Lumbar region bilaterally, shoulders, hips . Quality: radiating, numbness, burning, constant cramp. Severity: Pain score (on a scale of 1-10): 10 (unbearable) pain is currently 8...pt just left PT, pt took percocet this morning. Qualitative intensity: moderate-to-severe. Functional impairment is very severe - when present the patient is unable to carry out any daily activities. Effect of pain on sleeping: interferes with sleep. Trend in severity since onset: slightly increased. Investigations: MRI scan, Myelogram.

General:

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Jyoti Math, MD 12/05/2011
Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

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no Use of marijuana, cocaine, or similar drugs.

Allergies

codeine
penicillin
contrast dye: rash: Side Effects

Hospitalization/Major

Diagnostic Procedure

see surgery list

Diagnostic Imaging Studies: 1. MRI L-Spine 10/14/10: (a) there is increased stress at the lumbosacral junction. (b) severe bilateral L5-S1 facet arthritis. mild non-compressive L5-S1 disc bulge. mild L4-5 disc bulge (c) moderate left and milder right S1 lateral recess narrowing (d) moderate right and severe left L5 bony neural foraminal stenosis

2. CT L-Spine 6/2/11: (a) transitional vertebral bodies. there is grade 1 anterolisthesis of L5 appreciated secondary to facet degenerative changes. (b) no pars fractures are appreciated. there are multilevel degenerative changes from L4-5 through S1-2

3. FL-Lumbar Myelogram 6/2/11: (a) minimal anterolisthesis of L5. endplate degenerative changes noted. vertebral body heights maintained (b) fluoroscopically guided lumbar myelogram.

4. Lumbosacral Spine X-ray 9/12/11- Transitional vertebra at the lumbosacral junction. Facet degenerative changes in the lower lumbar spine and at the lumbosacral junction. Old right posterior rib fractures. No other acute injury identified.

Vital Signs

pain 6; pt took percocet this morning.

Examination

General Exam:

He is awake, alert, oriented. He is able to transfer independently. Gait is normal. Lumbar extension, side bending and rotation is severely restricted because of the pain, left side more than right. On palpation, he has tenderness over lower lumbar facet joints.

Assessments

1. Pain, Back - 724.5 (Primary)
2. Spondylolisthesis - 756.12
3. DISORDERS SACRUM - 724.6
4. Lumbar Facet Arthropathy - 721.3

Treatment

1. Pain, Back

Refill Flexeril tablet, 10 mg, 1 tab(s), orally, 3 times a day prn, 30 days, 90
Refill Percocet 7.5/325 tablet, 325 mg-7.5 mg, 1 tab(s), orally, every 6 hours (max4/day), 30 days, 120

2. Others

Procedure risk and benefits discussed with patient which includes but not limited to infection, bleeding, allergy, steroid flare and some chance of nerve damage. Patient voices understanding it.

I think most of his pain is secondary to lumbar facet arthropathy. We will consider lumbar medial branch block and radiofrequency ablation and I have discussed this procedure with him including risks and benefits. Risk includes but not limited to infection, bleeding, allergy and very rare chance of nerve damage. I will schedule him for medial branch block and if he has more than 50% pain relief we will consider bilateral lumbar radiofrequency ablation of facet joints. I have refilled his Lortab and Flexeril. The patient was advised to continue all other medications as prescribed by other treating physicians/providers.

JM/mat/120511.

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Jyoti Math, MD 12/05/2011

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12/29/2011

264

Referral To:

Reason: Bilateral Lumbar MBB WC: 3 levels

Preventive Medicine

MED RECONCILIATION: Pt. Ed: Current Meds Verified: Current meds/immunizations reviewed, including purpose with pt. Med Recon list given to pt/family. Pt advised to discard old med lists and provide all providers with current list at each visit and carry list with them in case of emergency.

Follow Up

1 Week (Reason: Bil Lumbar MBB)

Jmath

Electronically signed by Jyoti Math on 12/14/2011 at 01:22 PM EST

Sign off status: Completed

Upstate Medical Rehabilitation
111 Doctors Drive
Greenville, SC 29605
Tel: 864-797-7100
Fax: 864-241-9229

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Jyoti Math, MD 12/05/2011

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UNIVERSITY MEDICAL GROUP

HOUSTON, TOMMY GREGORY

55 Y old Male, DOB: 02/18/1956
204 BARTON ST, PO BOX 1099, EASLEY, SC-29640
Home: 864-855-0437

Guarantor: HOUSTON, TOMMY GREGORY

Insurance: UNITED HEALTHCARE

PCP: Richard Curry, MD External Visit ID: 127489276

Appointment Facility: Upstate Medical Rehabilitation

12/22/2011

Progress Notes: Jyoti Math, MD

Current Medications

niacin tablet, extended release 1000 mg 1 tab (s) once a day (at bedtime)
Ecotrin enteric coated tablet 325 mg 1 tab(s) once a day
isosorbide mononitrate tablet, extended release 60 mg 1 tab(s) once a day (in the morning)
Bystolic tablet 10 mg 1 tab(s) twice a day
amlodipine-benazepril capsule 10 mg-40 mg 1 cap(s) once a day
pravastatin tablet 80 mg 1 tab(s) once a day (at bedtime)
Flexeril tablet 10 mg 1 tab(s) 3 times a day prn
Percocet 7.5/325 tablet 325 mg-7.5 mg 1 tab (s) every 6 hours (max4/day)
Medication List reviewed and reconciled with the patient

Active Problem List

- 721.3 Lumbar and sacral arthritis
- 756.12 Spondylolisthesis
- 724.6 DISORDERS SACRUM
- 729.1 Pain, myofascial
- 724.4 Lumbar Radiculopathy
- 724.5 Pain, Back
- 721.3 Lumbar Facet Arthropathy
- 724.00 Spinal Stenosis

Past Medical History

Hypertension
High Cholesterol
Heart disease
Heart Attack
Fracture

Surgical History

left wrist 1978

Reason for Appointment

1. Followup to medial branch block

History of Present Illness

General:

Worker's Comp:

Interim History:

1. The patient is a 55 y/o male seen at the request of Dr. Buccì. He sustained a work injury on 3/11/08 requiring right shoulder scope and rotator cuff repair on 7/11/08 by Dr. Wessinger. Dr. Buccì does not think that his low back requires surgical intervention. The CT myelogram shows wide open canal. The case was closed in August 2010 and was put at MMI by Dr. Wessinger but was reopened because of aggravation of the symptoms. The patient has been out of work since his injury.

2. Low back pain, mainly secondary to facet and SI problem as well as myofascial in origin S/P trigger point injection by me on 9/12/11. s/p PT, The patient is S/P SI injection with no significant improvement.

3. Spondylolisthesis S/P x-ray.
MRI of lumbar spine done on 10/4/2010 shows there is increased stress at lumbosacral junction, severe bilateral L5/S1 facet arthritis, mild non compressive L5/S1 disc bulge, mild L4/L5 disc bulge, moderate left and milder right L5/S1 lateral recess narrowing, moderate right and severe left L5 body neural foraminal stenosis, which is consistent with his left L5/S1 radiculopathy.

5. 12/21/11 Bilateral MBB Lt side increased in pain and Rt side 75% less pain.

Patient returns today for followup. He had bilateral medial branch block yesterday. He had almost 75% pain relief on the right side, but he did not get any pain relief on the left side. He continues to have radicular symptoms on the left side in L5/S1 distribution. He denies any progressive weakness. No change in bowel or bladder habits. No fever or weight loss.

Pain Any pain at this time? Yes, chronic pain, Does your current medication impair your judgement, coordination or your ability to drive? No, Rate the pain you had before you began treatment (on a scale of 0-10): 10 (unbearable) left side, Rate your pain since you

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Jyoti Math, MD 12/22/2011

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right knee 1974
hernia 9/07
heart surgery 11/23
EXPLORATION AND REMOVAL OF
FOREIGN BODY, RT HAND. 06/01/09

Family History

Family: diabetes, Hypertension, Heart
Disease

Social History

Interpersonal/family relationships: Divorced.

Occupation: Employed, but currently not
working.
no Alcohol .
Smoking: yes PPD: , years:.
no Recreational drug use.
no Use of marijuana, cocaine, or similar
drugs.

Allergies

codeine
penicillin
contrast dye: rash: Side Effects

Hospitalization/Major**Diagnostic Procedure**

see surgery list

began treatment (on a scale of 0-10): 10 (unbearable), Is the current treatment working? No, Current treatment includes: Medication(s) Percocet 4 am, Are you experiencing any side effects from the medications prescribed by your Physician at UMR? No, Are you satisfied with the treatment? Yes.

Examination**General Exam:**

On examination, he is awake, alert, and oriented. He is able to transfer independently. Lumbar extension is limited because of the pain. He has good strength in bilateral lower extremities. He has some sensory impairment in L5/S1 distribution. Reflexes are 2+ at bilateral knees and ankles. Straight leg test is negative.

Assessments

1. Lumbar Facet Arthropathy - 721.3 (Primary)
2. Pain, Back - 724.5
3. Pain, myofascial - 729.1
4. Lumbar Radiculopathy - 724.4
5. Spinal Stenosis - 724.00

Treatment**1. Others**

I think his pain is multifactorial in origin. As he has responded very well to medial branch block on the right side, I will proceed with right lumbar facet radiofrequency ablation. For the left side, as he has not gotten good relief, he might get benefit with left intra-articular facet injection in the future. Considering his left radicular symptoms and after reviewing the MRI, his symptoms could be secondary to foraminal stenosis and he may benefit from epidural steroid injection. We will address that in the future. Follow up for radiofrequency ablation. The patient was advised to continue all other medications as prescribed by other treating physicians/providers.

JM/jp/122211.

Referral To:

Reason: Rt lumbar facet RFA

Follow Up

2 Weeks

Electronically signed by Jyoti Math on 12/29/2011 at 05:01 PM EST

Sign off status: Pending

Upstate Medical Rehabilitation
111 Doctors Drive
Greenville, SC 29605

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Jyoti Math, MD 12/22/2011

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Tel: 864-797-7100
Fax: 864-241-9229

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Jyoti Math, MD 12/22/2011

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UNIVERSITY MEDICAL GROUP

HOUSTON, TOMMY GREGORY

55 Y old Male, DOB: 02/18/1956
204 BARTON ST, PO BOX 1099, EASLEY, SC 29640

Home: 864-855-0437

Guarantor: HOUSTON, TOMMY GREGORY

Insurance: UNITED HEALTHCARE

PCP: Richard Curry, MD External Visit ID: 128909298

Appointment Facility: Upstate Medical Rehabilitation

02/02/2012

Progress Notes: Jyoti Math, MD

Current Medications

Flexeril tablet 10 mg 1 tab(s) 3 times a day .
pm
Percocet 7.5/325 tablet 325 mg-7.5 mg 1 tab
(s) every 6 hours (max4/day)
pravastatin tablet 80 mg 1 tab(s) once a day
(at bedtime)
amlodipine-benazepril capsule 10 mg-40 mg
1 cap(s) once a day
Bystolic tablet 10 mg 1 tab(s) twice a day
isosorbide mononitrate tablet, extended
release 60 mg 1 tab(s) once a day (in the
morning)
Ecotrin enteric coated tablet 325 mg 1 tab(s)
once a day
niacin tablet, extended release 1000 mg 1 tab
(s) once a day (at bedtime)
Medication List reviewed and reconciled with
the patient

Past Medical History

Hypertension
High Cholesterol
Heart disease
Heart Attack
Fracture

Surgical History

left wrist 1978
right knee 1974
hernia 9/07
heart surgery 11/23
EXPLORATION AND REMOVAL OF
FOREIGN BODY, RT HAND. 06/01/09

Family History

Family: diabetes, Hypertension, Heart
Disease

Social History

Interpersonal/family relationships: Divorced.

Occupation: Employed, but currently not
working.
no Alcohol
Smoking: yes PPD: , years.

Reason for Appointment

1. F/UTO RFA

History of Present Illness

General:

Worker's Comp:

Interim History:

1. The patient is a 55 y/o male seen at the request of Dr. Buccì. He sustained a work injury on 3/11/08 requiring right shoulder scope and rotator cuff repair on 7/11/08 by Dr. Wessinger. Dr. Buccì does not think that his low back requires surgical intervention. The CT myelogram shows wide open canal. The case was closed in August 2010 and was put at MMI by Dr. Wessinger but was reopened because of aggravation of the symptoms. The patient has been out of work since his injury. Low back pain, mainly secondary to facet and SI problem, S/P trigger point injection on 9/12/11. s/p PT, The patient is S/P SI injection with no significant improvement. 6. 1/12/12 Rt lumbar facet RFA 75% pain relief

3. Spondylolisthesis S/P x-ray.

MRI of lumbar spine done on 10/4/2010 shows there is increased stress at lumbosacral junction, severe bilateral L5/S1 facet arthritis, mild non compressive L5/S1 disc bulge, mild L4/L5 disc bulge, moderate left and milder right L5/S1 lateral recess narrowing, moderate right and severe left L5 body neural foraminal stenosis, which is consistent with his left L5/S1 radiculopathy.

The patient returns today for followup. He has been doing well since radiofrequency ablation on the right side but he has persistent pain on the left side that interferes with his daily activity, prolonged standing and walking exacerbates his symptoms. Pain shoots down the back of the thigh up to the knee, never goes beyond the knee. He denies any progressive weakness. Sitting alleviates his symptoms immediately. He says Percocet helps him a lot with his daily activities and improves his function. He cannot tell a difference with the Flexeril.

Pain Any pain at this time? Yes, chronic pain, Does your current medication impair your judgement, coordination or your ability to drive? No, Rate the pain you had before you began treatment (on a scale of 0-10): 3 Still pain on the left side 7, Rate your pain since you began treatment (on a scale of 0-10): 1, Is the current treatment

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Jyoti Math, MD 02/02/2012
Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

<http://ecw.ghs.org:8080/mobiledoc/jsp/catalog/xml/printMultipleChartOptions.jsp?encount...> 3/13/2012

no Recreational drug use.
no Use of marijuana, cocaine, or similar
drugs.

Allergies

codeine
penicillin
contrast dye: rash: Side Effects

Hospitalization/Major Diagnostic Procedure

see surgery list

working? Yes, Current treatment includes: Medication(s) percocet this
am, Are you experiencing any side effects from the medications
prescribed by your Physician at UMR? No, Are you satisfied with the
treatment? Yes.

Vital Signs

Temp (F) 99.5, Ht 70, Wt lbs 200, Wt kg 90.72, BMI 28.69, HR 87, BP
162/98, RR 20, O2 Sat 95RA.

Examination

General Exam:

He is awake, alert, oriented. He is able to transfer independently.
Lumbar extension reproduces the pain. On palpation he has some
tenderness over left posterior/superior iliac spine, minimal tenderness
over piriformis.

Assessments

1. DISORDERS SACRUM - 724.6 (Primary)
2. Pain, Back - 724.5
3. Lumbar Facet Arthropathy - 721.3

Treatment

1. DISORDERS SACRUM

Refill Flexeril tablet, 10 MG, 1 tab(s), orally, qhs, 30 days, 30, Refills 0
Refill Percocet 7.5/325 tablet, 325 mg-7.5 mg, 1 tab(s), orally, every 6
hours (max4/day), 30 days, 120

2. Others

Drug side effects discussed with pt which includes but not limited to
drug interaction, drowsiness, operating heavy machinery and driving
precautions and drug dependency.
We discussed the different possible etiologies. I tried medial branch
block on left facets but I could not reach the target nerves maybe
because of the osteophytes. Because of his activity limiting persistent
pain he wants to get a second opinion with a surgeon and I have made a
referral to Dr. McHenry. Followup in four weeks. The patient was
advised to continue all other medications as prescribed by other
treating physicians/providers.

JM/mat/020212.

Referral To:

Reason:Referral to Dr McHenry: Persistant back pain

Preventive Medicine

MED RECONCILIATION: Pt. Ed: Current Meds Verified: Current
meds/immunizations reviewed, including purpose with pt. Med Recon
list given to pt/family. Pt advised to discard old med lists and provide
all providers with current list at each visit and carry list with them in
case of emergency.

Follow Up

4 Weeks (Reason: PA)

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Jyoti Math, MD 02/02/2012
Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

<http://ecw.ghs.org:8080/mobiledoc/jsp/catalog/xml/printMultipleChartOptions.jsp?encount...> 3/13/2012

Jmath

Electronically signed by Jyoti Math on 02/14/2012 at 05:05 PM EST

Sign off status: Completed

Upstate Medical Rehabilitation
111 Doctors Drive
Greenville, SC 29605
Tel: 864-797-7100
Fax: 864-241-9229

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Jyoti Math, MD 02/02/2012

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

<http://ecw.ghs.org:8080/mobiledoc/jsp/catalog/xml/printMultipleChartOptions.jsp?encount...> 3/13/2012



UNIVERSITY MEDICAL GROUP

HOUSTON, TOMMY GREGORY

56 Y old Male, DOB: 02/18/1956
204 BARTON ST. PO BOX 1099, Easley, SC-29640
Home: 864-855-0437

Guarantor: HOUSTON, TOMMY GREGORY

Insurance: UNITED HEALTHCARE

PCP: Richard Curry, MD External Visit ID: 134978543

Appointment Facility: Upstate Medical Rehabilitation

04/30/2012

Progress Notes: Jyoti Math, MD

Current Medications

Bystolic tablet 10 mg 1 tab(s) twice a day
isosorbide mononitrate tablet, extended release 60 mg 1 tab(s) once a day (in the morning)
Ecotrin enteric coated tablet 325 mg 1 tab(s) once a day
Percocet 7.5/325 tablet 325 mg-7.5 mg 1 tab(s) every 6 hours (max 4/day)
niacin tablet, extended release 1000 mg 1 tab(s) once a day (at bedtime)
Flexcil tablet 10 MG 1 tab(s) qhs
pravastatin tablet 80 mg 1 tab(s) once a day (at bedtime)
amlodipine-benazepril capsule 10 mg-40 mg 1 cap(s) once a day
Medication List reviewed and reconciled with the patient

Past Medical History

Hypertension
High Cholesterol
Heart disease
Heart Attack
Fracture

Surgical History

left wrist 1978
right knee 1974
hernia 9/07
heart surgery 11/23
EXPLORATION AND REMOVAL OF FOREIGN BODY, RT HAND. 06/01/09

Family History

Family: diabetes, Hypertension, Heart Disease

Social History

Interpersonal/family relationships: Divorced.

Occupation: Employed, but currently not working.
no Alcohol.
Smoking: yes, PPD: , years:.
no Recreational drug use.

Reason for Appointment

1. FOLLOW UP

History of Present Illness

General:

Worker's Comp:

Interim History:

1. The patient is a 55 y/o male seen at the request of Dr. Bucci. He sustained a work injury on 3/11/08 requiring right shoulder scope and rotator cuff repair on 7/11/08 by Dr. Wessinger. Dr. Bucci does not think that his low back requires surgical intervention. The CT myelogram shows wide open canal. The case was closed in August 2010 and was put at MMI by Dr. Wessinger but was reopened because of aggravation of the symptoms. The patient has been out of work since his injury. Low back pain, mainly secondary to facet and SI problem. S/P trigger point injection on 9/12/11. S/p PT, The patient is S/P SI injection with no significant improvement. 6. 1/12/12 Rt lumbar facet RFA 75% pain relief

3. Spondylolisthesis S/P x-ray. He has persistent left lower back pain. I had made a referral to see Dr. McHenry. Patient has not heard anything yet.

MRI of lumbar spine done on 10/4/2010 shows there is increased stress at lumbosacral junction, severe bilateral L5/S1 facet arthritis, mild non compressive L5/S1 disc bulge, mild L4/L5 disc bulge, moderate left and milder right L5/S1 lateral recess narrowing, moderate right and severe left L5 body neural foraminal stenosis, which is consistent with his left L5/S1 radiculopathy

Patient returns today for followup. He continues to have left lower lumbar pain. He had significant improvement with the right RFA on the right side, but we could not reach the medial branch on the left side, so RFA has not been performed on the left side. Patient also reports that he feels that the Percocet is not helping much and he wants to know what are the other options. He continues to have radicular symptoms, all the way down to his foot that has not changed for the last one year or so. He had CT myelogram for the same symptom, which is unremarkable. He reports no change in pain pattern. No progressive weakness. No change in bowel or bladder habits. No fever or weight loss.

Pain Any pain at this time? Yes, chronic pain, Does your current

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Jyoti Math, MD 04/30/2012

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

no Use of marijuana, cocaine, or similar drugs.

Allergies

codeine
penicillin
contrast dye: rash: Side Effects

Hospitalization/Major

Diagnostic Procedure

see surgery list

medication impair your judgement, coordination or your ability to drive? No. Rate the pain you had before you began treatment (on a scale of 0-10): 10 (unbearable), Rate your pain since you began treatment (on a scale of 0-10): 8. Is the current treatment working? Yes, Current treatment includes: Medication(s) pt took percocet this morning, Are you experiencing any side effects from the medications prescribed by your Physician at UMK? No, Are you satisfied with the treatment? Yes.

Vital Signs

BP 158/98, Pain score 8, HR 90, O2 Sat 95, Temp (F) 97.9.

Examination

General Exam:

On examination, he is awake, alert, and oriented. He is able to transfer independently. Gait is normal. Strength in bilateral lower extremities is 5/5.

Assessments

1. Lumbar Facet Arthropathy - 721.3 (Primary)
2. Pain, Back - 724.5
3. ENCOUNTER LONG TERM USE OTH DRUGS - V58.69
4. Therapeutic drug monitoring - V58.83
5. Pain, Chronic - 338.29

Treatment

1. Lumbar Facet Arthropathy

Stop Flexeril tablet, 10 MG, 1 tab(s), orally, qhs
Stop Percocet 7.5/325 tablet, 325 mg-7.5 mg, 1 tab(s), orally, every 6 hours (max4/day)
Start Percocet-10/325 tablet, 325 mg-10 mg, 1 tab(s), orally, every 6 hours max of 4 aday, 30 days, 120
Start amitriptyline tablet, 25 mg, 1 tab(s), orally, once a day (at bedtime), 30 day(s), 30

2. ENCOUNTER LONG TERM USE OTH DRUGS

LAB: Fentanyl w/confirmation, urine
LAB: Opiate Metabolites drug screen, urine
LAB: Pain Therapy Drug Screen (14), urine

3. Therapeutic drug monitoring

LAB: Fentanyl w/confirmation, urine
LAB: Opiate Metabolites drug screen, urine
LAB: Pain Therapy Drug Screen (14), urine

4. Others

I do not think that he needs a new MRI as his symptoms have not changed much and the CT myelogram last year was unremarkable. He is still waiting for surgical opinion. I discussed the option of left facet intraarticular injection to see if that alleviates his symptoms. Patient wants to try medication first before he tries an injection. I have increased his Percocet to 10 mg and also added amitriptyline, which will help for chronic pain as well as for sleep. I discussed potential side effects with him. If he does not improve with this medication we will

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Jyoti Math, MD 04/30/2012

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



UNIVERSITY MEDICAL GROUP

HOUSTON, TOMMY GREGORY

56 Y old Male, DOB: 02/18/1956
204 BARTON ST. PO BOX 1099, EASLEY, SC 29640
Home: 864-855-0437

Guarantor: HOUSTON, TOMMY GREGORY
Insurance: UNITED HEALTHCARE

PCP: Richard Curry, MD Referring: comp workers
External Visit ID: 140944828

Appointment Facility: Upstate Medical Rehabilitation

Progress Notes: Jyoti Math, MD

08/27/2012

Current Medications

isosorbide mononitrate tablet, extended release 60 mg 1 tab(s) once a day (in the morning)
Ecotrin enteric coated tablet 325 mg 1 tab(s) once a day
Flexeril tablet 10 mg 1 tab(s) once daily at bedtime
Percocet 7.5/325 tablet 325 mg-7.5 mg 1 tab(s) every 4-6 hours, max 5/day
pravastatin tablet 80 mg 1 tab(s) once a day (at bedtime)
exforge HCT tablet 5 mg-12.5 mg-160 mg 1 tab(s) once a day
metformin tablet, extended release 500 mg 1 tab(s) once a day
Medication List reviewed and reconciled with the patient

Past Medical History

Hypertension
High Cholesterol
Heart disease
Heart Attack
Fracture

Surgical History

left wrist 1978
right knee 1974
hernia 9/07
heart surgery 11/23
EXPLORATION AND REMOVAL OF
FORIEGN BODY, RT HAND. 06/01/09

Family History

Family: diabetes, Hypertension, Heart Disease

Social History

Interpersonal/family relationships: Divorced.

Alcohol men 18-65 yrs Assessment completed: today, Alcohol intake: patient does not drink alcohol 8/27/12.
Smoking Status > 13 years old Are you a:

Reason for Appointment

1. 2 Months (Reason: FU Dr. MATH)

History of Present Illness

General:

Worker's Comp:

Interim History:

1. The patient is a 55 y/o male seen at the request of Dr. Buccì. He sustained a work injury on 3/11/08 requiring right shoulder scope and rotator cuff repair on 7/11/08 by Dr. Wessinger. Dr. Buccì does not think that his low back requires surgical intervention. The CT myelogram shows wide open canal. The case was closed in August 2010 and was put at MMI by Dr. Wessinger but was reopened because of aggravation of the symptoms. The patient has been out of work since his injury. Low back pain, mainly secondary to facet and SI problem, S/P trigger point injection on 9/12/11. ,s/p PT, The patient is S/P SI injection with no significant improvement. 6. 1/12/12 Rt lumbar facet RFA 75% pain relief.

Patient was recently evaluated by Dr. Kanos on 8/24/12. Repeat MRI showed spondylolisthesis. The plan is do left L5/S1 PLIF.

2. Spondylolisthesis S/P x-ray. He has persistent left lower back pain.

Patient returns today for followup. He continues to have pain in his legs, as well as back. He continues to have left-sided pain, but the pain has not changed in quality or character. He denies any progressive weakness.

Pain Any pain at this time? Yes, chronic pain, Does your current medication impair your judgement, coordination or your ability to drive? No, Rate the pain you had before you began treatment (on a scale of 0-10): 10 (unbearable), Rate your pain since you began treatment (on a scale of 0-10): 4, Is the current treatment working? Yes, Current treatment includes: Medication(s) am, Are you experiencing any side effects from the medications prescribed by your Physician at UMR? No, Are you satisfied with the treatment? Yes.

Vital Signs

Ht 70, Ht Cm 177.8, Wt lbs 211, Wt kg 95.71, BMI 30.27, BP 169/96, HR 53, Pain score 4/10, Tech Initial jt.

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Jyoti Math, MD 08/27/2012

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Current smoker, Pt counseled on the dangers of tobacco use and urged to quit.
08/27/2012.

Occupation: Employed, but currently not working.

no Alcohol.

Smoking: yes, PPD: , years:

no Recreational drug use.

no Use of marijuana, cocaine, or similar drugs.

Allergies

codeine

contrast dye: rash: Side Effects

penicillin

Hospitalization/Major

Diagnostic Procedure

see surgery list

Examination

General Exam:

On examination, he is awake, alert, and oriented. He is able to transfer independently. His gait is normal. He communicates appropriately. Strength in bilateral lower extremities is 5/5. Lumbar extension produces the pain.

Assessments

1. Spondylolisthesis - 756.12 (Primary)
2. Pain, Back - 724.5
3. Spinal Stenosis - 724.00

Treatment

1. Spondylolisthesis

Refill Percocet 7.5/325 tablet, 325 mg-7.5 mg, 1 tab(s), orally, every 4-6 hours, max 5/day, 30 day(s), 150, Refills 0

Refill Flexeril tablet, 10 MG, 1 tab(s), orally, once daily at bedtime, 30 day(s), 30, Refills 0

2. Others

Today we will refill his Percocet and Flexeril. He wanted to discuss surgery. I explained to him the possible surgery on the spine more. The patient was satisfied after explanation. I will see him back in four weeks for medication management. The patient was advised to continue all other medications as prescribed by other treating physicians/providers.

JM/jp/082712.

Preventive Medicine

MED RECONCILIATION: Pt. Ed: Current Meds Verified: Current meds/immunizations reviewed, including purpose with pt. Med Recon list given to pt/family. Pt advised to discard old med lists and provide all providers with current list at each visit and carry list with them in case of emergency.

Follow Up

4 Weeks (Reason: PA)

Jmath

Electronically signed by Jyoti Math on 08/30/2012 at 12:12 PM EDT

Sign off status: Completed

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Jyoti Math, MD 08/27/2012

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com).

<http://ecw.ghs.org:8080/mobiledoc/jsp/catalog/xml/printChartOptions.jsp?encounterID=80...> 8/30/2012²⁷⁵

Upstate Medical Rehabilitation
111 Doctors Drive
Greenville, SC 29605
Tel: 864-797-7100
Fax: 864-241-9229

Patient: HOUSTON, TOMMY GREGORY DOR: 02/18/1956 Progress Note: Jyoti Math, MD 08/27/2012

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

HOUSTON, TOMMY GREGORY



**GREENVILLE
HEALTH SYSTEM**

56 Y old Male, DOB: 02/18/1956
204 BARTON ST, PO BOX 1099, EASLEY, SC 29640

Home: 864-855-0437

Guarantor: HOUSTON, TOMMY GREGORY

Insurance: UNITED HEALTHCARE

PCP: Richard Curry, MD Referring: comp workers

External Visit ID: 153970703

Appointment Facility: Upstate Medical Rehabilitation

12/20/2012

Progress Note: Jyoti Math, MD

Current Medications

Percocet 7.5/325 tablet 325 mg-7.5 mg 1 tab(s) every 4-6 hours, max 5/day
isosorbide mononitrate tablet, extended release 60 mg 1 tab(s) once a day (in the morning)
Ecotrin enteric coated tablet 325 mg 1 tab(s) once a day
pravastatin tablet 80 mg 1 tab(s) once a day (at bedtime)
metformin tablet, extended release 500 mg 1 tab(s) once a day
Work Restrictions ** SEDENTARY WORK ONLY; no driving or getting in and out of armored truck
exforge HCT 10/320/25 1 daily
cyclobenzaprine tablet 10 mg 1 tab(s) at bedtime
Medication List reviewed and reconciled with the patient

Past Medical History

Hypertension
High Cholesterol
Heart disease
Heart Attack
Fracture

Surgical History

left wrist 1978
right knee 1974
hernia 9/07
heart surgery 11/23
EXPLORATION AND REMOVAL OF FOREIGN BODY, RT HAND. 06/01/09

Family History

Family: diabetes, Hypertension, Heart Disease

Social History

Interpersonal/family relationships: Divorced.

Alcohol men 18-65 yrs Assessment completed: today, Alcohol intake: patient

Reason for Appointment

1. 4 Weeks (Reason: FU PA)/PT CALLED 12/18 OUT OF MEDS FRIDAY/TO BE HERE @ 1030

History of Present Illness

General:

Worker's Comp:

Interim History:

1. The patient is a 55 y/o male seen at the request of Dr. Bucci. He sustained a work injury on 3/11/08 requiring right shoulder scope and rotator cuff repair on 7/11/08 by Dr. Wessinger. Dr. Bucci does not think that his low back requires surgical intervention.

Patient got a second opinion from Dr. Kanos on 8/24/12, who recommended L5/S1 PLIF and patient underwent surgery on 12/12/12 with significant improvement of the symptoms.

The case was closed in August 2010 and was put at MMI by Dr. Wessinger but was reopened because of aggravation of the symptoms. The patient has been out of work since his injury. Low back pain, mainly secondary to facet and SI problem, S/P trigger point injection on 9/12/11, s/p PT. The patient is S/P SI injection with no significant improvement. 6. 1/12/12 Rt lumbar facet RFA 75% pain relief.

Patient was recently evaluated by Dr. Kanos on 8/24/12. Repeat MRI showed spondylolisthesis. The plan is do left L5/S1 PLIF.

2. Spondylolisthesis S/P x-ray. He has persistent left lower back pain.

Patient has pain status post trigger point injections, SI injection, with no significant improvement, but we did a facet injection on 1/12/12 with significant pain relief on the right side.

Patient returns today for followup. He reports that his leg symptoms have significantly improved and he feels that he is improving every day. He is using a walker for ambulation, but he feels that he does not need it anymore. No progressive weakness. No change in bowel or bladder habits. No fever or weight loss. Dr. Kanos has switched him to oxycodone post surgically and he feels that he has been tolerating it very well. Other review of systems is negative. He denies any fever.

Pain Any pain at this time? Yes, chronic pain, Does your current medication impair your judgement, coordination or your ability to drive? Yes, Rate the pain you had before you began treatment (on a

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Jyoti Math, MD 12/20/2012

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

277

does not drink alcohol.

Smoking Status > 13 years old Are you a:
Current smoker, Pt counseled on the dangers
of tobacco use and urged to quit.
12/10/2012.

Occupation: Employed, but currently not
working.

no Alcohol.

Smoking: yes, PPD: , years:.

no Recreational drug use.

no Use of marijuana, cocaine, or similar
drugs.

Allergies

contrast dye: rash: Side Effects
codeine
penicillin

Hospitalization/Major

Diagnostic Procedure

see surgery list

scale of 0-10): 8, Rate your pain since you began treatment (on a scale
of 0-10): 6, Is the current treatment working? Yes, Current treatment
includes: Medication(s) this morning, Are you experiencing any side
effects from the medications prescribed by your Physician at UMR?
No, Are you satisfied with the treatment? Yes.

Vital Signs

Ht 70, Ht Cm 177.8, Wt lbs 207.2, Wt kg 93.99, BMI 29.73, BP 161/95,
HR 127, Pain score 6, O2 Sat 98%, Tech Initial tah.

Examination

General Exam:

On examination he is awake and alert. He communicates
appropriately. He has a slight antalgic gait. He walks with the walker.
Strength in bilateral lower extremities is within normal range.

Assessments

1. Pain, Back - 724.5 (Primary)
2. Pain, myofacial - 729.1

Treatment

1. Pain, Back

Stop Percocet 7.5/325 tablet, 325 mg-7.5 mg, 1 tab(s), orally, every 4-6
hours, max 5/day

Refill cyclobenzaprine tablet, 10 mg, 1 tab(s), orally, at bedtime, 30
days, 30

Start Roxicodone tablet, 5 mg, 2 tab(s), orally, every 6 hours, max 8 per
day, 30 days, 240

2. Others

Continue isosorbide mononitrate tablet, extended release, 60 mg, 1 tab
(s), orally, once a day (in the morning)

Continue Ecotrin enteric coated tablet, 325 mg, 1 tab(s), orally, once a
day

Continue pravastatin tablet, 80 mg, 1 tab(s), orally, once a day (at
bedtime)

Continue metformin tablet, extended release, 500 mg, 1 tab(s), orally,
once a day

Continue Work Restrictions *, *, SEDENTARY WORK ONLY;; no
driving or getting in and out of armored truck

Continue exforge HCT, 10/320/25, 1, by mouth, daily

Patient is recovering from the surgery. His gait appears to be normal,
except he needs minimal assistance of walker. We will switch him to
Roxicodone 5 mg two tablets every six hours. I have refilled Flexeril. I
would like to see him back in four weeks. The patient was advised to
continue all other medications as prescribed by other treating
physicians/providers. JM/jp/122012.

Preventive Medicine

MED RECONCILIATION: Pt. Ed: Current Meds Verified: Current
meds/immunizations reviewed, including purpose with pt. Med Recon
list given to pt/family. Pt advised to discard old med lists and provide
all providers with current list at each visit and carry list with them in
case of emergency.

Follow Up 4 Weeks

Knuth

Electronically signed by Jyoti Math on 12/31/2012 at 08:06 AM EST

Sign off status: Completed

Upstate Medical Rehabilitation
111 Doctors Drive
Greenville, SC 29605
Tel: 864-797-7100
Fax: 864-241-9229

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Jyoti Mathi, MD 12/20/2012

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

4/22/2014

Alcohol men 18-65 yrs Assessment completed: today, Alcohol intake: patient does not drink alcohol.
 Smoking Status > 13 years old Are you a: Current smoker, Pt counseled on the dangers of tobacco use and urged to quit.
 12/26/2012.
 Occupation: Employed, but currently not working.
 no Alcohol.
 Smoking: yes, PPD: , years..
 no Recreational drug use.
 no Use of marijuana, cocaine, or similar drugs.

Allergies

contrast dye: rash: Side Effects
 codeine
 penicillin

Hospitalization/Major

Diagnostic Procedure

see surgery list

effects from the medications prescribed by your Physician at UMR?
 No, Are you satisfied with the treatment? Yes.

Vital Signs

Ht 70, Ht Cm 177.8, Wt lbs 210, Wt kg 95.26, BMI 30.13, BP 152/93,
 HR 119, Pain score 3, O2 Sat 94, Tech Initial tah.

Examination

General Exam:

On examination he is awake, alert, and oriented. He is able to transfer independently. His gait is normal. Well-healed surgical scar.

Assessments

1. Pain, Chronic - 338.29 (Primary)
2. Low Back Pain - 724.2

Treatment

1. Pain, Chronic

Stop Roxicodone tablet, 5 mg, 1 tab(s), orally, every 6 hours
 Start Percocet 7.5/325 tablet, 325 mg-7.5 mg, 1 tab(s), orally, every 6 hours max 4 per day, 30 days, 120

2. Others

Continue isosorbide mononitrate tablet, extended release, 60 mg, 1 tab(s), orally, once a day (in the morning)

Continue Ecotrin enteric coated tablet, 325 mg, 1 tab(s), orally, once a day

Continue pravastatin tablet, 80 mg, 1 tab(s), orally, once a day (at bedtime)

Continue metformin tablet, extended release, 500 mg, 1 tab(s), orally, once a day

Continue Work Restrictions *, *, SEDENTARY WORK ONLY,, no driving or getting in and out of armored truck

Continue exforge HCT, 10/320/25, 1, by mouth, daily

Refill cyclobenzaprine tablet, 10 mg, 1 tab(s), orally, at bedtime, 30 days, 30

Patient has been doing very well. We will try to wean his medications. I will stop 10 mg of oxycodone and start him on Percocet 7.5 along with the Flexeril. Follow up in four weeks. The patient was advised to continue all other medications as prescribed by other treating physicians/providers.

JM/jp/011413.

Preventive Medicine

MED RECONCILIATION: Pt. Ed: Current Meds Verified: Current meds/immunizations reviewed, including purpose with pt. Med Recon list given to pt/family. Pt advised to discard old med lists and provide all providers with current list at each visit and carry list with them in case of emergency.

Follow Up

4 Weeks (Reason: PA)

Jmath

Electronically signed by Jyoti Math on 01/23/2013 at 03:56
PM EST

Sign off status: Completed

Upstate Medical Rehabilitation
111 Doctors Drive
Greenville, SC 29605
Tel: 864-797-7100
Fax: 864-241-9229

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Jyoti Math, MD 01/14/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



GREENVILLE HEALTH SYSTEM

HOUSTON, TOMMY GREGORY

57 Y old Male, DOB: 02/18/1956
204 BARTON ST, PO BOX 1099, EASLEY, SC-29640

Home: 864-855-0437

Guarantor: HOUSTON, TOMMY GREGORY

Insurance: CIGNA POS

PCP: Richard Curry, MD Referring: comp workers

External Visit ID: 167132133

Appointment Facility: Upstate Medical Rehabilitation

07/10/2013

Progress Note: Jyoti Math, MD

Current Medications

Oxycodone 10 MG tablet 1 tab(s) every 6 hours; max 4 a day
Isosorbide mononitrate 60 mg tablet, extended release 1 tab(s) once a day (in the morning)
Ecotrin 325 mg enteric coated tablet 1 tab(s) once a day
pravastatin 80 mg tablet 1 tab(s) once a day (at bedtime)
metformin 500 mg tablet, extended release 1 tab(s) once a day
Work Restrictions ** SEDENTARY WORK ONLY; no driving or getting in and out of armored truck
exforge HCT 10/320/25 1 daily
cyclobenzaprine 10 mg tablet 1 tab(s) at bedtime
Medication List reviewed and reconciled with the patient

Past Medical History

Hypertension
High Cholesterol
Heart disease
Heart Attack
Fracture

Surgical History

left wrist 1978
right knee 1974
hernia 9/07
heart surgery 11/23
EXPLORATION AND REMOVAL OF FOREIGN BODY, RT HAND. 06/01/09
L5-S1 posterior lumbar interbody fusion on 12/22/12 at GMH by Dr. Charles Kanos.
12/22/12

Family History

Family: diabetes, Hypertension, Heart Disease

Social History

Interpersonal/family relationships: Divorced.

Reason for Appointment

1. 4 Weeks, Math (Reason: after MRI)
2. Low back pain

History of Present Illness

General:

Worker's Comp:

Old History:

1. The patient is a 55 y/o male seen at the request of Dr. Bucci. He sustained a work injury on 3/11/08 requiring right shoulder scope and rotator cuff repair on 7/11/08 by Dr. Wessinger. Patient got a second opinion from Dr. Kanos on 8/24/12, who recommended L5/S1 PLIF and patient underwent surgery on 12/12/12 with significant improvement of the symptoms.

The case was closed in August 2010 and was put at MMI by Dr. Wessinger but was reopened because of aggravation of the symptoms. The patient has been out of work since his injury. Low back pain, mainly secondary to facet and SI problem, S/P trigger point injection on 9/12/11. s/p PT, The patient is S/P SI injection with no significant improvement. 1/12/12 Rt lumbar facet RFA 75% pain relief. Patient is work until he sees Dr. Kanos.

Spondylolisthesis S/P x-ray. He has persistent left lower back pain.

2. Right knee pain since the injury, recent MRI on 6/25/2013 shows extensive tear in the lateral meniscus, possible bucket handle tear and lateral tibiofibular chondromalacia, referred to Dr. Wessinger.

Patient returns today for followup. He reports that his back is doing very well. It is an aching pain, but it is nothing like what it used to be. He still requires to take the pain medication. Without medication his pain level is 10; with medication it is 3. He took oxycodone this morning. He feels that the Flexeril helps with his sleep. No side effects from the medication. He continues to have knee pain. As his back pain has improved he has been walking more and the knee pain is limiting his activity. Occasionally there is locking and clicking. Occasionally it gives out, but no fall. No fever. Other review of systems is negative. His last urine drug screen was on 3/11/2013.

Notes: UDS 3/11/13.

Vital Signs

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Jyoti Math, MD 07/10/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Alcohol men 18-65 yrs Assessment completed: today, Alcohol Intake: patient does not drink alcohol.
Smoking Status > 13 years old Are you a: Current smoker, Pt counseled on the dangers of tobacco use and urged to quit.
06/06/2013.
Occupation: Employed, but currently not working.
no Alcohol.
Smoking: yes, PPD: , years:..
no Recreational drug use.
no Use of marijuana, cocaine, or similar drugs.

Allergies

contrast dye: rash: Side Effects
codeine
penicillin

Hospitalization/Major

Diagnostic Procedure

see surgery list

Ht 70, Ht Cm 177.8, Wt lbs 211.6, Wt kg 95.98, BMI 30.36, BP 126/79, HR 115, Pain score 3, O2 Sat 94, Tech Initial tah
pt took oxycodone this morning.

Examination

General Exam:

On examination, vital signs are stable. He is well-built, well-nourished, a little overweight. He is awake, alert, and oriented. He communicates appropriately. He is able to transfer independently. He has a slight antalgic gait. He is breathing comfortably. No peripheral edema or varicose veins. Skin is supple. On inspection of right knee there is no swelling or erythema. On palpation he is tender diffusely along the patella with some positive meniscal signs with irritation. Knee range of motion is full and no atrophy of quadriceps noted. Some sensory impairment in L5 distribution on the right side.

Assessments

1. Chondromalacia of right knee - 733.92 (Primary)
2. Lateral meniscal tear - 836.1

Treatment

1. Chondromalacia of right knee

Refill Oxycodone tablet, 10 MG, 1 tab(s), orally, every 6 hours; max 4 a day, 30 day(s), 120, Refills 0

Refill cyclobenzaprine tablet, 10 mg, 1 tab(s), orally, at bedtime, 30 days, 30, Refills 0

2. Others

Continue isosorbide mononitrate tablet, extended release, 60 mg, 1 tab(s), orally, once a day (in the morning)

Continue Ecotrin enteric coated tablet, 325 mg, 1 tab(s), orally, once a day

Continue pravastatin tablet, 80 mg, 1 tab(s), orally, once a day (at bedtime)

Continue metformin tablet, extended release, 500 mg, 1 tab(s), orally, once a day

Continue Work Restrictions *, *, SEDENTARY WORK ONLY; no driving or getting in and out of armored truck

Continue exforge HCT, 10/320/25, 1, by mouth, daily

I reviewed the MRI results with him and he needs a followup appointment with Dr. Wessinger to get the surgical opinion. I have refilled oxycodone and Flexeril. I reviewed his last urine drug screen, which appears to be normal. Follow up in four weeks. The patient was advised to continue all other medications as prescribed by other treating physicians/providers.

JM/jp/071013.

Referral To:

Reason: Needs follow up with Dr Wessinger: New MRI meniscal tear

Preventive Medicine

MED RECONCILIATION: Pt. Ed: Current Meds Verified: Current meds/immunizations reviewed, including purpose with pt. Med Recon

list given to pt/family. Pt advised to discard old med lists and provide all providers with current list at each visit and carry list with them in case of emergency.

Follow Up

4 Weeks (Reason: PA)

Jmath

Electronically signed by Jyoti Math on 07/15/2013 at 03:42 PM EDT

Sign off status: Completed

Upstate Medical Rehabilitation
111 Doctors Drive
Greenville, SC 29605
Tel: 864-797-7100
Fax: 864-241-9229

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Jyoti Math, MD 07/10/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

HOUSTON, TOMMY GREGORY



**GREENVILLE
HEALTH SYSTEM**

57 Y old Male, DOB: 02/18/1956
204 BARTON ST, PO BOX 1099, EASLEY, SC-29640

Home: 864-855-0437

Guarantor: HOUSTON, TOMMY GREGORY

Insurance: CIGNA POS

PCP: Richard Curry, MD Referring: comp workers

External Visit ID: 174923220

Appointment Facility: Upstate Medical Rehabilitation

10/09/2013

Progress Note: Jyoti Math, MD

Current Medications

isosorbide mononitrate 60 mg tablet,
extended release 1 tab(s) once a day (in the
morning)
Ecotrin 325 mg enteric coated tablet 1 tab(s)
once a day
pravastatin 80 mg tablet 1 tab(s) once a day
(at bedtime)
metformin 500 mg tablet, extended release 1
tab(s) once a day
Work Restrictions ** SEDENTARY WORK
ONLY; no driving or getting in and out of
armored truck
exforge HCT 10/320/25 1 daily
Oxycodone 10 MG tablet 1 tab(s) every 6
hours; max 4 a day
cyclobenzaprine 10 mg tablet 1 tab(s) at
bedtime
Medication List reviewed and reconciled with
the patient

Past Medical History

Hypertension
High Cholesterol
Heart disease
Heart Attack
Fracture

Surgical History

left wrist 1978
right knee 1974
hernia 9/07
heart surgery 11/23
EXPLORATION AND REMOVAL OF
FOREIGN BODY, RT HAND. 06/01/09
L5-S1 posterior lumbar interbody fusion on
12/22/12 at GMH by Dr. Charles Kanos.
12/22/12

Family History

Family: diabetes, Hypertension, Heart
Disease

Social History

Interpersonal/family relationships: Divorced.

Reason for Appointment

1. WC 4 Weeks DR MATH
2. Low back, glut and knee pain

History of Present Illness

General:

Worker's Comp:

Old History:

1. The patient is a 55 y/o male seen at the request of Dr. Bucci. He sustained a work injury on 3/11/08 requiring right shoulder scope and rotator cuff repair on 7/11/08 by Dr. Wessinger. Patient got a second opinion from Dr. Kanos on 8/24/12, who recommended L5/S1 PLIF and patient underwent surgery on 12/12/12 with significant improvement of the symptoms.

The case was closed in August 2010 and was put at MMI by Dr. Wessinger but was reopened because of aggravation of the symptoms. The patient has been out of work since his injury. Low back pain, mainly secondary to facet and SI problem, S/P trigger point injection on 9/12/11. S/P PT, The patient is S/P SI injection with no significant improvement. 1/12/12 Rt lumbar facet RFA 75%

Patient has been put to MMI by Dr. Kanos on 4/24/2013 with 25% impairment rating for lumbar spine with work restrictions no lifting over 35 pounds and no repetitive bending more than 60 degrees, sit for eight hours a day or walking for two hours with brace.

2. Right knee pain since the injury, recent MRI on 6/25/2013 shows extensive tear in the lateral meniscus, possible bucket handle tear and lateral tibiofibular chondromalacia, referred to Dr. Wessinger.

Patient reports that his neck pain is getting worse. Pain level without medication is 10; with medication it is 3. Also lower back is bothering him. He describes his pain as an aching pain. He feels that the medication helps him a lot. He tried to cut back on his medication and instead of taking it every six hours he tried every eight hours, but his pain level significantly increased. He took oxycodone this morning. Recently he has been started on amlodipine. He denies any fever. No swelling of his right knee. He feels that there is a translation feeling in his right knee. Occasionally the knee gives out, but he reports no fall. Other review of systems is negative. He has not heard any information from Workers' Comp and has not seen Dr. Wessinger yet.

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Jyoti Math, MD 10/09/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

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Alcohol man 18-65 yrs Assessment
completed: today, Alcohol intake: patient
does not drink alcohol.
Smoking Status > 13 years old Are you a:
Current smoker, Pt counseled on the dangers
of tobacco use and urged to quit.
09/09/2013.
Occupation: Employed, but currently not
working.
no Alcohol.
Smoking: yes, PPD: , years:.
no Recreational drug use.
no Use of marijuana, cocaine, or similar
drugs.

Allergies

contrast dye: rash: Side Effects
codeine
penicillin

Hospitalization/Major

Diagnostic Procedure

see surgery list

Vital Signs

Ht 70, Ht Cm 177.8, Wt lbs 207.4, Wt kg 94.08, BMI 29.76, BP 196/101, HR 107, Pain score 3, O2 Sat 95, Tech Initial tah
pt took oxycodone this morning.

Examination

General Exam:

On examination vital signs are stable. He is well-built, well-nourished, awake, alert, and oriented. He communicates appropriately. He is able to transfer independently. Gait is slightly antalgic. He is breathing comfortably. No peripheral edema or varicose veins. Skin is supple. On inspection of right knee there is no swelling or erythema. On palpation he has tenderness around the knee joint. No atrophy of quadriceps noted. Anterior drawer sign is negative. Knee range of motion is full and causes pain.

Assessments

1. Lateral meniscal tear - 836.1
2. Knee pain - 719.46
3. Back pain - 724.5

Treatment

1. Others

Refill Oxycodone tablet, 10 MG, 1 tab(s), orally, every 6 hours; max 4 a day, 30 day(s); RELEASE 10/9/18, 120, Refills 0

Refill cyclobenzaprine tablet, 10 mg, 1 tab(s), orally, at bedtime, 30 days, 30, Refills 0

Start Voltaren Gel gel, 1%, 2.0 g, applied topically, 4 times a day, 30 day (s), 2 tubes

Patient continues to have right knee pain secondary to meniscal tear.

He needs to be seen by orthopedic surgeon, but has not heard from them and I think it is really concerning to me. I am going to send another request to Dr. Wessinger's followup appointment. Meanwhile, I will also arrange for the knee brace. I will start him on Voltaren gel and refill his medications. Follow up in four weeks.

The patient was advised to continue all other medications as prescribed by other treating physicians/providers.

JM/jp/100913.

Referral To:

Reason: Need follow up with Dr Wessinger: Dx Knee pain with meniscus tear

Referral To:

Reason: Hing brace with locking ability. Dx Rt knee pain with meniscal tear.

Preventive Medicine

MED RECONCILIATION: Pt. Ed: Current Meds Verified: Current meds/immunizations reviewed, including purpose with pt. Med Recon list given to pt/family. Pt advised to discard old med lists and provide all providers with current list at each visit and carry list with them in case of emergency.

Follow Up

4 Weeks (Reason: PA)

Jmath

Electronically signed by Jyoti Math on 10/14/2013 at 01:16 PM EDT

Sign off status: Completed

Upstate Medical Rehabilitation
111 Doctors Drive
Greenville, SC 29605
Tel: 864-797-7100
Fax: 864-241-9229

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Jyoti Math, MD 10/09/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

HOUSTON, TOMMY GREGORY



**GREENVILLE
HEALTH SYSTEM**

57 Y old Male, DOB: 02/18/1956
204 BARTON ST, PO BOX 1099, EASLEY, SC-29640

Home: 864-855-0437

Guarantor: HOUSTON, TOMMY GREGORY

Insurance: CIGNA POS

PCP: Richard Curry, MD Referring: comp workers

External Visit ID: 179501556

Appointment Facility: Upstate Medical Rehabilitation

12/05/2013

Progress Note: Jyoti Math, MD

Current Medications

exforge HCT 10/320/25 1 daily
Work Restrictions * * SEDENTARY WORK ONLY; no driving or getting in and out of armored truck
metformin 500 mg tablet, extended release 1 tab(s) once a day
pravastatin 80 mg tablet 1 tab(s) once a day (at bedtime)
Ecotrin 325 mg enteric coated tablet 1 tab(s) once a day
isosorbide mononitrate 60 mg tablet, extended release 1 tab(s) once a day (in the morning)
Oxycodone 10 MG tablet 1 tab(s) every 6 hours; max 4 a day
cyclobenzaprine 10 mg tablet 1 tab(s) at bedtime
Voltaren Gel 1% gel 2.0 g 4 times a day
Medication List reviewed and reconciled with the patient

Past Medical History

Hypertension
High Cholesterol
Heart disease
Heart Attack
Fracture

Surgical History

left wrist 1978
right knee 1974
hernia 9/07
heart surgery 11/23
EXPLORATION AND REMOVAL OF FOREIGN BODY, RT HAND. 06/01/09
L5-S1 posterior lumbar interbody fusion on 12/22/12 at GMH by Dr. Charles Kanos. 12/22/12

Family History

Family: diabetes, Hypertension, Heart Disease

Social History

Reason for Appointment

1. WC 4 Weeks MATH
2. Low back and hip pain

History of Present Illness

General:

Worker's Comp:

Old History:

1. The patient is a 55 y/o male seen at the request of Dr. Bucci. He sustained a work injury on 3/11/08 requiring right shoulder scope and rotator cuff repair on 7/11/08 by Dr. Wessinger. Patient got a second opinion from Dr. Kanos on 8/24/12, who recommended L5/S1 PLIF and patient underwent surgery on 12/12/12 with significant improvement of the symptoms.

The case was closed in August 2010 and was put at MMI by Dr. Wessinger but was reopened because of aggravation of the symptoms. The patient has been out of work since his injury. Low back pain, mainly secondary to facet and SI problem, S/P trigger point injection on 9/12/11, S/P PT, The patient is S/P SI injection with no significant improvement. 1/12/12 Rt lumbar facet RFA 75%

Patient has been put to MMI by Dr. Kanos on 4/24/2013 with 25% impairment rating for lumbar spine with work restrictions no lifting over 35 pounds and no repetitive bending more than 60 degrees, sit for eight hours a day or walking for two hours with brace.

2. Right knee pain since the injury, recent MRI on 6/25/2013 shows extensive tear in the lateral meniscus, possible bucket handle tear and lateral tibiofibular chondromalacia, referred to Dr. Wessinger. The patient was evaluated by Dr. Paylor at Piedmont Orthopedics who has recommended surgery. The patient is awaiting for approval from Worker's Comp.

The patient returns today for followup. He continues to have back pain and knee pain. He describes his pain as a burning pain but worse with the cold weather. Relieved with medication. Pain level without medication is 10 and with medication is 3. He took oxycodone this morning. He has been tolerating it very well. He also uses Flexeril for sleep as needed. No side effects from the Flexeril. No progressive weakness. No change in bowel or bladder habit, fever or weight loss. Other review of systems is negative. His last urine drug screen was on

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Jyoti Math, MD 12/05/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

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Interpersonal/family relationships: Divorced.

Alcohol men 18-65 yrs Assessment completed: today, Alcohol intake: patient does not drink alcohol.

Smoking Status > 13 years old Are you a: Current smoker, Pt counseled on the dangers of tobacco use and urged to quit.

11/07/2013.

Occupation: Employed, but currently not working.

no Alcohol.

Smoking: yes, PPD: , years:.

no Recreational drug use.

no Use of marijuana, cocaine, or similar drugs.

Allergies

contrast dye; rash; Side Effects

codeine

penicillin

Hospitalization/Major

Diagnostic Procedure

see surgery list

3/11/2013.

Notes: UDS 12/5/13.

Vital Signs

Ht 70, Ht Cm 177.8, Wt lbs 208, Wt kg 94.35, BMI 29.84, BP 151/97, HR 126, Pain score 3, O2 Sat 95, Tech Initial tab pt took oxycodone this morning.

Examination

General Exam:

On examination, vital signs are stable. He is well built, well nourished, awake, alert, oriented. Communicates appropriately. He is able to transfer independently. Gait is normal. Breathing comfortably. No peripheral edema or varicose veins. Skin is supple without any rashes. Strength in lower extremities is normal. Knee range of motion causes pain. On palpation, he has tenderness over left posterior/superior iliac spine and left lower lumbar facets.

Assessments

1. Spondylolisthesis - 756.12 (Primary)
2. Lateral meniscal tear - 836.1
3. Chondromalacia of right knee - 733.92
4. ENCOUNTER LONG TERM USE OTH DRUGS - V58.69
5. ENCTR THERAP DRUG MONITORING - V58.83
6. Sacroiliitis - 720.2

Treatment

1. Spondylolisthesis

Refill Oxycodone tablet, 10 MG, 1 tab(s), orally, every 6 hours; max 4 a day, 30 day(s); RELEASE 12/6/13, 120, Refills 0
Refill cyclobenzaprine tablet, 10 mg, 1 tab(s), orally, at bedtime, 30 days, 30, Refills 0

2. ENCOUNTER LONG TERM USE OTH DRUGS

LAB: Fentanyl w/confirmation, urine

LAB: Opiate Metabolites drug screen, urine

LAB: Pain Therapy Drug Screen (14), urine

3. ENCTR THERAP DRUG MONITORING

LAB: Fentanyl w/confirmation, urine

LAB: Opiate Metabolites drug screen, urine

LAB: Pain Therapy Drug Screen (14), urine

4. Others

1. Back pain could be secondary to exacerbation of sacroiliitis or facet syndrome. May benefit with an injection. The patient wants to wait. 2. Knee pain secondary to internal derangement and meniscal tear, awaiting surgical input. 3. Chronic pain management. Reviewed his last urine drug screen which was normal. He is due for a new screen today. Refill oxycodone and Flexeril. I advised him to take Flexeril as needed. Medication side effects discussed with patient. 4. The patient was advised to continue all other medications as prescribed by other treating physicians/providers.

JM/mat/120513.

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Jyoti Math, MD 12/05/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Labs

Lab: Tricyclic Antidepressants, urine (Amitriptyline, Nortriptyline)

Preventive Medicine

MED RECONCILIATION: Pt. Ed: Current Meds Verified; Current meds/immunizations reviewed, including purpose with pt. Med Recon list given to pt/family. Pt advised to discard old med lists and provide all providers with current list at each visit and carry list with them in case of emergency.

Follow Up

4 Weeks (Reason: PA)

Jmath

Electronically signed by Jyoti Math on 12/16/2013 at 04:13 PM EST

Sign off status: Completed

Upstate Medical Rehabilitation
111 Doctors Drive
Greenville, SC 29605
Tel: 864-797-7100
Fax: 864-241-9229

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Jyoti Math, MD 12/05/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



UNIVERSITY MEDICAL GROUP

HOUSTON, TOMMY GREGORY

56 Y old Male, DOB: 02/18/1956
204 BARTON ST. PO BOX 1099, EASLEY, SC-29640
Home: 864-855-0437

Guarantor: HOUSTON, TOMMY GREGORY

Insurance: UNITED HEALTHCARE

PCP: Richard Curry, MD Referring: comp workers

External Visit ID: 142420322

Appointment Facility: SE Neuro & Spine Institute

08/01/2012

Progress Note: Charles C. Kanos

Current Medications

isosorbide mononitrate tablet, extended release 60 mg 1 tab(s) once a day (in the morning)
Ecotrin enteric coated tablet 325 mg 1 tab(s) once a day
Flexeril tablet 10 mg 1 tab(s) once daily at bedtime
Percocet 7.5/325 tablet 325 mg-7.5 mg 1 tab(s) every 4-6 hours, max 5/day
pravastatin tablet 80 mg 1 tab(s) once a day (at bedtime)
exforge HCT tablet 5 mg-12.5 mg-160 mg 1 tab(s) once a day
Medication List reviewed and reconciled with the patient

Active Problem List

- 721.3 Lumbar and sacral arthritis
- 756.12 Spondylolisthesis
- 724.6 DISORDERS SACRUM
- 729.1 Pain, myofascial
- 724.4 Lumbar Radiculopathy
- 724.5 Pain, Back
- 721.3 Lumbar Facet Arthropathy
- 724.00 Spinal Stenosis
- 338.29 Pain, Chronic
- 724.2 Low Back Pain
- 729.5 Leg discomfort or pain
- 756.12 Spondylolisthesis
- 724.02 Lumbar Spinal Stenosis

Past Medical History

Reason for Appointment

1. WC 3.8.11. Patient states pain at the center of back to the left hip down leg. Patient states pain score today is a 6/10.

History of Present Illness

Pain:

Pain Screening: Any pain at this time? Yes, Pain is new onset, Location of pain: upper, lower, back, leg(s), What, if any, medication have you taken for this pain? Other Percocet, Pain Scale used: Number Scale 6/10, Is your pain satisfactorily controlled now? No.

Vital Signs

Ht 70, Ht Cm 177.8, Wt lbs 210.2, Wt kg 95.35, BMI 30.16, BP 144/76, HR 75, Pain score 6/10.

Examination

Imaging Studies:

MRI Lumbar 10.14.10 Innervation- CDs returned to patient.
CT Lumbar 6.2.11 Innervation.

General Exam:

General Appearance: Well developed, Well nourished and groomed, Communicates normally.

Neurological:

Capacity for sustained mental activity and abstract thinking within normal limits. Cerebellar: within normal limits. Cranial Nerves: 3rd, 4th, and 6th cranial nerves: Extraocular muscles with full conjugate range of motion, without nystagmus or complaints of diplopia, 7th Cranial Nerve: No facial asymmetries at rest or to grimacing. Gait: antalgic, walks with a limp. Level of consciousness: awake and alert. Orientation normal to time, place, person, and situation, judgement and insight, normal. Mental Status: immediate, recent, and remote memory seem normal. Mood and Affect: normal. Motor: Foot flexion is normal, Plantar flexion is normal. Nerve and Spinal Cord Tension-Compression Signs: Straight leg raising is negative on the right, Straight leg raising is negative on the left. Reflexes: Knee reflexes normal (2+) on the right, +1 on the left, Ankle reflexes normal (2+) bilaterally. Station: Normal.

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Charles C. Kanos 08/01/2012

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Hypertension
High Cholesterol
Heart disease
Heart Attack
Fracture

Surgical History

left wrist 1978
right knee 1974
hernia 9/07
heart surgery 11/23
EXPLORATION AND REMOVAL OF
FOREIGN BODY, RT HAND. 06/01/09

Family History

Family: diabetes, Hypertension, Heart Disease

Social History

Interpersonal/family relationships: Divorced.

Alcohol men 18-65 yrs Assessment completed: today, Alcohol intake: patient does not drink alcohol.
Smoking Status > 13 years old Are you a: Current smoker, Pt counseled on the dangers of tobacco use and urged to quit. 08/01/2012.
Occupation: Employed, but currently not working.
no Alcohol.
Smoking: yes, PPD: , years: no Recreational drug use.
no Use of marijuana, cocaine, or similar drugs.

Allergies

codeine
penicillin
contrast dye: rash: Side Effects

Hospitalization/Major

Diagnostic Procedure

see surgery list

Review of Systems

Musculoskeletal:

Muscle pain yes. Painful joints NO.
Weakness NO.

Integumentary:

Bruises easily YES. Poor wound healing NO. Skin dryness NO. Skin lesions NO. Skin pigmentation changes NO. Skin rash NO. Sores NO.

Neurological:

Change in alertness NO. Change in vision NO. Difficulty remembering NO. Difficulty speaking NO. Excessive daytime sleepiness NO. Headache NO. Seizures, unknown type NO. Paralysis NO.

Psychological:

Feels sad more than usual NO.

Lumbar Spine / Lower back:

Inspection: pain with flexion.

Assessments

1. Low Back Pain - 724.2 (Primary)
2. Leg discomfort or pain - 729.5
3. Spondylolisthesis - 756.12
4. Lumbar Spinal Stenosis - 724.02

Treatment

1. Low Back Pain

Referral To:

Reason: WC. Lumbar MRI w/out

2. Leg discomfort or pain

Referral To:

Reason: WC. Lumbar MRI w/out

3. Others

Continue isosorbide mononitrate tablet, extended release, 60 mg, 1 tab (s), orally, once a day (in the morning)

Continue Ecotrin enteric coated tablet, 325 mg, 1 tab(s), orally, once a day

Continue Flexeril tablet, 10 mg, 1 tab(s), orally, once daily at bedtime

Continue Percocet 7.5/325 tablet, 325 mg-7.5 mg, 1 tab(s), orally, every 4-6 hours, max 5/day

Continue pravastatin tablet, 80 mg, 1 tab(s), orally, once a day (at bedtime)

Continue exforge HCT tablet, 5 mg-12.5 mg-160 mg, 1 tab(s), orally, once a day

56 yo WM here for an evaluation of his low back following a work related injury on 3/11/2008. He was working at Garda and he was in the back of an armored car and was involved in an MVA. He was thrown around the back of the truck. I have reviewed numerous medical records, including notes from Dr. Math and Proaxis therapy. I also have notes from Dr. Wessinger. He has had right shoulder surgery on 7/11/08. Prolonged standing, walking, and sitting causes left hip pain that travels to the center of his back and burning down the left leg, thigh, and calf. He saw Dr. Bucci in the past, who did not recommend further treatment. Dr. Wessinger has evaluated his hip. He has not worked regularly since the injury. He has had a lumbar CT myelogram in 6/2011, and I have that for review. He has a lumbarized sacrum and there is a L5-S1 spondylolisthesis at the second to last disc space. There is significant foraminal stenosis bilaterally, and on the left at the level below. He has not slept in a bed in 2 years because sitting or lying on soft surfaces causes left low back and left leg pain. He does have a L5-S1 spondylolisthesis. He has had spinal injections and extensive therapy, and says that he is worsening. I will repeat his MRI without contrast.

Referral To:

Reason: WC. Lumbar MRI w/out

Preventive Medicine

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Charles C. Kanos 08/01/2012

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Endocrine:

Feels hot when others do not NO. Feels cold NO.

Allergic, Infectious, and Immunologic:

Food intolerance NO. Seasonal rhinitis NO.

Genitourinary:

Blood in urine NO. Urination frequent. Frequency of urination NO. Pain or burning with urination NO.

Respiratory:

Cough NO. Pain or tightness in chest NO. Shortness of breath or difficulty breathing NO. Wheezing NO.

Cardiovascular:

Chest pain YES. Irregular heartbeat or feeling of fast, pounding heartbeat NO. Swelling including ankles or legs NO.

Constitutional Symptoms:

Change in appetite NO. Fever and chills NO. Night sweats NO. Unintentional weight change NO.

Eyes:

Loss of vision NO. Spots or specks NO.

Ears, Nose, Mouth, and Throat:

Hearing loss NO. Nasal congestion NO.

MED RECONCILIATION: Pt. Ed: Current Meds Verified: Current meds/immunizations reviewed, including purpose with pt. Med Recon list given to pt/family. Pt advised to discard old med lists and provide all providers with current list at each visit and carry list with them in case of emergency.

MU Counseling: BMI Management plan provided? Yes, Dietary counseling provided? Yes, Activity counseling provided? Yes.

Follow Up
after MRI, prn

Electronically signed by Charles Kanos , MD on 08/06/2012 at 11:49 AM EDT

Sign off status: Pending

SE Neuro & Spine Institute
109 Doctors Drive
Greenville, SC 29605
Tel: 864-797-7150
Fax: 864-797-7145

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Charles C. Kanos 08/01/2012

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Progress Note

Patient: HOUSTON, TOMMY GREGORY
DOB: 02/18/1956 **Age:** 56 Y **Sex:** Male
Phone: 864-855-0437
Address: 204 BARTON ST, PO BOX 1099, EASLEY, SC-29640
Pcp: Richard Curry, MD

Provider: Charles C. Kanos
Date: 08/24/2012

Subjective:**CC:**

1. WC 3.8.11. Follow up on low back and left hip and leg pain. He complains today of low back and left leg pain. Pain score is 6/10 today. .

HPI:Pain:

Pain Screening: Any pain at this time? Yes, Pain is chronic, Pain Scale used: Number Scale, Is your pain satisfactorily controlled now? No, Plan for inadequately controlled pain: Reassessment of pain at next visit.

ROS:Musculoskeletal:

Muscle pain yes. Painful joints no. Weakness no.

Integumentary:

Bruises easily yes. Poor wound healing no. Skin dryness no. Skin lesions no. Skin pigmentation changes no. Skin rash no. Sores no.

Neurological:

Change in alertness no. Change in vision no. Difficulty remembering no. Difficulty speaking no. Excessive daytime sleepiness no. Headache no. Seizures, unknown type no. Paralysis no.

Psychological:

Feels sad more than usual no.

Endocrine:

Feels hot when others do not no. Feels cold no.

Allergic, Infectious, and Immunologic:

Food intolerance no. Seasonal rhinitis no.

Genitourinary:

Blood in urine no. Urination frequent. Frequency of urination no. Pain or burning with urination no.

Respiratory:

Cough no. Pain or tightness in chest no. Shortness of breath or difficulty breathing no. Wheezing no.

Cardiovascular:

Chest pain yes. Irregular heartbeat or feeling of fast, pounding heartbeat no. Swelling including ankles or legs no.

Constitutional Symptoms:

Change in appetite no. Fever and chills no. Night sweats no. Unintentional weight change no.

Eyes:

Loss of vision no. Spots or specks no.

Ears, Nose, Mouth, and Throat:

Hearing loss no. Nasal congestion no.

Medical History: Hypertension, High Cholesterol, Heart disease, Heart Attack, Fracture.

Surgical History: left wrist 1978, right knee 1974, hernia 9/07, heart surgery 11/23, EXPLORATION AND REMOVAL OF FOREIGN BODY, RT HAND. 06/01/09.

Hospitalization/Major Diagnostic Procedure: see surgery list .

Family History: Family: diabetes, Hypertension, Heart Disease

Social History: Interpersonal/family relationships: Divorced. Alcohol men 18-65 yrs Assessment completed: today, Alcohol intake: patient does not drink alcohol. Smoking Status > 13 years old Are you a: Current smoker, Pt counseled on the dangers of tobacco use and urged to quit. 08/01/2012. Occupation:

Employed, but currently not working. no Alcohol. Smoking: yes, PPD: , years:.. no Recreational drug use. no Use of marijuana, cocaine, or similar drugs.

Medications: isosorbide mononitrate tablet, extended release 60 mg 1 tab(s) once a day (in the morning), Ecotrin enteric coated tablet 325 mg 1 tab(s) once a day, Flexeril tablet 10 mg 1 tab(s) once daily at bedtime, Percocet 7.5/325 tablet 325 mg-7.5 mg 1 tab(s) every 4-6 hours, max 5/day, pravastatin tablet 80 mg 1 tab(s) once a day (at bedtime), exforge HCT tablet 5 mg-12.5 mg-160 mg 1 tab(s) once a day, metformin tablet, extended release 500 mg 1 tab(s) once a day, Medication List reviewed and reconciled with the patient

Allergies: codeine, contrast dye: rash: Side Effects, penicillin.

Objective:

Vitals: Ht 70, Ht Cm 177.8, Wt lbs 211, Wt kg 95.71, BMI 30.27, BP 172/86, HR 43, Pain score 6/10.

Examination:

General Exam:

General Appearance: well groomed, well developed and well nourished, communicates normally. Cardiovascular: RRR, no murmur. Respiratory: Auscultation: normal breath sounds, effort normal. Psych: appropriate mood and affect, normal speech.

Neurological:

Cranial Nerves: CN's III and VII grossly intact. Gait: normal. Mental Status: Orientation normal to time, place, person, and situation, Alert & oriented x 3. Motor: normal, Foot flexion. Nerve and Spinal Cord Tension-Compression Signs: Straight leg raising is positive on left. Reflexes: 2+ bilaterally and symmetric for knees.

Assessment:

Assessment:

1. Low Back Pain - 724.2 (Primary)
2. Leg discomfort or pain - 729.5
3. Spondylolisthesis - 756.12
4. Lumbar Spinal Stenosis - 724.02

Plan:

1. Low Back Pain

Referral To:

Reason: Left L5, S1 PLIF from the left with microscope and 2 C arms

2. Spondylolisthesis

Referral To:

Reason: Left L5, S1 PLIF from the left with microscope and 2 C arms

3. Lumbar Spinal Stenosis

Referral To:

Reason: Left L5, S1 PLIF from the left with microscope and 2 C arms

4. Others

56 year old man last seen three weeks. HE injured himself at work 3-11-2008 while involved in a MVA. Prolonged walking, standing, sitting causes pain in left hip down the back of his left thigh, that is described as burning. He has lateral calf pain. It feels like paresthesia. Has needles in the right heel. Right sided pain is minimal. He has a CT myelogram in 2011, the second to last disc space, L5-S1 has spondylolisthesis. There is a severe L5-S1 left sided facet arthropathy. I am calling L5, S1 the last disc space. I'm recommending a Left L5, S1 PLIF from the left. *Due to an error encountered by ECW the rest of this dictation was deleted.*

Immunizations:

Diagnostic Imaging: Lumbar Spine, 4+ views (AP, lat, 2 obliques) Bolding, Chris 08/24/2012 04:14:50 PM EDT < ap/lat/flex/ext

Labs:

Procedure Codes: 72110 X-RAY LS SPINE (4 VIEWS)

Preventive:

MED RECONCILIATION: Pt. Ed: Current Meds Verified: Current meds/immunizations reviewed, including purpose with pt. Med Recon list given to pt/family. Pt advised to discard old med lists and provide all providers with current list at each visit and carry list with them in case of emergency.

Follow Up: prn, post op

Provider: Charles C. Kanos

Patient: HOUSTON, TOMMY GREGORY **DOB:** 02/18/1956 **Date:** 08/24/2012

Progress Note

Patient: HOUSTON, TOMMY GREGORY
DOB: 02/18/1956 **Age:** 56 Y **Sex:** Male
Phone: 864-855-0437
Address: 204 BARTON ST, PO BOX 1099, EASLEY, SC-29640
Pcp: Richard Curry, MD

Provider: Charles C. Kanos
Date: 10/22/2012

Subjective:**CC:**

1. WC follow up on low back pain. Patient complains today of a burning and pins and needles sensation in his low back and down his left leg with a pain score of 5/10.

HPI:Pain:

Pain Screening: Any pain at this time? Yes, Pain is chronic, Location of pain: left, back, leg(s), Quality/Description of pain: stabbing, tingling, What, if any, medication have you taken for this pain? Other, Pain Scale used: Number Scale, Is your pain satisfactorily controlled now? No, Plan for inadequately controlled pain: Reassessment of pain at next visit. Pain Screening: Any pain at this time? Yes, Pain is chronic, Pain Scale used: Number Scale, Is your pain satisfactorily controlled now? No, Plan for inadequately controlled pain: Reassessment of pain at next visit.

ROS:Musculoskeletal:

Muscle pain yes. Painful joints no. Weakness no.

Integumentary:

Bruises easily yes. Poor wound healing no. Skin dryness no. Skin lesions no. Skin pigmentation changes no. Skin rash no. Sores no.

Neurological:

Change in alertness no. Change in vision no. Difficulty remembering no. Difficulty speaking no. Excessive daytime sleepiness no. Headache no. Seizures, unknown type no. Paralysis no.

Psychological:

Feels sad more than usual no.

Endocrine:

Feels hot when others do not no. Feels cold no.

Allergic, Infectious, and Immunologic:

Food intolerance no. Seasonal rhinitis no.

Genitourinary:

Blood in urine no. Urination frequent. Frequency of urination no. Pain or burning with urination no.

Respiratory:

Cough no. Pain or tightness in chest no. Shortness of breath or difficulty breathing no. Wheezing no.

Cardiovascular:

Chest pain yes. Irregular heartbeat or feeling of fast, pounding heartbeat no. Swelling including ankles or legs no.

Constitutional Symptoms:

Change in appetite no. Fever and chills no. Night sweats no. Unintentional weight change no.

Eyes:

Loss of vision no. Spots or specks no.

Ears, Nose, Mouth, and Throat:

Hearing loss no. Nasal congestion no.

Medical History: Hypertension, High Cholesterol, Heart disease, Heart Attack, Fracture.

Surgical History: left wrist 1978, right knee 1974, hernia 9/07, heart surgery 11/23, EXPLORATION AND REMOVAL OF FOREIGN BODY, RT HAND. 06/01/09.

Hospitalization/Major Diagnostic Procedure: see surgery list.

Family History: Family: diabetes, Hypertension, Heart Disease

Social History: Interpersonal/family relationships: Divorced. Alcohol men 18-65 yrs Assessment: completed: today, Alcohol intake: patient does not drink alcohol. Smoking Status > 13 years old Are you a: Current smoker, Pt counseled on the dangers of tobacco use and urged to quit. 10/22/2012. Occupation: Employed, but currently not working. no Alcohol. Smoking: yes, PPD: , years:.. no Recreational drug use. no Use of marijuana, cocaine, or similar drugs.

Medications: isosorbide mononitrate tablet, extended release 60 mg 1 tab(s) once a day (in the morning), Ecotrin enteric coated tablet 325 mg 1 tab(s) once a day, pravastatin tablet 80 mg 1 tab(s) once a day (at bedtime), exforge HCT tablet 5 mg-12.5 mg-160 mg 1 tab(s) once a day, metformin tablet, extended release 500 mg 1 tab(s) once a day, Percocet 7.5/325 tablet 325 mg-7.5 mg 1 tab(s) every 4-6 hours, max 5/day, Flexeril tablet 10 MG 1 tab(s) once daily at bedtime, Medication List reviewed and reconciled with the patient

Allergies: codeine, contrast dye: rash: Side Effects, penicillin.

Objective:

Vitals: Ht 70, Ht Cm 177.8, Wt lbs 211, Wt kg 95.71, BMI 30.27, BP 148/91, HR 128, Pain score 5/10.

Examination:

General Exam:

General Appearance: well groomed, well developed and well nourished, communicates normally. Psych: appropriate mood and affect, normal speech.

Neurological:

Cranial Nerves: CN's III and VII grossly intact. Gait: normal. Mental Status: Orientation normal to time, place, person, and situation, Alert & oriented x 3.

Assessment:

Assessment:

1. Low Back Pain - 724.2 (Primary)
2. Leg discomfort or pain - 729.5
3. Spondylolisthesis - 756.12
4. Lumbar Spinal Stenosis - 724.02

Plan:

1. Others Continue isosorbide mononitrate tablet, extended release, 60 mg, 1 tab(s), orally, once a day (in the morning) ; Continue Ecotrin enteric coated tablet, 325 mg, 1 tab(s), orally, once a day ; Continue pravastatin tablet, 80 mg, 1 tab(s), orally, once a day (at bedtime) ; Continue exforge HCT tablet, 5 mg-12.5 mg-160 mg, 1 tab(s), orally, once a day ; Continue metformin tablet, extended release, 500 mg, 1 tab(s), orally, once a day ; Continue Percocet 7.5/325 tablet, 325 mg-7.5 mg, 1 tab(s), orally, every 4-6 hours, max 5/day ; Continue Flexeril tablet, 10 MG, 1 tab(s), orally, once daily at bedtime .

56 year old man was last seen 2 months. For some reason the dictation got cut off. It was a long visit. He had a work injury in 2008 and has been having left hip pain into the thigh. Pain is aching and stabbing, which is more towards the back. He had needle sensation in his right foot. I reviewed his CT myelogram which shows a lumbar sacrum the last disc space has been labeled L5-S1 He has six non rib bearing vertebra. He has severe facet arthropathy, Grade I spondylolisthesis with bilateral filling defects worse on the left. He was out of work until May 2009. And then he's been out since August 2010. Main complaint is low back pain and left leg pain. I believe his MRI explains his pain. I don't think a decompression alone is going to help his back pain. My rationale on the last visit and today is that to treat him most appropriately he would need a L5-S1 PLIF and left sided decompression. He's had injections, rhizotomies, PT and been to pain management. He's been out of work for 2 years and the pain is getting worse. I would recommend the above procedure, risks include bleeding, infection, CSF leak, continued pain, recurrence, weakness, foot drop, numbness, tingling, non union and other risks. If he were to still hurt after this there wouldn't be anything else to surgical to consider.

Immunizations:

Labs:

Preventive:

MED RECONCILIATION: Pt. Ed: Current Meds Verified: Current meds/immunizations reviewed, including purpose with pt. Med Recon list given to pt/family. Pt advised to discard old med lists and provide all providers with current list at each visit and carry list with them in case of emergency.

Follow Up: prn

Provider: Charles C. Kanos

Patient: HOUSTON, TOMMY GREGORY **DOB:** 02/18/1956 **Date:** 10/22/2012

Summary View

Progress Note

Patient: HOUSTON, TOMMY GREGORY
DOB: 02/18/1956 **Age:** 57 Y **Sex:** Male
Phone: 864-855-0437
Address: 204 BARTON ST, PO BOX 1099, EASLEY, SC-29640
Pcp: Richard Curry, MD

Provider: Charles C. Kanos
Date: 03/08/2013

Subjective:

CC:
1. S/p L5-S1 posterior lumbar interbody fusion on 12/22/12 at GMH by Dr. Charles Kanos. He complains today of a pins and needles sensation in his low back and left lower extremity with a pain score of 4/10. .

HPI:

Follow Up After Surgery:

Surgery type: L5-S1 posterior lumbar interbody fusion on 12/22/12 at GMH by Dr. Charles Kanos. Date of procedure: 12/22/12. Overall response to treatment: much improved. Complications since surgery: none, more swelling than expected.

Pain:

Pain Screening: Any pain at this time? Yes, Pain is chronic, Location of pain: left, hip(s), leg (s), Quality/Description of pain: tingling, Pain Scale used: Number Scale, Is your pain satisfactorily controlled now? No, Plan for inadequately controlled pain: Reassessment of pain at next visit.

ROS:

Musculoskeletal:

Muscle pain yes. Painful joints no. Weakness no.

Integumentary:

Bruises easily yes. Poor wound healing no. Skin dryness no. Skin lesions no. Skin pigmentation changes no. Skin rash no. Sores no.

Neurological:

Change in alertness no. Change in vision no. Difficulty remembering no. Difficulty speaking no. Excessive daytime sleepiness no. Headache no. Seizures, unknown type no. Paralysis no.

Psychological:

Feels sad more than usual no.

Endocrine:

Feels hot when others do not no. Feels cold no.

Allergic, Infectious, and Immunologic:

Food intolerance no. Seasonal rhinitis no.

Genitourinary:

Blood in urine no. Urination frequent. Frequency of urination no. Pain or burning with urination no.

Respiratory:

Cough no. Pain or tightness in chest no. Shortness of breath or difficulty breathing no. Wheezing no.

Cardiovascular:

Chest pain yes. Irregular heartbeat or feeling of fast, pounding heartbeat no. Swelling including ankles or legs no.

Constitutional Symptoms:

Change in appetite no. Fever and chills no. Night sweats no. Unintentional weight change no.

Eyes:

Loss of vision no. Spots or specks no.

Ears, Nose, Mouth, and Throat:

Hearing loss no. Nasal congestion no.

Medical History: Hypertension, High Cholesterol, Heart disease, Heart Attack, Fracture.

Surgical History: left wrist 1978, right knee 1974, hernia 9/07, heart surgery 11/23, EXPLORATION AND REMOVAL OF FOREIGN BODY, RT HAND. 06/01/09, L5-S1 posterior lumbar interbody fusion on 12/22/12 at GMH by Dr. Charles Kanos. 12/22/12.

PIEDMONT ORTHOPAEDICS
COPY

Summary View

Hospitalization/Major Diagnostic Procedure: see surgery list .

Family History: Family: diabetes, Hypertension, Heart Disease

Social History: Interpersonal/family relationships: Divorced. Alcohol men 18-65 yrs Assessment completed: today, Alcohol intake: patient does not drink alcohol. Smoking Status > 13 years old Are you a: Current smoker, Pt counseled on the dangers of tobacco use and urged to quit. 03/07/2013. Occupation: Employed, but currently not working. no Alcohol. Smoking: yes, PPD: , years: . no Recreational drug use. no Use of marijuana, cocaine, or similar drugs.

Medications: isosorbide mononitrate tablet, extended release 60 mg 1 tab(s) once a day (in the morning), Ecotrin enteric coated tablet 325 mg 1 tab(s) once a day, pravastatin tablet 80 mg 1 tab(s) once a day (at bedtime), metformin tablet, extended release 500 mg 1 tab(s) once a day, exforge HCT 10/320/25 1 daily, cyclobenzaprine tablet 10 mg 1 tab(s) at bedtime, Percocet 7.5/325 tablet 325 mg-7.5 mg 1 tab(s) every 6 hours, Medication List reviewed and reconciled with the patient

Allergies: contrast dye: rash: Side Effects, codeine, penicillin.

Objective:

Vitals: Ht 70, Ht Cm 177.8, Wt lbs 206, Wt kg 93.44, BMI 29.55, BP 148/93, HR 99, Pain score 4/10.

Examination:

General Exam:

General Appearance: well groomed, well developed and well nourished, communicates normally. Psych: appropriate mood and affect, normal speech.

Neurological:

Cranial Nerves: CN's III and VII grossly intact. Gait: normal. Mental Status: Orientation normal to time, place, person, and situation, Alert & oriented x 3.

Assessment:

Assessment:

1. Examination following surgery - V67.00 (Primary)

Plan:

1. Examination following surgery

Diagnostic Imaging: Lumbar Spine, 2 or 3 views Scharf, Tricia 03/08/2013 09:43:17 AM EST > .

Referral To:

Reason: WC: Work hardening to add to PT

2. Others Continue isosorbide mononitrate tablet, extended release, 60 mg, 1 tab(s), orally, once a day (in the morning) ; Continue Ecotrin enteric coated tablet, 325 mg, 1 tab(s), orally, once a day ; Continue pravastatin tablet, 80 mg, 1 tab(s), orally, once a day (at bedtime) ; Continue metformin tablet, extended release, 500 mg, 1 tab(s), orally, once a day ; Continue exforge HCT, 10/320/25, 1, by mouth, daily ; Continue cyclobenzaprine tablet, 10 mg, 1 tab(s), orally, at bedtime ; Continue Percocet 7.5/325 tablet, 325 mg-7.5 mg, 1 tab(s), orally, every 6 hours .

57 year old man is here for an evaluation due to receiving information workman's comp to go back to work. He has spoken to Nancy and she recommended him to come in for an eval and Xrays. Pt is about 3 mths post-op from an L5-S1 fusion. Overall the pt is improving. He is participating with PT 3 days a week. He feels his standing tolerance has increased to 25-30 mins before he has low back/Lt buttock/paresthesias in the lateral calf and top of foot for which he has to sit down. Since surgery his left leg pain, that was present for 5 years, has resolved. He states that his left low back pain is 50% improved since surgery. He still complains of left hip pain. With prolonged standing his low back pain worsens. I expect him to go back to work. He needs more work hardening and I want him to continue PT for several more months. AT that time I recommend that he goes back to work with no standing over 2 hrs with breaks, no repetitive bending over 60 degrees and no lifting over 25 lbs. He states that he couldn't go back right now. I want to see him back in 2 months. In summary he is going to go back to work but he needs more conditioning prior to returning.

Immunizations:

Labs:

Procedure Codes: 72100 LS SPINE (2-3 VIEW) X-RAY

Preventive:

MED RECONCILIATION: Pt. Ed: Current Meds Verified: Current meds/immunizations reviewed, including purpose with pt. Med Recon list given to pt/family. Pt advised to discard old med lists and provide all

PEDMONT ORTHOPEDICS
COPY

MD Decision Making Comments:

MD signature

[Signature]

Date

3/20/13

Please fax this form to 866-271-6229.

Thank you for your assistance.

Dorothy Batton

Dorothy Batton RN, CCM
Markillie & Associates
Phone: 904-738-5289
Fax: 866-2716229

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PIEDMONT ORTHOPAEDICS
COPY



GREENVILLE HEALTH SYSTEM

HOUSTON, TOMMY GREGORY

57 Y old Male, DOB: 02/18/1956
204 BARTON ST, PO BOX 1099, EASLEY, SC-29640

Home: 864-855-0437

Guarantor: HOUSTON, TOMMY GREGORY

Insurance: UNITED HEALTHCARE

PCP: Richard Curry, MD Referring: comp workers

Appointment Facility: SE Neuro & Spine Institute

04/24/2013

Progress Note: Charles C. Kanos

Current Medications

isosorbide mononitrate 60 mg tablet,
extended release 1 tab(s) once a day (in the
morning)
Ecotrin 325 mg enteric coated tablet 1 tab(s)
once a day
pravastatin 80 mg tablet 1 tab(s) once a day
(at bedtime)
metformin 500 mg tablet, extended release 1
tab(s) once a day
exforge HCT 10/320/25 1 daily
cyclobenzaprine 10 mg tablet 1 tab(s) at
bedtime
oxycodone 10 mg tablet 1 tab(s) every 6 hours
Medication List reviewed and reconciled with
the patient

Past Medical History

Hypertension
High Cholesterol
Heart disease
Heart Attack
Fracture

Surgical History

left wrist 1978
right knee 1974
hernia 9/07
heart surgery 11/23
EXPLORATION AND REMOVAL OF
FORIEGN BODY, RT HAND. 06/01/09
L5-S1 posterior lumbar interbody fusion on
12/22/12 at GMH by Dr. Charles Kanos.
12/22/12

Family History

Family: diabetes, Hypertension, Heart
Disease

Social History

Interpersonal/family relationships: Divorced.

Alcohol men 18-65 yrs Assessment
completed: today, Alcohol intake: patient
does not drink alcohol.
Smoking Status > 13 years old Are you a:
Current smoker, Pt counseled on the dangers
of tobacco use and urged to quit.
04/23/2013.

Reason for Appointment

1. Follow up on low back pain

Assessments

1. Low Back Pain - 724.2 (Primary)

Treatment

1. Others

57 year old man who had long standing low back pain since 2008.
ultimately he had a L5-S1 fusion for spondylolisthesis. His left leg pain
is almost completely resolved. His back was doing better initially after
the surgery on 12-12-12. He's had extensive PT and I have notes for
review today at SF. He's changed therapists and the activities have
worsened his back pain. It's not constant burning like it was before but
he has diffuse paresthesias in his back to his buttocks. The pain is
worse with lifting, walking on uneven ground, and stairs. It's not
surprising, given the duration of his symptoms, that he has residual
pain. He's been under the care of Dr. Math. In terms of permanent
restrictions he is to not to lift over 35 lbs and no repetitive bending
more than 60 degrees. He can sit for an 8 hour day or walking for 2
hours with breaks. I'm going to place him at MMI with a 25%
impairment to hte lumbar spine. HE is a patient of Dr. Math's for pain
management and I think he will need to continue that. He's not getting
any PT and I would stop that. He can do home exercises as he's been to
PT enough to do this. I want to see him in 6 months with a xray to
make sure the fusion is progressing as it should.

Preventive Medicine

MED RECONCILIATION: Pt. Ed: Current Meds Verified: Current
meds/immunizations reviewed, including purpose with pt. Med Recon
list given to pt/family. Pt advised to discard old med lists and provide
all providers with current list at each visit and carry list with them in
case of emergency.

Follow Up

6 months with XR AP/Lat Lumbar, prn

History of Present Illness

Follow Up After Surgery:

Surgery type: L5-S1 posterior lumbar interbody fusion on 12/22/12

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Charles C. Kanos 04/24/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Occupation: Employed, but currently not working.
no Alcohol.
Smoking: yes, PPD: , years:
no Recreational drug use.
no Use of marijuana, cocaine, or similar drugs.

Allergies

contrast dye: rash: Side Effects
codeine
penicillin

Hospitalization/Major Diagnostic Procedure

see surgery list

Review of Systems

Musculoskeletal:

Muscle pain yes. Painful joints no.

Weakness no.

Integumentary:

Bruises easily yes. Poor wound healing no. Skin dryness no. Skin lesions no. Skin pigmentation changes no. Skin rash no. Sores no.

Neurological:

Change in alertness no. Change in vision no. Difficulty remembering no. Difficulty speaking no. Excessive daytime sleepiness no. Headache no. Seizures, unknown type no. Paralysis no.

Psychological:

Feels sad more than usual no.

Endocrine:

Feels hot when others do not no. Feels cold no.

Allergic, Infectious, and Immunologic:

Food intolerance no. Seasonal rhinitis no.

Genitourinary:

Blood in urine no. Urination frequent. Frequency of urination no. Pain or burning with urination no.

Respiratory:

Cough no. Pain or tightness in chest no. Shortness of breath or difficulty breathing no. Wheezing no.

Cardiovascular:

Chest pain yes. Irregular heartbeat or feeling of fast, pounding heartbeat no. Swelling including ankles or legs no.

Constitutional Symptoms:

Change in appetite no. Fever and chills no. Night sweats no. Unintentional weight change no.

Eyes:

Loss of vision no. Spots or specks no.

at GMH by Dr. Charles Kanos.. Date of procedure: 12/22/12. Overall response to treatment: much improved. Complications since surgery: none, more swelling than expected.

Pain:

Pain Screening: Any pain at this time? Yes, Pain is chronic, Location of pain: left, hip(s), leg(s), Quality/Description of pain: tingling, What, if any, medication have you taken for this pain? Other percocet, Pain Scale used: Number Scale 3, Is your pain satisfactorily controlled now? No, Plan for inadequately controlled pain: Reassessment of pain at next visit.

Previous Treatments / Therapies:

Injection therapy: with mild benefit. Medications: oxycodone. Physical therapy: with no benefit.

Vital Signs

Ht 70, Ht Cm 177.8, Wt lbs 205, Wt kg 92.99, BMI 29.41, BP 158/102, HR 106, Pain score 3/10.

Examination

General Exam:

General Appearance: well groomed, well developed and well nourished, communicates normally. Psych: appropriate mood and affect, normal speech.

Neurological:

Cranial Nerves: CN's III and VII grossly intact. Gait: normal. Mental Status: Orientation normal to time, place, person, and situation, Alert & oriented x 3.

Charles C. Kanos MD

Electronically signed by Charles Kanos, MD on 04/29/2013 at 10:51 AM EDT

Sign off status: Completed

SE Neuro & Spine Institute
109 Doctors Drive
Greenville, SC 29605
Tel: 864-797-7150
Fax: 864-797-7145

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Charles C. Kanos 04/24/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Ears, Nose, Mouth, and Throat:

Hearing loss NO. Nasal congestion NO.

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Charles C. Kanos 04/24/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



UNIVERSITY MEDICAL GROUP

HOUSTON, TOMMY GREGORY

55 Y old Male, DOB: 02/18/1956
204 BARTON ST. PO BOX 1099, EASTLEY, SC-29640
Home: 864-855-0437

Guarantor: HOUSTON, TOMMY GREGORY
Insurance: UNITED HEALTHCARE

PCP: Richard Curry, MD External Visit ID: 128967387
Appointment Facility: Upstate Medical Rehabilitation

01/04/2012

Progress Notes: April Smith, PA-C

Current Medications

Percocet 7.5/325 tablet 325 mg-7.5 mg 1 tab(s) every 6 hours (max 4/day)
Flexeril tablet 10 mg 1 tab(s) 3 times a day prn
pravastatin tablet 80 mg 1 tab(s) once a day (at bedtime)
amlodipine-benazepril capsule 10 mg-40 mg 1 cap(s) once a day
Bystolic tablet 10 mg 1 tab(s) twice a day
isosorbide mononitrate tablet, extended release 60 mg 1 tab(s) once a day (in the morning)
Ecotrin enteric coated tablet 325 mg 1 tab(s) once a day
niacin tablet, extended release 1000 mg 1 tab(s) once a day (at bedtime)
Medication List reviewed and reconciled with the patient

Active Problem List

- 721.3 Lumbar and sacral arthritis
- 756.12 Spondylolisthesis
- 724.6 DISORDERS SACRUM
- 729.1 Pain, myofascial
- 724.4 Lumbar Radiculopathy
- 724.5 Pain, Back
- 721.3 Lumbar Facet Arthropathy
- 721.00 Spinal Stenosis

Past Medical History

Hypertension
High Cholesterol
Heart disease
Heart Attack
Fracture

Surgical History

left wrist 1978

Reason for Appointment

1. FOLLOW UP PER TAMEKA

History of Present Illness

General:

Worker's Comp:

Interim History:

1. The patient is a 55 y/o male seen at the request of Dr. Bucci. He sustained a work injury on 3/11/08 requiring right shoulder scope and rotator cuff repair on 7/11/08 by Dr. Wessinger. Dr. Bucci does not think that his low back requires surgical intervention. The CT myelogram shows wide open canal. The case was closed in August 2010 and was put at MMI by Dr. Wessinger but was reopened because of aggravation of the symptoms. The patient has been out of work since his injury.

2. Low back pain, mainly secondary to facet and SI problem as well as myofascial in origin S/P trigger point injection by me on 9/12/11. s/p PT. The patient is S/P SI injection with no significant improvement.

3. Spondylolisthesis S/P x-ray.

MRI of lumbar spine done on 10/4/2010 shows there is increased stress at lumbosacral junction, severe bilateral L5/S1 facet arthritis, mild non compressive L5/S1 disc bulge, mild L4/L5 disc bulge, moderate left and milder right L5/S1 lateral recess narrowing, moderate right and severe left L5 body neural foraminal stenosis, which is consistent with his left L5/S1 radiculopathy.

5. 12/21/11 Bilateral MBB Lt side increased in pain and Rt side 75% less pain.

Today pt. reports that he is scheduled for RFA 1/12. He presents today for medication refills and information regarding procedure.

Pt. states that his pain goes down the posterior LLE to the knee. He also has paresthesias in the lateral lower leg and numbness in the plantar aspect to the great toe.

Pt. states that walking about 10-15 minutes increases his pain to the point that he has to sit down. If he sits on a hard surface, the pain is relieved after about 2 mins. He can often get up and walk another 10-15 mins. Sitting in the car x 30 mins increases his pain to the point that he has to get up and walk around a little. Soft seats seem to aggravate his problem. Lying down flat does not seem to fix anything. He states that

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: April Smith, PA-C 01/04/2012

right knee 1974
hernia 9/07
heart surgery 11/23
EXPLORATION AND REMOVAL OF
FOREIGN BODY, RT HAND. 06/01/09

Family History

Family: diabetes, Hypertension, Heart
Disease

Social History

Interpersonal/family relationships: Divorced.

Occupation: Employed, but currently not
working.
no Alcohol
Smoking: yes PPD: years:
no Recreational drug use.
no Use of marijuana, cocaine, or similar
drugs.

Allergies

codeine
penicillin
contrast dye: rash: Side Effects

Hospitalization Major

Diagnostic Procedure

see surgery list

his concrete step seems to do the best for him.

Pain Any pain at this time? Yes, chronic pain. Does your current
medication impair your judgement, coordination or your ability to
drive? No, Rate the pain you had before you began treatment (on a
scale of 0-10): 10 (unbearable) left side, Rate your pain since you
began treatment (on a scale of 0-10): 6, Is the current treatment
working? No, Current treatment includes: Medication(s) pt took
percocet this morning, Are you experiencing any side effects from the
medications prescribed by your Physician at UMR? No, Are you
satisfied with the treatment? Yes.

Vital Signs

Ht 70, HR 101, BP 108/104, O2 Sat 95%, Pain score 6
pt states that symptoms of high BP and states that he took his BP meds
this morning. Informed pt to contact PCP if he starts having symptoms.
pt expressed understanding...THudson, RMA.

Examination

Gait:

Heel Walk intact. Toe Walk intact - holds to furniture for balance.
ambulates with R toe pointed laterally d/t knee pain.

General Exam:

General Appearance Well developed, well nourished and groomed,
No apparent acute or chronic distress, alert, alert and oriented.
Back pain with extension, tender L SI joint and L gluts. + piriformis
stretch L buttock. Pysch Normal.

Assessments

1. Pain, Back - 724.5 (Primary)
2. Spondylolisthesis - 756.12
3. DISORDERS SACRUM - 724.6
4. Lumbar Facet Arthropathy - 721.3

Pt. has had good relief with MBB on the R. He seems to have a lot of
pain coming from L SI joint and possible piriformis syndrome. He has
been through PT and is still doing HEP. He states that piriformis
injection provided short term relief.

We will begin by following through with RFA and plan to address the
other issues after this procedure.

A great deal of time is spent with this patient discussing the nature of
his condition and treatment options. He is agreeable to RFA and will
continue HEP especially piriformis stretches.

Treatment

1. Pain, Back

Refill Flexeril tablet, 10 mg, 1 tab(s), orally, 3 times a day prn, 30 days,
90
Refill Percocet 7.5/325 tablet, 325 mg-7.5 mg, 1 tab(s), orally, every 6
hours (max4/day), 30 days, 120

Preventive Medicine

MED RECONCILIATION: Pt. Ed: Current Meds Verified: Current
meds/immunizations reviewed, including purpose with pt. Med Recon
list given to pt/family. Pt advised to discard old med lists and provide

Patient: HOUSTON, TOMMY GREGORY DOB: 02-18-1956 Progress Note: April Smith, PA-C 01/04/2012

all providers with current list at each visit and carry list with them in case of emergency.

Follow Up

after rhizotomy (Reason: FU Dr. Math)

Electronically signed by April (UMR) Smith, PA-C on
01/09/2012 at 08:52 AM EST

Sign off status: Pending

Upstate Medical Rehabilitation
111 Doctors Drive
Greenville, SC 29605
Tel: 864-797-7100
Fax: 864-241-9229

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: April Smith, PA-C 01/04/2012

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



UNIVERSITY MEDICAL GROUP

HOUSTON, TOMMY GREGORY

56 Y old Male, DOB: 02/18/1956
204 BARTON ST, PO BOX 1099, EASLEY, SC 29640

Home: 864-855-0437

Guarantor: HOUSTON, TOMMY GREGORY

Insurance: UNITED HEALTHCARE

PCP: Richard Curry, MD External Visit ID: 131209801

Appointment Facility: Upstate Medical Rehabilitation

03/01/2012

Progress Notes: April Smith, PA-C

Current Medications

pravastatin tablet 80 mg 1 tab(s) once a day.
(at bedtime)
amlodipine-benazepril capsule 10 mg-40 mg
1 cap(s) once a day
Bystolic tablet 10 mg 1 tab(s) twice a day
isosorbide mononitrate tablet, extended
release 60 mg 1 tab(s) once a day (in the
morning)
Ecotrin enteric coated tablet 325 mg 1 tab(s)
once a day
niacin tablet, extended release 1000 mg 1 tab
(s) once a day (at bedtime)
Flexeril tablet 10 MG 1 tab(s) qhs
Percocet 7.5/325 tablet 325 mg-7.5 mg 1 tab
(s) every 6 hours (max 4/day)
Medication List reviewed and reconciled with
the patient

Past Medical History

Hypertension
High Cholesterol
Heart disease
Heart Attack
Fracture

Surgical History

left wrist 1978
right knee 1974
hernia 9/07
heart surgery 11/23
EXPLORATION AND REMOVAL OF
FOREIGN BODY, RT HAND. 06/01/09

Family History

Family: diabetes, Hypertension, Heart
Disease

Social History

Interpersonal/family relationships: Divorced.

Occupation: Employed, but currently not
working.
no Alcohol.
Smoking: yes, PPD: , years:.
no Recreational drug use.

Reason for Appointment

1. FOLLOW UP

History of Present Illness**General:****Worker's Comp:****Interim History:**

1. The patient is a 55 y/o male seen at the request of Dr. Buccì. He sustained a work injury on 3/11/08 requiring right shoulder scope and rotator cuff repair on 7/11/08 by Dr. Wessinger. Dr. Buccì does not think that his low back requires surgical intervention. The CT myelogram shows wide open canal. The case was closed in August 2010 and was put at MMI by Dr. Wessinger but was reopened because of aggravation of the symptoms. The patient has been out of work since his injury. Low back pain, mainly secondary to facet and SI problem, S/P trigger point injection on 9/12/11, s/p PT. The patient is S/P SI injection with no significant improvement. 6.1/12/12 Rt lumbar facet RFA 75% pain relief

3. Spondylolisthesis S/P x-ray.

MRI of lumbar spine done on 10/4/2010 shows there is increased stress at lumbosacral junction, severe bilateral L5/S1 facet arthritis, mild non compressive L5/S1 disc bulge, mild L4/L5 disc bulge, moderate left and milder right L5/S1 lateral recess narrowing, moderate right and severe left L5 body neural foraminal stenosis, which is consistent with his left L5/S1 radiculopathy

Today pt. reports that his flexeril was decreased from q 8 hours to at bedtime. He states that this decrease has caused a flare up of his pain. He would like to go back on his flexeril TID.

Pt. reports that he has not yet heard from Dr. McHenry's office.

Pt. reports that when rotating to the L at the waist, his LLE "does not move in time" resulting in his falling. He states that this does not happen as frequently as it used since seeing PT.

Pain Any pain at this time? Yes, chronic pain, Does your current medication impair your judgement, coordination or your ability to drive? No, Rate the pain you had before you began treatment (on a scale of 0-10): 3, Rate your pain since you began treatment (on a scale of 0-10): 1, Is the current treatment working? Yes, Current treatment includes: Medication(s) percocet this am, Are you experiencing any side effects from the medications prescribed by your Physician at

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: April Smith, PA-C 03/01/2012

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

<http://ecw.ghs.org:8080/mobile/doc/jsp/catalog/xml/printMultipleChartOptions.jsp?encount...> 3/13/2012

no Use of marijuana, cocaine, or similar drugs.

Allergies

codeine
penicillin
contrast dye: rash: Side Effects

Hospitalization/Major**Diagnostic Procedure**

see surgery list

UMR? No, Are you satisfied with the treatment? Yes.

Vital Signs

Ht 70, Ht Cm 177.8, Wt lbs 200, Wt kg 90.72, BMI 28.69, BP 159/99,
Pain score 5, HR 103, O2 Sat 95, Temp (F) 98.2.

ExaminationGait:

Heel Walk intact. Toe Walk difficulty with balance. Tandem
Walk with some difficulty d/t balance. Squat full.

Gait: WNL, steady.

General Exam:

General Appearance obese, Well developed, well nourished and
groomed, No apparent acute or chronic distress, Communicates
normally, alert and oriented. Extremities strength 5/5, though LLE is
mildly weaker than RLE with still good strength, decreased sensation
lateral LLE, DTR brisk B. Back pain with flexion, knees slightly flexed;
pain limits extension. Psych appropriate mood and affect.

Assessments

1. DISORDERS SACRUM - 724.6 (Primary)
2. Pain, Back - 724.5
3. Lumber Facet Arthropathy - 721.3

Treatment**1. DISORDERS SACRUM**

Refill Flexeril tablet, 10 MG, 1 tab(s), orally, qhs, 30 days, 30, Refills 0
Refill Percocet 7.5/325 tablet, 325 mg-7.5 mg, 1 tab(s), orally, every 6
hours (max4/day), 30 days, 120

Preventive Medicine

MED RECONCILIATION: Pt. Ed: Current Meds Verified: Current
meds/immunizations reviewed, including purpose with pt. Med Recon
list given to pt/family. Pt advised to discard old med lists and provide
all providers with current list at each visit and carry list with them in
case of emergency.

Follow Up

4 Weeks (Reason: FU on referral)

Electronically signed by April(UMR) Smith, PA-C on
03/07/2012 at 01:28 PM EST

Sign off status: Completed

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: April Smith, PA-C 03/01/2012
Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

<http://ecw.ghs.org:8080/mobiledoc/jsp/catalog/xml/printMultipleChartOptions.jsp?encount...> 3/13/2012

Upstate Medical Rehabilitation
111 Doctors Drive
Greenville, SC 29605
Tel: 864-797-7100
Fax: 864-241-9229

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: April Smith, PA-C 03/01/2012

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



UNIVERSITY MEDICAL GROUP

HOUSTON, TOMMY GREGORY

56 Y old Male, DOB: 02/18/1956
204 BARTON ST. PO BOX 1099, EASLEY, SC-29640

Home: 864-855-0437

Guarantor: HOUSTON, TOMMY GREGORY

Insurance: UNITED HEALTHCARE

PCP: Richard Curry, MD External Visit ID: 133069906

Appointment Facility: Upstate Medical Rehabilitation

03/29/2012

Progress Notes: April Smith, PA-C

Current Medications

niacin tablet, extended release 1000 mg 1 tab (s) once a day (at bedtime)
Ecotrin enteric coated tablet 325 mg 1 tab(s) once a day
isusorbide mononitrate tablet, extended release 60 mg 1 tab(s) once a day (in the morning)
Bystolic tablet 10 mg 1 tab(s) twice a day
amlodipine-benazepril capsule 10 mg-40 mg 1 cap(s) once a day
pravastatin tablet 80 mg 1 tab(s) once a day (at bedtime)
Percocet 7.5/325 tablet 325 mg-7.5 mg 1 tab (s) every 6 hours (max4/day)
Flexeril tablet 10 MG 1 tab(s) qhs
Medication List reviewed and reconciled with the patient

Active Problem List

- 721.3 Lumbar and sacral arthritis
- 756.12 Spondylolisthesis
- 724.6 DISORDERS SACRUM
- 729.1 Pain, myofascial
- 724.4 Lumbar Radiculopathy
- 724.5 Pain, Back
- 721.3 Lumbar Facet Arthropathy
- 724.00 Spinal Stenosis

Past Medical History

Hypertension
High Cholesterol
Heart disease
Heart Attack
Fracture

Surgical History

left wrist 1978
right knee 1974

Reason for Appointment

1. FOLLOW UP

History of Present Illness

General:

Worker's Comp:

Interim History:

1. The patient is a 55 y/o male seen at the request of Dr. Bucci. He sustained a work injury on 3/11/08 requiring right shoulder scope and rotator cuff repair on 7/11/08 by Dr. Wessinger. Dr. Bucci does not think that his low back requires surgical intervention. The CT myelogram shows wide open canal. The case was closed in August 2010 and was put at MMI by Dr. Wessinger but was reopened because of aggravation of the symptoms. The patient has been out of work since his injury. Low back pain, mainly secondary to facet and SI problem, S/P trigger point injection on 9/12/11. ,s/p PT, The patient is S/P SI injection with no significant improvement. 6. 1/12/12 Rt lumbar facet RFA 75% pain relief

3. Spondylolisthesis S/P x-ray.

MRI of lumbar spine done on 10/4/2010 shows there is increased stress at lumbosacral junction, severe bilateral L5/S1 facet arthritis, mild non compressive L5/S1 disc bulge, mild L4/L5 disc bulge, moderate left and milder right L5/S1 lateral recess narrowing, moderate right and severe left L5 body neural foraminal stenosis, which is consistent with his left L5/S1 radiculopathy

Today pt. reports that his atty has gotten involved in the referral to Dr. McHenry. He hopes that this will result in getting this through a little more quickly.

He denies any changes in the character or quality of his pain. He states that he is still falling 1-2x/week when outside. He states that in the house, he is able to catch himself on furniture, walls, etc. He reports falling when he turns to the left and his LLE is not where it should be. He denies any new numbness, weakness, incontinence.

Pain Any pain at this time? Yes, chronic pain, Does your current medication impair your judgement, coordination or your ability to drive? No, Rate the pain you had before you began treatment (on a scale of 0-10): 10 (unbearable), Rate your pain since you began treatment (on a scale of 0-10): 6, Is the current treatment working? Yes, Current treatment includes: Medication(s) am med, Are you

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: April Smith, PA-C 03/29/2012

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

hernia 9/07
heart surgery 11/23
EXPLORATION AND REMOVAL OF
FOREIGN BODY, RT HAND. 06/01/09

Family History

Family: diabetes, Hypertension, Heart
Disease

Social History

Interpersonal/family relationships: Divorced.

Occupation: Employed, but currently not
working.

no Alcohol.

Smoking: yes, PPD: , years:.

no Recreational drug use.

no Use of marijuana, cocaine, or similar
drugs.

Allergies

codeine

penicillin

contrast dye: rash: Side Effects

Hospitalization/Major

Diagnostic Procedure

see surgery list

experiencing any side effects from the medications prescribed by your
Physician at UMR? No, Are you satisfied with the treatment? Yes.

Vital Signs

BP 160/96, HR 90, O2 Sat 95, Temp (F) 98.7.

Examination

General Exam:

General Appearance Well developed, well nourished and groomed,
Communicates normally, No apparent acute or chronic distress, alert
and oriented. Skin purpura on RUE s/p fall. Pysch appropriate mood
and affect.

Gait:

slightly flexed at waist, steady once going.

Assessments

1. DISORDERS SACRUM - 724.6 (Primary)

2. Pain, Back - 724.5

3. Lumbar Facet Arthropathy - 721.3

Treatment

1. DISORDERS SACRUM

Refill Flexeril tablet, 10 MG, 1 tab(s), orally, qhs, 30 days, 30, Refills 0

Refill Percocet 7.5/325 tablet, 325 mg-7.5 mg, 1 tab(s), orally, every 6
hours (max4/day), 30 days, 120

Preventive Medicine

MED RECONCILIATION: Pt. Ed: Current Meds Verified: Current
meds/immunizations reviewed, including purpose with pt. Med Recon
list given to pt/family. Pt advised to discard old med lists and provide
all providers with current list at each visit and carry list with them in
case of emergency.

Follow Up

4 Weeks (Reason: FU Dr. Math)

Electronically signed by April(UMR) Smith , PA-C on
04/03/2012 at 07:42 AM EDT

Sign off status: Pending

Upstate Medical Rehabilitation
111 Doctors Drive
Greenville, SC 29605
Tel: 864-797-7100
Fax: 864-241-9229

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: April Smith, PA-C 03/29/2012

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



UNIVERSITY MEDICAL GROUP

HOUSTON, TOMMY GREGORY

56 Y old Male, DOB: 02/18/1956
204 BARTON ST, PO BOX 1099, FASLEY, SC-29640
Home: 864-855-0437

Guarantor: HOUSTON, TOMMY GREGORY

Insurance: UNITED HEALTHCARE

PCP: Richard Curry, MD External Visit ID: 136908258

Appointment Facility: Upstate Medical Rehabilitation

05/31/2012

Progress Notes: April Smith, PA-C

Current Medications

Percocet-10/325 tablet 325 mg-10 mg 1 tab(s)
every 6 hours max of 4 aday
amitriptyline tablet 25 mg 1 tab(s) once a day
(at bedtime)
amlodipine-benazepril capsule 10 mg-40 mg
1 cap(s) once a day
pravastatin tablet 80 mg 1 tab(s) once a day
(at bedtime)
niacin tablet, extended release 1000 mg 1 tab
(s) once a day (at bedtime)
Ecotrin enteric coated tablet 325 mg 1 tab(s)
once a day
isosorbide mononitrate tablet, extended
release 60 mg 1 tab(s) once a day (in the
morning)
Bystolic tablet 10 mg 1 tab(s) twice a day
Medication List reviewed and reconciled with
the patient

Active Problem List

- 721.3 Lumbar and sacral arthritis
- 756.12 Spondylolisthesis
- 724.6 DISORDERS SACRUM
- 720.1 Pain, myofascial
- 724.4 Lumbar Radiculopathy
- 724.5 Pain, Back
- 721.3 Lumbar Facet Arthropathy
- 724.00 Spinal Stenosis
- 338.29 Pain, Chronic

Past Medical History

Hypertension
High Cholesterol
Heart disease
Heart Attack
Fracture

Reason for Appointment

1. FOLLOW UP

History of Present Illness

General:

Worker's Comp:

Interim History:

1. The patient is a 55 y/o male seen at the request of Dr. Bucci. He sustained a work injury on 3/11/08 requiring right shoulder scope and rotator cuff repair on 7/11/08 by Dr. Wessinger. Dr. Bucci does not think that his low back requires surgical intervention. The CT myelogram shows wide open canal. The case was closed in August 2010 and was put at MMI by Dr. Wessinger but was reopened because of aggravation of the symptoms. The patient has been out of work since his injury. Low back pain, mainly secondary to facet and SI problem, S/P trigger point injection on 9/12/11, s/p PT, The patient is S/P SI injection with no significant improvement. 6. 1/12/12 R/L lumbar facet RFA 75% pain relief

3. Spondylolisthesis S/P x-ray. He has persistent left lower back pain. I had made a referral to see Dr. McHenry. Patient has not heard anything yet.

MRI of lumbar spine done on 10/4/2010 shows there is increased stress at lumbosacral junction, severe bilateral L5/S1 facet arthritis, mild non compressive L5/S1 disc bulge, mild L4/L5 disc bulge, moderate left and milder right L5/S1 lateral recess narrowing, moderate right and severe left L5 body neural foraminal stenosis, which is consistent with his left L5/S1 radiculopathy

Today pt. reports that the percocet 10 improved his pain a little more than the 7.5, but caused HA and nausea. He also complained of profuse sweating. He denies any adverse effects with amitriptyline, but did not notice improvement either. He did notice increase pain with the stopping of flexeril. Pt. reports that he believes that if he could go back to his former medications, he would be okay. He states that he has 2 bad days each week and thinks that if he had a couple extra pills on those days with the lower dosage of percocet, he would be doing better.

Pain Any pain at this time? Yes, chronic pain, Does your current medication impair your judgement, coordination or your ability to drive? No, Rate the pain you had before you began treatment (on a scale of 0-10): 10 (unbearable), Rate your pain since you began

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: April Smith, PA-C 05/31/2012

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Surgical History

left wrist 1978
 right knee 1974
 hernia 9/07
 heart surgery 11/23
 EXPLORATION AND REMOVAL OF
 FOREIGN BODY, RT HAND. 06/01/09

Family History

Family: diabetes, Hypertension, Heart
 Disease

Social History

Interpersonal/family relationships: Divorced.

Occupation: Employed, but currently not
 working.
 no Alcohol.
 Smoking: yes, PPD: , years:
 no Recreational drug use.
 no Use of marijuana, cocaine, or similar
 drugs.

Allergies

codeine
 penicillin
 contrast dye: rash: Side Effects

Hospitalization/Major**Diagnostic Procedure**

see surgery list

treatment (on a scale of 0-10): 5, Is the current treatment working?

Yes, Current treatment includes: Medication(s) am, Are you
 experiencing any side effects from the medications prescribed by your
 Physician at UMR? No, Are you satisfied with the treatment? Yes.

Vital Signs

Pain score 5.

Examination**General Exam:**

General Appearance Well developed, well nourished and groomed,
 No apparent acute or chronic distress, Communicates normally, alert
 and oriented. Head atraumatic, normal facial symmetry,
 normocephalic. Back L spine: pulling in buttock with flexion; full
 extension with pain in L side; tender with palpation L L5/S1 facet and
 less so in SI joint. Pysch appropriate mood and affect.

Gait:

Gait: limps on RLE.

Assessments

1. Lumber Facet Arthropathy - 721.3 (Primary)
2. Pain, Back - 724.5
3. Pain, Chronic - 338.29

Treatment**1. Lumber Facet Arthropathy**

Stop Percocet-10/325 tablet, 325 mg-10 mg, 1 tab(s), orally, every 6
 hours max of 4 aday, 30 days, 120

Stop amitriptyline tablet, 25 mg, 1 tab(s), orally, once a day (at
 bedtime), 30 day(s), 30

Start Percocet 7.5/325 tablet, 325 mg-7.5 mg, 1 tab(s), orally, every 4-6
 hours, max 5/day, 30 days, 150, Refills 0

Start Flexeril tablet, 10 mg, 1 tab(s), orally, once daily at bedtime, 30
 days, 30, Refills 3

2. Others

Continue amlodipine-benazepril capsule, 10 mg-40 mg, 1 cap(s), orally,
 once a day

Continue pravastatin tablet, 80 mg, 1 tab(s), orally, once a day (at
 bedtime)

Continue niacin tablet, extended release, 1000 mg, 1 tab(s), orally, once
 a day (at bedtime)

Continue Ecotrin enteric coated tablet, 325 mg, 1 tab(s), orally, once a
 day

Continue Bystolic tablet, 10 mg, 1 tab(s), orally, twice a day

Continue isosorbide mononitrate tablet, extended release, 60 mg, 1 tab
 (s), orally, once a day (in the morning)

Follow Up

4 Weeks (Reason: mrf with PA)

Electronically signed by April(UMR) Smith , PA-C on

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: April Smith, PA-C 05/31/2012

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

06/05/2012 at 11:38 AM EDT

Sign off status: Pending

Upstate Medical Rehabilitation
111 Doctors Drive
Greenville, SC 29605
Tel: 864-797-7100
Fax: 864-241-9229

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: April Smith, PA-C 05/31/2012

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



UNIVERSITY MEDICAL GROUP

HOUSTON, TOMMY GREGORY

56 Y old Male, DOB: 02/18/1956
204 BARTON ST. PO BOX 1099, EASLEY, SC-29640

Home: 864-855-0437

Guarantor: HOUSTON, TOMMY GREGORY

Insurance: UNITED HEALTHCARE

PCP: Richard Curry, MD External Visit ID: 138899281

Appointment Facility: Upstate Medical Rehabilitation

06/28/2012

Progress Notes: April Smith, PA-C

Current Medications

Flexeril tablet 10 mg 1 tab(s) once daily at bedtime
Percocet 7.5/325 tablet 325 mg-7.5 mg 1 tab(s) every 4-6 hours, max 5/day
pravastatin tablet 80 mg 1 tab(s) once a day (at bedtime)
amlodipine-benazepril capsule 10 mg-40 mg 1 cap(s) once a day
isosorbide mononitrate tablet, extended release 60 mg 1 tab(s) once a day (in the morning)
Bystolic tablet 10 mg 1 tab(s) twice a day
Ecotrin enteric coated tablet 325 mg 1 tab(s) once a day
niacin tablet, extended release 1000 mg 1 tab(s) once a day (at bedtime)
Medication List reviewed and reconciled with the patient

Active Problem List

- 721.3 Lumbar and sacral arthritis
- 756.12 Spondylolisthesis
- 724.6 DISORDERS SACRUM
- 729.1 Pain, myofascial
- 724.4 Lumbar Radiculopathy
- 724.5 Pain, Back
- 721.3 Lumbar Facet Arthropathy
- 724.00 Spinal Stenosis
- 338.29 Pain, Chronic

Past Medical History

Hypertension
High Cholesterol
Heart disease
Heart Attack
Fracture

Reason for Appointment

1. FOLLOW UP/WC MRF

History of Present Illness

General:

Worker's Comp:

Interim History:

1. The patient is a 55 y/o male seen at the request of Dr. Buccì. He sustained a work injury on 3/11/08 requiring right shoulder scope and rotator cuff repair on 7/11/08 by Dr. Wessinger. Dr. Buccì does not think that his low back requires surgical intervention. The CT myelogram shows wide open canal. The case was closed in August 2010 and was put at MMI by Dr. Wessinger but was reopened because of aggravation of the symptoms. The patient has been out of work since his injury. Low back pain, mainly secondary to facet and SI problem, S/P trigger point injection on 9/12/11, s/p PT, The patient is S/P SI injection with no significant improvement. 6. 1/12/12 Rt lumbar facet RFA 75% pain relief

2. Spondylolisthesis S/P x-ray. He has persistent left lower back pain. I had made a referral to see Dr. McHenry. Patient has not heard anything yet.

MRI of lumbar spine done on 10/4/2010 shows there is increased stress at lumbosacral junction, severe bilateral L5/S1 facet arthritis, mild non compressive L5/S1 disc bulge, mild L4/L5 disc bulge, moderate left and milder right L5/S1 lateral recess narrowing, moderate right and severe left L5 body neural foraminal stenosis, which is consistent with his left L5/S1 radiculopathy

Today pt. reports that he is doing better with the medication change. His pain is a little higher, but without the adverse effects. He is able to take a couple of extra pills on bad days.

He states that his R sided pain is beginning to return after rhizotomy. He feels that the medications are still controlling this adequately and does not wish to repeat MBB and RFA at this time.

Pt. reports that medical review board has approved his appt. with Dr. McHenry. He should hear from their office in the near future.

Pain Any pain at this time? Yes, chronic pain, Does your current medication impair your judgement, coordination or your ability to drive? No, Rate the pain you had before you began treatment (on a scale of 0-10): 10 (unbearable), Rate your pain since you began

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: April Smith, PA-C 06/28/2012

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Surgical History

left wrist 1978
 right knee 1974
 hernia 9/07
 heart surgery 11/23
 EXPLORATION AND REMOVAL OF
 FOREIGN BODY, RT HAND. 06/01/09

Family History

Family: diabetes, Hypertension, Heart
 Disease

Social History

Interpersonal/family relationships: Divorced.

Occupation: Employed, but currently not
 working.
 no Alcohol.
 Smoking: yes, PPD: , years:.
 no Recreational drug use.
 no Use of marijuana, cocaine, or similar
 drugs.

Allergies

codeine
 penicillin
 contrast dye: rash: Side Effects

Hospitalization/Major**Diagnostic Procedure**

see surgery list

treatment (on a scale of 0-10): 5, Is the current treatment working?

Yes, Current treatment includes: Medication(s) am, Are you
 experiencing any side effects from the medications prescribed by your
 Physician at UMR? No, Are you satisfied with the treatment? Yes.

Vital Signs

Ht 70, Ht Cm 177.8, Wt lbs 209, Wt kg 94.8, BMI 29.99, BP 139/74, HR
 46, Pain score 5/10, Tech Initial jt.

ExaminationGeneral Exam:

General Appearance Well developed, well nourished and groomed,
 No apparent acute or chronic distress, Communicates normally, alert
 and oriented. Abdomen central obesity. Pysch appropriate mood and
 affect.

Gait:

Gait: stiff antalgic transitional movements, Gait: steady.

Assessments

1. Lumber Facet Arthropathy - 721.3 (Primary)
2. Pain, Back - 724.5
3. Pain, Chronic - 338.29

Treatment**1. Lumber Facet Arthropathy**

Refill Percocet 7.5/325 tablet, 325 mg-7.5 mg, 1 tab(s), orally, every 4-6
 hours, max 5/day, 30 days, 150, Refills 0
 Continue Flexeril tablet, 10 mg, 1 tab(s), orally, once daily at bedtime,
 30 days, 30, Refills 3

2. Others

Continue amlodipine-benazepril capsule, 10 mg-40 mg, 1 cap(s), orally,
 once a day
 Continue pravastatin tablet, 80 mg, 1 tab(s), orally, once a day (at
 bedtime)
 Continue niacin tablet, extended release, 1000 mg, 1 tab(s), orally, once
 a day (at bedtime)
 Continue Ecotrin enteric coated tablet, 325 mg, 1 tab(s), orally, once a
 day
 Continue Bystolic tablet, 10 mg, 1 tab(s), orally, twice a day
 Continue isosorbide mononitrate tablet, extended release, 60 mg, 1 tab
 (s), orally, once a day (in the morning)

Preventive Medicine

MED RECONCILIATION: Pt. Ed: Current Meds Verified: Current
 meds/immunizations reviewed, including purpose with pt. Med Recon
 list given to pt/family. Pt advised to discard old med lists and provide
 all providers with current list at each visit and carry list with them in
 case of emergency.

Follow Up

2 Months (Reason: FU Dr. Math)

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: April Smith, PA-C 06/28/2012
 Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Electronically signed by April(UMR) Smith , PA-C on
07/03/2012 at 09:07 AM EDT

Sign off status: Pending

Upstate Medical Rehabilitation
111 Doctors Drive
Greenville, SC 29605
Tel: 864-797-7100
Fax: 864-241-9229

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: April Smith, PA-C 06/28/2012

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



UNIVERSITY MEDICAL GROUP

HOUSTON, TOMMY GREGORY

56 Y old Male, DOB: 02/18/1956
204 BARTON ST. PO BOX 1099, EASLEY, SC-29640

Home: 864-855-0437

Guarantor: HOUSTON, TOMMY GREGORY

Insurance: UNITED HEALTHCARE

PCP: Richard Curry, MD External Visit ID: 140945197

Appointment Facility: Upstate Medical Rehabilitation

07/26/2012

Progress Notes: April Smith, PA-C

Current Medications

Ecotrin enteric coated tablet 325 mg 1 tab(s) once a day
niacin tablet, extended release 1000 mg 1 tab(s) once a day (at bedtime)
pravastatin tablet 80 mg 1 tab(s) once a day (at bedtime)
Flexeril tablet 10 mg 1 tab(s) once daily at bedtime
Percocet 7.5/325 tablet 325 mg-7.5 mg 1 tab(s) every 4-6 hours, max 5/day
isosorbide mononitrate tablet, extended release 60 mg 1 tab(s) once a day (in the morning)
Bystolic tablet 10 mg 1 tab(s) twice a day
Medication List reviewed and reconciled with the patient

Past Medical History

Hypertension
High Cholesterol
Heart disease
Heart Attack
Fracture

Surgical History

left wrist 1978
right knee 1974
hernia 9/07
heart surgery 11/23
EXPLORATION AND REMOVAL OF
FOREIGN BODY, RT HAND. 06/01/09

Family History

Family: diabetes, Hypertension, Heart Disease

Social History

Interpersonal/family relationships: Divorced.

Alcohol men 18-65 yrs Assessment completed: today. Alcohol intake: patient does not drink alcohol.
Smoking Status > 13 years old Are you a: Current smoker. Pt counseled on the dangers of tobacco use and urged to quit.

Reason for Appointment

1. FOLLOW UP/WC MRF

History of Present Illness

General:

Worker's Comp:

Interim History:

1. The patient is a 55 y/o male seen at the request of Dr. Bucci. He sustained a work injury on 3/11/08 requiring right shoulder scope and rotator cuff repair on 7/11/08 by Dr. Wessinger. Dr. Bucci does not think that his low back requires surgical intervention. The CT myelogram shows wide open canal. The case was closed in August 2010 and was put at MMI by Dr. Wessinger but was reopened because of aggravation of the symptoms. The patient has been out of work since his injury. Low back pain, mainly secondary to facet and SI problem, S/P trigger point injection on 9/12/11, s/p PT, The patient is S/P SI injection with no significant improvement. 6. 1/12/12 Rt lumbar facet RFA 75% pain relief

2. Spondylolisthesis S/P x-ray. He has persistent left lower back pain. I had made a referral to see Dr. McHenry. Patient has not heard anything yet.

MRI of lumbar spine done on 10/4/2010 shows there is increased stress at lumbosacral junction, severe bilateral L5/S1 facet arthritis, mild non compressive L5/S1 disc bulge, mild L4/L5 disc bulge, moderate left and milder right L5/S1 lateral recess narrowing, moderate right and severe left L5 body neural foraminal stenosis, which is consistent with his left L5/S1 radiculopathy

Today pt. reports that he has been approved to see Dr. McHenry next Thursday.

Pt. reports that he has once again been having trouble with panic attacks at night when he is trying to sleep. He states that he feels like he is unable to hold still and has to move around. He states that in the past he was prescribed ativan 0.5 at bedtime with possibility to take up to 4 if needed. He states that Dr. Curry was formerly prescribing this. He states that when Dr. Curry closed his practice, he was referred to Dr. Aragon. He states that WC was covering his care with Dr. Curry in the past for this medication.

Pt. is drinking about 5-6 8oz glasses of sweet tea. He also drinks 3-4 glasses of juice. He drinks sweet tea throughout the day.

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: April Smith, PA-C 07/26/2012

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

07/26/2012.

Occupation: Employed, but currently not working.

no Alcohol.

Smoking: yes, PPD: , years:.

no Recreational drug use.

no Use of marijuana, cocaine, or similar drugs.

Allergies

codeine

penicillin

contrast dye: rash: Side Effects

Hospitalization/Major**Diagnostic Procedure**

see surgery list

Pain Any pain at this time? Yes, chronic pain, Does your current medication impair your judgement, coordination or your ability to drive? No, Rate the pain you had before you began treatment (on a scale of 0-10): 10 (unbearable), Rate your pain since you began treatment (on a scale of 0-10): 6, Is the current treatment working? Yes, Current treatment includes: Medication(s) am, Are you experiencing any side effects from the medications prescribed by your Physician at UMR? No, Are you satisfied with the treatment? Yes.

Vital Signs

Ht 70, Ht Cm 177.8, Wt lbs 210, Wt kg 95.26, BMI 30.13, BP 148/88, HR 110, Pain score 6/10, Tech Initial jt.

ExaminationGeneral Exam:

General Appearance obese, Well developed, well nourished and groomed, No apparent acute or chronic distress, Communicates normally, alert and oriented. Pysch appropriate mood and affect.

Assessments

1. Lumber Facet Arthropathy - 721.3 (Primary)
2. Pain, Back - 724.5
3. Pain, Chronic - 338.29

Treatment**1. Lumber Facet Arthropathy**

Refill Percocet 7.5/325 tablet, 325 mg-7.5 mg, 1 tab(s), orally, every 4-6 hours, max 5/day, 30 days, 150, Refills 0

Continue Flexeril tablet, 10 mg, 1 tab(s), orally, once daily at bedtime, 30 days, 30, Refills 3

Pt. instructed to speak with Dr. Aragon about anxiety. He is to stop all caffeine at noon. He is encouraged to decrease his sugary drink consumption as he is struggling with some central obesity.

2. Others

Continue amlodipine-benazepril capsule, 10 mg-40 mg, 1 cap(s), orally, once a day

Continue pravastatin tablet, 80 mg, 1 tab(s), orally, once a day (at bedtime)

Continue niacin tablet, extended release, 1000 mg, 1 tab(s), orally, once a day (at bedtime)

Continue Ecotrin enteric coated tablet, 325 mg, 1 tab(s), orally, once a day

Continue Bystolic tablet, 10 mg, 1 tab(s), orally, twice a day

Continue isosorbide mononitrate tablet, extended release, 60 mg, 1 tab(s), orally, once a day (in the morning)

Preventive Medicine

MED RECONCILIATION: Pt. Ed: Current Meds Verified: Current meds/immunizations reviewed, including purpose with pt. Med Recon list given to pt/family. Pt advised to discard old med lists and provide all providers with current list at each visit and carry list with them in case of emergency.

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: April Smith, PA-C 07/26/2012

Not generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Follow Up
4 Weeks (Reason: Dr. Math)

April M. Smith PA-C

Electronically signed by April (UMR) Smith, PA-C on
07/27/2012 at 10:55 AM EDT

Sign off status: Completed

Upstate Medical Rehabilitation
111 Doctors Drive
Greenville, SC 29605
Tel: 864-797-7100
Fax: 864-241-9229

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: April Smith, PA-C 07/26/2012

Record generated by: eClinicalWorks EMR/PAI Software - www.eClinicalWorks.com



UNIVERSITY MEDICAL GROUP

HOUSTON, TOMMY GREGORY

56 Y old Male, DOB: 02/18/1956
204 HARTON ST, PO BOX 1099, EASLEY, SC-29640

Home: 864-855-0437

Guarantor: HOUSTON, TOMMY GREGORY

Insurance: UNITED HEALTHCARE

PCP: Richard Curry, MD Referring: comp workers

External Visit ID: 145079448

Appointment Facility: Upstate Medical Rehabilitation

09/24/2012

Progress Notes: April Smith, PA-C

Current Medications

isosorbide mononitrate tablet, extended release 60 mg 1 tab(s) once a day (in the morning)
Ecotrin enteric coated tablet 325 mg 1 tab(s) once a day
pravastatin tablet 80 mg 1 tab(s) once a day (at bedtime)
exforge HCT tablet 5 mg-12.5 mg-160 mg 1 tab(s) once a day
metformin tablet, extended release 500 mg 1 tab(s) once a day
Percocet 7.5/325 tablet 325 mg-7.5 mg 1 tab(s) every 4-6 hours, max 5/day
Flexeril tablet 10 MG 1 tab(s) once daily at bedtime

Past Medical History

Hypertension
High Cholesterol
Heart disease
Heart Attack
Fracture

Allergies

codeine
contrast dye: rash: Side Effects
penicillin

Reason for Appointment

1. 4 Weeks (Reason: PA)

History of Present Illness

General:

Worker's Comp:

Interim History:

1. The patient is a 55 y/o male seen at the request of Dr. Bucci. He sustained a work injury on 3/11/08 requiring right shoulder scope and rotator cuff repair on 7/11/08 by Dr. Wessinger. Dr. Bucci does not think that his low back requires surgical intervention. The CT myelogram shows wide open canal. The case was closed in August 2010 and was put at MMI by Dr. Wessinger but was reopened because of aggravation of the symptoms. The patient has been out of work since his injury. Low back pain, mainly secondary to facet and SI problem. S/P trigger point injection on 9/12/11. s/p PT. The patient is S/P SI injection with no significant improvement. 6. 1/12/12 Rt lumbar facet RFA 75% pain relief.

Patient was recently evaluated by Dr. Kanos on 8/24/12. Repeat MRI showed spondylolisthesis. The plan is do left L5/S1 PLIF.

2. Spondylolisthesis S/P x-ray. He has persistent left lower back pain.

Today pt. reports that he is having a rough day today. He states that he is planning to have PLIF with Dr. Kanos. HE does not yet have a tentative date as WC has not yet approved this.

Pt. denies any new numbness or weakness. He reports R sided pain coming back a little, but feels that he can tolerate this until surgery.

Pain Any pain at this time? Yes, chronic pain, Does your current medication impair your judgement, coordination or your ability to drive? No, Rate the pain you had before you began treatment (on a scale of 0-10): 10 (unbearable), Rate your pain since you began treatment (on a scale of 0-10): 7, Is the current treatment working? Yes, Current treatment includes: Medication(s) am, Are you experiencing any side effects from the medications prescribed by your Physician at UMR? No, Are you satisfied with the treatment? Yes.

Vital Signs

Ht 70, Ht Cm 177.8, Wt lbs 211, Wt kg 95.71, BMI 30.27, BP 151/76, HR

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: April Smith, PA-C 09/24/2012

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

115, Pain score 7, Tech Initial kp.

Examination**General Exam:**

General Appearance Well developed, well nourished and groomed, No apparent acute or chronic distress, Communicates normally, alert and oriented. Abdomen central obesity. Pysch appropriate mood and affect.

Gait:

steady, antalgic.

Assessments

1. Spondylolisthesis - 756.12 (Primary)
2. Pain, Back - 724.5
3. Spinal Stenosis - 724.00

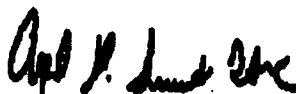
Treatment**1. Spondylolisthesis**

Refill Percocet 7.5/325 tablet, 325 mg-7.5 mg, 1 tab(s), orally, every 4-6 hours, max 5/day, 30 day(s), 150, Refills 0

Refill Flexeril tablet, 10 MG, 1 tab(s), orally, once daily at bedtime, 30 day(s), 30, Refills 0

Follow Up

4 Weeks (Reason: PA refill)



Electronically signed by April(UMR) Smith , PA-C on
09/27/2012 at 12:26 PM EDT

Sign off status: Completed

Upstate Medical Rehabilitation
111 Doctors Drive
Greenville, SC 29605
Tel: 864-797-7100
Fax: 864-241-9229

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: April Smith, PA-C 09/24/2012

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



GREENVILLE HEALTH SYSTEM

HOUSTON, TOMMY GREGORY

56 Y old Male, DOB: 02/18/1956
204 BARTON ST, PO BOX 1099, EASLEY, SC-29640
Home: 864-855-0437
Guarantor: HOUSTON, TOMMY GREGORY
Insurance: UNITED HEALTHCARE
PCP: Richard Curry, MD Referring: comp workers
External Visit ID: 147257794
Appointment Facility: Upstate Medical Rehabilitation

10/22/2012

Progress Notes: April Smith, PA-C

Current Medications

isosorbide mononitrate tablet, extended release 60 mg 1 tab(s) once a day (in the morning)
Ecotrin enteric coated tablet 325 mg 1 tab(s) once a day
Flexeril tablet 10 mg 1 tab(s) once daily at bedtime
Percocet 7.5/325 tablet 325 mg-7.5 mg 1 tab(s) every 4-6 hours, max 5/day
pravastatin tablet 80 mg 1 tab(s) once a day (at bedtime)
exforge HCT tablet 5 mg-12.5 mg-160 mg 1 tab(s) once a day
metformin tablet, extended release 500 mg 1 tab(s) once a day
Medication List reviewed and reconciled with the patient

Past Medical History

Hypertension
High Cholesterol
Heart disease
Heart Attack
Fracture

Surgical History

left wrist 1978
right knee 1974
hernia 9/07
heart surgery 11/23
EXPLORATION AND REMOVAL OF
FOREIGN BODY, RT HAND. 06/01/09

Family History

Family: diabetes, Hypertension, Heart Disease

Social History

Interpersonal/family relationships: Divorced.

Alcohol men 18-65 yrs Assessment completed: today, Alcohol intake: patient does not drink alcohol.
Smoking Status > 13 years old Are you a:

Reason for Appointment

1. 4 Weeks (Reason: PA refill)

History of Present Illness

General:

Worker's Comp:

Interim History:

1. The patient is a 55 y/o male seen at the request of Dr. Buccì. He sustained a work injury on 3/11/08 requiring right shoulder scope and rotator cuff repair on 7/11/08 by Dr. Wessinger. Dr. Buccì does not think that his low back requires surgical intervention. The CT myelogram shows wide open canal. The case was closed in August 2010 and was put at MMI by Dr. Wessinger but was reopened because of aggravation of the symptoms. The patient has been out of work since his injury. Low back pain, mainly secondary to facet and SI problem. S/P trigger point injection on 9/12/11. s/p PT. The patient is S/P SI injection with no significant improvement. 6. 1/12/12 Rt lumbar facet RFA 75% pain relief.

Patient was recently evaluated by Dr. Kanos on 8/24/12. Repeat MRI showed spondylolisthesis. The plan is do left L5/S1 PLIF.

2. Spondylolisthesis S/P x-ray. He has persistent left lower back pain.

Today pt. reports that he will see Dr. Kanos today. He states that WC has not processed his request for surgery as the last page did not fax properly. Apparently no contact was made with Dr. Kanos's office during that time and was only addressed when the surgery scheduler called to follow up on this.

Pt reports that he turned to the left and did fall coming out the front door this morning. He states that this was the first time in a while. He did not hit the ground, but caught himself on the wall.

Pain Any pain at this time? Yes, chronic pain, Does your current medication impair your judgement, coordination or your ability to drive? No, Rate the pain you had before you began treatment (on a scale of 0-10): 10 (unbearable), Rate your pain since you began treatment (on a scale of 0-10): 6, Is the current treatment working? Yes, Current treatment includes: Medication(s) am, Are you experiencing any side effects from the medications prescribed by your Physician at UMR? No, Are you satisfied with the treatment? Yes.

Current smoker, Pt counseled on the dangers of tobacco use and urged to quit.
10/22/2012.

Occupation: Employed, but currently not working.

no Alcohol.

Smoking: yes, PPD: , years:.

no Recreational drug use.

no Use of marijuana, cocaine, or similar drugs.

Allergies

codeine

contrast dye: rash: Side Effects

penicillin

Hospitalization/Major

Diagnostic Procedure

see surgery list

Vital Signs

Ht 70, Ht Cm 177.8, Wt lbs 211, Wt kg 95.71, BMI 30.27, BP 154/92, HR 123, Pain score 6, Tech Initial jdt.

Examination

General Exam:

General Appearance overweight, Well developed, No apparent acute or chronic distress, well nourished and groomed, Communicates normally, alert and oriented. Eyes

non-icteric

. Skin non-jaundiced. Pysch appropriate mood and affect.

Assessments

1. Spondylolisthesis - 756.12 (Primary)
2. Pain, Back - 724.5
3. Spinal Stenosis - 724.00

Treatment

1. Spondylolisthesis

Refill Percocet 7.5/325 tablet, 325 mg-7.5 mg, 1 tab(s), orally, every 4-6 hours, max 5/day, 30 day(s), 150, Refills 0

Refill Flexeril tablet, 10 MG, 1 tab(s), orally, once daily at bedtime, 30 day(s), 30, Refills 0

Preventive Medicine

MED RECONCILIATION: Pt. Ed: Current Meds Verified: Current meds/immunizations reviewed, including purpose with pt. Med Recon list given to pt/family. Pt advised to discard old med lists and provide all providers with current list at each visit and carry list with them in case of emergency.

Follow Up

4 Weeks (Reason: PA refill)

April M. Smith

Electronically signed by April(UMR) Smith , PA-C on 10/24/2012 at 02:45 PM EDT

Sign off status: Completed

Upstate Medical Rehabilitation
111 Doctors Drive
Greenville, SC 29605
Tel: 864-797-7100
Fax: 864-241-9229

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: April Smith, PA-C 10/22/2012

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



GREENVILLE HEALTH SYSTEM

HOUSTON, TOMMY GREGORY

56 Y old Male, DOB: 02/18/1956
204 BARTON ST, PO BOX 1099, EASLEY, SC-29640

Home: 864-855-0437

Guarantor: HOUSTON, TOMMY GREGORY

Insurance: UNITED HEALTHCARE

PCP: Richard Curry, MD Referring: comp workers

External Visit ID: 149469777

Appointment Facility: Upstate Medical Rehabilitation

11/19/2012

Progress Note: April Smith, PA-C

Current Medications

isosorbide mononitrate tablet, extended release 60 mg 1 tab(s) once a day (in the morning)
Ecotrin enteric coated tablet 325 mg 1 tab(s) once a day
pravastatin tablet 80 mg 1 tab(s) once a day (at bedtime)
exforge HCT tablet 5 mg-12.5 mg-160 mg 1 tab(s) once a day
metformin tablet, extended release 500 mg 1 tab(s) once a day
Percocet 7.5/325 tablet 325 mg-7.5 mg 1 tab(s) every 4-6 hours, max 5/day
Flexeril tablet 10 MG 1 tab(s) once daily at bedtime
Work Restrictions ** SEDENTARY WORK ONLY; no driving or getting in and out of armored truck
Medication List reviewed and reconciled with the patient

Past Medical History

Hypertension
High Cholesterol
Heart disease
Heart Attack
Fracture

Surgical History

left wrist 1978
right knee 1974
hernia 9/07
heart surgery 11/23
EXPLORATION AND REMOVAL OF FOREIGN BODY, RT HAND. 06/01/09

Family History

Family: diabetes, Hypertension, Heart Disease

Social History

Interpersonal/family relationships: Divorced.
Alcohol men 18-65 yrs Assessment

Reason for Appointment

1. 4 Weeks (Reason: PA refill)

History of Present Illness

General:

Worker's Comp:

Interim History:

1. The patient is a 55 y/o male seen at the request of Dr. Bucci. He sustained a work injury on 3/11/08 requiring right shoulder scope and rotator cuff repair on 7/11/08 by Dr. Wessinger. Dr. Bucci does not think that his low back requires surgical intervention. The CT myelogram shows wide open canal. The case was closed in August 2010 and was put at MMI by Dr. Wessinger but was reopened because of aggravation of the symptoms. The patient has been out of work since his injury. Low back pain, mainly secondary to facet and SI problem, S/P trigger point injection on 9/12/11. s/p PT, The patient is S/P SI injection with no significant improvement. 6. 1/12/12 Rt lumbar facet RFA 75% pain relief.

Patient was recently evaluated by Dr. Kanos on 8/24/12. Repeat MRI showed spondylolisthesis. The plan is do left L5/S1 PLIF.

2. Spondylolisthesis S/P x-ray. He has persistent left lower back pain.

Since last visit, Mr. Houston has been evaluated again by Dr. Kanos who has recommended L5/S1 PLIF.

He was released to sedentary work.

Today pt. reports that WC has approved his surgery last Friday. He is not sure yet when this will be scheduled.

Pt. reports that when he got to work, he was not placed at a desk but placed back in a truck. He states that DOT would not renew his licens while he was on narcotic pain medications.

He currently does not take the medication while driving.

Pain Any pain at this time? Yes, chronic pain, Does your current medication impair your judgement, coordination or your ability to drive? Yes Pt. does not take while driving., Rate the pain you had before you began treatment (on a scale of 0-10): 8, Rate your pain since you began treatment (on a scale of 0-10): 5, Is the current treatment working? Yes, Current treatment includes: Medication(s) this morning, Are you experiencing any side effects from the

completed: today, Alcohol intake: patient does not drink alcohol.
Smoking Status > 13 years old Are you a:
Current smoker, Pt counseled on the dangers of tobacco use and urged to quit. 11/19/2012.
Occupation: Employed, but currently not working.
no Alcohol.
Smoking: yes, PPD: , years..
no Recreational drug use.
no Use of marijuana, cocaine, or similar drugs.

Allergies

codeine
contrast dye; rash: Side Effects
penicillin

Hospitalization/Major

Diagnostic Procedure

see surgery list

medications prescribed by your Physician at UMR? No, Are you satisfied with the treatment? Yes.

Examination

General Exam:

General Appearance obese, Well developed, well nourished and groomed, No apparent acute or chronic distress, Communicates normally, alert and oriented. Eyes non-icteric. Skin non-jaundiced. Pysch appropriate mood and affect.

Assessments

1. Spondylolisthesis - 756.12 (Primary)
2. Pain, Back - 724.5
3. Spinal Stenosis - 724.00

Treatment

1. Spondylolisthesis

Refill Percocet 7.5/325 tablet, 325 mg-7.5 mg, 1 tab(s), orally, every 4-6 hours, max 5/day, 30 day(s), 150, Refills 0 Refill Flexeril tablet, 10 MG, 1 tab(s), orally, once daily at bedtime, 30 day(s), 30, Refills 0	
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Preventive Medicine

MED RECONCILIATION: Pt. Ed: Current Meds Verified: Current meds/immunizations reviewed, including purpose with pt. Med Recon list given to pt/family. Pt advised to discard old med lists and provide all providers with current list at each visit and carry list with them in case of emergency.

Follow Up

4 Weeks (Reason: FU PA)

Appl. to Land Use

Electronically signed by April(UMR) Smith , PA-C on
11/28/2012 at 07:59 AM EST

Sign off status: Completed

Upstate Medical Rehabilitation
111 Doctors Drive

Greenville, SC 29605
Tel: 864-797-7100
Fax: 864-241-9229

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: April Smith, PA-C 11/19/2012

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



GREENVILLE HEALTH SYSTEM

HOUSTON, TOMMY GREGORY

56 Y old Male, DOB: 02/18/1956
204 BARTON ST, PO BOX 1099, EASLEY, SC-29640
Home: 864-855-0437
Guarantor: HOUSTON, TOMMY GREGORY
Insurance: UNITED HEALTHCARE
PCP: Richard Curry, MD Referring: comp workers
External Visit ID: 155737752
Appointment Facility: Upstate Medical Rehabilitation

02/11/2013

Progress Note: April Smith, PA-C

Current Medications

Percocet 7.5/325 tablet 325 mg-7.5 mg 1 tab (s) every 6 hours max 4 per day
isosorbide mononitrate tablet, extended release 60 mg 1 tab(s) once a day (in the morning)
Ecotrin enteric coated tablet 325 mg 1 tab(s) once a day
pravastatin tablet 80 mg 1 tab(s) once a day (at bedtime)
metformin tablet, extended release 500 mg 1 tab(s) once a day
Work Restrictions ** SEDENTARY WORK ONLY; no driving or getting in and out of armored truck
exforge HCT 10/320/25 1 daily
cyclobenzaprine tablet 10 mg 1 tab(s) at bedtime
Medication List reviewed and reconciled with the patient

Past Medical History

Hypertension
High Cholesterol
Heart disease
Heart Attack
Fracture

Surgical History

left wrist 1978
right knee 1974
hernia 9/07
heart surgery 11/23
EXPLORATION AND REMOVAL OF FOREIGN BODY, RT HAND. 06/01/09
L5-S1 posterior lumbar interbody fusion on 12/22/12 at GMH by Dr. Charles Kanos.
12/22/12

Family History

Family: diabetes, Hypertension, Heart Disease

Social History

Interpersonal/family relationships: Divorced.

Reason for Appointment

1. WC Back pain

History of Present Illness

General:

Worker's Comp:

Interim History:

1. The patient is a 55 y/o male seen at the request of Dr. Bucci. He sustained a work injury on 3/11/08 requiring right shoulder scope and rotator cuff repair on 7/11/08 by Dr. Wessinger. Patient got a second opinion from Dr. Kanos on 8/24/12, who recommended L5/S1 PLIF and patient underwent surgery on 12/12/12 with significant improvement of the symptoms.

The case was closed in August 2010 and was put at MMI by Dr. Wessinger but was reopened because of aggravation of the symptoms. The patient has been out of work since his injury. Low back pain, mainly secondary to facet and SI problem, S/P trigger point injection on 9/12/11. s/p PT, The patient is S/P SI injection with no significant improvement. 1/12/12 Rt lumbar facet RFA 75% pain relief. Patient is work until he sees Dr. Kanos.

2. Spondylolisthesis S/P x-ray. He has persistent left lower back pain.

Pt. presents today with f/u appt. scheduled on 2/13 with Dr. Kanos. He is still out of work until this visit per Dr. Kanos.

Today pt. reports that Monday, Wednesday, and Friday are PT days so his pain is a little increased right now.

He is using cane only to maintain balance.

He feels like surgery has been a success. He states that as soon as he woke up in recovery, he had immediate relief in the LLE symptoms.

Pain Any pain at this time? Yes, chronic pain, Does your current medication impair your judgement, coordination or your ability to drive? Yes, Rate the pain you had before you began treatment (on a scale of 0-10): 8, Rate your pain since you began treatment (on a scale of 0-10): 6, Is the current treatment working? Yes, Current treatment includes: Medication(s) this morning, Are you experiencing any side effects from the medications prescribed by your Physician at UMR?

No, Are you satisfied with the treatment? Yes.

Alcohol men 18-65 yrs Assessment completed: today, Alcohol intake: patient does not drink alcohol.

Smoking Status > 13 years old Are you a: Current smoker, Pt counseled on the dangers of tobacco use and urged to quit.

02/11/2013.

Occupation: Employed, but currently not working.

no Alcohol.

Smoking: yes, PPD: , years:.

no Recreational drug use.

no Use of marijuana, cocaine, or similar drugs.

Allergies

contrast dye: rash: Side Effects

codeine

penicillin

Hospitalization/Major

Diagnostic Procedure

see surgery list

Vital Signs

Ht 70, Ht Cm 177.8, Wt lbs 210, Wt kg 95.26, BMI 30.13, BP 158/91, HR 116, Pain score 6, Tech Initial jdt.

Examination

General Exam:

General Appearance overweight, Well developed, well nourished and groomed, No apparent acute or chronic distress, Communicates normally; alert and oriented. Head atraumatic. Eyes non-icteric. Skin non-jaundiced, no pallor or cyanosis. Pysch appropriate mood and affect.

Gait:

using cane.

Assessments

1. Pain, Chronic - 338.29 (Primary)
2. Low Back Pain - 724.2

Treatment

1. Pain, Chronic

Refill Percocet 7.5/325 tablet, 325 mg-7.5 mg, 1 tab(s), orally, every 6 hours max 4 per day, 30 days, 120

2. Others

Continue isosorbide mononitrate tablet, extended release, 60 mg, 1 tab(s), orally, once a day (in the morning)

Continue Ecotrin enteric coated tablet, 325 mg, 1 tab(s), orally, once a day

Continue pravastatin tablet, 80 mg, 1 tab(s), orally, once a day (at bedtime)

Continue metformin tablet, extended release, 500 mg, 1 tab(s), orally, once a day

Continue Work Restrictions *, *, SEDENTARY WORK ONLY; no driving or getting in and out of armored truck

Continue exforge HCT, 10/320/25, 1, by mouth, daily

Refill cyclobenzaprine tablet, 10 mg, 1 tab(s), orally, at bedtime, 30 days, 30, Refills 2

Preventive Medicine

MED RECONCILIATION: Pt. Ed: Current Meds Verified: Current meds/immunizations reviewed, including purpose with pt. Med Recon list given to pt/family. Pt advised to discard old med lists and provide all providers with current list at each visit and carry list with them in case of emergency.

Follow Up

4 Weeks (Reason: FU)

April M. Smith PA-C

Electronically signed by April(UMR) Smith , PA-C on
02/13/2013 at 12:43 PM EST

Sign off status: Completed

Upstate Medical Rehabilitation
111 Doctors Drive
Greenville, SC 29605
Tel: 864-797-7100
Fax: 864-241-9229

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: April Smith, PA-C 02/11/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



GREENVILLE HEALTH SYSTEM

HOUSTON, TOMMY GREGORY

57 Y old Male, DOB: 02/18/1956
204 BARTON ST, PO BOX 1099, EASLEY, SC-29640

Home: 864-855-0437

Guarantor: HOUSTON, TOMMY GREGORY

Insurance: UNITED HEALTHCARE

PCP: Richard Curry, MD Referring: comp workers

External Visit ID: 157998972

Appointment Facility: Upstate Medical Rehabilitation

03/11/2013

Progress Note: April Smith, PA-C

Current Medications

isosorbide mononitrate tablet, extended release 60 mg 1 tab(s) once a day (in the morning)
Ecotrin enteric coated tablet 325 mg 1 tab(s) once a day
pravastatin tablet 80 mg 1 tab(s) once a day (at bedtime)
metformin tablet, extended release 500 mg 1 tab(s) once a day
exforge HCT 10/320/25 1 daily
cyclobenzaprine tablet 10 mg 1 tab(s) at bedtime
Percocet 7.5/325 tablet 325 mg-7.5 mg 1 tab(s) every 6 hours
Medication List reviewed and reconciled with the patient

Past Medical History

Hypertension
High Cholesterol
Heart disease
Heart Attack
Fracture

Surgical History

left wrist 1978
right knee 1974
hernia 9/07
heart surgery 11/23
EXPLORATION AND REMOVAL OF
FOREIGN BODY, RT HAND. 06/01/09
L5-S1 posterior lumbar interbody fusion on
12/22/12 at GMH by Dr. Charles Kanos.
12/22/12

Family History

Family: diabetes, Hypertension, Heart Disease

Social History

Interpersonal/family relationships: Divorced.

Alcohol men 18-65 yrs Assessment completed: today, Alcohol intake: patient

Reason for Appointment

1. 4 Weeks (Reason: FU)

History of Present Illness

General:

Worker's Comp:

Interim History:

1. The patient is a 55 y/o male seen at the request of Dr. Bucci. He sustained a work injury on 3/11/08 requiring right shoulder scope and rotator cuff repair on 7/11/08 by Dr. Wessinger. Patient got a second opinion from Dr. Kanos on 8/24/12, who recommended L5/S1 PLIF and patient underwent surgery on 12/12/12 with significant improvement of the symptoms.

The case was closed in August 2010 and was put at MMI by Dr. Wessinger but was reopened because of aggravation of the symptoms. The patient has been out of work since his injury. Low back pain, mainly secondary to facet and SI problem, S/P trigger point injection on 9/12/11, s/p PT. The patient is S/P SI injection with no significant improvement. 1/12/12 Rt lumbar facet RFA 75% pain relief. Patient is work until he sees Dr. Kanos.

2. Spondylolisthesis S/P x-ray. He has persistent left lower back pain.

Today pt. reports that he had some confusion regarding his work status regarding pc. He states that Dr. Kanos is keeping him out work for several more months to go to more therapy. He states that he would eventually like to get back to work when he is ready.

He feels like he is still doing well s/p surgery. He is still seeing PT 3x/week with some increasing pain in therapy days. He states the days off, he has some improved pain. Saturdays are going well for him.

Pt. reports that the percocet is no longer adequately relieving his pain on therapy days.

Pain Any pain at this time? Yes, chronic pain, Does your current medication impair your judgement, coordination or your ability to drive? Yes, Rate the pain you had before you began treatment (on a scale of 0-10): 8, Rate your pain since you began treatment (on a scale of 0-10): 6, Is the current treatment working? Yes, Current treatment includes: Medication(s) this morning, Are you experiencing any side effects from the medications prescribed by your Physician at UMR?

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: April Smith, PA-C 03/11/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

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R. 593

http://ecw.gbs.org:8080/mobiledoc/isp/catalog/xml/printMultipleChartOptions.isp?encount... 4/22/2014

does not drink alcohol.
 Smoking Status > 13 years old Are you a:
 Current smoker, Pt counseled on the dangers
 of tobacco use and urged to quit.
 03/07/2013.
 Occupation: Employed, but currently not
 working.
 no Alcohol.
 Smoking: yes, PPD: , years:.
 no Recreational drug use,
 no Use of marijuana, cocaine, or similar
 drugs.

Allergies

contrast dye, rash: Side Effects
 codeine
 penicillin

Hospitalization/Major

Diagnostic Procedure

see surgery list

No, Are you satisfied with the treatment? Yes. Notes: UDS 3/11/13.

Vital Signs

Ht 70, Ht Cm 177.8, Wt lbs 206, Wt kg 93.44, BMI 29.55, BP 140/70,
 HR 108, Pain score 5.

Examination

General Exam:

General Appearance Well developed, well nourished and groomed,
 No apparent acute or chronic distress, Communicates normally, alert
 and oriented. Head atraumatic, normal facial symmetry,
 normocephalic. Eyes non-icteric. Skin non-jaundiced, no pallor or
 cyanosis. Pysch appropriate mood and affect.

Gait:

steady, antalgic, using cane.

Assessments

1. Pain, Chronic - 338.29 (Primary)
2. Low Back Pain - 724.2
3. Encounter for long-term (current) use of medications - V58.69
4. ENCTR THERAP DRUG MONITORING - V58.83

Treatment

1. Pain, Chronic

Stop Percocet 7.5/325 tablet, 325 mg-7.5 mg, 1 tab(s), orally, every 6
 hours max 4 per day, 30 days, 120
 Start Oxycodone tablet, 10 MG, 1 tab(s), orally, every 6 hours; max 4 a
 day, 30 day(s), 120, Refills 0

2. Encounter for long-term (current) use of medications

LAB: Fentanyl w/confirmation, urine

LAB: Opiate Metabolites drug screen, urine

LAB: Pain Therapy Drug Screen (14), urine

3. ENCTR THERAP DRUG MONITORING

LAB: Fentanyl w/confirmation, urine

LAB: Opiate Metabolites drug screen, urine

LAB: Pain Therapy Drug Screen (14), urine

4. Others

Continue isosorbide mononitrate tablet, extended release, 60 mg, 1 tab
 (s), orally, once a day (in the morning)
 Continue Ecotrin enteric coated tablet, 325 mg, 1 tab(s), orally, once a
 day
 Continue pravastatin tablet, 80 mg, 1 tab(s), orally, once a day (at
 bedtime)
 Continue metformin tablet, extended release, 500 mg, 1 tab(s), orally,
 once a day
 Continue Work Restrictions *, *, SEDENTARY WORK ONLY,, no
 driving or getting in and out of armored truck
 Continue exforge HCT, 10/320/25, 1, by mouth, daily
 Refill cyclobenzaprine tablet, 10 mg, 1 tab(s), orally, at bedtime, 30
 days, 30, Refills 2

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: April Smith, PA-C 03/11/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

338

R. 594

4/22/2014

MED RECONCILIATION: Pt. Ed: Current Meds Verified: Current meds/immunizations reviewed, including purpose with pt. Med Recon list given to pt/family. Pt advised to discard old med lists and provide all providers with current list at each visit and carry list with them in case of emergency.

Follow Up

4 Weeks - PA refill

Appl. M. Lund 2000

Electronically signed by April(UMR) Smith , PA-C on
03/12/2013 at 08:31 AM EDT

Sign off status: Completed

Upstate Medical Rehabilitation
111 Doctors Drive
Greenville, SC 29605
Tel: 864-797-7100
Fax: 864-241-9229

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: April Smith, PA-C 03/11/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



GREENVILLE HEALTH SYSTEM

HOUSTON, TOMMY GREGORY

57 Y old Male, DOB: 02/18/1956
204 BARTON ST, PO BOX 1099, EASLEY, SC-29640
Home: 864-855-0437
Guarantor: HOUSTON, TOMMY GREGORY
Insurance: UNITED HEALTHCARE
PCP: Richard Curry, MD Referring: comp workers
External Visit ID: 160288080
Appointment Facility: Upstate Medical Rehabilitation

04/11/2013

Progress Note: April Smith, PA-C

Current Medications

cyclobenzaprine tablet 10 mg 1 tab(s) at bedtime
exforge HCT 10/320/25 1 daily
Work Restrictions ** SEDENTARY WORK ONLY; no driving or getting in and out of armored truck
metformin tablet, extended release 500 mg 1 tab(s) once a day
pravastatin tablet 80 mg 1 tab(s) once a day (at bedtime)
Ecostrin enteric coated tablet 325 mg 1 tab(s) once a day
isosorbide mononitrate tablet, extended release 60 mg 1 tab(s) once a day (in the morning)
Oxycodone tablet 10 MG 1 tab(s) every 6 hours; max 4 a day
Medication List reviewed and reconciled with the patient

Past Medical History

Hypertension
High Cholesterol
Heart disease
Heart Attack
Fracture

Surgical History

left wrist 1978
right knee 1974
hernia 9/07
heart surgery 11/23
EXPLORATION AND REMOVAL OF FOREIGN BODY, RT HAND. 06/01/09
L5-S1 posterior lumbar interbody fusion on 12/22/12 at GMH by Dr. Charles Kanos.
12/22/12

Family History

Family: diabetes, Hypertension, Heart Disease

Social History

Interpersonal/family relationships: Divorced.

Reason for Appointment

1. 4 Weeks - PA refill

History of Present Illness

General:

Worker's Comp:

Old History:

1. The patient is a 55 y/o male seen at the request of Dr. Bucci. He sustained a work injury on 3/11/08 requiring right shoulder scope and rotator cuff repair on 7/11/08 by Dr. Wessinger. Patient got a second opinion from Dr. Kanos on 8/24/12, who recommended L5/S1 PLIF and patient underwent surgery on 12/12/12 with significant improvement of the symptoms.

The case was closed in August 2010 and was put at MMI by Dr. Wessinger but was reopened because of aggravation of the symptoms. The patient has been out of work since his injury. Low back pain, mainly secondary to facet and SI problem, S/P trigger point injection on 9/12/11, s/p PT, The patient is S/P SI injection with no significant improvement. 1/12/12 Rt lumbar facet RFA 75% pain relief. Patient is work until he sees Dr. Kanos.

2. Spondylolisthesis S/P x-ray. He has persistent left lower back pain.

Pain Any pain at this time? Yes, chronic pain, Does your current medication impair your judgement, coordination or your ability to drive? No, Is the current treatment working? Yes, Current treatment includes: Medication(s), Are you experiencing any side effects from the medications prescribed by your Physician at UMR? No, Are you satisfied with the treatment? Yes. Notes: UDS 3/11/13.

Mr. Houston presents today having had his medication increased to oxycodone 10mg at last visit to help with pain while in PT.

Today he reports he is doing much better with the medication change. He states that he does not think that he could be doing his PT 5 days/week 2 hours/day as he is doing now if he did not have the medications.

He feels like the PT is helping.

He states that if he is standing 20-25 minutes, he is still having low back pain and numbness in the dorsum of the L foot. He states that this sometimes causes him to fall. He has fallen since the surgery 3-

Alcohol men 18-65 yrs Assessment completed: today, Alcohol Intake: patient does not drink alcohol.
Smoking Status > 13 years old Are you a: Current smoker, Pt counseled on the dangers of tobacco use and urged to quit.
04/11/2013.
Occupation: Employed, but currently not working.
no Alcohol.
Smoking: yes, PPD: , years:.
no Recreational drug use.
no Use of marijuana, cocaine, or similar drugs.

Allergies

contrast dye: rash: Side Effects
codeine
penicillin

Hospitalization/Major

Diagnostic Procedure

see surgery list

4x/week. He states that he is usually able to catch himself. He uses a cane when outside of the house just in case this happens.

He does not believe that he has fallen to the point where he has damaged his hardware.

Vital Signs

Ht 70, Ht Cm 177.8, Wt lbs 206, Wt kg 93.44, BMI 29.55, BP 145/95,
HR 111, Pain score 3, Tech Initial jdt
Pt took oxycodone this morning.

Examination

General Exam:

General Appearance overweight, Well developed, well nourished and groomed, No apparent acute or chronic distress, Communicates normally, alert and oriented. Eyes non-icteric. Skin non-jaundiced, no pallor or cyanosis. Back L spine: ROM limited post-op. Pysch appropriate mood and affect.

Gait:

Heel Walk intact. Toe Walk intact.

Gait: antalgic on RLE.

Assessments

1. Pain, Chronic - 338.29 (Primary)
2. Low Back Pain - 724.2

Treatment

1. Pain, Chronic

Refill Oxycodone tablet, 10 MG, 1 tab(s), orally, every 6 hours; max 4 a day, 30 day(s), 120, Refills 0

2. Others

Continue isosorbide mononitrate tablet, extended release, 60 mg, 1 tab (s), orally, once a day (in the morning)

Continue Ecotrin enteric coated tablet, 325 mg, 1 tab(s), orally, once a day.

Continue pravastatin tablet, 80 mg, 1 tab(s), orally, once a day (at bedtime)

Continue metformin tablet, extended release, 500 mg, 1 tab(s), orally, once a day.

Continue Work Restrictions *, *, SEDENTARY WORK ONLY; no driving or getting in and out of armored truck

Continue exforge HCT, 10/320/25, 1, by mouth, daily

Continue cyclobenzaprine tablet, 10 mg, 1 tab(s), orally, at bedtime, 30 days, 30, Refills 2

Preventive Medicine

MED RECONCILIATION: Pt. Ed: Current Meds Verified: Current meds/immunizations reviewed, including purpose with pt. Med Recon list given to pt/family. Pt advised to discard old med lists and provide all providers with current list at each visit and carry list with them in case of emergency.

Follow Up

4 Weeks - PA refill, 2 months - DR. Math

April M. Smith

Electronically signed by April(UMR) Smith , PA-C on
04/18/2013 at 02:04 PM EDT

Sign off status: Completed

Upstate Medical Rehabilitation
111 Doctors Drive
Greenville, SC 29605
Tel: 864-797-7100
Fax: 864-241-9229

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: April Smith, PA-C 04/11/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



GREENVILLE HEALTH SYSTEM

HOUSTON, TOMMY GREGORY

57 Y old Male, DOB: 02/18/1956
204 BARTON ST, PO BOX 1099, EASLEY, SC-29640
Home: 864-855-0437

Guarantor: HOUSTON, TOMMY GREGORY

Insurance: UNITED HEALTHCARE

PCP: Richard Curry, MD Referring: comp workers

External Visit ID: 162747646

Appointment Facility: Upstate Medical Rehabilitation

05/09/2013

Progress Note: April Smith, PA-C

Current Medications

cyclobenzaprine 10 mg tablet 1 tab(s) at
bedtime
exforge HCT 10/320/25 1 daily
metformin 500 mg tablet, extended release 1
tab(s) once a day
pravastatin 80 mg tablet 1 tab(s) once a day
(at bedtime)
Ecotrin 325 mg enteric coated tablet 1 tab(s)
once a day
isosorbide mononitrate 60 mg tablet,
extended release 1 tab(s) once a day (in the
morning)
oxycodone 10 mg tablet 1 tab(s) every 6 hours
Medication List reviewed and reconciled with
the patient

Past Medical History

Hypertension
High Cholesterol
Heart disease
Heart Attack
Fracture

Allergies

contrast dye: rash: Side Effects
codeine
penicillin

Reason for Appointment

1. 4 Weeks - PA refill

History of Present Illness

General:

Worker's Comp:

Old History:

1. The patient is a 55 y/o male seen at the request of Dr. Bucci. He sustained a work injury on 3/11/08 requiring right shoulder scope and rotator cuff repair on 7/11/08 by Dr. Wessinger. Patient got a second opinion from Dr. Kanos on 8/24/12, who recommended L5/S1 PLIF and patient underwent surgery on 12/12/12 with significant improvement of the symptoms.

The case was closed in August 2010 and was put at MMI by Dr. Wessinger but was reopened because of aggravation of the symptoms. The patient has been out of work since his injury. Low back pain, mainly secondary to facet and SI problem, S/P trigger point injection on 9/12/11, s/p PT, The patient is S/P SI injection with no significant improvement. 1/12/12 Rt lumbar facet RFA 75% pain relief. Patient is work until he sees Dr. Kanos.

2. Spondylolisthesis S/P x-ray. He has persistent left lower back pain.

Pain Any pain at this time? Yes, chronic pain, Does your current medication impair your judgement, coordination or your ability to drive? Yes Does not take the meds when driving., Is the current treatment working? Yes, Current treatment includes: Medication (s), Are you experiencing any side effects from the medications prescribed by your Physician at UMR? No, Are you satisfied with the treatment? Yes. Notes: UDS 3/11/13.

Today pt. reports that he has fallen since his last visit. He reports that he was changed to a different PT in April to the sports medicine center. He feels like he started going down hill at that point. He reports that his walking tolerance has decreased. He has been instructed by Dr. Kanos to continue HEP and stop PT at this point. He states that he has been doing this and is back up to almost his previous walking tolerance. He is still having burning pain in the lower back. He states that he went to a Japanese restaurant in Easley last night and when he turned to pick up the food out of the car, he had increased pain and his leg gave

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: April Smith, PA-C 05/09/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

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R. 599

http://www.eClinicalWorks.com/20090/mobiledoc/sign/catalog/xml/printMultipleChartOptions.jsp?encount

4/22/2014

out from under him.

Dr. Kanos is planning xrays to assess fusion.

He reports that the pins and needles in the heel and burning down the LLE is gone. He still has some numbness in the L5 distribution on the L. He feels a pins and needles sensation in the lateral aspect of the foot on the L if he "pushes it."

He feels like he is tolerating the medications well and these are improving his ability to exercise. He does not feel that the medications effect his judgement, but affect his reaction time. He states that he was previously driving an armored car and does not feel that he could do this while taking the medications.

Vital Signs

Ht 70, Ht Cm 177.8, Wt lbs 204, Wt kg 92.53, BMI 29.27, Pain score 4.

Examination

General Exam:

General Appearance overweight, Well developed, well nourished and groomed, No apparent acute or chronic distress, Communicates normally, alert and oriented. Eyes non-icteric. Skin non-jaundiced, no pallor or cyanosis. Extremities BLE: 2+ pulses, no edema, 5/5 strength - mildly decreased strength in L5 distribution on L compared to R, sensation diminished in L5 distribution. Psych appropriate mood and affect.

Gait:

Gait: steady, mildly flexed at waist.

Assessments

1. Pain, Chronic - 338.29 (Primary)
2. Low Back Pain - 724.2

Treatment

1. Pain, Chronic

Refill Oxycodone tablet, 10 MG, 1 tab(s), orally, every 6 hours; max 4 a day, 30 day(s), 120, Refills 0

2. Others

Continue isosorbide mononitrate tablet, extended release, 60 mg, 1 tab (s), orally, once a day (in the morning)

Continue Ecotrin enteric coated tablet, 325 mg, 1 tab(s), orally, once a day

Continue pravastatin tablet, 80 mg, 1 tab(s), orally, once a day (at bedtime)

Continue metformin tablet, extended release, 500 mg, 1 tab(s), orally, once a day

Continue Work Restrictions *, *, SEDENTARY WORK ONLY, no driving or getting in and out of armored truck

Continue exforge HCT, 10/320/25, 1, by mouth, daily

Continue cyclobenzaprine tablet, 10 mg, 1 tab(s), orally, at bedtime, 30 days, 30, Refills 2

Follow Up

4 Weeks - PA refill

April U. Smith PA-C

Electronically signed by April(UMR) Smith , PA-C on
05/15/2013 at 02:44 PM EDT

Sign off status: Completed

Upstate Medical Rehabilitation
111 Doctors Drive
Greenville, SC 29605
Tel: 864-797-7100
Fax: 864-241-9229

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: April Smith, PA-C 05/09/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



GREENVILLE HEALTH SYSTEM

HOUSTON, TOMMY GREGORY

57 Y old Male, DOB: 02/18/1956
204 BARTON ST, PO BOX 1099, EASLEY, SC-29640
Home: 864-855-0437
Guarantor: HOUSTON, TOMMY GREGORY
Insurance: CIGNA POS
PCP: Richard Curry, MD Referring: comp workers
External Visit ID: 166505636
Appointment Facility: Upstate Medical Rehabilitation

06/06/2013

Progress Note: Christopher L. Kelly, PA

Current Medications

oxycodone 10 mg tablet 1 tab(s) every 6 hours
cyclobenzaprine 10 mg tablet 1 tab(s) at
bedtime
exforge HCT 10/320/25 1 daily
Work Restrictions ** SEDENTARY WORK
ONLY; no driving or getting in and out of
armored truck
metformin 500 mg tablet, extended release 1
tab(s) once a day
pravastatin 80 mg tablet 1 tab(s) once a day
(at bedtime)
Ecotrin 325 mg enteric coated tablet 1 tab(s)
once a day
isosorbide mononitrate 60 mg tablet,
extended release 1 tab(s) once a day (in the
morning)
Oxycodone 10 MG tablet 1 tab(s) every 6
hours; max 4 a day
Medication List reviewed and reconciled with
the patient

Past Medical History

Hypertension
High Cholesterol
Heart disease
Heart Attack
Fracture

Surgical History

left wrist 1978
right knee 1974
hernia 9/07
heart surgery 11/23
EXPLORATION AND REMOVAL OF
FOREIGN BODY, RT HAND. 06/01/09
L5-S1 posterior lumbar interbody fusion on
12/22/12 at GMH by Dr. Charles Kanos.
12/22/12

Family History

Family: diabetes, Hypertension, Heart
Disease

Reason for Appointment

1. 4 Weeks - PA refill

History of Present Illness

General:

Worker's Comp:

Old History:

1. The patient is a 55 y/o male seen at the request of Dr. Bucci. He sustained a work injury on 3/11/08 requiring right shoulder scope and rotator cuff repair on 7/11/08 by Dr. Wessinger. Patient got a second opinion from Dr. Kanos on 8/24/12, who recommended L5/S1 PLIF and patient underwent surgery on 12/12/12 with significant improvement of the symptoms.

The case was closed in August 2010 and was put at MMI by Dr. Wessinger but was reopened because of aggravation of the symptoms. The patient has been out of work since his injury. Low back pain, mainly secondary to facet and SI problem, S/P trigger point injection on 9/12/11. S/P PT, The patient is S/P SI injection with no significant improvement. 1/12/12 Rt lumbar facet RFA 75% pain relief. Patient is work until he sees Dr. Kanos.

2. Spondylolisthesis S/P x-ray. He has persistent left lower back pain.

The patient comes in today for followup medication refill. The patient states that he has some right knee pain that has gotten worse. He has been trying to walk more as Dr. Kanos has prescribed for him to do but his right knee seems to be limiting him quite a bit and his knee has been bothering him since the accident. He had seen Dr. Wessinger about it back in August of 2010 but said that was the least of his worries and that we would focus on fixing the other parts before we come back to his knee and now that he is starting to walk again trying to get back to his normal life, the patient would like to get this knee evaluated since it is giving him so many problems. Today his right knee seems to be the most problematic for him. His other two, his back and his hip, are considered more stable today. His pain is a 3/10 with medications and 10 without. He said the pain is at the middle of his back and left hip burning pain. He did takes his oxycodone this morning. He is not having any adverse reactions or side effects to that.

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Christopher L. Kelly,
PA 06/06/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

346

R. 602

Social History

Interpersonal/family relationships: Divorced.

Alcohol men 18-65 yrs Assessment completed: today, Alcohol intake: patient does not drink alcohol.

Smoking Status > 13 years old Are you a: Current smoker, Pt counseled on the dangers of tobacco use and urged to quit.

06/06/2013.

Occupation: Employed, but currently not working.

no Alcohol.

Smoking: yes, PPD: , years:

no Recreational drug use.

no Use of marijuana, cocaine, or similar drugs.

Allergies

contrast dye: rash: Side Effects

codeine

penicillin

Hospitalization/Major**Diagnostic Procedure**

see surgery list

He is not taking any new medications. He denies any numbness, weakness or bowel or bladder changes. He said his knee pain does not radiate down his leg. It is localized over the front of the kneecap. He cannot put his weight down on his knee. He has not been able to do that since the accident. He has noticed a slight bit of swelling. It is like a bump on the end of his knee around the top of the tibia and it has been very tender, sometimes it hurts more on the medial side and sometimes it is just right at the kneecap. He says it does not give way but it cracks and pops. On uneven ground it is very difficult for him to walk over and causes lots of pain. All review of systems are negative.

Notes: UDS 3/11/13.

Vital Signs

Ht 70, Ht Cm 177.8, Wt lbs 204, Wt kg 92.53, BMI 29.27, BP 136/84, HR 124, Pain score 3, O2 Sat 94, Tech Initial jdt.

ExaminationGeneral Exam:**CONSTITUTIONAL:**

He is overweight, well developed, well nourished and well groomed. No apparent acute or chronic distress. Communicates normally. Alert and oriented. Eyes non-icteric. Skin non-jaundice. No pallor or cyanosis of extremities.

Gait is steady mildly flexed at the waist.

MUSCULOSKELETAL:

Bilateral lower extremities +2 pulses. Strength is 5/5 bilaterally. He does have some swelling underneath the patellar tendon which is tender to palpation. He is also tender at the patella and over the patellar tendon at the distal pole. He does not have any joint line tenderness. He does have some meniscal signs with irritation. He has full range of motion with the right knee. Sensation on the left compared to the right is diminished in the L5 distribution.

PSYCHIATRIC: Appropriate mood and affect.

Assessments

1. Knee pain, right - 719.46 (Primary)
2. Pain, Chronic - 338.29
3. Low Back Pain - 724.2

Treatment**1. Knee pain, right**

Diagnostic Imaging:Knee, 4 views, right (complete)

2. Pain, Chronic

Refill Oxycodone tablet, 10 MG, 1 tab(s), orally, every 6 hours; max 4 a day, 30 day(s); 120, Refills 0

3. Others

Continue isosorbide mononitrate tablet, extended release, 60 mg, 1 tab (s), orally, once a day (in the morning)

Continue Ecotrin enteric coated tablet, 325 mg, 1 tab(s), orally, once a day

Continue pravastatin tablet, 80 mg, 1 tab(s), orally, once a day (at

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Christopher L. Kelly,
PA 06/06/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

347

R. 603

bedtime)

Continue metformin tablet, extended release, 500 mg, 1 tab(s), orally, once a day

Continue Work Restrictions *, *, SEDENTARY WORK ONLY; no driving or getting in and out of armored truck

Continue exforge HCT, 10/320/25, 1, by mouth, daily

Continue cyclobenzaprine tablet, 10 mg, 1 tab(s), orally, at bedtime, 30 days, 30, Refills 2

The patient has not had an x-ray on that knee since 2008 so we are going to get another x-ray today and then have him check with Worker's Comp and see about getting an MRI covered since it is still giving him a good bit of trouble. We can make a decision as to what we need to do or where we need to send him and also get that fluid collection there evaluated to see if it might be some kind of cyst or if it is just fluid collecting into the bursa there or what. We will have him followup after the MRI and we will continue his medications and give him refills for his prescription and followup after that. We will call the patient if there are any abnormal findings on the right knee x-ray. The patient was advised to continue all other medications as prescribed by other treating physicians/providers.

CK/mat/060613.

Preventive Medicine

MED RECONCILIATION: Pt. Ed: Current Meds Verified: Current meds/immunizations reviewed, including purpose with pt. Med Recon list given to pt/family. Pt advised to discard old med lists and provide all providers with current list at each visit and carry list with them in case of emergency.

Follow Up

4 Weeks, Math (Reason: after MRI)

PA-C

Electronically signed by Christopher Kelly PA, MSPAC on
06/17/2013 at 11:22 AM EDT

Sign off status: Completed

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Christopher L. Kelly,
PA 06/06/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

348

R. 604

1. <https://www.0000/mobiledoc/sign/catalog/vm/printMultipleChartOptions.isn?encount>

4/22/2014

Upstate Medical Rehabilitation
111 Doctors Drive
Greenville, SC 29605
Tel: 864-797-7100
Fax: 864-241-9229

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Christopher L. Kelly,
PA 06/06/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



GREENVILLE HEALTH SYSTEM

HOUSTON, TOMMY GREGORY

57 Y old Male, DOB: 02/18/1956
204 BARTON ST, PO BOX 1099, EASLEY, SC-29640

Home: 864-855-0437

Guarantor: HOUSTON, TOMMY GREGORY

Insurance: CIGNA POS

PCP: Richard Curry, MD Referring: comp workers

External Visit ID: 169611548

Appointment Facility: Upstate Medical Rehabilitation

08/12/2013

Progress Note: Christopher L. Kelly, PA

Current Medications

exforge HCT 10/320/25 1 daily
metformin 500 mg tablet, extended release 1
tab(s) once a day
pravastatin 80 mg tablet 1 tab(s) once a day
(at bedtime)
Ecotrin 325 mg enteric coated tablet 1 tab(s)
once a day
isosorbide mononitrate 60 mg tablet,
extended release 1 tab(s) once a day (in the
morning)
cyclobenzaprine 10 mg tablet 1 tab(s) at
bedtime
Oxycodone 10 MG tablet 1 tab(s) every 6
hours; max 4 a day
Work Restrictions ** SEDENTARY WORK
ONLY; no driving or getting in and out of
armored truck

Past Medical History

Hypertension
High Cholesterol
Heart disease
Heart Attack
Fracture

Allergies

contrast dye: rash: Side Effects
codeine
penicillin

Reason for Appointment

1. 4 Weeks, PA

History of Present Illness

General:

Worker's Comp:

Old History:

1. The patient is a 55 y/o male seen at the request of Dr. Bucci. He sustained a work injury on 3/11/08 requiring right shoulder scope and rotator cuff repair on 7/11/08 by Dr. Wessinger. Patient got a second opinion from Dr. Kanos on 8/24/12, who recommended L5/S1 PLIF and patient underwent surgery on 12/12/12 with significant improvement of the symptoms.

The case was closed in August 2010 and was put at MMI by Dr. Wessinger but was reopened because of aggravation of the symptoms. The patient has been out of work since his injury. Low back pain, mainly secondary to facet and SI problem, S/P trigger point injection on 9/12/11, s/p PT, The patient is S/P SI injection with no significant improvement. 1/12/12 Rt lumbar facet RFA 75% pain relief. Patient is work until he sees Dr. Kanos.

Spondylolisthesis S/P x-ray. He has persistent left lower back pain.

2. Right knee pain since the injury, recent MRI on 6/25/2013 shows extensive tear in the lateral meniscus, possible bucket handle tear and lateral tibiofibular chondromalacia, referred to Dr. Wessinger.

He comes today for a follow up appointment, shoulder, knee, low back and hip. His pain today is a 3/10 with medications. He takes oxycodone, Flexeril. He tolerates medication without any side effects. He denies any bowel or bladder changes or progressive worsening of symptoms. His right knee is still causing him some pain. Dr. Math went over the MRI with him last time and we went over it again this time. We discussed and reviewed the MRI as well as the images on PACS. It does show large lateral meniscus tear. He is just waiting for his appointment to be approved to see Dr. Wessinger for the meniscal tear. The knee has been constantly giving him problems ever since the accident. It has just been the lowest on the totem pole as far as injuries go.

Notes: UDS 3/11/13.

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Christopher L. Kelly,
PA 08/12/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Vital Signs

Ht 70, Ht Cm 177.8, Wt lbs 211, Wt kg 95.71, BMI 30.27, BP 139/77, HR 115, Pain score 3, O2 Sat 94, Tech Initial jdt.

Examination**General Exam:**

On examination, vital signs are stable. He is well-built, well-nourished, a little overweight. He is awake, alert, and oriented. He communicates appropriately. He is able to transfer independently. He has a slight antalgic gait. He is breathing comfortably. No peripheral edema or varicose veins. Skin is supple. On inspection of right knee there is no swelling or erythema. On palpation he is tender diffusely along the patella with some positive meniscal signs with irritation. Knee range of motion is full and no atrophy of quadriceps noted. Some sensory impairment in L5 distribution on the right side.

Assessments

1. Chondromalacia of right knee - 733.92 (Primary)
2. Lateral meniscal tear - 836.1

Treatment**1. Chondromalacia of right knee**

Refill Oxycodone tablet, 10 MG, 1 tab(s), orally, every 6 hours; max 4 a day, 30 day(s), 120, Refills 0

Refill cyclobenzaprine tablet, 10 mg, 1 tab(s), orally, at bedtime, 30 days, 30, Refills 0

2. Others

Continue isosorbide mononitrate tablet, extended release, 60 mg, 1 tab(s), orally, once a day (in the morning)

Continue Ecotrin enteric coated tablet, 325 mg, 1 tab(s), orally, once a day

Continue pravastatin tablet, 80 mg, 1 tab(s), orally, once a day (at bedtime)

Continue metformin tablet, extended release, 500 mg, 1 tab(s), orally, once a day

Continue Work Restrictions *, *, SEDENTARY WORK ONLY; no driving or getting in and out of armored truck

Continue exforge HCT, 10/320/25, 1, by mouth, daily

We will continue to give him his medications. He will probably likely need chronic pain medication. He has a stable history as of this point. We are still waiting on him to get the appointment approved with Dr. Wessinger. We will have him follow up in four weeks for medication refill with Dr. Math. The patient was advised to continue all other medications as prescribed by other treating physicians/providers. CK/mat/081213.

Preventive Medicine

MED RECONCILIATION: Pt. Ed: Current Meds Verified: Current meds/immunizations reviewed, including purpose with pt. Med Recon list given to pt/family. Pt advised to discard old med lists and provide all providers with current list at each visit and carry list with them in

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Christopher L. Kelly, PA 08/12/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

case of emergency.

Follow Up
4 Weeks mrf

CL PA-C

Electronically signed by Christopher Kelly PA, MSPAC on
08/27/2013 at 09:20 AM EDT

Sign off status: Completed

Upstate Medical Rehabilitation
111 Doctors Drive
Greenville, SC 29605
Tel: 864-797-7100
Fax: 864-241-9229

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Christopher L. Kelly,
PA 08/12/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



GREENVILLE HEALTH SYSTEM

HOUSTON, TOMMY GREGORY

57 Y old Male, DOB: 02/18/1956
204 BARTON ST, PO BOX 1099, EASLEY, SC-29640
Home: 864-855-0437
Guarantor: HOUSTON, TOMMY GREGORY
Insurance: CIGNA POS
PCP: Richard Curry, MD Referring: comp workers
External Visit ID: 172132276
Appointment Facility: Upstate Medical Rehabilitation

09/09/2013

Progress Note: Christopher L. Kelly, PA

Current Medications

exforge HCT 10/320/25 1 daily
Work Restrictions * * SEDENTARY WORK
ONLY; no driving or getting in and out of
armored truck
metformin 500 mg tablet, extended release 1
tab(s) once a day
pravastatin 80 mg tablet 1 tab(s) once a day
(at bedtime)
Ecotrin 325 mg enteric coated tablet 1 tab(s)
once a day
isosorbide mononitrate 60 mg tablet,
extended release 1 tab(s) once a day (in the
morning)
cyclobenzaprine 10 mg tablet 1 tab(s) at
bedtime
Oxycodone 10 MG tablet 1 tab(s) every 6
hours; max 4 a day
Medication List reviewed and reconciled with
the patient

Past Medical History

Hypertension
High Cholesterol
Heart disease
Heart Attack
Fracture

Surgical History

left wrist 1978
right knee 1974
hernia 9/07
heart surgery 11/23
EXPLORATION AND REMOVAL OF
FOREIGN BODY, RT HAND. 06/01/09
L5-S1 posterior lumbar interbody fusion on
12/22/12 at GMH by Dr. Charles Kanos.
12/22/12

Family History

Family: diabetes, Hypertension, Heart
Disease

Social History

Reason for Appointment

1. WC 4 Weeks mrf

History of Present Illness

General:

Worker's Comp:

Old History:

1. The patient is a 55 y/o male seen at the request of Dr. Bucci. He sustained a work injury on 3/11/08 requiring right shoulder scope and rotator cuff repair on 7/11/08 by Dr. Wessinger. Patient got a second opinion from Dr. Kanos on 8/24/12, who recommended L5/S1 PLIF and patient underwent surgery on 12/12/12 with significant improvement of the symptoms.

The case was closed in August 2010 and was put at MMI by Dr. Wessinger but was reopened because of aggravation of the symptoms. The patient has been out of work since his injury. Low back pain, mainly secondary to facet and SI problem, S/P trigger point injection on 9/12/11. S/P PT. The patient is S/P SI injection with no significant improvement. 1/12/12 Rt lumbar facet RFA 75% pain relief. Patient is work until he sees Dr. Kanos.

Spondylolisthesis S/P x-ray. He has persistent left lower back pain.
2. Right knee pain since the injury, recent MRI on 6/25/2013 shows extensive tear in the lateral meniscus, possible bucket handle tear and lateral tibiofibular chondromalacia, referred to Dr. Wessinger.

Patient comes in today for followup appointment. He still has not seen doctor for his meniscal tear yet. His pain level with medication is a 3/10; without would be like an 8. He is having the same pain in his left hip, left lower back, right shoulder, right knee, and he says his pain is sharp when he moves the wrong way, and dull and aching constantly. He is taking oxycodone four a day and tolerating medication very well without any adverse side effects. He has not started any new medication at this time. He denies any bowel or bladder changes or progressive weakness, fever, weight loss, or constipation. All other systems reviewed were negative.

Vital signs were reviewed and are stable, except for slightly elevated blood pressure and heart rate, which he is asymptomatic.

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Christopher L. Kelly,
PA 09/09/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

353

R. 609

Interpersonal/family relationships: Divorced.

Alcohol men 18-65 yrs Assessment completed: today, Alcohol intake: patient does not drink alcohol.
Smoking Status > 13 years old Are you a: Current smoker, Pt counseled on the dangers of tobacco use and urged to quit.
09/09/2013.
Occupation: Employed, but currently not working.
no Alcohol.
Smoking: yes, PPD: , years:.
no Recreational drug use.
no Use of marijuana, cocaine, or similar drugs.

Allergies

contrast dye: rash: Side Effects
codeine
penicillin

Hospitalization/Major

Diagnostic Procedure

see surgery list

Notes: UDS 3/11/13.

Vital Signs

Ht 70, Ht Cm 177.8, Wt lbs 211, BMI 30.27, BP 148/91, HR 112, Pain score 3, O2 Sat 92, Tech Initial jdt.

Examination

General Exam:

On examination, vital signs are stable. He is well-built, well-nourished, a little overweight. He is awake, alert, and oriented. He communicates appropriately. He is able to transfer independently. He has a slight antalgic gait. He is breathing comfortably. No peripheral edema or varicose veins. Skin is supple.

Assessments

1. Chondromalacia of right knee - 733.92 (Primary)
2. Lateral meniscal tear - 836.1

Treatment

1. Chondromalacia of right knee

Refill Oxycodone tablet, 10 MG, 1 tab(s), orally, every 6 hours; max 4 a day, 30 day(s), 120, Refills 0

Refill cyclobenzaprine tablet, 10 mg, 1 tab(s), orally, at bedtime, 30 days, 30, Refills 0

2. Others

Continue isosorbide mononitrate tablet, extended release, 60 mg, 1 tab(s), orally, once a day (in the morning)

Continue Ecotrin enteric coated tablet, 325 mg, 1 tab(s), orally, once a day

Continue pravastatin tablet, 80 mg, 1 tab(s), orally, once a day (at bedtime)

Continue metformin tablet, extended release, 500 mg, 1 tab(s), orally, once a day

Continue Work Restrictions *, *, SEDENTARY WORK ONLY, no driving or getting in and out of armored truck

Continue exforge HCT, 10/320/25, 1, by mouth, daily

I confirmed with Ann that she has tried on multiple occasions to get in contact with the Workers' Comp and they never called us back, so she will keep trying working on that front. In the meantime, hopefully, he will not cause any further worsening damage to his knee, which needs some serious attention. We will have him follow up in four weeks for medication. We are just going to continue treating him conservatively at this point and otherwise he needs to see the orthopedic surgeon about meniscal tear. The patient was advised to continue all other medications as prescribed by other treating physicians/providers.

CK/jp/090913.

Preventive Medicine

MED RECONCILIATION: Pt. Ed: Current Meds Verified: Current meds/immunizations reviewed, including purpose with pt. Med Recon list given to pt/family. Pt advised to discard old med lists and provide

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Christopher L. Kelly,
PA 09/09/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

all providers with current list at each visit and carry list with them in case of emergency.

Follow Up
4 Weeks math

Ch PA-C

Electronically signed by Christopher Kelly PA, MSPAC on
09/17/2013 at 03:10 PM EDT

Sign off status: Completed

Upstate Medical Rehabilitation
111 Doctors Drive
Greenville, SC 29605
Tel: 864-797-7100
Fax: 864-241-9229

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Christopher L. Kelly,
PA 09/09/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



GREENVILLE HEALTH SYSTEM

HOUSTON, TOMMY GREGORY

57 Y old Male, DOB: 02/18/1956
204 BARTON ST, PO BOX 1099, EASLEY, SC-29640

Home: 864-855-0437

Guarantor: HOUSTON, TOMMY GREGORY

Insurance: CIGNA POS

PCP: Richard Curry, MD Referring: comp workers

External Visit ID: 176986909

Appointment Facility: Upstate Medical Rehabilitation

11/07/2013

Progress Note: Christopher L. Kelly, PA

Current Medications

exforge HCT 10/320/25 1 daily
Work Restrictions ** SEDENTARY WORK ONLY; no driving or getting in and out of armored truck
metformin 500 mg tablet, extended release 1 tab(s) once a day
pravastatin 80 mg tablet 1 tab(s) once a day (at bedtime)
Ecotrin 325 mg enteric coated tablet 1 tab(s) once a day
isosorbide mononitrate 60 mg tablet, extended release 1 tab(s) once a day (in the morning)
Voltaren Gel 1% gel 2.0 g 4 times a day
cyclobenzaprine 10 mg tablet 1 tab(s) at bedtime
Oxycodone 10 MG tablet 1 tab(s) every 6 hours; max 4 a day
Medication List reviewed and reconciled with the patient

Past Medical History

Hypertension
High Cholesterol
Heart disease
Heart Attack
Fracture

Surgical History

left wrist 1978
right knee 1974
hernia 9/07
heart surgery 11/23
EXPLORATION AND REMOVAL OF FOREIGN BODY, RT HAND. 06/01/09
L5-S1 posterior lumbar interbody fusion on 12/22/12 at GMH by Dr. Charles Kanos.
12/22/12

Family History

Family: diabetes, Hypertension, Heart Disease

Reason for Appointment

1. WC 4 Weeks PA

History of Present Illness

General:

Worker's Comp:

Old History:

1. The patient is a 55 y/o male seen at the request of Dr. Bucci. He sustained a work injury on 3/11/08 requiring right shoulder scope and rotator cuff repair on 7/11/08 by Dr. Wessinger. Patient got a second opinion from Dr. Kanos on 8/24/12, who recommended L5/S1 PLIF and patient underwent surgery on 12/12/12 with significant improvement of the symptoms.

The case was closed in August 2010 and was put at MMI by Dr. Wessinger but was reopened because of aggravation of the symptoms. The patient has been out of work since his injury. Low back pain, mainly secondary to facet and SI problem, S/P trigger point injection on 9/12/11. S/p PT, The patient is S/P SI injection with no significant improvement. 1/12/12 Rt lumbar facet RFA 75%

Patient has been put to MMI by Dr. Kanos on 4/24/2013 with 25% impairment rating for lumbar spine with work restrictions no lifting over 35 pounds and no repetitive bending more than 60 degrees, sit for eight hours a day or walking for two hours with brace.

2. Right knee pain since the injury, recent MRI on 6/25/2013 shows extensive tear in the lateral meniscus, possible bucket handle tear and lateral tibiofibular chondromalacia, referred to Dr. Wessinger.

Patient comes in today for followup appointment for low back and hip and knee pain. His pain is a 3/10 today with medication; without it would be a 5. He is having the same pain as he had been having. He finally got his approval to see the surgeon and he saw Dr. Paylor on Tuesday. Dr. Paylor said he did need meniscectomy and he would feel much better after that so he is now scheduled for that surgery. Talked to him about his medications and said it was okay for them to do his medications like Dr. Kanos did where he gave him a little bit extra codone to take just immediately after the surgery for the first two weeks or so and that would be fine. He is very stable and he did adhere to our policies so far. He is not having any side effects from medication. He

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Christopher L. Kelly,
PA 11/07/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Social History

Interpersonal/family relationships: Divorced.

Alcohol men 18-65 yrs Assessment completed: today, Alcohol intake: patient does not drink alcohol.

Smoking Status > 13 years old Are you a: Current smoker, Pt counseled on the dangers of tobacco use and urged to quit.

11/07/2013.

Occupation: Employed, but currently not working.

no Alcohol.

Smoking: yes, PPD: , years:.

no Recreational drug use.

no Use of marijuana, cocaine, or similar drugs.

Allergies

contrast dye: rash: Side Effects

codeine

penicillin

Hospitalization/Major**Diagnostic Procedure**

see surgery list

has not started any new medication at this time. All other systems reviewed were negative.

Vital signs were reviewed and are stable. He denies any bowel or bladder changes or progressive worsening of symptoms.

Vital Signs

Ht 70, Ht Cm 177.8, Wt lbs 207.8, Wt kg 94.26, BMI 29.81, BP 137/87, HR 105, Pain score 3, O2 Sat 95, Tech Initial jdt.

ExaminationGeneral Exam:

On examination vital signs are stable. He is well-built, well-nourished, awake, alert, and oriented. He communicates appropriately. He is able to transfer independently. Gait is slightly antalgic. He is breathing comfortably. No peripheral edema or varicose veins. Skin is supple. On inspection of right knee there is no swelling or erythema. On palpation he has tenderness around the knee joint. No atrophy of quadriceps noted. Anterior drawer sign is negative. Knee range of motion is full and causes pain.

Assessments

1. Lateral meniscal tear - 836.1 (Primary)
2. Knee pain - 719.46
3. Back pain - 724.5

Treatment

1. Lateral meniscal tear

2. Others

Refill Oxycodone tablet, 10 MG, 1 tab(s), orally, every 6 hours; max 4 a day, 30 day(s); RELEASE 11/7/13, 120, Refills 0

Refill cyclobenzaprine tablet, 10 mg, 1 tab(s), orally, at bedtime, 30 days, 30, Refills 0

Refill Voltaren Gel gel, 1%, 2.0 g, applied topically, 4 times a day, 30 days, 2, Refills 0

We will continue medication as it has helped with his quality of life and he has surgery scheduled for meniscectomy and he will follow up in four weeks. The patient was advised to continue all other medications as prescribed by other treating physicians/providers.

CK/jp/110713.

Preventive Medicine

MED RECONCILIATION: Pt. Ed: Current Meds Verified: Current meds/immunizations reviewed, including purpose with pt. Med Recon list given to pt/family. Pt advised to discard old med lists and provide all providers with current list at each visit and carry list with them in case of emergency.

Follow Up

4 Weeks math

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Christopher L. Kelly,

PA 11/07/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

CL PA-C

Electronically signed by Christopher Kelly PA, MSPAC on
11/19/2013 at 12:15 PM EST

Sign off status: Completed

Upstate Medical Rehabilitation
111 Doctors Drive
Greenville, SC 29605
Tel: 864-797-7100
Fax: 864-241-9229

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Christopher L. Kelly,
PA 11/07/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



GREENVILLE HEALTH SYSTEM

HOUSTON, TOMMY GREGORY

57 Y old Male, DOB: 02/18/1956
204 BARTON ST, PO BOX 1099, EASLEY, SC-29640
Home: 864-855-0437
Guarantor: HOUSTON, TOMMY GREGORY
Insurance: CIGNA POS
PCP: Richard Curry, MD Referring: comp workers
External Visit ID: 181736869
Appointment Facility: Upstate Medical Rehabilitation

01/06/2014

Progress Note: Christopher L. Kelly, PA

Current Medications

cyclobenzaprine 10 mg tablet 1 tab(s) at
bedtime
Oxycodone 10 MG tablet 1 tab(s) every 6
hours; max 4 a day
Voltaren Gel 1% gel 2.0 g 4 times a day
isosorbide mononitrate 60 mg tablet,
extended release 1 tab(s) once a day (in the
morning)
Ecotrin 325 mg enteric coated tablet 1 tab(s)
once a day
pravastatin 80 mg tablet 1 tab(s) once a day
(at bedtime)
metformin 500 mg tablet, extended release 1
tab(s) once a day
Work Restrictions ** SEDENTARY WORK
ONLY; no driving or getting in and out of
armored truck
exforge HCT 10/320/25 1 daily
Medication List reviewed and reconciled with
the patient

Past Medical History

Hypertension
High Cholesterol
Heart disease
Heart Attack
Fracture

Surgical History

left wrist 1978
right knee 1974
hernia 9/07
heart surgery 11/23
EXPLORATION AND REMOVAL OF
FOREIGN BODY, RT HAND. 06/01/09
L5-S1 posterior lumbar interbody fusion on
12/22/12 at GMH by Dr. Charles Kanos.
12/22/12

Family History

Family: diabetes, Hypertension, Heart
Disease

Reason for Appointment

1. WC 4 Weeks PA

History of Present Illness

General:

Worker's Comp:

Old History:

1. The patient is a 55 y/o male seen at the request of Dr. Bucci. He sustained a work injury on 3/11/08 requiring right shoulder scope and rotator cuff repair on 7/11/08 by Dr. Wessinger. Patient got a second opinion from Dr. Kanos on 8/24/12, who recommended L5/S1 PLIF and patient underwent surgery on 12/12/12 with significant improvement of the symptoms.

The case was closed in August 2010 and was put at MMI by Dr. Wessinger but was reopened because of aggravation of the symptoms. The patient has been out of work since his injury. Low back pain, mainly secondary to facet and SI problem, S/P trigger point injection on 9/12/11, s/p PT, The patient is S/P SI injection with no significant improvement. 1/12/12 Rt lumbar facet RFA 75%

Patient has been put to MMI by Dr. Kanos on 4/24/2013 with 25% impairment rating for lumbar spine with work restrictions no lifting over 35 pounds and no repetitive bending more than 60 degrees, sit for eight hours a day or walking for two hours with brace.

2. Right knee pain since the injury, recent MRI on 6/25/2013 shows extensive tear in the lateral meniscus, possible bucket handle tear and lateral tibiofibular chondromalacia, referred to Dr. Wessinger. The patient was evaluated by Dr. Paylor at Piedmont Orthopedics who has recommended surgery. The patient is awaiting for approval from Worker's Comp.

Patient comes in today for followup appointment. Pain in the right knee is still giving him a lot of trouble. It is starting to really make a lot of noise and cracking and popping whenever he walks. He does walk with a limp now from that knee pain. He is still waiting on Workers' Comp to come through to set up the surgery time. He did see Dr. Paylor at Piedmont Orthopedics. He is taking oxycodone and tolerating it well without any side effects and has not started any new medication at this time. All other systems reviewed were negative.

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Christopher L. Kelly,
PA 01/06/2014

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

359

Social History

Interpersonal/family relationships: Divorced.

Alcohol men 18-65 yrs Assessment completed: today, Alcohol intake: patient does not drink alcohol.

Smoking Status > 13 years old Are you a: Current smoker, Pt counseled on the dangers of tobacco use and urged to quit.

11/07/2013.

Occupation: Employed, but currently not working.

no Alcohol.

Smoking: yes, PPD: , years:.

no Recreational drug use.

no Use of marijuana, cocaine, or similar drugs.

Allergies

contrast dye: rash: Side Effects

codeine

penicillin

Hospitalization/Major**Diagnostic Procedure**

see surgery list

Vital signs were reviewed and are stable. His blood pressure is slightly elevated, but he is asymptomatic. No shortness of breath or chest pain or dizziness. He is going to go to his primary care and talk to them about the increase in blood pressure. He has a stable clinical history.

Notes: UDS 12/5/13.

Vital Signs

Ht 70, Ht Cm 177.8, Wt lbs 208, Wt kg 94.35, BMI 29.84, BP 160/97, HR 112, Pain score 4, O2 Sat 95, Tech Initial bb
pt. took oxycodone this morning.

ExaminationGeneral Exam:

On examination vital signs are stable. He is well-built, well-nourished, awake, alert, and oriented. He communicates appropriately. He is able to transfer independently. Gait is slightly antalgic. He is breathing comfortably. No peripheral edema or varicose veins. Skin is supple. On inspection of right knee there is no swelling or erythema. On palpation he has tenderness around the knee joint. No atrophy of quadriceps noted. Anterior drawer sign is negative. Knee range of motion is full and causes pain.

Assessments

1. Spondylolisthesis - 756.12 (Primary)
2. Lateral meniscal tear - 836.1
3. Chondromalacia of right knee - 733.92
4. ENCOUNTER LONG TERM USE OTH DRUGS - V58.69
5. ENCTR THERAP DRUG MONITORING - V58.83
6. Sacroiliitis - 720.2

Treatment**1. Spondylolisthesis**

Refill Oxycodone tablet, 10 MG, 1 tab(s), orally, every 6 hours; max 4 a day, 30 day(s); RELEASE 01/06/2014, 120, Refills 0

Refill cyclobenzaprine tablet, 10 mg, 1 tab(s), orally, at bedtime, 30 days, 30, Refills 0
eprescribed flexeril today.

2. Others

We are going to continue his medications as it does help with his quality of life. He will likely need pain medicine the rest of his life. He will have followup as per protocol in four weeks and we will see him back then.

The patient was advised to continue all other medications as prescribed by other treating physicians/providers.

CK/jp/010614.

Preventive Medicine

MED RECONCILIATION: Pt. Ed: Current Meds Verified: Current meds/immunizations reviewed, including purpose with pt. Med Recon

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Christopher L. Kelly,
PA 01/06/2014

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

list given to pt/family. Pt advised to discard old med lists and provide all providers with current list at each visit and carry list with them in case of emergency.

Follow Up

4 Weeks (Reason: math)

CL PAC

Electronically signed by Christopher Kelly PA, MSPAC on
01/14/2014 at 03:58 PM EST

Sign off status: Completed

Upstate Medical Rehabilitation
111 Doctors Drive
Greenville, SC 29605
Tel: 864-797-7100
Fax: 864-241-9229

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Christopher L. Kelly,
PA 01/06/2014

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



GREENVILLE HEALTH SYSTEM

HOUSTON, TOMMY GREGORY

57 Y old Male, DOB: 02/18/1956
204 BARTON ST, PO BOX 1099, EASLEY, SC-29640

Home: 864-855-0437

Guarantor: HOUSTON, TOMMY GREGORY

Insurance: CIGNA POS

PCP: Richard Curry, MD Referring: comp workers

External Visit ID: 183950237

Appointment Facility: Upstate Medical Rehabilitation

02/05/2014

Progress Note: Christopher L. Kelly, PA

Current Medications

cyclobenzaprine 10 mg tablet 1 tab(s) at bedtime
Oxycodone 10 MG tablet 1 tab(s) every 6 hours; max 4 a day
exforge HCT 10/320/25 1 daily
Work Restrictions ** SEDENTARY WORK ONLY; no driving or getting in and out of armored truck
metformin 500 mg tablet, extended release 1 tab(s) once a day
pravastatin 80 mg tablet 1 tab(s) once a day (at bedtime)
Ecotrin 325 mg enteric coated tablet 1 tab(s) once a day
isosorbide mononitrate 60 mg tablet, extended release 1 tab(s) once a day (in the morning)
Voltaren Gel 1% gel 2.0 g 4 times a day
Medication List reviewed and reconciled with the patient

Past Medical History

Hypertension
High Cholesterol
Heart disease
Heart Attack
Fracture

Surgical History

left wrist 1978
right knee 1974
hernia 9/07
heart surgery 11/23
EXPLORATION AND REMOVAL OF FOREIGN BODY, RT HAND. 06/01/09
L5-S1 posterior lumbar interbody fusion on 12/22/12 at GMH by Dr. Charles Kanos.
12/22/12

Family History

Family: diabetes, Hypertension, Heart Disease

Reason for Appointment

1. WC 4 Weeks PA

History of Present Illness

General:

Worker's Comp:

Old History:

1. The patient is a 55 y/o male seen at the request of Dr. Buccini. He sustained a work injury on 3/11/08 requiring right shoulder scope and rotator cuff repair on 7/11/08 by Dr. Wessinger. Patient got a second opinion from Dr. Kanos on 8/24/12, who recommended L5/S1 PLIF and patient underwent surgery on 12/12/12 with significant improvement of the symptoms.

The case was closed in August 2010 and was put at MMI by Dr. Wessinger but was reopened because of aggravation of the symptoms. The patient has been out of work since his injury. Low back pain, mainly secondary to facet and SI problem, S/P trigger point injection on 9/12/11, s/p PT. The patient is S/P SI injection with no significant improvement. 1/12/12 Rt lumbar facet RFA 75%

Patient has been put to MMI by Dr. Kanos on 4/24/2013 with 25% impairment rating for lumbar spine with work restrictions no lifting over 35 pounds and no repetitive bending more than 60 degrees, sit for eight hours a day or walking for two hours with brace.

2. Right knee pain since the injury, recent MRI on 6/25/2013 shows extensive tear in the lateral meniscus, possible bucket handle tear and lateral tibiofibular chondromalacia, referred to Dr. Wessinger. The patient was evaluated by Dr. Paylor at Piedmont Orthopedics who has recommended surgery. The patient is awaiting for approval from Worker's Comp.

Patient comes in today for followup appointment for Workers' Comp. His pain is a 4/10 with medication; without would be a 10. He is still having a hard time getting the knee surgery to get the meniscal repair done through Workers' Comp, but they are working on it and closing in soon. He is taking oxycodone and Flexeril and tolerating it well with good and bad days. He is taking his medications appropriately and his blood pressure is a little elevated today, although he is asymptomatic.

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Christopher L. Kelly, PA 02/05/2014

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Social History

Interpersonal/family relationships: Divorced.

Alcohol men 18-65 yrs Assessment completed: today, Alcohol intake: patient does not drink alcohol.
Smoking Status > 13 years old Are you a: Current smoker, Pt counseled on the dangers of tobacco use and urged to quit.
11/07/2013.
Occupation: Employed, but currently not working.
no Alcohol.
Smoking: yes, PPD: , years:.
no Recreational drug use.
no Use of marijuana, cocaine, or similar drugs.

Allergies

contrast dye: rash: Side Effects
codeine
penicillin

Hospitalization/Major**Diagnostic Procedure**

see surgery list

Notes: UDS 12/5/13.

Vital Signs

Ht 70, Ht Cm 177.8, Wt lbs 208, Wt kg 94.35, BMI 29.84, BP 154/91, HR 110, Pain score 4, O2 Sat 95, Tech Initial bb
pt. took oxycodone this morning.

Examination**General Exam:**

On examination vital signs are stable. He is well-built, well-nourished, awake, alert, and oriented. He communicates appropriately. He is able to transfer independently. Gait is slightly antalgic. He is breathing comfortably. No peripheral edema or varicose veins. Skin is supple. On inspection of right knee there is no swelling or erythema. On palpation he has tenderness around the knee joint. No atrophy of quadriceps noted. Anterior drawer sign is negative. Knee range of motion is full and causes pain.

Assessments

1. Spondylolisthesis - 756.12 (Primary)
2. Lateral meniscal tear - 836.1
3. Chondromalacia of right knee - 733.92
4. Sacroiliitis - 720.2

Treatment**1. Spondylolisthesis**

Refill Oxycodone tablet, 10 MG, 1 tab(s), orally, every 6 hours; max 4 a day, 30 day(s); RELEASE 02/5/2014, 120, Refills 0
Refill cyclobenzaprine tablet, 10 mg, 1 tab(s), orally, at bedtime, 30 days, 30, Refills 0
eprescribed flexeril today.

2. Others

We are going to continue his medication as it does help with his quality of life. We will see him back in four weeks. He has a very stable clinical history and quality and character of his pain is unchanged for quite some time.

The patient was advised to continue all other medications as prescribed by other treating physicians/providers.

CK/jp/020514.

Preventive Medicine

MED RECONCILIATION: Pt. Ed: Current Meds Verified: Current meds/immunizations reviewed, including purpose with pt. Med Recon list given to pt/family. Pt advised to discard old med lists and provide all providers with current list at each visit and carry list with them in case of emergency.

Follow Up

4 Weeks (Reason: pa)

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Christopher L. Kelly,
PA 02/05/2014

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Ch PAC

Electronically signed by Christopher Kelly PA, MSPAC on
02/14/2014 at 12:17 PM EST

Sign off status: Completed

Upstate Medical Rehabilitation
111 Doctors Drive
Greenville, SC 29605
Tel: 864-797-7100
Fax: 864-241-9229

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Christopher L. Kelly,
PA 02/05/2014

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



GREENVILLE HEALTH SYSTEM

HOUSTON, TOMMY GREGORY

58 Y old Male, DOB: 02/18/1956
204 BARTON ST, PO BOX 1099, EASLEY, SC-29640

Home: 864-855-0437

Guarantor: HOUSTON, TOMMY GREGORY

Insurance: CIGNA POS

PCP: Richard Curry, MD Referring: comp workers

External Visit ID: 186596730

Appointment Facility: Upstate Medical Rehabilitation

03/06/2014

Progress Note: Christopher L. Kelly, PA

Current Medications

cyclobenzaprine 10 mg tablet 1 tab(s) at bedtime
Oxycodone 10 MG tablet 1 tab(s) every 6 hours; max 4 a day
Voltaren Gel 1% gel 2.0 g 4 times a day
isosorbide mononitrate 60 mg tablet, extended release 1 tab(s) once a day (in the morning)
Ecotrin 325 mg enteric coated tablet 1 tab(s) once a day
pravastatin 80 mg tablet 1 tab(s) once a day (at bedtime)
metformin 500 mg tablet, extended release 1 tab(s) once a day
Work Restrictions ** SEDENTARY WORK ONLY; no driving or getting in and out of armored truck
exforge HCT 10/320/25 1 daily
Medication List reviewed and reconciled with the patient

Past Medical History

Hypertension
High Cholesterol
Heart disease
Heart Attack
Fracture

Surgical History

left wrist 1978
right knee 1974
hernia 9/07
heart surgery 11/23
EXPLORATION AND REMOVAL OF FOREIGN BODY, RT HAND. 06/01/09
L5-S1 posterior lumbar interbody fusion on 12/22/12 at GMH by Dr. Charles Kanos.
12/22/12

Family History

Family: diabetes, Hypertension, Heart Disease

Reason for Appointment

1. WC 4 Weeks PA

History of Present Illness

General:

Worker's Comp:

Old History:

1. The patient is a 55 y/o male seen at the request of Dr. Bucci. He sustained a work injury on 3/11/08 requiring right shoulder scope and rotator cuff repair on 7/11/08 by Dr. Wessinger. Patient got a second opinion from Dr. Kanos on 8/24/12, who recommended L5/S1 PLIF and patient underwent surgery on 12/12/12 with significant improvement of the symptoms.

The case was closed in August 2010 and was put at MMI by Dr. Wessinger but was reopened because of aggravation of the symptoms. The patient has been out of work since his injury. Low back pain, mainly secondary to facet and SI problem, S/P trigger point injection on 9/12/11. S/P PT, The patient is S/P SI injection with no significant improvement. 1/12/12 Rt lumbar facet RFA 75%

Patient has been put to MMI by Dr. Kanos on 4/24/2013 with 25% impairment rating for lumbar spine with work restrictions no lifting over 35 pounds and no repetitive bending more than 60 degrees, sit for eight hours a day or walking for two hours with brace.

2. Right knee pain since the injury, recent MRI on 6/25/2013 shows extensive tear in the lateral meniscus, possible bucket handle tear and lateral tibiofibular chondromalacia, referred to Dr. Wessinger. The patient was evaluated by Dr. Paylor at Piedmont Orthopedics who has recommended surgery. The patient is awaiting for approval from Worker's Comp.

Patient comes in today for follow up visit. Last UDS was on 12/5/13 and appears normal. His pain with medications is a 5/10 pain without medications is 8/10. His pain is located in his right knee, right shoulder and lower back. The cold weather does make it worse. He is tolerating his Oxycodone and Flexeril. Is not having any side effects, no constipation, and has not started any new medications at this time. He is hypertensive on exam today although he is asymptomatic. No chest pain or shortness of breath or dizziness. His heart rate is 125 as well.

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Christopher L. Kelly,
PA 03/06/2014

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Social History

Interpersonal/family relationships: Divorced.

Alcohol men 18-65 yrs Assessment completed: today, Alcohol intake: patient does not drink alcohol.

Smoking Status > 13 years old Are you a: Current smoker, Pt counseled on the dangers of tobacco use and urged to quit. 11/07/2013.

Occupation: Employed, but currently not working.

no Alcohol.

Smoking: yes, PPD: , years:.

no Recreational drug use.

no Use of marijuana, cocaine, or similar drugs.

Allergies

contrast dye; rash: Side Effects

codeine

penicillin

Hospitalization/Major**Diagnostic Procedure**

see surgery list

We had a long discussion about him stopping smoking and to start exercising. He is going to talk to his cardiologist about getting on some blood pressure medication. Otherwise he is doing okay.

Notes: UDS 12/5/13.

Vital Signs

Ht 70, Ht Cm 177.8, Wt lbs 208, Wt kg 94.35, BMI 29.84, BP 179/98, HR 125, Pain score 3/4, O2 Sat 97, Tech Initial bb.

Examination**General Exam:**

On examination vital signs are stable. He is well-built, well-nourished, awake, alert, and oriented. He communicates appropriately. He is able to transfer independently. Gait is slightly antalgic. He is breathing comfortably. No peripheral edema or varicose veins. Skin is supple. On inspection of right knee there is no swelling or erythema. On palpation he has tenderness around the knee joint. No atrophy of quadriceps noted. Anterior drawer sign is negative. Knee range of motion is full and causes pain.

Assessments

1. Spondylolisthesis - 756.12 (Primary)
2. Lateral meniscal tear - 836.1
3. Chondromalacia of right knee - 733.92
4. Sacroiliitis - 720.2

Treatment**1. Spondylolisthesis**

Refill Oxycodone tablet, 10 MG, 1 tab(s), orally, every 6 hours; max 4 a day, 30 day(s); RELEASE 03/6/2014, 120, Refills 0

Refill cyclobenzaprine tablet, 10 mg, 1 tab(s), orally, at bedtime, 30 days, 30, Refills 0

eprescribed flexeril today.

2. Others

We will see him back in 4 weeks. We are going to continue medications as it helps with his quality of life. The patient was advised to continue all other medications as prescribed by other treating physicians/providers. CK/dh/030614.

Preventive Medicine

MED RECONCILIATION: Pt. Ed: Current Meds Verified: Current meds/immunizations reviewed, including purpose with pt. Med Recon list given to pt/family. Pt advised to discard old med lists and provide all providers with current list at each visit and carry list with them in case of emergency.

Follow Up

4 Weeks (Reason: math)

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Christopher L. Kelly,
PA 03/06/2014

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

CL PA-C

Electronically signed by Christopher Kelly PA, MSPAC on
03/25/2014 at 02:29 PM EDT

Sign off status: Completed

Upstate Medical Rehabilitation
111 Doctors Drive
Greenville, SC 29605
Tel: 864-797-7100
Fax: 864-241-9229

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Christopher L. Kelly,
PA 03/06/2014

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



GREENVILLE HEALTH SYSTEM

HOUSTON, TOMMY GREGORY

58 Y old Male, DOB: 02/18/1956
204 BARTON ST, PO BOX 1099, EASLEY, SC-29640

Home: 864-855-0437

Guarantor: HOUSTON, TOMMY GREGORY

Insurance: CIGNA POS

PCP: Richard Curry, MD Referring: comp workers

External Visit ID: 189178361

Appointment Facility: Upstate Medical Rehabilitation

04/07/2014

Progress Note: Christopher L. Kelly, PA

Current Medications

exforge HCT 10/320/25 1 daily
Work Restrictions ** SEDENTARY WORK
ONLY; no driving or getting in and out of
armored truck
metformin 500 mg tablet, extended release 1
tab(s) once a day
pravastatin 80 mg tablet 1 tab(s) once a day
(at bedtime)
Ecotrin 325 mg enteric coated tablet 1 tab(s)
once a day
isosorbide mononitrate 60 mg tablet,
extended release 1 tab(s) once a day (in the
morning)
Voltaren Gel 1% gel 2.0 g 4 times a day
cyclobenzaprine 10 mg tablet 1 tab(s) at
bedtime
Oxycodone 10 MG tablet 1 tab(s) every 6
hours; max 4 a day
Medication List reviewed and reconciled with
the patient

Past Medical History

Hypertension
High Cholesterol
Heart disease
Heart Attack
Fracture

Surgical History

left wrist 1978
right knee 1974
hernia 9/07
heart surgery 11/23
EXPLORATION AND REMOVAL OF
FOREIGN BODY, RT HAND. 06/01/09
L5-S1 posterior lumbar interbody fusion on
12/22/12 at GMH by Dr. Charles Kanos.
12/22/12

Family History

Family: diabetes, Hypertension, Heart
Disease

Reason for Appointment

1. WC 4 Weeks W/PA

History of Present Illness

General:

Worker's Comp:

Old History:

1. The patient is a 55 y/o male seen at the request of Dr. Bucci. He sustained a work injury on 3/11/08 requiring right shoulder scope and rotator cuff repair on 7/11/08 by Dr. Wessinger. Patient got a second opinion from Dr. Kanos on 8/24/12, who recommended L5/S1 PLIF and patient underwent surgery on 12/12/12 with significant improvement of the symptoms.

The case was closed in August 2010 and was put at MMI by Dr. Wessinger but was reopened because of aggravation of the symptoms. The patient has been out of work since his injury. Low back pain, mainly secondary to facet and SI problem, S/P trigger point injection on 9/12/11. S/P PT, The patient is S/P SI injection with no significant improvement. 1/12/12 Rt lumbar facet RFA 75%

Patient has been put to MMI by Dr. Kanos on 4/24/2013 with 25% impairment rating for lumbar spine with work restrictions no lifting over 35 pounds and no repetitive bending more than 60 degrees, sit for eight hours a day or walking for two hours with brace.

2. Right knee pain since the injury, recent MRI on 6/25/2013 shows extensive tear in the lateral meniscus, possible bucket handle tear and lateral tibiofibular chondromalacia, referred to Dr. Wessinger. The patient was evaluated by Dr. Paylor at Piedmont Orthopedics who has recommended surgery. The patient is awaiting for approval from Worker's Comp.

Notes: UDS 12/5/13.

He comes for a Worker's Comp refill. His pain level is 3/10. He is having pain in his low back, left hip, right knee, tingling, burning, aching, throbbing. No changes since last visit and all the same with the Oxycodone and Flexeril. He is not having any side effects. He is not starting any medications. At this time, they've been evaluated by Dr. Patton. They now, at least, are moving forward with knee surgery. He would like to do surgery on him. We are just waiting on him to respond

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Christopher L. Kelly,
PA 04/07/2014

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Social History

Interpersonal/family relationships: Divorced.

Alcohol men 18-65 yrs Assessment completed: today, Alcohol intake: patient does not drink alcohol.

Smoking Status > 13 years old Pt counseled on the dangers of tobacco use and urged to quit. 11/07/2013, Are you a: Current smoker.

Occupation: Employed, but currently not working.

no Alcohol.

Smoking: yes, PPD: , years:.

no Recreational drug use.

no Use of marijuana, cocaine, or similar drugs.

Allergies

contrast dye: rash: Side Effects

codeine

penicillin

Hospitalization/Major**Diagnostic Procedure**

see surgery list

to that.

Vital Signs

Ht 70, Ht Cm 177.8, Wt lbs 203.8, Wt kg 92.44, BMI 29.24, BP 167/101, HR 109, Pain score 3, O2 Sat 96, Tech Initial bb
pt. took oxycodone this morning.

ExaminationGeneral Exam:

On examination vital signs are stable. He is well-built, well-nourished, awake, alert, and oriented. He communicates appropriately. He is able to transfer independently. Gait is slightly antalgic. He is breathing comfortably. No peripheral edema or varicose veins. Skin is supple. On inspection of right knee there is no swelling or erythema. On palpation he has tenderness around the knee joint. No atrophy of quadriceps noted. Anterior drawer sign is negative. Knee range of motion is full and causes pain.

Assessments

1. Spondylolisthesis - 756.12 (Primary)
2. Lateral meniscal tear - 836.1
3. Chondromalacia of right knee - 733.92
4. Sacroiliitis - 720.2

Treatment**1. Spondylolisthesis**

Refill Oxycodone tablet, 10 MG, 1 tab(s), orally, every 6 hours; max 4 a day, 30 day(s); RELEASE 04/7/2014, 120, Refills 0

Refill cyclobenzaprine tablet, 10 mg, 1 tab(s), orally, at bedtime, 15 days, 15, Refills 0
eprescribed flexeril today.

2. Others

Otherwise, we are just going to continue to manage him conservatively and keep doing his medications. It helps with his quality of life. We'll see him back in four weeks. The patient was advised to continue all other medications as prescribed by other treating physicians/providers.
CK/cm/040714.

Preventive Medicine

MED RECONCILIATION: Pt. Ed: Current Meds Verified: Current meds/immunizations reviewed, including purpose with pt. Med Recon list given to pt/family. Pt advised to discard old med lists and provide all providers with current list at each visit and carry list with them in case of emergency.

Follow Up

4 Weeks (Reason: Math)

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Christopher L. Kelly,
PA 04/07/2014

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Ch PA-C

Electronically signed by Christopher Kelly PA, MSPAC on
04/15/2014 at 01:47 PM EDT

Sign off status: Completed

Upstate Medical Rehabilitation
111 Doctors Drive
Greenville, SC 29605
Tel: 864-797-7100
Fax: 864-241-9229

Patient: HOUSTON, TOMMY GREGORY DOB: 02/18/1956 Progress Note: Christopher L. Kelly,
PA 04/07/2014

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



pledmont orthopaedic associates

Worker's Compensation

Authorization Form

Employee Name: Tommy Houston Date of Birth: 2.18.56
Social Security No.: 250-06-6278 Home Phone No: 864-855-0437
Name of Employer at time of accident: Garda World Security
Employer's Phone No.: _____
W/C Insurance Company: Gallagher Bassett Svc
Address: P.O. 23812 Tucson, AZ 85734
Phone No.: 800-843-8999 Ext: 3272 Fax No: _____
Adjuster's Name: Jeresa Gulionelli
Claim No.: 003170-00450 WC-01 Date of Accident: 3/11/08
Description of problem: Right Knee

Authorized Treatment

Evaluation / Treatment and X-rays: OK

One-time Evaluation: _____

Second Opinion Only: _____

Second Opinion and Treatment: _____

Authorized By (If Other Than Adjuster): _____

Phone No.: _____

Date: 10/28/13

Intake Correspondent: Debbie

204 Barden St
Easley, SC 29640

OK per JHP 10/28/13
Tues. 10/5/13
9:00 am.

C:\Forms\WCAuthor 10/06

PIEDMONT ORTHOPAEDIC ASSOCIATES
COPY

To: Dr. Paylor

From: Debbie

Date: 10/24/13

Patient: Tommy Houston

Comments: Right knee pain

will you see?

yes JAD

PIEDMONT COMMUNITY COLLEGE

11-5-13

JHP

PIEDMONT ORTHOPAEDIC ASSOCIATES

PATIENT DEMOGRAPHIC FORM

First: Tommy Middle: G. Last: HOUSTON

Home Address:

Billing Address (If Different):

Line1: 204 BARTON ST.Line1: SAMELine2: EasleyLine2: SAMEZip: 29640 City: Easley State: SC

Zip: _____ City: _____ State: _____

Do you live in a Skilled Nursing Facility?: ☐ Y ☒ N

Facility Name: _____

Home Phone Number: 864-855-0437

Cell Phone Number: _____

Email: thouston@gmail.comSSN: 250-06-6278 (Your SSN is Mandatory when scheduling anything with the hospital)DOB: 02/18/1956 Gender: ☒ Male ☐ Female Referred By: DR. MATHMarital Status: ☐ Single ☐ Married ☒ Divorced ☐ Separated ☐ WidowedPrimary Care Physician: Dr. Maria Oliver Responsible Party If Child: _____Primary Insurance: WORKER COMP GALLAGHER BASSETT Subscriber: GARDA World SecuritySubscriber's DOB: 02/18/1956 Policy #: _____ Group #: _____Patient's Relationship to Subscriber: ☒ Self ☐ Spouse ☐ Child ☐ OtherSecondary Insurance: CFBNA Subscriber: Tommy G. HoustonSubscriber's DOB: 02/18/1956 Policy #: 114372295501 Group #: 3334679Patient's Relationship to Subscriber: ☒ Self ☐ Spouse ☐ Child ☐ OtherEmployer: GARDA World Security Street Address: 1241 White Horse RdCity: GREENVILLE State: SC Zip: 29605 Phone#: 864-422-8450Was this an on the job injury?: ☒ Yes ☐ No Date of Injury: 03/11/2008 Body Part: RT. KNEEClaim #: 003170-000450-WC-01 Work Comp Insurance: GALLAGHER BASSETT SERVICESEmergency Contact: ANDREW HOUSTON Relationship: SON Phone #: 864-505-6339Pharmacy Name: PUBLIX PHARMACY Pharmacy Addr: 6525 Calhoun Mem. HwyPharmacy Phone #: 864-850-2276 Pharmacy Fax #: 864-850-2284

GOVERNMENT MANDATED QUESTIONS The following questions are required by the US Government

Primary Language: EnglishRace: ☐ American Indian ☐ Asian ☐ Black ☐ Native Hawaiian ☐ Unknown ☒ WhiteEthnicity: ☐ Non-Hispanic ☐ Hispanic ☐ UnknownHeight: 5 ft 10 inches Weight: 195Tobacco Use: ☒ Current Every Day ☐ Current Some Day ☐ Never ☐ FormerPIEDMONT ORTHOPAEDICS
COPY

PIEDMONT ORTHOPAEDIC ASSOCIATES

PATIENT CONSENT AND AUTHORIZATION

Name of Patient Tommy G. Houston Date of Birth 02/18/1956

Piedmont Orthopaedic Associates, P.A., referred to as POA in the remainder of this document, is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entities Authorized to Receive Information:

Please list the name of any person who you would like to have access to your information at our office.

Spouse: _____ Parent/Guardian: _____

Other: Andrew Houston - Son Other: _____

Description of Information to be Released:

Please check the box of the information that can be released to the entities you have listed above.

☐ Family Billing Information ☐ Financial ☒ Medical as Follows: ANY

Rights of the Patient Regarding Release of Information:

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to POA. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Payment is Required at Time of Service:

Payment for medical care is solely the responsibility of the patient or his/her legal guardian. By signing below I give POA authorization to treat my medical condition. I also allow them to release my medical information as necessary for treatment, payment and operation of POA.

Consent of Release of Medication History:

A patient's current and up to date medication history is very important to the treatment plan of the provider. By signing below I give POA authorization to download my current medication history. Each provider of POA reserves the right to not see a patient who refuses this consent.

Acknowledgement of Receipt of Patient Financial Policy:

I have read and understand POA "Patient Financial Policy" and I agree to all terms listed in the policy. I also give POA authorization to submit claims to my insurance carrier on my behalf and to accept assignment on my claims.

Acknowledgement of Receipt of Notice of Privacy Practice:

I understand that the purpose of this notice is to inform me of my rights in regards to my "Protected Health Information" (PHI) and also the ways in which POA may use my PHI. I also understand that POA has my permission to use my PHI as necessary for treatment, payment and/or operation.

TC Houston
Patient/Guardian Signature

11/03/2013
Date **PIEDMONT ORTHOPAEDICS**
COPY



**piedmont
orthopaedic
associates**



**BON SECOURS
MEDICAL GROUP**
Bon Secours St. Francis Health System

Piedmont Orthopaedic Associates

Authorization Release Form

Workers Compensation

Main Office
35 International Drive
Greenville, SC 29615
P: 864-234-7654
F: 864-675-1657

Grove Office
1050 Grove Road
Greenville, SC 29605
P: 864-234-7654
F: 864-675-1657

Appointments
864-734-9994

Sports Medicine
and Arthroscopy
Thomas E. Baumgarten, MD
B. Shay Koch, MD
John H. Paylor, III, MD
John R. Vann, MD

Shoulder, Elbow,
and Hand Surgery
W. Arnold Batson, Jr., MD
W. Clark Jernigan, MD
Marc A. Tenner, MD

Hip and Knee
Replacement Surgery
James E. Jennings, Jr., MD
Christopher H. Kavolus, MD
Stephen R. Ridgeway, MD

Foot and Ankle Surgery
Michael E. Tollison, MD
John W. Womack III, MD

Neuromuscular and
Spine Management
L. Breaden Hollis, Jr., MD
Jennifer P. Martin, MD

Spine Surgery
S. Emmett Lucas, III, MD
Christopher D. Van Pelt, MD

Physician Assistants
Amy S. Hunt, PA-C
Michael Lashley, PA-C
Jonathan York, PA-C

Physical Therapy
35 International Drive
1050 Grove Road

Administrator
J. Bland Burkhardt, Jr.

www.getmovingwithpoa.com

Patient's Name: Tommy G. Houston Date of Birth: 02/18/1956

I, T.G. Houston, hereby authorize my Employer and its Workers' Compensation Case Manager/Nurse to communicate both orally and in writing with the treating physicians or medical providers of any kind regarding all facts and opinions relevant to my workers' compensation claim. I authorize the release of all medical records; pertinent medical information relevant to my complaint of injury related to my workers' compensation claim. I understand pursuant to S.C. Code Ann. Section 42-15-80 that no fact communicated to or otherwise learned by any physician or surgeon who may have attended or examined me, or who may have been present at any examination is privileged. I understand I have the right to revoke this authorization by submitting a written revocation. My revocation is not effective for information used or disclosed prior to my revocation. I further understand that the information used or disclosed pursuant to my authorization may be subject to re-disclosure by the recipient.

Date of Injury: 04/11/08 Type of Injury: Right Knee
(Name of body part)

Employer at time of Injury: Carcla

Employer Representative (if specific): _____

Date: 11/05/2013 Signature: T.G. Houston

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C-Form Workers' Comp 1/2011

Name: Houston, Tommy
 DOB: 1956-02-18
 Age: 57 years
 Gender: Male
 Chart#: 55008925



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associates**



BON SECOURS MEDICAL GROUP
 Bon Secours St. Francis Health System

Office Visit: 99203 New Level 3		Diagnosis: 836.1 Tear-Lateral Cartilage/Meniscus-Current	
Fracture:	Laterality:	Fracture Diagnosis:	
Fracture:	Laterality:	Fracture Diagnosis:	
Casting:	Laterality:	Cast Supply: 1) x	2) x
Procedure 1: x 1 Unit	Laterality:	Med 1: x	Dx:
Procedure 2: x 1 Unit	Laterality:	Med 2: x	Dx:
NOTES:			
DME1: x 1 Unit	DME 2: x 1 Unit	DME 3: x 1 Unit	PQRS & E-cribe(MC patients only)
Laterality:	Laterality:	Laterality:	
XRAY RIGHT:		LEFT: BILATERAL:	

Follow up: Surgery

Date of Service: 2013-11-05 09:16:43

CC: Injury of the right knee.

Onset Date: 3/11/2008

HPI:

The injury occurred on the date of onset.
 The patient suffered the injury by being in a MVA. He was working at the time.
 The knee has been painful since initial injury.
 The location of the pain is anterior and lateral.
 Movement and use aggravate the pain.
 Associated signs are swelling, giving way, locking. He did have a MRI.

ROS/PMH/FH/SH: ROS AND PMFSH: This is included in the chart on the patient history form and is reviewed and signed today. Pertinent positives and negatives are addressed with the patient. Non-orthopedic concerns are referred to the patient's primary care physician.

Allergies:

Medications:

Physical Examination:

General appearance of the patient is normal for age.
 Sensation in LEs is intact with no numbness or tingling.
 DTRs are normal and symmetrical.
 Circulation is intact in LEs.
 The skin is noted to be normal over bilateral lower extremities.
 Gait is noted to be with a limp on the left.
 Palpation reveals tenderness over the lateral aspect of the right knee.
 Range of motion of right knee is normal.

**PIEDMONT ORTHOPAEDICS
COPY**

Name: Houston, Tommy
DOB: 1956-02-18
Age: 57 years
Gender: Male
Chart#: 55008925



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Bon Secours St. Francis Health System

Crepitus is not present.
Stability of the right knee is normal.
Muscular strength of right knee is normal.
Left knee: good ROM, normal stability, and normal muscular strength.

MEDICAL DECISION MAKING:

He did have an MRI scan which showed extensive tearing of the lateral meniscus with displaced tissue. He has advanced grade chondromalacia as well. His knee continues to bother him a great deal. His options are discussed. He would like to be scheduled for arthroscopy of the right knee with a lateral meniscectomy. The surgery is discussed. The risk and complications are discussed. The booklet is given. Alternatives were also discussed. He will be scheduled.

John H. Paylor

Electronically signed by John H Paylor MD on 2013-11-05 09:16:43

PIEDMONT ORTHOPAEDICS
COPY

Name: Houston, Tommy
 DOB: 1956-02-18
 Age: 58 years
 Gender: Male
 Chart#: 55008925



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 Bon Secours St. Francis Health System

Office Visit: 99212 EST Level 2		Diagnosis: 836.1 Lateral Meniscus Tear	
Fracture:	Laterality:	Fracture Diagnosis:	
Fracture:	Laterality:	Fracture Diagnosis:	
Casting:	Laterality:	Cast Supply: 1) x 2) x	
Procedure 1: x 1 Unit	Laterality:	Med 1: x	Dx:
Procedure 2: x 1 Unit	Laterality:	Med 2: x	Dx:
NOTES:			
DME1: x 1 Unit	DME 2: x 1 Unit	DME 3: x 1 Unit	PQRS & E-cribe(MC patients only)
Laterality:	Laterality:	Laterality:	
XRAY	RIGHT:	LEFT:	BILATERAL:

Follow up: Surgery

Date of Service: 2014-03-25 11:06:40

Allergies: Codeine; Penicillin

Medications: AmLODIPine Besylate; Atorvastatin Calcium; Cyclobenzaprine HCl; Ecotrin; Fluticasone Propionate; Isosorbide Dinitrate; Losartan Potassium; MetFORMIN HCl; OxyCODONE HCl

CC: right knee

His here today with his right knee. We are awaiting approval for surgery. The knee is getting worse. He is presently having to walk with a cane. He is not able to work. His knee is still swollen. His range of motion is 90° of flexion and -15° of extension. Hopefully his surgery will be approved soon.

John H. Paylor

Electronically Signed By John H Paylor MD

PIEDMONT ORTHOPAEDICS
COPY

Markillie & Associates, PLLC
Medical Case Management

December 18, 2013

Dr. John Paylor
PIEDMONT ORTHOPAEDIC ASSOCIATE
35 INTERNATIONAL DR
GREENVILLE, SC 29615

Claimant: Tommy Houston
Claim # F15580656
DOI: 3/11/2008
DOB: 2/18/1956

Dear Dr. Paylor,

My name is Dorothy Batton and I am the Nurse Case Manager working with the adjuster on this case and she has asked for a Completed Major Contributing Cause letter prior to a decision being made in regards to approving an arthroscopy of the right knee with a lateral meniscectomy.

1. In your opinion, what type of injury did claimant incur to the right knee on 3/11/08?

Car accident.

2. Is his current condition caused by the work injury of 3/11/08 or is it related to a pre-existing condition / prior injury? If related to a pre-existing condition or prior injury please explain.

The patient states it is from the accident

3. In your professional opinion is the 3/11/2008 injury a 100% the Major Contributing Cause for the arthroscopy of the right knee with a lateral meniscectomy? If not please explain and give the percentage related to the Major Contributing Cause of the need for surgery.

I do not know.

Thank you for your assistance.

Sincerely,

Dorothy Batton RN, CCM
Telephonic Case Manager/Field Case Manager
Markillie & Associates
Phone: 904-738-5289; Fax: 866-271-6229

**PIEDMONT ORTHOPAEDICS
COPY**

Jan. 24, 2013 10:10AM

Bon Secours Health System
ST. FRANCIS HOSPITAL
DOWNTOWN
ONE ST FRANCIS DRIVE
GREENVILLE, SC 29601-3955

HOUSTON, TOMMY GREGG
MRN: 785000591
DOB: 2/18/1956, Sex: M
Adm: 1/21/2013, D/C:

Progress Notes signed by Barry Kiser, PT at 01/21/13 2016

Author: Barry Kiser, PT

Service: (none)

Author
Type:

Physical Therapist

Filed: 01/21/13 2016

Note
Time: 01/21/13 1940



BON SECOURS
ST. FRANCIS HEALTH SYSTEM



785000591

Outpatient Physical Therapy at Powdersville

3407 Highway 153 Piedmont, SC 29673
Phone: (864)295-8700 Fax: (864)295-3959

OUTPATIENT PHYSICAL THERAPY: Initial Assessment

Fall Risk Score: 2 (a 3 = High Risk)

Treatment Diagnosis: *backache unspecified and abnormality of gait*

REFERRING PHYSICIAN: Dr Kanos

MD Orders: evaluate and treat

Return Physician Appointment: 2-13-13

MEDICAL/REFERRING DIAGNOSIS: (724.02)-low back pain/lumbago

DATE OF ONSET: surgery on 12-12-12

PRIOR LEVEL OF FUNCTION: unable to work since mva in March/ 2008-living with severe back pain x almost 5 years

PRECAUTIONS/ALLERGIES: forward bending and lifting

ASSESSMENT:

This section established at most recent assessment—
56 y/o male who was in a severe mva in March/2008-while unbelted in back of armored truck the vehicle was severely rear ended throwing the patient against metal interior of truck-subsequent surgery for shoulder and wrist injuries from accident and finally back surgery on 12/12/12-pain and muscle adaptation-x 5-years-very good candidate for skilled physical therapy To include manual therapy and pain modalities as needed and therapeutic stretching and conditioning and body mechanic training

PROBLEM LIST (Impairments causing functional limitations):

1. Decreased Strength affecting function
2. Decreased ADL/Functional Activities
3. Decreased Flexibility/joint mobility
4. Decreased transfer abilities
5. Increased Pain affecting function
6. Decreased Activity tolerance

GOALS: (Goals have been discussed and agreed upon with patient.)

SHORT-TERM FUNCTIONAL GOALS: Time Frame: 2-4-13

1. Pain in low back is less than 3/10 at rest and less than 8/10 with walking/standing to progress to DC goal
2. Instruction in exercise program to allow increased ADLs.

DISCHARGE GOALS: Time Frame: 3-7-13

1. Minimal pain at rest in low back and able to walk/stand for 45 minutes and able to drive for 60 minutes to allow increased ADLs
2. Trunk rom is at least 66% to 75% in all ranges to allow full personal care such as putting on shoes and socks and washing
3. Sleep at least 5 hours without wakened by back pain
4. Low back outcome measure is decreased from 68% to 40%

REHABILITATION POTENTIAL FOR STATED GOALS: FAIR TO GOOD

PLAN OF CARE:

Houston, Tommy Gregg (MR # 785000591) Printed by Sandra B Cole (1585) at 1/24/13 ... Page 1 of 5

Page 37

PIEDMONT ORTHOPAEDICS
COPY

380

R. 638

Jan. 24, 2013 10:11AM

INTERVENTIONS PLANNED: (Benefits and precautions of physical therapy have been discussed with the patient.)

1. cold
2. electrical stimulation
3. gait training
4. home exercise program (HEP)
5. manual therapy
6. therapeutic exercise/strengthening
7. transcutaneous electrical nerve stimulation (TENS)
- 8.

TREATMENT PLAN EFFECTIVE DATES: 1-21-13 to 3-7-13

FREQUENCY/DURATION: Follow patient 3 times a week for 6 weeks to address above goals.

Regarding Tommy Houston's therapy, I certify that the treatment plan above will be carried out by a therapist or under their direction.

Thank you for this referral,

Barry Kiser, PT

Referring Physician Signature: _____ Date _____

PIEDMONT ORTHOPAEDICS
COPY

Jan 24 2013 10:11AM

SUBJECTIVE:

The surgery has already done a lot for me as it has taken that severe burning and radiating pain down my leg that I had-I have felt the best I have in almost 5 years- I am still in a lot of pain especially if I try to stand more than 15 minutes or try to drive more than 30 minutes- by then my L low back pain gets as bad as a 8/10 but not like a 12/10 it used to be

History of Present Injury/Illness (Reason for Referral): mva in 2008- back surgery on 12-12-12

Present Symptoms: L low back pain with severe tightness and spasm in lumbar and L gluteus medius- very tight L Hamstrings and gastrocnemius

Pain Intensity 1: 3 (3/10 at rest and 7-8/10 with walking x 15 min)

Pain Location 1: Back/Hip

Pain Orientation 1: Lower/Left

Pain Intervention(s) 1: Cold pack; Heat applied; Exercise; Rest (percocet)

Dominant Side: RIGHT

Past Medical History: double hernia, HTN, R shoulder and wrist surgery, R knee surgery

Current Medications: percocet, pravastatin, isosorbide, ecotrin, flaxeril, exforge HCT

Date Last Reviewed: 1-21-13

Social History/Home Situation: lives at home with son

Home Environment: Private residence

Steps to Enter: 3

Rails to Enter: Yes

Wheelchair Ramp: No

One/Two Story Residence: One story

Living Alone: No

Support Systems: Child(ren)

Patient Expects to be Discharged to: Private residence

Current DME Used/Available at Home: Cane, straight

Tub or Shower Type: Tub/Shower combination

Work/Activity History: certified agent for Garda Cash Logistics

OBJECTIVE:**Outcome Measure:**

Tool Used: Modified Oswestry Low Back Pain Questionnaire

Most Recent: X% Disability (Date: --)

Score: Initial: 68% Disability

Interpretation of Score: Each section is scored on a 0-5 scale, 5 representing the greatest disability. The scores of each section are added together for a total score of 50. This number is multiplied by 2 to get a percent score. This value represents the percentage disability: 0-20% minimal disability; 20-40% moderate disability; 40-60% severe disability; 60-80% crippled; and 80-100% bed-bound or exaggerated symptom behavior. Minimal detectable change is 8% and minimal clinical important difference is 6%.

Observation/Orthostatic Postural Assessment: Posture (WDL): Exceptions to WDL (flattened lumbar curve)

Posture Assessment: Leg length discrepancy, left

Palpation: severe tightness in L lumbar and piriformis and hamstrings and gastrocnemius

ROM:

Lumbo-Sacral Flexion (% of Normal): 66
Lumbo-Sacral Extension (% of Normal): 60
Lumbo-Sacral Left Lateral (% of Normal): 80
Lumbo-Sacral Left Rotation (% of Normal): 80
Lumbo-Sacral Right Lateral (% of Normal): 66 (pain in L low back)
Lumbo-Sacral Right Rotation (% of Normal): 66 (pain in L low back)

PIEDMONT ORTHOPEDICS
COPY

Strength: R LE is 4+/5- L ankle and quads and hip flexors and hamstrings are 3+/5

Jan. 24, 2013 10:11AM

Special Tests: negative spring and compression and stork test-negative SLR test but very tight hamstrings
 Neurological Screen: decreased sensation to L5 pathway on lateral lower leg and on dorsum of L foot that increases with increased standing time
 Myotomes:

Dermatomes: minimally decreased to light touch on L5 pathway

Reflexes:

Neural Tension Tests:
 Functional Mobility: Gait Description (WDL): Exceptions to WDL (independent ambulation with moderate/mod+ antalgic gait)- needs to use cane for smoother, less jarring to low back gait

Balance: Sitting: Intact (leans to R)
 Standing: Intact

TREATMENT:

(In addition to Assessment/Re-Assessment sessions the following treatments were rendered)
 Therapeutic Exercise: () : reviewed in exercises and proper body mechanics- will progress LE strengthening

Exercises per grid below to improve mobility, strength, balance and coordination. Required minimal verbal cues to promote proper body alignment and promote proper body posture. Progressed resistance, range, repetitions and complexity of movement as indicated.

Activity/Exercise	Date: 1-21-13	Date:	Date:
	Parameters	Parameters	Parameters
Knee to chest			
Hamstring stretch			
Piriformis stretch			
Gluteal sets			

Manual Therapy (Soft Tissue Mobilization Duration
 Duration: 12 Minutes to L lumbar and gluteus medius while in R side lying position- effleurage and petrissage for tightness

Posteriorly rotated L innominate corrected with muscle energy and pubic balancing 15 minutes

Manual therapy x 14 minutes

Therapeutic Modalities: for pain and inflammation
 Lumbo-Sacral Spine Cold

Type: Cold/ice pack

Duration: 15 minutes

Patient Position: Lying right side

Lumbo-Sacral Spine Electric Stimulation

Jan. 24 2013 10:11AM

Type: Interferential
 Placement: L lumbar and gluteus medius
 Duration : 15 minutes
 Patient Position: Lying right side
 HEP: As above; handouts given to patient for all exercises.

Treatment Assessment: Decreased pain and spasm with muscle stimulation and cold pack- may be a good candidate for TENS unit.

Progression/Medical Necessity:

- Patient is expected to demonstrate progress in strength, range of motion, balance and coordination to increase independence with ADLs and improve safety during transfers and walking and driving.
- Skilled intervention continues to be required due to post surgical pain and weakness affecting function and gait.

Compliance with Program/Exercises: compliant most of the time. Will assess as treatment progresses.

Reason for Continuation of Services/Other Comments:

- Patient continues to require modification of therapeutic interventions to increase complexity of exercises.
- Patient continues to require skilled intervention due to LE weakness and low back pain affecting gait and function.

Recommendations/Intent for next treatment session: "Treatment next visit will focus on advancements to more challenging activities". Push soft tissue work and flexibility to L lumbar and gluteus medius-stretch tight hamstrings

Total Treatment Duration: 29 minutes for treatment and 46 minutes for evaluation

PT Patient Time In/Time Out

Time In: 0345

Time Out: 0500

Barry Kiser, PT

Electronically signed by Barry Kiser, PT at 1/21/2013 8:16 PM

PIEDMONT ORTHOPAEDICS
COPY

Bon Secours Health System ST FRANCIS MILLENIUM OFFICE HOUSTON, TOMMY GREGG
BU MRN: 785000591
2 Innovation Drive DOB: 2/18/1956, Sex: M
Greenville, SC 28607-5281 Adm: 4/10/2013, D/C:

Progress Notes signed by Matthew P Brandel, PT at 04/10/13 1854

Author: Matthew P Brandel, PT Service: (none) Author: Physical Therapist
Type:
Filed: 04/10/13 1854 Note: 04/10/13 1848
Time:



BON SECOURS
ST FRANCIS HEALTH SYSTEM



785000591

Therapy Center at St. Francis Millennium

2 Innovation Drive, Greenville, SC 28607
Phone: (864) 400-3630 Fax: (864) 400-3621

Work Conditioning

OUTPATIENT PHYSICAL THERAPY: Daily Note and Progress Report

Fall Risk Score: 7 (≥ 5 = High Risk)

REFERRING PHYSICIAN: Charles Kanos, M.D.

MD Orders: work conditioning program

Return Physician Appointment: 5/1/13

MEDICAL/REFERRING DIAGNOSIS: lumbar stenosis status post surgical repair

DATE OF ONSET: 3/11/08

PRIOR LEVEL OF FUNCTION: Independent

PRECAUTIONS/ALLERGIES:

Allergies

Allergen

• Codeine

Reactions

Rash

ASSESSMENT:

This section established at most recent assessment

Tommy Gregg Houston completes progress retesting on the Arcon today comparison to initial testing on 3/25/13. Patient demonstrates increased strength for 7 of 7 strength tests ranging from 9 to 129%. He now demonstrates 4 of 7 tests in the heavy work category. He also demonstrated improvement in all functional testing except for walking. He continues to fall below job demand levels in several categories. Based on his improvement with the initial two weeks, I recommend continued work conditioning program for an additional two weeks.

PROBLEM LIST (Impairments causing functional limitations):

1. Decreased Strength affecting function
2. Decreased Flexibility/joint mobility
3. Increased Pain affecting function
4. Increased Fatigue affecting function

GOALS: (Goals have been discussed and agreed upon with patient.)

SHORT-TERM FUNCTIONAL GOALS: Time Frame: four weeks

1. Subjective pain report of 2-3 times one week
2. 50% improvement in lumbar range of motion
3. Arcon testing indicates medium -- heavy work duty Goal Met 4/10/13

DISCHARGE GOALS: Time Frame: six weeks

1. Arcon testing indicates heavy work duty
2. Minimal to mild pain with activity
3. Increase endurance to 1-1.5 miles walking

REHABILITATION POTENTIAL FOR STATED GOALS: FAIR

PLAN OF CARE:

INTERVENTIONS PLANNED: (Benefits and precautions of physical therapy have been discussed with the patient.)

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1. Work conditioning program

TREATMENT PLAN EFFECTIVE DATES: 3/20/13 TO 4/30/13

FREQUENCY/DURATION: Follow patient 4 times a week for 6 weeks to address above goals.

Regarding Tommy Gregg Houston's therapy, I certify that the treatment plan above will be carried out by a therapist or under their direction.

Thank you for this referral,

Matthew P Brandel, PT

Referring Physician Signature: Dr. Kanos _____ Date _____

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SUBJECTIVE:

History of Present Injury/Illness (Reason for Referral): Patient reports on 3/11/08, he was riding in the back of an armored car when they were T-boned. Patient reports that he was bounced around the back of the truck. Patient reports surgical repair of the right shoulder July 2008 and of the right hand in July 2009. Patient reports he continued to have pain in the left hip. He did complete round of therapy for both the back and the shoulder. Patient states he returned to work in May of 2009, but by June of 2010 he had significant increase in pain in the left lower extremity and right shoulder. Patient reports MRI indicated lumbar fracture. Surgical repair was completed 12/12/12 by Dr. Kanos. Patient reports an immediate resolution in the burning of the left lower extremity. Patient reports a 50% reduction in left hip pain.

Present Symptoms: Patient demonstrates significant improvement with Arcon retesting.

Pain Intensity 1: 4

Pain Location 1: Back

Dominant Side: RIGHT

Past Medical History: Patient reports history of hypertension, cardiovascular disease and diabetes

Current Medications: Exforge, Isosorbide, Pravastatin, oxycodone, Flexeril, Metformin

Date Last Reviewed: 4/10/2013

Social History/Home Situation: Patient reports that he lives with his son in a one-story residence with a three-step entry.

Work/Activity History: Patient is employed with Garda World Security as a security agent. Patient reports he has been out of work since August of 2010.

OBJECTIVE:**Outcome Measure:**

Tool Used: Modified Oswestry Low Back Pain Questionnaire

Score: Initial: 34/50 3/20/13

Most Recent: X/50 (Date: --)

Interpretation of Score: Each section is scored on a 0-5 scale, 5 representing the greatest disability. The scores of each section are added together for a total score of 50.

Score	0	1-10	11-20	21-30	31-40	41-49	50
Modifier	CH	CI	CJ	CK	CL	CM	CN

• **Mobility - Walking and Moving Around:**

G8978 - CURRENT STATUS: CL - 60%-79% impaired, limited or restricted

G8979 - GOAL STATUS: CJ - 20%-39% impaired, limited or restricted

G8980 - D/C STATUS: -----To be determined-----

Observation/Orthostatic Postural Assessment: Patient maintains extremely rigid trunk posture.

Palpation: Patient with moderate tenderness to palpation over midline lumbosacral region

ROM:

--	--

Strength:

--	--

Special Tests: SLR positive on the left

Neurological Screen:

Myotomes: decreased left lower extremity

--	--

Dermatomes: decrease left lower extremity

--	--

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Functional Mobility:

Patient ambulating with straight cane

Balance: Fair dynamic standing balance

TREATMENT:

(In addition to Assessment/Re-Assessment sessions the following treatments were rendered)
 Work Conditioning (120 min): Patient completed retesting on the Arcon. Test results will be scanned in the medical record.

Activity	Date 3/28/13	Date 4/1/13	Date 4/2/13	Date 4/3/13	Date 4/4/13	Date 4/5/13	Date 4/10/13
Cardio gym							
Nu-step							
Walking track (17 laps + 1 mile)	5 laps x 2	5 laps x 2	6 laps x 2	6 laps x 2	7 laps x 2	7 laps x 2	
Lat pull down	40# 2 x 15	55# 2 x 15	55# 2 x 15	70# 2 x 15	70# 2 x 15	70# 2 x 15	
Shoulder press	20# 2 x 15	25# 2 x 15	25# 2 x 15	35# 2 x 15	35# 2 x 15	35# 2 x 15	
Pec fly	20# 2 x 15	25# 2 x 15	25# 2 x 15	35# 2 x 15	35# 2 x 15	35# 2 x 15	
Rear delt	20# 2 x 15	25# 2 x 15	25# 2 x 15	35# 2 x 15	35# 2 x 15	35# 2 x 15	
Leg curls	20# 2 x 15	25# 2 x 15	25# 2 x 15	35# 2 x 15	35# 2 x 15	45# 2 x 15	
Leg ext	20# 2 x 15	25# 2 x 15	25# 2 x 15	35# 2 x 15	35# 2 x 15	35# 2 x 15	
Leg press	40# 2 x 15	55# 2 x 1	55# 2 x 15	70# 2 x 15	70# 2 x 15	70# 2 x 15	
Tricep ext	20# 2 x 15	25# 2 x 15	25# 2 x 15	35# 2 x 15	35# 2 x 15	35# 2 x 15	
Vertical row	40# 2 x 15	55# 2 x 1	55# 2 x 15	70# 2 x 15	70# 2 x 15	70# 2 x 15	
Bicep curl	20# 2 x 15	25# 2 x 15	25# 2 x 15	35# 2 x 15	35# 2 x 15	35# 2 x 15	
Chest press	20# 2 x 15	25# 2 x 15	25# 2 x 15	35# 2 x 15	35# 2 x 15	35# 2 x 15	
Rehab gym							
UBE	Level 1 x 10'	Level 1 x 10'	Level 1 x 10'	Level 1 x 10'	Level 1 x 10'	Level 1.5 x 10'	Level 1.5 x 10'
Step ups ant/lat/post	X 10 each BLE	X 10 each BLE	X 10 each BLE	X 10 each BLE	X 10 each BLE	X 10 ea BLE	
Recumbent bike	Level 1 x 10'	Level 1 x 10'	Level 1 x 10'	Level 1 x 10'	Level 1 x 10'	Level 2 x 10'	Level 2 x 10'
shuttle							
Cone step overs ant/lat	X 10 each BLE	X 10 each BLE	X 10 each BLE	X 10 each BLE	X 10 each BLE	X 10 ea BLE	
Shrugs, lat raise, scaption	3# x 10 each	3# x 10 each	3# x 10 each	4# x 10 each	4# x 10 each	4# x 10 ea	
W,I,T,Y	Green x 10	Green x 10	Green x 10	Green x 10	Green x 10	Green x 10	

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HEP: As above; handouts given to patient for all exercises.

Treatment Assessment: Patient demonstrates good improvement with work conditioning program to date. We have recommended continued work conditioning

Progression/Medical Necessity:

- Patient is expected to demonstrate progress in strength, range of motion, balance and functional technique to increase independence with ambulation and return to work duties.

Compliance with Program/Exercises: Will assess as treatment progresses.

Reason for Continuation of Services/Other Comments:

- Patient continues to require modification of therapeutic interventions to increase complexity of exercises.

Recommendations/intent for next treatment session: "Treatment next visit will focus on advancements to more challenging activities".

Total Treatment Duration:

PT Patient Time In/Time Out

Time In: 1500

Time Out: 1700

Matthew P Brandel, PT

Electronically signed by Matthew P Brandel, PT at 4/10/2013 6:54 PM

Chart Review Routing History

No Routing History on File

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CO-OP



St Francis Physical Therapy at Millennium
 2 Innovation Drive Suite 250, Greenville, SC 29607
 Phone: 864-400-3630 Fax: 864-400-3621

**Progress
Re-testing**

PATIENT INFORMATION:

Report Date: 04/10/13

Patient: Tommy G. Houston ID#: 785000591
 Address: 204 Barton St DOB: 02/18/56 Age: 57 Sex: M
 Easley, SC 29640 Height: 70 in Weight: 195 lb
 Phone (H): 864-855-0437 Phone (W): n/a
 Initial Visit: 03/20/13 Occupation: armored car agent
 ... Referred by: n/a Employer: n/a
 ... Resting Pulse Rate: n/a Insurance Co: n/a
 ... Blood Pressure (sitting): n/a Physician: n/a
 Tested By: Matt Brandel, PT Attorney: n/a

Injury: Diagnosis	Side	Injury Date	ICD-9 Code
lumbar fracture	L	03/11/08	n/a

JOB INFORMATION:

Company: n/a Department: n/a
 Address: n/a n/a, n/a n/a
 Phone: n/a FAX: n/a
 Job Title: armored car agent Job Subtitle: n/a

SUMMARY:

Mr. Houston completes progress re-testing for comparison with initial testing on 3/25/13. He demonstrates increased strength for 7 of 7 strength tests ranging from 9 to 129%. He now demonstrates 4 of 7 tests in the heavy work category. He also demonstrated improvement in all functional testing except for walking. He continues to fall below job demand in several categories. Based on his improvement in initial 2 weeks, I recommend continuing work conditioning program an additional 2 weeks.

Matt Brandel, PT

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Tommy G. Houston - 785000591

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VerNova ST - Static Strength Report:

The patient was evaluated using the VerNova ST static strength testing system. This system is designed to quantify an individual's ability to lift, push, or pull in various postures and to compare strength to norms adopted by the U. S. Dept. of Health and Human Services, National Institute for Occupational Safety and Health (NIOSH).

Individual Test Results		Strength Data		Job Related Strength and Lifting Recommendations†		
TASK NAME	DATE	Avg Force	CV† (%)	Desired Strength	% of Desired	Occasional Lift (Table ST4)
FLOOR LIFT (1)	03/25/13	55.7 lb	13.5	n/a	n/a	28 lb (Medium)
LEG LIFT (2)	03/25/13	74.9 lb	11.9	n/a	n/a	37 lb (Medium)
TORSO LIFT (3)	03/25/13	41.2 lb	5.4	n/a	n/a	21 lb (Medium)
ARM LIFT (4)	03/25/13	39.3 lb	2.7	n/a	n/a	20 lb (Light)
HIGH NEAR LIFT (5)	03/25/13	52.9 lb	3.1	n/a	n/a	26 lb (Medium)
PUSH OUT (6)	03/25/13	52.3 lb	6.8	n/a	n/a	52 lb (Heavy)
PULL IN (7)	03/25/13	46.8 lb	8.6	n/a	n/a	46 lb (Medium)
FLOOR LIFT (8)	04/10/13	64.8 lb	7.9	n/a	n/a	32 lb (Medium)
LEG LIFT (9)	04/10/13	109.2 lb	5.3	n/a	n/a	55 lb (Heavy)
TORSO LIFT (10)	04/10/13	47.3 lb	10.0	n/a	n/a	24 lb (Medium)
ARM LIFT (11)	04/10/13	49 lb	2.6	n/a	n/a	25 lb (Medium)
HIGH NEAR LIFT (12)	04/10/13	121.6 lb	7.3	n/a	n/a	61 lb (Heavy)
PUSH OUT (13)	04/10/13	65.2 lb	0.9	n/a	n/a	65 lb (Heavy)
PULL IN (14)	04/10/13	51.1 lb	6.9	n/a	n/a	51 lb (Heavy)

("n/a" indicates results that are not available or applicable for the listed task)

If the patient repeated any task on one or more testing dates, results are shown in the table below. Strength changes (shown as "% Change" - positive indicating *stronger*, negative indicating *weaker*) are presented as a means of evaluating either consistency in performance, progress in rehabilitation, or loss due to injury or degeneration.

Comparison Results		Original Test		Repeated Test		
TASK NAME	DATE	Avg Force	DATE	Avg Force	% Change	
FLOOR LIFT	03/25/13	55.7 lb	04/10/13	64.8 lb	16.3 %	
LEG LIFT	03/25/13	74.9 lb	04/10/13	109.2 lb	45.7 %	
TORSO LIFT	03/25/13	41.2 lb	04/10/13	47.3 lb	14.8 %	
ARM LIFT	03/25/13	39.3 lb	04/10/13	49 lb	24.6 %	
HIGH NEAR LIFT	03/25/13	52.9 lb	04/10/13	121.6 lb	129 %	
PUSH OUT	03/25/13	52.3 lb	04/10/13	65.2 lb	24.6 %	
PULL IN	03/25/13	46.8 lb	04/10/13	51.1 lb	9.1 %	

COMMENTS (referenced by number from test result table)	Comment Picture
(1) pain 3/10	

† Donald B. Chaffin, Ph.D.; Gary D. Herrin, Ph.D.; W. Monroe Keyserling, M.S.; "Pre-Employment Strength Testing, An Updated Position", Journal of Occupational Medicine, Vol 20, No. 6, June, 1978.

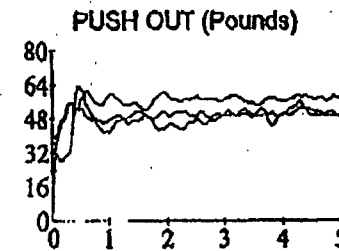
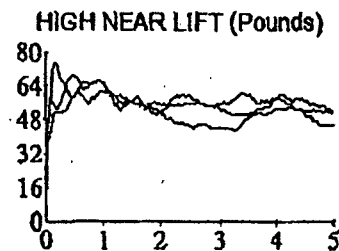
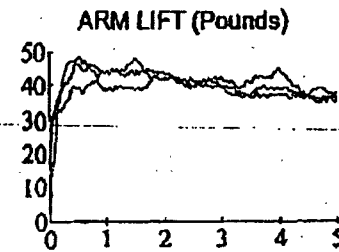
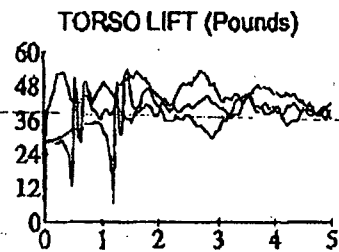
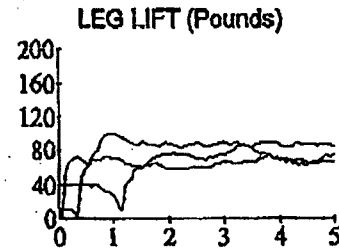
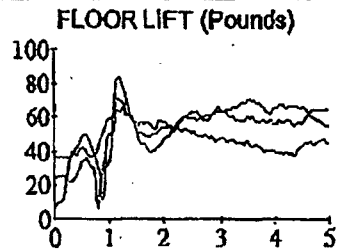
† Based on the NIOSH guideline for validity, test results that exhibit a coefficient of variation greater than or equal to 15% cannot be considered as valid, consistent and reproducible.

Tommy G. Houston - 785000591

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<i>COMMENTS (referenced by number from test result table)</i>	<i>Comment Picture</i>
(2) 3/10	
(3) 5/10 left glut and lumbar	
(4) 3/10	
(5) 3/10	
(6) no c/o	
(7) 3/10 left lumbar	
(8) 6/10 lumbar and right knee	
(9) 6/10 lumbar right shoulder	
(10) 8/10 lumbar only	
(11) 5/10 lumbar right shoulder	
(12) 2/10 right shoulder	
(13) 3/10	
(14) 5/10 lumbar	

ST Test Graphs (in order of Test Results)



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ST Test Graphs (in order of Test Results)

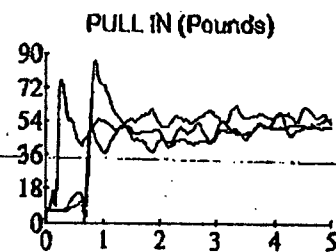
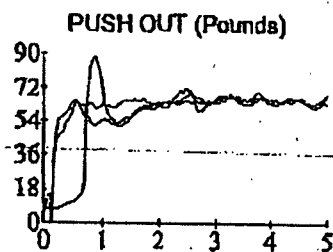
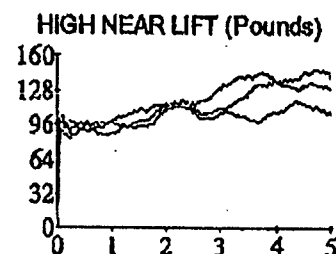
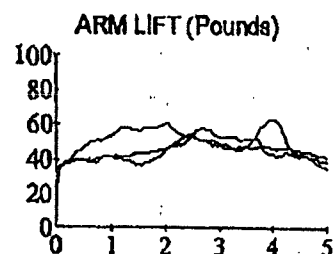
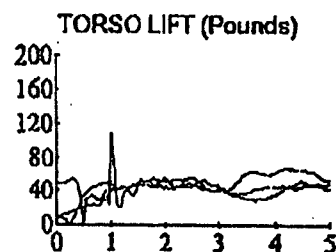
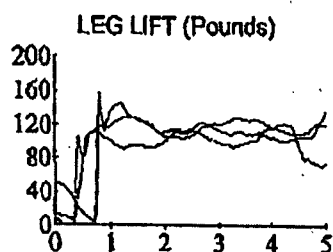
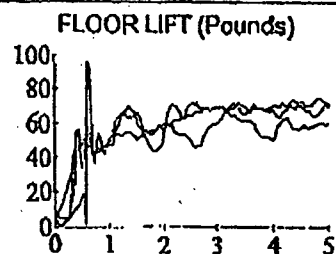
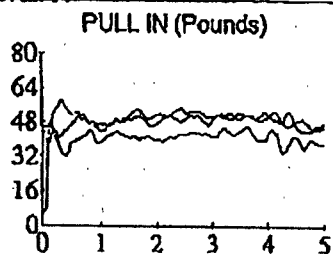


Table ST1 - Physical Demand Characteristics Of Work (Dictionary of Occupational Titles - Volume II, Fourth Edition, Revised 1991)			
Physical Demand Level	OCCASIONAL 0-33% of the workday	FREQUENT 34-66% of the workday	CONSTANT 67-100% of the workday
Sedentary	1 - 10 lbs.	Negligible	Negligible
Light	11 - 20 lbs.	1 - 10 lbs.	Negligible
Medium	21 - 50 lbs.	11 - 25 lbs.	1 - 10 lbs.
Heavy	51 - 100 lbs.	26 - 50 lbs.	11 - 20 lbs.
Very Heavy	Over 100 lbs.	Over 50 lbs.	Over 20 lbs.

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VerNova MTM Functional Abilities Evaluation:

VerNova MTM evaluates occupational Physical Demand Characteristics (PDC) based on Methods-Time Measurement (MTM) data, the most widely developed and validated work analysis system in the world. MTM data is used to establish fair labor standards by numerous employers and unions and has been accepted in the courts and in arbitration as a valid standard of work performance. The MTM system has been used in personnel selection and disability evaluation for thirty years (Ackler and Thompson, 1960; Anderson and Edstrom; Birdsong, 1972; Birdsong and Chyatto, 1970; Brickley, Drewes, 1961; Farrell, 1993; Foulke; Grant et al., 1975; Mink, 1975; McQuaid and Winkler; Poncke; Todd et al., 1979; Wilcock, 1980; Wilcock and Mink, 1982; Yokomizo, 1985).

An evaluatee's demonstrated ability in the assessment is compared to the MTM Industrial Standard (IS), the time it takes an average worker with average skill to perform a specific motion throughout an average eight hour day (Karger and Hancock, 1982; Karger and Bayha, 1987; Maynard et al., 1948; MTM Assoc, 1972, 1980).

The VerNova MTM Report presents data from the evaluation in tabular form, as shown and defined below:

Trial	Body Side	Wgt/Pos.	Dist/Plane	Reps	Time (sec)	% IS	CV (%)	PE:HR	Time Set Completed

Trial	Count of repetitions of the identical task, repeated for consistency and endurance measurement. A series of Trials comprise a Set. MTM tests may consist of several sets of data.
Body Side	Indicating if the activity was performed with the right, left or both body members, if applicable. Dominant side, if applicable, is indicated by "Dom."
Wgt/Pos.	The weight of the object being handled in the activity, or the body position used for this activity (varies by activity).
Dist/Plane	Distance over which the activity was performed (for return trips, the distance is one way through the round trip), or the plane in which the activity was performed (varies by activity).
Reps	Repetitions that the activity was performed through the distance noted. Definition of Reps is presented in each table footnote.
Time (sec)	The evaluatee's time to perform a single trial of the activity.
% IS	The evaluatee's time compared to the Industrial Standard (IS) time, and reported as a percentage of the IS. An evaluatee can score at, above or below 100% IS, representing an ability that meets, exceeds or falls below the Industrial Standard for that activity.
CV (%)	Coefficient of variance (CV) is a statistical representation of consistency of evaluatee trial times. A minimum of three trials must be collected to calculate a CV. The empirically derived CV for MTM data is 8%. This evaluation uses a consistency threshold of 10% to allow for a 'learning curve' that is present in these activities. Many factors can affect test scores, including physical impairment, environmental conditions and motivation. CV's slightly greater than 10% should not automatically be interpreted as indication of lack of evaluatee reliability. Reliability must be determined by a suitably qualified evaluator. This data is computed at the end of a set, hence the CV is presented in the Avg table row for sets with three or more trials. When multiple sets are performed, the CV reported in the MTM Summary Table is calculated from all trials and thus does NOT represent the consistency within sets. The reader should refer to the MTM details for valid consistency data.
PE:HR	The Borg Perceived Exertion (PE) Scale is a self-report scale of degree of exertion the evaluatee perceived during the activity. Heart Rate (HR), if present, is the evaluatee's measured heart rate. Perceived exertion "integrates various information, including the many signals elicited from the peripheral muscles and joints, from the central cardiovascular and respiratory functions, and from the central nervous system" (Borg, 1982). This data is optionally collected at the end of a set, hence PE and HR are shown in the Avg row.
Time Set Completed	The time (recorded by the computer) when the last trial of the set of activity was completed.
<i>The following items appear within or below the table of results</i>	
Avg: S1	The averages per set (i.e. S1 represents Set 1). Evaluatee time is averaged across all trials, the average time forms the basis for a comparison to the Industrial Standard to calculate the average % IS.
Comments (listed below results table)	Evaluator notation of inappropriate body mechanics and/or presence of symptom complaints by evaluatee is indicated by a ☒ . Comments in reference to the completed set of activity follow if noted by the evaluator. Pictures associated with the activity are presented to the right of the comments box if the evaluator indicated a picture for the activity.

Tommy G. Houston - 785000591

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VerNova MTM Functional Abilities Summary

Methods-Time Measurement (MTM) data provides a quantifiable description of the functions required of a worker in the performance of certain physical job demands. An evaluator's demonstrated ability in the assessment is compared to the MTM Industrial Standard (IS), which is the time an average worker with average training could perform the listed activity, assuming the activity is performed over an average eight hour day. Percent of Industrial Standard (%IS) is the evaluator's demonstrated ability as a percent of the Industrial Standard, where 100% and up indicates performance at or above the Standard, while below 100% indicates performance below the Standard.

Figure 1 - Percent of Industrial Standard Rating Chart

Activity	Date Time	CV ¹	%IS	<30	40	50	60	70	80	90	100	110	120	130	140+
Walk - 12 Ft	3/25/2013 15:41	2.6	94.5												
Walk - 12 Ft	4/10/2013 15:46	2.3	84.8												
Carry - 10 Lb	3/25/2013 15:44	3.4	121.5												
Carry - 20 Lb	3/25/2013 15:44	1	118.3												
Carry - 50 Lb	3/25/2013 15:44	1.9	107.8												
Carry - 10 Lb	4/10/2013 15:48	1	117.2												
Carry - 20 Lb	4/10/2013 15:48	2.3	110.9												
Carry - 50 Lb	4/10/2013 15:48	1.8	116.2												
Stoop	3/25/2013 15:51	0.3	53.7												
Stoop	4/10/2013 15:54	8.7	101.2												
Reach Immediate (L)	3/25/2013 15:55	6.2	105.1												
Reach Immediate (R)	3/25/2013 15:55	5.6	95.9												
Reach Immediate (L)	4/10/2013 15:57	15.6	158.1												
Reach Immediate (R)	4/10/2013 15:57	13.3	121.1												
Reach Overhead (L)	3/25/2013 15:59	4.2	97.4												
Reach Overhead (R)	3/25/2013 15:59	14.1	67.9												
Reach Overhead (L)	4/10/2013 16:01	6.6	129.2												
Reach Overhead (R)	4/10/2013 16:01	5.2	78.7												
PDC Category →				<30	40	50	60	70	80	90	100	110	120	130	140+
				Occasional ²				Frequent ³				Constant ⁴			

¹ Coefficient of Variance. If value is underlined, CV calculated for multiple test sets. For CV > 10%, value is shaded to call attention to results that may indicate a problem in consistency or ability to perform this task.

² Occasional - allows 31-70% Rest Allowance Standard (RAS) from the IS, or activity performed 0 - 2.6 hours/day

³ Frequent - allows up to 30% RAS from the IS, or activity performed 2.7 - 5.33 hours/day

⁴ Constant - allows no RAS, or activity performed 5.33 - 8 hours/day

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Walk:

(tested 3/25/2013)

Trial	Body Side	Weight	Distance	Reps	Time (sec)	% IS	CV (%)	PE:HR	Time Set Completed
1	None	None	12 Ft	3	27.7	92.4			
2	None	None	12 Ft	3	27.5	93.1			
3	None	None	12 Ft	3	26.1	98.1			
Avg: S1	None	None	12 Ft	3	27.1	> 94.5 <	2.6	n/a : n/a	15:43

(Reps indicates Return Trips for this activity)

Comments for Walk, by Set (e.g. S1)

S1: ☐ Inappropriate Body Mechanics ☐ Symptom Complaints or Behaviors
2/10

Walk:

(tested 4/10/2013)

Trial	Body Side	Weight	Distance	Reps	Time (sec)	% IS	CV (%)	PE:HR	Time Set Completed
1	None	None	12 Ft	3	30.8	83.1			
2	None	None	12 Ft	3	29.2	87.7			
3	None	None	12 Ft	3	30.5	83.9			
Avg: S1	None	None	12 Ft	3	30.2	> 84.8 <	2.3	n/a : n/a	15:48

(Reps indicates Return Trips for this activity)

Comments for Walk, by Set (e.g. S1)

S1: ☐ Inappropriate Body Mechanics ☐ Symptom Complaints or Behaviors
4/10

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Carry:

(tested 3/25/2013)

Trial	Body Side	Weight	Distance	Reps	Time (sec)	% IS	CV (%)	PE:HR	Time Set Completed
1	Both	10 Lb	12 Ft	1	8.0	124.5			
2	Both	10 Lb	12 Ft	1	8.0	124.5			
3	Both	10 Lb	12 Ft	1	8.6	115.8			
Avg: S1	Both	10 Lb	12 Ft	1	8.2	> 121.5 <	3.4	n/a : n/a	15:45
1	Both	20 Lb	12 Ft	1	8.4	119.7			
2	Both	20 Lb	12 Ft	1	8.6	116.9			
3	Both	20 Lb	12 Ft	1	8.5	118.3			
Avg: S2	Both	20 Lb	12 Ft	1	8.5	> 118.3 <	1.0	9 : n/a	15:47
1	Both	50 Lb	12 Ft	1	11.9	105.1			
2	Both	50 Lb	12 Ft	1	11.4	109.7			
3	Both	50 Lb	12 Ft	1	11.5	108.8			
Avg: S3	Both	50 Lb	12 Ft	1	11.6	> 107.8 <	1.9	n/a : n/a	15:49

(Reps indicates Return Trips for this activity)

Comments for Carry, by Set (e.g. S1)

S1: ☐ Inappropriate Body Mechanics ☐ Symptom Complaints or Behaviors
2/10S2: ☐ Inappropriate Body Mechanics ☐ Symptom Complaints or Behaviors
4/10 left lumbar and glutS3: ☐ Inappropriate Body Mechanics ☐ Symptom Complaints or Behaviors
8/10 left and glut lumbar - more antalgic gait noted

Carry:

(tested 4/10/2013)

Trial	Body Side	Weight	Distance	Reps	Time (sec)	% IS	CV (%)	PE:HR	Time Set Completed
1	Both	10 Lb	12 Ft	1	8.4	118.6			
2	Both	10 Lb	12 Ft	1	8.6	115.8			
3	Both	10 Lb	12 Ft	1	8.5	117.2			
Avg: S1	Both	10 Lb	12 Ft	1	8.5	> 117.2 <	1.0	n/a : n/a	15:50
1	Both	20 Lb	12 Ft	1	9.3	108.1			
2	Both	20 Lb	12 Ft	1	9.1	110.5			
3	Both	20 Lb	12 Ft	1	8.8	114.2			
Avg: S2	Both	20 Lb	12 Ft	1	9.1	> 110.9 <	2.3	n/a : n/a	15:51
1	Both	50 Lb	12 Ft	1	10.9	114.8			
2	Both	50 Lb	12 Ft	1	10.9	114.8			
3	Both	50 Lb	12 Ft	1	10.5	119.1			
Avg: S3	Both	50 Lb	12 Ft	1	10.8	> 116.2 <	1.8	n/a : n/a	15:53

(Reps indicates Return Trips for this activity)

Comments for Carry, by Set (e.g. S1)

S1: ☐ Inappropriate Body Mechanics ☐ Symptom Complaints or BehaviorsS2: ☐ Inappropriate Body Mechanics ☐ Symptom Complaints or Behaviors
7/10 lumbar leftS3: ☐ Inappropriate Body Mechanics ☐ Symptom Complaints or Behaviors
9/10 lumbarPIEDMONT ORTHOPEDICS
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Stoop:

(tested 3/25/2013)

Trial	Body Side	Weight	Distance	Reps	Time (sec)	% IS	CV (%)	PE:HR	Time Set Completed
1	Dom.	<2 Lb	None	6	24.6	53.5			
2	Dom.	<2 Lb	None	6	24.4	53.9			
3	Dom.	<2 Lb	None	6	24.5	53.7			
Avg: S1	Dom.	<2 Lb	None	6	24.5	> 53.7 <	0.3	n/a : n/a	15:54

(Reps indicates Return Trips for this activity)

Comments for Stoop, by Set (e.g. S1)

S1: ☐ Inappropriate Body Mechanics ☐ Symptom Complaints or Behaviors
7.5/10 left lumbar

Stoop:

(tested 4/10/2013)

Trial	Body Side	Weight	Distance	Reps	Time (sec)	% IS	CV (%)	PE:HR	Time Set Completed
1	Dom.	<2 Lb	None	6	14.6	90.1			
2	Dom.	<2 Lb	None	6	12.3	106.9			
3	Dom.	<2 Lb	None	6	12.1	108.7			
Avg: S1	Dom.	<2 Lb	None	6	13.0	> 101.2 <	8.7	n/a : n/a	15:56

(Reps indicates Return Trips for this activity)

Comments for Stoop, by Set (e.g. S1)

S1: ☐ Inappropriate Body Mechanics ☐ Symptom Complaints or Behaviors
7/10 lumbar

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Reach Immediate:

(tested 3/25/2013)

Trial	Body Side	Position	Plane	Reps	Time (sec)	% IS	CV (%)	PE-HR	Time Set Completed
1	Right	Sitting	Front	6	7.3	91.7			
2	Right	Sitting	Front	6	6.4	104.6			
3	Right	Sitting	Front	6	6.4	104.6			
Avg: S1	Right	Sitting	Front	6	6.7	> 99.9 <	6.3	n/a : n/a	15:56
1	Left	Sitting	Front	6	6.2	108.0			
2	Left	Sitting	Front	6	5.9	113.5			
3	Left	Sitting	Front	6	5.9	113.5			
Avg: S2	Left	Sitting	Front	6	6.0	> 111.6 <	2.4	n/a : n/a	15:57
1	Right	Sitting	Side	6	7.6	88.1			
2	Right	Sitting	Side	6	7.3	91.7			
3	Right	Sitting	Side	6	6.7	99.9			
Avg: S3	Right	Sitting	Side	6	7.2	> 93.0 <	5.2	n/a : n/a	15:58
1	Left	Sitting	Side	6	6.3	106.3			
2	Left	Sitting	Side	6	6.4	104.6			
3	Left	Sitting	Side	6	6.4	104.6			
Avg: S4	Left	Sitting	Side	6	6.4	> 105.2 <	0.7	n/a : n/a	15:58
1	Right	Sitting	Across	6	7.2	93.0			
2	Right	Sitting	Across	6	7.0	95.7			
3	Right	Sitting	Across	6	7.0	95.7			
Avg: S5	Right	Sitting	Across	6	7.1	> 94.8 <	1.3	n/a : n/a	15:59
1	Left	Sitting	Across	6	7.2	93.0			
2	Left	Sitting	Across	6	6.9	97.0			
3	Left	Sitting	Across	6	6.3	106.3			
Avg: S6	Left	Sitting	Across	6	6.8	> 98.5 <	5.5	n/a : n/a	15:59

(Reps indicates Return Trips for this activity)

Comments for Reach Immediate, by Set (e.g. S1)	
S1: ☐ Inappropriate Body Mechanics	☐ Symptom Complaints or Behaviors
S2: ☐ Inappropriate Body Mechanics	☐ Symptom Complaints or Behaviors
S3: ☐ Inappropriate Body Mechanics	☐ Symptom Complaints or Behaviors
S4: ☐ Inappropriate Body Mechanics	☐ Symptom Complaints or Behaviors
S5: ☐ Inappropriate Body Mechanics	☐ Symptom Complaints or Behaviors
S6: ☐ Inappropriate Body Mechanics	☐ Symptom Complaints or Behaviors
no c/o	

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04/10/13 - Page 11

Reach Immediate:

(tested 4/10/2013)

Trial	Body Side	Position	Plane	Reps	Time (sec)	% IS	CV (%)	PE:HR	Time Set Completed
1	Right	Sitting	Front	6	4.8	139.5			
2	Right	Sitting	Front	6	4.6	145.6			
3	Right	Sitting	Front	6	4.4	152.2			
Avg: S1	Right	Sitting	Front	6	4.6	> 145.6 <	3.5	n/a : n/a	15:58
1	Left	Sitting	Front	6	3.7	181.0			
2	Left	Sitting	Front	6	3.6	186.0			
3	Left	Sitting	Front	6	3.1	216.0			
Avg: S2	Left	Sitting	Front	6	3.5	> 193.2 <	7.6	n/a : n/a	15:58
1	Right	Sitting	Side	6	6.0	111.6			
2	Right	Sitting	Side	6	6.3	106.3			
3	Right	Sitting	Side	6	6.1	109.8			
Avg: S3	Right	Sitting	Side	6	6.1	> 109.2 <	2.0	n/a : n/a	15:59
1	Left	Sitting	Side	6	4.4	152.2			
2	Left	Sitting	Side	6	4.7	142.5			
3	Left	Sitting	Side	6	4.7	142.5			
Avg: S4	Left	Sitting	Side	6	4.6	> 145.6 <	3.1	n/a : n/a	15:59
1	Right	Sitting	Across	6	6.4	104.6			
2	Right	Sitting	Across	6	5.9	113.5			
3	Right	Sitting	Across	6	6.2	108.0			
Avg: S5	Right	Sitting	Across	6	6.2	> 108.6 <	3.3	n/a : n/a	16:00
1	Left	Sitting	Across	6	5.4	124.0			
2	Left	Sitting	Across	6	4.7	142.5			
3	Left	Sitting	Across	6	4.7	142.5			
Avg: S6	Left	Sitting	Across	6	4.9	> 135.7 <	6.7	n/a : n/a	16:00

(Reps indicates Return Trips for this activity)

Comments for Reach Immediate, by Set (e.g. S1)	
S1: ☐ Inappropriate Body Mechanics	☐ Symptom Complaints or Behaviors
S2: ☐ Inappropriate Body Mechanics	☐ Symptom Complaints or Behaviors
S3: ☐ Inappropriate Body Mechanics	☐ Symptom Complaints or Behaviors
S4: ☐ Inappropriate Body Mechanics	☐ Symptom Complaints or Behaviors
S5: ☐ Inappropriate Body Mechanics	☐ Symptom Complaints or Behaviors
S6: ☐ Inappropriate Body Mechanics	☐ Symptom Complaints or Behaviors

4/10 right shoulder

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Reach Overhead:

(tested 3/25/2013)

Trial	Body Side	Position	Plane	Reps	Time (sec)	% IS	CV (%)	PE:HR	Time Set Completed
1	Right	Sitting	Front	6	12.5	53.6			
2	Right	Sitting	Front	6	10.7	62.6			
3	Right	Sitting	Front	6	10.1	66.3			
Avg: S1	Right	Sitting	Front	6	11.1	> 60.3 <	9.2	n/a : n/a	16:01
1	Left	Sitting	Front	6	6.9	97.0			
2	Left	Sitting	Front	6	7.3	91.7			
3	Left	Sitting	Front	6	7.2	93.0			
Avg: S2	Left	Sitting	Front	6	7.1	> 93.9 <	2.4	n/a : n/a	16:01
1	Right	Sitting	Side	6	9.8	68.3			
2	Right	Sitting	Side	6	8.3	80.7			
3	Right	Sitting	Side	6	8.5	78.8			
Avg: S3	Right	Sitting	Side	6	8.9	> 75.5 <	7.5	n/a : n/a	16:02
1	Left	Sitting	Side	6	6.6	101.5			
2	Left	Sitting	Side	6	6.8	98.5			
3	Left	Sitting	Side	6	6.5	103.0			
Avg: S4	Left	Sitting	Side	6	6.6	> 100.9 <	1.9	n/a : n/a	16:02

(Reps indicates Return Trips for this activity)

Comments for Reach Overhead, by Set (e.g. S1)	
S1: ☐ Inappropriate Body Mechanics	☐ Symptom Complaints or Behaviors
S2: ☐ Inappropriate Body Mechanics	☐ Symptom Complaints or Behaviors
S3: ☐ Inappropriate Body Mechanics	☐ Symptom Complaints or Behaviors
S4: ☐ Inappropriate Body Mechanics	☐ Symptom Complaints or Behaviors

3/10 right shoulder

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2

Tommy G. Houston - 785000591

04/10/13 - Page 13

Reach Overhead:

(tested 4/10/2013)

Trial	Body Side	Position	Plane	Reps	Time (sec)	% IS	CV (%)	PE:HR	Time Set Completed
1	Right	Sitting	Front	6	9.4	71.2			
2	Right	Sitting	Front	6	8.7	77.0			
3	Right	Sitting	Front	6	8.1	82.7			
Avg: S1	Right	Sitting	Front	6	8.7	> 76.7 <	6.1	n/a : n/a	16:02
1	Left	Sitting	Front	6	5.8	115.4			
2	Left	Sitting	Front	6	5.0	133.9			
3	Left	Sitting	Front	6	5.1	131.3			
Avg: S2	Left	Sitting	Front	6	5.3	> 126.3 <	6.7	n/a : n/a	16:02
1	Right	Sitting	Side	6	8.5	78.8			
2	Right	Sitting	Side	6	8.2	81.7			
3	Right	Sitting	Side	6	8.2	81.7			
Avg: S3	Right	Sitting	Side	6	8.3	> 80.7 <	1.7	n/a : n/a	16:03
1	Left	Sitting	Side	6	5.4	124.0			
2	Left	Sitting	Side	6	5.1	131.3			
3	Left	Sitting	Side	6	4.7	142.5			
Avg: S4	Left	Sitting	Side	6	5.1	> 132.2 <	5.7	n/a : n/a	16:03

(Reps indicates Return Trips for this activity)

Comments for Reach Overhead, by Set (e.g. S1)S1: ☐ Inappropriate Body Mechanics ☐ Symptom Complaints or BehaviorsS2: ☐ Inappropriate Body Mechanics ☐ Symptom Complaints or BehaviorsS3: ☐ Inappropriate Body Mechanics ☐ Symptom Complaints or BehaviorsS4: ☐ Inappropriate Body Mechanics ☐ Symptom Complaints or Behaviors
5/10 right shoulder

PIEDMONT ORTHOPAEDICS
COPY

Houston, Tommy

Sex:M

BD:02/18/1956

MR#:250066276

Print this Page
PT#:48000031822

HISTORY AND PHYS

Mar 11, 2008 08:00

GREENVILLE HOSPITAL SYSTEM
MEDICAL RECORD

NAME: HOUSTON, TOMMY GREGORY ROOM NO:

PATIENT MR#: 000-250-06-6278

Billing NO: 080010319565

PATIENT SS#: 250-06-6278

DATE OF SURGERY: 03/11/2008

DATE OF ADMISSION: 03/11/06

CHIEF COMPLAINT: Motor vehicle collision with right side pain.

HISTORY OF PRESENT ILLNESS: A 53-year-old white male was riding in the rear of an armored car when he was struck from behind. He complained of right chest pain. There was no shortness of breath and no loss of consciousness. He was seen by the emergency room physician, evaluated, and found to have a negative fast exam and some right rib tenderness. He underwent a chest x-ray which showed right rib fractures. Pelvis x-ray was negative. Also complained of some left knee pain, however was able to move his knee.

PAST MEDICAL HISTORY: Positive for hypertension.

PREVIOUS SURGERY: Bilateral inguinal hernia repair.

ALLERGIES: CODEINE.

SOCIAL HISTORY: Positive for tobacco, one pack of cigarettes per day for 15 years.

FAMILY HISTORY: Positive for hypertension.

REVIEW OF SYSTEMS: Positive for right chest wall pain, right flank pain, and left knee pain. The remainder of the 10-point review of systems is negative.

PHYSICAL EXAMINATION:

VITAL SIGNS: Blood pressure 226/109, respirations 14, pulse 80, O2 saturation 97%.

HEENT: Normal.

CHEST: Clear. He is tender on the right rib cage to palpation.

CARDIAC: Shows a regular rate with no murmurs.

ABDOMEN: Soft and nontender. Local abdominal sonogram for trauma was negative in all 4 area.

PELVIS: Nontender.

GENITOURINARY: He has had no blood in the urethral meatus.

BACK: His back is nontender. There is no step-off.

EXTREMITIES: Small abrasion on the left forearm.

NEUROLOGIC: Moves all extremities. Glasgow coma scale is 15. There are palpable pulses in all extremities.

Chest x-ray showed multiple rib fractures on the right. Pelvis is negative. We did get a CT of the chest, abdomen, and pelvis which are all pending.

DIAGNOSIS: Motor vehicle collision and multiple rib fractures.

PLAN: Admit for observation, pain control, and we will check his CT scan.

Joseph Camunas, MD

cc: Joseph Camunas, MD

D: 03/11/2008 5:47 P T: 03/11/2008 6:51 P zcc DVI: 000232693

C/S#: 2452963

 Print this Page

Houston, Tommy Gregory

Sex:M

BD:02/18/1956

MR#:250066278

PT#:8010319565

OUTPATIENT NOTES

Mar 21, 2008 08:00

UNIVERSITY MEDICAL GROUP

DEPARTMENT OF SURGERY

GENERAL SURGERY

35 MEDICAL RIDGE DRIVE

GREENVILLE, SOUTH CAROLINA 29605

PHONE (864) 232-0055. FAX (864) 232-0499

PATIENT: HOUSTON, TOMMY GREGORY

SSN: 250-06-6278

March 21, 2008

CHIEF COMPLAINT: Fifty-two year old white male status post MVA for follow-up from a hospital visit for the motor vehicle collision. He had some right-sided flank pain. CT from that time just showed some healing rib fractures on the right. He is here for follow-up of this. His soreness is slightly improved but he still has some moderate-to-severe pain and does have, in particular, pain in the right side when he is lying on that right side. Otherwise he denies any history of chest pain or shortness of breath since the accident on Tuesday. Also denies any history of fevers, weakness, focal or neurologic deficits and no fevers. No dysuria. No hematuria. No melena. The patient was found to have gallstones on his CT that was performed at that time. He denies any history of postprandial pain. No pain with fatty foods. No nausea. No decreased po intake. No poor appetite. No weight changes.

PAST MEDICAL HISTORY: Hypertension and history of CVA.

SURGICAL HISTORY: Hernia repair in September 2007 bilaterally and knee and wrist surgery in approximately 1978.

MEDICATIONS: Metoprolol, Clonidine, and Lisinopril

ALLERGIES: Codeine which causes a rash and pruritus

FAMILY HISTORY: Noncontributory.

SOCIAL HISTORY: The patient is a one pack per day smoker times 20 years. He denies any alcohol use.

REVIEW OF SYSTEMS: Positive for some heartburn otherwise ten point review of systems is negative.

PHYSICAL EXAMINATION: Weight 205 pounds, height 5'10". Neck is general and oriented white male in no acute distress. HEENT head normocephalic, atraumatic. Mucous membranes are moist. Pharynx is normal. Neck is supple. Cardiovascular: Regular rate and rhythm. No murmurs, rubs, or gallops. Respiratory: Lungs are clear to auscultation bilaterally. The patient has no flaring and no retraction and no evidence of any respiratory distress. Respiratory rate is normal. Abdomen is soft. Positive bowel sounds.

Nontender. No hepatosplenomegaly. The patient does have some flank tenderness in approximately the area of the ribs he had previously injured with no acute injury to them. He doesn't have any spinal tenderness.

Extremities: No edema. No tenderness.

LABORATORIES AND STUDIES REVIEWED: CBC was normal. CMP was also reviewed and was normal.

CT was reviewed and shows multiple healed and chronic nonunion right-sided rib fractures. No acute rib, thoracic, or lumbar spine injuries.

Incidental note of a small persistent left-sided superior vena cava with some fatty liver infiltration, gallstones without signs of cholecystitis, and a small 1.7 cm low density lesion in the right kidney probably representing a cyst but ultrasound is suggested.

ASSESSMENT AND PLAN: This is a 52-year-old white male status post MVA with some bruising. No evidence of acute injury. The patient does have

gallstones that are asymptomatic at this time. Also has note of a cystic lesion on the kidney and will follow-up in two weeks. At that time a renal ultrasound will be done to further follow-up on this.

for

Blythe S. Winchester, MD

BSW/af

Joseph A. Camunas, MD

T: 03/24/08

Page created Friday April 4, 2008 1 13 PM For FNWC3A

Top of Page

0



GREENVILLE (060053)
1 Cannon Drive
Greenville, SC 29605
(864) 242-4011
(864) 233-2877

TH616545

Final Report

Patient Name: HOUSTON, TOMMY
DOB: 02/18/1956 **Sex:** M
Accession: 3040536
Visit Number: 1049385
Exam: (53) MRISLDWO - SHOULDER WO CONTRAST MRI RT

MRN: 2258969

Completed: 05/14/2008 4:28 PM EDT

Requesting Provider: WESSINGER MD, PHILIP
727 SE MAIN ST.
SIMPSONVILLE, SC 29681

Phone: (864) 454-6600

Fax: (864) 454-6605

MRI RIGHT SHOULDER

HISTORY: Right shoulder pain. Motor vehicle accident March 11, 2008.

TECHNICAL: Axial PD fat sat, coronal T2 fat sat. PD and T2, sagittal PD and T2-weighted images of the right shoulder were obtained.

FINDINGS: Long head of the biceps tendon appears intact. There may be an accessory ossification center at the lateral aspect of the acromion. Mild and small osteophyte is identified at the inferior aspect of the clavicle laterally. Subacromial joint space appears borderline at 6 mm. Some degenerative blunting of the superior labrum is identified but no acute tear. There is tendinopathy-type signal change along the articular surface of the subscapularis tendon. No acute tear. There appears to be either a near-full-thickness tear of a full-thickness tear at the anterior aspect of the supraspinatus tendon at its insertion site best appreciated on sagittal image #5, coronal image #14 and 15. Some tendinopathy-type signal change is identified along the bursal surface of the supraspinatus tendon more posteriorly near the musculotendinous junction. The infraspinatus muscle and tendon appear unremarkable. The teres minor muscle and tendon appear normal. There appears to be some subchondral cystic change within the acromion process near the acromioclavicular joint along the inferior margin. Fibrocystic changes are identified in the humeral head anterolaterally adjacent to the bicipital groove.

CONCLUSION:

- 1) NEAR-FULL-THICKNESS-PARTIAL TEAR OF THE SUPRASPINATUS TENDON ANTERIORLY NEAR ITS INSERTION SITE.
- 2) TENDINOPATHY-TYPE SIGNAL CHANGES WITHIN THE SUBSCAPULARIS TENDON WITHOUT ACUTE TEAR.
- 3) MILD ACROMIOCLAVICULAR JOINT OSTEOARTHRITIC CHANGE.



GREENVILLE (060053)
† Cannon Drive
Greenville, SC 29605
(864) 242-4011
(864) 233-2677

Final Report

Patient Name: HOUSTON, TOMMY
DOB: 02/18/1956 **Sex:** M
Accession: 3040536
Visit Number: 1049385
Exam: (53) MRISHLW - SHOULDER WO CONTRAST MRI RT

MRN: 2258969

Completed: 05/14/2008 4:28 PM EDT

Requesting Provider: WESSINGER MD, PHILIP
727 SE MAIN ST.
SIMPSONVILLE, SC 29681

Phone: (864) 454-6600

Fax: (864) 454-6605

End of diagnostic report for accession:3040536

Interpreting Provider: MAMRICK MD, RICHARD RADIOLOGIST
Transcribed By: LW 05/15/2008 2:06 PM EDT
Signed By: MAMRICK MD, RICHARD 05/15/2008 4:03 PM EDT

2



INNERVISION

MEDICAL IMAGING CENTER

One Marcus Drive Greenville, SC 29615
Phone (864) 289-9977 Fax (864) 751-2050
www.innervisionmedical.com

PATIENT: Houston, Tommy
DOB: 2/18/1956
MRN: 722650
PHYSICIAN: Phillip Wessinger, MD
DATE: 9/8/2010

EXAM: MRI OF THE RIGHT SHOULDER

HISTORY: Right shoulder pain. MVA 03-08. Injury and shoulder surgery. Pain with weakness. Decreased grip strength.

TECHNIQUE: Axial FSPD. Oblique COR T1, FSPD, and FS T2. Oblique SAG FS T2. Exam performed on an 18-channel 1.5 Tesla Siemens Espree large bore MRI system with a 550 lb. weight limit at Innervision-Eastside.

FINDINGS: Status post supraspinatus tendon repair and without re-tear. There is increased signal within the terminal and distal aspect of the supraspinatus tendon to its insertion or anchor. There has been an interval increase in abnormal signal within the distal 25mm of the infraspinatus tendon which reflects tendinosis primarily. Small amount of subacromial-subdeltoid bursal fluid. Mild acute on chronic AC arthropathy. Small superior and inferior AC joint osteophytes. Type II acromion configuration. Displacement of the fat plane inferior to the AC joint.

No subscapularis or teres minor tear. No rotator cuff muscle belly edema or atrophy.

No abnormal glenohumeral joint fluid. Proliferative bone changes of the greater tuberosity as well as along the anterior aspect of the proximal humerus medial to the lesser tuberosity. Mild signal changes within the anterior glenoid cartilage and base of the labrum. Mild irregularity and signal changes within the posterior labrum which may signify fraying or tear. There has been a change in the appearance of the posterior labrum since the prior examination. Intact and normally positioned long head biceps tendon.

IMPRESSION:

1. No recurrent full-thickness rotator cuff tear. Status post supraspinatus tendon repair.
2. Questionable tear or fraying of the posterior labrum.
3. Primarily chronic AC arthropathy. Supraspinatus and infraspinatus tendinosis.

Jeff Shramek, MD
JS / kp

DD: 9/9/2010
DT: 9/9/2010
Job: 11292709

This document has been electronically reviewed and signed.

Jeffrey K. Shramek, MD.

Patient: Houston, Tommy
MRN: 722650
Exam: MRI OF THE RIGHT SHOULDER

Radiologist



INNERVISION

MEDICAL IMAGING CENTER

One Marcus Drive Greenville, SC 29615
Phone (864) 289-9977 Fax (864) 751-2050
www.innervisionmedical.com

PATIENT: Houston, Tommy
DOB: 2/18/1956
MRN: 722650
PHYSICIAN: Philip Wessinger, MD
DATE: 10/14/2010

EXAM: MRI OF THE LUMBAR SPINE WITHOUT CONTRAST

HISTORY: Low back pain. Two years post MVA. Low back pain radiates to the left leg with burning and numbness.

TECHNIQUE: Multi-sequence, multi-planar imaging was performed.

FINDINGS: Transitional lumbosacral anatomy. Please refer to the labelings on the images.

S1-2: Mild degeneration of the S1-2 disc, but without disc displacement.

L5-S1: Mild anterolisthesis of L-5 on S-1 secondary to facet disease. Mild degeneration of the disc and non-compressive disc bulge. Severe bilateral L5-S1 facet arthropathy. Obliteration of the left L5-S1 facet joint. Increased fluid within both L5-S1 facet joints. Large left L5-S1 medial facet osteophytes. Thickened ligamentum flavum and with posterolateral sac impressions. Moderate left and mild right S-1 lateral recess narrowings. Facet osteophytes produce severe left and moderate right L-5 bony neural foraminal narrowings.

L4-5: Mild degeneration of the disc. Mild annular bulge. This is non-compressive. Mild facet and ligamentous changes.

At T12-L1 through L3-4, there are no moderate or advanced disc degenerative changes. At these levels, there are no disc displacements.

Benign cavernous hemangioma within the lower one half of the L-4 vertebral body measures 11mm in size.

Hyperintense STIR signal within the L5 pedicles and facets. There are degenerative cysts associated with these STIR signal changes. Distended bilateral L4-5 and L5-S1 inferior recesses.

IMPRESSION: There is increased stress at the lumbosacral junction. Severe bilateral L5-S1 facet arthritis. Mild non-compressive L5-S1 disc bulge. Mild L4-5 disc bulge. Moderate left and milder right S-1 lateral recess narrowings. Moderate right and severe left L-5 bony neural foraminal stenoses. Does the patient have a left L-5 or S-1 radiculopathy? Are there symptoms more of a facet syndrome?

Jeff Shramek, MD
JS / kp

DD: 10/15/2010
DT: 10/15/2010
Job: 11528914

Patient: Houston, Tommy
MRN: 722650
Exam: MRI OF THE LUMBAR SPINE WITHOUT CONTRAST

This document has been electronically reviewed and signed.

Jeffrey K. Strametz, MD.

Neuroradiologist

INNERVISION MRI & IMAGINGInnervision
Innervision at Grove
Open MRI of Simpsonville

Grove

One Cannon Drive Greenville, SC 29605

Phone (864) 242-4011 Fax (864) 233-2677

PATIENT: Houston, Tommy
DOB: 2/18/1956
MRN: 722650
PATIENT PHONE: 864-855-0437
PHYSICIAN: Michael Buccl, MD
DATE: 6/2/2011

EXAM: FL-LUMBAR MYELOGRAM**HISTORY:** Spondylosis.**PROCEDURE:**

AP and lateral scout films were performed. Minimal anterolisthesis appreciated of L5. Endplate degenerative changes noted. Vertebral body heights maintained.

Procedure was explained to the patient and informed consent was obtained. The patient was then placed in a prone position on the fluoroscopy table and prepped and draped in a sterile manner. 1% lidocaine was used for local anesthesia. 22-gauge spinal needle was then advanced at the L4-5 level into the intrathecal space. Position was demonstrated by visualization of CSF in the hub of the needle. 20 mL of Isovue M 200 was then administered intrathecally. No complication or contrast reaction was appreciated. No obstruction to flow of contrast was noted. There is narrowing of the contrast column appreciated on the AP view at the L4-5 and L5-S1 levels from degenerative changes.

IMPRESSION: Fluoroscopically guided lumbar myelogram.

Christopher Sidden, M.D.
CS / bm

DD: 6/2/2011
DT: 6/2/2011
Job: 12908370

This document has been electronically reviewed and signed by Christopher Sidden, M.D.

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Innervision at Grove
Open MRI of Simpsonville

Grove

One Cannon Drive Greenville, SC 29605

Phone (864) 242-4011 Fax (864) 233-2677

PATIENT: Houston, Tommy
DOB: 2/18/1956
MRN: 722650
PATIENT PHONE: 864-855-0437
PHYSICIAN: Michael Buccl, MD
DATE: 6/2/2011

EXAM: CT SCAN OF THE LUMBAR SPINE WITH CONTRAST**HISTORY:** Back pain.**TECHNIQUE:** Axial imaging obtained of the lumbar spine after intrathecal administration of 20 mL of Isovue M200.**COMPARISON:** Study is compared to prior dated October 14, 2010.**FINDINGS:**

Transitional vertebral bodies are appreciated. Utilizing the numbering schema of the vertebral bodies from the prior study from October 14, 2010, there is Grade 1 anterolisthesis of L5 on S1. No pars defects appreciated. There is partial lumbarization appreciated of the S1 vertebral body with a rudimentary disc space. There are posterior element degenerative changes. There are rudimentary ribs appreciated at L1. There are endplate degenerative changes.

Conus is appreciated at T12-L1 and is unremarkable in appearance. No clumping or nodularity of the nerve roots of the cauda equina are appreciated.

L1-2: No posterior disc bulging or herniation. No central or foraminal stenosis.

L2-3: Mild posterior disc bulging. No central or foraminal stenosis.

L3-4: Mild posterior disc bulging. No central or foraminal stenosis.

L4-5: Mild posterior disc bulging and posterior facet hypertrophy. Mild bilateral proximal foraminal stenosis. No central stenosis.

L5-S1: Mild posterior disc bulging and posterior facet hypertrophy left greater than right with ligamentum flavum hypertrophy. Stenosis of the lateral recesses bilaterally left greater than right. Severe left and moderate to severe right foraminal stenosis from a combination of bony and disc degenerative changes.

S1-2: Posterior facet hypertrophy, left greater than right. Left transverse process is sacralized and right transverse process is lumbarized. No central stenosis detected. Mild right and moderate left foraminal narrowing from bony degenerative changes.

Atherosclerotic ectatic imaged aorta. Imaged retroperitoneal structures are otherwise grossly unremarkable.

IMPRESSION:

Transitional vertebral bodies. There is grade 1 anterolisthesis of L5 appreciated secondary to facet degenerative changes. No pars fractures are appreciated. There are multilevel degenerative changes from L4-5 through S1-2.

Christopher Sidden, M.D.
CS / CH

DD: 6/2/2011

PATIENT: Houston, Tommy

MRN: 722650

EXAM: CT SCAN OF THE LUMBAR SPINE WITH CONTRAST

DT: 6/2/2011

Job: 12909922

This document has been electronically reviewed and signed by Christopher Sidden, M.D.

This document has been electronically reviewed and signed by Christopher Sidden, M.D.



INNERRVISION

MEDICAL IMAGING CENTER

One Marcus Drive Greenville, SC 29615
Phone (864) 289-9977 Fax (864) 751-2050
www.innervisionmedical.com

PATIENT: Houston, Tommy
DOB: 2/18/1956
MRN: 722650
PATIENT PHONE: 864-855-0437
PHYSICIAN: Charles C Kanos, MD
DATE: 8/20/2012

EXAM: MRI LUMBAR SPINE WITHOUT CONTRAST

COMPARISON: Comparison made to 10/14/10.

HISTORY: MVA 03/08. Back and bilateral leg pain, left greater than right, left leg worse with numbness, tingling and burning. Lumbar strain.

TECHNIQUE: Sag/Ax T1 and T2 and sagittal STIR.

FINDINGS: L5-S1: Mild anterolisthesis of L5 on S1, disc degeneration, and disc bulge with severe facet arthropathy. Moderately thickened ligamentum flava.

L4-5: Mild degeneration of the disc and disc bulge. Mild-moderate facet and ligamentous changes.

L3-4: Mild degeneration of the disc and annular bulge.

L2-3: Mild degeneration of the disc and annular bulge.

Tip of the conus medullaris terminates appropriately.

S1-2: Mild degeneration of the disc but without disc displacement.

IMPRESSION: Severe bilateral L5-S1 facet arthropathy with grade I spondylolisthesis of L5 on S1 and disc bulge. Milder L4-5 and L3-4 disc bulges. No interval development of a lumbar disc extrusion.

Jeff Shramek, MD
JS / bl

DD: 8/20/2012
DT: 8/20/2012
Job: 15707043

This document has been electronically reviewed and signed.

Jeffrey K. Shramek, MD.

Neuroradiologist



SOUTH CAROLINA DIAGNOSTIC IMAGING

Innervision Medical Imaging Eastside
One Marcus Drive Greenville, SC 29615
p: (864) 242-2020 f: (864) 240-5776

PATIENT: HOUSTON, TOMMY
DOB: 02/18/1956
MRN: 722650
PHYSICIAN: JYOTI MATH, MD
EXAM DATE: 06/25/2013

EXAM: MR Right Knee Without Contrast

REASON FOR EXAM: right knee pain

ADDITIONAL HISTORY: MVA in 2008. Had to be cut out of the car. Multiple other injuries to his body. Anterior and lateral knee pain. Also swelling and numbness in the knee.

TECHNIQUE: Triplanar imaging of the right knee without contrast with water and fat sensitive techniques.

FINDINGS:

Medial joint: Mild mucoid degeneration but without tear. Unremarkable contour of the cartilage of the medial joint. Intact MCL.

Lateral joint: Extensively torn body, posterior horn, and anterior horn of the lateral meniscus with displaced meniscal tissue. Advanced grade chondromalacia of the lateral joint involving the lateral femoral condyle and the lateral tibial plateau. Minor subchondral marrow edema of the lateral tibial plateau with moderate lateral marginal osteophytes. Intact popliteus tendon as well as fibular collateral ligament and iliotibial band.

Intercondylar notch: Enthesophytes of the tibial spines. No acute ACL or PCL transection.

Patellofemoral joint: Intact quadriceps and patellar tendons. Small patellofemoral osteophytes. Mild subchondral marrow edema of the lateral patellar facet. Mild signal brightening of the cartilage of the lateral patellar facet with intermediate depth cartilage abnormality of the trochlear groove. Fluid is seen within the lateral gutters, more so to the lateral side. Minor signal brightening within the distal aspect of the iliotibial band.

IMPRESSION:

1. Extensive tear involving the entire lateral meniscus with displaced meniscal tissue. This may have been a bucket-handle tear based on this pattern but the handle of the bucket is no longer seen. There are some meniscal or cartilage tissue identified within the posterior aspect of the lateral tibiofemoral joint.
2. Advanced grade lateral tibiofemoral chondromalacia.
3. Intermediate severity chondromalacia of the trochlear groove.
4. Bakers cyst measures 5.4 cm CC.

Jeffrey K Shramek, MD

JS/fl

PIEDMONT ORTHOPAEDICS
COPY

Dec.:19. 2012 2:02AM SOUTHEASTERN NEUROSURGICAL

No. 4451 P. 1

727 7895181

OP Notes/GI Lab Results Report

Pt Name:	HOUSTON, TOMMY G	MRN:	250086278
Pt ID:	20101407384	Acct No:	08010702172
DOB:	02/8/1958	Age/Sex:	58Y/M
Adm DTime:	12/12/2012 06:37	Attn Dr:	Kanos, Charles MD
Nurse Sta:	GMH 20	Rm/Bed:	
Dx:			
Allrg:	ALLERGY HX REVIEWED BY RPH, Codeina, Penicillins		
Order Name:		Observation Date:	12/12/2012 08:00
Result Name:	OP Notes/GI Lab	Result Status:	Final Result

GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER
GREENVILLE MEMORIAL HOSPITAL
MEDICAL RECORD

NAME: HOUSTON, TOMMY GREGORY Patient Location: 08202405PM
PATIENT MR#: 000-250-06-6278 Billing NO: 080016702172
DATE OF PROCEDURE: 12/12/2012

PREOPERATIVE DIAGNOSES:

1. L5-S1 spondylolysis with grade 1 spondylolisthesis.
2. L5-S1 foraminal stenosis.
3. Severe intractable left lower extremity pain.

POSTOPERATIVE DIAGNOSES:

1. L5-S1 spondylolysis with grade 1 spondylolisthesis.
2. L5-S1 foraminal stenosis.
3. Severe intractable left lower extremity pain.

PROCEDURES:

1. L5-S1 posterior lumbar interbody fusion.
2. Orthofix Phoenix minimally disruptive L5-S1 pedicle screw fixation.
3. StaRx BEEK L5-S1 interbody fusion cage.
4. L5-S1 decompressive laminectomy.
5. L5-S1 total facetectomy.
6. L5-S1 foraminotomies.
7. Operative microscopic was used for microdissection.

SURGEON: Charles C. Kanos, MD

ANESTHESIA: General endotracheal anesthesia.

ESTIMATED BLOOD LOSS: One hundred mL.

COMPLICATIONS: None.

INDICATIONS:

1. L5-S1 spondylolysis with grade 1 spondylolisthesis.
2. L5-S1 foraminal stenosis.
3. Severe intractable left lower extremity pain.

DESCRIPTION OF PROCEDURE: The patient was taken to the operating room. Following general endotracheal anesthesia, the patient was placed prone on the OSI frame with all bony prominences padded. Lumbar region was sterilely prepared and draped. Fluoroscopic examination confirmed the L5-S1 interspace. The space was marked in midline, infiltrated with 1% lidocaine with epinephrine. Using a 10 blade, an incision was carried down through the skin, subcutaneous tissue. The lumbar dorsal fascia was exposed. Attention was then given to pedicle screw fixation. Utilizing simultaneous AP and lateral fluoroscopy, the Jamshidi needle was used to swl bilateral L5 and S1 pedicles under fluoroscopic confirmation. KR was

Pt Name: HOUSTON, TOMMY G

Rm/Bed:

Page 1 of 3

MRN: 250086278

OP Notes/GI Lab Results Report

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Printed On: 16-Dec-12 12:57

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GREENVILLE MEMORIAL HOSPITAL
COPY

No. 4451 P. 2

OP Notes/GI Lab Results Report

Pt Name:	HOUSTON, TOMMY G
----------	------------------

MRN: 250068278

PR ID: 20101407364

Acct No: 08016702172

DOB: 02/18/1868

Age/Sex: 66Y/M

Adm DTme: 12/12/2012 08:37

Attn Dr: Kenos. Charles MD

Nurse Sta: **GMH 2D**

Rm/Bed:

Öz:

Alrg: ALLERGY HX REVIEWED BY RPH, Codeine, Penicillins

Order Name:

Observation Date: 12/12/2012 08:00

Result Name:	OP Notes/GI Lab
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Result Status: Final Result

placed through the needle followed by a 5.5 mm tap. Bilateral 6.5 x 45 mm Orthofix Phoenix titanium pedicle screws were then placed into each pedicle with excellent purchase. There did not appear to be any pedicle disruption. The screw extenders were applied on the left sided screws later in the case. With the screw extenders on the right side attached, a 50 mm rod was measured and then passed percutaneously with no additional fascial wound into the screw heads. The construct was temporarily tightened under distraction. Attention was then given to the decompression and fusion. The lumbar dorsal fascia was divided, and the soft tissue was subperiosteally dissected off the spinous processes lamina on the left side at L5-S1. Levels were confirmed by fluoroscopy and the microscope was used for microdissection. Partial hemilaminectomy was performed with the Kerrison rongeurs. There was a severe facet arthropathy. Local bone harvest was retained. The hemilaminectomy was performed and the total facetectomy was performed. The decompression extended from the pedicle of L5 to the pedicle of S1. There was severe _____ exuberant osteophytes coming off the superior S1 facet and this appeared to markedly compress the _____ nerve root. Similarly, there was severe L5 foraminal stenosis due to the L5 facet arthropathy. Wide decompressions were performed until nerve hook went around the L5 and S1 roots and around the respective pedicles without any residual compression. Epidural veins were coagulated with bipolar cautery. The annulus was opened with an 11 blade. Discectomy was performed with pituitary pullers. The cartilaginous endplates were removed and the bony endplates were prepared for fusion. The copious local harvest was packed in the interspace. A 23 mm StaRx fusion cage was then passed into the disk space, tamped, countersunk 3 mm and expanded from 7 mm to 11 mm. There was an anatomic reduction and there was no over distraction. At this point, the decompression site hemostasis was achieved with bipolar cautery, Gelfoam thrombin, Surgiflo irrigation meticulously. The wound was bone dry. The right side screws were permanently tightened, and the screw sleeves were removed. The fascial wound for the screws and midline lumbar dorsal fascia was closed with 0 Vicryl interrupted fascia. At this point, the screw sleeves were placed on the existing left side at L5-S1 pedicle screws, and a 50 mm rod was placed in an identical fashion and permanently tightened under compression. Extra AP and lateral x-ray looked good. The fascia wounds were closed with 0 Vicryl interrupted fashion; subcutaneous subcuticular tissue were closed with 2-0 Vicryl interrupted fashion. Skin edges were closed with staples. Sterile dressing was applied. Sponge, needle and instrument counts were correct at the end of the case. There were no complications.

PL Name: HOUSTON, TOMMY B

MRN: 250066278

Return:

Page 2 of 3

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INP Noise/GI Lab Results Report

OR# 9125, 04/16/00 1.00

EDWARD B. KELLEY, NAGDY

Printed On: 18-Dec-12 15:57

Dec. 19. 2012 2:02AM

SOUTHEASTERN NEUROSURGICAL

OP Notes/GI Lab Results Report

Pt Name: HOUSTON, TOMMY G
PID: 20101407364
DOB: 02/18/1956
Adm DTime: 12/12/2012 08:37
Nurse Sta: OMH 2D
Dx:
Allrg:

MRN: 250066278
Acct No: 08016702172
Age/Sex: 56Y/M
Attn Dr: Kanos, Charles MD
Rm/Bed:

ALLERGY HX REVIEWED BY RPH, Codeine, Penicillins

Order Name:
Result Name: OP Notes/GI Lab

Observation DTime: 12/12/2012 08:00
Result Status: Final Result

Charles C. Kanos, MD
cc: Charles C. Kanos, MD
d: 12/12/2012 06:37 P
DVI: 644984 C/S#: 3768961

T: 12/13/2012 08:42 A zah

Comments
Result Comments:
Requisition Comments:

Ordering Dr: Order Date/Time:
Order Occurrence#: 1

PIEDMONT ORTHOPEDICS
COPY

Pt Name: HOUSTON, TOMMY G
Rm/Bed:

MRN: 250066278

Page 3 of 3

OP Notes/GI Lab Results Report
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Printed On: 18-Dec-12 16:57

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**SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
WCC NO. 0802605**

TOMMY G. HOUSTON,

Claimant,

vs.

GARDA WORLD SECURITY,

Employer,

and

GALLAGHER BASSETT SERVICES INC,

Carrier.

**NOTICE OF WITNESSES AND
WRITTEN REPORT(S) PHYSICIAN OR
OTHER EVIDENCE TO BE
INTRODUCED ON BEHALF OF THE
EMPLOYER/CARRIER**

**TO: SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION AND
KATHRYN WILLIAMS, ATTORNEY FOR CLAIMANT:**

YOU ARE HEREBY NOTIFIED THAT THE employer/carrier, pursuant to the provisions of the South Carolina Workers' Compensation Act and South Carolina Code §1-23-330 (1976, as amended), herewith submits the following reports/physicians or other evidence on behalf of the employer/carrier, to wit:

TAB	NAME OF PHYSICIAN/OTHER	DATE OF REPORTS	NO.
13	Dr. Phillip Wessinger	4/30/08-11/3/10	192-238
14	Piedmont Spine and Neurosurgical Group	4/21/11-6/28/11	239-249
15	Dr. Jyoti Math	8/18/11-12/16/13	250-291
16	Dr. Charles Kanos	8/1/12-4/24/13	292-308
17	Upstate Medical Rehabilitation	1/4/12-4/15/14	309-370
18	Dr. John Paylor	10/28/13-12/18/13	371-379
19	Bon Secours/St. Francis Hospital	1/21/13-4/10/13	380-402
20	Greenville Hospital System	3/11/08	403-405
21	Diagnostic Health	5/14/08	406-407
22	Innervisions	9/8/10-8/20/12	408-415
23	SC Diagnostic Imaging	6/25/13	416
24	Greenville Memorial Hospital	12/12/12	417-419

YOU ARE FURTHER HEREBY NOTIFIED that you have the right to cross-examination; and, should you desire to exercise said right, you are to forthwith schedule the deposition(s) of any of the physicians or other person(s), whose reports are submitted, for the purposes of cross-examination.

YOU ARE FURTHER HEREBY NOTIFIED that the originals of the documents referred herein, or photocopies received from said physicians/others, are being herewith forwarded to the South Carolina Workers' Compensation Commission, for insertion in the file of the South Carolina Workers' Compensation Commission and inclusion into evidence on behalf of the employer.

YOU ARE FURTHER NOTIFIED that the following witnesses may be called on behalf of the employer/carrier:

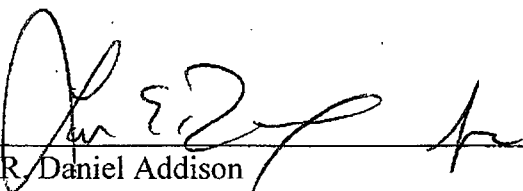
Claimant

Anyone named by Claimant

Dr. John Paylor (via deposition)

Dr. Jyoti Math (via deposition)

Dr. Phillip Wessinger (via deposition)


R. Daniel Addison
HEDRICK GARDNER KINCHELOE &
GAROFALO, LLP
P.O. Box 11267
Columbia, SC 29211
(803) 727-1200
Attorneys for Defendant(s)

November 4, 2014

**SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
WCC FILE NO. 0802605**

TOMMY G. HOUSTON,

Claimant,

vs.

GARDA WORLD SECURITY,

Employer,

and

GALLAGHER BASSETT SERVICES INC,

Carrier.

**APPELLANTS' BRIEF
TO THE FULL COMMISSION**

STATEMENT OF THE CASE

This claim was originally heard before Commissioner Aisha Taylor ("Single Commissioner") on November 14, 2014, in Columbia, South Carolina on Claimant's Form 50, *Employee's Request for Hearing*. Tommy Houston ("Claimant") alleged compensable injuries to his right shoulder, back, ribs, right knee, right hand, left hip and left leg as a result of a work-related motor vehicle accident that occurred on March 11, 2008. By consent order, Garda World Security ("Employer") and Gallagher Bassett Services, Inc. ("Carrier") (collectively, "Defendants") had previously admitted a change of condition to the low back and right shoulder but denied all other body parts. The purpose of the hearing was determine whether Claimant had sustained a compensable change of condition to the right knee.

On February 17, 2015, the Single Commissioner issued an order finding that Claimant had sustained a compensable change of condition to the right knee and that Claimant is entitled to causally-related medical treatment, including surgery recommended by Dr. Paylor. Defendants filed a Form 30, *Application for Commission Review*, on March 4, 2015, assigning

error to the Single Commissioner order on the basis that Single Commissioner erred in finding jurisdiction to review an award to the right knee and in finding that Claimant sustained a compensable change of condition to the right knee.

STATEMENT OF THE CASE

The claim arises out of an accepted March 11, 2008 motor vehicle accident. On February 4, 2010, Claimant executed a Form 16A, *Agreement for Permanent Disability*, to resolve his permanent disability. The Form 16A identified **injuries** to the right shoulder and low back and listed **affected** body parts: ribs, right knee, right hand, left hip and left leg. Permanency was paid solely on the right shoulder and low back. On July 13, 2010, Claimant filed a Form 50, *Notice of Claim for Change of Condition*, seeking additional medical care. The Form 50 recited each body part mentioned in the Form 16A; namely the right shoulder, back, ribs, right knee, right hand, left hip and left leg. Claimant filed an amended Form 50, claim only, on October 6, 2010 specifically alleging a change of condition for the worse but not specifying which body part(s) had sustained the alleged change of condition. On November 11, 2010, Claimant filed a Form 50, *Request for Hearing*. Attached to the hearing request was a signed questionnaire by Dr. Wessinger stating only "Tommy Houston has sustained a change of condition for the worse since I released him on July 1, 2009." This attachment contained no statement as to what body parts had sustained a change of condition.

Defendants filed a Form 51, *Employer's Answer*, denying the changes of condition. Prior to a hearing on Claimant's Form 50, but after the expiration of the twelve month period following the date of the Form 16A, the parties entered into a Consent Order, dated March 16, 2011, in which Defendants admitted that Claimant had sustained a change of condition for the worse to his low back and right shoulder. Defendants further consented to authorize an evaluation of Claimant's low back and to provide temporary total disability benefits. The

Consent Order contained a general, boilerplate provision stating that all remaining issues would be held in abeyance. The Consent Order contained no reference to any allegation that the right knee was at issue in the case. Defendants provided treatment for the shoulder and low back, including surgery to the back in December 2012. Thereafter, in mid-2013, Claimant began complaining of pain in his right knee.

On July 22, 2014, Claimant filed another Form 50, *Request for Hearing*. The hearing on Claimant's Form 50 was held before the Single Commissioner on November 14, 2014. The principal issue for determination was Defendants' liability for treatment to Claimant's right knee, including past and future medical expenses. Defendants denied that the additional treatment for the right knee was compensable on two grounds: (1) that Claimant did not timely pursue a change of condition to the right knee as required by S.C. Code §42-17-90, and (2) the substantial evidence in the record does not support a finding that Claimant sustained a change of condition to the right knee related to his March 11, 2008 accident.

On February 17, 2015, the Single Commissioner issued an order finding that Claimant timely reported his change of condition to the right knee, properly preserved his claim for change of condition to the right knee and sustained a change of condition for the worse to his right knee. The Single Commission found that Claimant was not at maximum medical improvement and Defendants were responsible for all causally-related medical care.

STATEMENT OF THE FACTS

At the hearing, Defendants asserted a jurisdictional challenge to the Form 50. Defendants asserted that Claimant resolved his claim on a Form 16A on February 4, 2010. Defendants argued that S.C. Code §42-17-90 creates a jurisdictional requirement that any change of condition for the worse to a compensable body part must occur within one year of the date of the Form 16A. Defendants argued that, in this case, Claimant did not seek any treatment for any

alleged change of condition to the right knee within that one year period, that no change of condition for the worse to the right knee had been diagnosed within that one year period and, as such, the Commission did not have jurisdiction to make an award based on a change of condition to the right knee.

Claimant contends that the filing of his Form 50 in July 2010 alleging a change of condition and listing every body part that had been affected by the 2008 accident satisfied the requirements of S.C. Code §42-17-90 with respect to his right knee. Claimant also argues that the March 16, 2011 Consent Order held "all other issues" in abeyance while Claimant actively pursued medical treatment on his back and shoulder so there was no reason to litigate the change of condition to the right knee until Defendants denied treatment in 2014.

Claimant testified on his behalf at the hearing. Claimant testified that he is forty-eight (48) years old, is a college graduate and attended two years of college but did not graduate. Claimant testified that he started working for Employer in May, 2005 as a driver/messenger. Claimant testified that his job duties included driving and transporting money to and from the Federal Reserve Bank, local banks, and merchants. Claimant testified he was originally injured in a motor vehicle accident at work on March 11, 2008. Claimant testified that he was in the back of the armored vehicle when the driver pulled out on the highway and struck another vehicle. Claimant testified that he sustained injuries to his right shoulder injury, broken ribs, punctured right kidney, and right knee. He also testified he had left hip issues that were later determined to be related to his lumbar spine.

Claimant testified he underwent right shoulder surgery with Dr. Wessinger in July 2008. and was out of work until May 11, 2009. Claimant testified that he settled his case on a Form 16A in February 2010 and he was unrepresented by counsel at the time. Claimant testified that when he signed the Form 16A he was still having problems with his right knee and his back but

his shoulder was a lot better. Claimant testified that his right knee and back started getting worse when he went back to work and became active again.

Claimant testified that he returned to Dr. Wessinger in September 2010 complaining of his back and right knee. He states that Dr. Wessinger wanted to do another MRI of his shoulder and then he checked out Claimant's back and advised Claimant he did not see anything surgically wrong with the back. Claimant testified he then saw Dr. Charles Kanos, who evaluated his back but who would not address his right knee. Referencing an October 6, 2010 office Patient Recheck Questionnaire, Claimant testified that his problems were identified as back, shoulder, and knee. Claimant testified that he filled out FMLA application paperwork the same day that listed shoulder, right knee and lower back in the description of disability or accident.

Claimant testified that at his deposition in November 2010 he admitted to having swelling in his right knee when he went back to work and of soreness and swelling when he settled his case in February, 2010. He admitted to testifying that he went back to Dr. Wessinger in September 2010 because of pain in his shoulder, pain in his back and legs and his knee giving way sometimes. He further testified that he was not going to settle his claim unless his back and right knee were included. Claimant testified he retained counsel to get Defendants to cover the back surgery then recommended by Dr. Kanos. Claimant testified that after the consent order was entered into, Dr. Kanos performed back surgery on December 12, 2012 and then referred him back to Dr. Jyoti Math for chronic pain management. Claimant testified that he began to notice his knee was getting worse after his back surgery. Claimant testified he requested treatment for his right knee in 2013 and Defendants sent him to Dr. Paylor for an evaluation. Claimant testified that the carrier approved all subsequent treatment with Dr. Paylor until surgery was recommended, at which point all further treatment was denied. Claimant testified that he

has not received any treatment for his right knee since the carrier denied authorization but that he would like the surgery that Dr. Paylor had recommended.

On cross examination, Claimant testified that he saw Dr. Bucci prior to seeing Dr. Kanos and Dr. Bucci did not think Claimant needed back surgery. Claimant testified that he told Dr. Math about his knee problems in 2011 even though the records do not reflect that. He testified that he back was bothering him more than his knee but he told Dr. Math about both in 2011. Claimant admitted to having left leg problems that he reported to Dr. Wessinger on October 6, 2010. He admitted to having back and hip pain going down his left side since the accident but they were getting worse. He testified that he told Dr. Kanos verbally about his right knee pain even though Dr. Kanos' records do not reflect that. Claimant testified that Dr. Kanos told him that he was only going to work on the back and someone else would be working on his knee. Dr. Kanos' records do not corroborate these statements.

Claimant admitted to having right knee surgery in 1974. He testified that in April 2009 he was able to push himself to do normal activities like cut grass. Despite the fact that the medical records do not corroborate his testimony, Claimant maintained that he consistently complained to Dr. Wessinger about problems in his right knee but was never provided any treatment. Claimant admitted that he executed the Form 16A after a meeting with a Commissioner. He testified that he hired an attorney to help with problems that had started in the fall of 2010. He testified that his right knee began to get worse after he returned to work in 2010. Claimant testified he has not worked since September of 2010 and has been receiving temporary total disability payments through the present.

Medical Evidence – Pre-Settlement

On the day of his accident, Claimant was initially treated at the Greenville Hospital System. He was admitted following a motor vehicle accident complaining of right side pain.

(APA, p. 403) Claimant was noted as complaining of right chest pain, right flank pain and some left knee pain but he was able to move his knee. A follow up on March 21, 2008 revealed Claimant was still having right side pain. (APA, p. 404) The records contain no reference to the right knee.

The medical evidence in the APA submissions shows that Claimant was first treated by Dr. Wessinger, Steadman Hawkins, on April 30, 2008. (APA, p. 192) Dr. Wessinger noted that Claimant was involved in a March 11, 2008 motor vehicle accident. He noted that Claimant reported several rib fractures, that he initially had right knee pain and that those had improved. Claimant reported increased left shoulder pain and left hip pain that radiated down to the left knee. The shoulder pain was noted as constant. Dr. Wessinger diagnosed him with subacromial impingement and bursitis of the hip. (APA, p. 193). Following an MRI, Claimant was diagnosed with a rotator cuff tear and underwent a surgical repair. On September 3, 2008, Claimant returned to Dr. Wessinger for a post-surgical follow up and reported increased left hip pain. (APA, p. 204) On October, 22, 2008, Claimant reported that his hip and low back had responded well to physical therapy. (APA, p. 208) On February 4, 2009, Claimant reported his back continued to be better and Claimant was able to walk 2-3 hours without pain. (APA, p. 216) On April 15, 2009, Dr. Wessinger noted that Claimant was doing well and able to cut his grass the other day. (APA, p. 218) On April 29, 2009, Claimant reported a problem with his right hand related to the IV he had inserted after the accident. (APA, p. 220) Dr. Wessinger notes that Claimant reported the problem had occurred since the accident but this was the first time he reported it to Dr. Wessinger. Dr. Wessinger ordered a biopsy. On May 27, 2009, Dr. Wessinger added a diagnosis of a localized superficial swelling, mass or lump to Claimant's list of issues. (APA, p. 224) On July 1, 2009, Dr. Wessinger found Claimant to be at maximum medical improvement with regard to his shoulder and back. (APA, p. 230) Claimant was

assigned a 15% impairment to the right shoulder and 7 % impairment to the back. Claimant did not receive any treatment to his right knee from Dr. Wessinger and no injury to his right knee was ever diagnosed during this period. Claimant settled his claim on a Form 16A on February 4, 2010.

Medical Evidence – Post-Settlement

Claimant returned to Dr. Wessinger on September 1, 2010 reporting increased pain in his right shoulder as well as left leg pain and low back pain. (APA, p. 232) Dr. Wessinger ordered an MRI of the shoulder and noted an MRI of the back may be needed if his symptoms were not controlled. On October 6, 2010, Dr. Wessinger noted continued back and hip pain, primarily on the left. (APA, p. 234) Claimant reported that this pain had been present since his accident but are apparently getting worse. Dr. Wessinger ordered an MRI. A Patient Recheck Questionnaire filled out by Claimant on this date indicates the location of pain or problem as “Back-Shoulder-Knee”, the box for right or left was unchecked. (APA, p. 10) On October 27, 2010, Claimant returned to Dr. Wessinger following his MRI. Dr. Wessinger notes that Claimant is at MMI for his shoulder. (APA. P. 236) He noted that Claimant’s MRI revealed arthritic problems that could have been aggravated by the accident and ordered a referral to get a surgical evaluation. On November 3, 2010, Dr. Wessinger filled out a questionnaire indicating that Claimant had sustained a change of condition for the worse since his release on July 1, 2009 but did not specify what body parts had sustained the change of condition and did not make any reference to the right knee. (APA, p. 238)

Claimant completed an Information for Disability/FMLA Benefits Form on October 6, 2010, indicating that he was injured in an auto accident on March 11, 2008, and sustained injury to his right shoulder, right knee, and lower back. (APA, p. 238)

Claimant was referred to Dr. Michael Bucci, Piedmont Spine and Neurosurgical Group, on April 21, 2011. Dr. Bucci notes that Claimant complained of low back pain radiating to the left buttock, down the back of the left leg to the foot. (APA, p. 239) He notes that Claimant reported occasionally having symptoms in the right groin region and leg. Dr. Bucci ordered a lumbar myelogram. Claimant's review of symptoms listed leg cramps and muscle pain. (APA, p. 243) No reference to the right knee was noted.

Claimant was evaluated by Dr. Jyoti Math, Upstate Medical Rehabilitation, on August 18, 2011 for pain management. Dr. Math notes the Claimant reporting that his job required heavy lifting and that aggravated his shoulder pain, as well as his back pain. (APA, p. 251) She notes that his pain is worse with prolonged standing, and is located in the back of the thigh on the left side and occasionally up the heel. He reported numbness in the L5 distribution with some weakness secondary to pain. Dr. Math ordered physical therapy with possible trigger point injections in the future. On September 12, 2011, Claimant received trigger point injections. (APA, p. 254) On October 10, 2011, Claimant returned and reported doing well with physical therapy but reported some continued low back pain. (APA, p. 257) Claimant received additional SI and medial branch block injections and radiofrequency ablation from Dr. Math and on April 30, 2012, she recommended a new MRI of the spine. (APA, p. 273)

Claimant was evaluated by Dr. Charles C. Kanos, SE Neuro & Spine Institute, on August 1, 2012. Claimant reported his pain was at the center of his back to the left hip and down the leg. (APA, p. 292) Dr. Kanos ordered a new MRI. On August 24, 2012, Claimant reported low back and left leg pain. (APA, p. 295) Dr. Kanos recommended an L5-S1 PLIF.

On August 27, 2012, Claimant returned to Dr. Math. She notes that he reported continued pain in his legs, as well as his back, that the pain was on the left-side and had not changed in quality or character. (APA, p. 274)

On October 22, 2012, Dr. Kanos notes that Claimant was complaining of burning and pins and needles in his low back and down his left leg. (APA, p. 298) Dr. Kanos further notes that Claimant has been having left hip pain into the thigh as well as needle sensation in his right foot. (APA, p. 299) Claimant's main complaint was low back pain and left leg pain.

On December 12, 2012, Claimant underwent back surgery with Dr. Kanos, who performed: 1) L5-S1 posterior lumbar interbody fusion; 2) Orthofix Phoenix L5-S1 pedicle screw fixation; 3) L5-S1 interbody fusion cage; 4) L5-S1 decompressive laminectomy; 5) L5-S1 total facetectomy; and 6) L5-S1 foraminotomies.

On March 8, 2013, Dr. Kanos notes that Claimant reported that his standing tolerance had improved, that his left leg pain had resolved and his low back pain was 50% improved since surgery. (APA, p. 302) Claimant still reported left hip pain. On April 24, 2013, Dr. Kanos assigned Claimant permanent restrictions of no lifting over 35 pounds, no repetitive bending more than 60 degrees, and restricted his ability to sit for 8 hours a day or walk for 2 hours with breaks. (APA, p. 306) Dr. Kanos placed him at maximum medical improvement for his back with a 25% impairment rating to the lumbar spine.

First medical record referencing significant right knee issues - On June 6, 2013, Claimant reported to Dr. Math's PA, Christopher Kelly, for a medication follow up. During that visit, Claimant reported having some right knee pain that had gotten worse. (APA, p. 346) Claimant advised the PA that he had been trying to walk more per Dr. Kanos' instructions, but his right knee was limiting him. Claimant also reported that the knee has been bothering him since his accident and that he saw Dr. Wessinger about it back in August, 2010. Claimant wanted to get his knee evaluated since it had given him so many problems. Claimant described the pain in the knee as not radiating but localized over the front of his kneecap. (APA, p. 347) According to the note, Claimant advised he could not put his weight down on his knee and "hle

has not been able to do that since the accident." (APA, p. 347) An x-ray and MRI of the knee were ordered. On July 10, 2013, Dr. Math notes that Claimant reported that his back pain was improved but he continued to have knee pain. (APA, p. 283) Claimant reported occasional locking or clicking. She notes that a June 25, 2013 MRI showed an extensive tear in the lateral meniscus, possible bucket handle tear and lateral tibiofibular chondromalacia. She referred Claimant to Dr. Wessinger.

On an October 21, 2013 follow up, Dr. Kanos noted that Claimant used a cane because of right knee pain and a recent diagnosis of a meniscal tear. (APA, p. 172)

On an October 9, 2013 recheck, Dr. Math noted Claimant continued to have right knee pain secondary to a meniscal tear. (APA, p. 287) Dr. Math noted that Claimant had not yet been seen by an orthopedic surgeon and recommended a knee brace.

Claimant underwent an evaluation with Dr. Paylor for his right knee on November 5, 2013. Dr. Paylor noted the date of onset as March 11, 2008 (APA, p. 376) He indicates that the knee had been painful since the initial injury. Dr. Paylor noted advanced grade chondromalacia as well as extensive tearing of the lateral meniscus. (APA, p. 377). Dr. Paylor recommended a arthroscopy of the right knee with a lateral meniscectomy.

Claimant continued to receive pain management treatment from Dr. Math through July 2, 2014. In a June 13, 2014 questionnaire, Dr. Math indicated that it was her opinion that it is more likely than not that the increased activity and walking that Claimant engaged in pursuant to his medical providers' advice following his back surgery aggravated his right knee pain causing the need for additional evaluation and treatment of his right knee. (APA, p. 140)

In a questionnaire dated November 18, 2013, Dr. Paylor indicates that it was his opinion that Claimant sustained an injury to his right knee in a car accident on 3/11/08 and that the patient stated his current condition was from the accident. (APA, p. 379)

In a June 26, 2014 statement, Dr. Paylor opined that it is more likely than not that Claimant suffered injury to his right knee as a result of his motor vehicle accident while working on or about March 11, 2008, that his right knee symptoms became less noticeable as he pursued treatment for other injuries and was less active, and then became more symptomatic again as treatment for his other injuries wound down and he increased his activity and began walking more following his back surgery. (APA, p. 185)

Dr. John H. Paylor, III Deposition

Dr. Paylor was deposed on July 1, 2014. Dr. Paylor testified that he did not see Claimant until November 5, 2013. Dr. Paylor testified that he did not review Claimant's prior medical records at that time. Dr. Paylor testified that the June 26, 2013 statement he signed was prepared by Claimant's counsel but he agreed with its contents. He testified that he conducted a limited review of Claimant's prior medical records at that time but primarily relied on statements from counsel as to Claimant's prior treatment. He testified that he may have reviewed some records from the Greenville Hospital System but he did not review the records of Dr. Wessinger, Dr. Kanos, or Dr. Bucci.

Dr. Paylor agreed that Claimant's prior medical records do not reference any right knee pain until 2013. Dr. Paylor testified that the only evidence he has that Claimant's meniscal tear existed since 2008 was Claimant's statement to him that the problem had existed since his accident. Dr. Paylor opined that the medical records do not include reference to right knee pain because the prior physicians did not ask him directly about his right knee. Dr. Paylor testified that his opinion that the knee injury occurred in 2008 is based solely on what the Claimant told him in 2013. Dr. Paylor testified that he could not tell how old the injury was from the diagnostic imaging. Dr. Paylor testified that he did not know of any reason why Claimant would not have been capable of complaining to his other doctors about his right knee if

a problem existed. Dr. Paylor did not ask and Claimant did not offer any explanation for why he waited until 2013 to seek treatment. Dr. Paylor testified that Claimant's treatment records from 2013 indicate that Claimant reported that the problem had existed since his accident.

Dr. Joyti K. Math Deposition

Dr. Math was deposed on September 3, 2014. Dr. Math testified that she did not see Claimant until August 18, 2011 and has seen him routinely since then. In 2011, Claimant was a new patient being seen for a workers' comp injury. She testified Claimant was referred by Dr. Bucci for management of his low back pain. Dr. Math testified that knee pain was discussed very vaguely but Claimant's main issue was his back. Dr. Math admits that her notes do not identify which knee was discussed. Dr. Math testified that Claimant reported back problems going down his left leg and that working had aggravated his shoulder pain and back pain. Dr. Math testified that Claimant's gait was normal at this initial visit. She admits doing some leg testing with normal results and put him on a medication for his back pain. Dr. Math testified that the first specific reference to a right knee issue in her notes was on June 6, 2013 when it was noted by her PA.

Dr. Math testified that Claimant's June 25, 2013 MRI revealed a lateral meniscal possible bucket-handle tear and lateral tibiofibular chondromalacia. She testified that chondromalacia is an arthritic condition in the cartilage, a degenerative condition. Dr. Math testified that she felt that the motor vehicle accident most likely caused Claimant's right knee tear based on the history she received from Claimant. Dr. Math explained the absence of references to the right knee prior to 2013 on the possibility that the initial tear may have been minor and gradually got worse. She also admitted that there was no way of knowing if the injury occurred somewhere between the accident in 2013 and when it was diagnosed in 2013. Dr. Math testified that Claimant was tested

routinely for gait and walking and she did not note any issues until 2013 and no specific reference to right knee pain until June 2013.

Upon diagnosing him with right knee problems in June 2013, Claimant was referred to an orthopedist. Dr. Math opined that Claimant became aware of right knee pain after his December 2012 back surgery because he was able to ambulate more and this aggravated his pre-existing right knee problem. She opined that this aggravation is what caused Claimant to need to be evaluated and treated in 2013.

Dr. Philip H. Wessinger Deposition

Dr. Wessinger was deposed on October 10, 2014. Dr. Wessinger testified that he first treated Claimant on April 30, 2008. Dr. Wessinger testified that he noted in his initial report that Claimant had indicated he initially had right knee pain after the accident but it had improved. Following that visit, Dr. Wessinger provided treatment primarily to Claimant's back, shoulder and left hip. Dr. Wessinger reviewed his treatment notes after that initial visit through his release at MMI on July 1, 2009 and testified that there was no evidence of any complaints by Claimant for his right knee during that time.

Dr. Wessinger testified that when Claimant returned to him on September 1, 2010, Claimant did not complain of any right knee pain. Claimant did report shoulder problems, as well as left leg pain and back pain. Dr. Wessinger testified that the November 3, 2010 questionnaire he filled out was intended to refer to a change of condition to the shoulder and/or back only, which were the only issues Claimant had identified to him. He testified that at no time during his treatment of Claimant did he document anything about Claimant's right knee beyond the initial note from 2008 indicated that the right knee had resolved before Dr. Wessinger has ever seen him.

Dr. Wessinger testified that, given the length of time and number of times he had treated Claimant, he felt it unlikely that Claimant has any kind of substantial right knee issue that occurred in the 2008 accident. Dr. Wessinger testified that a bucket-handle tear is a pretty significant tear and it would be unlikely for a person to have one and not bring it up for two and a half years. Dr. Wessinger testified that, based on his history of treating Claimant, it was not probable, to a reasonable degree of medical certainty, that Claimant was dealing with a meniscal tear from 2008 through 2010. Dr. Wessinger testified that Claimant had become pretty active during his course of treatment and indicated he was able to walk two to three hours without pain and complete household activities, like mow the lawn.

Claimant's Deposition

In his November 17, 2010 deposition, Claimant testified that when he was 18 years old he was involved in a motor vehicle accident in which he was struck by a drunk driver. As a result of the accident, Claimant testified that he had right knee surgery to repair cartilage but did not have any further problems with his right knee until his March 11, 2008 motor vehicle accident at work. After his March 11, 2008 accident, Claimant testified that he treated with Dr. Wessinger for his right shoulder, back, and right knee. Claimant testified that while he was treating with Dr. Wessinger, his right knee symptoms improved as he recovered from surgery but when he returned to work on May 11, 2009, his knee symptoms returned and slowly got worse.

Claimant testified that at the time of signing the Form 16A in February 2010, he had soreness and swelling in his right knee and that the next treatment he received was a return visit to Dr. Wessinger on September 1, 2010 for pain in his right shoulder, back, and right knee. Claimant testified that he began to notice soreness and a worsening of his right knee when he returned to work and became active after remaining largely immobile after surgery. Claimant testified that if he walked for 10 minutes, he needed something to hold for support because he

felt like his knee would give away. Claimant testified that he thought his back was the worst problem initially but Dr. Wessinger was focused on his right shoulder.

ARGUMENT

As set forth above, Claimant sustained an admitted injury on March 11, 2008 when he was involved in a motor vehicle accident. Claimant's medical records show that on the day of the accident he complained of right side pain, right flank pain and some **left** knee pain. On April 30, 2008, Claimant apparently reported to Dr. Wessinger that he initially had right knee pain following the accident but it had improved. Following those initial reports, Claimant's medical records do not reflect any complaints from Claimant about his right knee until sometime in 2013.

As evidenced by the records, Claimant's post-accident treatment was focused entirely on his shoulder and back and he was released at MMI on July 1, 2009 with a 15% permanent impairment to his shoulder and 7% permanent impairment to his back. No other body parts were rated. It was at that point that Claimant elected to settle his case and accepted payment of \$37,018.89 on a Form 16A dated February 4, 2010. At no time prior to that was any **injury** to his right knee diagnosed or treated. Nevertheless, the Form 16A was paid on his shoulder and back and included reference to all body parts identified as potentially affected by the 2008 accident: ribs, right knee, right hand, left hip and left leg.

1. The Single Commissioner erred in finding jurisdiction over the claim for a change of condition to the right knee.

Under S.C. Code §42-17-90, a review of an award on the grounds of a change in condition "must not be made after twelve months from the date of the last payment of compensation." A change in condition occurs when the claimant experiences a change in "physical condition" as a result of his original injury, occurring after the first award. Gattis v. Murrells Inlet VFW No. 10420, 353 S.C. 100, 109, 576 S.E.2d 191, 196 (Ct. App. 2003) (citing Causby v. Rock Hill Printing & Finishing Co., 249 S.C. 225, 227, 153 S.E.2d 697, 698 (1967))

(emphasis added). "Generally, an appeal of a workers' compensation order is concerned with the conditions prior to and at the time of the original award of the commission. Review for a change of condition is concerned with conditions that have arisen thereafter." Causby, 249 S.C. at 228, 153 S.E.2d at 698-99. Pursuant to S.C. Code Regs 67-602(C), a claimant alleging a change of condition "must attach to the hearing request form a medical report(s) indicating a change in the claimant's conditions."

In this case, Claimant clearly settled his claim with Employer on Form 16A on February 4, 2010. The settlement involved paying permanency on the only two body parts that had been determined to have been injured and sustained permanent impairment (back and shoulder). As is routine, the Form 16A also listed every body part that had potentially been affected by the work-related accident but for which no permanency was paid, including the right knee. When Claimant filed his Form 50 (claim only) on July 13, 2010, alleging a change of condition, he listed all affected body parts identified on the Form 16A without identifying the basis of the change of condition or the specific body parts alleged to have sustained the change of condition. No additional information was provided by Claimant when he filed an Amended Form 50 (claim only) on October 6, 2010. On November 11, 2010, Claimant filed his hearing request and attached the medical report required by S.C. Code Regs 67-602(C). That report was a single questionnaire executed by Dr. Wessinger that stated simply "Tommy G. Houston has sustained a change of condition for the worse since I released him on July 1, 2009." As Dr. Wessinger testified, at no time during his initial treatment following the accident, and at no time prior to his execution of this questionnaire, did he diagnose or treat Claimant with respect to his right knee. Dr. Wessinger specifically testified that the change of condition he was referring to in that November 3, 2010 questionnaire was the "issues that he complained to me about with regard to his shoulder and/or back." (Wessinger Depo, p. 46, l. 11 – p. 47, l. 2)

Based on the foregoing, there is no competent medical evidence establishing the existence of a change of condition to the right knee during the twelve month period following his settlement and, as such, the right knee is not properly before the Commission for adjudication.

Claimant contends that the laundry list of affected body parts set forth in his Form 50 is sufficient to preserve the issue of the right knee despite the absence of contemporaneous medical evident. This argument fails to take into account the requirement to prove by competent medical evidence that a physical change of condition occurred within the twelve month period. It is disingenuous of Claimant to contend that he was putting Defendants on notice of the existence of a change of condition to the right knee when he also lists on the Form 50 his ribs, right hand, left hip and left leg. Much like the right knee until 2013, Claimant's medical records are completely devoid of any reference to additional problems, treatments or changes of condition for these body parts. It is contrary to the intent of S.C. Code §42-17-90 and S.C. Code Regs 67-602 to allow the filing of a laundry list of body parts to preserve a claim for a change of condition that is not documented until nearly three years later. Surely Claimant could not show up tomorrow alleging a new change of condition to his right hand and rely on the Form 50 filed in 2010 as a basis for claiming that the issue is preserved. In this case, it is clear from the contemporaneous medical records that Claimant was seeking a change of condition to his back and shoulder when he filed his Form 50 in 2010. The discovery of an injury to his right knee in 2013 is untimely and not preserved for a review under S.C. Code §42-17-90.

This result is further supported by the Consent Order entered into between the parties on March 16, 2011. In that order, Defendants specifically agreed to accept a change of condition to the low back and right shoulder and to provide causally-related treatment. It is clear from the Dr. Wessinger's records that evidence existed to support a finding of a change of condition as to those body parts. The Consent Order is utterly silent as to any additional body parts that were at

issue and were denied. If Claimant were also alleging a change of condition to his right knee that required treatment, he failed to raise it as an issue otherwise the Consent Order would have addressed any additional denied body parts. Claimant seeks to relay on the boilerplate language in the Consent Order indicating that “all remaining issues shall be held in abeyance.” This catch-all provision included in virtually every consent order does not and cannot preserve to the Claimant issues that were not known or contemplated at the time of the filing of the Form 50. Claimant’s right knee was simply not an issue in the case or with his physicians at the time and did not become an issue for over two years.

For the above reasons, Defendants contend that Claimant’s claim for a change of condition to the right knee was not properly raised in accordance with S.C. Code §42-17-90 and, consequently, the Single Commissioner did not have jurisdiction to adjudicate the claim as to the right knee.

2. The Single Commissioner erred in finding a change of condition to the right knee.

In order to establish a modification based on a change of condition, the claimant must show a change of condition, and the change must be based upon a causal connection to the original compensable accident. Krell v. S.C. State Highway Dep’t, 237 S.C. 584, 588, 118 S.E.2d 322, 323 (1961). A change in condition occurs when the claimant experiences a change in *physical condition* as a result of his original injury, occurring after the first award. Gattis, 353 S.C. at 109, 576 S.E.2d at 196 (emphasis added). A change resulting from the natural progression of a pre-existing condition and not the result of the original injury is not compensable. Carter v. Verizon Wireless, 407 S.C. 641, 649, 757 S.E.2d 528, 532 (Ct. App. 2014) (citing Brown v. R.L. Jordan Oil Co., 291 S.C. 272; 275, 353 S.E.2d 280, 282 (1987)).

Notwithstanding the jurisdictional issue of the timeliness of the claim for a change of condition to the right knee, the medical evidence in this case is not sufficient to find that such a

change has occurred in this case. Aside from one or two minor references in the month or two following his accident, the medical evidence is indisputable that no injury was ever diagnosed and Claimant never received any treatment whatsoever for his right knee until 2013. Admittedly, in 2013, Claimant's records contain a number of references that he has had right knee problems since 2008. It also undisputed that these reference are based solely on the subjective reports of Claimant to his physicians in 2013. These references are wholly self-serving and not corroborated by the competent medical records or the testimony of his authorized treating physician during the relevant time period. According to Dr. Wessinger, it was his opinion to a reasonable degree of medical certainty that Claimant did not have a meniscal tear during the 2008 to 2010 time period in which he treated him regularly for numerous problems resulting from the 2008 accident. While Dr. Math and Dr. Paylor certainly defer to Claimant's subjective reports of his history, neither of these physicians treated Claimant during the initial years of his recovery from the accident. Defendants certainly do not dispute that Claimant had a right knee injury in 2013, however, the medical evidence in this case is insufficient to support a finding that the 2013 injury was causally-related to the 2008 accident.

Moreover, even if Claimant's position is assumed to be true, his claim for a change of condition must fail. Claimant argues that his right knee had been bothering him since the date of the accident but he was so focused on receiving treatment for his other issues he did not know the extent of the problem. Claimant contends that it was not until he was able to be more active after his back surgery in 2012 that his right knee became more symptomatic. In short, Claimant cannot prove a "physical change of condition" because there is no evidence that the meniscal tear that was diagnosed in 2013 was a change from his condition at the time of his settlement in 2010 because, according to him, the problem had been there since 2008.

In the case of Robbins v. Walgreens & Broadspire Servs., Inc., the Court of Appeals addressed a similar situation. In that case, the claimant settled his back injury claim but later sought a change of condition alleging his back pain had gotten “much worse” after his settlement. The claim was denied by the Commission finding no evidence of a physical change of condition. The Court of Appeals affirmed stating:

Thus, the evidence both before and after the settlement of his claim showed the same condition. Neither Dr. Chokshi nor Dr. Wingate opined that Robbins' condition had worsened; they only noted that his pain was continuing. Robbins testified at the hearing before the single commissioner that his pain never abated after his injury, he just failed to inform Walgreens prior to the settlement for fear of being terminated. It is irrelevant that Dr. Chokshi took Robbins out of work in April 2004 because the only evidence in the record regarding the state of Robbins' condition was that it was similar both before and after the settlement. Further, although the single commissioner's order stated that Robbins failed to prove he sustained a “significant change” in his condition, the commissioner used the correct standard in reviewing the evidence and found it did not support a finding that he suffered a “physical change of condition for the worse.” Accordingly, there was substantial evidence in the record to support the finding that Robbins failed to prove a change or worsening of his condition.

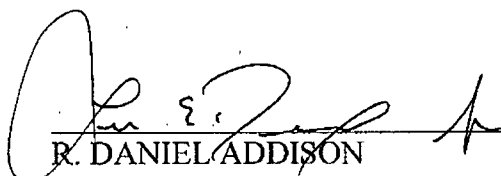
Robbins v. Walgreens & Broadspire Servs., Inc., 375 S.C. 259, 265-66, 652 S.E.2d 90, 94 (Ct. App. 2007) (emphasis added). In this case, the only evidence of Claimant's condition prior to his settlement are his statements in 2013 that this problem had persisted since 2008 but only became intolerable after he recovered from his back surgery and was able to move around more. Claimant's 2013 radiology exams show a defect in Claimant's knee but there is no testimony from which the Commission can determine whether this defect was present in 2008 or if it occurred at some later date. Thus, even if Claimant's testimony is believed, there is no substantial evidence from which the Commission can conclude that Claimant sustained a physical change of condition after his settlement that is causally-related to his 2008 accident.

CONCLUSION

The substantial evidence in this case demonstrates that Claimant settled his 2008 workers' comp claim in 2010 and that he later sustained an admitted change of condition to his

shoulder and low back. At no time prior to 2013 was Claimant's right knee ever and issue in the case. Consequently, Claimant's right knee was not timely raised, and was not supported by competent medical evidence at the time the change of condition was asserted. As such the Single Commissioner's order should be reversed as the Commission does not have jurisdiction, pursuant to S.C. Code § 42-17-90 to hear a claim on a change of condition to the right knee. The Single Commissioner's order should be reversed on the merits as well as there is insufficient credible medical evidence that Claimant's right knee problems that were diagnosed in 2013 were causally-related to his 2008 accident. Even taking the Claimant's testimony at face value that his knee has been a persistent problem since 2008, Claimant's position is that it only became apparent once he recovered from his back surgery. Claimant's testimony on this issue is, therefore, insufficient to prove a physical change of condition that must have occurred after the date of settlement. Claimant's testimony on this issue, even if believed, is susceptible of only one inference and that is that Claimant's problems were present at the time of his settlement and his pain symptoms increased as a result of the natural progression of those problems and increased use, not a physical change of condition for the worse that occurred after the date of the settlement.

Respectfully submitted, this, the 11th of May, 2015.


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BEFORE THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION
W.C.C. FILE NO: 0802605

Tommy Houston,
Claimant/Respondent,

vs.

Garda World Security,
Employer,

and

Gallagher Bassett Services, Inc.,
Carrier,
Defendants/Appellants.

**CLAIMANT'S
BRIEF OF RESPONDENT**

This claim came before the Single Commissioner on November 14, 2014 on Claimant's Form 50 seeking for a change of condition for the worse to his right knee subsequent to an accepted claim and award with a date of injury of March 11, 2008. Claimant, then unrepresented by counsel, entered into a Form 16A settlement agreement on February 4, 2010 with Defendants for injuries sustained in a motor vehicle accident in the course and scope of his employment to his right shoulder and low back with affected ribs, right knee, right hand, left hip, and left leg. Claimant, after retaining counsel, pursued a change of condition for additional medical treatment by filing a Form 50, claim only, on July 13, 2010 for the all the body parts listed above. Claimant continued to pursue additional medical treatment for his change of condition by filing a Form 50, request for hearing, on November 11, 2010.

Prior to the hearing set on Claimant's Form 50, the parties entered into a Consent Order dated March 16, 2011. In that Consent Order, the parties agreed that Claimant sustained a change of condition to his low back and right shoulder, Defendants would provide treatment with Dr.

Phillip Wessinger and temporary total disability benefits, and all other issues were held in abeyance.

The hearing before the Single Commissioner was set on Claimant's Form 50, request for hearing, filed July 22, 2014, where Claimant contended he sustained an injury to his right knee in the original accident that was an undiagnosed condition or, alternatively, has since become worse and needs additional medical treatment, including surgery recommended by Dr. John Paylor. Claimant asserted that he met the requirements for preserving the issue of treatment and benefits for his right knee, and that at the time of the March 16, 2011 Consent Order, surgery to his low back was the immediate medical issue. Additionally, Claimant asserted that he was not sitting on his rights to bring a claim for his right knee because, in the interest of judicial economy, there was no reason to seek an Order from the Commission for treatment until such time as treatment was denied – which did not occur until after March 2014.

Defendants asserted Claimant did not timely pursue his right knee change of condition claim as required by S.C. Code Ann. § 42-17-90. Defendants did not object to the Commission's jurisdiction to hear the claim but asserted that the Single Commissioner must make a finding that Claimant timely pursued his claim under § 42-17-90 before addressing the merits. Defendants further argued that if the Single Commissioner held the change of condition claim was timely pursued, Claimant's current right knee symptoms were new and not related to his original injury by accident.

By Order filed February 17, 2015, the Single Commissioner found that the term "held in abeyance" in the March 16, 2011 Consent Order preserved Claimant's right to file for a change of condition for his right knee as it was initially pled in his Form 50 for a change of condition that was filed within the one year period per the statute. As Claimant's right to file for a change of

condition for his right knee was preserved, the Single Commissioner found that the Commission has jurisdiction to hear Claimant's change of condition claim. After finding the Commission has jurisdiction, the Single Commissioner held that Claimant met his burden of proving a change of condition for the worse to his right knee; that Claimant is entitled to all causally related medical treatment and evaluation expenses to his right knee, including the right knee surgery recommended by Dr. Paylor; and that Claimant has not reached maximum medical improvement. The Single Commissioner also found Claimant credible in his testimony, wherein he described the gap between his initial report of his right knee injury and later complaints as being due to the greater pain he felt and priority he gave to addressing his back and right shoulder, which both required surgery.

Defendants now appeal to the Full Commission Panel contending the Single Commissioner erred in finding jurisdiction to review an award to the right knee and in finding Claimant sustained a compensable change of condition to the right knee.

LEGAL ANALYSIS

I. The Single Commissioner correctly determined jurisdiction over the claim for a change of condition to the right knee as a matter of fact and law.

A review of all the evidence on the record in this claim shows that the Single Commissioner correctly determined the Commission has jurisdiction over Claimant's change of condition claim under the Act. The Commissioner specifically found, in part, that:

5. Claimant, unrepresented by counsel, initially resolved his workers' compensation claim via a Form 16A settlement on February 4, 2010. Although Claimant's right knee was listed as an affected body part, Claimant only received compensation for his back and his right shoulder. Other affected body parts included Claimant's ribs, right hand, left hip, and left leg.

6. On July 13, 2010, after retaining counsel, Claimant filed a Form 50, claim only, alleging a change of condition to his right shoulder, back, ribs, right knee, right hand, left hip, and left leg.
7. On November 11, 2010, within the one year period per § 42-17-90, Claimant filed a Form 50, request for hearing, alleging a change of condition to his right shoulder, back, ribs, right knee, right hand, left hip, and left leg.
8. The change of condition hearing notice was served on the parties on January 7, 2011, with a hearing date of February 17, 2011.
9. Prior to the February 17, 2011 hearing, the parties entered in to a Consent Order, dated March 16, 2011, wherein Defendants admitted that Claimant sustained a change of condition to his back and right shoulder and that "all other issues are held in abeyance."
10. The undersigned finds that the term "held in abeyance" in the March 16, 2011 Consent Order preserved Claimant's right to file for a change of condition for his right knee as it was initially pled in his Form 50 for a change of condition that was filed within the one year period per the statute.
11. As Claimant's right to file for change of condition for his right knee was preserved, the undersigned finds the Commission has jurisdiction to hear Claimant's change of condition claim as it pertains to his right knee.

These Findings of Fact were made based on documents contain in the Commission's file; Claimant's testimony; the Form 16A settlement agreement dated February 4, 2010; Claimant's Form 50, request for hearing dated November 11, 2010; and the Consent Order dated March 16, 2011. (APA pp. 186 and 188)

Against the weight of the evidence, Defendants argue that Claimant's Form 50, request for hearing, filed within the twelve months after the last payment of compensation with supporting medical documentation, was not timely pursued.

The statute of limitations applicable to workers' compensation claims, like the Workers' Compensation Act as a whole, should be given liberal construction, and any reasonable doubts should be resolved in favor of coverage. Rogers v. Spartanburg Regional Medical Center, 328 S.C. 415, 491 S.E.2d 708 (Ct. App. 1997). The time limit in § 42-17-90 is in effect a notice

provision and the Single Commissioner determined that the Form 50 filed on November 11, 2010 plead the right knee timely putting Defendants on notice of the Claimant's intent to pursue a change of condition claim. The South Carolina Supreme Court has held that so long as the change of condition application is filed with the Commission within the one-year period, the actual hearing on the issue need not be adjudicated within the one-year period. Allen v. Benson Outdoor Adver. Co., 236 S.C. 22, 112 S.E.2d 722 (1960). In so doing, the Court reiterated the guiding principle that "a liberal construction [of the statute] is required" and that:

'[t]o sustain appellants' contention would lead to a rather unreasonable result clearly not within the intent of the Legislature. An application might be seasonably made but due to crowded dockets *or other causes could* not be heard within the statutory period.'

Allen, 112 S.E.2d at 725-26 (emphasis added). The Court also approvingly quoted the following language from a West Virginia case:

'The filing of a claim for further compensation within the statutory period *and partial but not complete development thereof within such period, with loss of jurisdiction by the commissioner during the progress of the case, would be an absurd result* which the legislature certainly did not have in mind, and we feel warranted in holding that the statute in question should be given a construction which permits the commissioner to hear and pass upon any application in writing for a further adjustment of a claim, if filed within the statutory period applicable to the nature of the claim filed.'

Allen, 112 S.E.2d at 726 (quoting Wilkins v. State Comp. Comm'r, 198 S.E. 869, 871 (W.Va. 1938)(emphasis added).

In the current case, and as a direct result of the March 11, 2008 accident, Claimant was out of work until May 11, 2009 from right shoulder surgery with Dr. Wessinger then settled his

Workers' Compensation claim on a Form 16A, unrepresented by counsel, in February 2010. (Hrg. tr. p. 16, line 5 – p. 17, line 3; APA p. 192) Claimant testified that when he signed the Form 16A, his right shoulder had improved post-surgery but his right knee and back were getting worse after starting work and becoming more active again. (Hrg. tr. p. 17, line 18 – p. 18, line 9) Additionally, Claimant testified that during the time of his November 2010 deposition that he complained of his right knee as part of his injury by accident and would not have settled his claim unless his back and right knee were included. (Hrg. tr. p. 29, line 18 – p. 30, line 13; Claimant's depo. p. 33, lines 2 – 15)

Claimant returned to Dr. Wessinger in September 2010 complaining of pain in his back and right knee. (Hrg. tr. p. 18, line 20 – p. 19, line 16; APA p. 10) He then saw Dr. Michael Bucci and then Dr. Charles Kanos, who evaluated his back and recommended surgery but would not address his right knee. (Hrg. tr. p. 19, line 21 – p. 20, line 1; p. 33, lines 16 – 23; APA p. 101) Dr. Kanos recommended back surgery, which Claimant pursued unrepresented by counsel as his most symptomatic medical condition, until Defendants denied treatment and the recommended back surgery. (Hrg. tr. p. 30, line 7 – p. 31, line 7; APA p. 175) At that point, Claimant retained counsel to seek approval of the back surgery recommended by Dr. Kanos. (Id.) Claimant filed a Form 50 then entered into a Consent Order receive treatment for his most symptomatic condition at the time.

While recovering from back surgery, Claimant testified that his medical care providers encouraged him to increase walking, and he noticed his right knee was worse. (Hrg. tr. p. 32, lines 3-7) Claimant requested treatment for his right knee and Defendants sent him to Dr. Paylor for treatment. (Hrg. tr. p. 32, lines 8 – 13; APA pp. 178 – 182) Claimant underwent treatment with Dr. Paylor until he recommended right knee surgery, at which point Defendants denied all further

treatment. (Hrg. tr. 32, line 14 – p. 33, line 5; APA p. 179) After the Defendants denied treatment, Claimant filed a Form 50, request for hearing, on July 22, 2014, wherein Claimant pursued the recommended treatment for his right knee.

As the evidence shows, Claimant has consistently been active in pursuing treatment and at no point rested on his rights to pursue a change of condition claim for his right knee. Claimant actively sought and underwent all recommended treatment provided by Defendants, including surgery, until they denied right knee surgery with Dr. Paylor.

Now Defendants expect this Panel to entertain a strict reading of the Statute but glance over the specific language the parties agreed upon in the Consent Order dated March 16, 2011. Defendants expect a strict reading of the twelve-month period following the Form 16A settlement and assert Claimant did not timely pursue or preserve his right knee change of condition claim during that period. In contrast, Defendants request this Panel to treat the agreement of parties memorialized in the Consent Order as boilerplate language insufficient to preserve the known and properly plead issues as noticed by Claimant's Form 50 filing on November 16, 2010. Defendants agreed in the Consent Order to hold all other issues in abeyance

As referenced by the case law, it is an absurd result to suggest that Claimant, in need of recommended back surgery, should refuse the opportunity of treatment by an agreement of the parties rather than prolonged and continued adjudication of all issues plead. Claimant opted to undergo treatment for his most symptomatic injury at the time while continuing to pursue treatment for his other injuries. Further, it is also an absurd result to assume that the Commission, properly noticed of issues plead in the Form 50 filing and held in abeyance by the parties in a Consent Order, should lose jurisdiction while Claimant is in active treatment and bar him from pursuing those issues once he is in the position to do so. Claimant actively pursued and received treatment

for his back and then his right knee, all authorized by Defendants, until Dr. Paylor recommended right knee surgery. At that time, Claimant filed a hearing request to continue treatment for his right knee. Therefore, Claimant's change of condition claim for his right knee is proper and the Commission has jurisdiction to hear the claim.

As noted herein, the Supreme Court's language clearly indicates that a claim be made—that the notice of the change of condition claim be given—within the one-year time period and that subsequent development of the case, hearing, and decision can all be accomplished outside the one-year time period. See also Candado Stevedoring Corp. v. Willard, 91 F. Supp. 77, 80 (E.D.N.Y. 1950) aff'd, 185 F.2d 232 (2d Cir. 1950) ("it was sufficient if proceedings were 'begun' within the year which . . . means from the time of the filing of the claim and giving of notice"). This interpretation is the only reasonable one because, as the Court in Allen recognized, it takes time to develop a case for hearing and there is no need to adjudicate a change of condition claim for treatment if such treatment is already being provided. It is disingenuous to think that a Claimant should pursue something that Defendants are authorizing. Even outside the purview of Claimant's right to pursue a change of condition claim, adjudicating a request for treatment already being provided is not in the interest of judicial economy.

Defendants' arguments are contrary to the plain language of the Commission's rules and the applicable statute, as interpreted by the Supreme Court. For these reasons, the Single Commissioner's order should be affirmed.

II. The Single Commissioner correctly determined that Claimant sustained a compensable change of condition to the right knee.

A review of all the evidence on the record in this claim shows that the Single Commissioner correctly determined that Claimant sustained a compensable change of condition and is entitled to

further medical treatment. Specifically, the Single Commissioner correctly determined that Claimant is entitled to all causally related medical evaluation and treatment expenses, including right knee surgery as recommended by Dr. Paylor.

In order to prove a change of condition under § 42-17-90, the claimant must show a change in condition as a result of his original injury, occurring after the first award. Causby v. Rock Hill Printing & Finishing Co., 249 S.C. 225, 227, 153 S.E.2d 697, 698 (1967). To justify a modification of an award based on a change of condition, the claimant must show the change of condition and its causal connection to the original compensable accident. Krell v. S.C. State Hwy. Dept., 237 S.C. 584, 588, 118 S.E.2d 322, 323 (1961). The Claimant in this case has carried this burden in both regards.

The medical evidence shows that Claimant first made mention of his right knee injury to Dr. Wessinger on April 30, 2008; then again on a Patient Recheck Questionnaire completed at Dr. Wessinger's office on October 6, 2010; and on FMLA application paperwork, and a FMLA patient addendum from Steadman Hawkins dated October 6, 2010. (APA pp. 10, 14, and 191) During this period, Claimant actively treated for his back and right shoulder, both of which required surgery and periods of immobility. (APA p 175, 230; Hrg. tr. p. 17, line 18 – p. 18, line 9)

While in pain management following surgery, Dr. Math noted Claimant complained of right knee pain that had gotten worse after returning to activity post-surgery; that she attempted to contact workers' compensation as his right knee needed serious medical attention; and that claimant's June 25, 2013 MRI was read to reveal an extensive tear in the lateral meniscus, possible bucket handle tear, and lateral tibiofibular chondromalacia. (APA pp. 101, 110, 121, 416) While waiting for authorization of treatment, Claimant's knee started to make noises – cracking and popping – when he walked and he developed a limp from right knee pain. (APA pp. 121) On June

13, 2014, Dr. Math opined that it is more likely than not that the increased activity and walking that Claimant engaged in pursuant to his medical providers' advice following his back surgery aggravated his right knee pain causing the need for additional evaluation and treatment of his right knee. (APA p. 140)

Claimant requested, and Defendants authorized, treatment with Dr. Paylor for Claimant's right knee. (APA pp. 181 and 182) During a March 25, 2014 follow up visit, Dr. Paylor noted that Claimant's right knee was getting worse and still swollen; that he required a cane to walk; was unable to work; and still waiting for surgery as recommended on November 5, 2013. (APA pp. 178 – 180) In a June 26, 2014 statement, Dr. Paylor opined that it is more likely than not that Claimant suffered injury to his right knee as a result of his motor vehicle accident while working on or about March 11, 2008, that his right knee symptoms became less noticeable as he pursued treatment for other injuries and was less active, and then became more symptomatic again as treatment for his other injuries wound down and he increased his activity and began walking more following his back surgery. (APA 185; also see, Paylor depo p. 40, lines 11 - 18)

Dr. Paylor testified in his deposition that the only known cause for Claimant's right knee problems was the March 11, 2008 motor vehicle accident and that it is a regular occurrence for the severe injuries from an auto accident to be treated first and then other injuries that were not as noticeable at the time of the injury to arise later. (Paylor depo p. 24, lines 12 – 24; p. 25, lines 12 – 21; p. 30, lines 8 – 13; p. 30, lines 23 – 25) Dr. Paylor testified that on Claimant's right knee MRI, the handle portion of the bucket-handle tear can no longer be seen, indicating the tear has been present a long time. (Paylor depo. p. 34, line 22 – p. 35, line 2)

In her September 3, 2014 deposition, Dr. Math opined to a degree of certainty, greater than 50 percent, that the motor vehicle accident most likely caused Claimant's right knee traumatic tear.

(Math depo. p. 34, line 20 – p. 35, line 8; p. 58, lines 5 – 22) Dr. Math testified that in her experience, she commonly sees patients complain about the most symptomatic body part, receive treatment for that one body part, the body part improves, and then the focus shifts to the next more symptomatic body part that was injured but underlying. (Math depo. p. 67, lines 10 – 21) Dr. Math maintained and reiterated her June 13, 2014 statement that, to a reasonable degree of medical certainty, more likely than not, Claimant's increased activity after his back surgery aggravated his right knee pain causing the need for additional evaluation and treatment. (Math depo. p. 173, lines 2 – 18)

In Dr. Wessinger's October 10, 2014 deposition, outside the period of Claimant's treatment with him, he testified that he would defer to the opinion of Dr. Paylor who had the opportunity to see the diagnostic imaging and examine Claimant's right knee. (Wessinger depo. p. 70, lines 15 – 21; p. 71, lines 13 – 21)

As the record reflects, Claimant has consistently reported his right knee condition to his providers as he recovered from right shoulder and back surgery. Additionally, the Single Commissioner found Claimant credible in his testimony, wherein he described – consistent with the medical records – the gap between his initial reporting of his right knee injury and his later complaints as being due to the greater pain he felt and priority he gave to addressing his back and right shoulder.

Defendants' reliance on Robbins regarding the sufficiency of evidence for a change of condition claim is misplaced, as the factual and legal framework in that claim differs from the current claim. Robbins v. Walgreens & Broadspire Servs., Inc., 375 S.C. 259, 652 S.E.2d 90 (Ct. App. 2007). In Robbins, claimant "was afraid to inform his employer or request additional treatment [for his injury] for fear of being terminated" and sought to hide the extent of his injury.

Robbins, 375 S.C. 259, 263, 652 S.E.2d 90, 92. Additionally, the only evidence regarding claimant's condition was that it was similar both before and after the settlement and that his treating physicians did not opine his condition had worsened. *Id.*, 375 S.C. 259, 265-266, 652 S.E.2d 90, 94.

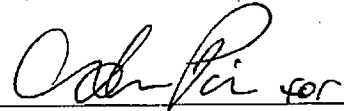
In the present case, Claimant has pursued treatment for his right knee and told all his providers. (Hrg. tr. p. 31, line 13 – 25) Even before retaining counsel, his right knee was listed in the Form 16A settlement agreement drafted by Defendants. Claimant has not, nor sought to, shy away from reporting his injury or requesting additional treatment. Additionally, Claimant's testimony, supported by the opinions of Dr. Math and Dr. Paylor, is that his right knee condition has changed for the worse. Again, the Single Commissioner found this testimony creditable.

Based on the record as whole, Claimant met his burden of proof in establishing a change of condition claim. Claimant properly gave notice of his change of condition, pursued treatment, and course of treatment shows his condition has deteriorated since the original award. Therefore, the Single Commissioner's decision should be affirmed in its entirety.

CONCLUSION

Claimant respectfully submits that the Single Commissioner committed no error and correctly determined based on the facts and law that the Commission has jurisdiction over Claimant's claim for a change of condition to his right knee. Based on the facts and law, the Single Commissioner also correctly determined Claimant sustained a compensable change of condition to his right knee. Defendants' arguments against these findings should be rejected by the Panel, and the Single Commissioner's Order should be affirmed in its entirety.

Respectfully submitted,



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Date: May 26, 2015
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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM THE SOUTH CAROLINA WORKERS'
COMPENSATION COMMISSION APPELLATE PANEL

Gene McCaskill, Commissioner
Melody L. James, Commissioner
R. Michael Campbell, Commissioner

W.C.C. File No. 0802605
Appellate Case No.2015-002120

Tommy G. Houston, ... Claimant,

v.

Garda World Security, ... Employer/Defendant,

and

Gallagher Bassett Services, Inc., ... Carrier/Defendant,

Of Whom

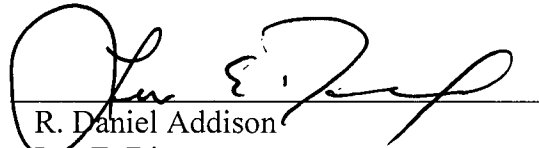
Defendants are Appellants,

and

Claimant is Respondent.

CERTIFICATE OF COUNSEL

This is to certify that the **Record on Appeal** contains all material proposed to be included
by any of the parties and not any other material.

A handwritten signature in black ink, appearing to read "Lee E. Dixon", is written over a horizontal line.

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