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SC Court of Appeals

THE STATE OF SOUTH CAROLINA

In The Court of Appeals

APPEAL FROM THE WORKERS COMPENSATION COMMISSION

T. Scott Beck, Commissioner
Susan S. Barden, Commissioner
Gene McCaskill, Commissioner

Appellate Case No. 2016-002294

Timothy McDuffie, Employee, Claimant, Respondent,

v.

Johnson Food Services, LLC, Employer, and Great American Alliance Insurance Co./Strategic
Comp., Carrier, Appellants.

RECORD ON APPEAL

Volume II

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South Carolina Workers' Compensation Commission
WCC File # 1413546

Timothy McDuffie,	)	
	)	
Employee,	)	Deposition
	)	
Claimant,	)	of
	)	
vs.	)	Christopher Mazoue, MD
	)	
Johnson Food Services, LLC,	)	
	)	
Employer,	)	
	)	
Great American Alliance	)	
Insurance Company,	)	
	)	
Carrier,	)	
	)	
Defendants.	)	
	)	

Deposition of Christopher Mazoue, MD, taken pursuant to the South Carolina Rules of Civil Procedure and the Administrative Procedures Act, commencing at the hour of 2:08 p.m., Monday, October 19, 2015, at University of South Carolina School of Medicine, Department of Orthopaedic Surgery, Two Medical Park, Suite 404, Columbia, South Carolina.

COPY

Reported by
Barbara P. Scott, CVR-M

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Exhibits

No exhibits marked.

Court Reporter's Note: This transcript may contain quoted material. Such material is reproduced as read or quoted by the speaker. Double hyphens (--) denote interruption of speech, incomplete sentence/phrase, or trailing off. [ph] denotes phonetically written. [sic] denotes written as spoken.

Stipulations

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

Whereupon,

Christopher Mazoue, MD, being duly sworn and cautioned to speak the truth, the whole truth, and nothing but the truth, testified and deposed as follows:

The Court Reporter: State your name for the record.

The Deponent: Christopher George Mazoue.

Examination

By Ms. Hapeshis:

Q Dr. Mazoue, I'm here today on behalf of the Huff -- Huff & Hapeshis Law Firm, and I've got a few questions to ask you in reference to a patient that you saw. But before we do that, let me go to some background. Where are you currently employed?

A University of South Carolina School of Medicine, Department of Orthopaedic Surgery.

Q And how long have you been there?

A Thirteen years.

Q Have you ever testified in a deposition before?

A Yes, ma'am.

1 Q And have you ever been qualified as an expert?

2 A Yes, ma'am.

3 Q In what fields have you been qualified as an
4 expert?

5 A Orthopedic surgery.

6 Q Orthopedic surgery.

7 Ms. Hapeshis: I have no objection to
8 qualifying him as an expert in --

9 Mr. Safran: Stipulation is fine.

10 Ms. Hapeshis: Okay.

11 Mr. Safran: We can put his CV in if you
12 want.

13 Ms. Hapeshis: That's great. That'll cut
14 some time out.

15 Q All right. What I'm going to do is go through --
16 and I don't know if you have Mr. McDuffie's records
17 in front of you, but what I'm looking at looks to
18 be your IME report. It is from June 10th of 2015.

19 A Yes, ma'am.

20 Ms. Hapeshis: Do you have that, as well,
21 Andy?

22 Mr. Safran: I do, yes. Yes.

23 Ms. Hapeshis: Okay.

24 Q What I'm going to do is just kind of go through the
25 report and just ask you some questions on it.

1 A Yes, ma'am.

2 Q All right. On June the 10th, were you -- did you

3 actually perform the visit that day?

4 A Yes, ma'am.

5 Q And was that for Mr. Timothy McDuffie?

6 A Yes, ma'am.

7 Q And how did you come to have Mr. McDuffie in your

8 office?

9 A It says in my note he was referred by his lawyer,

10 Lawyer Andy Safran.

11 Q Okay. About how many referrals do you get from Mr.

12 Safran?

13 A I have absolutely no idea. I don't know the answer

14 to that.

15 Q Okay. Would it be more than ten, more than 20 or

16 --

17 A More than ten.

18 Q Okay.

19 A You said per year or per --

20 Q Per year.

21 A More than ten.

22 Q Okay. Just a few questions on the visit that day.

23 What was Mr. McDuffie's chief complaint?

24 A Left knee pain.

25 Q Okay. And did he happen to tell you what happened

1 to him?

2 A He said that on September 19, 2014 he tripped over
3 a pipe at work and felt a pop in his knee,
4 referring to the left knee. He stated that he did
5 not land on his knee but he caught himself with his
6 hand. So, that was his -- his -- that was the
7 incident that occurred.

8 Q Okay. And your knowledge of that incident, was
9 that from his statement to you?

10 A Yes, ma'am.

11 Q Okay. Obviously, you know, you weren't hanging out
12 at his job.

13 A Correct.

14 Q Okay. He said that this is the first time being
15 seen for his knee. Is that your understanding,
16 this is the first visit he's had for knee problems?

17 A With us.

18 Q Okay. And the pain is constant. When someone says
19 the pain is constant, did he indicate that anything
20 made it better, worse?

21 A He said that standing for long periods of time,
22 laying down or twisting made his pain worse.

23 Q Okay. Do you know if he was working at the time
24 that he saw you?

25 A He stated that he was at full duty.

- 1 Q Okay. And do you know when this incident occurred?
- 2 A September 19, 2014.
- 3 Q So, this -- That's correct. This visit that you
- 4 had with him, is that -- would it have been about
- 5 nine months after the accident?
- 6 A Yes, ma'am.
- 7 Q Okay. I'm going to go to the second page of your
- 8 report. It looks like you did do a physical exam.
- 9 A Yes, ma'am.
- 10 Q Okay. And I'm looking at the first sentence where
- 11 it says the patient is alert and oriented, healthy-
- 12 appearing, in no acute distress. What does that
- 13 usually mean?
- 14 A That's pretty standard terminology, just meaning
- 15 that he's not in any significant -- he doesn't have
- 16 a significant medical condition. You know, he
- 17 doesn't look like he's diaphoretic or sweating,
- 18 short of breath, things that might suggest a heart
- 19 attack or a stroke or some major situation.
- 20 Q And pleasant affect. I'm going to ask this. What
- 21 does it usually mean when y'all notate pleasant
- 22 affect?
- 23 A Affect is just your personality.
- 24 Q Okay.
- 25 A It just means are they coming in -- are they nice,

1 are they appear depressed, are they crying, are
2 they cooperative with the examination. And, so,
3 he's a very pleasant person. His personality is
4 very nice.

5 Q Okay. It looks like your exam did pretty
6 thoroughly notate everything. You also said that
7 he had a good gait pattern.

8 A Mm-hmm.

9 Q What does that usually mean?

10 A He was walking well.

11 Q Okay. And when you say well, would you just say
12 walking, you know, --

13 A We didn't see an obvious major limp --

14 Q Got you.

15 A -- or anything like that. Yeah. We don't do a
16 gait analysis. We don't have them do force plate
17 measurements or things like that. But just on
18 gross observation, he was walking well.

19 Q Okay. And it says under alignment --

20 A Mm-hmm.

21 Q -- you found that was normal?

22 A Correct.

23 Q And effusion is none. Effusion, what do you do for
24 that?

25 A Effusion is swelling inside the knee joint.

1 Q Okay. And that would -- There was no swelling
2 present?

3 A No, ma'am.

4 Q Okay. A patella apprehension test was negative.

5 A Mm-hmm.

6 Q Can you just quickly tell me what that test --

7 A Mm-hmm.

8 Q -- was for?

9 A Mm-hmm. So, we push on the kneecap toward the
10 outside of the knee, and we're looking for
11 patellofemoral instability or patella instability.
12 And, so, a positive test means that when we push on
13 the inside of the kneecap toward the outside of the
14 knee, they don't like that. It develops pain and
15 discomfort.

16 Q Okay. And that test was negative?

17 A Correct.

18 Q So, is it a fair statement that he didn't have pain
19 or discomfort when you were pushing on it?

20 A Correct.

21 Q Okay. The next -- The next thing you noted was
22 patella tracking, normal. How is that different?

23 A Looking at the kneecap and when we bend the knee,
24 is the kneecap tracking basically in the groove how
25 it's supposed to track, because there are some

1 cases where the kneecap will track toward the
2 outside of the knee, and, in his case, it was
3 tracking normally.

4 Q Okay. A Lachman exam, negative. What does Lachman
5 tell you?

6 A Lachman exam is a test for the anterior cruciate
7 ligament.

8 Q Okay. Pivot shift?

9 A Mm-hmm. It's another test for the anterior
10 cruciate ligament.

11 Q Okay. And posterior drawer was also negative?

12 A That's a test for the posterior cruciate ligament.

13 Q Okay. And then you also noted the valgus and the
14 varus stress tests were negative.

15 A Mm-hmm.

16 Q And what does that usually test for?

17 A Valgus stress test, we're testing the medial
18 collateral ligament, and a varus stress test, we're
19 testing the lateral collateral ligament.

20 Q Okay. You also mentioned posteolateral -- you're
21 going to laugh at me -- stability was normal.

22 A Right.

23 Q And what is that test?

24 A So, the posteolateral corner is a series of
25 structures, ligaments, muscles, that provide

1 stability to the posterolateral part of the knee,
2 and he was not showing any evidence of an injury to
3 that first lateral corner, that series of
4 structures that provide stability there.

5 Q Okay. The TTP medial joint line, there's two signs
6 beside that. Was that a positive test?

7 A Yeah. So, tenderness to palpation -- TTP is
8 tenderness to palpation -- to the medial joint
9 line. I use the positive. So, I would have used 1
10 or 2 or 3, basically looking at their -- what the
11 perceived severity of the discomfort was. And, so,
12 the 2 means basically 2 out of 3, so a moderate
13 level of discomfort to palpation.

14 Q And how do you know he's in discomfort.

15 A Oh, he just hurts, says he hurts.

16 Q He says he hurts. Okay.

17 A Yes. Yes, ma'am.

18 Q So, it's subjective, what he -- Once you perform
19 the exam, he will subjectively --

20 A I mean, we're looking at his face, looking at his
21 expressions, and we'll ask, "Does that hurt?"

22 Q Okay. The lateral joint line, it says negative.
23 What's the difference between the medial and the
24 lateral?

25 A The medial joint line is on the inside of the knee.

1 The lateral joint line is on the outside of the
2 knee.

3 Q Okay. And the McMurray's test, if you can just
4 quickly -- what does that test for?

5 A McMurray's test is when you take the knee and you
6 basic -- you basically flex the knee, you bend the
7 knee, and then you put it into -- you rotate the
8 knee either toward the inside or the outside. When
9 we rotate it toward the inside, that's a -- and
10 there's pain, that's a positive medial joint line
11 McMurray's test. And then we bend it toward the
12 outside. That's the lateral joint line. So, in
13 his particular case, when we bent his knee and we
14 rotated it toward -- his foot toward the inside, it
15 hurt, and that's a test that we use primarily in
16 meniscus pathology, a meniscus tear, a meniscus
17 injury.

18 Q Okay. And when -- Again, when you said it was
19 positive and it hurt, it was what the -- Mr.
20 McDuffie --

21 A Again, objectively. We're looking at him. We're
22 looking for any signs of distress or discomfort,
23 but it is also we are asking him does it hurt and
24 does it hurt a lot, does it hurt a little. So,
25 there's both an objective and subjective portion of

1 it.

2 Q All right. On to the motor sensation. Says it's
3 normal.

4 A Correct.

5 Q I think both of those have -- were normal. And
6 then you state, "There is no gross --" and I'm not
7 even going to attempt to say that word.

8 A Lymphadenopathy.

9 Q What does that mean?

10 A That means swelling of the lymph nodes. So, we
11 might see swelling of the lymph nodes if there is
12 evidence of an infection, cancer, things like that,
13 and he didn't show any evidence of that.

14 Q Okay. Overall on this exam, would you say it was
15 normal?

16 A I would say that with the exception of the medial
17 joint line pain and the positive McMurray's, which
18 were -- were significantly positive, in my
19 assessment, the rest of -- The ligamentous exam
20 was normal. The patellofemoral exam was normal.

21 Q Okay. The problems that Mr. McDuffie had, -- It
22 looks like you did do a diagnosis. And what was
23 the diagnosis?

24 A Knee pain, and I was concerned about a medial
25 meniscus tear.

- 1 Q Okay. And what raised your concern about a
2 meniscus tear?
- 3 A His physical examination. So, his history and his
4 physical examination.
- 5 Q Okay. Combined. And when you say examination, are
6 you talking about the two positive --
- 7 A Yes, ma'am.
- 8 Q -- findings?
- 9 A Yes, ma'am.
- 10 Q Okay. All right. Let's go on to -- it's a letter
11 from July 9th of 2015 from Attorney Safran.
- 12 A Mm-hmm.
- 13 Q I'm just going to go through it briefly.
- 14 A Yes, ma'am.
- 15 Q Oh. Before I start that, this is the only visit
16 you had for Mr. McDuffie; is that correct?
- 17 A Yes, ma'am.
- 18 Q Okay. And I see from -- If you look at Mr.
19 Safran's letter, it says that you evaluated him for
20 left knee symptoms. And, again, what symptoms was
21 he having? Was it pain? Was it anything in
22 addition to pain?
- 23 A Just what we talked about earlier. So, the pain to
24 the inside of his left knee.
- 25 Q Okay. Again, in -- it looks like in Mr. Safran's

1 letter, he says that the claimant was involved in a
2 tripping injury that was followed by back and left
3 knee pain. Do you happen to see anything about
4 popping, any kind of popping, as part of the
5 description of the event in this letter?

6 A If you want, I can take time and read through it,
7 but --

8 Q Let's see. We can move along and compare, but I
9 believe in your medical note it says that he felt a
10 pop in his knee.

11 A Mm-hmm.

12 Q So, we can just stay clear with that, that with the
13 medical record, he did, in fact, tell you he had a
14 pop?

15 A Yes, ma'am.

16 Q Okay. And how did he say again it happened? I
17 believe this is Mr. Safran's description of it. If
18 you'll look at the second paragraph, he caught
19 himself, left lower extremity, jarring of left
20 lower back and buttock area. Is that -- Was that
21 your understanding of what happened?

22 A Can you show me where you're looking at?

23 Q If you look at the second paragraph, --

24 A Mm-hmm.

25 Q -- it's the one that says, "On September 23, 2014

1 --"

2 A Okay. Yeah. Okay.

3 Q Okay. Just making sure that that was --

4 A Yes, ma'am.

5 Q -- consistent.

6 A Yeah. It's consistent.

7 Q Okay. If you'll look on the second page of the

8 questionnaire, --

9 A Mm-hmm.

10 Q -- it goes through some medical certainty

11 questions, which I'm sure you've seen before.

12 A Yes, ma'am.

13 Q And, again, it talks about the mechanism of injury.

14 Is that what you believe happened that day?

15 A It's very consistent. Yes, ma'am.

16 Q Okay. And your knowledge of what happened that day

17 would have been based on the claimant's description

18 of the incident?

19 A Yes, ma'am.

20 Q Okay. Again, number 2, which talks about left-leg

21 symptoms, pain in the area of knee, and you say are

22 most probably consistent with the September 19,

23 2014 mechanism of injury?

24 A Yes, ma'am.

25 Q His symptoms, again, are pain; is that correct?

- 1 A Yes, ma'am.
- 2 Q Okay. Number 3, when you say there is well-
- 3 documented symptoms of both radicular left leg pain
- 4 and left medial knee pain, what did you base that
- 5 on?
- 6 A That was from the report from Mr. Safran.
- 7 Q Okay.
- 8 A So, I'm assuming he was correct in what he was
- 9 telling me.
- 10 Q Okay. Was it like a synopsis or was it past
- 11 medical reports he sent over?
- 12 A No. That was just from his letter.
- 13 Q His letter. Okay.
- 14 A Yes, ma'am.
- 15 Q Number 4, it talks again about the left knee
- 16 symptoms from the June 10th report. Once again,
- 17 it's talking about the September injury, and it
- 18 says do you believe that description identified in
- 19 the report result from that September 19th injury.
- 20 Is it your belief that they are related?
- 21 A Yes, ma'am.
- 22 Q Okay. And where it talks about treatment
- 23 modalities, it says that you recommended MRI. And
- 24 why is that?
- 25 A Because I was concerned about a meniscus tear. So,

1 here's an individual who's having pain to the
2 inside of his knee, the medial aspect of his knee,
3 for nine months. He had an injury that was -- that
4 was very consistent with the development of a
5 meniscus tear, and his physical exam was highly
6 consistent with a meniscus tear. Also included in
7 that were the x-rays that -- that did not show any
8 evidence of any arthritis in his knee or any --
9 And, so, all of those things we put together, and,
10 so, there was a -- in my mind a high likelihood of
11 a meniscus tear. And, so, I wanted to get an MRI
12 to -- to identify the meniscus tear, if it was
13 present, but, also, obviously, the MRI gives us
14 some ability to rule out other causes, whether or
15 not there's a synovitis within the knee, articular
16 cartilage in the knee, other things that could
17 potentially be causing pain, loose bodies, things
18 like that.

19 Q Okay. And when you talk about a meniscus tear, --
20 and you've talked about some of the tests that were
21 performed, and you said it was highly positive, the
22 test was. Were there any other tests or exams that
23 you would do normally that would also come back
24 positive to indicate a meniscal tear?

25 A Not that I do. There are all sorts of different

1 things that are written for meniscus tears.
2 There's a -- You know, you put the patient prone,
3 you lay him on his belly, and then you push down on
4 the knee and rotate the knee, and, you know, our
5 athletic training and physical therapy colleagues
6 have a-whole-nother set of different examinations
7 that they do, but, in my mind, for every patient,
8 it's -- tenderness to the joint line is the
9 McMurray's exam, in addition to their history and
10 what their radiographs looks like, that I'm making
11 that determination.

12 Q Okay. The McMurray's was positive on just one
13 aspect of it; is that correct?

14 A Just the medial joint line, yes.

15 Q Okay. You also say in number 5 that you recommend
16 an MRI scan and then some other treatment options
17 that are medically necessary. What would you say
18 would be medically necessary?

19 A Well, if he's got -- if he's got an MRI that
20 confirms that he has a meniscus tear, then I would
21 say he's a candidate for additional medical
22 treatment. That would -- Most likely I would be
23 talking to him about an arthroscopy or surgery.
24 Now, there are other options. You could talk to
25 him about doing an intra-articular corticosteroid

1 injection. That doesn't heal the meniscus tear,
2 but it may lessen his discomfort. So, that is
3 something that we will do on occasion. But in a
4 relatively young individual who has a clear
5 meniscus tear that I feel is the cause of his
6 symptoms, oftentimes we will recommend surgical
7 intervention for that.

8 Q To your knowledge, has he has the MRI performed
9 yet?

10 A I do not know.

11 Q Okay. And one other question. Have you had any
12 in-person or phone conversations with Attorney
13 Safran regarding your opinion?

14 A I don't know if we've talked specifically about
15 him. I wouldn't doubt it. You know, we talk about
16 patients on occasion, but I can't recall -- I just
17 don't know.

18 Q Okay.

19 A I don't know about him.

20 Ms. Hapeshis: If you'll -- I beg the
21 court's indulgence real quick -- or the court
22 reporter's indulgence. That's all that I
23 have, unless Mr. Safran has some.

24 The Deponent: Okay. Thank you.

25 Examination

1 By Mr. Safran:

2 Q Doctor, let me just ask you a couple of quick
3 things. These are -- This is a document that was
4 generated by the employer, and I guess this has
5 been submitted into evidence.

6 Ms. Hapeshis: What document is that,
7 Andy?

8 Mr. Safran: APA number 1.

9 Ms. Hapeshis: APA 1.

10 Q Would you look at the highlighted portion. Does
11 that history generally coincide with what you
12 understood the nature of this gentleman's mechanism
13 of injury was?

14 A Yes, sir.

15 Q All right. Let me ask you also -- I'm showing you
16 pages 23, highlighted portion, and page 39 of his
17 deposition.. I'd just ask you if you'd look at the
18 highlighted portion and see if that description is
19 also consistent with at least what you understood.

20 A Yes, sir.

21 Q Okay. I want to ask you just a couple of other
22 quick things. There were several places that this
23 gentleman went to, but in your experience have you
24 had people who have had injuries that involved the
25 lumbar spine and also leg pain in the past?

- 1 A Yes, sir.
- 2 Q Is there at least some potential for the leg
3 symptoms to come from multiple sources?
- 4 A Yes.
- 5 Q And can it be radicular as one component?
- 6 A Yes, sir.
- 7 Q Can it be proximal to the knee?
- 8 A Yes, sir.
- 9 Q Can it be both?
- 10 A Yes, sir.
- 11 Q And in your experience have you run into occasions
12 where people may have an injury of this type,
13 complaining of radiating pain, where it ultimately
14 proves to be multifaceted in terms of the source of
15 the pain?
- 16 A Yes, sir.
- 17 Q So, that's not necessarily uncommon?
- 18 A No, sir.
- 19 Q Okay. Let me ask you this. It looks like the
20 first medical I've got here highlighted -- and it's
21 in my APA -- from MedCare Urgent Care, presents
22 with left lower back pain that radiates down his
23 leg. Would that be similar to what you saw as far
24 as the gentleman reporting he had a back injury and
25 also pain in his leg?

1 A You're going to have to rephrase --

2 Q Well, let me rephrase --

3 A I'm sorry.

4 Q If, in fact, this gentleman initially reported back
5 pain and leg pain, is that consistent with what he
6 later told you, that he had a back injury and also
7 pain in his leg?

8 A Yes, sir.

9 Q Okay. And then I think he then went to the
10 hospital. And I'm looking again -- This has been
11 submitted from Baptist, where there's a history
12 here that says jarring his left lower back area --
13 excuse me -- catching himself on his left lower
14 extremity but jarring his lower back buttock area
15 and has since started to have pain down his left
16 lower extremity, from the buttock area to the
17 ankle. Is that history consistent with what you
18 understood?

19 A Yes, sir.

20 Q I see also that when he was at the hospital, that
21 there was a reference in the notes that were taken
22 I guess during the course of his stay specifically
23 -- I'm sorry. I thought I had it clipped. Here,
24 where there was an examination of the knee, range
25 of motion, left lower extremity, pain with

1 movement.

2 A Yes, sir.

3 Q Can you have a meniscus tear and still have range
4 of motion that's relatively normal?

5 A Yes, sir.

6 Q But you can have pain associated with the presence
7 of a meniscus tear?

8 A Yes, sir.

9 Q So, would that examination ultimately be consistent
10 with what you later saw in a focused knee exam?

11 A Yes, sir.

12 Q Let me ask you also -- And, again, from a time
13 standpoint, I'm sure that there have been questions
14 directly because of your seeing him, as was noted,
15 nine months later. From a temporal standpoint,
16 this happened on the 19th, and I'm looking here on
17 the date of this report. This is what date?

18 A September 23rd, 2014.

19 Q So, within a matter of days?

20 A Yes, sir.

21 Ms. Hapeshis: Andy, which report are you
22 referring to?

23 Mr. Safran: Baptist Hospital.

24 Q And I think the one that initially --

25 Ms. Hapeshis: What's the page number --

1 I'm sorry -- on the APA?

2 Mr. Safran: I really don't have it in
3 front of me.

4 Q This one that we mentioned earlier, also, what's
5 the date on this one?

6 A September 20th, 2014.

7 Q So, this would have been roughly within a day, and
8 the complaints were back pain and radiating down
9 the left leg?

10 A Yes, sir.

11 Q Okay. Let me ask you also -- At some point this
12 gentleman was referred over to Dr. Young, and I
13 want to just ask you this. And, again, this would
14 have been 9/24. So, again, we're talking days,
15 correct?

16 A Yes, sir.

17 Q Does he mention pain of the left medial knee here
18 in his history? And let me just show you that,
19 that paragraph.

20 A Mild medial left knee pain.

21 Q Would that pain be consistent with the pathology
22 that you ultimately suspect?

23 A Yes, sir.

24 Q And with your clinical exam?

25 A Yes, sir.

1 Q I see also that in this second page of the report
2 it says tenderness over the MCL area. For a non-
3 orthopedic surgeon, again, is that something that
4 you would find to be consistent, from that doctor,
5 --

6 A Yeah. The MCL actually lies directly over and is
7 actually -- The deep MCL attaches to the medial
8 meniscus, and, so, it could be highly consistent
9 that you could say that it's an MCL -- there's
10 tenderness of the MCL where it's actually the
11 medial meniscus.

12 Q Okay. And, again, would you, as an orthopedic
13 surgeon who specializes in sports medicine, have
14 probably a better ability to identify the source of
15 pain than maybe somebody who's more or less a
16 general practitioner?

17 A I believe so, yes, sir.

18 Q Okay. But when you see this, does this history, as
19 documented by Dr. Young, confirm what ultimately
20 your suspicions have been?

21 A Yes, sir.

22 Q And is this consistent, at least now after you're
23 giving -- doing your clinical exam, with a medial
24 meniscal tear?

25 A Yes, sir.

1 Q And this is as of the 24th of September, as I
2 understand it.

3 A Yes, sir.

4 Q Doctor, let me ask you this. On subsequent review
5 or re-evaluation, -- I'm looking here on September
6 29th. Is there still, also on this, reference to
7 mild medial knee pain?

8 Ms. Hapeshis: I'm sorry again, Andy. On
9 September 29th, is that still Dr. Young?

10 Mr. Safran: Dr. Young.

11 Ms. Hapeshis: Okay.

12 A Yes, sir.

13 Q All right. And I think -- Clinical examination,
14 does he also again reference does have some MCL
15 pain?

16 A Yes, sir.

17 Q And would these findings, again, be consistent with
18 what you're seeing at the time of your evaluation?

19 A Yes, sir.

20 Q All right. Doctor, I'm going to just show you
21 again quickly, when he came -- This gentleman came
22 back to see Dr. Young on October 13th, where he
23 said that follow-up for left knee, thigh and left
24 low back, he's still having some pain in these
25 areas. Is that, again, consistent, as far as the

1 knee, with what you ultimately saw and diagnosed?

2 A You would assume that's the knee he's referring to,

3 yes, sir.

4 Q Well, -- And I guess -- Let me ask you this.

5 When he actually does -- In the plan, does he not

6 say he is still having some complaints of the left

7 knee?

8 A Yes, sir.

9 Q All right. Doctor, let me just show you again a

10 report from November the 28th of 2014, where he

11 actually says PT made his left knee worse.

12 A Yes, sir.

13 Q If you have a meniscal tear that's untreated, can

14 the exercises that you would normally see, at least

15 in some type of spectrum of PT, have an

16 exacerbating effect, at least in terms of your

17 symptoms?

18 A It can, certainly, yes.

19 Q Okay. So, that would not be unusual, if he's got a

20 tear, that he would be having pain potentially with

21 PT?

22 A No, sir.

23 Q I think also -- Does he not mention on that same

24 visit pain in the medial anterior knee?

25 A Yes, sir.

1 Q Is that, again, consistent with what you ultimately
2 observed/diagnosed?

3 A Yes, sir.

4 Q All right. Let me ask you this. I know when you
5 were asked a question earlier about what this
6 gentleman complained about, -- I know in my
7 experience, but, just in general, when you see
8 somebody on a referral, you don't see them for back
9 pain, do you? That's not your area?

10 A Oh, I can see people with back pain, and I have
11 seen people with back pain.

12 Q Right, but I guess my question --

13 A That is not a common referral to me.

14 Q Right. If I make a referral to you, do I normally
15 send you back pain or do I send you things within
16 your expertise?

17 A Within my expertise, yes.

18 Q Okay. So, if, in fact, he was coming to see you
19 for your knee, you wouldn't have really focused on
20 anything on his back, I'm assuming.

21 A No, unless there was something within his history
22 or his exam that -- that warranted more of a focus
23 toward his back.

24 Q And did you feel comfortable, based upon your
25 request to evaluate his knee, that what you were

1 finding was something that needed some focused
2 treatment as it related to his knee?

3 A Yes, sir.

4 Q Okay. Doctor, let me just ask a couple of other
5 things, and I'll be done. Based upon the medicals
6 I've shown you, do you still believe to a
7 reasonable degree of medical certainty that in view
8 of the mechanism of injury, the documentation of
9 left medial knee pain, really from the outset, his
10 presentation to you, and, you know, his basic
11 clinical findings, that most probably this
12 gentleman has a high likelihood of having a medial
13 meniscal tear?

14 A Yes, sir.

15 Q And is the MRI really confirmatory in order to make
16 particular treatment recommendations?

17 A It is extremely helpful in diagnosing a medial -- a
18 meniscus tear.

19 Q Let me ask this. Is it safe to say that even
20 though there may be a spectrum of tests that people
21 may choose to use, that the McMurray's test has
22 actually kind of always been the one, at least in
23 recent times, that is associated with determining
24 whether or not, clinically, somebody has a medial
25 meniscal tear?

- 1 A Yes, sir.
- 2 Q I mean, for lack of a better word, clinically, is
- 3 that kind of the standard that you look for?
- 4 A Yes, sir.
- 5 Q So, is that, again, something, when he has three
- 6 pluses next to it, that you feel like is reliable
- 7 in your exam to determine that yes, mostly likely
- 8 this guy has got a medial meniscal tear?
- 9 A Yes, sir.
- 10 Q And you can put a 1 or up to a 3?
- 11 A Yes, sir.
- 12 Q When you put 3, that's a significant finding?
- 13 A Yeah. Again, that's my own --
- 14 Q Sure.
- 15 A -- nomenclature, but yes. So, a -- 3 pluses for me
- 16 is highly significant.
- 17 Q Now, I know you were asked several times about what
- 18 this gentleman said and what was subjective versus
- 19 objective. Aren't there clinical tests that have
- 20 been devised that are supposed to have, as you
- 21 mentioned earlier, some level of objectivity to
- 22 give you --
- 23 A Yes, sir.
- 24 Q -- information that kind of goes beyond what --
- 25 maybe what somebody says?

- 1 A Yes, sir.
- 2 Q We don't do a McMurray's test in a vacuum, then,
3 I'm assuming.
- 4 A Correct.
- 5 Q When you're doing that, -- I think you had
6 mentioned earlier -- not only are you moving the
7 knee; you're gauging the facial response, I'm
8 assuming also the response of the body, --
- 9 A Yes, sir.
- 10 Q -- as you're doing that?
- 11 A Yes, sir.
- 12 Q You've been actually here for 13 years, correct?
- 13 A Right. Yes, sir.
- 14 Q You had a fellowship training with Dr. Andrews,
15 also?
- 16 A Yes, sir.
- 17 Q So, you've actually been doing examinations of that
18 type for about how long?
- 19 A Well, including residency, you add another five
20 years to that. So, 13 plus 1 plus 5. So, 19 --
- 21 Q So, almost 20 years. And you've done the
22 McMurray's examination countless times, I'm
23 assuming:
- 24 A Yes, sir.
- 25 Q Over time, have you developed, in your own mind, a

1 -- for lack of a better word, kind of a litmus test
2 or a smell test to see if somebody's being less
3 than candid with you when they are giving a
4 response to a clinical exam?

5 A Yes, sir.

6 Q Do you have to do that, actually, in order to be
7 able to accurately assess people's injuries?

8 A Yes, sir.

9 Q Did you find anything in the presentation from this
10 gentleman that would in any way have been
11 inconsistent with what his response to you was
12 verbally as compared to what you clinically
13 perceived in moving the leg?

14 A No, sir.

15 Q Are you comfortable with the reliability of the
16 clinical exam that you performed on that day?

17 A Yes, sir.

18 Q And, again, with the type of injury this guy had,
19 where I think he ended up -- kind of tripped over
20 something he wasn't expecting was there and it kind
21 of snagged his leg, is that something that you
22 would expect, with these symptoms, to be the source
23 of them, you know, given the circumstances?

24 A Yes, sir.

25 Q Okay. When you're treating meniscal pathology, is

1 it better to deal with it sooner rather than later
2 in terms of a recovery?

3 A I would say obviously if you can treat it earlier
4 and you take away their pain and dysfunction, then
5 clearly that is a better outcome.

6 Q And when you have a meniscal tear, if it's a bad
7 meniscal tear, what are the long-term consequences
8 that you see, even if you do a resection or try to
9 do a repair?

10 A Articular cartilage damage.

11 Q Okay. And is the fact that there's an extended
12 delay in repairing it -- does that in any way have
13 an impact on the potential for articular cartilage
14 damage down the road?

15 A Yes, sir.

16 Q So, is it -- am I safe in saying the longer we go,
17 at least it increases the possibility or the
18 likelihood that somebody's going to develop
19 articular cartilage damage?

20 A Yeah. So, there can be a direct injury with regard
21 to the meniscus and the torn part of the meniscus
22 creating damage to the articular cartilage, but
23 then there is the other portion of it where he has
24 a tear to the meniscus, so the meniscus isn't
25 functioning properly, and that increases his risk

1 for articular cartilage injury.

2 Q Is it safe to say that the lack of function of the
3 meniscus is what kind of starts more or less
4 involving the articular cartilage element of it?

5 A Yes, sir.

6 Q So, the longer you go with a torn meniscus that at
7 least is not stabilized, the higher your potential
8 of articular cartilage damage is going to be with
9 the passage of time?

10 A Yes, sir.

11 Q Okay. Give me one quick second. I think I will be
12 done. Let me ask also -- I have a reference in
13 the deposition where the gentleman was talking
14 about that when he sits, there's a period of time
15 where he has to keep his leg extended, and then if
16 he keeps it there too long, he needs to bring it
17 back and bend it, but then after a while he has to
18 extend it again. Would that phenomena be something
19 consistent with a medial meniscal tear?

20 A Yes, sir.

21 Q Also, is it possible for somebody to have
22 intermittent limp when they had a medial meniscal
23 tear? And by that I mean it's not present
24 constantly but that it does manifest itself, just
25 depending, during the course of activities or any

1 time of day actually.

2 A Yes, sir.

3 Q So, the fact that somebody may perceive, you know,
4 a mild limp, then another person might not
5 necessarily appreciate it, that would not in any
6 way detract from the fact that there seems, in your
7 mind, that most probably there is a medial meniscus
8 tear that's been occurring here?

9 A Correct.

10 Q So, again, the limp or the gait issue is variable
11 as it relates to the level of dysfunction at a
12 given moment?

13 A Yes, sir.

14 Q And is it safe to say that you've seen in the past
15 where that has been the case in patients, that they
16 may one day present with some limp, another day
17 they may not have really anything noticeable?

18 A Yes, sir.

19 Q Okay. And would the fact that a limp is not a
20 constant presence with this gentleman in any way
21 change your mind about causal relationship or the
22 need for treatment in this instance?

23 A No, sir.

24 Q Have all the answers that you've given to my
25 questions been to a reasonable degree of medical

1 certainty, most probably?

2 A Yes, sir.

3 Q Okay. Give me one second. Oh. One last thing.

4 Does the fact that the tests that were done
5 clinically for things like the ACL, the MCL, the --
6 any type of posterior or lateral issue -- does the
7 fact they're negative in any way undermine or take
8 away from the fact that the meniscal pathology is
9 present?

10 A No, sir.

11 Q You can have one without the other?

12 A Correct.

13 Q So, even though all those things were normal, this
14 gentleman has symptoms that have a -- at least in
15 your estimation and most probably to a reasonable
16 degree of medical certainty your opinion, an
17 objective pathological basis?

18 A Correct.

19 Q Okay. And that basis, again, stems from most
20 probably the September 19, 2014 work-related
21 accident?

22 A Yes, sir.

23 Mr. Safran: I have nothing else. Thank
24 you.

25 Ms. Hapeshis: I have a few in follow-up.

1 Andy, if I could see that APA 1.

2 Mr. Safran: Sure.

3 Ms. Hapeshis: I don't have a copy of
4 your most recent.

5 Mr. Safran: I think it's the same as the
6 original one.

7 Ms. Hapeshis: Okay. They must not have
8 put the APAs behind it. Okay.

9 Re-examination

10 By Ms. Hapeshis:

11 Q On APA 1, I believe Mr. Safran had asked you some
12 questions, if this description of injury is
13 consistent with a possible meniscal tear.

14 A Mm-hmm.

15 Q Do you know who Ernest Roberts is?

16 A I do not know.

17 Q But is that Mr. McDuffie's --

18 A That is not Mr. --

19 Q -- statement?

20 A Ernest Roberts is different than --

21 Q Than Mr. McDuffie?

22 A -- Timothy McDuffie, yes.

23 Q Okay. I just wanted to make the record clear for
24 that. Also, we can go to your note of June the
25 10th of 2015. And you can take as much time as you

1 need, but do your notes at all state that Mr.
2 McDuffie had back pain?

3 A Let me take a second. He stated that he had a back
4 injury and was seen for that. Yes, ma'am.

5 Q Okay. But does he mention anything about pain in
6 his back at your examination of him?

7 A No, ma'am.

8 Ms. Hapeshis: Okay. That's all I have.

9 Mr. Safran: Thank you. Nothing else.

10 The Deponent: Okay. Thank you.

11 (Whereupon the deposition was concluded at
12 2:45 p.m.)

13 **(Deponent has waived reading and signing.)**

STATE OF SOUTH CAROLINA
BEFORE THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO. 1413546

Timothy McDuffie,)
)
Employee,)
)
vs.)
)
Johnson Food Services, LLC,)
)
Employer,)
)
and)
)
Great American Alliance Insurance)
Company,)
)
Carrier.)

* * * * *

DEPOSITION OF: JOHN F. JOHNSON, M.D.

DATE TAKEN: Thursday, October 22, 2015

TIME: 4:30 p.m.

PLACE: 1106 Chuck Dawley Blvd.
 Suite 200
 Mt. Pleasant, SC 29464

REPORTED BY: TERI L. SAMPSON, RPR,
 Notary Public and Certified
 Live Note Reporter

* * * * *

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A P P E A R A N C E S

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I N D E X

WITNESS: JOHN F. JOHNSON, M.D.

Examination	Page
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EXHIBITS:

(No exhibits were offered or marked for
identification.)

S T I P U L A T I O N S

It is hereby stipulated and agreed by and
between the parties hereto, through their respective
counsel, that the reading and signing of the
transcript is waived by the Deponent.

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1 MT.. PLEASANT, SC, THURSDAY, OCTOBER 22, 2015

2 4:35 P.M.

3 P R O C E E D I N G S

4 - - - - -

5 WHEREUPON,

6 JOHN F. JOHNSON, M.D.,

7 being first duly sworn, testified as follows:

8 EXAMINATION

9 BY MS. HAPESHIS:

10 Q Dr. Johnson, my name is Shelby Hapeshis and
11 I'm here today from the law firm of Huff & Hapeshis to
12 ask you some questions about a patient you have by the
13 name of Timothy McDuffie.

14 Before I ask you some questions, we would
15 like to put on the record, stipulate that you are an
16 expert in physical medicine, with an emphasis in spinal
17 pathology, by agreement of the parties.

18 With that said, what I'm going to do first is
19 I'm going to go to your visit that you had with him on
20 June the 11th of 2015. Do you have that report handy
21 by any chance?

22 A Yes.

23 Q Okay. And how did Mr. McDuffie come to your
24 office that day? Was he a referral or a regular
25 patient, or was this an IME?

1 A It was for an Independent Medical Exam.

2 Q Okay. And was he sent by Mr. Safran?

3 A Yes.

4 Q Okay. How long had it been since his date of
5 injury that you had this examination?

6 A I saw him on 6-11-15. His injury was
7 9-19-14.

8 Q Okay. So that was about nine or 10 months,
9 approximately?

10 A Yes.

11 Q Okay. And as a part of that exam, did you
12 review any medical reports?

13 A Yes -- well, I believe so. I don't have any
14 personal recollection, but that's normally how it
15 works. Let's see if I --

16 Q Okay. Did you -- if we can go down to the
17 second paragraph of your report, you talk about an
18 x-ray -- or an MRI, rather, that Mr. Peelle performed.
19 If you look down towards the end of that second
20 paragraph, it says, "Dr. Peelle ordered a lumbar MRI
21 scan. Dr. Peelle saw no evidence of structural
22 abnormalities on his MRI and released the patient to
23 full-duty work, no restrictions, as of January 2nd,
24 2013."

25 A Yes.

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1 Q Were you able to review that same MRI?

2 A Yes.

3 Q And is your opinion the same as to seeing no
4 evidence of structural abnormality?

5 A Yes.

6 Q Okay. What I'm going to do is go down to the
7 next paragraph, before you talk about that he was seen
8 at MEDcare, he was seen at Baptist emergency room, he
9 was seen at Moore clinic and Dr. Peelle is at Moore
10 clinic, and then you say, "I do not have any other
11 medical records," but then you talk about some history
12 he sends to you. It says that he saw a female doctor
13 and I guess he also told you about seeing an orthopedic
14 physician. Have you reviewed those records yet from
15 either of those two?

16 A I believe so.

17 Q Okay.

18 A Looking at lots of different records here.
19 If you give me the doctors' names, I could tell you for
20 sure.

21 Q They would be -- Dr. Mazoue would have been
22 the ortho?

23 A Give me a second to go through my records.

24 MR. SAFRAN: Mazoue is spelled M-a-z-o-u-e,
25 by the way.

1 MS. HAPESHIS: Thanks, Andy.

2 COURT REPORTER: Thank you.

3 BY MS. HAPESHIS:

4 Q And, Doctor, the reason I ask is at the time
5 of your IME, you said that you hadn't reviewed those
6 reports or the reports of Dr. Lembo, who I'm assuming
7 was the female physician, and I was just going to make
8 sure that was still the case today.

9 A No. I've got some reports that I received
10 recently and they include some records, but, yeah, I've
11 got them both.

12 Q Okay.

13 A Christopher Mazoue, is that right?

14 Q Right.

15 A I've got his and I've got some from -- let's
16 make sure I've got -- yeah, Dr. Lembo, I've got those
17 in front of me, yes.

18 Q Okay. I just wanted to make sure that you
19 had received those records as of today or reviewed
20 them.

21 A Yes.

22 Q I'll move on to the next question. When you
23 go down talking about the patient's pain, it says, "The
24 patient's pain is constant, 7 out of 10," he gives a
25 percentage to what's the back, what's the leg, "he

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1 denies any relieving or exacerbating factors. He
2 states no matter what he does, it seems to be worse."
3 What does that mean to you, the part about there's no
4 relieving or exacerbating factors?

5 A It means there's -- in his case, he had
6 severe pain that was unchanged regardless of anything
7 he did to try to get improvement such as changing his
8 position or altering activities or taking any
9 over-the-counter medicines, things like that.

10 Q Okay. All right. If we can move on to the
11 second page, did you do a physical examination of
12 Mr. McDuffie?

13 A Yes.

14 Q Okay. Let's just go to that physical
15 examination, just a few things, when you talk about
16 cranial nerves are grossly intact, what does that mean?

17 A It basically means the nerves from the brain
18 that don't have any direct bearing on his case, that
19 there's no evidence that they're abnormal. In other
20 words --

21 Q Okay, and --

22 A -- normal.

23 Q Oh, sorry.

24 A I was just going to say grossly intact is
25 normal.

1 Q Okay. And then you say, "a normal appearing
2 spine to gross inspection." So that's just a normal
3 inspection of the spine?

4 A Just looking at the spine under his clothes,
5 having him take his shirt off and examining, it looks
6 normal.

7 Q Okay. Next is, "Gait is slightly antalgic
8 with a flexed posture of the spine to five degrees."
9 Is five degrees good or bad?

10 A Well, it's not necessarily either. It's just
11 abnormal. In his case, I think it was a reflection of
12 him compensating because of some pain he was having by
13 leaning a little forwards. That gave him some
14 biomechanical advantage to lessen his pain. But it
15 was, I think, an unconscious thing. He wasn't even
16 aware he was doing it. The slightly antalgic gait just
17 means that it's an abnormal way of walking. He's
18 limping to a degree on that left leg.

19 Q Okay. I'm going to skip elsewhere and it
20 talks about upper extremity strength is five out of
21 five. Is that normal?

22 A Yes.

23 Q Okay. Lower extremity strength is five out
24 of five. Is that normal?

25 A Yes.

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1 Q "Hip and leg extension cause worsening pain,"
2 what was your alert that he was having worsening pain?

3 A He probably said ow or had a look of
4 discomfort on his face.

5 Q Okay. "Positive straight leg raise on the
6 left," what does that mean?

7 A That means from a sitting and lying position,
8 if his leg was extended at the knee, when I lifted it
9 up past parallel on the sitting and past 40 degrees
10 lying, that he had symptoms of pain from his back that
11 radiated down his leg, below his knee.

12 Q Okay. Patrick's sign is negative
13 bilaterally, what's a Patrick's sign?

14 A Patrick's sign is a finding on a test where
15 the hip joint is flexed and laterally bent, so it's
16 just twisting of the hip joint in a specific manner to
17 try to illustrate if there's a problem with the hip
18 joint or sometimes the sacroiliac joint.

19 Q Okay. And what was your diagnosis after the
20 physical exam of the client?

21 A Either lumbar radiculitis versus sacroiliitis
22 versus facetogenic pain. It appears that the
23 facetogenic pain was my No. 1 diagnosis because I went
24 on to say I thought he needed treatment to start in the
25 facet joints.

1 Q Okay. Finally, let me go down to the
2 treatment plan and look at the last sentence, it says,
3 "Since he has been working for the past six months
4 full-time, full-duty, I do not think there is any
5 reason to assign any restrictions." And is that your
6 opinion today?

7 A Today?

8 Q Yes.

9 A Well, I haven't seen him since. From the
10 records I've looked at from doctors who have seen him
11 more recently, he's having an even more difficult time.
12 I think I even noted in my records that while he was
13 working that way, he was still having a difficult time
14 doing it. My recollection was he just felt he couldn't
15 financially afford not to work.

16 So I would have to see him back and I guess
17 talk to him to see if I really thought he shouldn't
18 work, but my feeling is that at the time, I thought
19 he -- there was no reason to keep him out since it was
20 necessary for his livelihood.

21 Q Okay. And finally -- I'm sorry, I said
22 finally before, but the patient is instructed to return
23 if pain or symptoms arise. Has he returned to your
24 office?

25 A No.

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1 MS. HAPESHIS: Okay. That's all the
2 questions that I have unless Mr. Safran has
3 anything.

4 MR. SAFRAN: Yeah, I have a few.

5 EXAMINATION

6 BY MR. SAFRAN:

7 Q Dr. Johnson, let me just ask a couple of
8 quick things just -- we were just going over the
9 clinical examination. When you're dealing with a facet
10 problem, what's the significance of what you found in
11 terms of range of motion decreased particularly with
12 full extension?

13 A I think it's just another sign that's
14 suggestive of the pathology being in the facet joint
15 region. Biomechanical irritation of that joint that's
16 already aggravated or irritated or damaged is going to
17 happen with certain movements like the ones you just
18 talked about.

19 Q I make the comment or make the question
20 because I was looking at records I think I provided you
21 from Dr. Riber and Dr. Lembo where they both talk about
22 range of motion being particularly painful and abnormal
23 in terms of the extension. So they, I believe, are
24 using that also as kind of an indication of facet
25 problems. So, I mean, are their findings on clinical

1 exam of diminished extension and pain with extension,
2 No. 1, consistent with what you observed?

3 A Yes. It looks to me in reading their notes
4 that we're all three talking about the same thing.

5 Q All right. And again, is that difficulty
6 with extension something that classically is seen as
7 part of a facetogenic type of problem?

8 A Yes.

9 Q Let me ask you also, I think there was some
10 question about the MRI scan. In your practice, do you
11 see a reasonable number of patients who are suffering
12 from facetogenic or -- pain, which I think we would
13 define as pain coming from facet involvement?

14 A Yes. Maybe as many as 20 percent.

15 Q Okay. And so you're pretty familiar with the
16 idea of a post-traumatic facet syndrome, which is the
17 term you used in your report?

18 A Yes.

19 Q Basically, is facetogenic pain something that
20 really lends itself to accurate diagnosis by way of MRI
21 scan?

22 A No. Particularly if it's traumatic, it's --
23 very commonly, if it's a young person, there's not
24 going to be any objective pathology noted on scan
25 because it's more of a soft tissue, even microscopic

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1 tearing and inflammation of the joint area.

2 Q And the facet joints, are they, I guess,
3 innervated themselves to some degree?

4 A Yes.

5 Q And is the facet pain something that comes
6 from trauma to those facets where those nerves that are
7 in the facet joints basically start producing pain and
8 respond negatively to movements of the back in a
9 certain way?

10 A That's correct.

11 Q So I guess my question is, you deal with
12 post-traumatic facet syndrome pretty regularly, as I
13 understand it, is that correct?

14 A Yes.

15 Q And is what you're seeing in this gentleman,
16 particularly with the mechanism of injury that was
17 described in your report, really an unusual finding in
18 your practice?

19 A It is not, no.

20 Q With the mechanism of injury that I think is
21 noted in your report, and I believe it says that he
22 tripped and he kind of fell forward, but caught himself
23 to where he really didn't go completely down, severely
24 jarred his back and leg, is that mechanism of injury
25 one that would, based upon your experience, be

1 consistent with producing the type of symptoms that
2 have been documented in the medical records on this
3 gentleman going back to really right after he got hurt?

4 A Yes.

5 Q And when I talk about being documented, I
6 think the history has been throughout low back pain
7 that goes into the left buttock, that also went into
8 the left thigh. I mean, is that type of constellation
9 of symptoms something that you would routinely see with
10 a post-traumatic facet type of syndrome?

11 A Yes.

12 Q Now, also, when you mention that the straight
13 leg raise was, you know, somewhat positive, when you've
14 ruled out the nerve -- any kind of nerve impingement on
15 an MRI scan and you still are getting that straight leg
16 raise in the face of a post-traumatic facet type of
17 condition, is one generally kind of indicative of the
18 other?

19 A I'm not sure I understand the question.

20 Q All right. Well, let me ask this: If this
21 gentleman is having pain in his left buttock and left
22 upper thigh area on straight leg raise, would that be
23 consistent with the kind of pain that is referred from
24 the facet after they've been damaged like this?

25 A Yes.

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1 Q So really your finding of straight leg raise
2 of the type you did without any MRI findings of nerve
3 impingement would be consistent with your diagnosis of
4 a post-traumatic facet syndrome?

5 A Correct.

6 Q Okay. Let me ask you just a couple of other
7 things. I think one of the questions that came up
8 earlier was, you know, how do you know the guy is
9 hurting, and I think you mentioned it would either be a
10 facial expression or maybe a bodily movement. When you
11 do an exam on someone trying to kind of figure out
12 what's going on, do you build in through your own
13 procedure some safeguards to see if somebody is at
14 least responding appropriately?

15 A Yes.

16 Q And I saw that at one point earlier,
17 Dr. Peelle had mentioned that when he did his initial
18 exam on this gentleman, he referenced a negative
19 Waddell sign. What's the significance of that?

20 A It's referring to somebody who's essentially
21 trying to fake symptoms. In other words, if someone is
22 exaggerating or acting as if they have pain with
23 movements that -- or procedures that shouldn't cause
24 pain, then that's one of the things that's noted. But
25 it's a -- Waddell signs are a constellation of

1 different findings that are checked to see is the
2 patient reliable, are you therefore able to do a valid
3 exam, as opposed to someone with positive Waddell
4 signs, which would give an unreliable or inaccurate
5 diagnosis.

6 Q Let me ask you this: Even though you don't
7 mention Waddell signs as part of your clinical exam, do
8 you, again, also look for evidence that somebody might
9 not be responding in an appropriate way in terms of how
10 they give you indications of pain or any type of
11 limitation?

12 A Yeah. I respond both ways, if I think
13 somebody is not truthful with their complaints, then I
14 will make note of that. Over 25 years, I think I've
15 gotten pretty good in telling who's faking and who
16 isn't.

17 Q And was there anything that you saw in the
18 clinical examination of Mr. McDuffie that led you to
19 believe that his presentation was anything less than
20 valid?

21 A No.

22 Q Let me ask you also, there was some question
23 about the -- when you're measuring strength, and in
24 particular this situation, lower extremity strength,
25 five out of five, does the fact that somebody has a

Page 18

1 five out of five have anything to do with really
2 whether or not he's got a facet syndrome that is
3 creating symptoms?

4 A No. I would expect the muscles to be
5 functioning normally in light of -- or even with a
6 facet syndrome.

7 Q And I'm assuming that when the muscle would
8 be responding abnormally in that kind of test, it would
9 be indicative of, you know, some type of neurologic
10 process that really has nothing to do with the facets?

11 A Or a patient not giving forth a genuine
12 effort.

13 Q Okay. And neither of those are present here?

14 A Correct.

15 Q So basically, just for the commissioner, the
16 fact that somebody has a five out of five is in no way
17 inconsistent with your diagnosis of post-traumatic
18 facet syndrome or this gentleman's presentation that
19 you used to support the diagnosis?

20 A That's correct.

21 Q Let me ask you also, as far as looking at the
22 records I sent you, I believe you saw recent records
23 from Dr. Riber, who had an opportunity to look -- to
24 see this gentleman again on October the 12th?

25 A Yes.

1 Q I think when I was looking at his note, he
2 talks about his pain and dysfunction have become
3 progressively worse.

4 A Yes.

5 Q If a facet syndrome is untreated over a
6 period of time and somebody tries to maintain
7 relatively normal activities, is a worsening something
8 that would likely be expected?

9 A I believe so, yes.

10 Q And let me ask you this: If a facet syndrome
11 is untreated, basically, is it ever really going to get
12 better?

13 A It -- I guess it could get better in the
14 sense that the symptoms may abate, but may very well
15 get worse. Certainly in his case, he has the problem I
16 think that's completely separate in his knee, and
17 that's going to potentially exacerbate or not allow his
18 facet syndrome to necessarily get better or get better
19 as quick as it would. So...

20 Q So I guess the question is, if somebody, as
21 Dr. Mazoue has indicated to us in testimony, likely has
22 a torn meniscus, does the failure to treat the meniscus
23 compound the problems that are going to be coming from
24 the facet syndrome?

25 A Yes. I see similar cases with different kind

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1 of knee or hip or ankle pathology where I oftentimes
2 will tell patients until they get that fixed, they're
3 just not going to reach their potential for wellness,
4 even if we are treating the spine.

5 Q Okay. And I guess to a reasonable degree of
6 medical certainty, assuming Dr. Mazoue is correct, if
7 there is a torn meniscus, most probably would he need
8 to have treatment of that at least in conjunction with
9 the facet treatment in order to be able to try to have
10 some resolution eventually of his facet symptoms?

11 A Yes.

12 Q And does the failure to treat that really, as
13 you say, feed the continued presence of the facet
14 syndrome and likely prolong it?

15 A Absolutely.

16 Q Let me ask you also, Dr. Riber had indicated,
17 at least as of that day, that he felt like certain
18 restrictions of no twisting, stooping, or bending and
19 no lifting greater than 10 pounds were appropriate
20 given the nature of the symptoms and the presence of at
21 least clinical evidence of the facet syndrome. Given
22 those findings, I mean, do you have any reason to
23 disagree with that as the current status of what this
24 gentleman's work capacity should be?

25 A I don't. I've worked professionally with --

1 or I know Dr. Riber in a professional setting having
2 seen many of the same patients and I think he does a
3 fine job and trust him. And if he's seen him recently
4 and feels that way, then I would agree with it.

5 Q Okay. Let me ask you just a few other things
6 and I'll probably be finished. And again, Doctor, does
7 the absence of disc herniation or any kind of arthritis
8 or degeneration on an MRI scan in any way conflict with
9 your diagnosis of a post-traumatic facet syndrome or
10 the presence of the symptoms that this gentleman has
11 continued to experience now for quite some time?

12 A No.

13 Q Is extension -- and for the record, is
14 extension basically when you move your torso in a way
15 to move back, to, I guess, move your back like if you
16 were going to push backwards as opposed to bending
17 forward?

18 A That's correct.

19 Q All right. So if somebody is unconsciously
20 trying to walk maybe with a slight flexion, again, is
21 that consistent with somebody having facetogenic pain?

22 A Yes. The idea is biomechanically unloading
23 the facet, so we see that a lot in people who have
24 facet syndrome.

25 Q Did Mr. McDuffie ever ask you to take him out

Page 22

1 of work?

2 A No.

3 Q And in a workers' comp setting, if somebody
4 feels like they have to work to be able to make money
5 and continue, do you ever, you know, in a situation
6 like that, unless it's something that you feel like
7 they just can't possibly do it, ever discourage them
8 from trying?

9 A No, I don't.

10 Q Doctor, you had filled out a questionnaire
11 for me a little while back and I just want to go over a
12 couple of questions with you and just ask, is it still
13 your opinion, to a reasonable degree of medical
14 certainty, that the post-traumatic facet syndrome you
15 have diagnosed proximally results from the September
16 19, 2014 compensable accident that we described in
17 terms of his tripping and, you know, falling forward,
18 catching himself?

19 A Yes, it is.

20 Q All right. Is it still your opinion, to a
21 reasonable degree of medical certainty, that without
22 treatment and particularly in light of, you know, the
23 increased symptoms that have taken this gentleman out
24 of work for at least some period of time, that he is
25 going to continue to have difficulty in terms of

1 performing work activities, as well as activities of
2 daily living?

3 A Yes.

4 Q Is it also your opinion, to a reasonable
5 degree of medical certainty, that the facet directed
6 treatment that you, Dr. Lembo, and Dr. Riber have now
7 recommended is reasonable, medically necessary, and
8 aimed towards lessening the ultimate disability that
9 this gentleman is going to experience as a result of
10 this back injury that comes from his September 19, 2014
11 compensable accident?

12 A Yes.

13 Q And lastly, based on what I heard from you
14 also, do you believe, to a reasonable degree of medical
15 certainty, that the treatment of the left knee in
16 accordance with what Dr. Mazoue has suggested, which
17 specifically is get an MRI scan and if, in fact, there
18 is a scan, proceed with a meniscectomy, is also
19 essential to being able to effectively treat the back
20 symptoms?

21 A Yes.

22 Q And to a reasonable degree of medical
23 certainty is what Dr. Mazoue has proposed as it relates
24 to your or anyone's treatment of this post-traumatic
25 facet syndrome, is it reasonable, medically necessary,

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1 and aimed toward lessening the disability that
2 ultimately is coming from the September 19, 2014
3 accident through both the knee and the back?

4 A Yes.

5 Q Doctor, have all the answers that you've
6 given to my questions been to a reasonable degree of
7 medical certainty?

8 A Yes.

9 Q And they are most probably?

10 A Yes.

11 Q All right. Give me one second. I may be
12 done. I'm just looking at one thing.

13 Doctor, just a couple of quick things. The
14 Patrick's sign that you said was negative, is that
15 something in this context that you would generally
16 associate, I guess, if you're dealing with the spine
17 area, with like an SI joint problem?

18 A Yes.

19 Q And at least at this point, you feel like
20 that that is kind of low down in terms of the likely
21 source of the predominant pain here?

22 A Yeah, at this point, I feel much more
23 confident that it's all coming from -- well, not all,
24 but the facet joint in the spine and the, like I said,
25 exacerbation by the altered biomechanics from the knee

1 problem.

2 Q Okay. One last thing, I think you mentioned
3 here that -- when talking about constant pain, if this
4 gentleman's testimony basically is that, "I'm never not
5 hurting, and, you know, I try to sit, you know, for a
6 little while, but then I've got to get up, and after I
7 stand for a little while, I've got to get down, that
8 there's really nothing I've done to make this pain go
9 away," is that consistent with what you wrote down in
10 terms of "denies any relieving or exacerbating factor,
11 states no matter what he does, it seems to be worse"?

12 A Yes.

13 Q So effectively, if he's not getting any real
14 relief from medication, if alternating sitting and
15 standing doesn't provide any lasting relief, i.e., that
16 you have to go back and kind of keep doing that and
17 that he's really found nothing that really kind of
18 makes it stop, is that, No. 1, how you would interpret
19 the comments?

20 A Yes.

21 Q And is it also something in terms of a
22 symptom pattern that you would see routinely with a
23 facet syndrome?

24 A Yes, it is.

25 Q Okay. Doctor, I don't have anything else.

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1 Thank you very much.

2 A You're welcome.

3 MS. HAPESHIS: Nothing further. That
4 concludes the deposition.

5 (Deposition concluded at 5:05 p.m.)

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South Carolina Workers' Compensation Commission
WCC File # 1413546

Timothy McDuffie,	)	
	)	
Employee,	)	Deposition
	)	
Claimant,	)	of
	)	
vs.	)	Ezra B. Riber, MD
	)	
Johnson Food Services, LLC,	)	
	)	
Employer,	)	
	)	
Great American Alliance	)	
Insurance Company,	)	
	)	
Carrier,	)	
	)	
Defendants.	)	
	)	

Deposition of Ezra B. Riber, MD, taken pursuant to the South Carolina Rules of Civil Procedure and the Administrative Procedures Act, commencing at the hour of 4:14 p.m., Monday, October 26th, 2015, at Palmetto Pain Management, 1655 Bernardin Avenue, Suite 240, Columbia, South Carolina.

COPY

Reported by
Sandra M. Austin

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Sandra M. Austin

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Exhibits

<u>Marked as Plaintiff's Exhibit Number 1; Palmetto Pain Management Visit Note dated January 12, 2015; letter/questionnaire dated July 15, 2015; Palmetto Pain Management letter dated October 12, 2015; Palmetto Pain Management Visit Note dated October 12, 2015; eight pages.. . . .</u>	3
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Stipulations

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

(Prior to the deposition, the following exhibit was marked.)

Marked as Plaintiff's Exhibit Number 1;

Palmetto Pain Management Visit Note dated January 12, 2015; letter/questionnaire dated July 15, 2015; Palmetto Pain Management letter dated October 12, 2015; Palmetto Pain Management Visit Note dated October 12, 2015; eight pages.

Whereupon,

Ezra B. Riber, MD, being duly sworn and cautioned to speak the truth, the whole truth, and nothing but the truth, testified and deposed as follows:

The Court Reporter: State your name for the record.

The Deponent: Ezra B. Riber.

Examination

By Mr. Huff:

Q Dr. Riber, my name is Ros Huff. I'm the attorney that represents the employer. I know in the past

1 I've had the pleasure of having your deposition,
2 and I remember meeting you, and we were here
3 recently, but we had to reconvene. So, what I'd
4 like for you to do for me today -- because the
5 commissioner probably has read your deposition
6 before, but, just to make the record clean, can you
7 just give me a brief overview as to your
8 qualifications, any degrees and work history? Make
9 it 20 seconds, and then we can stipulate.

10 A Certainly. I have a medical degree from Marshall
11 University School of Medicine, an internship in
12 internal medicine from Marshall. I completed a
13 residency in anesthesiology at the University of
14 Cincinnati Medical Center where I also did a
15 fellowship in pain management. I've been in
16 practice in South Carolina for 28 years, and I'm
17 board-certified in anesthesiology and pain
18 medicine.

19 Mr. Huff: Andy, can we stipulate to his
20 qualifications --

21 Mr. Safran: Yes.

22 Mr. Huff: -- in anesthesiology and pain
23 medicine?

24 Mr. Safran: That -- That's fine.

25 Q All right. So, we don't have to do any more than

1 that. Where is your practice located, Doctor?

2 A Right here at 1655 Bernardin Avenue, Suite 240.

3 Q Right here next to the hospital?

4 A Correct.

5 Q Can you identify the hospital for me?

6 A Providence Hospital, --

7 Q Okay.

8 A -- downtown.

9 Q In the course of that practice, did you have an

10 opportunity to see a Timothy McDuffie?

11 A I did.

12 Q Will you tell me how you came about seeing him? In

13 other words, did he just walk in the door? Did

14 someone refer him to you? Just give me a brief

15 background.

16 A Looking at my HPI, History of Present Illness, it

17 just says he was seen for consultation and

18 evaluation.

19 Q And does --

20 A I don't recall.

21 Q Does it say who sent him to you at all? Do you

22 remember that?

23 A It does not.

24 Q The reason I ask, I'm looking at the -- Mr.

25 Safran's APA, -- that's Administrative Procedures

1 Act -- page 10, and it shows the first encounter
2 date could have been January 12th of 2015. Does
3 that sound correct?

4 A Yes.

5 Q And if you go down there, it will say, "Insurance,"
6 and it says, "Andy N. -- Andrew N. Safran." Would
7 that indicate that Mr. Safran may have ordered him
8 over to you?

9 A Yes.

10 Q Okay. I -- I forgot to tell you, if any time I ask
11 you a question you do not understand, just let me
12 know, --

13 A Yes, sir.

14 Q -- and I -- I've been doing this for 40 years.
15 I'm not here to trick anybody. Just trying to get
16 the facts. Mr. Safran sent him to you. Has Mr.
17 Safran sent any other of his clients to you, to
18 your knowledge?

19 A I'm sure he has.

20 Q All right. Just from your -- your personal
21 experience, do you think it's been more than ten or
22 less than ten clients, or patients, that he's
23 referred to you?

24 A In the 16 years I've been in practice, I would
25 think it's more than ten.

- 1 Q All right. When a person is referred to you,
2 whether by Mr. Safran or anybody, do they normally
3 send you a letter requesting certain information
4 from you or a certain type of testing they want and
5 certain medical records that may have predated you
6 seeing them?
- 7 A Do they request from us?
- 8 Q No. Do they send to you -- When they send --
9 refer a patient, do they send like a --
- 10 A Oh.
- 11 Q -- medical synopsis or medical record from previous
12 providers?
- 13 A Yes.
- 14 Q Do you know what medical records you had in this
15 case to review?
- 16 A I don't recall.
- 17 Q I notice that today you have what's known as an
18 exhibit that's a copy of all your records. Do you
19 have a file that you maintain, whether it be in
20 paper form or computer form?
- 21 A Yes.
- 22 Q How do you normally maintain your records, paper or
23 a computer?
- 24 A We have an EMR, electronic medical records.
- 25 Q Okay. And, thus, that's something that you could

1 print if needed, correct?

2 A Of course.

3 Mr. Huff: Andy, would you have any
4 objection, so I can make sure I have
5 everything, to ask the doctor to present a
6 complete copy of everything you have. We
7 don't have to have it today but before the
8 deposition because I just need them so I can
9 review them before my hearing.

10 The Deponent: Sure.

11 Q How soon do you think you could get those to us?

12 A It shouldn't take very long.

13 Q All right.

14 A What I have in front of me is most likely the
15 majority of everything from the two visits.

16 Q Yeah, what I'm looking at, there may have been some
17 handwritten notes that he could have filled out and
18 given that I may not have. Just to be on the safe
19 side.

20 A Okay.

21 Q Thank you very much. Now, it appears, from the
22 records that I have, the first appointment you have
23 is January 12th of 2015.

24 A Correct.

25 Q Tell me, in that appointment, what happens when a

1 person first comes to see you? In other words, I
2 want you to tell me they fill out a document while
3 sitting in a room, then they come in and we review
4 the documents, I do an examination. Just tell me
5 what happens when you see a patient the first time.

6 A We take a history. We have an intake document, and
7 then --

8 Q Who takes that history?

9 A One of the staff.

10 Q All right. In other words, the document is given
11 to the patient to fill out?

12 A We give them documents to fill out, and then they
13 take the vitals, and then we see them to take a
14 much more detailed history, exam, and come up with
15 a diagnosis and treatment plan, hopefully.

16 Q In this situation, Dr. Riber, where the -- excuse
17 me -- with Mr. McDuffie, were you sent Mr. McDuffie
18 to treat or to give a medical opinion?

19 A Well, we assume everybody is sent for potential
20 treatment. So, the opinion given is a combination
21 of our evaluation and what treatment we would
22 recommend, whether we get to treat the patient or
23 not.

24 Q Do you know, in this situation, when he was
25 referred to you, whether or not there was any

1 written statement or any type of statement for
2 treatment purposes or just for rendering a medical
3 opinion regarding causation and recommended
4 treatment?

5 A It looks like he was sent for an IME.

6 Q What does that mean?

7 A Independent medical evaluation. So, that's the
8 consultation evaluation, and following, which we
9 have recommendations that we make, and --

10 Q All right.

11 A -- if we see the patient back for treatment, that's
12 fine. If not, hopefully somebody else that treats
13 them benefits from our evaluation.

14 Q And I imagine they would. Okay. A different set
15 of eyes. Okay. No problem. All right. Looking
16 at this, it -- you have something that's written
17 down as chief complaint. What does that mean when
18 you say chief complaint?

19 A That's the main reason the patient is there, what
20 they are complaining of.

21 Q So, in other words, in this situation, can you tell
22 me -- It looks like there were three things that
23 he was complaining of. Is that correct?

24 A Yes.

25 Q What were those three things?

1 A Low back and left buttock pain as well as pain in
2 his left knee.

3 Q He didn't complain of any other body part, did he?

4 A These were the chief complaints. These were the
5 primary complaints. He may have had others, but
6 those are the other -- only ones I listed.

7 Q All right. If there were other complaints, is
8 there a reason why you would not list them, like
9 they're not that significant, or why would you not
10 list them?

11 A Typically, just by definition, chief complaint is
12 the main reason the -- the patient is there.

13 Q All right. I notice you're saying left buttock and
14 left knee pain which -- Can you tell me where was
15 the low back pain -- because, you know, in the low
16 back, we've got the left, the right, and the
17 middle. Where would that low back pain be?

18 A If I wrote low back, then it was typically across
19 the whole low back.

20 Q Okay. Did you put down -- because I do notice
21 further down, when you talk about he continues to
22 have the back, gluteal and knee pain, he rates his
23 overall pain as a five to six out of zero to ten.
24 So, when you say five to six, are you talking about
25 all three levels, the low back, the left buttocks

1 and the left knee? What do you mean when you say
2 that?

3 A In this case, it indicates just his overall pain
4 level.

5 Q Okay. Did he tell you -- Did he give you a
6 history of what may have been the precipitating
7 event that caused him to have this chief complaints
8 that you've listed?

9 A He fell while at work and fell in an awkward
10 position, injuring his back and knee.

11 Q All right. Do you know what date he said that
12 occurred?

13 A 9/9/14.

14 Q Okay. Did he state to you whether or not he -- he
15 fell and struck the ground, or was it more of a
16 twisting type of motion where he contained himself
17 and did not fall to the ground?

18 A I can't remember exactly, but I believe one of the
19 key points about his fall was that it was with a
20 twisting motion and in an awkward position.

21 Q Do you know whether or not he actually fell and
22 struck the ground or struck any object?

23 A I don't recall.

24 Q Would that have been important? And if it was,
25 would you have documented it?

1 A It is important, but it's possible that I didn't
2 document that particular detail of the fall.

3 Q I notice you show that his height is six-foot-two
4 and weight is 217. How would you characterize
5 that? Is that being a moderate weight, overweight,
6 slim? How would you define that?

7 A I'd say it was just somewhat over average.

8 Q He didn't seem to be obese to you or anything like
9 that?

10 A No.

11 Q Did you see anything in his weight that would cause
12 a restriction in his range of motion?

13 A Not from the weight alone.

14 Q All right. And there's no doubt, from looking at
15 your report, you're indicating that his low back
16 pain and discomfort is left-sided, not on his right
17 side. Is that correct? I'm looking at the next to
18 last sentence of the HIP paragraph -- HPI
19 paragraph. It says, "Low back discomfort --
20 A His --
21 Q -- is left-sided."
22 A Are you referring to the gluteal pain or --
23 Q Well, it -- it says here, "Denies new onset bladder
24 or bowel dysfunction, and most of his low back
25 discomfort is left-sided." You --

- 1 A Correct. That's just self-explanatory.
- 2 Q He didn't say anything significant enough that
- 3 would make you want to indicate there was any pain
- 4 anyplace else, like the right side?
- 5 A Well, he has back pain, but it's worse on the left.
- 6 Q Okay.
- 7 A So, it sounds like the history I got was that he
- 8 has pain across his back, including what I wrote in
- 9 the chief complaint, but it's worse on the left
- 10 side --
- 11 Q All right.
- 12 A -- as compared with somebody who may have
- 13 exclusively pain just on one side.
- 14 Q Okay. I also noticed in your first page, -- and I
- 15 think it's Andy's page ten on his APA -- it talks
- 16 about ROS. What does ROS stand for?
- 17 A It's review of systems. That's a basic review of
- 18 the various systems in the body that we go over
- 19 head-to-toe with the intake, and if we have
- 20 anything that's not directly related to the problem
- 21 but isn't in the History of Present Illness, we
- 22 will then include it there.
- 23 Q All right. Did you see anything that needed to be
- 24 noted?
- 25 A No.

1 Q So, what does that mean to you, then?

2 A That just means I've told the whole relevant story
3 in the HPI.

4 Q All right. Then I notice on page two of your
5 report, which is Andy's page 11 of his
6 Administrative Procedures Act inclusion, there's a
7 thing labeled Examination. I guess that speaks for
8 itself. You actually did an examination?

9 A Yes.

10 Q All right. These notes that you have, do you write
11 these notes down while doing the examination, like
12 by -- handwritten or dictation, or do you do it
13 subsequent to the patient leaving?

14 A I go to the EMR, electronic medical record, once I
15 am done. I like to focus on what I'm doing and not
16 try to deal with the medical record at the same
17 time of the examination.

18 Q So, at the conclusion of the examination, within a
19 close proximity of time, you -- you dictate this?

20 A Correct.

21 Q All right, sir. Is it a dictation or actually
22 keying in?

23 A It's a combination of both.

24 Q Okay. All right. And you pretty much do this on
25 all examinations; it's your standard procedure?

- 1 A Every single one.
- 2 Q Okay. That's good. Now, when you say in the
3 examination he's pleasant with no acute distress,
4 he's alert and oriented, what does that mean?
- 5 A Just the average patient showing up with a pain
6 problem. You know, he's able to talk, able to
7 converse, and he's not riving on the floor, and
8 he's not, you know, -- He's not looking like he
9 shouldn't be there. It's --
- 10 Q You put down here -- What you put down, is that
11 what you observe and also what he tells you? Is it
12 a combination of both?
- 13 A Well, what he tells me is in the HPI, and,
14 typically, the exam is mostly observation with some
15 feedback from the patient.
- 16 Q All right. So, basically, the examination is
17 you're actually hands-on touching him, asking him
18 questions?
- 19 A Yes, sir.
- 20 Q Okay. Now, you -- it says that he exhibits no pain
21 behavior. You didn't say exhibits slight pain
22 behavior or moderate pain behavior or severe. Why
23 did -- Why did you put down no pain behavior? Is
24 that what you saw?
- 25 A Yes. Pain behavior is somebody who we consider to

1 be histrionic and over-dramatical, and they're --
2 they're in so much pain, they can't even talk to
3 you -- and try to tell you that their pain scale is
4 a 12 on a zero-to-ten.

5 Q Okay.

6 A They're being overly dramatic, and it almost
7 invalidates the whole exam. So, when we say
8 they're exhibiting pain behavior, it's a negative
9 suggestion on the validity of the patient's
10 reporting capabilities.

11 Q And here you found him to be very pleasant?

12 A Well, he -- Nothing he was saying was
13 inconsistent. It was a -- It was a -- a valid
14 encounter --

15 Q But you used --

16 A -- in my opinion.

17 Q -- the word pleasant?

18 A Oh, he was pleasant, yes.

19 Q Okay. And you put down the word no acute distress?

20 A Again, the same, not riving in pain. The patient
21 is able to tell you what happened to them, give you
22 an accurate history and help you out to try to find
23 out what's wrong as opposed to just trying to
24 convey the message that they're in so much pain
25 they can't even talk with you.

1 Q Okay. And if I'm correct -- Let me know if I'm
2 wrong, also. Let me know. You were able to look
3 at him, and you saw him do nothing that exhibited
4 to you that he had any type of pain behavior; is
5 that correct?

6 A Again, pain behavior being over-dramatic behavior.
7 It doesn't mean that he wasn't in pain. It just
8 means that he was able to be cooperative with the
9 exam and history.

10 Q All right. Words you used was, "He exhibited no
11 pain behavior." When you looked at him, he made no
12 motion or movement or anything to indicate and
13 exhibit to you that he was in any type of pain; is
14 that --

15 Mr. Safran: I'm going to object.

16 A No, sir. No, sir. This is --

17 Mr. Safran: Now, you've asked it three
18 times.

19 Mr. Huff: That's okay.

20 A This is the terminology that I have used for 30
21 years. This is what I was trained to say during my
22 residency and fellowship and what I use
23 consistently to convey a certain type of individual
24 who's there to get help and is cooperative with the
25 exam. It does not by any stretch mean he's not

1 having any pain. Pain behavior could be -- If it
2 helps you out more, I can put pain behavior in
3 quotation marks. It's a -- It's a negative point
4 if we say that they're exhibiting pain behavior.
5 We're saying the rest of this exam and history may
6 not be valid because the patient is clearly
7 distracting the evaluator with statements and body
8 language that is not consistent with why they're
9 there. So, this is actually -- It indicates that
10 this is a gentleman who's here trying to get some
11 help. That's all that means.

12 Q What would be a normal pain behavior? If you wrote
13 down he exhibits pain behavior, what would that
14 include?

15 A If he exhibits pain behavior?

16 Q In here, it says, "No pain behavior." What if it
17 says pain behavior, leaving the word "no" out?
18 What is -- What would that mean?

19 A Again, I would say the patient saying their pain is
20 a 12 on a ten scale, they said I can't sit down, I
21 can't lie down, I can't really even talk to you
22 now, do you have anything for pain that I can take
23 right now, I wasn't even going to come to the
24 appointment today I was in so much pain, I -- I
25 don't even know what I'm doing here, this is so

1 much pain, I should have stayed home. That's pain
2 behavior.

3 Q Okay.

4 A So, no pain behavior is just the -- the normal
5 average person that comes in. And they may have
6 significant pain. They may be in severe pain, but
7 they are trying to be cooperative. So, pain
8 behavior is uncooperative and unbelievable, whereas
9 no pain behavior just means -- Again, so, I think
10 what you're hung up on, Counselor, is the two words
11 that say no pain, but what I want you to focus on
12 is the word "behavior."

13 Q All right. And from your meeting with him, it
14 appears that it was in the lower part of the back
15 and on the left side?

16 A Yes.

17 Q All right. And then I notice in the -- on page two
18 of your report, which is page 11 in the APAs, that
19 you then examine the cervical spine. Is that
20 correct?

21 A A very cursory exam on the cervical spine. Yes,
22 that -- just that his range of motion was full,
23 basically to contrast that with his back.

24 Q So, in other words, he was not complaining of
25 anything with his cervical to be related to this

1 accident that he had on September 20th of 2014?

2 A Correct.

3 Q All right. And, of course, nothing -- he's not
4 claiming any lung problem because of that accident,
5 again, on September 20th of 2014?

6 A Well, this wouldn't be a complaint. It's an exam,
7 but his lungs were clear.

8 Q Yes. You didn't see anything when you examined him
9 to relate any --

10 A No.

11 Q Okay. Now, upper extremities, in his grip strength
12 and other changes, did you find anything in the
13 upper extremities that he would relate he had a
14 problem with because of the injury on September
15 20th of 2014?

16 A No, sir.

17 Q Okay. Let's do thoracic spine. Unremarkable.
18 What does that mean? Did you examine it and find
19 it unremarkable?

20 A Correct.

21 Q Okay. Was there anything in the thoracic spine
22 area that you examined him that you would relate
23 was injured because of the September 20th of 2004
24 stumbling in the kitchen?

25 A No.

1 Q All right. Now, -- Now, I think we're going to
2 get to the area that I think you did find
3 something. Is that correct? The lumbar spine is
4 where you then examined him, and that's where his
5 complaints were?

6 A Well, I examined him all the way up to the lumbar
7 spine. Everything you've just listed was an exam.

8 Q Okay. And then you also, in that exam, examined
9 the lumbar spine, correct?

10 A Correct.

11 Q Did you put him through a range of motion?

12 A I did.

13 Q And you did that personally, hands-on?

14 A Yes.

15 Q Okay. And I'm not implying you didn't. I just
16 want to make sure we have that clear for the
17 record. Did you put him through a range of motion
18 which would be forward flexion, extension, lateral
19 bending and rotation?

20 A We did forward flexion and then returning upright
21 and extension.

22 Q Please define for the commissioner what extension
23 is.

24 A Extension is if you're bent forward, it's returning
25 upright, and then full extension is going backwards

1 from just standing straight as if you are looking
2 up at the ceiling.

3 Q In other words, forward flexion would be bending
4 forward?

5 A Right.

6 Q And then when you talk about the extension, that's
7 going backwards from whatever position you're in?

8 A Well, you can call it returning upright, but you
9 have to extend to go upright. And then extension
10 is termed -- From the neutral position, you're --

11 Q Which is --

12 A -- bending backwards.

13 Q Got you. Okay. So, you did those two things,
14 forward flexion and extension. Did you do any
15 lateral bending or lateral rotation, anything like
16 that?

17 A If I did, I didn't document it there, but --

18 Q You also wrote there no PSIS -- could you -- and
19 SI. Could you define for the commission what PSIS
20 is and what SI is?

21 A PSIS is the posterior superior iliac spine. It's a
22 portion of the low back where the sacrum joins the
23 ilium, and it's an oftentimes site of pain. So, we
24 usually check that with palpation. SI is
25 sacroiliac joint, which is also an area where

1 individuals can have pain, as is the sciatic notch
2 where they may have pain if they have a sciatic
3 condition.

4 Q Did you find any pain? I don't see the word pain.

5 A Well, I used the word tenderness instead.

6 Q All right. Did you also do a lower extremity,
7 right and left leg?

8 A I did.

9 Q Did you also check the hips?

10 A I did.

11 Q All right. What does it mean when you say, "Hips
12 provocation is negative"? What does that mean to
13 you?

14 A There are certain motions you can do, such as
15 Patrick's maneuver, extension of the hip against
16 resistance, there -- you know, crossing the legs.
17 There's a number of things you can do to check
18 someone's hips, but if they're not related, I
19 usually just sum it up with provocation is
20 negative.

21 Q Did you actually do the examinations and write down
22 provocation is negative?

23 A Yes, sir.

24 Q Okay. That's fine. Now, he also -- You did some
25 knees range of motion?

- 1 A Yes.
- 2 Q "Extend to 120 degrees." How close is that to
3 normal? In other words, what is normal?
- 4 A Well, normal would be 180.
- 5 Q Okay. So, he extended to 120 without pain?
- 6 A That's as far as he could extend, and after which
7 he was having pain, yes, sir.
- 8 Q What is flexion in the knee?
- 9 A That's when you bend it back.
- 10 Q When you bend it back. If I'm laying on a table
11 with my knee straight -- or sitting on the table
12 with my knee hanging down, tell me what you mean by
13 that. Make it clearer for me. I probably --
- 14 A Could you ask me that again?
- 15 Q Yes. Please.
- 16 A Well, --
- 17 Q I'm trying to --
- 18 A -- extending -- extending the knee is what a
19 placekicker does when they -- the moment they hit
20 the ball trying to hit a field goal. Flexing the
21 knee is what a ballerina will do to exercise,
22 bringing her heel up to her buttock.
- 23 Q So, the knee can go to how many degrees again?
- 24 A Well, can it --
- 25 Q Flexion, are you saying with flex -- What's --

1 Zero to what?

2 A That's -- That's (demonstrating) 180, straight
3 out. That's 180 degrees, a flat line, right?

4 Q Right.

5 A And then flexion is up like -- like this
6 (demonstrating).

7 Q All right. So, what's the difference when you
8 bring it up? What's the change in degree, 180 to
9 what?

10 A He was only able to go to 120 with extension, and
11 then it became too painful for him.

12 Q All right.

13 A But the flexion was actually more painful for him,
14 so we didn't get very far with that at all.

15 Q You're saying he describes that pain anterior and
16 posterior. What does that mean?

17 A The front and back of the knee.

18 Q All right. All right. After the examination, I
19 notice you then come up with a diagnosis.

20 A Yes.

21 Q And could you just please just briefly go over what
22 your diagnosis was?

23 A Well, my primary diagnosis is of a lumbar facet
24 syndrome, but the coding available at this time is
25 a 724.8 for that, and that's considered, quote,

1 other back symptoms, unquote. It's a horribly
2 antiquated coding system that now has been upgraded
3 to be decidedly worse than it was before they
4 upgraded it. So, this is ICD-9. Now it's ICD-10,
5 which is unbelievably bad, but --

6 Q If it could get worse, it got worse.

7 A That's right.

8 Q All right.

9 A But my diagnosis in the old days, --

10 Q Yes.

11 A -- let's say more than five years ago, before we
12 were committed to the EMRs, I would have wrote
13 posttraumatic lumbar facet syndrome, descriptively.

14 Q All right. Which would mean exactly what symptom?

15 A Exactly what his symptoms are, the low back pain,
16 --

17 Q All right.

18 A -- worse on the left side, radiating into the
19 gluteal, or buttock, region.

20 Q And you related this finding or diagnosis to the
21 accident that occurred September 2014?

22 A Yes, sir.

23 Q And it was your opinion his left side was worse
24 than the right?

25 A Yes.

- 1 Q You have some other things under Impression.
2 Chronic facetogenic low back and gluteal pain.
3 What does that actually mean in layman's terms?
- 4 A That means he has the facet syndrome which is
5 producing the low back and gluteal pain. So, what
6 it means is that's the medical diagnosis for
7 facetogenic pain, which explains his complaints.
- 8 Q So, low back and butt pain, in other words?
- 9 A Right.
- 10 Q Okay. And then you put down, "Chronic left knee
11 pain following a fall on 9/19/14." So, you relate
12 this left knee pain to the fall on the job,
13 correct?
- 14 A Yes.
- 15 Q Okay. What treatment plan did you have?
- 16 A I suggested that his knee be treated first because
17 the significant knee pain was affecting his gait,
18 or the way he walks, which would affect his back
19 indirectly, and it would be better to improve his
20 gait before offering him the low back treatment.
21 So, my first recommendation was that somewhere,
22 somehow he get some treatment for the left knee.
- 23 Q All right. And any --
- 24 A And, of course, we offered to do it.
- 25 Q Okay.

- 1 A And then if no improvement from a simple injection,
2 an orthopedic evaluation would be necessary. And
3 then I discussed the treatment that we'd do for his
4 low back pain, specifically for the facet syndrome.
- 5 Q So, the ortho evaluation, then, at that time was
6 going to be with the knee first?
- 7 A Only the knee.
- 8 Q All right. And after that, what was your next
9 suggestion, Doctor?
- 10 A Perform medial branch blocks where -- which are the
11 injections of the small nerves that supply the
12 facet joints.
- 13 Q And that's to treat what body part?
- 14 A The low back and gluteal region.
- 15 Q The low back and buttock, in other words?
- 16 A Right.
- 17 Q All right. Anything else that you recommended?
- 18 A That was it.
- 19 Q Okay. Then I notice that was done in January of
20 2015. After that, I think Mr. Safran wrote a
21 letter to you in July of 2015. Is that correct?
- 22 A Yes.
- 23 Q All right. When you got that letter, had you seen
24 Mr. McDuffie only one time?
- 25 A Yes.

1 Q So, there was no evaluation, treatment or contact
2 with Mr. McDuffie in February, March, April, May,
3 June or even July?
4 A Correct.
5 Q It was just answering some questions?
6 A Yes, sir.
7 Q All right. Between the visit of January 2015 and
8 you receiving this letter that he wanted you to
9 respond to, did you have any communication with Mr.
10 Safran in person, by letter, by phone or anything?
11 A I believe he just said he was going to send this
12 questionnaire over and could I please fill it out
13 to the best of my ability.
14 Q All right. When you got this questionnaire, then
15 would your testimony be that you do not remember
16 any communication from January through the time you
17 got this questionnaire with Mr. Safran?
18 A No, sir.
19 Q All right. If you had had any communication, do
20 you think you would have documented it?
21 A I don't think so, but I don't believe there was
22 any. We just saw this gentleman for an IME, --
23 Q Yes, sir.
24 A -- and the questionnaire would be answered based on
25 that IME.

1 Q And your answers to this questionnaire would be
2 based upon what facts or interaction you had with
3 Mr. McDuffie in January of 2015?

4 A As well as the information that was provided in the
5 cover part of the letter.

6 Q All right. In other words, it's based upon the
7 comments made by Mr. Safran to you, where he says
8 that he's continued to experience these pains in
9 the leg and lumbar, but you did no examination to
10 verify that; is that correct?

11 A Well, more so what I meant was that he did, in
12 fact, have an orthopedic evaluation and he saw two
13 other pain specialists who felt the same way I did.
14 So, I -- I would assume, since those records would
15 be available for me to look at, that counselor
16 wouldn't say they are in agreement with you if they
17 weren't because then I would be able to look at
18 those records and say, oh, well, they're not. So,
19 that would be a credibility issue.

20 Q Well, do you know what clinical observations Dr.
21 Johnson and Dr. Lembo made by -- In other words,
22 did you ever review their reports?

23 A I did not, but I've known both of them for longer
24 than -- well, at least 15 years, so I would respect
25 their opinion, so -- Long-time pain specialists.

1 Q But, basically, you have never read their opinions,
2 correct?

3 A I recently reviewed the deposition from John
4 Johnson, but I've not seen any actual records.

5 Q So, when you filled out this questionnaire on --
6 this July 15th, 2015 questionnaire on July 20th,
7 2015, you had not, at that time, seen any of Dr.
8 John Johnson or Nancy Lembo's reports. Is that a
9 true statement?

10 A Yes.

11 Q You had not talked with them at all. Is that a
12 true statement?

13 A Yes.

14 Q Have you reviewed any reports to date of Dr.
15 Christopher Mazoue?

16 A I don't recall.

17 Q All right. So, it would be a true statement that
18 when you completed this questionnaire on July 20th,
19 2015, a four-question questionnaire, you had not
20 reviewed any reports of Dr. John Johnson and Nancy
21 Lembo or Dr. Christopher Mazoue? Is that correct?

22 A Correct. This was based on my own evaluation of
23 Mr. McDuffie.

24 Q And your evaluation occurred back in January of
25 2015?

- 1 A Correct.
- 2 Q And it's based upon facts that you learned in
3 January of 2015?
- 4 A Yes.
- 5 Q All right. And these four questions that you
6 answered is based upon your knowledge and exam
7 completed on January 2015?
- 8 A Well, reading the questionnaire now, more than
9 three months since I filled it out, it does
10 indicate that the records were made available to
11 me, and I may very well have reviewed them.
- 12 Q What makes that -- Where does that say that?
- 13 A Well, I'm just reading what I -- what I said here,
14 "Based on exam and review," and -- that's in number
15 two -- and then Dr. Mazoue's recommendations, so --
16 I see a lot of patients daily, and I review records
17 daily, so they may very well have been made
18 available to me and I took a look at them before
19 filling this out, so --
- 20 Q All right. If they were made available to you,
21 would they be contained in your file?
- 22 A Probably.
- 23 Q Okay. And I think we requested a complete copy,
24 and you can provide that to us. Is that correct,
25 Doctor?

1 A Yes, sir.

2 Q And I thank you very much. Appreciate it. I'm
3 looking at this page nine of the letter from Mr.
4 Safran. I'm trying to see on this letter -- Does
5 it have any indication that any documents were
6 enclosed, where you'd normally put down the word
7 ENCL? I don't see that.

8 Mr. Safran: For the record, if I typed
9 that letter, I'm sure I didn't put anything
10 like that.

11 Q I would ask you to take the time to look at page
12 eight of the letter. Just read the letter before
13 you go to the questionnaire. Can you find for me,
14 Dr. Riber, any indication that documents were
15 included with this letter? Just take your time.

16 A No, I don't see anything in this letter.

17 Q Okay. And subsequent to that letter, did you have
18 any other communication regarding any appointments
19 or treatments that you -- you had with Mr.
20 McDuffie?

21 A Can you ask me that again?

22 Q Yes, sir. Let me just turn to my paper. That
23 report was January of 2015. Did you fill out any
24 other documents or questionnaires --

25 Mr. Huff: Andy, is that yours or mine?

1 Mr. Safran: I think it's yours.

2 Mr. Huff: Thank you.

3 Q I noticed that there is a October 12th, 2015 To
4 Whom It May Concern. Are you familiar with that
5 document, Doctor?

6 A Yes. I wrote it.

7 Q All right. Can you tell me what prompted you to
8 write this document? In other words, were you
9 contacted by somebody for you to issue this
10 document?

11 A I saw the patient on that date, and he related to
12 me that he was having more and more difficulty with
13 just carrying on ADLs, activities of daily living,
14 --

15 Q Yes, sir.

16 A -- and he was certain that continuing to work was
17 making him worse.

18 Q And I do notice that Andy has provided to us,
19 before today's date, a report of yours dated
20 October 12th of 2015, which is a two-page report,
21 and October 12th, '15 does coincide with this To
22 Whom It May Concern. Is that why you -- you did
23 that after this appointment?

24 A Well, I'll read to you from my HPI, and then --

25 Q Yes, sir.

1 A -- which is from October 12. My initial impression
2 was that of posttraumatic facet, which we just
3 covered, and then he told me he has continued to
4 work and reports that his pain and dysfunction have
5 become progressively worse. In fact, he was
6 indicating to me that sometimes when he bends
7 forward, he can't even straighten up, which is
8 consistent with the facet syndrome. So, while he
9 was waiting for treatment, -- It is not unusual
10 for me either, in a case like this or while
11 someone's having treatment, to outline some
12 restrictions for them. So, this was a very simple
13 basic note to try to prevent this gentleman from
14 getting any worse until he gets some treatment
15 since it already had been nine months since I saw
16 him.

17 Q So, make sure I've got this right. You saw him on
18 January 12th of 2015, and the second time you saw
19 him was October 12th, 2015?

20 A Correct.

21 Q Have you seen him anytime subsequent to October the
22 12th of 2015?

23 A In the last two weeks, no, sir.

24 Q Do you know how he came about to come back to your
25 office? Was he referred? Did he call? How did he

1 come back?

2 A I wouldn't know. He was just on my schedule.

3 Q Okay. Yes, sir. And, on that day, there's no

4 doubt that you physically saw him, put hands on and

5 examined him; is that correct?

6 A No doubt.

7 Q Okay. It says that -- under HPI, that he had the

8 same complaints that he had before?

9 A Well, when I first saw him, I wrote, "Low back,

10 left buttock and left knee pain." This time, I

11 wrote, "Low back, hip and leg pain, worse on the

12 left; left knee pain." So, the description is

13 slightly different, but it means about the same.

14 Q All right.

15 A People oftentimes refer to their buttock as their

16 hip.

17 Q All right. It says his pain level is a six, and it

18 seems like the last time you saw him the pain level

19 was five to six. So, it was pretty much the same?

20 A Well, it's hard to compare those pain scores nine

21 months between them. We don't rely on them as much

22 as the people who read them.

23 Q But you did write down six?

24 A I did.

25 Q And the max that he had the first time was six?

- 1 A That's correct.
- 2 Q All right. I notice the same words were used under
- 3 the Examination, "He was pleasant with no acute
- 4 distress." Is that correct?
- 5 A Yes.
- 6 Q He made no medication request from you?
- 7 A That's what I wrote.
- 8 Q And --
- 9 A We -- We -- That goes along with pain behavior.
- 10 We tend to be suspicious of people coming in and
- 11 asking for Percocet, hydrocodone, what have you.
- 12 It sort of indicates that he's not there for
- 13 medication. It doesn't mean that medication isn't
- 14 indicated. It doesn't mean that he wouldn't
- 15 benefit from any. It means that the patient's not
- 16 in there -- as you can imagine the type of patients
- 17 we see in a pain management setting -- that he's
- 18 not in there asking for meds.
- 19 Q And again, "He exhibits no pain behavior." That's
- 20 what you wrote?
- 21 A Yes, again with the emphasis on behavior.
- 22 Q Okay. And when you did a range of motion of the
- 23 cervical spine, it was full?
- 24 A Still full.
- 25 Q Okay. Now, I notice under lumbar spine, -- let me

1 turn to that, if I may -- you wrote down the word
2 minimal low back discomfort. What does the word
3 minimal mean to you?

4 A Well, you need to read that entire sentence to
5 understand what I was trying to say. So, the
6 entire sentence reads, "Minimal low back discomfort
7 is elicited with forward flexion." If you don't
8 add the rest of the sentence, then that doesn't
9 make any sense.

10 Q It doesn't talk about any other range of motion,
11 though, other than forward flexion; is that
12 correct?

13 A No, sir, that is not correct. "...and his pain is
14 more closely reproduced with returning upright,"
15 which means when he straightened out from bending
16 forward, his pain was more closely reproduced, but,
17 "...extension most closely reproduces pain." So,
18 what that describes in lay terms is that bending
19 forward from the waist produced only a little bit
20 of discomfort, but when he tried to straighten up,
21 that was really painful, but extension was very,
22 very painful. That's what that means. I also
23 added here that we did bilateral rotation about his
24 hips, which is what you were asking me about
25 before, sort of checking the lateral bending, and

1 that's another way to check for facet. So, I kind
2 of reinforced my diagnosis for myself there with
3 the bilateral rotation.

4 Q And then you came up with an impression; is that
5 correct?

6 A I did.

7 Q And were the impressions different now or pretty
8 much the same as when you first saw this gentleman?

9 A Well, he has the posttraumatic facet syndrome. He
10 has a chronic back and gluteal, the chronic knee
11 and work-related injury. The only thing that's
12 different is I indicated it's -- it's worse than it
13 was on his initial visit.

14 Q Do you have a treatment plan?

15 A I did, and it basically states what I had stated
16 previously with respect to the low back. There's
17 an absence of the orthopedic recommendation because
18 I think he told me that he is seeing an
19 orthopedist, Dr. Mazoue.

20 Q Subsequent to this -- I think you've already
21 answered, but subsequent to this October 12th, 2015
22 visit, have you seen this gentleman again?

23 A Not in the past two weeks.

24 Q All right. So, your opinion would be based upon
25 your encounter with him on these two occasions?

1 Your examination is the basis for your opinion?

2 A Yes.

3 Q And again, Doctor, your opinions are to a
4 reasonable degree of medical certainty?

5 A Yes, sir.

6 Mr. Huff: I have nothing further.

7 Examination

8 By Mr. Safran:

9 Q Let me just ask you a few questions, Dr. Riber.
10 First, I think earlier in the deposition -- and I
11 know you've touched on this again a couple of
12 times. When you say pain behavior, is that
13 basically something similar to Waddell's or, you
14 know, any type of observations that are there to
15 see if somebody is acting in a way that's
16 inconsistent with their physical exam?

17 Mr. Huff: Objection to leading.

18 Mr. Safran: All right. I'll rephrase
19 the question.

20 Q Is pain behavior something that would be similar to
21 what we call Waddell's signs?

22 Mr. Huff: Objection. Leading.

23 Q Go ahead and answer it.

24 A It's the same focus, yes.

25 Q Okay. And would Waddell's -- And are you familiar

1 with Waddell's?

2 A Of course.

3 Q Would Waddell's signs be something that would be, I
4 guess, more or less in that overall spectrum of
5 what you're referring to as pain behavior?

6 Mr. Huff: Objection. Leading.

7 A Yes, that all has to do with the validity and the
8 consistency with which the patient is appearing and
9 reporting --

10 Q Okay.

11 A -- their issues.

12 Q When you are talking about pain behavior, at least
13 from what I heard, your testimony, are you looking
14 for something that is, as you've described, kind of
15 a negative type of presentation from a person in
16 terms of their validity?

17 Mr. Huff: Objection to leading.

18 A If I say the patient is exhibiting pain behavior,
19 it is a negative suggestion that the history and
20 the exam are not valid. After doing this for
21 almost 30 years, you get a feel for whether
22 patients are presenting in an honest way or not.
23 And most of them do.

24 Q What are the types of observations, just in
25 general, that you would make that would be

1 consistent with your definition of pain behavior?

2 A As I mentioned previously, somebody who's trying to
3 let me know that they're in so much pain that they
4 should be in the hospital instead of in the room
5 talking with me, and they're rating their pain --
6 When I tell them a ten is taking a knife to their
7 abdomen for a gallbladder operation, that the
8 anesthesiologist has forgotten to put them asleep,
9 so they're wide awake and they're getting their
10 belly open, that's a ten, and I ask them do you
11 still want to tell me that your pain is a 12, those
12 -- those type of things, that they're -- they're
13 trying to convey to you that they're so -- in so
14 much pain, but they're not giving you any
15 information, where it hurts; they're -- they can't
16 sit, they can't stand. Even people in severe pain
17 are able to be cooperative and helpful to the
18 physician when you're trying to help them. So, if
19 I say pain behavior, it's an assessment that
20 somebody is carrying on in a way that's not
21 consistent with a pain issue but some other
22 distraction, secondary gain, possibly, we call it.

23 Q Okay. So, that's what pain behavior is; in your
24 mind, they would be synonymous, --

25 A Yes.

1 Q -- secondary gain?

2 A Yes.

3 Q Let me ask you, also, would -- would pain behavior
4 be -- For instance, if you were to maneuver them
5 in a certain way and where they shouldn't have any
6 pain but they say they hurt, is that pain behavior
7 in your mind?

8 A Yes, and that's --

9 Mr. Huff: Objection. Leading.

10 A -- consistent with Waddell's signs.

11 Q Okay. All right. So, what I'm understanding is --
12 Is pain behavior something that has any
13 relationship to malingering?

14 Mr. Huff: Objection to leading.

15 A Quite possibly.

16 Q Okay. All right. And, in this situation, did you
17 observe anything, in terms of this gentleman's
18 presentation, that was reflective of him
19 embellishing symptoms?

20 Mr. Huff: Object to leading.

21 Mr. Safran: Ros, --

22 Mr. Huff: I'm going to object, Andy, for
23 the record. He can answer the questions, but
24 I've got to place the objection or I abandon
25 it, and I can't do that. I'm not trying to be

1 that disruptive.

2 Mr. Safran: Yeah. For the record, when
3 I ask a question, did you observe something of
4 this -- and you're characterizing that as
5 leading. Is that correct?

6 Mr. Huff: I'm not answering any
7 questions, Andy.

8 Mr. Safran: Okay. I'd like to have a
9 motion for sanctions for continued questions
10 of that type. Okay? So, just so we're clear.

11 Mr. Huff: Okay.

12 A He -- He presented as a very straightforward
13 individual with -- evoking no suspicion on my part,
14 and that's when we write the phrase exhibits no
15 pain behavior. What that means is I am expecting
16 that this is a straightforward and valid
17 presentation.

18 Q Okay. All right. And, I guess, does your term
19 pain behavior mean that this gentleman is not
20 experiencing pain?

21 Mr. Huff: Objection. Leading.

22 A It has nothing to do with that.

23 Q All right.

24 A The emphasis on that phrase is behavior.

25 Q Okay.

1 A You can take the word pain out of that. We're
2 talking -- Pain behavior has nothing to do with
3 pain. I can exhibit pain behavior and have no pain
4 at all.

5 Q When you did the exam on this gentleman, did
6 certain aspects of your exam result in him
7 reporting pain?

8 A Yes.

9 Mr. Huff: Objection to leading.

10 Q Did you have any reason to question the
11 physiological legitimacy of any pain he reported?

12 A The exam was consistent. I have no reason to doubt
13 it.

14 Q Doctor, let me ask you this. There were
15 references, I think, to different dates here, I
16 think 9/9, 9/19. I think something I may have sent
17 said 9/19. If it says the 9th, is that potentially
18 here -- because I think on the first report it says
19 the 9th at one time. It says the 19th at another.
20 If, in fact, it was the 19th, do you have any
21 reason to question that?

22 A No. That's just a typo.

23 Q All right. Let me ask you, also in terms of -- of
24 history, I think you were asked whether or not this
25 gentleman fell and actually struck something, and

1 you said you didn't know or didn't remember?

2 A I don't recall.

3 Q Okay. Assume that the mechanism of injury occurred
4 where someone was walking and, apparently, there
5 was something sticking out of the floor that he
6 didn't notice, his foot caught on it, it caused him
7 to fall in a stumbling way forward, but he did not
8 actually hit the ground, he caught himself before,
9 you know, he actually went all the way to the floor
10 -- but I think you mentioned there was a twisting
11 of the back, and assume that occurred. Would that
12 mechanism of injury be one that is consistent with
13 the clinical exam that you ultimately did,
14 particularly the findings that you made?

15 Mr. Huff: Object to the form of the
16 question --

17 A It certainly could be.

18 Mr. Huff: -- as leading.

19 Q Okay. And is that mechanism of injury one that has
20 the potential to produce any type of facet injury?

21 A Yes.

22 Mr. Huff: Object to the form of the
23 question as leading.

24 Q Okay. Based upon the clinical exam that you did,
25 if we looked at the mechanism of injury, are the

1 findings that you ultimately documented ones that
2 would be appropriate, I guess, given that
3 mechanism?

4 A Yes.

5 Mr. Huff: Object to the form of the
6 question as leading.

7 Q Okay. Were the clinical findings that you've
8 documented in your reports consistent with the
9 mechanism of injury that hypothetically I have
10 described to you?

11 A Yes.

12 Mr. Huff: Objection. Leading.

13 Q Okay. Did you have any reason at all to doubt the
14 sincerity of any complaints of pain that you
15 obtained from Mr. McDuffie during either of your
16 examinations?

17 A I did not.

18 Mr. Huff: Objection. Leading.

19 Q Did you observe any evidence of symptom
20 magnification at any time that this gentleman
21 presented to you for clinical exam?

22 A I did not.

23 Q Okay. I think there was a previous report from Dr.
24 Peelle where he made a comment of negative
25 Waddell's. What does that mean, negative

1 Waddell's?

2 A That means that his assessment was that of a valid
3 examination.

4 Q Okay.

5 A There was no symptom magnification, no
6 embellishment.

7 Q Tell me this. Is a facet syndrome one that is --
8 Well, first, let me ask this. In your practice, do
9 you treat facet syndromes?

10 A Yes.

11 Q How frequently do you see facet syndromes?

12 A Very commonly.

13 Q Okay. And I know Dr. Johnson tried to give an
14 estimate of about 20 percent of what he sees for
15 backs. Would yours be at least in that range?

16 A At least.

17 Q Okay. My question is, is it -- A facet syndrome,
18 in terms of being able to do a diagnosis, is that a
19 diagnosis that you would rely on an MRI scan in
20 order to make?

21 A You would not.

22 Q Why is that?

23 A It's a clinical diagnosis based on the mechanism of
24 injury, which is part of the history, the
25 complaints and then the exam. You can have a

1 perfectly normal MRI and have a very clear-cut
2 facet syndrome.

3 Q Can you also have a situation where an MR -- MRI
4 may not be normal, as it relates to the facets,
5 where the facets really aren't the source of the
6 pain? I guess maybe the better way to put it is,
7 does an arthritic facet necessarily mean that the
8 facet is generating pain in the back?

9 Mr. Huff: Object to leading.

10 A No.

11 Q So, I guess my question is, is it -- You said it
12 could be a normal MRI, and you could be, well, it's
13 dealing with facetogenic pain. Can it be an
14 abnormal MRI, as it relates to the facets, where
15 you're not dealing with facetogenic pain?

16 A That's correct.

17 Q Okay.

18 Mr. Huff: Objection as to leading.

19 Q When you have an individual that is experiencing
20 what we refer to as facetogenic pain, where can it
21 affect you other than right in the back itself?

22 A Well, for the lumbar, --

23 Q Mm-hmm.

24 A -- it can affect the back going into the gluteal
25 region. It can go down the leg.

1 Q All right. When it goes down the leg, what would
2 you call that type of pain? Is it radicular or is
3 it a different kind?

4 A Depending on where it travels. I would just say
5 it's lower extremity pain as part of the facet
6 syndrome.

7 Q Can that be what they call referred pain?

8 A Yes.

9 Mr. Huff: Object to the question as
10 leading.

11 Q Can a facet syndrome produce lower extremity pain
12 that can either be referred or, as you say, just
13 into the lower extremity?

14 A Sure.

15 Mr. Huff: Object as leading.

16 Q When you did a straight leg raise test, I think you
17 indicated in each of your reports that produces low
18 back, gluteal and hamstring discomfort mostly on
19 the left side at greater than 45 degrees. What is
20 the significance of that?

21 A That he has some nerve involvement that is
22 producing that, and the nerves that supply the
23 facet joint run with the main spinal nerves. So,
24 if you do a straight leg raise, which oftentimes is
25 done for a radicular syndrome, it can also be

1 positive on the facet syndromes.

2 Q So, is that finding, as it relates to a facet
3 syndrome, one that would be consistent with a facet
4 -- or -- Excuse me. Well, let me rephrase the
5 question. Is that finding consistent with your
6 diagnosis?

7 A Yes.

8 Q All right. Is that finding consistent with his
9 overall clinical presentation?

10 A It was.

11 Q Okay. Does that finding more or less support your
12 diagnosis of a posttraumatic facet syndrome?

13 A Yes.

14 Q All right.

15 Mr. Huff: Objection to leading.

16 Q Let me ask you, also, the thing Mr. Huff had talked
17 about earlier, some of, kind of, the general exam,
18 does somebody being pleasant in any way negate
19 their being in pain or having a problem?

20 A No. Most of the people we see are just
21 appreciative of being seen and that they are
22 sitting in a room with someone who is trying to
23 help them.

24 Q Okay.

25 Mr. Huff: Objection to leading.

1 Q Does no -- What does no acute distress mean when
2 it -- in connection with this type of examination?

3 A Again, it means that the person isn't exhibiting so
4 much discomfort that you're wondering if you have
5 to call EMS to transport them to the emergency
6 room.

7 Q Does no acute distress, that reference, in any way
8 mean that somebody is not having pain?

9 A No, --

10 Mr. Huff: Object to leading.

11 A -- not at all.

12 Q All right.

13 The Court Reporter: Can we go off the
14 record for one second?

15 Mr. Safran: Sure.

16 [Off the record at 5:18 p.m.;
17 back on the record at 5:20
18 p.m.]

19 Mr. Huff: I'm going to stipulate for the
20 record that there was no discussion regarding
21 this claim or any questions asked while off
22 the record.

23 Examination Continues

24 By Mr. Safran:

25 Q Doctor, I think you mentioned you had seen this,

1 but I'm going to show you Dr. John Johnson's report
2 again. If you'd take a quick look at it.

3 Mr. Huff: Could you identify that for
4 me, Andy, the date?

5 Mr. Safran: The -- It's the only date.
6 It's 6/11/15.

7 Mr. Huff: Dr. Johnson's report. Okay.

8 Q And particularly look at the clinical exam and the
9 -- also the history of injury, I think, that's
10 listed.

11 Mr. Huff: How many pages is it, Andy?

12 Mr. Safran: Two pages.

13 Mr. Huff: Thank you.

14 (The deponent reviews document.)

15 A Yes, sir.

16 Q And, I guess, the complaints that were made.

17 A Yes, sir.

18 Q And what is the diagnosis ultimately in that
19 report?

20 A The diagnosis here is a radiculitis versus
21 sacroiliitis versus facetogenic, so --

22 Q And read down to the treatment plan.

23 A -- Dr. Johnson had entertained those. He was
24 leaning more toward a posttraumatic facet
25 syndrome.

- 1 Q And I think I provided you with a copy of his
2 deposition you said you looked at?
- 3 A Yes, sir.
- 4 Q Is that his working diagnosis at this point?
- 5 A It was.
- 6 Q Okay. Is -- Are his clinical findings consistent
7 and compatible with yours?
- 8 A Yes.
- 9 Q I think each of you talk about extension. Why is
10 extension, in terms of the motion testing,
11 important as it relates to a facet syndrome?
- 12 A Well, forward flexion unloads the facets, which
13 means, in regular terms, it takes any pressure off
14 them and eases that up. Extension loads the facet
15 joints and is basically -- We used the term
16 previously on the hip joint, but it's provocative.
17 So, if you have normal facet joints and you extend,
18 that will be okay with them, but if you have a
19 facet joint issue and you either return upright or
20 extend, then you are going to provoke an issue
21 there and it's going to declare itself.
- 22 Q You mentioned earlier that in making a diagnosis,
23 it's based, to some extent, on a clinical exam?
- 24 A Sure.
- 25 Q Is that component of a clinical exam an important

1 one?

2 A Definitely.

3 Q And, again, based on what you're seeing between
4 examiners here, you see Dr. Johnson apparently
5 coming up with that same finding as it relates to
6 extension?

7 A He did.

8 Q Okay. I'm going to ask you -- I think I --
9 Again, we've looked at this before. This is Dr.
10 Lembo's initial report, and I'm asking you, I
11 guess, to look at, basically, what the complaints
12 were and the exam.

13 A Yes. Range of motion is painful in extension, and
14 it's mostly the left side.

15 Q Are those findings consistent with your clinical
16 examination?

17 A Yes.

18 Q Is -- Ultimately, what was the diagnosis and the
19 treatment plan, particularly, just outlined here?

20 A Her primary descriptive diagnosis is lumbar facet
21 pain, and the recommendation is also for facet
22 injections.

23 Q Is -- Is that diagnosis and treatment
24 recommendation consistent with yours?

25 A It is.

1 Mr. Huff: Object to leading.

2 Q Okay. Dr. Lembo, I think, saw him again right
3 around the same time you recently did, and I just
4 wanted you to look at that.

5 (The deponent reviews document.)

6 A I still feel that symptoms are consistent with the
7 mechanism of injury, and she indicates again a
8 facet syndrome.

9 Q Is there any real difference between her findings
10 and diagnosis on that date and the one you just
11 looked at from June the 9th of 2015?

12 A No.

13 Q It's basically the same?

14 A It is.

15 Q Doctor, I think previously we've also mentioned
16 that there was a report at one point that was
17 referenced from Dr. Mazoue. We had the opportunity
18 to take his deposition a week or so ago. I'm
19 looking here -- Bear with me. I think -- Did he
20 give a focus, I guess, on his, -- and I think
21 that's another one I think I had provided to you --
22 particularly under his assessment?

23 A Concerned about a medial meniscus tear of the left
24 knee.

25 Q Based upon the pain that this gentleman was

1 exhibiting when you did the initial exam, -- which
2 I think you did look closely at his knee -- would
3 that diagnosis be consistent with at least what you
4 recall and what -- your record?

5 Mr. Huff: Object to leading.

6 A Yes.

7 Q Okay. If, in fact, this gentleman has been
8 complaining in previous treatment records of the
9 same constellation of symptoms, particularly left
10 low back, buttock and pain going down to the knee,
11 would those complaints be consistent with your
12 clinical findings?

13 A Yes.

14 Mr. Huff: Objection to leading.

15 Q Would those complaints be consistent with your
16 diagnosis?

17 A Yes.

18 Mr. Huff: Object to leading.

19 Q Okay. If a person continues to try to perform
20 activities of daily living or try to work with an
21 untreated facet syndrome, what is the -- the most
22 likely consequence long term?

23 Mr. Huff: Object. It calls for
24 speculation.

25 A There's no mechanism for it to get better on its

1 own, and it's likely to progress, especially with
2 -- when combined with an altered gait.

3 Q And when I ask you that question, you mentioned
4 earlier that you have treated posttraumatic facet
5 syndromes prior to this case?

6 A I have.

7 Q I mean, how many would you estimate,
8 conservatively, over the years?

9 A Hundreds and hundreds and hundreds.

10 Q Okay. So, do you feel comfortable, based upon
11 having done these treatments before, and followed
12 people at different stages, I assume, of treatment,
13 that you can, to a reasonable degree of medical
14 certainty, indicate most probably what the natural
15 course of facet syndrome is, both in a treated
16 scenario and an untreated scenario?

17 A Yes, I am comfortable with that.

18 Q And, so, back to your question. Mr. Huff said it
19 was speculative. To a reasonable degree of medical
20 certainty, most probably, based upon what you saw
21 in January, what -- were you surprised or not
22 surprised when you saw similar symptoms in
23 October?

24 A There's no surprise.

25 Q Okay. So, can those symptoms progress if

1 untreated?

2 Mr. Huff: Objection to leading.

3 A Definitely.

4 Q In order to try to improve these symptoms, what
5 would you recommend for Mr. McDuffie?

6 A At this point, hopefully he's getting reasonable
7 knee treatment, and, hopefully his knee pain can
8 improve. Independent of the knee pain, with
9 respect to his low back, he needs just to go
10 through the short facet treatment algorithm
11 beginning with left-sided medial branch blocks,
12 which will hopefully cover his back, gluteal and
13 leg pain, and, if he has very good relief, we can
14 see how well he does and send him for some type of
15 rehab. He needs to take the pain relief and
16 translate that into functioning at this point, with
17 this injury being more than a year old, I believe.
18 Q Assuming this gentleman has not gotten any knee
19 treatment at this point, other than Dr. Mazoue's
20 initial visit and recommendation, and MRI scan --
21 Assume, also, that Dr. Mazoue has indicated that if
22 that MRI scan were to show a medial meniscal tear,
23 his recommendation would be surgery. Is that
24 course of treatment reasonable, medically
25 necessary, and aimed toward lessening the overall

1 disability that this gentleman has experienced as a
2 result of his accident?

3 Mr. Huff: Objection --

4 A I would have to refer to the expert, Dr. Mazoue, on
5 that, but certainly my experience with Dr. Mazoue
6 is he is an excellent orthopedist, and I would --
7 From my experience, just being a doctor for 30
8 years, that sounds perfectly reasonable.

9 Mr. Huff: Object to the form of the
10 question as leading and calls for speculation.
11 Didn't want to interrupt you.

12 Q Let me just ask you in a different way. In order
13 to effectively treat the back, does Mr. McDuffie's
14 knee also need to be treated?

15 A To get the -- the best -- give him the best chance
16 of improving in the back, it would be best to have
17 that knee feeling better first so that he could
18 work -- walk better.

19 Q Okay. Doctor, to a reasonable degree of medical
20 certainty, most probably, what is the most likely
21 source of Mr. McDuffie's posttraumatic facet
22 syndrome?

23 A The injury he sustained in September 2014.

24 Q Okay. And the treatment recommendations that
25 you've made, -- I think you've already indicated in

1 a questionnaire, but are they medically reasonable,
2 medically necessary, and are they aimed toward
3 lessening the disability that's he's experienced
4 and particularly the symptoms, also, that you've
5 documented that you've attributed to his work
6 accident?

7 A Yes.

8 Q Are the restrictions that you have imposed at this
9 time also reasonable and medically necessary?

10 A Absolutely.

11 Q And for the type of injury that this gentleman has,
12 are they ones that you've given in the past?

13 A Yes.

14 Q Not just necessarily for him but for other people?

15 A Yes.

16 Q I may be done. Just give me one second. I think
17 Mr. Huff had gone through this with you previously,
18 but I'll just -- Let me look at this real fast.

19 (Attorney Safran presents document to the
20 deponent.)

21 Q Are these responses still accurate?

22 A Yes.

23 Q And sitting here today -- I think Mr. Huff had
24 asked you this question. Having again looked at
25 Dr. Lembo's reports, looked at Dr. Johnson's

1 reports and deposition, done your own physical
2 exams, are all those pieces of information and
3 evidence helpful to you in -- in your diagnosis?

4 A Sure.

5 Q And do they support your diagnosis?

6 A They do.

7 Mr. Huff: Andy, I need to take a break,
8 if we may.

9 Mr. Safran: Sure. I'm about done, but
10 go ahead.

11 Mr. Huff: If it'll be another minute, I
12 can wait. I just need to go to the men's
13 room. You tell me.

14 Mr. Safran: Yeah, I'm going to be
15 literally a minute, and then --

16 Mr. Huff: All right. That's okay.

17 Mr. Safran: -- we'll be done.

18 Mr. Huff: Well, I can wait one minute,
19 if we could.

20 Mr. Safran: All right.

21 Mr. Huff: Being diabetic, I have that
22 problem.

23 Mr. Safran: No. I understand.

24 Q And I think you've already looked at this. This is
25 something that -- I guess in giving us some

1 opinions, you have looked at this report from Dr.
2 Lembo?

3 A Yes.

4 Q This is the one from October 13, 2015?

5 A I believe so.

6 Q All right.

7 Mr. Safran: Give me one second, Ros.

8 Q In the event the facet blocks -- I think it's in
9 your report -- were to be beneficial, I think you
10 said that the concept of radiofrequency rhizotomy
11 was discussed. Is -- Is that a next step in the
12 event of a successful but not complete relief from
13 these blocks?

14 A Typically, if one has very good quality but short-
15 term relief and the results are reproducible, RF
16 would be the next logical step.

17 Q And when -- I've just referred to those
18 questionnaire responses. Those are the ones that
19 you completed in July, as I understand it?

20 A Yes.

21 Mr. Safran: Okay. That's all I've got.
22 Thank you.

23 Mr. Huff: Thank you. I have nothing
24 further.

25 (Whereupon the deposition was concluded at

1 5:34 p.m.)

2 (Deponent has waived reading and signing.)

Palmetto Pain Management

1655 Bernardin Avenue Suite 240
Columbia SC 292042039
Phone: 803-779-3263 Fax: 803-779-3207

Visit Note - Office Visit

Provider: Ezra B Riber, MD
Encounter Date: Jan 12, 2015

Patient: McDuffie, Timothy (PT00001571)
Sex: Female DOB: [REDACTED] Age: 37 year
Race: Black/African American
Address: 2442 Washington St, Columbia SC 29204
Insurance: ANDREW N SAFRAN, LLC

Chief Complaints:

Low back; left buttock; and left knee pain.

HPI:

This right-handed 37-year-old African American male is seen today for consultation and evaluation. Mr. McDuffie was in a generally good state of health working in food service at Fort Jackson when he tripped and fell on 9/9/14. He fell forward with his left foot in an awkward position and injured his low back and left knee. He was initially seen by Dr. Young who diagnosed him with a lumbar strain. He has had medication trials without any residual benefit and continues to have the back, gluteal and knee pain. He rates his overall pain as a 5 to 6 on the 0-to-10 scale, denies new onset bladder or bowel dysfunction and most of his low back discomfort is left sided. The gluteal pain is worse with sitting and he tends to avoid left sided weightbearing. He is aware that the knee pain alters his gait and his back is seemingly becoming worse.

Vital Signs:

Weight:	217 lbs
Height:	6' 2"
BMI:	27.86
BSA:	2.26
Temperature:	98.1 F (Tympanic)
BP:	134/80(Right Arm)(Sitting)
Pulse:	60(Right brachial)(Sitting)(Regular)
Respiration:	14
Oxygen:	96(Room air)

Allergy:

No Known Drug Allergies

ROS:

Twelve system review by Dr. Riber, scanned into the record, and considered part of today's initial history and physical evaluation, and assessment.

Current Medication:

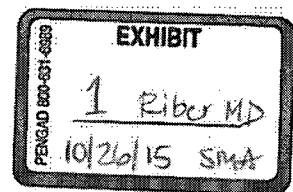
1 Ibuprofen 800 Mg Tablet (Other MD) SIG: Take 1 by mouth three times daily as needed for pain

Medical History:

Patient is not currently taking a blood thinner.

Social History:

Marital Status: Single.



COPY

Smoking/Tobacco Use: Quit smoking or using tobacco products. Patient stopped smoking 2 month ago, he smoked a pack every week.

Alcohol Use: Patient admits to consuming alcohol. Frequency: socially.
She denies recreational drug use. Patient has Brown eyes.

Examination:

Pleasant, no acute distress, alert and oriented, good historian. Unaccompanied today.

Exhibits no pain behavior; makes no specific medication request.

Patient appears stated age.

HEENT: Alert and Oriented X 3. Speech and content are appropriate. Patient is a good historian No
tics ptosis nystagmus or strabismus.

Cervical Spine: Range of motion is full.

Spurling's negative Lhermitte's absent.

Symmetrical contour of the shoulders.

No winging of the scapulae.

Lungs: clear; no wheezing, rales, or rhonchi.

Pain does not change with cough or valsava.

Heart: Regular rate and rhythm without murmur, gallops or rubs.

Upper Extremities: Similar in appearance.

Grip strength Symmetrical bilaterally.

No atrophic or dystrophic changes noted.

Thoracic Spine: Unremarkable.

Abdomen: Deferred.

Lumbar Spine: Forward flexion reproduces some of his low back discomfort which is most closely reproduced with returning upright and with extension of less than 10°. No specific PSIS and SI or sciatic notch tenderness.

Lower Extremities: Similar in appearance.

Hips: Provocation is negative.

Knees: He can extend to 120° without pain; flexion is more painful. He describes pain anterior and posterior. No masses in the popliteal fossa are appreciated.

Straight Leg Raise Produces some low back and gluteal discomfort on the left at greater than 45°.

Has difficulty standing on heels and toes Slightly on the left.

Gait: Gait favors the left lower extremity.

Integumentary: Warm and dry throughout.

No sudomotor or vasomotor changes noted.

Diagnosis/Decision Making:

724.8 Other Back Symptoms

724.2 Lumbago

719.46 Pain in Joint of Lower Leg

781.2 Abnormality of Gait

338.4 Chronic Pain Syndrome

V58.69 Long-Term (Current) use of other Medications

Impression:

Status post work-related fall 9/19/14

Posttraumatic lumbar facet syndrome left worse than right

Chronic facetogenic low back and gluteal pain

Chronic left knee pain following a fall 9/19/14.

Treatment Plan (R):

In an effort to improve the knee pain and altered gait I would initially treat him with a fluoroscopically guided Intra-articular left knee Injection

If there is no improvement orthopedic evaluation is indicated

The facet treatment algorithm can be followed for the low back pain

Medial branch blocks L3-4 through L5-S1 left side

These were discussed with him including using models

Following discussion of the risks and benefits and alternative treatment options he would be agreeable to proceed once authorization was obtained

Radiofrequency rhizotomy would be a follow up treatment option if he has very good quality but short term relief following the medial branch blocks.

The patient reviewed and signed an opioid use agreement, which outlines our policies and procedures for patient's prescribed opioid analgesics.

- Continue with current medications.
- No adjustments recommended today.
- Call between appointments with questions or concerns.
- More than 50% of the time spent with the patient today was devoted to counseling and coordination of care.

Followup:

The above findings and opinions are made to a reasonable degree of medical certainty. We can followup with him to move forward with the above treatment plan if authorized to do so.

ANDREW N. SAFFRAN, LLC
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July 15, 2015

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Palmetto Pain Management
1655 Bernardin Avenue, Suite 240
Columbia, South Carolina 29204-2023

RE: Timothy McDuffie
Chart No.: PT00001571

Dear Dr. Ribor:

As you will recall, on January 12, 2015, you evaluated Mr. Timothy McDuffie for lumbar symptoms that began in the aftermath of a compensable accident he previously experienced on September 19, 2014 while employed as a cook by Johnson Food Service. At that time, you: (a) noted his history involved a tripping injury that was followed by back and left knee pain; (b) learned Mr. McDuffie continued to experience persistent symptoms involving the back and left leg, including the knee; (c) observed he exhibited pain with lumbar range of motion testing (particularly extension) and difficulty standing on heels/toes, as well painful left knee flexion; (d) determined his lumbar symptoms were indicative of a posttraumatic lumbar facet syndrome; and (e) recommended facet-directed treatment commencing with medial branch blocks.

Since that time, Mr. McDuffie has: (a) continued to experience lumbar and left knee symptoms which negatively impact upon his ability to perform job duties and activities of daily living; (b) nonetheless attempted to remain working due to a desire to be productive; (c) undergone lumbar spine evaluations by Drs. John Johnson and Nancy Lembo, who have each made similar clinical observations, while likewise recommending facet-directed treatment; and (d) obtained a focused left knee orthopaedic examination by Dr. Christopher Mazoue, who believes the September 19, 2014 accident also produced meniscal pathology.

At this time, I would greatly appreciate your answering the following questions so that the parties to Mr. McDuffie's pending workers' compensation claim, as well as the South Carolina Workers' Compensation Commission, will fully understand your opinions as to these material issues:

1) Do you believe, to a reasonable degree of medical certainty, that the posttraumatic lumbar facet syndrome you have diagnosed proximately results from Mr. McDuffie's September 19, 2014 compensable accident?

Yes ☒ No ☐

Ezra B. Riber, M.D.

July 15, 2015

Page 2

2) Based on your examination and review of the reports generated by Drs. Johnson and Lembo, do you believe, to a reasonable degree of medical certainty, that without treatment, Mr. McDuffie's causally related lumbar symptoms will most probably remain problematic and materially/negatively impact upon his ability to sustain work activities?

Yes ☒ No ☐

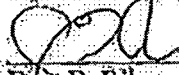
3) Do you believe, to a reasonable degree of medical certainty, that the course of treatment you, Dr. Johnson and Dr. Lembo have recommended for Mr. McDuffie's lumbar injury component is reasonable, medically necessary and geared toward lessening the ultimate period of disability produced by his September 19, 2014 compensable accident?

Yes ☒ No ☐

4) Do you believe, to a reasonable degree of medical certainty, that Dr. Mazoue's treatment recommendations relative to the left knee injury component are likewise reasonable, medically necessary and geared toward lessening the ultimate period of disability produced by Mr. McDuffie's September 19, 2014 compensable accident?

Yes ☒ No ☐

I, Ezra B. Riber, M.D., hereby certify that my responses to the above-listed questions represent my opinions, to a reasonable degree of medical certainty, as to each issue.



Ezra B. Riber, M.D.

Date

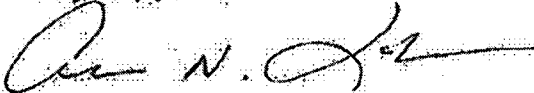
7/20/15

At this time, I would greatly appreciate your answering each of the above-listed questions and executing the certification as soon as possible.

Thank you for your assistance.

With kindest regards, I am

Very truly yours,



Andrew N. Saftan

ANS/as

**PALMETTO PAIN MANAGEMENT
PAIN MANAGEMENT & SPINAL DIAGNOSTICS
EZRA B. RIBER, M.D.
JENNIFER D. STANISLAUS, M.D.**

1655 Bernardin Ave. St. 240
Columbia, SC 29204

Office: 803-779-3263
Fax: 803-779-3207

October 12th, 2015

Re: Timothy McDuffie

To whom it may concern,

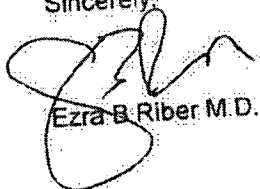
Mr. McDuffie was originally seen here on 01/12/15, he has chronic intractable low back pain and dysfunction secondary to a post-traumatic lumbar facet syndrome as a result of a work related injury on 09/09/14.

The following restrictions should apply until he is treated as outlined in my 1/12/15 and 10/12/15 notes:

- No stooping, bending or twisting
- No lifting more than 10 lbs

If I can be of further assistance please do not hesitate to contact me.

Sincerely,



Ezra B. Riber M.D.

Palmetto Pain Management

1655 Bernardin Avenue Suite 240
Columbia SC 292042039
Phone: 803-779-3263 Fax: 803-779-3207

Visit Note - Office Visit

Provider: Ezra B Riber, MD
Encounter Date: Oct 12, 2015

Patient: McDuffie, Timothy (PT00001571)
Sex: Female DOB: [REDACTED] Age: 37 year
Race: Black/African American
Address: 2442 Washington St, Columbia SC 29204
Insurance: ANDREW N SAFRAN, LLC

Chief Complaints:

Low back, hip and leg pain, worse on the left; left knee pain.

HPI:

Mr. McDuffie is back today for follow up. He is a 37-year-old gentleman first evaluated here on 1/12/15. He presented with the same complaints that developed following a work related incident that occurred more than a year ago on 9/9/14. Patient was working in his usual capacity at Fort Jackson when he fell with a twisting motion injuring his back, as well as the left knee. My initial impression was that of a posttraumatic lumbar facet syndrome worse on the left side with pain radiating from the low back into the gluteal and upper thigh regions. I have not seen him since and he is back today for reevaluation. He has continued to work and reports that his pain and dysfunction have become progressively worse. When bending forward he has difficulty straightening up and any type of lifting or twisting motion causes his pain to be decidedly worse. He rates his overall pain as a 6 on the 0-to-10 scale, but he is any.

Vital Signs:

Weight:	216 lbs
Height:	6' 2"
BMI:	27.73
BSA:	2.26
Temperature:	96.9 F (Tympanic)
BP:	131/79(Right Arm)(Sitting)
Pulse:	62(Right brachial)(Sitting)(Regular)
Respiration:	14
Oxygen:	97(Room air)

Allergy:

No Known Drug Allergies

ROS:

Constitutional: Negative except as documented in history of present illness.
Eye: Negative except as documented in history of present illness.
Ear/Nose/Mouth/Throat: Negative except as documented in history of present illness.
Respiratory: Negative except as documented in history of present illness.
Cardiovascular: Negative except as documented in history of present illness.
Gastrointestinal: Negative except as documented in history of present illness.
Genitourinary: Negative except as documented in history of present illness.
Hematology/Lymphatics: Negative except as documented in history of present illness.
Endocrine: Negative except as documented in history of present illness.
Immunologic: Negative except as documented in history of present illness.
Musculoskeletal: Negative except as documented in history of present illness.
Integumentary: Negative except as documented in history of present illness.
Neurologic: Negative except as documented in history of present illness.
Psychiatric: Negative except as documented in history of present illness.

Current Medication:

1 Ibuprofen 800 Mg Tablet (Other MD) SIG: Take 1 by mouth three times daily as needed for pain

Medical History:



Patient is not currently taking a blood thinner.

Social History:

Marital Status: Single.

Smoking/Tobacco Use: Quit smoking or using tobacco products. Patient stopped smoking 2 month ago, he smoked a pack every week.

Alcohol Use: Patient admits to consuming alcohol. Frequency: socially.
She denies recreational drug use. Patient has Brown eyes.

Examination:

Pleasant, no acute distress, alert and oriented, good historian. Unaccompanied today.
Exhibits no pain behavior; makes no medication request.
Patient appears stated age.

HEENT: Alert and Oriented X 3. Speech and content are appropriate. Patient is a good historian Noncontributory.

Cervical Spine: Range of motion reasonably full.

Lungs: Clear; no wheezing, rales, or rhonchi.

Heart: Regular rate and rhythm without murmur, gallops or rubs.

Abdomen: Deferred.

Lumbar Spine: Minimal low back discomfort is elicited with forward flexion and his pain is more closely reproduced with returning upright and extension most closely reproduces his pain. Bilateral rotation about the hips with the feet planted also reproduces his pain, worse on the left side.

Lower Extremities: Similar in appearance.

Hips: Provocation is negative.

Straight Leg Raise: Produces low back, gluteal and hamstring discomfort, mostly on the left side at greater than 45°.

Gait: Gait favors the left lower extremity slightly.

Integumentary: Warm and dry throughout.

Impression:

Posttraumatic lumbar facet syndrome worse on the left side

Chronic low back and gluteal pain, worse on the left

Chronic left knee pain, posttraumatic

Status post work-related injury 9/9/14

Worsening of symptoms since his initial visit here, 9 months ago.

Treatment Plan (R):

The facet treatment algorithm was discussed with him

Left lumbar medial branch blocks supplying L3, 4 through L5-S1 are recommended

This was discussed with him including using models

The concept of radiofrequency rhizotomy was briefly discussed in the event he would have very good quality but short term relief following the medial branch blocks

The RF treatment can be discussed at a later time should the need arise

At this point patient needs to have work restrictions in order to not cause a worsening of symptoms.

I've given him a note that I recommend no twisting, stooping or bending and no lifting greater than 10 pounds.

- Call between appointments with questions or concerns.

- More than 50% of the time spent with the patient today was devoted to counseling and coordination of care.

Followup:

Per treatment plan outlined above if and when treatment is authorized

JOHNSON FOOD SERVICES, L.L.C.
P.O. BOX 10422
FORT JACKSON, SOUTH CAROLINA 29207

STATEMENT

I, Ernest Roberts would like to make the following statement:

Print Name

ON 20 2014, Around 1500 hr, Mr
McDuffie Came to Me And Said he Triped
on a electrical outlet pole in the Floor And
didn't Fall, But wanted to go to med
care, Because he was in pain in his
Calf And Lower Back. SO I Called the
Main office to get a ride for him to seek
Medical Attention, SO when he Came back
he told me that he was back to work And
Med Care said he had a SPAIN Back,
But WAS released to Come Back to work.


Signature

Employee #

Position

Date

WE ARE AN EQUAL EMPLOYMENT OPPORTUNITY EMPLOYER M/F/V/H

Lower Extremity MAZ

Patient: MCDUFFIE, TIMOTHY MRN: 199300 FIN: 161596
Age: 37 years Sex: Male DOB: [REDACTED]
Associated Diagnoses: Knee pain
Author: Mazoue MD, Christopher

Visit Information

Date of Service: 06/10/2015 10:01 am Performing Location: Sports Medicine Encounter#: 161596

Primary Care Provider (PCP): Not recorded.

Referring Provider: No referring provider recorded for selected visit.

Chief Complaint

6/10/2015 10:43 AM EDT LEFT knee

History of Present Illness

Workman's Comp

Mr. McDuffie is a pleasant 37 y/o male who is here for LEFT knee pain referred by his lawyer Andy Safran. September 19, 2014, he tripped over a pipe at work and felt a pop in his knee. He did not land on his knee, but caught himself with his hands. He also had a back injury and was seen for that. This is the first time being seen for his knee. Location of pain is in the. Pain is constant and worsens with standing for long period of time, laying down, or twisting. He did have PT, but sales that made it worse. He did that for 7 weeks. No medications or injections. He is a cook for Johnson food service at Fort Jackson. He is at work full duty, but is struggling with his knee pain. He is a civilian.

Review of Systems

Constitutional: Negative.
Cardiovascular: Negative.
Hematology/Lymphatics: Negative.
Musculoskeletal: Negative except as documented in history of present illness.
Integumentary: Negative.
Neurologic: Negative.
All other systems reviewed and negative

Health Status**Allergies:**

Allergic Reactions (All)

No known allergies

Medications: (Selected)

Problem list:

No problem items selected or recorded.

Histories**Past Medical History:**

No active or resolved past medical history items have been selected or recorded.

Family History:

No family history items have been selected or recorded.

Procedure history:

No active procedure history items have been selected or recorded.

Social History:

Alcohol Assessment: Current

Tobacco Assessment: Current

Comments:

06/10/2015 - Taylor, Andrea

Trying to stop

Physical Examination

The patient is alert and oriented, healthy appearing, in no acute distress, with a pleasant affect.

The patient ambulates with a good gait pattern.

Examination of the L knee shows:

Alignment: normal

Effusion: none

Patella apprehension test: negative.

Patella tracking: normal.

ROM: 0 - 135 degrees.

Lachman exam: negative.

Pivot shift: negative.

Posterior drawer: negative.

Valgus stress test: negative.

Varus stress test: negative.

Posterolateral stability: normal.

TTP medial joint line: ++.

TTP lateral joint line: negative.

McMurray's test: +++ medial joint line
negative lateral joint line.

Motor, sensation, pulses R LE: normal

Motor, sensation, pulses L LE: normal

There is no gross lymphadenopathy B LE.

Radiographs of L knee: ? calcifications at posterior knee.

Health Maintenance**Recommendations**

Pending (in the next year)

Due

Alcohol Misuse Screen (Male) due 06/10/15 and every 1 year(s)

Body Mass Index Check (Male) due 06/10/15 and every 1 year(s)

Depression Screen (Male) due 06/10/15 and every 1 year(s)

HIV Screen (if sexually active) (Male) due 06/10/15 and every 1 year(s)

High Blood Pressure Screen (Male) due 06/10/15 and every 1 year(s)

Lipid Disorders Screen (Male) due 06/10/15 and every 5 year(s)

STD Counseling (if sexually active) (Male) due 06/10/15 and every 1 year(s)

Syphilis Screen (if sexually active) (Male) due 06/10/15 and every 1 year(s)

Tetanus Vaccine due 06/10/15 and every 10 year(s)

Tobacco Use Screen (Male) due 06/10/15 and every 1 year(s)

Satisfied (in the past 1 year)

There are no satisfied recommendations within the defined date range

Impression and Plan**Diagnosis**

Knee pain (ICD9 719.46).

Summary: I am clearly concerned about a medial meniscus tear of his left knee. There are some inch to an calcifications also on his radiographs at the posterior knee. We will obtain an MRI of the left knee. He will follow up with me after the MRI of his left knee..

Orders

Orders

Charges:

73564 radiologic exam knee complete 4/more views (Task/Charge) (Order): Quantity: 1, Instructions: LEFT knee 4v rom 4.

Professional Services

cc: Andy Safran

Printed by: Earley, Cynthia
Printed on: 6/16/2015 10:46 AM EDT

Page 2 of 3
(Continued)

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Attorney At Law
1400 Pickens Street
Suite 104
Columbia, SC 12089
Fax (803) 799-1003

Note: This note was created using speech recognition software.

Signature Line

Signed and Authored by Christopher Mazoue MD on 06/10/2015 11:36 AM EDT

Charted Date: June 10, 2015 10:45 AM EDT
Subject / Title: Lower Extremity MAZ
Performed By: Mazoue MD, Christopher on June 10, 2015 10:52 AM EDT
Electronically Signed By: Mazoue MD, Christopher on June 10, 2015 11:36 AM EDT
Visit Information: 161596, USC Orthopedics, Outpatient, 6/10/2015 - 6/12/2015

ANDREW N. SAFRAN, LLC
ATTORNEY AT LAW
1400 PICKENS STREET, SUITE 104
COLUMBIA, SOUTH CAROLINA 29201

TELEPHONE 803 250 6889
FACSIMILE 803 799 1008

MAILING ADDRESS
Post Office Box 15089
COLUMBIA, SOUTH CAROLINA 29911

July 9, 2015

Christopher G. Mazoue, M.D.
Department of Orthopaedic Surgery
University of South Carolina School of Medicine
Two Medical Park, Suite 404
Columbia, South Carolina 29203

RE: Timothy McDuffie
MRN: 199300

Dear Dr. Mazoue:

As you will recall, on June 10, 2015, you evaluated Mr. Timothy McDuffie for left knee symptoms that began in the aftermath of a compensable accident he previously experienced on September 19, 2014 while employed as a cook by Johnson Food Service. At that time, you: (a) noted his history involved a tripping injury that was followed by back and left knee pain; (b) were apprised Mr. McDuffie had attempted to continue working, notwithstanding the presence of persistent left knee pain; (c) observed he exhibited a positive McMurray's test response indicative of medial meniscal pathology, as well tenderness to palpation of the medial joint line; (d) expressed your concern as to the presence of a medial meniscal tear; and (e) recommended performance of an MRI scan.

In this regard, review of Mr. McDuffie's relevant medical history confirms: (a) his mechanism of injured involved tripping over an exposed pipe; (b) an incident report dated September 20, 2014 references complaints of "pain in his back and calf area"; (c) a September 20, 2014 record from MedCare Urgent Care Center similarly notes the presence of low back pain that radiated down the left leg; (d) on September 23, 2014, he again described the tripping accident ("catching himself on his left lower extremity but jarring his left lower back/buttock area"), while reporting persistent "pain down his left lower extremity from the buttock area to the ankle"; (e) he was next directed to First Care (September 24, 2014 - November 28, 2014), where Dr. Stewart Young not only identified the presence of left leg pain, but also left medial knee symptoms on multiple occasions; and (f) although he was subsequently examined by several specialists who noted left leg pain that encompassed an area that included the left knee, none of these physicians performed a focused examination of this knee.

At this time, I would greatly appreciate your answering the following questions so that the parties to Mr. McDuffie's pending workers' compensation claim, as well as the South Carolina Workers' Compensation Commission, will fully understand your opinions as to these material issues:

Christopher G. Mazoue, M.D.

July 9, 2015

Page 2

1) Do you believe, to a reasonable degree of medical certainty, that the mechanism of injury which Mr. McDuffie described (tripping over a pipe with his left leg followed by jarring while attempting to his maintain balance and avoid falling to the floor) was sufficient to create not only Mr. McDuffie's documented left leg symptoms, but also left medial meniscal pathology?

Yes ☒ No ☐

2) Do you believe, to a reasonable degree of medical certainty, that Mr. McDuffie's documented left leg symptoms, including references to pain in the area of his left knee, are most probably consistent with this September 19, 2014 mechanism of injury?

Yes ☒ No ☐

3) Given Mr. McDuffie's mechanism of injury, as well as his documented symptoms of both radicular left leg pain and left medial knee pain, do you believe, to a reasonable degree of medical certainty, that at least a portion of his current left leg symptoms most probably result from a left knee injury component?

Yes ☒ No ☐

4) Do you believe, to a reasonable degree of medical certainty, that the left knee symptoms and clinical abnormalities identified in your June 10, 2015 report most probably result from the consequences of Mr. McDuffie's September 19, 2014 compensable accident?

Yes ☒ No ☐

5) Do you believe, to a reasonable degree of medical certainty, that the treatment modalities you have recommended, including an MRI scan and reevaluation to assess treatment options, are reasonable, medically necessary and geared toward lessening the ultimate period of disability produced by Mr. McDuffie's September 19, 2014 compensable accident?

Yes ☒ No ☐

I, Christopher G. Mazoue, M.D., hereby certify that my responses to the above-listed questions represent my opinions, to a reasonable degree of medical certainty, as to each issue.

Christopher G. Mazoue, M.D.

Date

7/13/15

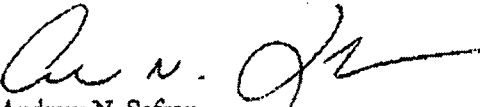
Christopher G. Mazoue, M.D.
July 9, 2015
Page 3

At this time, I would greatly appreciate your answering each of the above-listed questions and executing the certification as soon as possible.

Thank you for your assistance.

With kindest regards, I am

Very truly yours,


Andrew N. Safran

ANS/rmm

Palmetto Pain Management

1655 Bernardin Avenue Suite 240
Columbia SC 292042039
Phone: 803-779-3263 Fax: 803-779-3207

Visit Note - Office Visit

Provider: Ezra B Riber, MD
Encounter Date: Jan 12, 2015

Patient: McDuffie, Timothy (PT00001571)
Sex: Female DOB: [REDACTED] Age: 37 year
Race: Black/African American
Address: 2442 Washington St, Columbia SC 29204
Insurance: ANDREW N SAFRAN, LLC

Chief Complaints:

Low back; left buttock; and left knee pain.

HPI:

This right-handed 37-year-old African American male is seen today for consultation and evaluation. Mr. McDuffie was in a generally good state of health working in food service at Fort Jackson when he tripped and fell on 9/9/14. He fell forward with his left foot in an awkward position and injured his low back and left knee. He was initially seen by Dr. Young who diagnosed him with a lumbar strain. He has had medication trials without any residual benefit and continues to have the back, gluteal and knee pain. He rates his overall pain as a 5 to 6 on the 0-to-10 scale, denies new onset bladder or bowel dysfunction and most of his low back discomfort is left sided. The gluteal pain is worse with sitting and he tends to avoid left sided weightbearing. He is aware that the knee pain alters his gait and his back is seemingly becoming worse.

Vital Signs:

Weight:	217 lbs
Height:	6' 2"
BMI:	27.86
BSA:	2.26
Temperature:	98.1 F (Tympanic)
BP:	134/80(Right Arm)(Sitting)
Pulse:	60(Right brachial)(Sitting)(Regular)
Respiration:	14
Oxygen:	96(Room air)

Allergy:

No Known Drug Allergies

ROS:

Twelve system review by Dr. Riber, scanned into the record, and considered part of today's initial history and physical evaluation, and assessment.

Current Medication:

1 Ibuprofen 800 Mg Tablet (Other MD) SIG: Take 1 by mouth three times daily as needed for pain

Medical History:

Patient is not currently taking a blood thinner.

Social History:

Marital Status: Single.

Smoking/Tobacco Use: Quit smoking or using tobacco products. Patient stopped smoking 2 month ago, he smoked a pack every week.

Alcohol Use: Patient admits to consuming alcohol. Frequency: socially.
She denies recreational drug use. Patient has Brown eyes.

Examination:

Pleasant, no acute distress, alert and oriented, good historian. Unaccompanied today.
Exhibits no pain behavior; makes no specific medication request.

Patient appears stated age.

HEENT: Alert and Oriented X 3. Speech and content are appropriate. Patient is a good historian No
tics ptosis nystagmus or strabismus.

Cervical Spine: Range of motion is full.

Spurling's negative Lhermitte's absent.

Symmetrical contour of the shoulders.

No winging of the scapulae.

Lungs: clear; no wheezing, rales, or rhonchi.

Pain does not change with cough or valsalva.

Heart: Regular rate and rhythm without murmur, gallops or rubs.

Upper Extremities: Similar in appearance.

Grip strength Symmetrical bilaterally.

No atrophic or dystrophic changes noted.

Thoracic Spine: Unremarkable.

Abdomen: Deferred.

Lumbar Spine: Forward flexion reproduces some of his low back discomfort which is most closely reproduced with returning upright and with extension of less than 10°. No specific PSIS and SI or sciatic notch tenderness.

Lower Extremities: Similar in appearance.

Hips: Provocation is negative.

Knees: He can extend to 120° without pain; flexion is more painful. He describes pain anterior and posterior. No masses in the popliteal fossa are appreciated.

Straight Leg Raise Produces some low back and gluteal discomfort on the left at greater than 45°.

Has difficulty standing on heels and toes Slightly on the left.

Gait: Gait favors the left lower extremity.

Integumentary: Warm and dry throughout.

No sudomotor or vasomotor changes noted.

Diagnosis/Decision Making:

724.8	Other Back Symptoms
724.2	Lumbago
719.46	Pain in Joint of Lower Leg
781.2	Abnormality of Gait
338.4	Chronic Pain Syndrome
V58.69	Long-Term (Current) use of other Medications

Impression:

Status post work-related fall 9/19/14

Posttraumatic lumbar facet syndrome left worse than right

Chronic facetogenic low back and gluteal pain

Chronic left knee pain following a fall 9/19/14.

Treatment Plan (R):

In an effort to improve the knee pain and altered gait I would initially treat him with a fluoroscopically guided intra-articular left knee injection

If there is no improvement orthopedic evaluation is indicated

The facet treatment algorithm can be followed for the low back pain

Medial branch blocks L3-4 through L5-S1 left side

These were discussed with him including using models

Following discussion of the risks and benefits and alternative treatment options he would be agreeable to proceed once authorization was obtained

Radiofrequency rhizotomy would be a follow up treatment option if he has very good quality but short term relief following the medial branch blocks.

The patient reviewed and signed an opioid use agreement, which outlines our policies and procedures for patient's prescribed opioid analgesics.

- Continue with current medications.
- No adjustments recommended today.
- Call between appointments with questions or concerns.
- More than 50% of the time spent with the patient today was devoted to counseling and coordination of care.

Followup:

The above findings and opinions are made to a reasonable degree of medical certainty. We can followup with him to move forward with the above treatment plan if authorized to do so

ANDREW N. SAFRAN, LLC
ATTORNEY AT LAW
1400 PICKENS STREET, SUITE 104
COLUMBIA, SOUTH CAROLINA 29201

TELEPHONE 803 250 0000
FACSIMILE 803 798 1000

MAILING ADDRESS:
POST OFFICE BOX 18089
COLUMBIA, SOUTH CAROLINA 29311

July 15, 2015

Ezra B. Riber, M.D.
Palmetto Pain Management
1655 Bernardin Avenue, Suite 240
Columbia, South Carolina 29204-2023

RE: Timothy McDuffie
Chart No.: PT00001571

Dear Dr. Riber:

As you will recall, on January 12, 2015, you evaluated Mr. Timothy McDuffie for lumbar symptoms that began in the aftermath of a compensable accident he previously experienced on September 19, 2014 while employed as a cook by Johnson Food Service. At that time, you: (a) noted his history involved a tripping injury that was followed by back and left knee pain; (b) learned Mr. McDuffie continued to experience persistent symptoms involving the back and left leg, including the knee; (c) observed he exhibited pain with lumbar range of motion testing (particularly extension) and difficulty standing on heels/toes, as well painful left knee flexion; (d) determined his lumbar symptoms were indicative of a posttraumatic lumbar facet syndrome; and (e) recommended facet-directed treatment commencing with medial branch blocks.

Since that time, Mr. McDuffie has: (a) continued to experience lumbar and left knee symptoms which negatively impact upon his ability to perform job duties and activities of daily living; (b) nonetheless attempted to remain working due to a desire to be productive; (c) undergone lumbar spine evaluations by Drs. John Johnson and Nancy Lembo, who have each made similar clinical observations, while likewise recommending facet-directed treatment; and (d) obtained a focused left knee orthopaedic examination by Dr. Christopher Mazoue, who believes the September 19, 2014 accident also produced meniscal pathology.

At this time, I would greatly appreciate your answering the following questions so that the parties to Mr. McDuffie's pending workers' compensation claim, as well as the South Carolina Workers' Compensation Commission, will fully understand your opinions as to these material issues:

1) Do you believe, to a reasonable degree of medical certainty, that the posttraumatic lumbar facet syndrome you have diagnosed proximately results from Mr. McDuffie's September 19, 2014 compensable accident?

Yes ☒ No ☐

Ezra B. Riber, M.D.
July 15, 2015
Page 2

2) Based on your examination and review of the reports generated by Drs. Johnson and Lembo, do you believe, to a reasonable degree of medical certainty, that without treatment, Mr. McDuffie's causally related lumbar symptoms will most probably remain problematic and materially/negatively impact upon his ability to sustain work activities?

Yes ☒ No ☐

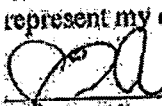
3) Do you believe, to a reasonable degree of medical certainty, that the course of treatment you, Dr. Johnson and Dr. Lembo have recommended for Mr. McDuffie's lumbar injury component is reasonable, medically necessary and geared toward lessening the ultimate period of disability produced by his September 19, 2014 compensable accident?

Yes ☒ No ☐

4) Do you believe, to a reasonable degree of medical certainty, that Dr. Mazoue's treatment recommendations relative to the left knee injury component are likewise reasonable, medically necessary and geared toward lessening the ultimate period of disability produced by Mr. McDuffie's September 19, 2014 compensable accident?

Yes ☒ No ☐

I, Ezra B. Riber, M.D., hereby certify that my responses to the above-listed questions represent my opinions, to a reasonable degree of medical certainty, as to each issue.


Ezra B. Riber, M.D.

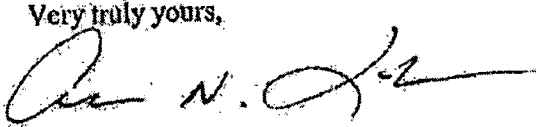
Date 7/20/15

At this time, I would greatly appreciate your answering each of the above-listed questions and executing the certification as soon as possible.

Thank you for your assistance.

With kindest regards, I am

Very truly yours,


Andrew N. Safran

ANS/as

Palmetto Pain Management

1655 Bernardin Avenue Suite 240
Columbia SC 292042039
Phone: 803-779-3263 Fax: 803-779-3207

Visit Note - Office Visit

Provider: Ezra D Riber, MD
Encounter Date: Oct 12, 2015

Patient: McDuffie, Timothy (PT00001571)
Sex: Female DOB: [REDACTED] Age: 37 year
Race: Black/African American
Address: 2442 Washington St, Columbia SC 29204
Insurance: ANDREW N SAFRAN, LLC

Chief Complaints:

Low back, hip and leg pain, worse on the left; left knee pain.

HPI:

Mr. McDuffie is back today for follow up. He is a 37-year-old gentleman first evaluated here on 1/12/15. He presented with the same complaints that developed following a work related incident that occurred more than a year ago on 9/9/14. Patient was working in his usual capacity at Fort Jackson when he fell with a twisting motion injuring his back, as well as the left knee. My initial impression was that of a posttraumatic lumbar facet syndrome worse on the left side with pain radiating from the low back into the gluteal and upper thigh regions. I have not seen him since and he is back today for reevaluation. He has continued to work and reports that his pain and dysfunction have become progressively worse. When bending forward he has difficulty straightening up and any type of lifting or twisting motion causes his pain to be decidedly worse. He rates his overall pain as a 6 on the 0-to-10 scale, but he is any.

Vital Signs:

Weight:	216 lbs
Height:	6' 2"
BMI:	27.73
BSA:	2.26
Temperature:	96.9 F (Tympanic)
BP:	131/79(Right Arm)(Sitting)
Pulse:	62(Right brachial)(Sitting)(Regular)
Respiration:	14
Oxygen:	97(Room air)

Allergy:

No Known Drug Allergies

ROS:

Constitutional: Negative except as documented in history of present illness.
Eye: Negative except as documented in history of present illness.
Ear/Nose/Mouth/Throat: Negative except as documented in history of present illness.
Respiratory: Negative except as documented in history of present illness.
Cardiovascular: Negative except as documented in history of present illness.
Gastrointestinal: Negative except as documented in history of present illness.
Genitourinary: Negative except as documented in history of present illness.
Hematology/Lymphatics: Negative except as documented in history of present illness.
Endocrine: Negative except as documented in history of present illness.
Immunologic: Negative except as documented in history of present illness.
Musculoskeletal: Negative except as documented in history of present illness.
Integumentary: Negative except as documented in history of present illness.
Neurologic: Negative except as documented in history of present illness.
Psychiatric: Negative except as documented in history of present illness.

Current Medication:

1 Ibuprofen 800 Mg Tablet (Other MD) SIG: Take 1 by mouth three times daily as needed for pain

Medical History:



Patient is not currently taking a blood thinner.

Social History:

Marital Status: Single.

Smoking/Tobacco Use: Quit smoking or using tobacco products. Patient stopped smoking 2 months ago, he smoked a pack every week.

Alcohol Use: Patient admits to consuming alcohol. Frequency: socially.
She denies recreational drug use. Patient has Brown eyes.

Examination:

Pleasant, no acute distress, alert and oriented, good historian. Unaccompanied today.

Exhibits no pain behavior; makes no medication request.

Patient appears stated age.

HEENT: Alert and Oriented X 3. Speech and content are appropriate. Patient is a good historian Noncontributory.

Cervical Spine: Range of motion reasonably full.

Lungs: clear; no wheezing, rales, or rhonchi.

Heart: Regular rate and rhythm without murmur, gallops or rubs.

Abdomen: Deferred.

Lumbar Spine: Minimal low back discomfort is elicited with forward flexion and his pain is more closely reproduced with returning upright and extension most closely reproduces his pain. Bilateral rotation about the hips with the feet planted also reproduces his pain, worse on the left side.

Lower Extremities: Similar in appearance.

Hips: Provocation is negative.

Straight Leg Raise Produces low back, gluteal and hamstring discomfort, mostly on the left side at greater than 45°.

Gait: Gait favors the left lower extremity slightly.

Integumentary: Warm and dry throughout.

Impression:

Posttraumatic lumbar facet syndrome worse on the left side

Chronic low back and gluteal pain, worse on the left

Chronic left knee pain, posttraumatic

Status post work-related injury 9/9/14

Worsening of symptoms since his initial visit here, 9 months ago.

Treatment Plan (R):

The facet treatment algorithm was discussed with him

Left lumbar medial branch blocks supplying L3, 4 through L5-S1 are recommended

This was discussed with him including using models

The concept of radiofrequency rhizotomy was briefly discussed in the event he would have very good quality but short term relief following the medial branch blocks

The RF treatment can be discussed at a later time should the need arise

At this point patient needs to have work restrictions in order to not cause a worsening of symptoms.

I've given him a note that I recommend no twisting, stooping or bending and no lifting greater than 10 pounds.

- Call between appointments with questions or concerns.

- More than 50% of the time spent with the patient today was devoted to counseling and coordination of care.

Followup:

Per treatment plan outlined above if and when treatment is authorized



1106 Chuck Dawley Blvd., Suite 200 Mt. Pleasant, SC 29464

Patient Name: Timothy McDuffie

Encounter Date: 6/11/2015

Date of Birth: [REDACTED]

Account Number: [REDACTED]

History of Present Illness: Mr. McDuffie is a 37-year-old black male seen for the first time today at Southeastern Spine Institute for an independent medical examination. He claims he was in his normal state of health until 09-19-14 when he was involved in a work-related injury. At that time he was working as a cook for Johnson Food Service, a position he had for a year and four months when the accident occurred. He states he was cleaning up the kitchen area at a building that was different than the one he normally worked in. He was cleaning a grill and turned to get a broom and tripped over a pipe that was sticking up through the floor. This was a metal pipe about an inch in diameter and stuck up about 4 inches from the floor; this is an apparent architectural mistake that had never been corrected. He states the pipe normally was covered with a table but the table had been moved and he had not been informed. As he was walking, his left toe caught the pipe causing him to trip over. He was able to right himself without hitting the ground, but still had his foot caught which caused a severe jar to his back and leg. He tried to continue work sweeping and twisting but had almost immediate severe intense pain in his left low back, buttock and down the posterior lateral aspect of his left lower extremity to his calf.

He reported this to his supervisor and the next morning was seen by a physician at MedCare. That physician gave him medications for pain and a muscle relaxant and anti-inflammatory with an x-ray performed, also. Within a few days his symptoms were so severe he went to Baptist emergency room. Two days after he was seen at Doctors Care by Dr. Young who diagnosed him with a sprain and recommended physical therapy along with his medications. He had eight sessions of therapy but stated this caused worsening of his symptoms. He went back to Dr. Young who cancelled the therapy and referred him to the Moore Clinic. At Moore Clinic he was seen by Dr. Peelle who ordered a lumbar MRI scan. Dr. Peelle saw no evidence of structural abnormalities on his MRI and released the patient to full work duty with no restrictions as of 01-02-15. Since that time the patient has continued suffering with the same symptoms of sharp stabbing low back and buttock pain on the left that radiates down the left lower extremity to just below the popliteal fossa. His worst pain is his left low back and popliteal fossa area.

I do not have any other medical records. According to the patient he has recently seen a female doctor who recommended possible joint injections. He has also seen an orthopaedic physician who felt he had an abnormality in his knee and recommended a MRI scan of his knee for what the patient feels is secondary to an abnormal physical finding.

The patient's pain is constant. He rates his pain 7 out of 10. He gives a ratio of 25% back 75% leg pain. He denies any relieving or exacerbating factors. He states no matter what he does it seems to be worse.

Prior to the accident, he never had similar symptoms.

Past Medical History: No known medical conditions.

Current Medications: He takes no daily medications.

Dictated, Not Read
6/12/2015

1 of 2

399

Patient Name: McDuffie, Timothy
Account number: [REDACTED]
DOB: [REDACTED]
Encounter Date: 6/11/2015

Drug Allergies: No known allergies.

Family History: Noncontributory.

Personal and Social History: He is working full-time at full duty but states he has great difficulty doing so at times because of pain. He lives in Columbia with his girlfriend and her 12-year-old child. He smokes 2-3 cigarettes per day and drinks alcohol occasionally.

Review of Systems: Negative.

Physical Examination: The patient is a pleasant, cooperative, young adult black male who appears somewhat distressed with sit to stand position. He is alert and oriented x3. Cranial nerves II-XII are grossly intact. He has a normal-appearing spine to gross inspection. Gait is slightly antalgic with a flexed posture of the spine to 5 degrees. He seems to favor his left lower extremity. He has mild tenderness to palpation in the left lower lumbar region. Range of motion is decreased particularly with full extension secondary to pain. Upper extremity strength is 5/5. Sensation is intact. Lower extremity strength is 5/5. Hip and leg extension cause worsening pain. Positive straight leg raise on the left, negative on the right. Patrick's sign is negative bilaterally. No myelopathic findings. Sensation to light touch is decreased below the knee, left greater than right.

Diagnosis Codes:

724.4 UNS THORACIC/LUMB NEURITIS/RADICUL

Impression: Lumbar radiculitis versus sacroiliitis versus facetogenic pain.

Treatment Plan: At this point I believe Mr. McDuffie's persistent symptoms are a result of the 09-19-14 accident and very likely reflective of posttraumatic facet syndrome. As such, I feel these symptoms require focused treatment that could include medial branch blocks which could be diagnostic as well as therapeutic. Because of this, I do not feel he has reached maximum medical improvement. I think it would be premature to assign any type of impairment. With regard to work restrictions, since he has been working for the past six months full time full duty, I do not think there is any reason to assign any restrictions.

Please contact me personally with any further questions regarding this patient.

The patient is instructed to return if pain or symptoms arise.

John F. Johnson, MD

JFJ/jbe

ANDREW N. SAFFRAN, LLC
 ATTORNEY AT LAW
 1400 PICKENS STREET, SUITE 104
 COLUMBIA, SOUTH CAROLINA 29201

TELEPHONE 803 253 9889
 FACSIMILE 803 799 1002

MAILING ADDRESS
 POST OFFICE BOX 12089
 COLUMBIA, SOUTH CAROLINA 29211

July 15, 2015

John F. Johnson, M.D.
 Southeastern Spine Institute
 1106 Chuck Dawley Blvd., Suite 200
 Mount Pleasant, South Carolina 29464

RE: Timothy McDuffie
 Chart No.: 845200

Dear Dr. Johnson:

As you will recall, on June 11, 2015, you evaluated Mr. Timothy McDuffie for lumbar symptoms that began in the aftermath of a compensable accident he previously experienced on September 19, 2014 while employed as a cook by Johnson Food Service. At that time, you: (a) noted his history involved a tripping injury that was followed by back and left knee pain; (b) learned Mr. McDuffie continued to experience persistent symptoms involving the back and left leg, including the knee, which resulted in his having "great difficulty" performing his job duties at times; (c) observed he exhibited pain with lumbar range of motion testing (particularly extension) and positive left straight leg test response, as well some difficulty going from sitting to standing; (d) determined his lumbar symptoms were likely indicative of a posttraumatic lumbar facet syndrome; and (e) recommended facet-directed treatment.

Since that time, Mr. McDuffie has: (a) continued to experience lumbar and left knee symptoms which negatively impact upon his ability to perform job duties; (b) attempted to remain working, despite encountering problems sustaining this activity; (c) not received the facet-directed treatment you, Dr. Ezra Riber and Dr. Nancy Lembo have recommended; and (d) obtained a focused left knee orthopaedic examination by Dr. Christopher Mazoue, who believes the September 19, 2014 accident also produced meniscal pathology.

At this time, I would greatly appreciate your answering the following questions so that the parties to Mr. McDuffie's pending workers' compensation claim, as well as the South Carolina Workers' Compensation Commission, will fully understand your opinions as to these material issues:

1) Do you believe, to a reasonable degree of medical certainty, that the posttraumatic lumbar facet syndrome you have diagnosed proximately results from Mr. McDuffie's September 19, 2014 compensable accident?

Yes ☒ No ☐

John F. Johnson, M.D.

July 15, 2015

Page 2

2) Based on your examination and review of the reports generated by Drs. Riber and Lembo, do you believe, to a reasonable degree of medical certainty, that without treatment, Mr. McDuffie's causally related lumbar symptoms will most probably remain problematic and materially/negatively impact upon his ability to sustain work activities?

Yes ☒ No ☐

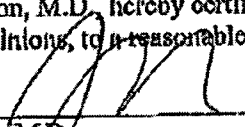
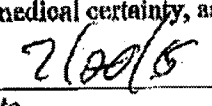
3) Do you believe, to a reasonable degree of medical certainty, that the course of treatment you, Dr. Riber and Dr. Lembo have recommended for Mr. McDuffie's lumbar injury component is reasonable, medically necessary and geared toward lessening the ultimate period of disability produced by his September 19, 2014 compensable accident?

Yes ☒ No ☐

4) Do you believe, to a reasonable degree of medical certainty, that Dr. Mazone's treatment recommendations relative to the left knee injury component are likewise reasonable, medically necessary and geared toward lessening the ultimate period of disability produced by Mr. McDuffie's September 19, 2014 compensable accident?

Yes ☒ No ☐

I, John F. Johnson, M.D. hereby certify that my responses to the above-listed questions represent my opinions, to a reasonable degree of medical certainty, as to each issue.

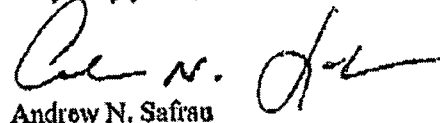

John F. Johnson, M.D.
Date

At this time, I would greatly appreciate your answering each of the above-listed questions and executing the certification as soon as possible.

Thank you for your assistance.

With kindest regards, I am

Very truly yours,


Andrew N. Safran

ANS/as



Name: Timothy McDuffey
DOB: 12/19/1977
Age: 37
Date of Visit: [REDACTED]

HISTORY OF PRESENT ILLNESS:

Patient presents today for an Initial consultation.

He was injured at work Sept 2014 - he was working in kitchen helping to clean when he tripped over a pipe - he was able to reach out with hands to catch himself

He tried to keep working but pain increased

The pain was left sided lower back

It does radiate into the posterior left thigh to his knee

The pain is described as sharp, throbbing.

There is no numbness or tingling

The symptoms are aggravated by sitting, standing, bending, twisting

He denies any bowel or bladder changes.

There is no prior history of similar symptoms.

His treatment has consisted of Doctors Care, Moore Clinic, Dr. Peele, PT for 7 wks, medication, MRI

General Appearance:

Well developed, well nourished male.

Affect is appropriate.

Gait is not antalgic or widened.

Balance is normal.

Spine Examination:

Examination of the spine does not reveal any evidence of a thoracolumbar shift

There is no point tenderness in the midline

There is left sided lumbar paraspinal hypertrophy.

Range of motion is painful in extension.

There is no tenderness over the PSIS

Neurologic Examination:

Examination of the lower extremities reveals no evidence of atrophy fasciculations or erythema.

Calves are nontender.

Motor strength is 5/5

DTR's are hypoactive and symmetrical

Sensory examination is normal.

Slump Testing is normal

Musculoskeletal Examination:

Palpation over the greater trochanteric bursa does not reproduce the typical pain.

Range of motion of the hips is symmetrical and painfree.

Review of Systems:

CONSTITUTIONAL: No Fever/chills; No Weight loss

CARDIOVASCULAR: No Shortness of breath; No Chest pain; No Peripheral edema

RESPIRATORY: No Cough; No Dyspnea; No Wheezing

GASTROINTESTINAL: No Abdominal pain; No Nausea/vomiting; No Change in bowel habits

GENITOURINARY: No Dysuria; No Urgency; No Incontinence

NEUROLOGICAL: No Mental status changes; No Motor weakness; No Sensory changes

MUSCULOSKELETAL: See CC and HPI

SOCIAL HISTORY:

Tobacco Assessment: Smoking Status: Current every day smoker; Tobacco User: Yes; Counseling on tobacco cessation;
Discussed Smoking/Tobacco Use Cessation Strategies

VITAL SIGNS:

Clinical Note

Weight 90.72 kg; Height 6 ft 2 in BMI 25.7

06/09/2015 11:07 AM (EST)

Pulse Rate 64 bpm; Blood Pressure 135 / 75 mm/Hg

DIAGNOSIS:

1. LBP
2. Lumbar Facet Pain
3. Myofascial Pain

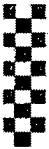
PLAN:

Physical Activity Counseling

1. Discussed treatment options and reviewed available records including MRI lumbar spine
2. reassured patient it appears to be more mechanical - no evidence of disc pathology
3. rec lumbar facet joint injection vs. medial branch block to identify pain generator - consistent with Physical exam and imaging findings
4. rec resuming naprosen and trial of robaxin
5. RTW - no lifting greater than 30 lbs

Electronically Signed By: Nancy Lembo DO

Electronically signed: 6/9/2015 12:08:24 PM



ANDREW N. SAFRAN, LLC
ATTORNEY AT LAW
1400 PICKENS STREET, SUITE 104
COLUMBIA, SOUTH CAROLINA 29201

TELEPHONE 803 255 0000
FACSIMILE 803 799 1000

MAILING ADDRESS:
Post Office Box 18000
COLUMBIA, SOUTH CAROLINA 29201

July 15, 2015

Nancy R. Lembo, D.O.
Carolina Spine & Sport Rehabilitation Specialists, P.A.
763 Travelers Boulevard, Suite D
Summerville, South Carolina 29485

RE: Timothy McDuffie
Date of Birth: [REDACTED]

Dear Dr. Lembo:

As you will recall, on June 9, 2015, you evaluated Mr. Timothy McDuffie for lumbar symptoms that began in the aftermath of a compensable accident he previously experienced on September 19, 2014 while employed as a cook by Johnson Food Service. At that time, you: (a) noted his history involved a tripping injury that was followed by back and left knee pain; (b) learned Mr. McDuffie continued to experience persistent symptoms involving the back and left leg, including the knee, which worsened with sitting, standing, bending and twisting; (c) observed he exhibited pain with lumbar range of motion testing (particularly extension) and left sided lumbar hypertrophy; (d) determined his lumbar symptoms were likely indicative of a posttraumatic lumbar facet syndrome; and (e) recommended facet-directed treatment, while limiting his lifting to 30 pounds.

Since that time, Mr. McDuffie has: (a) continued to experience lumbar and left knee symptoms which negatively impact upon his ability to perform job duties; (b) attempted to remain working, despite encountering problems sustaining this activity; (c) not received the facet-directed treatment you, Dr. Ezra Riber and Dr. John Johnson have recommended; and (d) obtained a focused left knee orthopaedic examination by Dr. Christopher Mazoue, who believes the September 19, 2014 accident also produced meniscal pathology.

At this time, I would greatly appreciate your answering the following questions so that the parties to Mr. McDuffie's pending workers' compensation claim, as well as the South Carolina Workers' Compensation Commission, will fully understand your opinions as to these material issues:

1) Do you believe, to a reasonable degree of medical certainty, that the posttraumatic lumbar facet syndrome you have diagnosed proximately results from Mr. McDuffie's September 19, 2014 compensable accident?

Yes ☒ No ☐

Nanoy R. Lembo, D.O.
July 15, 2015
Page 2

2) Based on your examination, do you believe, to a reasonable degree of medical certainty, that without treatment, Mr. McDuffie's causally related lumbar symptoms will most probably remain problematic and materially/negatively impact upon his ability to sustain work activities?

Yes ☒ No ☐

3) Do you believe, to a reasonable degree of medical certainty, that the course of treatment you have recommended for Mr. McDuffie's lumbar injury component is reasonable, medically necessary and geared toward lessening the ultimate period of disability produced by his September 19, 2014 compensable accident?

Yes ☒ No ☐

4) Do you believe, to a reasonable degree of medical certainty, that Dr. Mazoue's treatment recommendations relative to the left knee injury component are likewise reasonable, medically necessary and geared toward lessening the ultimate period of disability produced by Mr. McDuffie's September 19, 2014 compensable accident?

Yes ☒ No ☐

I, Nanoy R. Lembo, D.O., hereby certify that my responses to the above-listed questions represent my opinions, to a reasonable degree of medical certainty, as to each issue.


Nanoy R. Lembo, D.O.

7/20/15
Date

At this time, I would greatly appreciate your answering each of the above-listed questions and executing the certification as soon as possible.

Thank you for your assistance.

With kindest regards, I am

Very truly yours,


Andrew N. Saftan

ANS/ns

MCDUFFIE, TIMOTHY (id #115597, dob: [REDACTED])

Encounter Summary

Patient

Name MCDUFFIE, TIMOTHY (37, M) ID# 115597 Appt. Date/Time 12/17/2014 03:00PM
 DOB [REDACTED] Service Dept. Northeast
 Provider MICHAEL W. PEELLE, MD
 Insurance Med Worker's Comp: SEDGWICK
 Employer Name : JOHNSON FOOD SERVICES
 Case Injury Date : 09/24/2014
 Prescription:

Chief Complaint

Left leg pain.

HPI

This is a 36-year-old male, who has probably work-related injury on 09/19/2014. The patient was tripping on a pipe and twisted his back. The patient describes buttock pain that radiates down to the posterior thigh. He describes back pain is aching, stabbing, throbbing, shooting, simply worse with standing, walking, sitting, lying, walking stairs and bending backwards. He has found nothing to help reduce the pain despite undergoing eight sessions of physical therapy and tried multiple medications. The patient relates lower back pain is 6/10, leg pain 8/10. The patient has difficulty walking more than ten minutes. He has had no bowel or bladder incontinence. The patient was on light duty restrictions now for a period of time.

Problems

- Lumbar radiculopathy

Medications

Reviewed Medications	
Name	Date
cyclobenzaprine 10 mg tablet Take 1 tablet(s) twice a day by oral route.	12/17/14 entered

Allergies

Reviewed Allergies
 NKDA

Vitals

12/17/2014 03:00 pm
 Ht: 6 ft 2 in Wt: 217 lbs BMI: 27.9
 BP: 143/88 sitting

Past Medical History

Reviewed Past Medical History

Surgical History

Reviewed Surgical History

Family History

Reviewed Family History

Social History

Reviewed Social History
Social History
 Smoking Status: Former smoker.
 Alcohol intake: Occasional.
 Non-smoker.
 Chewing tobacco: none.
 Marital status: Single.
 Currently Pregnant: N.
 Work related injury?: Y.
 Is this a sport related injury?: N.

ROS

MCDUFFIE, TIMOTHY (id #115597, dob: [REDACTED])

Patient reports no fever, no night sweats, no significant weight gain, no significant weight loss, and no exercise intolerance. He reports no chest pain, no arm pain on exertion, no shortness of breath, no palpitations, no known heart murmur, and no lightheadedness. He reports no cough, no wheezing, no coughing up blood, no shortness of breath, and no sleep apnea. He reports no reflux, no indigestion, no abdominal pain, no vomiting, and no loss of bowel control. He reports no muscle aches, no muscle weakness, no arthralgias/joint pain, no back pain, no swelling in the extremities, and normal ROM. He reports no jaundice, no rashes, no itching, no dry skin, no growths/lesions, no skin ulcers, no hives, and no shingles. He reports no loss of consciousness, no weakness, no numbness, no tingling, no seizures, no dizziness, no headaches, no migraines, and no restless legs. He reports no swollen glands, no bruising, and no excessive bleeding.

Results / Interpretations

X-RAY, LUMBAR SPINE

- Possibility of Pregnancy?: N

Physical Exam

Patient is a 36-year-old male.

The patient is a young male, who is alert, oriented, and in no apparent distress. His lumbar flexion is limited at about 50 degrees with reproduction of buttock and hamstring pain on left side. He has a positive straight leg raise test in the seated position. He has no focal weakness in his lower extremities. Sensory exam was grossly intact to light touch. No lower extremity edema. No pain with hip or knee range of motion. Negative Waddell sign. There is spinous process tenderness. No skin lesion is noted over the lumbar spine.

IMAGING

The patient and I reviewed x-rays of lumbar spine. No osseous abnormalities are noted.

Assessment / Plan

Left lower extremity radiculopathy.

I recommend the patient to obtain an MRI of his lumbar spine to help evaluate for his ongoing radiculopathy. He had a conversation with Karen, the patient's case manager for which we discussed the treatment plan as well. The patient will continue to be on light duty restrictions that were outlined today and given to him.

1. Lumbar radiculopathy

724.4: Thoracic or lumbosacral neuritis or radiculitis, unspecified

- X-RAY, LUMBAR SPINE
Possibility of Pregnancy?: N
- MRI, LUMBAR SPINE - Note to Imaging Facility: without contrast, FAX to Dr. MICHAEL PELLE (803) 227-8225
Height (ft.): 6 ft 2 in Weight (lbs): 217
Possibility of Pregnancy?: N

Return to Office

- Michael W. Pelle, MD for Work Comp Recheck at Northeast on 12/31/2014 at 01:30 PM

Encounter Sign-Off

Encounter signed-off by Michael W. Pelle, MD, 12/22/2014.

Encounter performed and documented by Michael W. Pelle, MD

Encounter reviewed & signed by Michael W. Pelle, MD on 12/22/2014 at 9:06am

MCDUFFIE, TIMOTHY (Id #115597, dob: [REDACTED])

Encounter Summary

Encounter Sign-Off

Encounter signed-off by Michael W. Peelle, MD, 01/05/2015.

Patient

Name	MCDUFFIE, TIMOTHY (37, M) ID# 115597	Appt. Date/Time	12/31/2014 01:30PM
DOB	[REDACTED]	Service Dept.	Northeast
Provider	MICHAEL W. PEELLE, MD		
Insurance	Med Worker's Comp: SEDGWICK Employer Name : JOHNSON FOOD SERVICES Case # : 564615078 Case Injury Date : 09/24/2014 Prescription:		

Chief Complaint

L-Spine Recheck, Worker's Comp Recheck

ROS

Patient reports **night sweats** but reports no fever, no significant weight gain, no significant weight loss, and no exercise intolerance. He reports **muscle aches, muscle weakness, arthralgias/joint pain, back pain, and restricted ROM** but reports no swelling in the extremities. He reports **rash, itching, and dry skin** but reports no jaundice, no growths/lesions, no skin ulcers, no hives, and no shingles. He reports no chest pain, no arm pain on exertion, no shortness of breath, no palpitations, no known heart murmur, and no lightheadedness. He reports no cough, no wheezing, no coughing up blood, no shortness of breath, and no sleep apnea. He reports no reflux, no indigestion, no abdominal pain, no vomiting, and no loss of bowel control. He reports no loss of consciousness, no weakness, no numbness, no tingling, no seizures, no dizziness, no headaches, no migraines, and no restless legs. He reports no swollen glands, no bruising, and no excessive bleeding.

HPI

Mr. McDuffie returns stating he still has some mild ongoing discomfort in his lower back, but the patient feels like he is going to be ready to return to his regular duty job. He does not have any specific new complaints and he is also here today to review his MRI.

Physical Exam

Patient is a 37-year-old male.

The patient is alert and oriented in no apparent distress. Limited exam was performed today.

IMAGING STUDIES

The patient and I reviewed with the results of his lumbar MRI. This is essentially completely normal. No evidence of disc herniations, protrusions, central, or foraminal stenosis, osteoarthritic changes, or any evidence of disc degeneration either.

Previous Assessment / Plan

Date of Service
12/17/2014

Left lower extremity radiculopathy.

I recommend the patient to obtain an MRI of his lumbar spine to help evaluate for his ongoing radiculopathy. He had a conversation with Karen, the patient's case manager for which we discussed the treatment plan as well. The patient will continue to be on light duty restrictions that were outlined today and given to him.

1. Lumbar radiculopathy

724.4: Thoracic or lumbosacral neuritis or radiculitis, unspecified

• X-RAY, LUMBAR SPINE

Possibility of Pregnancy?: N

• MRI, LUMBAR SPINE - Note to Imaging Facility: without contrast, FAX to Dr. MICHAEL PEELLE (803) 227-8225

Height (ft.): 6 ft 2 in Weight (lbs): 217

Possibility of Pregnancy?: N

Assessment / Plan

Lumbar strain.

The patient and I discussed that there is no evidence of structural abnormalities on his MRI. The patient is now three and half

MCDUFFIE, TIMOTHY (id #115597, dob: [REDACTED])

months since this time of injury. I believe he is ready to return to work full duty and the patient agrees with this as well. I had a conversation with the patient's case manager Kelley Wells as well today per which we discussed his progress to date MRI findings as well as explained to return to work full duty, no restrictions as of 01/02/2015. The patient will not require future medical care as the result of this injury. He was given a prescription for ibuprofen today, which should supply some for the next couple of months as needed. He also has some Flexeril on hand if needed and he understands when to take this medication as well. The patient has no permanent impairment as a result of this injury.

1. Lumbar sprain

847.2: Sprain of lumbar

- ibuprofen 800 mg tablet - Take 1 tablet(s) 3 times a day by oral route. Qty: 120 tablet(s) Refills: 0 Pharmacy: CVS/PHARMACY #4399

Return to Office
None recorded.

Allergies

Reviewed Allergies
NKDA

Medications

Reviewed Medications	
Name	Date
cyclobenzaprine 10 mg tablet Take 1 tablet(s) twice a day by oral route.	12/17/14 entered
ibuprofen 800 mg tablet Take 1 tablet(s) 3 times a day by oral route.	12/31/14 prescribed

Encounter performed and documented by Michael W. Peelle, MD
Encounter reviewed & signed by Michael W. Peelle, MD on 01/05/2015 at 7:17am

Patient: Timothy McDuffie (DOB: [REDACTED])
Seen On: 09/20/2014 by Kyle Gehres, DO

Seen At: Medcare Urgent Care Center Garners Ferry, 7418 Garners Ferry Road, Columbia, SC 29209-9998; Phone: 8035096310; Fax: 8035096307

Chief Complaint: Patient comes in today for a Back Pain. (SOURCE: Patient)

History of Present Illness: **Patient Reports:**
 Back Pain [Onset: 1 Day(s); Duration: 1 Day(s); Hx of: Reports Trauma, Radiation of pain, Sharp pain; Location: Reports Left; Free text: 36 yr old aam presents with L lower back pain that radiates down his L leg. Patient states he feel over a pole at work last night and landed on his back.]
 Trauma
 Radiation of pain
 Back Lumbar Pain
 Leg Pain [Onset: 1 Day(s); Duration: 1 Day(s); Location: Reports Left]

PMH: Past Medical History is unremarkable

Surgical History: No Surgical History

Review of Systems:
 Constitutional
Patient Denies: Fever; Weight Change; Appetite Change; Fatigue
 Eyes
Patient Denies: Eye Pain; Eye Discharge
 ENT/Mouth
Patient Denies: Ear Hearing Change; Nose Sinus Problems; Throat Voice Loss; Sore Throat; Ear Drainage; Ear Ache
 Cardio
Patient Denies: Swelling - Feet/Ankle; Palpitations; Chest Pain; Swelling - Hands
 Respiratory
Patient Denies: Cough; Wheezing; Congestion
 GI
Patient Denies: Abdominal Pain; Change in Bowel Habits; Diarrhea; Nausea; Vomiting
 GU
Patient Denies: Urinary Incontinence; Painful Urination; Hematuria
 Musc/Skel
Patient Reports: Back Lumbar Pain, Back Pain, Leg Pain
Patient Denies: Muscle cramps; Joint swelling; Joint pain
 Skin/Breast
Patient Denies: Skin Varicose Veins; Skin Color Change; Skin Change in Nails
 Hema/Lymph
Patient Denies: Easily Bleed; Swollen glands; Easy bruising
 Allergy/Immun
Patient Denies: itching; Itching; Rash
 Neurologic
Patient Denies: Seizures; Lightheaded; Tingling; Dizziness
 Psych
Patient Denies: Confusion; Sleeping problems, All non-documented systems have been reviewed and are considered negative.

Current Meds: Patient is not currently on any medications

Allergies: Active: No known allergies; No known drug allergies

Social History: Patient denies smoking. Patient denies chewing tobacco; Patient denies drug use [REDACTED]

Patient: Timothy McDuffie (DOB: [REDACTED])
Seen On: 09/20/2014 by Kyle Gehres, DO

Seen At: Medcare Urgent Care Center Garners Ferry, 7418 Garners Ferry Road, Columbia, SC 29209-9998; Phone: 8035096310; Fax: 8035096307

Patient denies alcohol use.

Family History: Family history is unremarkable

Vitals: BP: 133/80 mmHg; PULSE: 101 bpm; RESP: 18 breaths/min; TEMP: 98.1; WEIGHT: 178 lb(80.74 kg); O2SAT: 100% (2:40 PM)

Exam: General - NORMAL: General appearance is normal to examination, Mood normal, Well developed, No acute distress, Appears to be well nourished, Affect is normal, Normal hygiene
 Skin, Hair, Nails - NORMAL: Normal skin temperature upon palpation, Normal skin moisture, No rashes noted
 Head - NORMAL: No evidence of trauma, Normocephalic
 Eyes - NORMAL: Lids and lashes are normal, PERRLA, Sclera normal, Normal conjunctiva, Iris appears normal
 Ears - NORMAL: Normal pinna bilaterally, Normal TM(s)
 Nose - NORMAL: Normal nasal mucosa, Nasal discharge absent, No septal deviation, Normal nostril(s) noted
 Oral pharynx - NORMAL: Normal appearing tonsils, Normal oral mucosa, Normal posterior pharynx, Lips appear normal
 Neck - NORMAL: Neck is supple, No deformity
 Respiratory - NORMAL: Breathing Rate is Normal, Chest normal to auscultation and/or percussion, No wheezing auscultated, No Rhonchi on auscultation, No Rales on auscultation
 Cardiac - NORMAL: Heart murmur absent, Bruit absent, Rub absent, Normal heart rate noted, Normal rhythm noted
 Neurological - NORMAL: Patient is appropriately alert
 Musculoskeletal - NORMAL: Gait and stance normal, Normal posture, Full range in motion to all four extremities without restriction, Normal strength against resistance, Normal musculoskeletal exam of the back, No TTP noted to the lumbar region muscles upon examination while sitting; ABNORMAL: Positive L leg raise test
 Psych - NORMAL: Normal psychiatric screening, Memory appears normal, Insight appears normal, Patient is oriented to time, place and person, Mood appears to be Normal, Affect Normal

Procedures: X-ray: L-Spine 5 View [72110] QTY (1) [Completed by: Russ Dantzler]
 Urinalysis - IH [81003] QTY (1) [Completed by: Sarah Citro]
 Discharge [Z9800] QTY (1) [Completed by: Cheyenne Arnold]

X-ray Procedure: Verbal consent obtained. The risks and benefits were explained. The patient, or individual acting on behalf of the patient, appears to understand and granted permission to perform the procedure.
 Spine-Lum - Normal: Bony structures normal, alignment normal, no soft tissue swelling, non-specific bowel pattern. I ordered, obtained and reviewed X-ray: L-Spine 5 View Dr. Kyle Gehres on 09/20/2014 at 3:41 PM.

Assessment/Plan: Sprain Back (847.9)

The creation of this record is based on physician observations and their statements to the scribe. This document has been checked and approved by the provider.

-Scribe was: C. Arnold

Pain Lower Back (724.2)

Discharge Instructions: BACK SPRAIN/STRAIN

Drink plenty of fluids

From:

06/01/2015 11:36

#547 P.008/013

Patient: Timothy Mcduffie (DOB: [REDACTED])
Seen On: 09/20/2014 by Kyle Gehres, DO

Seen At: Medcare Urgent Care Center Garners Ferry, 7418 Garners Ferry Road, Columbia, SC 29209-9998; Phone: 8035096310; Fax: 8035096307

Get plenty of rest
Apply warm compresses to the area for 15-20 minutes 4 times a day.
Prescribed Naprosyn 500 MG tablet: Take 1 tablet (ORAL) 2 times per day with food; Total Qty: 30 (Thirty) tablet; No refills; Allow substitutions
* Prescription sent by e-prescribing to CVS/pharmacy #4399 on 09/20/2014
15:45:19.923 by camold.sc002

Orders: Order Results - Urinalysis - IH
Order Results - X-ray: L-Spine 5 View
Order Results - Discharge

Signature: This record was electronically signed by Kyle Gehres, DO on 09/20/2014 at 21:23

From:

06/01/2015 11:35

#547 P.004/013

Patient: Timothy Mcduffie (DOB: [REDACTED])
Seen On: 09/20/2014 by Nurse Visit,

Seen At: Medcare Urgent Care Center Garners Ferry, 7418 Garners
Ferry Road, Columbia, SC 29209-9998; Phone: 8035096310;
Fax: 8035096307

Chief Complaint: Patient comes in today for a Drug Screen Instant (SOURCE: Patient)

History of Present Illness: **Patient Reports:**
Drug Screen Instant

Procedures: Drug Screen: Instant [Z0034] QTY (1) [Completed by: Sarah Citro]
Discharge [Z9800] QTY (1) [Completed by: Sarah Citro]

Assessment/Plan: HEALTH EXAMINATION DEFINED SUBPOP (V70.5)

Orders: Order Results - Drug Screen: Instant
Order Results - Discharge

PDF Forms: Rapid Drug Screen Results-1
\\10.240.12.53154534252247Drug Screen Results.pdf

Facility Info: Palmetto Health Baptist
TAYLOR AT MARION
COLUMBIA, SC 29220-

Attending Physician: Plaza MD, Jose Luis
Admitting Physician: Plaza MD, Jose Luis

Patient Info: MCDUFFIE, TIMOTHY
2442 WASHINGTON ST
APT. #8
COLUMBIA, SC 29204-
Pt. Age: 38 years
Date of Birth: [REDACTED]
CMRN: 000733041

MRN: B000248374; R011153278
FIN: B1426000898

ED Documentation

Burnside RN, Candace J - 09/23/2014 09:18
(As Of: 09/23/2014 9:21:22 EDT)

Allergies (Active)
NKA

Estimated Onset Date: Unspecified ; *Created By:* Mastin RN,
Douglas L; *Reaction Status:* Active ; *Category:* Drug Allergy ;
Substance: NKA ; *Type:* Allergy ; *Updated By:* Mastin RN,
Douglas L; *Source:* Patient ; *Reviewed Date:* 09/23/2014
09:20

DOCUMENT NAME:
SERVICE DATE/TIME:
RESULT STATUS:
PERFORM INFORMATION:
ELECTRONICALLY SIGNED BY:

Emergency Dept
9/23/2014 10:01 EDT
Auth (Verified)
Plaza MD, Jose Luis (9/23/2014 10:01 EDT)
Plaza MD, Jose Luis (9/24/2014 11:19 EDT)

Emergency Dept

CHIEF COMPLAINT: Left lower extremity pain.

HISTORY OF PRESENT ILLNESS: This patient is a 38-year-old black male who presents status post tripping on this past Friday, approximately 4 days ago, and catching himself on his left lower extremity but jarring his left lower back buttock area and has since started to have pain down his left lower extremity from the buttock area to the ankle. The patient reports the pain is pressure in nature with some associated numbness or tingling. It seems to be worse with movement. Nothing makes it better and reports it as severe. The patient denies any bowel or bladder incontinence, has had no associated fever or chills with it, and denies any dysuria, urgency, or frequency. He did not fall and denies any associated hip pain. The patient was seen by Occupational Health after the accident and was prescribed naproxen, but naproxen has not been helping much.

REVIEW OF SYSTEMS: Denies any sore throat, nasal drainage, and congestion. No fevers, chills, generalized weakness, cough, trouble breathing, chest pain, abdominal pain, nausea, vomiting, diarrhea, black or bloody stools, dysuria, urgency, frequency, or rash. No headache, vision, hearing, or speech problems. Review of systems as above otherwise negative.

PAST MEDICAL HISTORY: Negative.

PAST SURGICAL HISTORY: None.

ALLERGIES: No known drug allergies.

MEDICATIONS: Currently on naproxen.

Facility Info: Palmetto Health Baptist
TAYLOR AT MARION
COLUMBIA, SC 29220-

Attending Physician: Plaza MD, Jose Luis
Admitting Physician: Plaza MD, Jose Luis

Patient Info: MCDUFFIE, TIMOTHY
2442 WASHINGTON ST
APT. #B
COLUMBIA, SC 29204-
Pt. Age: 36 years
Date of Birth: [REDACTED]
CMRN: 000733041

MRN: 8000248374; R011153276

FIN: 81426600896

ED Documentation

SOCIAL HISTORY: Patient reports tobacco, EtOH use, but denies drug use.

PHYSICAL EXAMINATION: Vital signs: Temperature 98.1, pulse 63, respirations 20, blood pressure 137/95, pulse oximetry 98 percent on room air. General: This is a well-developed, well-nourished, black male in no apparent distress. HEENT: Normocephalic. Conjunctivae noninjected. TMs opaque with light reflex bilaterally. Oropharynx is moist mucous membranes, pink. No posterior pharyngeal erythema or exudate. Neck: Supple. Full range of motion. No lymphadenopathy. Heart: Regular rate and rhythm without rubs, murmurs, or gallops. Lungs: Clear to auscultation bilaterally. Abdomen: Soft, nontender, nondistended. Positive bowel sounds. No rebound or guarding. Extremities: No clubbing, cyanosis, or edema. Pulses 2 plus throughout. Skin: Pink and warm. No rashes. Neurologic: Alert and oriented x3. Cranial nerves II through XII intact. Back: Patient with some palpable reproducible tenderness at the left sciatic notch. Patient with a positive left legged straight leg raise with pain elicited at approximately 50 degrees. Negative on the right. Patient with full range of motion at the left hip, knee, and ankle. Two-plus dorsalis pedis, posterior tibial pulses. Sensation to light touch is intact, and reflexes are 2 plus at the right and left knees and symmetric.

CLINICAL IMPRESSION: Left buttock pain with acute sciatica.

DISPOSITION: The patient was discharged to home in stable condition.

PLAN: The patient had Flexeril added to his naproxen regimen and is to follow up with Occupational Health as scheduled.

D: 09/23/2014 09:51 T: 09/23/2014 10:01 TID: 420072
Job #: 82496 Doc #: 20707886
cc: Jose L. Plaza, MD

*Electronically Signed & Verified on 09/24/2014 11:19
by Plaza MD, Jose Luis*

Facility Info: Palmetto Health Baptist

TAYLOR AT MARION
COLUMBIA, SC 29220-

Attending Physician: Plaza MD, Jose Luis

Admitting Physician: Plaza MD, Jose Luis

Patient Info: MCDUFFIE, TIMOTHY

2442 WASHINGTON ST
APT. #8
COLUMBIA, SC 29204-
Pt. Age: 36 years

Date of Birth: [REDACTED]

CMRN: 000733041

MRN: B000248374; R011153278

FIN: B1426600898

Nursing Documentation

DOCUMENT NAME:

SERVICE DATE/TIME:

RESULT STATUS:

PERFORM INFORMATION:

ELECTRONICALLY SIGNED BY:

Triage PHED

9/23/2014 09:08 EDT

Modified

Smith RN, Kelli J (9/23/2014 09:08 EDT)

Burnside RN, Candace J (9/23/2014 09:18 EDT); Smith RN,

Kelli J (9/23/2014 09:17 EDT); Smith RN, Kelli J (9/23/2014

09:08 EDT)

Triage PHED Entered On: 09/23/2014 09:08

Performed On: 09/23/2014 09:08 by Smith RN, Kelli J

Chief Complaint PHED

ED Pain Screen : Yes

Latex Allergy Screen : Open

Allergies Screen : Open

Accompanied by-ED : Self

Information Obtained From : Patient

Home Meds Listed : Open

Open Past Medical History : Open

Communicable Disease Exposure : None

Abuses : Alcohol, Tobacco

Abuse Signs Yes/No : No

Risk for Harm to Self or Others : No

Immunizations : Unknown

Influenza Vaccine Status : Unknown

Pneumococcal Vaccine Status : Unknown

Last Tetanus PHA : Unknown

ED Private Physician Call? : Wants EMS to see

Primary Care Physician : none

Burnside RN, Candace J - 09/23/2014 09:18

Temperature Oral : 98.1 DegF

Peripheral Pulse Rate : 63 bpm

Resp. Rate : 20 br/min

Pulse Ox Sat : 98 %

Systolic : 137 mmHg

Diastolic : 95 mmHg

NIBP Mean Calculated : 109 mmHg

Smith RN, Kelli J - 09/23/2014 09:17

ED Mode of Arrival : Ambulatory

ED Chief Complaint : Extremity Pain

Chief Complaint : reports left leg pain after injury at work on Friday. states he tripped. was seen at MedCare

Smith RN, Kelli J - 09/23/2014 09:08

DGP GENERIC CODE

ED Tracking Group : B Tracking Group

ED Tracking Acuity : 4

Smith RN, Kelli J - 09/23/2014 09:08

ED Triage Nurse : Smith RN, Kelli J

Triage Date-Time : 09/23/2014 09:08

Facility Info: Palmetto Health Baptist
TAYLOR AT MARION
COLUMBIA, SC 29220-

Attending Physician: Plaza MD, Jose Luis
Admitting Physician: Plaza MD, Jose Luis

Patient Info: MCDUFFIE, TIMOTHY
2442 WASHINGTON ST
APT. #B
COLUMBIA, SC 29204-
Pt. Age: 36 years
Date of Birth: [REDACTED]
CMRN: 000733041

MRN: B000248374; R011153276

FIN: B1426600896

Nursing Documentation

Pregnant: N/A
Gynecological Status: N/A
Implantable Devices: None

Smith RN, Kelli J - 09/23/2014 09:08

Social History

(As Of: 09/23/2014 9:21:21 EDT)

Past Medical History

(As Of: 09/23/2014 9:21:21 EDT)

Past Medical History

None

Name of Problem: None ; Recorder: Ron E Shuford, RN;
Confirmation: Confirmed ; Cancel Reason: Error ;
Classification: Medical ; Code: 387958016 ; Contributor
System: PowerChart ; Last Updated: 11/02/2012 11:22 ; Life
Cycle Date: 11/02/2012 ; Life Cycle Status: Canceled ;
Vocabulary: SNOMED CT

Panic attack

Name of Problem: Panic attack ; Recorder: Ron E Shuford,
RN; Confirmation: Confirmed ; Cancel Reason: Error ;
Classification: Medical ; Code: 300.01 ; Contributor System:
PowerChart ; Last Updated: 11/02/2012 11:25 ; Life Cycle
Date: 11/02/2012 ; Life Cycle Status: Canceled ; Vocabulary:
ICD-9-CM

GSW (gunshot wound)

Name of Problem: GSW (gunshot wound) ; Recorder: Ron E
Shuford, RN; Confirmation: Confirmed ; Cancel Reason: Error
; Classification: Medical ; Code: 879.8 ; Contributor System:
PowerChart ; Last Updated: 06/12/2014 00:47 ; Life Cycle
Date: 11/02/2012 ; Life Cycle Status: Canceled ; Vocabulary:
ICD-9-CM

None

Name of Problem: None ; Recorder: Mastin RN, Douglas L;
Confirmation: Confirmed ; Classification: Medical ; Code:
387958016 ; Contributor System: PowerChart ; Last Updated:
11/15/2012 09:33 ; Life Cycle Date: 11/15/2012 ; Life Cycle
Status: Active ; Vocabulary: SNOMED CT

Home Medications

Home Medication Information: Home Medication Information Incomplete

Burnside RN, Candace J - 09/23/2014 09:18

Medication List

(As Of: 09/23/2014 9:21:22 EDT)

Facility Info: Palmetto Health Baptist
TAYLOR AT MARION
COLUMBIA, SC 29220-

Attending Physician: Plaza MD, Jose Luis
Admitting Physician: Plaza MD, Jose Luis

Patient Info: MCDUFFIE, TIMOTHY
2442 WASHINGTON ST
APT. #8
COLUMBIA, SC 29204-
Pt. Age: 36 years
Date of Birth: [REDACTED]
CMRN: 000733041

MRN: B000248374; R011153276

FIN: B1426600898

Nursing Documentation

Prescription/Discharge Order

naproxen

: naproxen ; Status: Prescribed ; Ordered As Mnemonic:
Anaprox-DS 550 mg oral tablet ; Simple Display Line: 550 mg,
1 tab, PO, 2xdaily, 14 tab ; Ordering Provider: Stover PA-C,
Ashley E; Catalog Code: naproxen ; Order Dt/Tm: 12/01/2012
11:22:24

naproxen

: naproxen ; Status: Prescribed ; Ordered As Mnemonic:
Anaprox-DS 550 mg oral tablet ; Simple Display Line: 550 mg,
1 tab, PO, 2xdaily, 10 tab ; Ordering Provider: Stover PA-C,
Ashley E; Catalog Code: naproxen ; Order Dt/Tm: 11/15/2012
13:26:45

acetaminophen-hydrocodone

: acetaminophen-hydrocodone ; Status: Prescribed ; Ordered
As Mnemonic: Lortab 5/500 oral tablet ; Simple Display Line:
1 tab, PO, q6hr(s), 15 tab ; Ordering Provider: Robinson MD,
John G; Catalog Code: acetaminophen-hydrocodone ; Order
Dt/Tm: 11/02/2012 11:57:56

cyclobenzaprine

: cyclobenzaprine ; Status: Prescribed ; Ordered As
Mnemonic: cyclobenzaprine 5 mg oral tablet ; Simple Display
Line: 5 mg, 1 tab, PO, 3xdaily, 30 tab ; Ordering Provider:
Robinson MD, John G; Catalog Code: cyclobenzaprine ; Order
Dt/Tm: 11/02/2012 11:57:52

Oxygen Modality-ED

Oxygen Modality: Room Air

Smith RN, Kelli J - 09/23/2014 09:17

Pain Evaluation

Primary Pain Location : Other: hip; calf on left

Quality : Pulling

Preferred Pain Tool : Numeric rating scale

Numeric Rating at Rest : 8

Numeric Rating Score at Rest : 8

Burnside RN, Candace J - 09/23/2014 09:18

Facility Info: Palmetto Health Baptist

TAYLOR AT MARION
COLUMBIA, SC 29220-

Attending Physician: Plaza MD, Jose Luis

Admitting Physician: Plaza MD, Jose Luis

Patient Info: MCDUFFIE, TIMOTHY

2442 WASHINGTON ST
APT. #B
COLUMBIA, SC 29204-
Pt. Age: 36 years

Date of Birth: [REDACTED]

CMRN: 000733041

MRN: B000248374; R011153276

FIN: B1426600896

Nursing Documentation

Image 3 - Images currently included in the form version of this document have not been included in the text rendition version of the form.

Latex Screen

Diagnosed as Latex Allergic : No

Problem-Allergic Rxn to Rubber? : No

Medical Cond. Requiring Many Surgeries : No

Allergic Rxn to any foods : None listed below

Hx of Spina Bifida : No

Rxn During Surgery or Procedure : No

Burnside RN, Candace J - 09/23/2014 09:18

Allergies

Allergy Information : Allergy Information Complete

Burnside RN, Candace J - 09/23/2014 09:18
(As Of: 09/23/2014 9:21:22 EDT)

Allergies (Active)

NKA

Estimated Onset Date: Unspecified ; Created By: Mastin RN,
Douglas L; Reaction Status: Active ; Category: Drug Allergy ;
Substance: NKA ; Type: Allergy ; Updated By: Mastin RN,
Douglas L; Source: Patient ; Reviewed Date: 09/23/2014
09:20

Nursing Direct Charting

Vital Signs

		Recorded Time	09:08 EDT
		Recorded By	Smith RN/Kelli J
		Recorded Date	9/23/2014
Procedure	Units	Reference Range	
Temperature Oral	DegF	[98-102]	98.1
Peripheral Pulse Rate	bpm	[60-100]	63
Respiratory Rate	br/min	[12-20]	20
Pulse Ox Sat	%		98
NIBP Systolic	mmHg		137
NIBP Diastolic	mmHg		85
NIBP Mean Calculated	mmHg		109

Neuro

		Recorded Time	09:21 EDT
		Recorded By	Burnside RN/Candace J
		Recorded Date	9/23/2014
Procedure	Units	Reference Range	
All Extremities Strength			Normal
All Extremities Tone			Normal
Left Upper Extremity Sensation			Present
Range of Motion Left Upper Extremity			Full motion
Right Upper Extremity Sensation			Present
Range of Motion Right Upper Extremity			Full motion
Left Lower Extremity Sensation			Pain

Facility Info: Palmetto Health Baptist

TAYLOR AT MARION
COLUMBIA, SC 29220-

Attending Physician: Plaza MD, Jose Luis

Admitting Physician: Plaza MD, Jose Luis

Patient Info: MCDUFFIE, TIMOTHY

2442 WASHINGTON ST
APT. #B
COLUMBIA, SC 29204-
Pt. Age: 36 years

Date of Birth: [REDACTED]

CMRN: 000733041

MRN: B000248374; R011153276

FIN: B1426600898

Nursing Direct Charting

Neuro

Recorded Time: 09:21 EDT
Recorded By: Burnside RN, Candace J.
Recorded Date: 9/23/2014

Procedure	Units	Reference Range
Range of Motion Left Lower Extremity		Pain with movement
Right Lower Extremity Sensation		Present
Range of Motion Right Lower Extremity		Full motion
Neurological Documentation		Neuro System WNL

Behavioral

Recorded Time: 09:21 EDT
Recorded By: Burnside RN, Candace J.
Recorded Date: 9/23/2014

Procedure	Units	Reference Range
Behavior Documentation		Behavior WNL

EENT View

Recorded Time: 09:21 EDT
Recorded By: Burnside RN, Candace J.
Recorded Date: 9/23/2014

Procedure	Units	Reference Range
EENT Documentation		EENT System WNL

Respiratory

Recorded Time: 09:21 EDT 09:08 EDT
Recorded By: Burnside RN, Candace J. Smith RN, Kelli J.
Recorded Date: 9/23/2014 9/23/2014

Procedure	Units	Reference Range
Oxygen Modality		-
Respiratory Documentation		Room Air Respiratory System WNL

Cardiovascular

Recorded Time: 09:21 EDT
Recorded By: Burnside RN, Candace J.
Recorded Date: 9/23/2014

Procedure	Units	Reference Range
Cardiovascular Documentation		Cardiovascular System WNL

Gastrointestinal

Recorded Time: 09:21 EDT
Recorded By: Burnside RN, Candace J.
Recorded Date: 9/23/2014

Procedure	Units	Reference Range
Gastrointestinal Documentation		Gastrointestinal Syst WNL

Facility Info: Palmetto Health Baptist

TAYLOR AT MARION
COLUMBIA, SC 29220-

Attending Physician: Plaza MD, Jose Luis

Admitting Physician: Plaza MD, Jose Luis

Patient Info: MCDUFFIE, TIMOTHY

2442 WASHINGTON ST
APT. #B
COLUMBIA, SC 29204-
Pt. Ago: 36 years

Date of Birth: [REDACTED]

CMRN: 000733041

MRN: B000246374; R011153276

FIN: B1426600896

Nursing Direct Charting

Renal-Urinary

Recorded Time: 09:21 EDT
Recorded By: Burnside RN, Candace J
Recorded Date: 9/23/2014

Procedure	Units	Reference Range
Renal-Urinary Documentation		Renal/Urinary System WNL

Reproductive

Recorded Time: 09:21 EDT
Recorded By: Burnside RN, Candace J
Recorded Date: 9/23/2014

Procedure	Units	Reference Range
Reproductive Documentation		Reproductive System WNL

Integumentary

Recorded Time: 08:21 EDT
Recorded By: Burnside RN, Candace J
Recorded Date: 9/23/2014

Procedure	Units	Reference Range
Integumentary Documentation		Integumentary System WNL

Musculoskeletal System

Recorded Time: 09:21 EDT
Recorded By: Burnside RN, Candace J
Recorded Date: 9/23/2014

Procedure	Units	Reference Range
Musculoskeletal Comment		See Below ¹
Musculoskeletal Documentation		Musculoskeletal Documentation
Musculoskeletal Condition:		Painful
Musculoskeletal Site:		Left, Hip, Leg

Textual Results

T1: 9/23/2014 09:21 EDT (Musculoskeletal Comment)

pt c/o left hip and leg pain after tripping over pipe at work on Friday; seen at MedCARE and pt states that "they didn't give me no pain medicine"; pt in NAD

Risk Precautions

Recorded Time: 09:21 EDT
Recorded By: Burnside RN, Candace J
Recorded Date: 9/23/2014

Procedure	Units	Reference Range	09:08 EDT Burnside RN, Candace J 9/23/2014
Safety		See Below ¹	
Risk for Harm to Self or Others		-	No
Suicide Risk		No	-
History of Fall in Last 3 Months Morse		No	-
Presence of Secondary Diagnosis Morse		No	-
Use of Ambulatory Aid Morse		None, bedrest, wheelchair, nurse	-
IV/INT Fall Risk Morse		No	-
Gait Weak or Impaired Fall Risk Morse		Normal, bedrest, immobile	-
Mental Status Fall Risk Morse		Oriented to own ability	-

Facility Info: Palmetto Health Baptist
TAYLOR AT MARION
COLUMBIA, SC 29220-

Attending Physician: Plaza MD, Jose Luis
Admitting Physician: Plaza MD, Jose Luis

Patient Info: MCDUFFIE, TIMOTHY
2442 WASHINGTON ST
APT. #B
COLUMBIA, SC 29204-
Pt. Age: 36 years
Date of Birth: [REDACTED]
CMRN: 000733041

MRN: B000248374; R011153276
FIN: B1426800886

Nursing Direct Charting

Risk Precautions

Procedure	Units	Reference Range	Recorded Time	Recorded By	Recorded Date
			09:21 EDT	Burnside RN, Candace J	9/23/2014
Morae Fall Risk Score			0		
Participative in Fall Prevention			Yes		

Textual Results

T2: 9/23/2014 09:21 EDT (Safety)

Adequate day/night lighting, Bed Low/Brakes Locked, Call device within reach, Fall Prevention Education, ID Band Checked, ID Band on, Instruct to Call, Non-skid socks/shoes with non-skid soles, Pt/Family Able to Use

Direct Charting View

General Information

Recorded Date	Recorded By	Procedure	Mode of Arrival	Chief Complaint	ED Chief Complaint	Accompanied by-ED
		Units	Reference Range			
9/23/2014	Smith RN, Kelli J			Ambulatory	See Below	Extremity Pain
9/23/2014	Burnside RN, Candace J			-	-	Self
9/23/2014	Skorupski, Mary C			Ambulatory	-	Extremity Pain

Textual Results

T3: 9/23/2014 09:08 EDT (Chief Complaint)

reports left leg pain after injury at work on Friday, states he tripped, was seen at MedCare

Recorded Date	Recorded By	Procedure	Private Physician Called in	Acuity	Information Obtained
		Units	ED?		from
9/23/2014	Smith RN, Kelli J			4	Patient

ED Documentation

DOCUMENT NAME: Triage PHED
SERVICE DATE/TIME: 9/23/2014 09:08 EDT
RESULT STATUS: Modified
PERFORM INFORMATION: Smith RN, Kelli J (9/23/2014 09:08 EDT)
ELECTRONICALLY SIGNED BY: Burnside RN, Candace J (9/23/2014 09:18 EDT); Smith RN, Kelli J (9/23/2014 09:17 EDT); Smith RN, Kelli J (9/23/2014 09:08 EDT)

Triage PHED Entered On: 09/23/2014 09:08
Performed On: 09/23/2014 09:08 by Smith RN, Kelli J

Chief Complaint PHED
ED Pain Screen : Yes

Facility Info: Palmetto Health Baptist

TAYLOR AT MARION
COLUMBIA, SC 29220-

Attending Physician: Plaza MD, Jose Luis

Admitting Physician: Plaza MD, Jose Luis

Patient Info: MCDUFFIE, TIMOTHY

2442 WASHINGTON ST
APT. #B
COLUMBIA, SC 29204-
Pt. Age: 36 years

Date of Birth: [REDACTED]

CMRN: 000733041

MRN: B000248374; R011163276

FIN: B1426600896

ED Documentation

Latex Allergy Screen : Open
Allergies Screen : Open
Accompanied by-ED : Self
Information Obtained From : Patient
Home Meds Listed : Open
Open Past Medical History : Open
Communicable Disease Exposure : None
Abuses : Alcohol, Tobacco
Abuse Signs Yes/No : No
Risk for Harm to Self or Others : No
Immunizations : Unknown
Influenza Vaccine Status : Unknown
Pneumococcal Vaccine Status : Unknown
Last Tetanus PHA : Unknown
ED Private Physician Call? : Wants EMS to see.
Primary Care Physician : none

Burnside RN, Candace J - 09/23/2014 09:18

Temperature Oral : 98.1 DegF
Peripheral Pulse Rate : 63 bpm
Resp. Rate : 20 br/min
Pulse Ox Sat : 98 %
Systolic : 137 mmHg
Diastolic : 95 mmHg
NIBP Mean Calculated : 109 mmHg

Smith RN, Kelli J - 09/23/2014 09:17

ED Mode of Arrival : Ambulatory
ED Chief Complaint : Extremity Pain
Chief Complaint : reports left leg pain after injury at work on Friday. states he tripped. was seen at MedCare

Smith RN, Kelli J - 09/23/2014 09:08

DCP GENERIC CODE

ED Tracking Group : B Tracking Group
ED Tracking Acuity : 4

Smith RN, Kelli J - 09/23/2014 09:08

ED Triage Nurse : Smith RN, Kelli J
Triage Date-Time : 09/23/2014 09:08
Pregnant : N/A
Gynecological Status : N/A
Implantable Devices : None

Smith RN, Kelli J - 09/23/2014 09:08

Social History

(As Of: 09/23/2014 9:21:21 EDT)

Past Medical History

(As Of: 09/23/2014 9:21:21 EDT)

Past Medical History

Facility Info: Palmetto Health Baptist
TAYLOR AT MARION
COLUMBIA, SC 29220-

Attending Physician: Plaza MD, Jose Luis
Admitting Physician: Plaza MD, Jose Luis

Patient Info: MCDUFFIE, TIMOTHY
2442 WASHINGTON ST
APT. #B
COLUMBIA, SC 29204-
Pt. Age: 36 years
Date of Birth: [REDACTED]
CMRN: 000733041

MRN: B000248374; R011163276
FIN: B1426600896

ED Documentation

None

Name of Problem: None ; Recorder: Ron E Shuford, RN;
Confirmation: Confirmed ; Cancel Reason: Error ;
Classification: Medical ; Code: 387958016 ; Contributor
System: PowerChart ; Last Updated: 11/02/2012 11:22 ; Life
Cycle Date: 11/02/2012 ; Life Cycle Status: Canceled ;
Vocabulary: SNOMED CT

Panic attack

Name of Problem: Panic attack ; Recorder: Ron E Shuford,
RN; Confirmation: Confirmed ; Cancel Reason: Error ;
Classification: Medical ; Code: 300.01 ; Contributor System:
PowerChart ; Last Updated: 11/02/2012 11:25 ; Life Cycle
Date: 11/02/2012 ; Life Cycle Status: Canceled ; Vocabulary:
ICD-9-CM

GSW (gunshot wound)

Name of Problem: GSW (gunshot wound) ; Recorder: Ron E
Shuford, RN; Confirmation: Confirmed ; Cancel Reason: Error
; Classification: Medical ; Code: 879.8 ; Contributor System:
PowerChart ; Last Updated: 06/12/2014 00:47 ; Life Cycle
Date: 11/02/2012 ; Life Cycle Status: Canceled ; Vocabulary:
ICD-9-CM

None

Name of Problem: None ; Recorder: Mastin RN, Douglas L;
Confirmation: Confirmed ; Classification: Medical ; Code:
387958016 ; Contributor System: PowerChart ; Last Updated:
11/15/2012 09:33 ; Life Cycle Date: 11/15/2012 ; Life Cycle
Status: Active ; Vocabulary: SNOMED CT

Home Medications

Home Medication Information : Home Medication Information Incomplete

Burnside RN, Candace J - 09/23/2014 09:18

Medication List

(As Of: 09/23/2014 9:21:22 EDT)

Prescription/Discharge Order

naproxen

: naproxen ; Status: Prescribed ; Ordered As Mnemonic:
Anaprox-DS 550 mg oral tablet ; Simple Display Line: 550 mg,
1 tab, PO, 2xdaily, 14 tab ; Ordering Provider: Stover PA-C,
Ashley E; Catalog Code: naproxen ; Order Dt/Tm: 12/01/2012
11:22:24

naproxen

: naproxen ; Status: Prescribed ; Ordered As Mnemonic:
Anaprox-DS 550 mg oral tablet ; Simple Display Line: 550 mg,
1 tab, PO, 2xdaily, 10 tab ; Ordering Provider: Stover PA-C,

Facility Info: Palmetto Health Baptist

TAYLOR AT MARION
COLUMBIA, SC 29220-

Attending Physician: Plaza MD, Jose Luis

Admitting Physician: Plaza MD, Jose Luis

Patient Info: MCDUFFIE, TIMOTHY

2442 WASHINGTON ST
APT. #B
COLUMBIA, SC 29204-
Pt. Age: 38 years

Date of Birth: [REDACTED]

CMRN: 000733041

MRN: B000248374; R011153276

FIN: B1428600886

ED Documentation

Ashley E; Catalog Code: naproxen ; Order Dt/Tm: 11/15/2012
13:26:45

acetaminophen-hydrocodone : acetaminophen-hydrocodone ; Status: Prescribed ; Ordered
As Mnemonic: Lortab 5/500 oral tablet ; Simple Display Line:
1 tab, PO, q6hr(s), 15 tab ; Ordering Provider: Robinson MD,
John G; Catalog Code: acetaminophen-hydrocodone ; Order
Dt/Tm: 11/02/2012 11:57:56

cyclobenzaprine : cyclobenzaprine ; Status: Prescribed ; Ordered As
Mnemonic: cyclobenzaprine 5 mg oral tablet ; Simple Display
Line: 5 mg, 1 tab, PO, 3xdaily, 30 tab ; Ordering Provider:
Robinson MD, John G; Catalog Code: cyclobenzaprine ; Order
Dt/Tm: 11/02/2012 11:57:52

Oxygen Modality-ED

Oxygen Modality: Room Air

Smith RN, Kelli J - 09/23/2014 09:17

Pain Evaluation

Primary Pain Location : Other: hip; calf on left

Quality : Pulling

Preferred Pain Tool : Numeric rating scale

Numeric Rating at Rest : 8

Numeric Rating Score at Rest : 8

Burnside RN, Candace J - 09/23/2014 09:18

Image 3 - Images currently included in the form version of this document have not been included in the text rendition
version of the form.

Latex Screen

Diagnosed as Latex Allergic : No

Problem-Allergic Rxn to Rubber? : No

Medical Cond. Requiring Many Surgeries : No

Allergic Rxn to any foods : None listed below

Hx of Spina Bifida : No

Rxn During Surgery or Procedure : No

Burnside RN, Candace J - 09/23/2014 09:18

Allergies

Allergy Information : Allergy Information Complete

Facility Info: Palmetto Health Baptist
TAYLOR AT MARION
COLUMBIA, SC 29220-

Attending Physician: Plaza MD, Jose Luis
Admitting Physician: Plaza MD, Jose Luis

Patient Info: MCDUFFIE, TIMOTHY
2442 WASHINGTON ST
APT. #B
COLUMBIA, SC 29204-
Pt. Age: 36 years
Date of Birth: [REDACTED]
CMRN: 000733041

MRN: B000248374; R011163276
FIN: B1426600896

ED Discharge Summary

DOCUMENT NAME: Discharge Summary PHED
SERVICE DATE/TIME: 9/23/2014 09:59 EDT
RESULT STATUS: Auth (Verified)
PERFORM INFORMATION: Burnside RN, Candace J (9/23/2014 09:59 EDT)
ELECTRONICALLY SIGNED BY:

Discharge Summary PHED
09/23/14 09:59 am Performed by Burnside RN, Candace J
Entered on 09/23/14 10:01 am

Discharge Summary PHED

Patient Disposition Home or Self Care
Mode of Discharge Ambulatory
Accompanied by-ED Self
Reassessment of Chief Complaint-ED Improved
Current Pain-Yes-No No
IV/INT Discontinued NA
Valuable-Belonging Return-ED None taken
Discharge Instructions ED Instructions Given, Patient
Verbalizes Understanding
Comments-ED Discharge pt alert, oriented and in NAD at time
of d/c. Pt verbalized understanding
of d/c instructions, medications and
to f/u with Free Clinic in 2-4 days.

Patient & Family Education

Charting Department ED
Person Educated Patient
Able to Read Yes
Patient Learning Preferences Verbal, Written
Patient Willingness To Learn Consents to Education
Patient Readiness to Learn No Barriers
Patient Outcomes-Participation Verbalized Understanding
Education Method Verbal, Written, Teach-back
Patient Follow Up Needed After Discharge, As Ordered

Nursing-Nutrition-Surginet-L&D Pt-Fam Ed

Information Provided Disease/Diagnosis, Discharge
Instructions, Medication Teaching
Medication Teaching Discharge
Name of Medication flexeril

Facility Info: Palmetto Health Baptist
TAYLOR AT MARION
COLUMBIA, SC 29220-

Attending Physician: Plaza MD, Jose Luis
Admitting Physician: Plaza MD, Jose Luis

Patient Info: MCDUFFIE, TIMOTHY
2442 WASHINGTON ST.
APT. #B
COLUMBIA, SC 29204-
Pt. Age: 36 years
Date of Birth: [REDACTED]
CMRN: 000733041

MRN: B000248374; R011153276

FIN: B1426600896

ED Discharge Summary

DOCUMENT NAME: Depart Summary
SERVICE DATE/TIME: 9/23/2014 10:01 EDT
RESULT STATUS: Auth (Verified)
PERFORM INFORMATION: Burnside RN, Candace J (9/23/2014 10:01 EDT)
ELECTRONICALLY SIGNED BY: Burnside RN, Candace J (9/23/2014 10:01 EDT)

Depart Summary

Palmetto Health Emergency Department Depart Summary

PERSON INFORMATION

Name MCDUFFIE, TIMOTHY a	Age 36 Years	DOB [REDACTED] 12:00 AM
Sex Male	Language English	PCP
Marital Status Single	Phone (803)476-5702	
MRN R011153276	Visit Id	Acct# B1426600896
Visit Reason LT LEG PAIN	Specialty	Referred by
Enc Type ERB-Emergency Room	Med Service Emergency Services	
Track Group B Tracking Group	Discharge	
Tracking Id 985018270	Checkout 9/23/2014 10:01 AM	
Checkin 9/23/2014 9:07 AM	Acuity 4	Dispo Type
Arrival 9/23/2014 9:07 AM	Reg Status	LOS 000 00:54
Address: 2442 WASHINGTON ST COLUMBIA SC 29204		

POWERFORMS

Discharge Summary PHED

09/23/14 09:59 am Performed by Burnside RN, Candace J

Entered on 09/23/14 10:01 am

Discharge Summary PHED

Patient Disposition: Home or Self Care

Mode of Discharge: Ambulatory

Accompanied by-ED: Self

Reassessment of Chief Complaint-ED: Improved

Current Pain-Yes-No: No

IV/INT Discontinued: NA

Valuable-Belonging Return-ED: None taken

Discharge Instructions ED: Instructions Given, Patient Verbalizes Understanding

Comments-ED Discharge: pt alert, oriented and in NAD at time of d/c. Pt verbalized understanding of d/c instructions, medications and to f/u with Free Clinic in 2-4 days.

Patient & Family Education

Charting Department: ED

Person Educated: Patient

Able to Read: Yes

Patient Learning Preferences: Verbal, Written

Patient Willingness To Learn: Consents to Education

Patient Readiness to Learn: No Barriers

Facility Info: Palmetto Health Baptist

TAYLOR AT MARION
COLUMBIA, SC 29220-

Attending Physician: Plaza MD, Jose Luis

Admitting Physician: Plaza MD, Jose Luis

Patient Info: MCDUFFIE, TIMOTHY

2442 WASHINGTON ST

APT. #B

COLUMBIA, SC 29204-

Pt. Age: 36 years

Date of Birth: [REDACTED]

CMRN: 000733041

MRN: 8000248374; R011153276

FIN: B1426600806

ED Discharge Summary

Patient Outcomes-Participation: Verbalized Understanding

Education Method: Verbal, Written, Teach-back

Patient Follow Up Needed: After Discharge, As Ordered

Nursing-Nutrition-Surginet-L&D Pt-Fam Ed

Information Provided: Disease/Diagnosis, Discharge Instructions, Medication Teaching

Medication Teaching: Discharge

Name of Medication: flexeril

SCHEDULING

PHYS DOC NOTES

DEPART REASON INCOMPLETE INFORMATION

PROVIDER INFORMATION

Provider	Role	Assigned	Unassigned
Plaza MD, Jose Luis	ED Physician	9/23/2014 9:35 AM	

VITALS INFORMATION

Vital Sign	Triage	Latest
Job		
Involve Family		
Contact		
Pain Onset		
Temp Intravascular		
Pulse Rate		
Respiratory Rate		
Blood Pressure	137 mmHg / 95 mmHg	137 mmHg / 95 mmHg

EVENTS INFORMATION

Event Name	Event Status	Request Date/Time	Start Date/Time	Complete Date/Time
Arrival	Complete	9/23/2014 9:07 AM	9/23/2014 9:07 AM	9/23/2014 9:07 AM
MDXam	Complete	9/23/2014 9:07 AM	9/23/2014 9:46 AM	9/23/2014 9:46 AM
Med Hx	Request	9/23/2014 9:07 AM		

Facility Info: Palmetto Health Baptist
TAYLOR AT MARION
COLUMBIA, SC 29220-

Attending Physician: Plaza MD, Jose Luis
Admitting Physician: Plaza MD, Jose Luis

Patient Info: MCDUFFIE, TIMOTHY
2442 WASHINGTON ST
APT. #B
COLUMBIA, SC 29204-
Pt. Age: 36 years
Date of Birth: XXXXXXXXXX
CMRN: 000733041

MRN: B000248374; R011163276

FIN: B1426600896

ED Discharge Summary

Nurse Exam	Complete	9/23/2014 9:07 AM	9/23/2014 9:23 AM	9/23/2014 9:23 AM
Triage	Complete	9/23/2014 9:07 AM	9/23/2014 9:08 AM	9/23/2014 9:08 AM
ED Bed Assign	Complete	9/23/2014 9:14 AM	9/23/2014 9:14 AM	9/23/2014 9:14 AM
Discharge	Request	9/23/2014 9:46 AM		
Registration	Complete	9/23/2014 9:46 AM	9/23/2014 10:00 AM	9/23/2014 10:00 AM

LOCATION INFORMATION

Arrival	Nurse Unit	Room	Bed
9/23/2014 9:07 AM	B Silver Zone	Slv WR	
9/23/2014 9:14 AM	B Silver Zone	Slv	16
9/23/2014 10:01 AM	B Silver Zone	CC Ck-Out	

ORDERS INFORMATION

Start Time	Order	Type	Status	Stop Time	Provider
9/23/2014 9:46 AM	Discharge	Patient Care	Ordered	9/23/2014 9:46 AM	SYSTEM, SYSTEM
	Complete				
9/23/2014 9:21 AM	Home Medication Information	Patient Care	Ordered	9/23/2014 9:21 AM	SYSTEM, SYSTEM
9/23/2014 9:21 AM	Influenza Evaluation	Patient Care	Ordered	9/23/2014 9:21 AM	SYSTEM, SYSTEM
9/23/2014 9:21 AM	Pneumovax Evaluation	Patient Care	Ordered	9/23/2014 9:21 AM	SYSTEM, SYSTEM
9/23/2014 9:07 AM	Facility Charge Ticket	Health Information Management	Ordered	9/23/2014 9:07 AM	SYSTEM, SYSTEM

MEDICAL INFORMATION

Allergy Info:
NKA

Facility Info: Palmetto Health Baptist

TAYLOR AT MARION
COLUMBIA, SC 29220-

Attending Physician: Plaza MD, Jose Luis

Admitting Physician: Plaza MD, Jose Luis

Patient Info: MCDUFFIE, TIMOTHY

2442 WASHINGTON ST
APT. #B
COLUMBIA, SC 29204-
Pt. Age: 36 years

Date of Birth: [REDACTED]

CMRN: 000733041

MRN: B000246374; R011153276

FIN: B1426600896

ED Discharge Summary

Prescriptions Given

Prescription	Display
cyclobenzaprine (Flexeril 10 mg oral tablet)	10 mg = 1 tab, PO, 3xdaily, # 15 tab, 0 Refill(s)

DISCHARGE INFORMATION

Discharge Disposition:

Discharge Location:

PATIENT EDUCATION INFORMATION

Instructions:

BACK PAIN w/ SCIATICA

Follow up:

With:

1801 Medicine Clinic

Address:

1801 Sunset Drive Columbia, SC 29203
(803) 434-4100 Business (1)

When:

Within 2 to 4 days

Comments:

With:

Follow Up with primary care provider

Comments:

Address:

When:

Within 2 to 4 days

DIAGNOSIS

Facility Info: Palmetto Health Baptist

TAYLOR AT MARION
COLUMBIA, SC 29220-

Attending Physician: Plaza MD, Jose Luis

Admitting Physician: Plaza MD, Jose Luis

Patient Info: MCDUFFIE, TIMOTHY

2442 WASHINGTON ST
APT. #B
COLUMBIA, SC 29204-
Pl. Age: 36 years

Date of Birth: [REDACTED]

CMRN: 000733041

MRN: B000248374; R011163276

FIN: B1426600896

Allergies

Substance	Updated Date/Time	Updated By	Allergy Type	Allergy Category	Severity	Recorded On Behalf Of	Reaction Status	Reaction Symptom	Information Source	Estimated Onset	Reviewed Date/Time	Reviewed By	Data Source
NKA	9/1/2011 15:40 EDT	Mastin RN, Douglas L	Allergy	Drug Allergy		Mastin RN, Douglas L	Active		Patient		9/23/2014 09:20 EDT	Burnside RN, Candaca J	

Allergy History

Substance: NKA	Recorded Date/Time: 9/1/2011 15:40 EDT	Recorded By: Mastin RN, Douglas L	Allergy Type: Allergy; Recorded On Behalf Of: Mastin RN, Douglas L; Reaction Status: Active; Information Source: Patient; Reviewed Date/Time: 9/23/2014 09:20 EDT; Reviewed By: Burnside RN, Candaca J; Category Drug Allergy;
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Non Medication Orders

Order: Complete Home Medication Information			
Order Start Date/Time: 9/23/2014 09:21 EDT			
Order Date/Time: 9/23/2014 09:21 EDT			
Order Status: Discontinued	Department Status: Discontinued	Catalog Type: Patient Care	Activity Type: Communication Orders
End-state Date/Time: 9/24/2014 01:34 EDT		End-state Reason:	
Ordered and Electronically Signed By: SYSTEM,SYSTEM		Consulting Physician:	
Entered By: SYSTEM,SYSTEM on 9/24/2014 01:34 EDT			
Order Details: 09/23/14 9:21:22			
Order Comment: From Allergies - Home Medications Form			
Action Type: Order	Action Date/Time: 9/23/2014 09:21 EDT	Action Personnel: SYSTEM,SYSTEM	
Responsible Provider: SYSTEM,SYSTEM	Supervising Provider:	Communication Type: Discern Expert	
Order Details: 09/23/14 9:21:22			
Review Information:			
Doctor Cosign: Not Required			
Order Comment: From Allergies - Home Medications Form			
Action Type: Discontinue	Action Date/Time: 9/24/2014 01:34 EDT	Action Personnel: SYSTEM,SYSTEM	
Responsible Provider: SYSTEM,SYSTEM	Supervising Provider:	Communication Type:	
Order Details: 09/23/14 9:21:22			
Review Information:			
Doctor Cosign: Not Required			
Order Comment:			

Facility Info: Palmetto Health Baptist
TAYLOR AT MARION
COLUMBIA, SC 29220-

Attending Physician: Plaza MD, Jose Luis
Admitting Physician: Plaza MD, Jose Luis

Patient Info: MCDUFFIE, TIMOTHY
2442 WASHINGTON ST
APT. #B
COLUMBIA, SC 29204-
Pt. Age: 36 years
Date of Birth: [REDACTED]
CMRN: 000733041

MRN: B000248374; R011153276
FIN: B1426600896

Non Medication Orders

Order: Discharge

Order Start Date/Time: 9/23/2014 09:46 EDT

Order Date/Time: 9/23/2014 09:46 EDT

Order Status: Discontinued

Department Status: Discontinued

Catalog Type: Patient Care

Activity Type: Communication Orders

End-state Date/Time: 9/24/2014 01:34 EDT

End-state Reason:

Ordered and Electronically Signed By: SYSTEM,SYSTEM

Consulting Physician:

Entered By: SYSTEM,SYSTEM on 9/24/2014 01:34 EDT

Order Details: 09/23/14 9:46:45, 09/23/14 9:46:45

Order Comment:

Action Type: Order

Action Date/Time: 9/23/2014 09:46 EDT

Action Personnel: SYSTEM,SYSTEM

Responsible Provider: SYSTEM,SYSTEM

Supervising Provider:

Communication Type: Discern Expert

Order Details: 09/23/14 9:46:45, 09/23/14 9:46:45

Review Information:

Doctor Cosign: Not Required

Order Comment:

Action Type: Discontinue

Action Date/Time: 9/24/2014 01:34 EDT

Action Personnel: SYSTEM,SYSTEM

Responsible Provider: SYSTEM,SYSTEM

Supervising Provider:

Communication Type:

Order Details: 09/23/14 9:46:45, 09/23/14 9:46:45

Review Information:

Doctor Cosign: Not Required

Order Comment:

Order: Facility Charge Ticket

Order Start Date/Time: 9/23/2014 09:07 EDT

Order Date/Time: 9/23/2014 09:07 EDT

Order Status: Completed

Department Status: Completed

Catalog Type: Health Information
Management

Activity Type: Health Information
Management

End-state Date/Time: 9/25/2014 09:44 EDT

End-state Reason:

Ordered and Electronically Signed By: SYSTEM,SYSTEM

Consulting Physician:

Entered By: Skorupski, Mary C on 9/25/2014 09:44 EDT

Order Details: 09/23/14 9:07:50, Stop 09/23/14 9:07:50

Order Comment:

Action Type: Order

Action Date/Time: 9/23/2014 09:07 EDT

Action Personnel: SYSTEM,SYSTEM

Responsible Provider: SYSTEM,SYSTEM

Supervising Provider:

Communication Type: Discern Expert

Order Details: 09/23/14 9:07:50, Stop 09/23/14 9:07:50

Review Information:

Doctor Cosign: Not Required

Order Comment:

Action Type: Complete

Action Date/Time: 9/25/2014 09:44 EDT

Action Personnel: Skorupski, Mary C

Responsible Provider: SYSTEM,SYSTEM

Supervising Provider:

Communication Type:

Order Details: 09/23/14 9:07:50, Stop 09/23/14 9:07:50

Review Information:

Doctor Cosign: Not Required

Order Comment:

Facility Info: Palmetto Health Baptist

TAYLOR AT MARION
COLUMBIA, SC 29220-

Attending Physician: Plaza MD,Jose Luis

Admitting Physician: Plaza MD,Jose Luis

Patient Info: MCDUFFIE, TIMOTHY

2442 WASHINGTON ST
APT. #B
COLUMBIA, SC 29204-
Pt. Age: 36 years

Date of Birth: [REDACTED]

CMRN: 000733041

MRN: B000248374; R011153276

FIN: B1426600886

Non Medication Orders

Order: Influenza Evaluation

Order Start Date/Time: 9/23/2014 09:21 EDT

Order Date/Time: 9/23/2014 09:21 EDT

Order Status: Discontinued Department Status: Discontinued Catalog Type: Patient Care Activity Type: Communication Orders

End-state Date/Time: 9/24/2014 01:34 EDT End-state Reason:

Ordered and Electronically Signed By: SYSTEM,SYSTEM Consulting Physician:

Entered By: SYSTEM,SYSTEM on 9/24/2014 01:34 EDT

Order Details: 09/23/14 9:21:22

Order Comment: Order created by result of Influenza Vaccine not received or unknown.

Action Type: Order Action Date/Time: 9/23/2014 09:21 EDT Action Personnel: SYSTEM,SYSTEM

Responsible Provider: SYSTEM,SYSTEM Supervising Provider: Communication Type: Discern Expert

Order Details: 09/23/14 9:21:22

Review Information:

Doctor Cosign: Not Required

Order Comment: Order created by result of Influenza Vaccine not received or unknown.

Action Type: Discontinue Action Date/Time: 9/24/2014 01:34 EDT Action Personnel: SYSTEM,SYSTEM

Responsible Provider: SYSTEM,SYSTEM Supervising Provider: Communication Type:

Order Details: 09/23/14 9:21:22

Review Information:

Doctor Cosign: Not Required

Order Comment:

Order: Pneumovax Evaluation

Order Start Date/Time: 9/23/2014 09:21 EDT

Order Date/Time: 9/23/2014 09:21 EDT

Order Status: Discontinued Department Status: Discontinued Catalog Type: Patient Care Activity Type: Communication Orders

End-state Date/Time: 9/24/2014 01:34 EDT End-state Reason:

Ordered and Electronically Signed By: SYSTEM,SYSTEM Consulting Physician:

Entered By: SYSTEM,SYSTEM on 9/24/2014 01:34 EDT

Order Details: 09/23/14 9:21:22

Order Comment: Order created by Pneumococcal Vaccine status: Received prior to admission, greater than 5 years, Not received, or Unknown

Action Type: Order Action Date/Time: 9/23/2014 09:21 EDT Action Personnel: SYSTEM,SYSTEM

Responsible Provider: SYSTEM,SYSTEM Supervising Provider: Communication Type: Discern Expert

Order Details: 09/23/14 9:21:22

Review Information:

Doctor Cosign: Not Required

Order Comment: Order created by Pneumococcal Vaccine status: Received prior to admission, greater than 5 years, Not received, or Unknown

Action Type: Discontinue Action Date/Time: 9/24/2014 01:34 EDT Action Personnel: SYSTEM,SYSTEM

Responsible Provider: SYSTEM,SYSTEM Supervising Provider: Communication Type:

Order Details: 09/23/14 9:21:22

Review Information:

Doctor Cosign: Not Required

Order Comment:

Facility Info: Palmetto Health Baptist
TAYLOR AT MARION
COLUMBIA, SC 29220-

Attending Physician: Plaza MD, Jose Luis
Admitting Physician: Plaza MD, Jose Luis

Patient Info: MCDUFFIE, TIMOTHY
2442 WASHINGTON ST
APT. #8
COLUMBIA, SC 29204-
Pt. Age: 38 years
Date of Birth: XXXXXXXXXX
CMRN: 000733041

MRN: B000248374; R011153278
FIN: B1426800898

Medication Orders

Order: cyclobenzaprine (Flexeril 10 mg oral tablet)

Order Start Date/Time: 9/23/2014 09:46 EDT

Order Date/Time: 9/23/2014 09:46 EDT

Order Status: Completed

Clinical Category: Medications

Medication Type: Prescription

End-date Date/Time: 10/23/2014 09:46 EDT

End-date Reason:

Ordered and Electronically Signed By: Plaza MD, Jose Luis

Consulting Physician:

Entered By: SYSTEM, SYSTEM on 10/23/2014 09:50 EDT

Order Details: 10 mg = 1 tab, PO, 3x daily, # 15 tab, 0 Refill(s)

Order Comment:

Immunizations

Vaccine:

Date Given:

Age:

diphtheria/pertussis, acel/tetanus adult ⁰¹

9/1/2011 17:48 EDT

33 years

Admin Person:

Data Source:

Youman LPN, Rumika L

PowerChart

Site:

Route:

Amount:

Manufacturer:

Right Arm

IM

0.5ml

PHR Pharmacy

Expiration Date:

Lot Number:

12/20/2013

C3927BA

Order Comments

O1: diphtheria/pertussis, acel/tetanus adult (Tdap)

Nursing Comment: document manufacturer, lot number, and exp date on Immunization Tab after administration

Education

General Progress Note (Physician)

MCDUFFIE, TIMOTHY - 654185

Back/Leg Injury

Patient: MCDUFFIE, TIMOTHY MRN: 664185 FIN: B2014092402387
Age: 36 years Sex: Male DOB: [REDACTED]
Associated Diagnoses: Lower back injury; Left knee sprain; Left leg injury
Author: Young MD, Stewart

Chief Complaint

9/24/2014 1:39 PM EDT Workers Comp Visit, DOI 9/19/14, JFS. Pt was working in the kitchen when he tripped over a pipe in the floor. C/O left leg pain and low back pain. Seen@ MedCare on 9/20. Had an Xray of the back and was diagnosed with Back Sprain. Seen@ Baptist ER on 9/23

History of Present Illness

Chief complaint confirmed. The patient has some mild medial left knee pain, some left thigh muscular pain, and some low back pain. I reviewed the ER records, or he was seen subsequent to his MedCare visit (the x-ray report from which is still pending). He has got good relief from Naprosyn and Flexeril and has sufficient quantity for several days. He is however unable to stand/weight-bear on the left lower extremity without pain.

Review of Systems

Constitutional: Negative.
Musculoskeletal: Negative except as documented in history of present illness.
Integumentary: Negative.
Neurologic: Negative.

Health Status

Allergies:

Allergic Reactions (Selected)

No known allergies

Medications: (Selected)

Documented MedicationsDocumented

cyclobenzaprine 10 mg oral tablet: 1 tab(s) (10 mg), PO, TID, PRN: for spasm, Type: Maintenance
naproxen 500 mg oral tablet: 1 tab(s) (500 mg), PO, BID, Type: Maintenance

Problem list:

All Problems

Tobacco user / SNOMED CT 175325014 / Probable

Histories

Past Medical History:

No active or resolved past medical history items have been selected or recorded.

Family History:

No family history items have been selected or recorded.

Procedure history:

No active procedure history items have been selected or recorded.

Physical Examination

Vital Signs

9/24/2014 1:39 PM EDT

Peripheral Pulse Rate
Pulse Site
Respiratory Rate
Systolic Blood Pressure
Diastolic Blood Pressure
Mean Arterial Pressure
BP Site
Pain Present

60 bpm
Radial artery
16 br/min
122 mmHg
80 mmHg
94 mmHg
Left arm
Yes (Provider Notified)

Measurements from flowsheet : Measurements

9/24/2014 1:39 PM EDT

Height

74 in

General Progress Note (Physician)

MCDUFFIE, TIMOTHY - 654185

Weight	198.6 lb
BSA	2.17 m2
Body Mass Index	25.6 kg/m2

General: Alert and oriented, No acute distress.

Eye: Extraocular movements are intact, Normal conjunctiva.

HENT: Normal hearing.

Neck: Supple.

Respiratory: Respirations are non-labored.

Musculoskeletal: The patient has pain in the left thigh musculature with weightbearing/walking;

Musculature is not particularly tender to palpation and is without spasm.

The left knee is normal in all regards except for some tenderness over the MCL area.

The low back area is tender in the bilateral paraspinous musculature, which also demonstrates some spasm;

The midline is nontender;

Torso rotation bilaterally induces some pain in the low back;

Negative straight leg raises..

Integumentary: Warm, Dry.

Neurologic: No focal deficits, Cranial Nerves II-XII are grossly intact.

Cognition and Speech: Speech clear and coherent, Functional cognition intact.

Impression and Plan**Diagnosis**

Lower back injury (ICD9 959.19).

Left knee sprain (ICD9 844.9).

Left leg injury (ICD9 959.7).

Plan: All injuries are minor, however the patient is not able to stand or walk comfortably so I am putting him on sedentary duties only, to recheck on Monday 09/29 in the AM.

He has meds to last;

Advised rest twice a day and activity within the limits of his comfort (avoid painful activity)..

Patient instructions: Counseled: Patient, Regarding diagnosis, Regarding treatment, Verbalized understanding.

Orders**Orders**

Charges (Evaluation and Management):

99214 office outpatient visit 25 minutes (Charge) (Order): Quantity: 1.

Signature Line

Signed and Authored by Stewart Young on 09/24/2014 02:20 PM EDT

Charted Date: September 24, 2014 2:05 PM EDT

Subject / Title: Back/Leg Injury

Performed By: Young MD, Stewart on September 24, 2014 2:20 PM EDT

Electronically Signed By: Young MD, Stewart on September 24, 2014 2:20 PM EDT

Visit Information: B2014092402387, First Care, Outpatient, 9/24/2014 - 9/26/2014

Return to Work Form

MCDUFFIE, TIMOTHY - 654185

Return to Work Status Entered On: 9/24/2014 2:20 PM EDT
Performed On: 9/24/2014 2:16 PM EDT by James RMA, Jessica

Return to Work Status

Employer : Johnson Food Service

Injured at Work : Yes

Work Status : Return to work with restrictions

Return to Work Start Date : 9/25/2014 EDT

Special Work Instructions : Other: Sedentary duties only (sitting only)

Further Follow-Up Needed : Yes

Date to Follow Up with Physician : 9/29/2014 EDT

Follow-Up Physician : Stewart Young, M.D.

James RMA, Jessica - 9/24/2014 2:16 PM EDT

Charted Date: September 24, 2014 2:16 PM EDT
Subject / Title: Return to Work Status
Performed By: James RMA, Jessica on September 24, 2014 2:16 PM EDT
Electronically Signed By: James RMA, Jessica on September 24, 2014 2:16 PM EDT
Visit Information: B2014092402388, First Care, Outpatient, 9/24/2014 - 9/26/2014

General Progress Note (Physician)

MCDUFFIE, TIMOTHY - 654185

Back/Leg Injury

Patient: MCDUFFIE, TIMOTHY MRN: 664185 FIN: B2014092900712
Age: 36 years Sex: Male DOB: [REDACTED]
Associated Diagnoses: Left knee sprain; Lower back injury; Left leg injury
Author: Young MD, Stewart

Chief Complaint

9/29/2014 10:49 AM EDT Chief Complaint (Modified)

History of Present Illness

The patient is feeling better in general but still has some mild medial knee pain and some mild low back pain with certain movements. He is prepared to return to work without restrictions. Chart reviewed

Review of Systems

Constitutional: Negative.
Musculoskeletal: Negative except as documented in history of present illness.
Integumentary: Negative.
Neurologic: Negative.

Health Status

Allergies:

Allergic Reactions (Selected)

No known allergies

Medications: (Selected)

Documented MedicationsDocumented

cyclobenzaprine 10 mg oral tablet; 1 tab(s) (10 mg), PO, TID, PRN: for spasm, Type: Maintenance
naproxen 500 mg oral tablet; 1 tab(s) (500 mg), PO, BID, Type: Maintenance

Problem list:

All Problems

Tobacco user / SNOMED CT 175325014 / Probable
Left knee sprain / SNOMED CT 91240012 / Confirmed
Lower back injury / SNOMED CT 421160018 / Confirmed
Left leg injury / SNOMED CT 567016 / Confirmed

Histories

Past Medical History:

No active or resolved past medical history items have been selected or recorded.

Family History:

No family history items have been selected or recorded.

Procedure history:

No active procedure history items have been selected or recorded.

Physical Examination

Vital Signs

9/29/2014 10:49 AM EDT

Temperature Oral	98.6 DegF
Peripheral Pulse Rate	62 bpm
Pulse Site	Radial artery
Systolic Blood Pressure	120 mmHg
Diastolic Blood Pressure	80 mmHg
Mean Arterial Pressure	93 mmHg
BP Site	Right arm
Pain Present	Yes (Provider Notified)

Measurements from flowsheet : Measurements

9/29/2014 10:49 AM EDT

Height	74.25 in
Weight	205.2 lb

General Progress Note (Physician)

MCDUFFIE, TIMOTHY - 654185

BSA
Body Mass Index2.21 m2
26.17 kg/m2

General: Alert and oriented, No acute distress.

Eye: Extraocular movements are intact, Normal conjunctiva.

Neck: Supple.

Respiratory: Respirations are non-labored.

Musculoskeletal: Normal gait, Left knee is normal to palpation and has normal range of motion;

And crossing the left leg over the right he does have some MCL pain but there is no ligament instability;

The patella is freely movable, not ballotable, and nontender;

Passive needed chest is nonpainful.

The low back is nontender and he has normal range of motion in torso rotation, with some mild low back pain on full rotation to the right;
Negative straight leg raises.

Left thigh musculature is non-tender and without spasm..

Integumentary: Warm, Dry.

Neurologic: No focal deficits, Cranial Nerves II-XII are grossly intact.

Cognition and Speech: Speech clear and coherent, Functional cognition intact.

Impression and Plan

Diagnosis

Left knee sprain (ICD9 844.9).

Lower back injury (ICD9 859.19).

Left leg injury (ICD9 959.7).

Plan: The patient is vastly improved and has no residual findings that would suggest he is not able to work without restriction, with which he agrees.

I have advised him to move slowly at first until he gets a feel for how he is doing and return if he has any problems;

Otherwise he is released as of tomorrow state..

Patient Instructions: COUNSELED: Patient, Verbalized understanding.

Orders

Orders

Charges (Evaluation and Management):

99214 office outpatient visit 25 minutes (Charge) (Order): Quantity: 1.

Signature Line

Signed and Authored by Stewart Young on 09/29/2014 11:47 AM EDT

Charted Date: September 29, 2014 11:35 AM EDT
Subject / Title: Back/Leg Injury
Performed By: Young MD, Stewart on September 29, 2014 11:47 AM EDT
Electronically Signed By: Young MD, Stewart on September 29, 2014 11:47 AM EDT
Visit Information: B2014092900712, First Care, Outpatient, 9/29/2014 - 10/1/2014

Return to Work Form

MCDUFFIE, TIMOTHY - 654185

Return to Work Status Entered On: 9/29/2014 11:46 AM EDT
Performed On: 9/29/2014 11:45 AM EDT by Bowers , Genene

Return to Work Status

Employer : Johnson Foods Service

Injured at Work : Yes

Work Status : Return to work no restrictions

Return to Work Start Date : 9/30/2014 EDT

Further Follow-Up Needed : As needed

Bowers , Genene - 9/29/2014 11:45 AM EDT

Charted Date: September 29, 2014 11:45 AM EDT
Subject / Title: Return to Work Status
Performed By: Bowers , Genene on September 29, 2014 11:45 AM EDT
Electronically Signed By: Bowers , Genene on September 29, 2014 11:45 AM EDT
Visit Information: B2014092900712, First Care, Outpatient, 9/29/2014 - 10/1/2014

General Progress Note (Physician)

MCDUFFIE, TIMOTHY - 654185

Back/Leg Injuries

Patient: MCDUFFIE, TIMOTHY MRN: 654185 FIN: B2014101302762
Age: 38 years Sex: Male DOB: [REDACTED]
Associated Diagnoses: Left knee sprain; Lower back injury; Left leg injury
Author: Young MD, Stewart

Chief Complaint

10/13/2014 2:22 PM EDT D.O.I 9/19/14

History of Present Illness

patient is here for follow-up of left knee, thigh, and low back injury for which she was previously released, however he's still having some pain in all these areas particularly after having done a lot of heavy work.

Review of Systems

Constitutional: Negative.
Musculoskeletal: Negative except as documented in history of present illness.
Integumentary: Negative.
Neurologic: Negative.

Health Status

Allergies:

Allergic Reactions (Selected)

No known allergies

Medications: (Selected)

Documented MedicationsDocumented

cyclobenzaprine 10 mg oral tablet: 1 tab(s) (10 mg), PO, TID, PRN: for spasm, Type: Maintenance
naproxen 500 mg oral tablet: 1 tab(s) (500 mg), PO, BID, Type: Maintenance

Problem list:

All Problems

Tobacco user / SNOMED CT 176325014 / Probable
Left knee sprain / SNOMED CT 91240012 / Confirmed
Lower back injury / SNOMED CT 421160018 / Confirmed
Left leg injury / SNOMED CT 567016 / Confirmed

Histories

Past Medical History:

No active or resolved past medical history items have been selected or recorded.

Family History:

Entire family history is negative.

Procedure history:

None (387958016).

Physical Examination

Vital Signs

10/13/2014 2:22 PM EDT

Temperature Oral	98.1 DegF
Peripheral Pulse Rate	76 bpm
Pulse Site	Radial artery
Respiratory Rate	16 br/min
Systolic Blood Pressure	126 mmHg
Diastolic Blood Pressure	70 mmHg
Mean Arterial Pressure	89 mmHg
BP Site	Left arm

Measurements from flowsheet : Measurements

10/13/2014 2:22 PM EDT

Height	74 in
Weight	187.6 lb

Printed by: Blackmon, Lisa
Printed on: 6/1/2015 1:37 PM EDT

General Progress Note (Physician)

MCDUFFIE, TIMOTHY - 654185

BSA
Body Mass Index2.16 m2
25.37 kg/m2

General: Alert and oriented, No acute distress.

Musculoskeletal: the low back is nontender and without spasm;

He is normal rotational range of motion bilaterally, with some pain in the left low back induced by rotating to the full right stop.

The left thigh musculature is relaxed and nontender;
Negative left straight leg raise.The left knees without swelling or heat;
he has normal range of motion with a conflict on full extension;
No ligament instability.

The patella is normal.

Integumentary: Warm, Dry.

Neurologic: No focal deficits, Cranial Nerves II-XII are grossly intact.

Cognition and Speech: Speech clear and coherent, Functional cognition intact.

Impression and Plan

Diagnosis

Left knee sprain (ICD9 844.0).

Lower back injury (ICD9 959.10).

Left leg injury (ICD9 959.7).

Plan: the patient is really doing fairly well, however he still has some complaints of left knee thigh and low back which persist particularly if he overexerts at work.

Going to have him get 6 treatments of physical therapy and try to keep him working without restrictions, having cautioned him to be careful about how he does his work.

he has medication for as needed;

Recheck after completion of PT;

Return in the meantime if problems..

Patient Instructions: Counseled: Patient, Regarding diagnosis, Regarding treatment, Regarding medications, Verbalized understanding.

Orders

Orders

Requests (Consults / Referrals):

Referral (Request) (Order): Referred to: Physical Therapy, Referred to: Workmen's Comp. choice (Johnson food services),
Reason for referral: persistent left knee, thigh, and low back pain., Priority: Soon, Instructions: please start as soon as possible for maximizing efficacy; evaluate and treat the left knee, left thigh, and low back x 6 over 2-3 wks; f/up w/ Dr. Young upon completion.

Charges (Evaluation and Management):

99214 office outpatient visit 25 minutes (Charge) (Order): Quantity: 1.

Signature Line

Signed and Authored by Stewart Young on 10/13/2014 02:41 PM EDT

Charted Date: October 13, 2014 2:30 PM EDT

Subject / Title: Back/Leg Injuries

Performed By: Young MD, Stewart on October 13, 2014 2:41 PM EDT

Electronically Signed By: Young MD, Stewart on October 13, 2014 2:41 PM EDT

Printed by: Blackmon, Lisa
Printed on: 6/1/2015 1:37 PM EDT

06-01-15:01:53PM;

;803-736-4830

11/ 16

General Progress Note (Physician)

MCDUFFIE, TIMOTHY - 654185

Visit Information: B2014101302762, First Care, Outpatient, 10/13/2014 - 10/15/2014

444

Printed by: Blackmon, Lisa
Printed on: 6/1/2015 1:37 PM EDT



Return to Work Form

MCDUFFIE, TIMOTHY - 654185

Return to Work Status Entered On: 10/13/2014 2:40 PM EDT
Performed On: 10/13/2014 2:38 PM EDT by Johnson , Shuyunna

Return to Work Status

Employer: Johnson Food Service

Injured at Work: Yes

Work Status: Return to work no restrictions

Further Follow-Up Needed: Yes

Work Status Comment: Patient will continue to have Physical Therapy and f/u after Physical Therapy is completed
Johnson , Shuyunna - 10/13/2014 2:38 PM EDT

Charted Date: October 13, 2014 2:38 PM EDT
Subject / Title: Return to Work Status
Performed By: Johnson , Shuyunna on October 13, 2014 2:38 PM EDT
Electronically Signed By: Johnson , Shuyunna on October 13, 2014 2:38 PM EDT
Visit Information: B2014101302762, First Care, Outpatient, 10/13/2014 - 10/15/2014



General Progress Note (Physician)

MCDUFFIE, TIMOTHY - 654185

Back/leg injuries

Patient: MCDUFFIE, TIMOTHY MRN: 654186 FIN: B2014112800122
Age: 36 years Sex: Male DOB: [REDACTED]
Associated Diagnoses: Left leg Injury; Lower back Injury; Left knee sprain
Author: Young MD, Stewart

Chief Complaint

11/28/2014 10:33 AM EST pt states that he is here to f/u on WC Injury to L leg, currently still doing physical therapy. DOI: 9/19/2014

History of Present Illness

Chief complaint confirmed. He has had 7 or 8 sessions of physical therapy which she says have not helped, and have even made his left knee worse. Naprosyn was ineffective for pain; Flexeril was helpful when taking the bedtime.

Review of Systems

Constitutional: Negative.
Musculoskeletal: Negative except as documented in history of present illness.
Neurologic: Negative.

Health Status

Allergies:

Allergic Reactions (Selected)

No known allergies

Medications: (Selected)

Documented MedicationsDocumented

cyclobenzaprine 10 mg oral tablet: 1 tab(s) (10 mg), PO, TID, PRN: for spasm, Type: Maintenance
naproxen 500 mg oral tablet: 1 tab(s) (500 mg), PO, BID, Type: Maintenance

Problem list:

All Problems

Tobacco user / SNOMED CT 175325014 / Probable
Left knee sprain / SNOMED CT 91240012 / Confirmed
Lower back injury / SNOMED CT 421160018 / Confirmed
Left leg injury / SNOMED CT 567016 / Confirmed

Histories

Past Medical History:

No active or resolved past medical history items have been selected or recorded.

Family History:

Entire family history is negative.

Procedure history:

None (387958016).

Physical Examination

Vital Signs

11/28/2014 10:33 AM EST

Peripheral Pulse Rate	64 bpm
Respiratory Rate	16 br/min
Systolic Blood Pressure	116 mmHg
Diastolic Blood Pressure	72 mmHg
Mean Arterial Pressure	87 mmHg

Measurements from flowsheet : Measurements

11/28/2014 10:33 AM EST

Height	74 in
Weight	212.4 lb
BSA	2.24 m2
Body Mass Index	27.27 kg/m2

General Progress Note (Physician)

MCDUFFIE, TIMOTHY - 654185

General: Alert and oriented, No acute distress.

Musculoskeletal: The left lumbar paraspinous musculature is tense and tender to palpation; He has pulling in this area with torso rotation bilaterally.

He has normal range of motion of the left knee with pain in the medial anterior knee just lateral to the patella, which area is tender to palpation;

The patella is movable without pain;
No ligament instability.

The posterior left thigh musculature is tense and tender in the distal thigh. .

Integumentary: Warm, Dry.

Neurologic: No focal deficits, Cranial Nerves II-XII are grossly intact.

Cognition and Speech: Speech clear and coherent, Functional cognition intact.

Impression and Plan**Diagnosis**

Left leg injury (ICD9 959.7).

Lower back injury (ICD9 959.19).

Left knee sprain (ICD9 844.9).

Plan: The patient is at least know better and states his left knee is worse, even after having had separate sessions of physical therapy.

It also seems that his work which is very physical has been an exacerbating factor in preventing him from getting well so I'm going to give him a sedentary duties only work excuse.

Refer to orthopedics;
Discontinue PT.

Flexeril refilled;

Naprosyn was ineffective so no refill..

Patient instructions: Counseled; Patient, Caregiver, Verbalized understanding.

Orders**Orders****Requests (Consults / Referrals):**

Referral (Request) (Order): Referred to: Orthopaedics, Referred to: Workmen's Compensation's choice, Reason for referral: Persistent low back, left thigh, and left knee pain approximately 2 months post injury., Priority: Soon, Instructions: Please refer him as soon as practicable.

Charges (Evaluation and Management):

99214 office outpatient visit 25 minutes (Charge) (Order): Quantity: 1.

Orders**Pharmacy:**

cyclobenzaprine 10 mg oral tablet (Prescribe); See instructions, instructions: 1 tab at bedtime for muscle spasm., PRN: for spasm, # 30 tab(s), 0 Refill(s), Type: Maintenance, Pharmacy: CVS/pharmacy #4399

cyclobenzaprine 10 mg oral tablet (Discontinue)

Charges:

G8553 prescrip transmit via orx sy (Charge) (Order): Quantity: 1.

Signature Line

Signed and Authored by Stewart Young on 11/26/2014 11:00 AM EST

Charted Date: November 28, 2014 10:44 AM EST
Subject / Title: Back/leg injuries

Printed by: Blackmon, Lisa
Printed on: 6/1/2015 1:38 PM EDT

General Progress Note (Physician)

MCDUFFIE, TIMOTHY - 654185

Performed By: Young MD, Stewart on November 28, 2014 11:00 AM EST
Electronically Signed By: Young MD, Stewart on November 28, 2014 11:00 AM EST
Visit Information: B2014112800122, First Care, Outpatient, 11/28/2014 - 11/30/2014



Return to Work Form

MCDUFFIE, TIMOTHY - 654185

Return to Work Status Entered On: 11/28/2014 10:55 AM EST
Performed On: 11/28/2014 10:54 AM EST by Johnson , Shyunna

Return to Work Status

Employer: JFS

Injured at Work: Yes

Work Status: Other: LIGHT DUTY WORK EXCUSE: SEDENTARY WORK ONLY (seated)

Work Status Comment: Pt will stop Physical Therapy and will need to be referred to Orthopedist

Johnson , Shyunna - 11/28/2014 10:54 AM EST

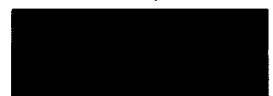
Charted Date: November 28, 2014 10:54 AM EST

Subject / Title: Return to Work Status

Performed By: Johnson , Shyunna on November 28, 2014 10:54 AM EST

Electronically Signed By: Johnson , Shyunna on November 28, 2014 10:54 AM EST

Visit Information: B2014112800122, First Care, Outpatient, 11/28/2014 - 11/30/2014



MCDUFFIE, TIMOTHY (id #115597, dob: [REDACTED])

12/22/2014 10:03:43 AM

->

Page 1 / 1

InMed

Diagnostic Services

126 South Assembly St.
Columbia, SC 29201
Phone: (803)-988-0082
Fax: (803) 988-0095

Timothy Mcduffie

Patient/Account Number: 324583

DOB: [REDACTED] Age: 37 /Male

Exam Date: 12/19/14

Referring Physician: Michael Peelle

Referring Phone: (803) 227-8000

Referring Fax: (803) 227-8225

MRI Lumbar Spine no IV contrast

INDICATION: Left hip pain.

TECHNIQUE: T1 and water-weighted sequences through the lumbar spine were obtained in sagittal and axial planes.

FINDINGS: The lumbar vertebral bodies are grossly normal in height and alignment. The disc spaces are maintained and show normal high signal on T2 weighted sequences. The spinal canal is congenitally normally in caliber. The cord terminates normally at the thoracolumbar junction.

At L3-4, L4-5, and L5-S1, no disc deformities are seen. There is no spinal stenosis. The lateral recesses and neural foramina are patent.

IMPRESSION: No abnormalities are seen to account for left-sided pain.

Mark Lovern, M.D.

ML/skd

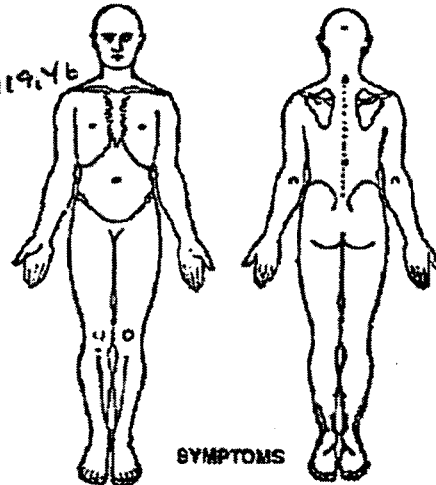
This examination was performed at InMed Diagnostic Services Of SC-Columbia, 126 S Assembly St, Columbia, SC 29201-4545.

Electronically Signed By:



THE MCKENZIE INSTITUTE LUMBAR SPINE ASSESSMENT

Date 11-5-14
 Name Timothy McDuffie Sex M/F
 Address 221 W. 1st St. S. LBP 724.2
 Telephone Dr. Stewart Young Leg Pain 719.46
 Date of Birth [redacted] Age 37
 Referral: GP / Orth / Self / Other _____
 Work: Mechanical stresses work - lifting, standing, bending/twisting
 Leisure: Mechanical stresses as
 Functional disability from present episode _____
 Functional disability score _____
 VAS Score (0-10) High 7/10 low 3/10 now 3/10



HISTORY
 Present symptoms Left side LB & Left knee
 Present since 9/18/14
 Commenced as a result of trip on pipe on floor at work & had near fall Improving / unchanging / worsening
 Symptoms at onset back / thigh / leg + "cramping" in (L) leg or no apparent reason
 Constant symptoms: back / thigh / leg "leg cramping" Intermittent symptoms: back / thigh / leg
 Worse standing forward sitting / rising standing walking lying
arm has the day progresses / pm when still / on the move
 other twisting stretching
 Better bending sitting standing walking lying
am / as the day progresses / pm when still / on the move
 other cramping position
 Disturbed sleep: yes / No Sleeping postures: prone / sup / side R. / L Surface: firm / soft / sag
 Previous episodes: 0 1-5 6-10 11+ Year of first episode _____
 Previous history as
 Previous treatments as meds

SPECIFIC QUESTIONS

cough / sneeze / strain / +ve no Bladder: normal / abnormal Gait: normal / abnormal
 Medications: Nil / NSAIDS / Analg / Steroids / Anticoag / Other mus relaxers, w/proton
 General health: good / fair / poor
 Imaging: yes / no XRAY L-spine
 Recent or major surgery: yes / no Night pain: yes / no
 Accidents: yes / no Unexplained weight loss: yes / no
 Other: _____



**Carolina Physical Therapy
and Sports Medicine, Inc.**

received
10/24/09

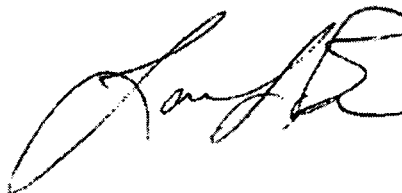
Date: 11-13-14

Name: Timothy McDuffie

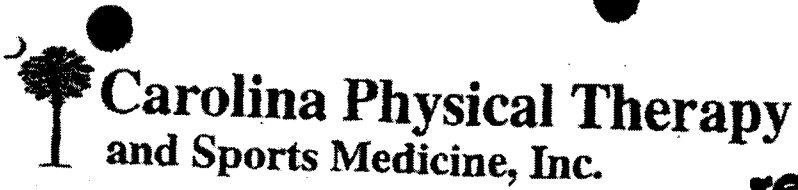
Time In: 2:30 p **Time Out:** 3:30 p

To Whom It May Concern:

**Please be informed that the above mentioned person was
seen in our clinic on this date for Physical Therapy
treatment.**

 DPT, MDT

**Carolina Physical Therapy
And Sports Medicine
1812 Hampton St.
Columbia, SC 29201
(803) 256-0303**



received
11/24/14

Date: November 20th 2014

Name: Timothy McDuffie

Time In: 3:10 **Time Out:** 4:30

To Whom It May Concern:

Please be informed that the above mentioned person was seen in our clinic on this date for Physical Therapy treatment.

**Carolina Physical Therapy
And Sports Medicine
1812 Hampton St.
Columbia, SC 29201
(803) 256-0303**



A DIVISION OF ONE CALL CARE MANAGEMENT

Please send a recent progress summary with objective measurements. Please fax or email: 904-309-8942 or requests@alignnetworks.com



Discharge Patient Progress Note (needed every 2 weeks)

Provider Name: Carolina Physical Therapy &
 Today's Date: Thursday, November 27, 2014
 DOB: [REDACTED]
 Eval Date: 11/5/2014 8:00:00 AM
 Diagnosis: Other, please see details.

Patient's Name: Timothy McDuffie
 Claim #:
 Surgery Date:
 Service: Physical Therapy

AROM / PROM	Joint:	Eval Date	Re-Assess:	Re-Assess:
	LS	11/5/14	11/28/14	---
	flex	75%	N/A	
	ext	50%	75%	
PAIN LEVEL				

STRENGTH	Joint:	Eval Date	Re-Assess:	Re-Assess:
	LE	11/5/14	11/28/14	---
	hip flex	4+/5	4+/5	
	hip ext	4+/5	4+/5	

Progress toward work related goals: Min. progress p 6 visits

Remaining Deficits: 46 LB + (10) LE pain, slight L/R knee & LE strength

New Goals: 0

Summary of treatment provided: MHFE-SL US, ex

Co-morbidities slowing progress: ☐ Diabetes/Metabolic Disease ☐ Infection ☐ Scarring ☐ Stroke
☐ Auto-Immune Disease ☐ Morbid Obesity ☐ Heart Disease ☐ Pregnancy ☐ Osteoporosis

Recommendations:

- ☐ Cont Current POC with current authorization; _____ Visits remaining
☐ Recommend Continued therapy _____ x wk for _____ wks** (NEW RX REQUIRED BY MD)
☒ Discharge 25% Goals Met ☐ D/C - poor compliance ☒ D/C - plateau - f/u MD

Plan for D/C ☐ < 2 wks ☐ 2-4 wks ☐ 4-6 wks ☐ > 6 wks ☐ D/C expected w/in requested auth? Y/N

Therapist Name: Laurie Whitcomb Signature: [Signature] Date: 11/28/14

**If Provider recommending additional therapy, provider must obtain MD RX and submit to Align

Pt seen by Dr & referred to Chiropractor (per pt) D/C P.T.

CAROLINA PHYSICAL THERAPY
PROGRESS NOTES

Date

Name

Timothy McDuffie

NOV 07 2014

NOV 11 2014

S: States he's feeling better in pain but back is stiff + tight this am.

O: Rx: ① mhip/Estim x 15' to @ side 4s + 4s in prone.
② manual - IT bands to 4s + 4s for ext in prone.
③ skilled TE per F/S.

A: Tolerating adduct Ex w/o complaints. ↓ tightness.

P: cont POC

NOV 13 2014

S: States back pain is better but having pain lateral left knee (region of fibular head).

O: Increased tightness @ ITB + tenderness at distal attachment. Rx: ① mhip/Estim x 15' to LB in prone. ② manual IT bands PA for ext to 4s in prone. ③ skilled Ther Ex per F/S.

A: Tightness left ITB. Progress well w/ Ex. Added ITB stretching + SLR.

P: cont POC - cont PA mbs 4s + ITB CFM/MFR

NOV 18 2014

NOV 18 2014

S: States he continues to have a lot of pain left knee - especially w/ bending + squatting.

O: Rx: ① mhip/Estim x 15' to LB in prone. ② STM/MFR + IT bands TLJ + L spin. ③ skilled TE per F/S.

A: lumbar spine extension mobility improving.

P: cont POC - monitor @ knee sk.

CAROLINA PHYSICAL THERAPY
PROGRESS NOTES

Date

Name

Timothy McDuffie

NOV 28 2014

S: States his LB is painful + he has a pain along the lateral aspect of his left knee

O: R x (1) MHT + E-St (Hx/Fx) bil LS pain
(2) Skilled TE per F/S

A: Can't get off of IT Band. Better feeling
ex

P: Can't

11/24/14

S: Pain (L) patella + LS + stretching. Knee pain is fairly constant + aching.

O: R x (1) MHT + E-St Hx/Fx bil LS pain

(2) Phom + dex (1) patella tendon + lateral knee

(3) Skilled TE per F/S

A: rel of (1) ITB + patella tendon

P: Can't

NOV 28 2014

MCDUFFIE, TIMOTHY (id #115597, dob: [REDACTED])

12/19/2014 13:38 NE-ZFLCT

(FAX)8034623312

P.007/028

MCDUFFIE, TIMOTHY [REDACTED]



* 4182771w2585 E-Healthix

Primary Care Physician: N/A

Age 36 Occupation: _____

Who referred you here? Work

Is this a work related injury? ☒ Yes ☐ No Date of specific event See-12-14

Is a lawyer involved because of your injury? ☒ Yes ☐ No

Name of lawyer or law office: ASST Phone: 803 744-0426

SPINAL HISTORY (Please tell us about your current back or leg problems)

1. What is the primary problem or location of pain? Back and leg
When did this problem start? See 20, 2014
How did your problem start? at work
2. How much of your problem is back pain compared to leg pain?
☐ All leg pain ☐ Mostly leg ☒ 30% Back, 50% Leg ☐ Mostly back ☐ All back pain
Where is your leg pain? ☐ No leg pain ☒ Buttock ☐ Thigh ☐ Lower leg/foot
3. Back pain type: ☒ Aching ☐ Stabbing ☐ Throbbing ☐ Shooting ☐ Dull ☐ Click or Pop
4. Pain Worsened By: ☐ Standing ☒ Walking ☒ Sitting ☐ Lying ☐ Driving ☒ Working ☐ Stairs
☐ Bending forward ☒ Bending backward ☐ Coughing ☐ Sneezing
5. What reduces the pain ☐ Lying Down ☐ Sitting ☐ Standing ☐ Walking ☐ Manipulation
☐ Exercises / therapy ☐ Pain Medications ☐ Injections for pain ☐ Muscle relaxant pills
☐ Anti-inflammatory pills ☐ Nothing ☐ Other _____
6. Do you have numbness or pins & needles sensation in your feet or legs? ☐ Yes ☐ No
Location? ☐ Buttock ☐ Thigh (back/ side/ front) ☐ Calf ☐ Shin ☐ Top of foot ☐ Outside of foot
How long has this been present? _____
7. Do you have weakness in your legs or feet? ☒ Yes ☐ No Which side? ☐ Right ☒ Left ☐ Both
Location? ☐ Entire leg ☒ Thigh/knee ☐ Lifting foot/ankle ☐ Pushing off with foot
How long has this been present? _____
8. Do you have difficulty walking because of legs feeling tired or weak? ☐ Yes ☐ No
How far (or how many minutes) can you walk before stopping? 10 min
9. Do you have any bowel or bladder incontinence? ☐ Yes ☒ No
10. Have you been hospitalized for your pain problem? ☐ Yes ☒ No Most recent visit: _____
Tests/treatments: _____
11. Treatments: Please check all the treatments you have had for this problem.
☐ Physical therapy ☐ Epidural steroid injections
Dates of treatment: _____ How many? _____
Helped for how long? _____
☐ Massage ☐ Foot Joint injections
☐ Traction ☐ How many? _____
Helped for how long? _____
☐ Manipulation/Chiropractor ☐ Other _____
☐ TENS Unit ☐ How many? _____
☐ Braces ☐ Helped for how long? _____
☐ Anti-inflammatory medications ☐ Other _____
☐ Narcotic Medication



MCDUFFIE, TIMOTHY (id #115597, dob: [REDACTED])

12/19/2014 13:38 NE-ZF LCT

(FAX) 803 462 3312

P. 005/028

MCDUFFIE, TIMOTHY [REDACTED]



* 4182771w2585 E-HealthHx

12. What tests have been done? (Check all that apply & provide dates of most recent test)

☐ MRI ☐ CT Scan ☐ EMG/nerve study ☐ Other _____

13. Have you ever had back surgery? ☐ Yes ☒ No

How many? _____

Procedures:

Surgeon name / hospital location _____

Did the surgery relieve the initial problem/pain? ☐ Yes ☒ No ☐ Partially

Did you have any complications? ☐ Yes ☒ No ☐ Spinal Fluid Leak ☐ Infection ☐ Other _____

Has the pain returned? ☐ Yes ☒ No ☐ My pain is different now

14. Have you ever had MRSA infection (methicillin-resistant staphylococcus aureus)? ☐ Yes ☒ No

My lower back pain is (circle number):



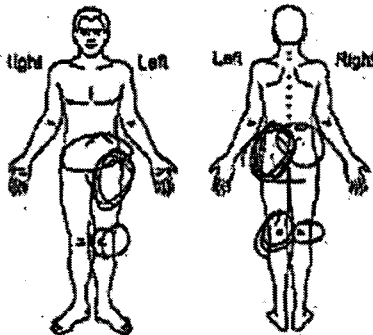
My leg pain is: (circle number):



Please indicate type and location of your pain on the figures below:

Please use the following key to shade in the location of pain on figures.

NUMBNESS	PINS & NEEDLES	ACHE	PAIN
_____	OOOOOO	XXXXXX	



MCDUFFIE, TIMOTHY (id #115597, dob: [REDACTED])

12/17/2014 16:33 NE110-C1

(FAX) 8037854739

P.016/032

MCDUFFIE, TIMOTHY [REDACTED]



Financial Policy
for the offices of Moore Center for Orthopedics
Corporate Office located at 104 Saluda Pointe Dr. Lexington, SC 29072 (803) 227-8000

* 6182770w2585 A-FormLet

Thank you for choosing Moore Center for Orthopedics as your orthopedic specialty healthcare provider. We are committed to providing you and your family with the best medical care available. In our ongoing process to make sure that all of your medical needs are met, we ask that all responsible parties read and sign our financial policy.

Payments for all services will be due at the time the services are rendered. In order to serve you better, we accept cash, check, Visa, MasterCard, Discover and American Express. As a courtesy to you, it is the policy of the Moore Center for Orthopedics to bill your insurance carrier(s), although you are ultimately responsible for the entire bill. As the responsible party, please understand:

1. Your insurance policy is a contract between you, your employer and the insurance company. We will not become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance and "usual and customary" charges. As your medical provider, we will gladly supply factual information to facilitate claim processing.
2. Most insurance plans differentiate between PCP and specialist benefits. Orthopedic providers are considered specialists and, if applicable, you will be required to remit a specialist co-pay at check-in.
3. Fees for services, which include unpaid balances, deductibles and co-payments, are due at the time of service. Returned checks and unpaid balances may be subject to collection placement and collection fees.
4. If any insurance payment is made directly to you for services billed by the Moore Center for Orthopedics, you recognize an obligation to promptly remit payment to our office.
5. I understand that any billed patient balance not paid within 60 days is subject to referral to an outside collections agency. If part or all of the account(s) for which I am responsible are referred to an outside collections agency, future appointments may not be scheduled until the account balance is resolved in full.
6. If I default on an agreed-upon payment arrangement – either by not paying the agreed amount or missing a payment – the account is subject to referral to an outside collections agency.
7. The above does not apply for those patients that are considered Worker's Compensation; however, be advised that as a worker's compensation patient you may be held responsible for charges in the event that your claim is controverted.
8. If an injury is a result of a motor vehicle accident or similar event:
 - It is the policy of Moore Center for Orthopedics not to become involved in or file charges to third-party liability payors (ex: MVA companies such as State Farm, Progressive, homeowner's insurance, life insurance, etc.). Upon request, we will provide you with an itemized billing statement which has all required information to submit to the third-party payor for direct reimbursement.
 - We will file your private medical insurance or you will be treated as a self-pay patient. You are responsible for any balance due and prompt payment is required. If a settlement is reached, your attorney and the third-party payor will coordinate applicable reimbursement to your medical insurance carrier(s).
 - We do not accept letters of protection from representing law firms which waive your responsibility to pay the account balance. Refer to #5.
9. If you receive a durable medical supply item (brace, orthotic, etc.), be advised that payment by your insurance carrier is not guaranteed. The billed cost includes a high-quality product specially ordered by your provider and, if applicable, customized instruction and fitting of the product. Once a durable medical supply item leaves the building, it cannot be returned and you are responsible for all charges incurred.
10. Our billing mailbox is located in Maine; therefore, your monthly billing statement will request that you remit payment to a post office box in Belfast, Maine. You may also remit payment on-line through the Patient Portal or call our office directly. We do not keep credit/debit card numbers on file or do automatic draft payments.
11. Please be mindful that procedures conducted at the Moore Center Surgery Center may process differently through your insurance carrier than the same procedure conducted in our office setting. It is your responsibility to discuss this with your insurance carrier as well as the physician's Care Team prior to having the procedure completed so that you have a full understanding of your insurance benefits and your financial responsibility.

At the Moore Center for Orthopedics, we understand that financial problems may affect timely payment, so it is imperative that you communicate any such problems to us so that we may assist you in keeping your account in good standing. If you have any questions, please contact your physician's Care Team directly.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE REVIEWED AND UNDERSTAND THE ABOVE INFORMATION AND ACCEPT FINANCIAL RESPONSIBILITY FOR THIS ACCOUNT.

Signature of patient

12-17-14

Date

MCDUFFIE, TIMOTHY (id #115597, dob: [REDACTED])

12/17/2014 16:33NE110-C1

(FAX) 803.788.4739

P. 015/032

MCDUFFIE, TIMOTHY [REDACTED]



Consent to Treat

* 6182768w2585 A-Consent

I voluntarily give my permission to the health care providers of Moore Center for Orthopedics and such assistants and other health care providers as they may deem necessary to provide medical services to me. I understand by signing this form, I am authorizing them to treat me for as long as I seek care from Moore Center for Orthopedics providers, or until I withdraw my consent in writing.

[Signature] 12-17-14
Signature of the Patient or Guardian Date
Timothy McDuffie
Printed Name of the Patient or Guardian Relationship to Patient

I authorize the release of any medical information by the Moore Center for Orthopedics, as necessary to process any insurance claim and request payment of benefits to the Moore Center for Orthopedics for surgery, fracture fee, or any unpaid bills

[Signature] 12-17-14
Signature of the Patient or Guardian Date
Timothy McDuffie
Printed Name of the Patient or Guardian Relationship to Patient

MCDUFFIE, TIMOTHY (id #115597, dob: [REDACTED])

12/17/2014 16:33 NE110-CI

(FAX) 803/7884739

P.014/032

MCDUFFIE, TIMOTHY [REDACTED]



* 0182768w2585 A-HIPAA

Acknowledgement of Receipt of Notice of Privacy Practices

for the office of Moore Center for Orthopedics
Corporate office located at 104 Saluda Pointe Dr. Lexington, SC 29072 (803)227-8000

I hereby acknowledge that I have received the Notice of Privacy Practices for the above office.

[Signature]

Signature of Patient or Personal Representative (as defined by HIPAA)

12-17-14
Date

Description of Personal Representative's Authority (Attach necessary documentation)

Documentation of "Good Faith" Attempt to get acknowledgement signature.

- ☐ Document presented to patient, but patient refused to sign acknowledgement.
- ☐ Patient presented with an emergency situation and there was no time to give the Notice or receive a signature. Attempt to give the Notice, and get an acknowledgement will be handled as soon as possible.
- ☐ Documentation was presented to the patient but a communication failure prevented us from receiving the acknowledgement.
- ☐ The documentation was mailed to the patient but never returned to us.

☐ Other: _____

For office use only		
Signature <u>[Signature]</u>	Title <u>CTM</u>	Date <u>12/17/14</u>

MCDUFFIE, TIMOTHY (id #115597, dob: [REDACTED])

12/17/2014 16:33 NE110-C1

(FAX) 803/784733

P.013/032

MCDUFFIE, TIMOTHY [REDACTED]



* 2182767w2685 A-HIPAA



AUTHORIZATION FORM

I hereby authorize Moore Center for Orthopedics to use or disclose protected health information to the entity or person listed below for the following patient:

Name/Entity:

Relationship:

☐ Appointment times and dates ☐ Diagnosis ☐ Plan of treatment ☐ Radiology results ☐ Lab/test results
☐ Account balances ☐ Work/School/Athletic restrictions ☐ Other

Name/Entity:

Relationship:

☐ Appointment times and dates ☐ Diagnosis ☐ Plan of treatment ☐ Radiology results ☐ Lab/test results
☐ Account balances ☐ Work/School/Athletic restrictions ☐ Other

I hereby authorize to receive automated phone calls from Moore Center for Orthopedics: ☒ Yes ☐ No

Cosch at (Name of School):

☐ Appointment times and dates ☐ Diagnosis ☐ Plan of treatment ☐ Radiology results ☐ Lab/test results
☐ Account balances ☐ Work/School/Athletic restrictions ☐ Other

Purpose: The purpose of this authorization is to meet the patient's request for information disclosure and use.

Expiration date or event: This authorization shall be enforce until revoked by the patient in writing or

Verification Method: This practice will verify the identity of any entity requesting protected health information.

Verification information will be the patient's birthday.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. I understand that I have the right to revoke this authorization at any time by sending a written notification to the address listed at the bottom of this form. I understand that a revocation is not effective in cases where the information has already been used or 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.

Signature of Patient or Personal Representative (as defined by HIPAA)

Date

Description of Personal Representative's Authority (Attach necessary documentation)

For office use only	Copy of this form given to the Patient ☐ Yes ☐ No
Signature <i>Linda Mathias</i>	Title <i>CTM</i> Date <i>12/17/14</i>

Moore Center for Orthopedics, 104 Saluda Pointe Drive, Lexington, SC 29072 (803)227-8000

MCDUFFIE, TIMOTHY (id #115597, dob: [REDACTED])

12-01-14:09:51AM;
11/10/2014 13:45 Suite-E-check in

(FAX) 8032278034

P.003/003

MOORE CENTER FOR ORTHOPEDICS

OFFICE REFERRAL FORM

First Name: <u>Timothy</u>	MI: _____	Last Name: <u>McDuffie</u>
Street Address: <u>2442 Washington St.</u>		
City: <u>Cola</u>	State: <u>SC</u>	Zip: <u>29204</u>
Home Phone: <u>(803) 476-5702</u>		Work Phone: <u>(803) 782-1461</u>
Cell: <u>(803) 422-8634</u>		
DOB: [REDACTED]	SSN: [REDACTED]	Gender (circle): <u>Male</u> Female

*If patient is a minor and/or covered under their parent's insurance, please complete:

Guardian's First Name: _____ MI: _____ Last Name: _____

DDI: <u>1</u>	BODY PART(S): <u>Low Back, Left V-Lig & Knee</u>
Diagnosis: <u>Pain</u>	
Referring Physician's Name: <u>Stewart Young, MD</u>	Phone #: <u>296-8766</u>
Referring Physician's Fax #: <u>765-6831</u>	
Has patient had X-rays? Yes or No (Please make sure patient is aware these are required at appointment)	
Has patient been treated by another specialist for this problem? Yes or No <u>No</u>	
Ins. Carrier Name: <u>None Listed</u>	Id #: _____
Phone to Verify Benefits: () _____	Group #: _____
Please attach a copy of the front/back of insurance card with this fax	
If this is a Workers Comp Injury - we cannot file private insurance, carrier must contact us. <u>Please call 446-5579</u>	

Request sent by: Julie Phone #: 296-8766

Please fax your requests directly to:

Sports Medicine:
Dr. Wendell Horne (Arthroscopy) - (803) 227-8036
Dr. Frank Nodjin (Arthroscopy) - (803) 227-8221
Dr. Mickey Phymale (Arthroscopy) - (803) 227-8225
Dr. David Scott (NonOp) - (803) 227-8272
Pediatric Orthopedics:
Dr. Mark Locke - (803) 227-8034
Dr. Christopher Nydom - (803) 227-8034
Dr. Michael Horen - (803) 227-8034

Foot & Ankle:
Dr. Bret Smith - (803) 227-8278
Dr. Ryan Putnam - (803) 227-8272
Upper Extremity:
Dr. Earl McPadden - (803) 227-8223
Dr. David Fulton - (803) 227-8224
Joint Replacement:
Dr. Kim Chilling - (803) 227-8026
Dr. Bradley Presnal - (803) 227-8028
Dr. Jeffrey Hopkins - (803) 227-8228

Spine:
Dr. Bill Febrly - (803) 227-8029
Dr. Michael Peelle - (803) 227-8225
Dr. Doug deHoll - (803) 227-8231
Physiatry:
Dr. Alvin Van Dam - (803) 227-8229
Dr. John Clavet - (803) 227-8227
Dr. Jacquelyn Van Dam - (803) 227-8229

*WE WILL BE HAPPY TO RESPOND TO ALL REFERRAL REQUESTS WITHIN 24 HRS OF RECEIPT MONDAY-THURSDAY, AND BY THE NEXT BUSINESS DAY ON FRIDAYS. MOORE STAFF WILL SCHEDULE ALL APPOINTMENTS WITH PATIENT AND THEN COMMUNICATE APPOINTMENT INFORMATION BACK TO REFERRING MD OFFICE.

MCO OFFICE USE ONLY: Completed by: _____ Date: _____
Appointment Date: _____ Time: _____ Doctor: _____

☒ Lexington
104 Saluda Pointe Dr.
Lexington, SC 29072

☐ Northeast
14 Gateway Corp Blvd.
Columbia, SC 29203

☐ Timbo
7936 Broad River Rd.
Umo, SC 29063

☐ Richland
14 Medical Park
Columbia, SC 29203

12-01-14:09:51AM;

2 / 8

First Care

Order Requisition

463

MCDUFFIE, TIMOTHY (id #115597, dob: [REDACTED])

12-01-14:09:51AM;

2/ 8

Order Requisition

First Care

2406 Decker Blvd
Columbia, SC, 29206
Phone: (803) 736-2530 Fax: (803) 736-4830

Patient: MCDUFFIE, TIMOTHY

Birthdate: [REDACTED]	Age: 36 Years	Sex: Male	Weight: 212.4 lb (11/28/14)
MRN: 654185	FIN: B2014112800122		Height: 74 in (11/28/14)
PCP: Jones FNP, Sandra			
CMRN: 733041			
Allergies: No known allergies			

****Please note - Allergy list may be incomplete****

Patient Home Address: 2442 WASHINGTON ST
COLUMBIA, SC 29204

Home Phone: (803) 476-5702
Work Phone: (803) 782-1461
Cell Phone: (803) 422-8634

Primary Health Plan: _____

Secondary Health Plan: _____

Guarantor: MCDUFFIE, TIMOTHY
2442 WASHINGTON ST, COLUMBIA, SC 29204

Phone: (803) 476-5702

Order Requisition(s): Requests (Consults / Referrals)

Order/Test: Referral

Requested Date/Time:	11/28/2014 10:55
Referred to Specialty:	Orthopedics
Referred To Provider:	Workman's Compensation's choice
Reason for Referral:	Persistent low back, left thigh, and left knee pain approximately 2 months post injury.
Priority:	Soon
Additional Instructions:	Please refer him as soon as possible. This has already been authorized by Kelly Wells case manager. If any questions please call her at 446-6379
Original Order Date/Time:	11/28/2014 10:55
Order Status:	Ordered
Order ID:	1150189137
Diagnoses: 1 - 959.7	Left leg injury
2 - 959.19	Lower back injury
3 - 844.9	Left knee sprain

Electronically signed by Stewart Young MD on 11/28/2014 10:55 (Ordering Provider)
NPI: 1932166329

- Moore Ortho. -

Schedule Appt Date/Time & Location: _____

Comments: _____

12-01-14:09:51AM;

3/ 8

1464

MCDUFFIE, TIMOTHY (id #115597, dob: [REDACTED])

 MOORE CENTER
FOR ORTHOPEDICS

114 Gateway Corporate Blvd
Columbia, SC 29203-9785
Phone: (803) 227-8000, Fax: (803) 227-8015

FOOT AND ANKLE

W. Bret Smith, D.O., M.S.
Ryan M. Putnam, M.D.

PEDIATRICS

Mark D. Looka, M.D.
Christopher R. Hydam, M.D.
Michael P. Horan, M.D., M.S.

SPINE

William T. Feinly, M.D.
Michael W. Peede, M.D.
W. Alarie Van Dam, M.D.
John Clavett, M.D.
Jacquelyn F. Van Dam, M.D.

SPORTS MEDICINE

S. Wendell Holmes Jr., M.D.
Frank K. Noojin III, M.S.
Mickey F. Plymale, M.D.
David A. Scott, M.D.

JOINT REPLACEMENT

Kim J. Chilling, M.D.
Bradley P. Presnell, M.D.
Jeffrey S. Hopkins, M.D.

UPPER EXTREMITY

Earl B. McFadden Jr., M.D.
David B. Fulton, M.D.

REPORT OF MEDICAL EXAMINATION

Timothy McDuffie

Employee's Name

[REDACTED]
Social Security Number

SEDGWICK

Employer/Carrier

12/17/2014

Date of Office Visit

RETURN TO WORK STATUS:

_____ Regular Duties

☒ Light Duties

_____ Remain Out of Work

_____ Date to Return

_____ Date to Return

_____ Duration

PHYSICAL LIMITATIONS:

_____ None

_____ No Walking or climbing

_____ No standing

_____ No prolonged standing

_____ No sitting

☒ No bending or stooping

_____ No twisting or stretching

_____ No change from previous status

_____ Pushing and pulling limit _____ lbs.

☒ Lifting and carrying limit 20 lbs.

_____ Sedentary duties only

_____ No kneeling, squatting, crawling

_____ No work involving _____ arm/hand

_____ No overhead work

_____ No work at heights

_____ Other: _____

FOLLOW UP:

_____ Days

_____ Discharged with limitations above

MCDUFFIE, TIMOTHY (id #115597, dob: [REDACTED])

2 Weeks

 Months

 PRN

Next Appointment: 12/31/14 @ 3pm



Electronically Signed by: MICHAEL W. PEELLE, MD

MCDUFFIE, TIMOTHY (id #115597, dob: [REDACTED])

12/31/2014 15:14 NE-2P1CT

(FAX) 803-462-3312

P. 026/035

MCDUFFIE, TIMOTHY [REDACTED]



* 6183180w2585 E-Health/ix

MOORE CENTER FOR ORTHOPEDICS

Dr. Michael Poelle, MD
14 Medical Park, Suite 200, Columbia, SC 29205
104 Saluda Pointe Drive, Lexington, SC 29072
(803) 227-8125

Primary Care Physician: _____

Please let us know how you are doing.

1. Overall, how are you feeling: ☐ Better ☐ Worse ☒ Same
2. My back or neck is: ☐ Better ☐ Worse ☒ Same
3. My leg or arm is: ☐ Better ☐ Worse ☒ Same
4. My strength is: ☐ Better ☐ Worse ☒ Same
5. Have you had any new symptoms since your last visit? ☐ Yes ☒ No
If yes, please explain: _____
6. What treatments have you tried since your last visit?
☒ None ☐ Pain Medications ☐ Anti-Inflammatory ☐ Ice ☐ Traction
☐ Injections - If so, has it helped? ☐ Yes ☐ Yes, but only for a few minutes or hours ☐ No
☐ Physical Therapy - If so, has it helped? ☐ Yes ☒ No
7. New Medications since last visit: NO

My lower back pain is: (circle number)



My arm/leg pain is: (circle number)



My neck pain is: (circle number)



Patient Signature: [Signature]

Date: 12-31-14

MCDUFFIE, TIMOTHY (id #115597, dob: [REDACTED])

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



Physician's Statement

Claimant's Name: Timothy McDuffie
Physician's Name: Michael W. Proff, MD
Practice/Clinic: Moore Center for Orthopedics
Preparer's Name: _____
Phone: (803) 227-8125

Employer's Name: Johnson Food Services
Insurance Carrier: Scotgwick
SCWCC File No: _____

The undersigned physician has been authorized by the Employer/Carrier to treat this Claimant for his or her injury by accident pursuant to §§42-15-60, 42-1-172 or 42-11-10.

Date of Injury or Illness: 9/20/14

Date of first office visit: 12/17/14 Date of last visit: 12/31/14

Diagnosis or nature of injury or illness: lumber strain, sciatica

Body part(s) injured: lumber spine Body part(s) affected: lumber, left leg

Date of Maximum Medical Improvement: 12/31/14

Based on the AMA Guidelines, the claimant has sustained a 0 % medical impairment to lumber spine injured body part(s) and a _____ % medical impairment to other affected body part(s).

- ☒ The claimant is able to return to work without restriction.
☐ The claimant is able to return to work with the following restrictions:

☐ The claimant is unable to return to work at his or her current employment.

☐ Claimant possesses retained hardware causally related to this injury.

As of the date I last saw this patient, it is my professional medical opinion the claimant:

☒ will not need future medical care related to his or her work related injury or illness based on a reasonable degree of medical certainty (more likely than not).

☐ will need future medical care and treatment related to his or her work related injury or illness based on a reasonable degree of medical certainty (more likely than not) and that medical care and treatment including medication is as follows:

Treating Physician

12/31/14
Date

Moore Center for Orthopedics • 104 Saluda Pointe Drive, Lexington, SC 29072-7295

MCDUFFIE, TIMOTHY (id #115597, dob: [REDACTED])

Prescription Documents



MOORE CENTER FOR ORTHOPEDICS

Approved Prescription
Date Ordered: 12/31/2014

Pharmacy	Prescriber
CVS/PHARMACY #4399 2871 FOREST DRIVE COLUMBIA, SC 29204 Phone: (803) 252-8007 Fax: (803) 779-4107	Moore Orthopaedic Clinic 104 Saluda Pointe Drive Lexington, SC 29072-7295 Phone: (803) 227-8000 Fax: (803) 227-8015

Prescription Information

Medication	Ibuprofen 800 mg tablet
Quantity	120 (one hundred twenty) tablet(s)
SIG	Take 1 tablet(s) 3 times a day by oral route.
Refills Allowed	No Refills
DAW?	N
Note to Pharmacy	

Patient Information

Patient Name	MCDUFFIE, TIMOTHY
Sex - DOB - Age	[REDACTED] 37 YR
Address	2442 WASHINGTON STREET COLUMBIA, SC 29204
Phone	H: (803) 422-8634 W: (803) 782-1461 M: (803) 422-8634
Primary Insurance	SEDGWICK Policy Holder: JOHNSON FOOD SERVICES
Secondary Insurance	None recorded.

Dispense as Written	Substitutions Permitted
---------------------	-------------------------

MICHAEL W. PEELLE, MD

DEA# BP9589522

--

MCDUFFIE, TIMOTHY (Id #115597, dob: [REDACTED])

MOORE CENTER FOR ORTHOPEDICS

114 Gateway Corporate Blvd
Columbia, SC 29203-9785
Phone: (803) 227-8000, Fax: (803) 227-8015

FOOT AND ANKLE
W. Bret Smith, D.O., M.S.
Ryan M. Putnam, M.D.

PEDIATRICS
Mark D. Locke, M.D.
Christopher R. Hydom, M.D.
Michael P. Horan, M.D., M.S.

SPINE
William T. Feimly, M.D.
Michael W. Poole, M.D.
W. Alaric Van Dam, M.D.
John Clavet, M.D.
Jacquelyn F. Van Dam, M.D.

SPORTS MEDICINE
S. Wendell Holmes Jr., M.D.
Frank K. Noojin III, M.S.
Mickey F. Plymale, M.D.
David A. Scott, M.D.

JOINT REPLACEMENT
Kim J. Chitlag, M.D.
Bradley P. Presnal, M.D.
Jeffrey S. Hopkins, M.D.
UPPER EXTREMITY
Earl D. McFadden Jr., M.D.
David B. Fulton, M.D.

REPORT OF MEDICAL EXAMINATION

Timothy McDuffie

Employee's Name

Social Security Number

SEDGWICK

Employer/Carrier

12/31/2014

Date of Office Visit

RETURN TO WORK STATUS:

☒ Regular Duties

☐ 1/2/15 Date to Return

☐ Light Duties

☐ Date to Return

☐ Remain Out of Work

☐ Duration

PHYSICAL LIMITATIONS:

☐ None

☐ Pushing and pulling limit ____ lbs.

☐ No Walking or climbing

☐ Lifting and carrying limit ____ lbs.

☐ No standing

☐ Sedentary duties only

☐ No prolonged standing

☐ No kneeling, squatting, crawling

☐ No sitting

☐ No work involving ____ arm/hand

☐ No bending or stooping

☐ No overhead work

☐ No twisting or stretching

☐ No work at heights

☐ No change from previous status

☐ Other: _____

MCDUFFIE, TIMOTHY (id #115597, dob: [REDACTED])

FOLLOW UP:

____ Days

____ Weeks

____ Months

____ Discharged with limitations above

__X__ PRN

Next Appointment: _____

A handwritten signature in cursive script, appearing to read "M. Pelle".

Electronically Signed by: MICHAEL W. PELLE, MD

MOORE CENTER FOR ORTHOPEDICS

114 Gateway Corporate Blvd
Columbia, SC 29203-9785
Phone: (803) 227-8000, Fax: (803) 227-8015

FOOT AND ANKLE
W. Bret Smith, D.O., M.S.
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PEDIATRICS
Mark D. Locke, M.D.
Christopher R. Hydon, M.D.
Michael P. Horen, M.D., M.S.

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David B. Fulton, M.D.

REPORT OF MEDICAL EXAMINATION

Timothy McDuffie

Employee's Name

SEDGWICK

Employer/Carrier

Social Security Number

Date of Office Visit

RETURN TO WORK STATUS:

☒ Regular Duties
☐ Light Duties
☐ Remain Out of Work

1/2/15 Date to Return
Date to Return
Duration

PHYSICAL LIMITATIONS:

☐ None
☐ No Walking or climbing
☐ No standing
☐ No prolonged standing
☐ No sitting
☐ No bending or stooping
☐ No twisting or stretching
☐ No change from previous status

☐ Pushing and pulling limit ____ lbs.
☐ Lifting and carrying limit ____ lbs.
☐ Sedentary duties only
☐ No kneeling, squatting, crawling
☐ No work involving ____ arm/hand
☐ No overhead work
☐ No work at heights
☐ Other: _____

FOLLOW UP:

☐ Days
☐ Weeks
☐ Months

☐ Discharged with limitations above
☒ PRN
Next Appointment: _____



Electronically Signed by: MICHAEL W. PELLE, MD

Moore Center for Orthopedics

McDuffie, Timothy (ID: 115597), DOB: _____

Order Requisition

First Care

2406 Decker Blvd
Columbia, SC, 29206
Phone: (803) 736-2530 Fax: (803) 736-4830

Patient: MCDUFFIE, TIMOTHY

Birthdate: [REDACTED] Age: 36 Years Sex: Male Weight: 212.4 lb (11/28/14)
MRN: 654185 FIN: B2014112800122 Height: 74 in (11/28/14)
PCP: Jones FNP, Sandra
CMRN: 733041

Allergies: No known allergies

****Please note -- Allergy list may be incomplete****

Patient Home Address: 2442 WASHINGTON ST
COLUMBIA, SC 29204

Home Phone: (803) 476-5702
Work Phone: (803) 782-1461
Cell Phone: (803) 422-8634

Primary Health Plan: _____

Secondary Health Plan: _____

Guarantor: MCDUFFIE, TIMOTHY
2442 WASHINGTON ST, COLUMBIA, SC 29204

Phone: (803) 476-5702

Order Requisition(s): Requests (Consults / Referrals)

Order/Test: Referral

Requested Date/Time: 11/28/2014 10:55
Referred to Specialty: Orthopaedics
Referred To Provider: Workmen's Compensation's choice
Reason for Referral: Persistent low back, left thigh, and left knee pain approximately 2 months post injury.
Priority: Soon
Additional Instructions: Please refer him as soon as practicable.
Original Order Date/Time: 11/28/2014 10:55
Order Status: Ordered
Order ID: 1150289137
Diagnoses: 1 - 959.7 Left leg injury
2 - 959.19 Lower back injury
3 - 844.9 Left knee sprain

Electronically signed by Stewart Young MD on 11/28/2014 10:55 (Ordering Provider)
NPI: 1932166329

Schedule Appt Date/Time & Location: _____

Comments: _____

Physician's Discharge Summary

Name: TIMOTHY MCDUFFIE

DOB: [REDACTED]

MRN: B000248374

Visit Date: 09/23/14 09:07:00

FIN/Acct. Number: B1426600896

Current Date: 09/23/14 09:46:44

Address: 2442 WASHINGTON ST COLUMBIA SC 29204

Phone: (803)476-5702

Primary Care Provider:

Name: Jones FNP, Sandra G, PH10 CPOE NP/PA

Phone: 8032963244

Palmetto Health would like to thank you for allowing us to assist you with your healthcare needs. The following includes patient education materials and information regarding your injury/illness.

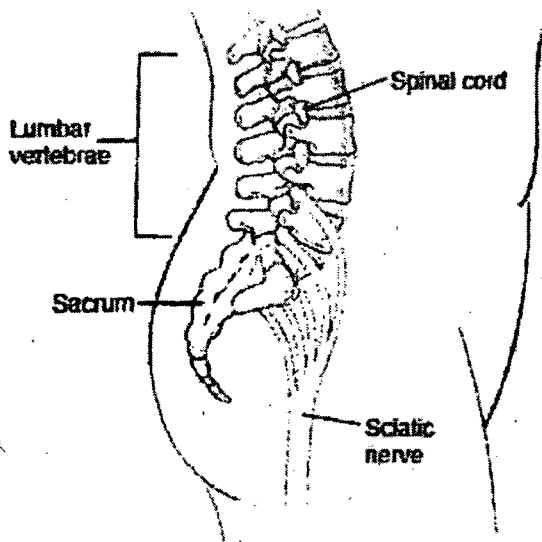
I understand that the emergency care which I received is not intended to be complete and definitive medical care and treatment. I acknowledge that I have been instructed to contact the above physician immediately for continued and complete medical diagnosis, care and treatment. EKG's, X-rays, and lab studies will be reviewed by appropriate specialists and I will be notified of significant discrepancies. I also understand that my signature authorizes this Medical Center to release all or and part of my medical record (including, if applicable, information pertaining to AIDS and/or HIV testing, mental health records, and drug and/or alcohol treatment) to the referred physician listed above.

Follow-Up Instructions

TIMOTHY MCDUFFIE has been given the following patient education materials:

Ortho

Sciatica



Sciatica ("Lumbar Radiculopathy") causes a pain that spreads from the lower back down into the buttock, hip and leg. Sometimes leg pain can occur without any back pain. Sciatica is due to irritation or pressure on a spinal nerve as it comes out of the spinal canal. This is most often due to a bulge or rupture of a nearby spinal disk (the cartilage cushion between each spinal bone), which presses on a nearby nerve. Other causes include spinal stenosis (narrowing of the spinal canal) and spasm of the piriform muscle (a muscle in the buttocks that the sciatic nerve passes through).

Sciatica may begin after a sudden twisting/bending force (such as in a car accident), or sometimes after a simple awkward movement. In either case, muscle spasm is commonly present and contributes to the pain.

The diagnosis of sciatica is made from the symptoms and physical exam. Unless you had a physical injury (such as a car accident or fall), X-rays are usually not ordered for the initial evaluation of sciatica because the nerves and disks cannot be seen on an x-ray. If signs of a compressed nerve are present (for example, loss of tendon reflex or strength in the leg), an MRI (magnetic resonance imaging) scan will need to be scheduled as an outpatient.

Most sciatica (80-90%) gets better with medicine, exercise, physical therapy. If symptoms continue after at least three months of medical treatment, surgery may be considered.

Home Care:

You may need to stay in bed the first few days. But, as soon as possible, begin sitting or

walking to avoid problems with prolonged bed rest.

When in bed, try to find a position of comfort. A firm mattress is best. Try lying flat on your back with pillows under your knees. You can also try lying on your side with your knees bent up towards your chest and a pillow between your knees.

Avoid prolonged sitting. This puts more stress on the lower back than standing or walking.

Some persons find relief with heat (hot shower, hot bath or heating pad) and massage, while others prefer cold packs (crushed or cubed ice in a plastic bag, wrapped in a towel). Try both and use the method that feels best for 20 minutes several times a day.

You may use acetaminophen (Tylenol) or ibuprofen (Motrin, Advil) to control pain, unless another pain medicine was prescribed. [**NOTE:** If you have chronic liver or kidney disease or ever had a stomach ulcer or GI bleeding, talk with your doctor before using these medicines.]

Be aware of safe lifting methods and do not lift anything over 15 pounds until all the pain is gone.

Follow Up

with your doctor or this facility if your symptoms do not start to improve after one week. Physical therapy or further testing may be needed.

[NOTE: If X-rays were taken, they will be reviewed by a radiologist. You will be notified of any new findings that may affect your care.]

Get Prompt Medical Attention

if any of the following occur:

- Pain becomes worse, not controlled by the prescribed medicine
- Weakness or numbness in one or both legs
- Numbness in the groin, genital area
- Loss of bowel or bladder control

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Prescriptions

TIMOTHY MCDUFFIE has been given the following prescriptions:
(cyclobenzaprine (Flexeril 10 mg oral tablet))

Patient Visit Summary

TIMOTHY MCDUFFIE has been given the following list of patient education materials, prescriptions and follow-up instructions:

Patient Education Materials:

Ortho

BACK PAIN w/ SCIATICA

Prescriptions:

cyclobenzaprine (Flexeril 10 mg oral tablet); 10 mg, by MOUTH, 3 times a day, , , 0,

Home Meds:

Follow-Up Instructions:

Read and follow instructions provided.

Take medications as directed.

Return to the ER for new or worse problems.

Follow Up With:

Follow Up with primary care
provider

Comments:

Where:

When:

Within 2 to 4 days

Follow Up With:

1801 Medicine Clinic

Comments:

Where:

1801 Sunset Drive
Columbia, SC 29203
(803) 434-4100 Business (1)

When:

Within 2 to 4 days



MEDcare
GET BETTER. FASTER.

Lab Results Form

Name

Module, Time: 154534

DOB: [REDACTED]

Time: 9/20/2014 2:53:32PM

Technician: [REDACTED]

Room # 1

Physician/PA Aehers

I Stat

AST/ALT

Siemens
Cinitel Status®

Serial Number: 218F12

Patient Name: T4L

Patient ID: 5166

Multistix® 10 SG
Test date: 09-20-2014

Time: 2:37PM

Operator: SC

Test number: 5000

Color: Yellow

Clarity: Clear

GLU Negative

BIL Negative

KET Negative

SG 1.025

BLO Negative

pH 7.0

PRO Negative

URO 1.0 E.U./dL

NIT Negative

LEU Negative

Biosite Meter

Flu	Pos	Neg
RSV	Pos	Neg
Strep	Pos	Neg
Mono	Pos	Neg
H. Pylori	Pos	Neg

Occult	Pos	Neg
UPT	Pos	Neg
BV	Pos	Neg
Trich	Pos	Neg

JOHNSON FOOD SERVICES, L.L.C.
P.O. BOX 10422
FORT JACKSON, SOUTH CAROLINA 29207

Memorandum For: Preston Wider III, Project Manager

Name: Ernest Roberts

Building # 11500

Subject: Incident, Damage or Loss Report

Property Description: employee tripped in kitchen area

Tag: _____

I. **INCIDENT:** Explain how and when the property was lost or incident:
employee tripped in the kitchen area

II. **DAMAGE:** Explain what damage occurred to property:
employee stated, that he feels a pain in his back and calf area

III. **PROPOSED ACTION:** Explain action to prevent re-occurrence:
take to medic care

IV. **FOLLOW-UP:** Explain follow-up action that was taken:
Ensure employees have on slip guards and ensure employees watch their step in kitchen area.



Manager Signature

11500
Building #

9/20/14
Date

Area Manager Signature

Date

Asst. Project Manager Signature

Date

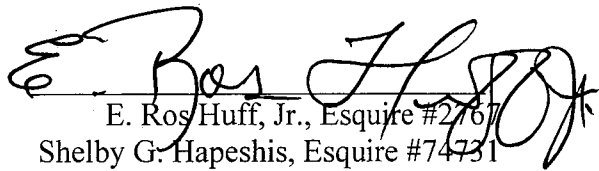
(See Reverse Side)

WE ARE AN EQUAL EMPLOYMENT OPPORTUNITY EMPLOYER M/F/V/H

Certificate of Counsel

The undersigned hereby certifies that the Record on Appeal contains all material proposed to be included by any of the parties and no other material.

July 13, 2017



E. Ros Huff, Jr., Esquire #2767

Shelby G. Hapeshis, Esquire #74731

HUFF & HAPESHIS, LLC

Post Office Box 1935

7244 Woodrow Street

Irmo, South Carolina 29063

(803) 252-2232 telephone

Attorneys for Johnson Food Services, LLC,
Employer, and Great American Alliance Insurance
Co./Strategic Comp., Carrier, Appellants.